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	14E095	A. BUILDING _____ B. WING _____	06/30/2011

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BATAVIA REHABILITATION & HEALTH CARE CENTER	**520 FABYAN PARKWAY BATAVIA, IL 60510**

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey An extended survey was conducted	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation record review and staff interview the facility failed to ensure that restraint are used to treat the medical symptoms, have a plan for reduction, and to use the least restrictive device for two of four residents R2 and R6 with restraints in a sample of 13. Example includes: R6 was observed on all days of the survey to be in use of a lap cushion restraint. R6 was noted on 6/8/11 in her room alone with a lap restraint on. R6 unable to state why she need the lap cushion and unable to release it her self. A review of the 2/28/11 physician orders state lap cushion restraint in wheel chair for positioning and to prevent sliding and falls related to Dementia ,Psychosis and Agitation A review of the 5/25/11 the Physical Restraint Eliminations assessments documents R6 to be a (26) a 21 -35 is a good candidate for restraint reductions. The 6/10/11 documentation recommends to continue usage	F 221		7/8/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 221	Continued From page 1 of lap buddy for positioning to maintain proper position. R2 was observed on 6/9/11 at 1:00pm in the living room sitting in a wheel chair with lap buddy in place and a pillow in between resident and the lap cushion. R2's family was visiting at this time, R2 was still slumped over with her neck and head leaning towards her chest. R2's family member said that they do not like this devise, and feel the reclining chair is more comfortable for R2 but that one of the family members thinks that R2 should be up and in the wheel chair.	F 221		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to actively seek residents preferences with regard to the shower schedule and time to get up in the morning. This applies to 2 residents in the sample of 13, R 4 and R11 and 1 resident in the supplemental sample R29 for showers, and 1 resident in the supplemental sample for get up time R36. Findings include:	F 242		7/8/11

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F 242	Continued From page 2 During the group interview on 6/9/11 at 10:30am residents stated that showers are given according to a schedule , most residents in the A bed get a shower during the nursing staff day shift, and most residents in the B bed get a shower during the afternoon shift. This is not necessarily according to their preferences. R4 told surveyor during an individual interview on 6/8/11, and in the group interview on 6/9/11 that she would like to get a shower every other day. The facility did an audit of all residents in the facility after this concern was brought to their attention on 6/9/11. This record identifies that residents are satisfied with the shower schedule times except two residents R29 and R11. A separate audit of residents who are scheduled to get up by the night shift was conducted after the group interview on 6/9/11. R 36 was identified as wanting to sleep later.	F 242		
F 252 SS=C	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to keep shower rooms which most residents use clean and safe. Findings include;	F 252		7/8/11

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F 252	Continued From page 3 Both showers rooms (100 and 200 wing) used by the residents have mildew growing in the tile grout and wall corners. The floor molding across the shower stalls floors to keep water in the shower area is worn, torn and missing. The molding base is exposed, leaving to long metal edges that are not easily cleaned and would be uncomfortable on bare feet. The 100 wing shower also has an unfurnished floor of rough concrete that is not easily cleaned. One of the shower stalls did not have a call light. Residents (R47, R4, R36, R37, R22 and R3) in the group interview on 6/9/11 at 10:30am expressed concerns about the physical condition and mold in the shower rooms.	F 252		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		7/8/11

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F 279	Continued From page 4 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: R12 has a criminal record and is identified as low risk. The facility did not have a care plan developed for R 12's criminal conviction. E1 presented an up dated care plan for R12 as of 6/09/11. 1..Based on observation record review and staff interview the facility failed to ensure that the therapeutic diet and fluid restriction is divided between nursing and dietary to ensure hydration and to prevent recurrent urinary tract infections for one of one resident R11 on a fluid restriction in the sample of 13 2. Based on observation, record review and staff interview the facility failed to develop a specific plan of care to address the maladaptive behaviors for one of one resident with behaviors R11 in the sample of 13 3. Failed to develope a care plan for 1 resident (R12) with a criminal background. Findings include: A review R11 on two days of the survey noted to have a water pitcher with three 4 oz glasses of a red substance at bed side. On 6/9/11 during lunch, R11 lunch tray was noted with coffee cups of water and juice A review of the tray card states, A regular diet. However, the diet list notes general , No added salt at table ,no concentrated sweets , 1000 cc fluid restrictions.	F 279		

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F 279	Continued From page 5 Interview with E1 and E2 the diet order was incorrect and was clarified with the physician. A review of the plan of care does not address the fluid restriction or how the facility has divided the fluid between the dietary and nursing. Interview with E2 and E1 was not aware of the fluid restrictions. R11 is identified with diagnosis of Dementia and is identified to by other residents as disruptive win activities ,loud and demanding in the dinning room , screams the 3/25/11 social service assessment indicates R11 has loud persona and demanding. The 4/5/11 is not specific to R11's behaviors and does not address how the facility has analyzed the behaviors to determine what R11 is trying to express. The facility does not show how the interventions are adjusted to decrease the behaviors. or address if the residents hearing has concerns in her interacting with staff and other residents. Interview with E4 (social services) as to how she was monitoring R11's behaviors on 6/9/11. E4 stated she has not analyzed the behaviors. R12 has a criminal record and is identified as low risk. The facility did not have a care plan developed for R 12's criminal conviction. E1 presented an up dated care plan for R12 as of 6/09/11.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		7/8/11

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F 309	Continued From page 6 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview & record review the facility failed to provide care & services to address & manage the back pain of one of 8 residents (R16). Evaluate & develop a comprehensive assessment of R 16 ' s existing back pain. Notify the doctor of R 16 ' s complaint of pain not relieved by medication prescribed. Develop an appropriate pain management plan and pain relieving strategies. Implement non pharmacological interventions for R 16. Findings include: R1 ' s sitting in her wheelchair poorly positioned in the small dining room on 06-09-11 at 10:55 AM. R 16 stated " I have severe pain in my back since last night, they gave me the pain medication at mid night but it didn ' t help. I think it ' s my wheelchair that ' s causing me the pain but they made this specially for me from the other nursing home. The nurses & the doctors are aware of my pain but they don ' t do anything. It comes & goes (the pain), I think it get worst with the weather like this (rainy). The medication that they ' re giving me doesn ' t help. I don ' t need regular pain medication, like I said the pain comes & goes, sometimes after I lay down & my back warms up, that helps. Maybe a warm compress will help. " On 06-09-11 at 11:10 AM, the CNA (E7) stated " she ' s (R16) alert & oriented, she can tell us what she wants, she got a colostomy, she ' s	F 309		

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F 309	Continued From page 7 doesn ' t use the bathroom, she can feed herself. Her complaint of pain is on & off sometimes she will say on her leg or sometimes her back. " R 16 ' s pain assessment dated 04-29-11 & 05-10-11 showed R 16 has no pain, she was scored " zeros. " R 1 physician order sheet for the month of June 2011 showed Hydrocodone/Acetaminopen (Vicodin) 5/500 tablet, take one by mouth every 6 hours (pain management) & an order of Acetaminophen 325 mg take 2 tablets (650 mg) by mouth every 8 hours as needed On 06-09-11 at 12:25 PM, E 5 (Nurse) stated " upon admission the admitting nurse will do the initial pain screening, it ' s 2 pages then proceed to pain assessment which was done quarterly. The MDS Coordinator will do that. In the medication administration book when the nurses give PRN medication then they fill out the pain flow sheet. R 16 is alert & oriented X3. There ' s an order for scheduled Hydrocodone/Acetaminopen (Vicodin) 5/500 tablet for her chronic back pain. " A comprehensive pain assessment has not been found in R 16 ' s clinical record & this was confirmed by E 5 on 06-09-11 at 12:25 PM. R 16 took Hydrocodone/Acetaminopen (Vicodin) 5/500 tablet one tablet at 11:00 AM on 06-09-11 as documented at pain management flow sheet, there were no documented location of pain, aggravating/precipitating factors identified & no non medical interventions (physical modalities such as heat, ice or massage) were offered. At 11:45 AM, R 1 took 2 tablets (650 mg) Acetaminophen (325 mg each). There were no documentations found in the clinical record that the facility staff notified the attending physician regarding R 16 ' s pain not relieved by the	F 309		

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F 309	Continued From page 8 medication prescribed. R 16 ' s has no individualized & specific plan of care to address R 16 ' s pain & this was confirmed by the Director of Nursing (E 2) on 06-19-11 at 11:20 AM.	F 309		
F 312 SS=D	F 314 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide one resident (R7), who was dependent upon staff to assist her with eating, appropriate and timely intervention/services to maintain good nutrition. This failure resulted in the resident experiencing a 20 pound weight loss R7 is a resident in a sample of 3 residents, who were identified as requiring help with activities of daily living (such as eating and grooming). Finding include: R7 was observed sitting at dining table on 6/09/2011, eating a mechanical soft diet. Two certified nurse aides were sitting beside R7. Both CNA's reported that R7 needed to be	F 312		7/8/11

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F 312	Continued From page 9	F 312		

reminded to pick up her fork and spoon to eat. One of the CNS's also reported that R7 sometimes pocket her food.
Surveyor also observed that R7 had yellow, brown, discolored and broken teeth, which did not ensure she could chew her food.

The dietary supervisor was interviewed on 6/09/2011. E9 told surveyor that R7 was assessed to pocket food in December of 2010. But, R7'd daughter did not agree with her being on a pureed diet. R7 was changed back to mechanical soft diet. E9 reported that R7 experienced a 20 pound weight loss between May and June of 2011. When asked if a second weight was obtained, E9 told surveyor that a second weight would be obtain 15th of the month. When asked about swallowing evaluation, E9 told surveyor one was not done yet for R7.

The nurse (E5) responsible for R7's care was interviewed on 6/09/2011 at 11:55 AM. When asked, E5 told surveyor that R7 was evaluated by the dentist awhile ago. E5 said that the dentist recommended that R7 get dentures, but the daughter did not want R7 to have dentures at the time. E5 stated, "We put her at the feeding table to monitor her."

The facility's director of social service (E4) was interviewed on 6/09/2011. E4 told surveyor that R7's daughter had not inform the facility what she wanted to do for R7's dental care. When asked, E4 could not tell surveyor how much dentures would cost for R7. or any efforts done by staff to obtain services to address R7's poor dental condition.

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F 312	Continued From page 10 Review of R4's dietary assessment, dated 6/06/2011, documented that R4 loss significant weight over the last 3 months. R7 went from 193 to 173 between May and June 2011. However, the dietary note did not document the assessment for the weight loss.	F 312		
F 314 SS=J	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview & record review the facility failed to: -Conduct a comprehensive assessment for the development of R 1's Stage IV pressure sore on the coccyx. -Prevent the worsening of R 1 ' s acquired (coccyx) pressure ulcer by not developing & implementing individualized interventions consistent with R 1 ' s needs. -Monitor the impact of the interventions & revised the plan of care as appropriate in order to improve & heal R 1 ' s existing acquired pressure ulcer. -Develop a specific repositioning plan when R 1 ' s up in chair.	F 314		7/8/11

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F 314	Continued From page 11 -Follow the plan of care to provide pressure relieving device on R 1 ' s wheelchair and evaluate a more appropriate assistive sitting device. -Train & educate nurses (E 6) on the correct identification of pressure ulcers stages. This is for one (R1) of two residents in the sample who acquired pressure sores in the facility. These failures contributed to the development and worsening of R 1 ' s avoidable stage IV pressure sore that was acquired in the facility An Immediate Jeopardy was identified on 6/28/11 at 12:05 pm. It began on 1/5/10. The Immediacy was removed on 6/30/11 at 8:00 AM. The facility remains out of compliance at a level 2 due to the need for the facility to assure implementation of removal plan. E1 (Administrator) was informed of the Immediate Jeopardy on 6/28/11 at 12:30 pm. Findings include: On 06-08-11 at 11:00 AM, R 1's sitting in a regular adult reclining chair in the dining room, poorly repositioned, sitting directly on her buttocks and without any pressure relieving device noted. R 1 is non verbal and totally dependent on facility staff with all of her activities of daily living. R 1 ' s Minimum Data Set dated 06-03-11 showed R 1 was admitted in the facility on 06-30-07, unable to make self neither understood nor able to understand others, cognitive skills for daily decision making- severely impaired. R1 ' s totally dependent on staff with two person assist on her functional status (bed mobility, transfer, eating & toilet use).	F 314		

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F 314	Continued From page 12 R 1's weekly wound tracking for the month of April 2010 showed two areas of pressure ulcer marked in bold letters Acquired these areas are in R 1 ' s sacrum & coccyx. On 04-06-10 the area in the coccyx was measured at 1.0cm X 0.5 cm X 1.0 cm - with no tunneling documented. On 06-08-11 the Director of Nursing (E2) presented a copy of the facility wound tracking report dated 06-01-11. The report showed the following: Acquired pressure ulcer - Stage IV - 0.8 cm (Length) X 0.2 cm (Width) X 1.7 cm (Depth) with 2.3 cm tunneling @3 0 ' clock - Status - improving Drainage- moderate The facility wound tracking report dated 06-07-11 showed a slight decreased on R 1 ' s wound size but increased size with the tunneling. The measurements are: 0.5 cm X 0.2 cm X 1.6 cm, with 3.0 cm tunneling at 3 0 ' clock. On 06-09-11 at 2:00 PM E 5 (Full time Nurse) confirmed that R 1 pressure ulcer on the coccyx was acquired in the facility. On 06-09-11 at 1:35 PM, the Registry Nurse (E 6) conducted wound assessment & dressing change to R 1. R 1 ' s wound progressed and increased in size. E 6 provided the following measurements: (L x W x D) 1.2 cm x 0.4 cm x 1.5 cm with 4.0 cm tunneling at 3 0 ' clock, a Stage IV. E 6 failed to identify the stage of R 1 ' s pressure ulcer correctly. E 6 stated " this is a Stage III, well I can ' t see what's in there, I think it's unstageable because there's tunneling. " E 6 stated she was provided an in service training about everything including pressure ulcer during orientation years ago. The facility administrative	F 314		

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F 314	Continued From page 13 Staff (Administrator, Director of Nursing & Corporate Nurse Consultant) failed to present in service training given to E 6 regarding pressure ulcer staging. There was no comprehensive assessment found in R 1 ' s clinical record to show the facility analyzed R 1's risk factors for developing pressure sores or to analyze factors for R 1's delayed wound healing and to indicate if the risk factors could be modified or removed. This finding was confirmed by the Director of Nursing & the Nurse Consultant meeting on 06-09-11. R 1 ' s 06-03- 11 Pressure Ulcer CAA (Care Area Assessment) reads: She (R1) scores a high risk for skin breakdown on the Braden Scale. She has a diagnosis of Alzheimer ' s & has poor cognition. She is incontinent of bowel & bladder, barrier cream is used is used PRN (as needed). She is dependent on staff for Activities of Daily Living, mobility, food intake. She is turned & repositioned by staff every 1-2 hours & PRN. She has a low air loss mattress on her bed. Skin checks are done daily ...She currently has 2 wounds ... R 1 ' s Resident Assessment Protocol sheets dated 07-01-09 reads: scores a high risk for skin breakdown on the Braden scale. She has an alternating pressure /low air loss mattress. She is turned & repositioned every 1-2 hours & PRN. Skin checks are done daily ... She currently has 2 wound ... The physician progress notes dated 08-04-10 reads as follows: She (R 1) is non verbal & does not have any meaningful ways of communicating ...she is unable to make her needs known. She is in the end stage of Alzheimer ' s, she is bedridden ...shearing forces are unavoidable when transferring the patient to a wheelchair to	F 314		

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F 314	Continued From page 14 bring her to the dining room. Shearing forces also occur if the patient has to slide on any surfaces to move her. The patient ' s dementia has also resulted in urinary & bowel incontinence causing maceration of the skin in the perineal & buttocks region. The presence of feces & urine also makes it difficult to treat existing ulcer due to possible contamination of the existing wounds. The patient is also mildly dehydrated at times... These concerns identified by the physician were not addressed in R 1 ' s care plan. R 1 ' s plan of care to apply pressure relieving device while in her wheelchair & to offer fluid during care was not followed on 06-08-11 & 06-09-11. There has no specific plan based on R 1 ' s needs in order to promote healing & prevent the wound from progressing. The surveyor confirmed the facility took the following actions to remove the immediacy of the situation: 1. Nursing management immediately completed a " full- house " skin audit to identify any new pressure areas or skin problems. 2. Contracted with the wound Medical Doctor to conduct weekly rounds for residents with compromised skin for assessment & additional treatment. 3. Random audits of residents with compromised skin will be conducted by the Director of Nursing &/or designee weekly for three residents times six weeks to ensure effectiveness of treatment. 4. Skin integrity & wound issues will be discussed with the Medical Director as part of the facility Quality Assurance process. 5. Director of Nursing will assess resident ' s with pressure ulcer using the avoidable	F 314		

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F 314	Continued From page 15 /unavoidable pressure ulcer assessment	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation record and interview the facility failed to ensure: 1. Residents are assessed for the type of incontinence for both bowel and bladder. Ensure voiding patterns are analyzed to determined specific treatment to prevent incontinence. Develop a plan of care and reevaluate intervention to assist residents to there highest level. And determine if the incontinence for bowel and bladder is avoidable or unavoidable. For 1 (R11) of 35 residents identified with bladder incontinence in a sample of 13 and 18 residents in a sample of 50 identified with bowel incontinence. Example includes: A review of the Residents Census and Condition	F 315		7/8/11

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F 315	Continued From page 16 report, the facility has identified 35 residents who are occasionally or frequently incontinent of bladder. No resident are on a specific bowel and bladder program. Interview with E1 (administrator) stated, the facility currently does not have a Certified Restorative Nurse in the facility to address the restorative issues. A review of R11's 4/6/11 initial minimal Data Set , the facility indicates there is a concern with urinary incontinence for R11. however, a Care Area Assessments (CAA) was not done to address incontinence. As verified with E 3(MDS). The MDS documents R11 to be frequently incontinence of urine and continent of bowel. A review of the 4/5/11 assessment for incontinence does not address specific interventions for R11's specific condition. The bladder assessment of 4/5/11 does not identify the type of incontinence R11 has or how the voiding patterns are analyzed to address R11's specific patterns. B. Based on interviews and record reviews, the facility failed to ensure that one resident (R4), who was at risk for urinary retention and infection, received the intermitten catheterization, and appropriate services to prevent urinary retention and infections. This failure did not ensure that R4 recieved the treatment and services she wanted, and not the services that was convenent for staff to give her. This was for one resident (R4) in a sample of 9 residents, who were identified as incontinent, which was part of a total sample of 13 residents. Findings include:	F 315		

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F 315	Continued From page 17 On 6/10/2011, surveyor observed R4 tell her primary physician that she wanted to be straight intermittenly catheterization as recommended by her urologist. R4 told her physician that the nursing staff informed her that they could not straight cath a resident in the facility. R4 and her physician talked about an indwelling catheter. But, R4 expressed concerns that an indwelling catheter may prevent her from enjoying being close to her boyfriend. R4 was seen by a urologist on 5/27/2011. R4's primary physician was interviewed on 6/10/2011. Z1 told surveyor that R4 has MS (Multiple Sclerosis) and was at risk for urinary retention and infection. Z1 described R4 frequently having urinary tract infections (UTI), and was becoming resistant to antibiotic treatment. Z1 said his choice for treating her at the facility would be to get a urine culture and insert an indwelling catheter into R4. However, Z1 told surveyor this would increase R4's risk for UTI's. E4, was the nursing working with R4. E4 was interviewed on 6/09/2011. When asked, E4 told surveyor that she was aware of R4's urologist's recommendation for straight cath 4 times a day. But, E4 told surveyor that the facility was not able to straight cath R4, because the facility was not a skill facility. E4 told surveyor not decision move R4 to a facility that could imtermittenly catheerize her. E4 also told surveyor R4's urologist had not been contacted to obtained the consultation report, which had the reccommendations. Later, on 6/10/2011, the facility staff obtained	F 315		

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F 315	Continued From page 18 R4's urologist consult with his treatment reccommendation. Review of R4's urology consultation, dated 5/27/2011, documented that: "R4 is a 38 year old female... has significant difficulty with inefficient bladder emptying, incontinence and recurrent infections. The bacteria causing the urinary tract infections are becoming increasingly resistant.... Her neurologist, downtown Chicago ...has recommended placement of suprapubic tube. The place where she is presently living, does not have skilled nursing facilities and therefore cannot manage a suprapubic catheter... Assessment: Multiple sclerosis, poor bladder emptying and recurrent urinary tract infections... Plan: Options were discussed with the patient (R4) and her mother... Patient and her mother seemed to prefer intermittent catheterization, but I am not sure that the rehab facility has enough personnel to perform this..." During the Daily Status Meeting with the administrative Staff on 6/09/2011, the survey team expressed concerns that R4 was not getting services/treatments to try to prevent/address her urinary retention and UTI"s. E2 and E1 told the survey team that straight cath was a skill care that they did not provide. However, E1 nor E2 identified assessments or other treatments given to R4 to ensure that R4 urinary retention was being addressed. R4 was reported to be getting antibiotics to prevent infections. But, Z1 and urologist identified R4 is getting more resisted to antibiotic therapy.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		7/8/11

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F 323	Continued From page 19 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to analyze the the multiple falls and reevaluate interventions of the plan of care to prevent the the recurrence of falls for one of one resident (R6) with falls in the sample of 13 example includes: R6 on all days of the survey noted with the use of a lap cushion restraints to be used for postioning. Record review of facility incidents from 1/20/11 thru 5/13/11 R6 is identified to have falls 2/18/11, unwitnessed where R6 was found face down on the floor with the wheel chair on top of her while in the TV room with lap buddy in place R6 sustained a quarter sized bump to the right side of the fore head. 2/26/11 R6 at 11:00a.m. R6 was found in the TV room sitting on her buttocks on the floor in front of the wheel chair the lapbuddy in place 3/2/11 8:40 am in living room. Staff heard a thump and observed resident on the floor. R6 sustain a bump to the right lateral side of the forehead with pinkish / light purple discoloration to the fore head	F 323		

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F 323	Continued From page 20 3/3/11 6:00a.m , R6 sitting in the wheel chair .report of incident documents R6 went under neath the safety device the lapbuddy and was scooting on the floor . A review of the plan of care dated 12/13/10 with update signatures for 3/2/11 and 5/28/11 list the same plan of care and interventions for falls. The plan of care does not show how the interview are specific to R6 and the use of the lap buddy. The plan does not address each of the falls or how the facility analyzed the wheel chair and restraint to ensure R6 was using the most appropriate devices that would not tip or that R6 could go under.	F 323		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation record review and staff interview the facility failed to ensure that therapeutic diets are followed as ordered for one of one resident (R11) with a therapeutic diet in the sample of 13 Finding include: R11 on two days of the survey noted to have a water pitcher with three 4 oz glasses of a red substance at bed side. On 6/9/11 during lunch, R11 lunch tray was noted with coffee cups of water and juice A review of the tray card states, A regular diet. However, the diet list notes general , No added salt at table ,no concentrated	F 367		7/8/11

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F 367	Continued From page 21 sweets , 1000 cc fluid restrictions. Interview with E1 and E2 the diet order was incorrect and was clarified with the physician. R11 has a diagnosis of Congestive Heart Failure	F 367		
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide an impervious pad for the garbage dumpster. Findings include; The garbage dumpster sits on the dirt about 30 feet from the kitchen door. Rodents can make burrows under the dumpster and climb into the dumpster to eat garbage. E1 was not aware the dumpster was on the dirt.	F 372		7/8/11
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.	F 412		7/8/11

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F 412	Continued From page 22	F 412		

This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure that one resident (R7), who has discolored and broken teeth, received the appropriate dental services, to maintain good oral hygiene. R7 is a resident in a sample of 13 residents.

Findings include:

On 6/08/2011 at 1:50 AM, surveyor observed R7 lying in bed. When engaging R7 in a verbal conversation, surveyor observed that R7's teeth were yellow, brown, discolored and broken.

The nurse (E5) responsible for R7's care was interviewed on 6/09/2011 at 11:55 AM. When asked, E5 told surveyor that R7 was evaluated by the dentist awhile ago. E5 said that the dentist recommended that R7 get dentures, but the daughter did not want R7 to have dentures at the time. E5 stated, "We put her at the feeding table to monitor her."

The facility's director of social service (E4) was interviewed on 6/09/2011. E4 told surveyor that R7's daughter had not inform the facility what she wanted to do for R7's dental care. When asked, E4 could not tell surveyor how much dentures would cost for R4. or any efforts done by staff to obtain services to address R4's poor dental condition.

During the Daily Status Meeting on 6/09/2011 with administrative staff (E1/administrator and

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F 412	Continued From page 23 E2/director of nursing), the survey team expressed concerns that R4 was not given appropriate help or assistance to get the dental services she needed. E1 provided the dental assessment of R4 dated 4/23/2010. R4 dental assessment documented that R4 was evaluated to need 2 crowns and lower partial dentures. E1 reported that the facility attempted to bill Medicaid for dentures in 2010. However, E1, E2, nor E4 presented any denial of payment from Medicaid for R4's dental services. Then E1 informed the survey team that a request for payment of services was sent to R4's public aide case worker on 4/23/2011. But, this did not support that the facility staff were ensuring that R4 get the dental services her condition required.	F 412		
F9999	. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)5) 300.1220b)2)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	F9999		

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F9999	Continued From page 24 each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24 hour, seven day a week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs	F9999		

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F9999	Continued From page 25 and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on observation, interview & record review the facility failed to: -Conduct a comprehensive assessment for the development of R1's Stage IV pressure sore on the coccyx. -Prevent the worsening of R1's acquired (coccyx) pressure ulcer by not developing and implementing individualized interventions consistent with R1's needs. -Monitor the impact of the interventions and revise the plan of care as appropriate in order to improve and heal R1's existing acquired pressure ulcer. -Develop a specific repositioning plan when R1 is up in chair. -Follow the plan of care to provide pressure relieving device on R1's wheelchair and evaluate a more appropriate assistive sitting device.	F9999		

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F9999	Continued From page 26 -Train and educate nurses (E 6) on the correct identification of pressure ulcers stages. This is for one (R1) of two residents in the sample who acquired pressure sores in the facility. These failures contributed to the development and worsening of R 1's avoidable stage IV pressure sore that was acquired in the facility Findings include: On 06-08-11 at 11:00 AM, R1 was observed sitting in a regular adult reclining chair in the dining room, poorly repositioned, sitting directly on her buttocks and without any pressure relieving device noted. R 1 is non verbal and totally dependent on facility staff with all of her activities of daily living. R 1's Minimum Data Set dated 06-03-11 showed R 1 was admitted in the facility on 06-30-11, unable to make self neither understood nor able to understand others, cognitive skills for daily decision making- severely impaired. R1 ' s totally dependent on staff with two person assist on her functional status (bed mobility, transfer, eating & toilet use). R 1's weekly wound tracking for the month of April 2010 showed two areas of pressure ulcer marked in bold letters "Acquired." These areas were in R 1's sacrum and coccyx. On 04-06-10 the area in the coccyx was measured at 1.0cm X 0.5 cm X 1.0 cm - with no tunneling documented. On 06-08-11 the Director of Nursing (E2) presented a copy of the facility wound tracking report dated 06-01-11. The report showed the following:	F9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATAVIA REHABILITATION & HEALTH CARE CENTER	520 FABYAN PARKWAY BATAVIA, IL 60510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 27 Acquired pressure ulcer - Stage IV - 0.8 cm (Length) X 0.2 cm (Width) X 1.7 cm (Depth) with 2.3 cm tunneling @3 0 ' clock - Status - improving Drainage- moderate The facility wound tracking report dated 06-07-11 showed a slight decrease in R 1's wound size but increased size in the tunneling. The measurements are: 0.5 cm X 0.2 cm X 1.6 cm, with 3.0 cm tunneling at 3 0'clock. On 06-09-11 at 2:00 PM E 5 (Full time Nurse) confirmed that R 1's pressure ulcer on the coccyx was acquired in the facility. On 06-09-11 at 1:35 PM, the Registry Nurse (E6) conducted wound assessment and dressing change to R 1. R 1's wound progressed and increased in size. E 6 provided the following measurements: (L x W x D) 1.2 cm x 0.4 cm x 1.5 cm with 4.0 cm tunneling at 3 0'clock, a Stage IV. E 6 failed to identify the stage of R1's pressure ulcer correctly. E 6 stated, "this is a Stage III, well I can't see what's in there, I think it's unstageable because there's tunneling." E 6 stated she was provided an inservice training about everything including pressure ulcer during orientation years ago. The facility administrative staff (Administrator, Director of Nursing & Corporate Nurse Consultant) failed to present inservice training given to E 6 regarding pressure ulcer staging. There was no comprehensive assessment found in R1's clinical record to show the facility analyzed R1's risk factors for developing pressure sores or to analyze factors for R1's delayed wound healing and to indicate if the risk	F9999		

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F9999	Continued From page 28	F9999		

factors could be modified or removed. This finding was confirmed by the Director of Nursing and the Nurse Consultant meeting on 06-09-11.
R1's 06-03- 11 Pressure Ulcer CAA (Care Area Assessment) reads: "She (R1) scores a high risk for skin breakdown on the Braden Scale. She has a diagnosis of Alzheimer's & has poor cognition. She is incontinent of bowel & bladder, barrier cream is used is used PRN (as needed). She is dependent on staff for Activities of Daily Living, mobility, food intake. She is turned & repositioned by staff every 1-2 hours & PRN. She has a low air loss mattress on her bed. Skin checks are done daily ...She currently has 2 wounds ..." R1's Resident Assessment Protocol sheets dated 07-01-09 reads: "scores a high risk for skin breakdown on the Braden scale. She has an alternating pressure /low air loss mattress. She is turned & repositioned every 1-2 hours & PRN. Skin checks are done daily ... She currently has 2 wound ..."
The physician progress notes dated 08-04-10 read as follows: "She (R1) is non verbal & does not have any meaningful ways of communicating ...she is unable to make her needs known. She is in the end stage of Alzheimer's, she is bedridden ...shearing forces are unavoidable when transferring the patient to a wheelchair to bring her to the dining room. Shearing forces also occur if the patient has to slide on any surfaces to move her. The patient's dementia has also resulted in urinary & bowel incontinence causing maceration of the skin in the perineal & buttocks region. The presence of feces & urine also makes it difficult to treat existing ulcer due to possible contamination of the existing wounds. The patient is also mildly dehydrated at times..."
These concerns identified by the physician were

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F9999	Continued From page 29 not addressed in R 1's care plan. R1's plan of care to apply pressure relieving device while in her wheelchair & to offer fluid during care was not followed on 06-08-11 and 06-09-11. There was no specific plan based on R1's needs in order to promote healing and prevent the wound from progressing. (A)	F9999		