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	145969	A. BUILDING _____ B. WING _____	C 09/16/2011

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BERKSHIRE NURSING & REHAB CENTER	**8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130**

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F 000	INITIAL COMMENTS Complaint Investigation #'s 1191542/ IL52998- F312 1191687/ IL53149 - F312 1192078/ IL53616 - F328 1192470/ IL54081- F333 1192471/ IL54085 - F312, F314, F318 1192513/ IL54133- F 226 1192772/ IL54428 - F312, F318	F 000		
F 226 SS=G	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on closed record review and interviews, the facility failed to follow its Abuse Prevention Program policy and conduct a thorough investigation for an incident of injury of unknown origin for 1 of 1 residents (R11) reviewed for injuries of unknown origin in a sample of 14. R11 sustained a Left Proximal Tibia and Fibula Fracture that was not found for days even though were aware an incident had occurred. Findings include: During a phone interview with Z2, family Member, on 9/9/11 at 8:50am, Z2 stated R11 informed her that on 8/1/11 R11 was sitting in a wheel chair in the activity room with her left leg around the leg of the table when a staff member pulled the	F 226		10/6/11

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

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wheelchair backward causing injury to R11 ' s leg. Z2 stated that R11 informed the staff that her leg was caught in the table and told staff " you are breaking my leg. " Z2 went on to say that R11 suffered a fractured left leg.

R11 is a 91 year old resident whose Minimum Data Set (MDS) dated 5/27/11 shows diagnoses that include Alzheimer ' s disease and Dementia. The MDS describes R11 as having no alterations in speech and hearing and is usually understood. Nurses notes dated 6/22/11 describes R11 as alert with confusion, participates in activities and socializes with peers.
An Incident/Accident Notification report dated 8/1/11 with time of occurrence as 7:45am states Certified Nurses Aide (CNA) on duty observed swelling on resident's(R11) left leg, when she made her initial rounds and notified the nurse. Upon assessment by the nurse on duty, R11 was found with swelling below the left knee with reddish discoloration,warm to touch and with tenderness upon palpation.
R11 ' s nurses notes dated 8/1/11 at 4:18pm states observation of left lower extremity swelling, bluish, pain with movement, and resident sent out to hospital for evaluation.

E1 (Administrator) presented a Final Incident Investigation Report on 9/9/11 at 2:30pm completed by Z3 (former director of nursing), describing the discovery of the swollen leg by a certified nurses aide (CNA) occurring on 8/1/11 at 7:45am. The Report summarizes that R11 denied having an accident and denied inappropriate treatment, however, there was no investigative statement from R11. The Report also states that Z2 (family member) was interviewed and agreed

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that R11 would be able to recall if any incident had occurred. However, there was no statement from Z2.found. The Report also states that all nurses and CNA ' s that took care of R11 on 8/1/11 and several days prior were interviewed.

Only three staff interviews were done. E10, Certified Nurses Aide,stated on 09-09-2011 at 11:40am that she was a witness to the initial discovery of the injury but was not interviewed during the investigation. E10 also said that all the staff on the 4th floor where R11 resided knew what had happened. E10 stated that R11 ' s leg was injured on a Wednesday (7/27/11) when activity staff was transferring R11 from the activity room to the bed room, and that she, E10, could not understand why nothing was done about it immediately. E10 was not able to identify the activity staff. E10 stated that the injury was not reported to the nursing staff until 8/1/11. E10 recalls that on 8/1/11 she was assisting E13 (CNA) with turning of R11 who was in bed, when R11 cried out complaining of pain in the left leg. E10 stated that R11, who is usually up in her wheelchair participating in activities on the unit, remained in bed from the day of the injury to the day the injury was reported.
During a phone interview with Z3 on 9/10/11 at approximately 2:30pm, Z3 stated that she conducted the investigation. Z3 confirmed that she did not record the interview conducted with R11 nor Z2. Z3 also confirmed that the only staff interviewed were 2 CNA s and 1 nurse. Z3 was not aware that E10 was a witness to the discovery of the injury. Z3 was not aware that an injury had occurred to R11 while being transported by an activity staff on 7/27/11.
Z3 ' s investigation conclusion states " The

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F 226	Continued From page 3 allegation of abuse or neglect cannot be substantiated due to lack of evidence and factual information. " The policy titled "Abuse Prevention Program Facility Policy" states in part.....The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect, or abuse of our residents. This will be done by: -identifying occurrences and patterns of potential mistreatment; -implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively, and making the necessary changes to prevent future occurrences; and -filing accurate and timely investigative reports.	F 226		
F 312 SS=E	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, records reviews and interviews the facility failed provide incontinence care for 4 of 7 sampled residents (R2, R3 , R8 and R14) reviewed for incontinence care in a sample of 14 residents. R2, R3, R8 and R14 were assessed and identified by the facility as requiring extensive assistance with incontinence care to prevent further medical complications.	F 312		10/6/11

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F 312	Continued From page 4 Findings include: The initial tour was conducted on 09-06-2011 with E1 (Director of Nurses) and E3(Treatment Nurse) accompaning surveyor. 1. R3 was observed on 9-6-11 at 11:30AM lying in her bed telling the nursing staff that her behind is hurting. Further observations of R3, R3 was lying on a thick incontinence pad, wet from urine and both of her buttocks were excoriated and red. R3's admission records reads, R3 is an 86 year old female admitted to the facility on 5-2-06 with the diagnoses which includes cerebral vascular accident and stress incontinence. R3's care plan, revised on 4-19-11 and updated on 9-11-11 reads the following: "Altered urine pattern, incontinence" related to mobility deficit, neuromuscular impairment related to cerebral vascular accident." R3's Minimum Data Set (MDS) dated 6-07-11 reads extensive assistance and one person physical assist with toileting and personal hygiene. E1(Director of Nursing) stated on 9-6-11 at 11:30AM, that she would find out the last time R3 was toileted. 2. R2 was observed in her bed on 09-06-2011 with her oxygen tubing on the floor, R2 was lying on a incontinence pad and no undergarment. R2 was soiled with a moderated amount of feces and urine and had 2 open small wounds on her buttock and back of her thigh. R2 is only able to	F 312		

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F 312	Continued From page 5 answer simple questions. R2's admission records notes, R2 is an 87 year old female admitted to the facility on 12-31-08 with the diagnoses which includes osteoporosis, joint pain and rheumatica. R2's care plan dated 9-7-11 reads, "potential for complications related to incontinence relate to impaired cognitive, impaired mobility and memory deficits." R2 MDS dated 6-5-11 notes," extensive assistance and a two person physical assist with toileting and personal hygiene. E3 (Treatment Nurse) stated on 9-6-11 at 11:30AM, I was not aware of the other open wound on R2 and said nothing about R2 being soiled from feces and urine. E3 did not have knowledge of this resident's NEW open wound until she was questioned about the wound. No treatment was done , nor was the resident's physician called until then. 3. R8 was observed on 9-6-11 at 11:45AM in her room lying on an air mattress and thick incontinence pad. R8 was lying in a large amount of feces and urine. The incontinence pad had several dried brown urine rings around R8's buttocks. The room had a strong odor of urine. R8 was unable to request her needs or answer questions. R8 has healed tissue from a previous buttock wound. R8's admission records notes R8 is an 90 year old female admitted to the facility on 5-17-02 with	F 312		

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F 312	Continued From page 6 the diagnoses which includes contractures, constipation, dementia with delusions. R8's care plan revised on 4-25-11 and updated on 6-23-11 notes the following," altered urine pattern, total incontinence related to cognitive deficit, mobility deficit and neuromuscular impair." R8's MDS dated 6-1-11 reads the following,"total dependence with one person physical assist for toileting and personal hygiene. E3 stated on 9-6-11 at 12:30PM, " R8 has just healed from a stage II pressure sores and needs to be kept clean and dry to prevent the sacral pressure sore from re-opening. Review of R8's treatment notes dated 3-24-11 reads the following," R8's stage II pressure sores has resolved/healed." E4 (Certified Nurse's Aide) stated on 9-6-11 at 12:30PM, " how else are we to keep the bed/air mattress clean if we do not use an incontinence pad. We are not allowed to put any under garments on the residents while in bed at this facility." 4). R14 was observed on 9-16-11 at 10:15AM in bed in his room. R14 is alert and oriented. R14 had protective boots on his feet, able to move his upper extremities not not able to move his lower extremities without extensive assistance. R14 has a healed pressure sore scars on both os his buttocks. R14 told surveyor," he defecate in the bed and then lay in it until someone came to help him. R14 told surveyor that he does not like to wait such a long time before someone can help	F 312		

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F 312	Continued From page 7 him. It must be that the facility does not have enough staff." E2(Administrator) stated on 9-16-11 at 11:15AM," she was aware of R14 defecating in his bed and immediately instructed the staff. E2 stated she did not write up anyone in particular or even have a written in-service she just spoke to the staff." R14's is a 55 year old male admitted to the facility on 8-30-11 with the diagnoses which includes cardiac dysrhythmias, atrial tachycardia, difficulty in walking, acute deep vein thrombus, foot drop, gouty arthritis and eyeball enucleation. Review of R14's care plan dated 9-5-11, does not mention assistance needed to use the bathroom. Review of the facility's incontinence policy called "Incontinency Care" notes the following: " The purpose is to prevent excoriation and skin breakdown, discomfort and maintain dignity. Incontinent residents will be checked periodically in accordance with the assessed incontinent episodes or every two hours and provide perineal and genital care after each episode. " E1 stated on 9-6-11 at 4:00PM in the conference room, " the incontinence policy needs to be implemented. E1 also stated that his is her first week as Director of Nursing."	F 312		
F 314 SS=G	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	F 314		10/6/11

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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, record review and interview the facility failed to implement care nd follow up on the prevention / care of pressure sores for 5 of 6 sampled residents (R1, R2, R3, R5 and R8) reviewed for pressure sores out of a sample of 14 residents.. R1, R2, R3, R5 and R8 acquired pressure sores in the facility (ranging from stage II to stage IV). There was also a delay in medical treatment and a delay in implementing preventive therapy to prevent the re-occurrence of these pressure sores.

Findings include:

The initial tour was conducted on 09-06-2011 with E1(Director of Nurses) and E3(Treatment Nurse) accompaning surveyor.

1. R1 was observed on 9-6-11 at 1:00PM in her room in her bed. R1 is alert and oriented. Observations of R1's pressures sores on her left hip and sacral areas were redden, small amount of drainage and muscle tissue. R1 lower extremities were contracted and she was unable to move.

R1's admission records reads, R1 is an 60 year old female admitted to the facility on 2-21-11 with

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the diagnoses of dehydration, sacral wounds, subarachnoid hemorrhage and rupture vertebral artery.

Review of R1's pressure sore treatment log dated 9-2-11 reads, R1 has a stage IV pressure sore on her sacral area an acquired excoriation on her left hip. The dated it was acquired in the facility is stated as 5-10-11. The size of the excoriated area is 3cm x 4.5cm x 1.1.

E3 (Treatment Nurse) stated," the left pressure sore started off as an excoriation a few months ago but then developed into a pressure sore." E3 had no comments as to why on the pressure sore log R1's left hip pressure sore is being continuously documented as excoriation instead of its existing status.

Nursing notes dated 5-17-11 reads, open area left buttock (ischium) size is 7.2cm x 4.0cm x .4cm. The pressure sore tissue is 40% slough, 50% necrotic tissue and 10% reddened yellow and black tissue. Scant serosanguinous and the surrounding tissue is reddened and excoriation. This wound is unstageable and worsening.

Review of the clinical records and the treatment log the first treatment of the left pressure sore was 5-17-11.

E1(Director of Nursing) on 9-8-11 at 3:30PM did an extensive review of the records and also stated," R1 initial treatment was on 5-17-11. E1 stated," there are no further indications in the records that R1's left hip pressure sore was medically treated prior to 50% necrotic tissues and 40% slough."

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F 314	Continued From page 10 Review of R1's Minium Data Set dated 2-21-11 (upon admission) notes R1 has one stage III pressures sores one her sacral area. E6 (MDS coordinator) stated on 9-8-11 at 12:30PM," she assess R1 and there was only one pressure sore on R1's body. E6 stated that R1 developed the second pressure sore later." Wound physician notes dates for 8-22-11 reads, R1 etiology of her left hip (ischium) wound is pressure. The stage of the pressure sores is a stage IV. The characteristic of R1's left hip pressure sores is: size, 3.5cm x 3.5cm x 1.3cm with drainage/exudate of serosanguinous. Wound physician notes dated 8-29-11 reads, etiology of her left hip is pressure. The stage is an IV, the size is 3cm x 4.5cm x 1.1cm with light drainage of serosanguinous. E1(Director of Nursing) stated on 9-8-11 at 4:00PM in the conference room, " R1 is being seen by a wound doctor but gave no response as to why 2 months later the wound doctor was notified instead of immediately after the wound was assess in May, 2011. E3(Treatment Nurse) stated on 9-8-11 at 1:00PM, R1 had another wound physician, we now have a different wound physician" E3 never obtained the previous wound physician's notes after several requests. Z1 (R1's Attending Physician) stated on 9-9-11 at 11:30AM, "R1 is a very difficult patient. Z1	F 314		

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stated, "I do not remember anyone from the facility telling him about R1's additional or second pressure sore, but R1 is currently being seen by a wound physician for care. Z1 gave no comments as to why the treatments were not done before it developed in a an unstageable pressure sore."

2. R2 was observed on 9-6-11 at 12:15PM in bed with her oxygen tubing on the floor. R2 was lying on a thick incontinence pad and had a plastic diaper on. Further observations of R2's, she had plastic diaper on and it was wet from urine. R2 had 2 open redden areas on her buttock and upper thigh.

E3 stated on 9-6-11 at 12:15PM,"she did not know that R2 had pressure sores, no one told her about it.

Review of R2's admission records reads R2 is an 77 year old female admitted to the facility on 12-31-08 with diagnoses of rheumatica, joint pain, paroxysmal stoke.

Review of R2's nursing notes dated 9-6-11 at 2:11PM reads, open area to sacrum and right posterior thigh. The size of both wounds are: .5 x .5 and reddened. R2's pressure sores are acquired in the facility with partial thickness loss of skin layers and they are both, a stage II pressure sores.

Physician orders dated 9-6-11 reads: clean with normal saline and apply hydrocolloid every 3 days until healed for both stage II's pressure sores.

3). R3 was observed in her room in her bed on

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9-6-11 at 12:30PM. R3 was complaining about her buttock hurting and being wet. R3 was observed with many redden open small areas on both buttocks.

E6(MDS coordinator) stated on 9-6-11 at 1:00PM stated," R3 is receiving ointment to prevent skin breakdown.

Review of sR3's treatment records for the month of September, 2011 reads, barrier cream/protective ointment three times a day or as needed. For the month of September the 3:00PM to 11:00PM and the 11:00PM to 7:00AM shifts documentation for the cream on the treatment log was blank.

4). R8 was observed on 9-6-11 at 12:15PM in her room lying on an air mattress. R8 was lying in feces and urine. The thick incontinence pad had several dried brown urine rings on it. R8 has healed tissue on both of her buttock. R8 is unable to speak and express her needs. R8

E3(Treatment Nurse) stated on 9-6-11 at 12:30PM, "R8 should be kept clean and dry to prevent the re-opening of her stage II buttocks pressure sores.

R8's admission records notes R8 is an 90 year old female admitted to the facility on 5-17-02 with the diagnoses which includes contractures, constipation, dementia with delusions.

Review of R8's treatment notes dated 3-24-11 reads the following," R8's stage II pressure sores has resolved/healed."

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(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
F 314	Continued From page 13 E4 (Certified Nurse's Aide) stated on 9-6-11 at 12:30PM, " how else are we to keep the bed/air mattress clean if we do not use an incontinence pad. We are not allowed to put any under garments on the residents while in bed at this facility." 5). R5 admission records notes the following," R5 is a 80 year old male admitted to the facility from 12-30-10 to 4-9-11. R12 had diagnoses which includes subdural hematoma, dementia, and hypernatremia." Physician orders dated 3-24-11 and 3-25-11 notes the following: ,"clean open areas with normal saline and apply triple antibiotic ointment with dressing daily or until it heals." Nursing notes dated 3-25-11 reads the following: lower right buttock 1.0cm x 1.5cm opening. Review of additional pressure sore treatment physician orders dated 3-29-11 reads: discontinue pervious orders. right lower buttock cleanse with normal saline then apply hydrocolloid every 3 days. Nursing notes dated 3-31-11 notes the size of R5's sacral pressure sore is: 3cm x 2.5cm x 1. Increased in size width and depth. Nursing notes dated 4-7-11 notes the size of R5's sacral pressure sore is: 3cm x 2.0cm x 1cm. Review of R5 treatment records (close record) notes R5 had no treatment records from 3-24-11 until 4-1-11.	F 314		

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F 314	Continued From page 14 E1 and E2 confirmed that the facility could not find any treatment records for R5 for the treatment of R5's sacral pressure sore for the month of March, 2011. The treatment records dated for April , 2011 notes R5 did not receive hydrocolloid every 3 days. The treatment was omitted for 4-3-11, given on 4-4-11 and that again on 4-6-11, on the second day. E1 and E2 had no comments as to why the records could not be found, Nor did they have any comments if R5 ever received the medical treatments for March, 2011 when there was an increase in size, width and depth of his sacral pressure sore.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide maintenance restorative care with a custom made orthotic brace to prevent further contractures and pain management for 2 of 3 sampled residents (R 1, R14) reviewed for contractures in a sample of 14 residents. R14 who has limited results because	F 318		10/6/11

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F 318	Continued From page 15	F 318		

of uncontrollable pain.

Findings include:

1. R1 was observed on 9-6-11 at 1:00PM in her room in her bed. R1 is alert and oriented. R1's lower extremities are contracted and she was unable to move them. Both lower extremities were bent at the knees and she complains of pain when someone moves her legs.

R1's admission records reads, R1 is an 60 year old female admitted to the facility on 2-21-11 with the diagnoses of dehydration, sacral wounds, subarachnoid hemorrhage, rupture vertebral artery.

Additional observations of R1 on 9-7-11 at 11:30AM , R1's custom made orthotic leg braces were in the cabinet under some of her clothing and belongings.

R1 has physician orders reads," Passive range of motion to both lower extremities daily as tolerated to bilateral knees for corrective orthosis to treat and prevent further knee flexion contracture. On in AM up to 8 hours as tolerated. 24 hours restorative nursing care. "

R1 stated on 9-7-11 at 11:30AM," I refuse to were the braces because they hurt and because I have lost so much weight recently."

R1's physical therapy notes dated 3-16-11 reads," patient has severe lower extremities contractures. R1 has not met her goals. Patient is discharged from skilled therapy and referred to restorative."

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F 318	Continued From page 16 E12 (Physical Therapist Aide) stated on 9-9-11 at 12:30PM, " the physical therapy department customized leg braces for R1. The braces purpose is to prevent further contractures. E12 also stated he was not aware that the braces hurt or cause pain R1. E12 stated that if he or the physical therapy department were aware of the pain R1 was experiencing they would have contracted nursing and R1's physician. Other disciplines should have been made aware so something could have been done. E12 explained that the pain R1 is experiencing is directly related to the pulling of the muscle to straight it out but R1 could not tolerate the therapy. R1's physician and nursing department needed to control the pain so R1 could tolerate the therapy. Z1 (R1's Attending Physician) stated on 9-9-11 at 11:30AM, "no one told me about the pain that was being caused by R1's brace. We could have control the pain. I do not particularly like the use of braces on patients but this is the therapy that was chosen by R1." E5 (Restorative Aide) stated on 9-9-11 at 12:15PM," we do restorative care on R1 daily but she does not or refuses to allow us to put the leg braces on her because she says it hurt. This has been going on for awhile and besides we do not have a rehab nurse in this facility to help us." E1(Director of Nursing) stated on 9-9-11 at 12:15PM, we will be hiring a rehab nurse next week. We have only been without a rehab nurse for a short period of time. E2(Administrator) stated on 9-9-11 at 1:00PM, "	F 318		

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F 318	Continued From page 17 we are hiring a rehab nurse next week." E1 had no comments as to the pain that R1 had been experiencing when wearing the leg braces, but stated the pain could have been controlled. 2. R14 was observed on 9-16-11 alert and oriented in his room in his bed. R14 stated," his back side hurt when he goes to physical therapy and he has told the staff." Admission records notes that R14's is a 55 year old male admitted to the facility on 8-30-11 with the diagnoses which includes cardiac dysrhythmias, atrial tachycardia, difficulty in walking, acute deep vein thrombus, foot drop, gouty arthritis and eyeball enucleation. Physician orders dated 9-01-11 reads as follows: physical therapy to evaluate and treat for 3 -4 weeks for neuro training, gait training and group treatment. E14 (Physical Therapist) stated on 9-16-11 at 10:30AM, "R14 has very bad pain when he is at physical therapy, this is why he his limited in therapy. E14 stated the facility knows about it." E1(Director of Nursing) stated on 9-16-11 at 11:15AM, "R14 receives pain medications and documentation show it on the medications administration. E2 had no comments as to if R14 was being assess for pain before or after physical therapy that limits his progress.	F 318		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive	F 328		10/6/11

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F 328	Continued From page 18 proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to monitor the administration of respiratory treatment for 2 of 5 sampled residents (R12, R13) reviewed for respiratory treatment administration in a sample of 14 residents.. Findings include: 1. R12 ' s Physician Order Sheet (POS) shows diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Morbid Obesity and Sleep Apnea. R12 ' s treatment orders include 1) Oxygen at 2.5 liters per minute into BIPAP machine at bedtime, EP (expiratory pressure) -16, IP (inspiratory pressure) -20 - patient may apply and remove; 2) Advair Diskus 250/50, inhale one puff by mouth twice daily (9am, 5pm), (rinse mouth after each use), may self administer; 3) Ventolin, two puffs by mouth every 6 hours as needed for wheezing (may self administer and keep at bedside); 4) Ventolin 0.083%, one vial per nebulizer every 6 hours as needed for SOB (shortness of breath), may self administer.	F 328		

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F 328	Continued From page 19 During medication administration observation with E11, Nurse, on 9/9/11 at 9:30am, R12 was in his room. There was an Oxygen condenser and a BIPAP machine at the bedside. E11 did not instruct R12 to take his scheduled dose of Advair Diskus. R12 told surveyor at 10am, that he keeps the Advair in a locked cabinet at his bedside and he administers it on his own. When asked by surveyor how often he uses the Advair, R12 stated he takes two puffs whenever he needs it. R12 went on to say that he applies the BIPAP machine on his own every night. Upon completion of the medication administration observation, R12 ' s Medication Administration Record (MAR) review shows the Advair signed off as given at 9am. E11 confirmed during interview that it is her signature. 2. On 9/9/11 at approximately 9am, there was a BIPAP machine at R13 ' s bedside. R13 was observed ambulating on the 4th floor with the assistance of a cane. R13 is alert, talkative and elicits appropriate responses when communicating with staff. R13 ' s Physician Order Sheet (POS) shows diagnoses which include Sleep Apnea and Coronary Artery Disease. R13 ' s treatment orders includes 1) BIPAP machine to be worn at bedtime and remove in the morning; 2) BIPAP auto device with a range of 4-25CM H2O (cubic millimeter of water). According to the POS, R12 is to be monitored for use of the BIPAP. At approximately 10am, R13 told surveyor that he does not receive his BIPAP treatment on a nightly basis because he does not know how to apply it himself and the nurses do not help him to put it on. R13 went on to say that he gets help	F 328		

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F 328	Continued From page 20 from the nurses every other night, and when he doesn ' t, he is not able to sleep well. R13 further stated that the certified nurses aide (CNA) do not put it on right. E11(licensed practical nurse-LPN) told surveyor on 9/9/11 at approximately 10:45am, that nurses are the only personnel authorized to administer BIPAP treatments because the equipment needs to be adjusted to the prescribed setting. E11 confirmed that R13 is unable to self-administer the BIPAP treatment.	F 328		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to administer medications that were ordered by a physician for the treatment of a chronic illness for 1 of 3 residents(R6) reviewed for medication in a sample of 14 residents . Findings include: Review of R 6' s' admission records reads, R6 is a 80 year old male admitted from 7-1-11 to 7-6-11 for a respite stay. R6 had the diagnoses which includes Parkinson, cerebral vascular accident and hypertension. R 6' s' medication administration records (MAR) notes the following: Sinemet (Antiparkinsonian medication) 10/100 mg one tab three times a day per gastrostomy	F 333		10/6/11

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F 333	Continued From page 21 tube. An error of omission on the following dates occurred. The 9:00AM doses 7-1-11, 7-4-11 and 7-5-11 The 1:00PM doses 7-1-11, 7-4-11, and 7-5-11 The 5:00PM doses 7-3-11 Folic Acid 1 mg per gastrostomy tube daily. An error of omission on the following dates occurred: 7-1-11, 7-4-11 and 7-5-11 Milk of Magnesium 1 tablespoon per gastrostomy tube every even date at 6:00PM. An error of omission on the following dates occurred. 7-4-11 Milk of Magnesium 2 tablespoon per gastrostomy tube every odd date at 6:00PM. An error of omission occurred on the following dates- 7-1-11 and 7-5-11. E1 (Director of Nursing) stated on 9-8-11 at 4:00PM in the conference room," if it was not documented as given then if was not done." E2(Administrator) stated on 9-8-11 at 4:00PM in the conference room, "I remember that family complaining about R6 not receiving medication, but we give respite residents medication from our house stock. There is such a confusion with respite residents about medications and care. We are no longer excepting respite residents currently."	F 333		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 22 LICENSURE VIOLATIONS 300,1210b) 300.1210d)5) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 each resident's comprehensive resident care plan. 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. d) Pursuant to subsection (a), 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. These Regulations were not met as evidenced	F9999		

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by:

Based on observation, record review and interview the facility failed to implement care nd follow up on the prevention / care of pressure sores for 5 of 6 sampled residents (R1, R2, R3, R5 and R8) reviewed for pressure sores out of a sample of 14 residents.. R1, R2, R3, R5 and R8 acquired pressure sores in the facility (ranging from stage II to stage IV). There was also a delay in medical treatment and a delay in implementing preventive therapy to prevent the re-occurrence of these pressure sores.

Findings include:

The initial tour was conducted on 9-6-11 with E1 (Director of Nurses) and E3 (Treatment Nurse) accompaning surveyor.

1. R1 was observed on 9-6-11 at 1:00PM in her room in her bed. R1 is alert and oriented. Observations of R1's pressures sores on her left hip and sacral areas were redden, small amount of drainage and muscle tissue. R1's lower extremities were contracted and she was unable to move.

R1's admission records reads, R1 is a 60 year old female admitted to the facility on 2-21-11 with the diagnoses of dehydration, sacral wounds, subarachnoid hemorrhage and ruptured vertebral artery.

Review of R1's pressure sore treatment log dated 9-2-11 reads, R1 has a stage IV pressure sore on her sacral area an acquired excoriation on her left hip. The date it was acquired in the facility is

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stated as 5-10-11. The size of the excoriated area is 3cm x 4.5cm x 1.1.

E3 (Treatment Nurse) stated, "the left pressure sore started off as an excoriation a few months ago but then developed into a pressure sore." E3 had no comments as to why on the pressure sore log R1's left hip pressure sore is being continuously documented as excoriation instead of its existing status.

Nursing notes dated 5-17-11 reads open area left buttock (ischium) size is 7.2cm x 4.0cm x .4cm. The pressure sore tissue is 40% slough, 50% necrotic tissue and 10% reddened yellow and black tissue. Scant serosanguinous and the surrounding tissue is reddened and excoriated. This wound is unstageable and worsening.

Review of the clinical records and the treatment log the first treatment of the left pressure sore was 5-17-11.

E1 (Director of Nursing), on 9-8-11 at 3:30PM, did an extensive review of the records and also stated," R1 initial treatment was on 5-17-11. E1 stated, "there are no further indications in the records that R1's left hip pressure sore was medically treated prior to 50% necrotic tissues and 40% slough."

Review of R1's Minium Data Set dated 2-21-11 (upon admission) notes R1 has one stage III pressures sore on her sacral area.

E6 (MDS coordinator) stated on 9-8-11 at 12:30PM, "she assessed R1 and there was only one pressure sore on R1's body. E6 stated that

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R1 developed the second pressure sore later."

Wound physician notes dates for 8-22-11 read, R1 etiology of her left hip (ischium) wound is pressure. The stage of the pressure sores is a stage IV. The characteristic of R1's left hip pressure sores is: size, 3.5cm x 3.5cm x 1.3cm with drainage/exudate of serosanguinous.

Wound physician notes dated 8-29-11 read, etiology of her left hip is pressure. The stage is an IV, the size is 3cm x 4.5cm x 1.1cm with light drainage of serosanguinous.

E1 (Director of Nursing) stated on 9-8-11 at 4:00PM in the conference room, "R1 is being seen by a wound doctor but gave no response as to why 2 months later the wound doctor was notified instead of immediately after the wound was assess in May, 2011.

E3 (Treatment Nurse) stated on 9-8-11 at 1:00PM, "R1 had another wound physician, we now have a different wound physician"

E3 never obtained the previous wound physician's notes after several requests.

Z1 (R1's Attending Physician) stated on 9-9-11 at 11:30AM that R1 is a very difficult patient. He did not remember anyone from the facility telling him about R1's additional or second pressure sore, but R1 is currently being seen by a wound physician for care. Z1 gave no comments as to why the treatments were not done before it developed into a an unstageable pressure sore."

2. R2 was observed on 9-6-11 at 12:15PM in bed

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with her oxygen tubing on the floor. R2 was lying on a thick incontinence pad and had a plastic diaper on which was wet from urine. R2 had 2 open reddened areas on her buttock and upper thigh.

E3 stated on 9-6-11 at 12:15PM she did not know that R2 had pressure sores, no one told her about it.

R2's admission records read R2 is a 77 year old female admitted to the facility on 12-31-08 with diagnoses of rheumatica, joint pain and paroxysmal stoke.

R2's nursing notes dated 9-6-11 at 2:11PM reads open area to sacrum and right posterior thigh. The size of both wounds are .5 x .5 and reddened. R2's pressure sores were acquired in the facility with partial thickness loss of skin layers and they are both, a stage II pressure sores.

Physician orders dated 9-6-11 read: clean with normal saline and apply hydrocolloid every 3 days until healed for both stage II's pressure sores.

3. R3 was observed in her room in her bed on 9-6-11 at 12:30PM. R3 was complaining about her buttock hurting and being wet. R3 was observed with many redden open small areas on both buttocks.

E6 (MDS coordinator) stated on 9-6-11 at 1:00PM, "R3 is receiving ointment to prevent skin breakdown."

Review of R3's treatment records for the month

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of September, 2011 reads, barrier cream/protective ointment three times a day or as needed. For the month of September the 3:00PM to 11:00PM and the 11:00PM to 7:00AM shift documentation for the cream on the treatment log was blank.

4. R8 was observed on 9-6-11 at 12:15PM in her room lying on an air mattress. R8 was lying in feces and urine. The thick incontinence pad had several dried brown urine rings on it. R8 has healed tissue on both of her buttocks. R8 is unable to speak and express her needs.

E3 (Treatment Nurse) stated on 9-6-11 at 12:30PM, "R8 should be kept clean and dry to prevent the re-opening of her stage II buttocks pressure sores."

R8's admission records notes R8 is a 90 year old female admitted to the facility on 5-17-02 with the diagnoses which include contractures, constipation and dementia with delusions.

R8's treatment notes dated 3-24-11 reads the following, "R8's stage II pressure sores has resolved/healed."

E4 (Certified Nurse's Aide) stated on 9-6-11 at 12:30PM, "how else are we to keep the bed/air mattress clean if we do not use an incontinence pad. We are not allowed to put any under garments on the residents while in bed at this facility."

5. R5's admission records note the following: "R5 is a 80 year old male admitted to the facility from 12-30-10 to 4-9-11. R12 had diagnoses which

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includes subdural hematoma, dementia, and hypernatremia."

Physician orders dated 3-24-11 and 3-25-11 note the following: "clean open areas with normal saline and apply triple antibiotic ointment with dressing daily or until it heals."

Nursing notes dated 3-25-11 read the following: lower right buttock 1.0cm x 1.5cm opening.

Additional pressure sore treatment physician orders dated 3-29-11 reads: "discontinue pervious orders. right lower buttock cleanse with normal saline then apply hydrocolloid every 3 days."

Nursing notes dated 3-31-11 note the size of R5's sacral pressure sore is: 3cm x 2.5cm x 1. Increased in size width and depth.

Nursing notes dated 4-7-11 notes the size of R5's sacral pressure sore is: 3cm x 2.0cm x 1cm.

Review of R5 treatment records (close record) notes R5 had no treatment records from 3-24-11 until 4-1-11.

E1 and E2 confirmed that the facility could not find any treatment records for R5 for the treatment of R5's sacral pressure sore for the month of March, 2011.

The treatment records dated for April, 2011 note R5 did not receive hydrocolloid every 3 days. The treatment was omitted for 4-3-11, given on 4-4-11 and then again on 4-6-11, on the second day.

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F9999	Continued From page 29 E1 and E2 had no comments as to why the records could not be found, nor did they have any comments if R5 ever received the medical treatments for March, 2011 when there was an increase in size, width and depth of his sacral pressure sore. (B) 300.610a) 300.1210b) 300.3240a) 300.3240b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest	F9999		

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practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. 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.

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)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

These Regulations were not met as evidenced by:

Based on closed record review and interviews, the facility failed to follow its Abuse Prevention Program policy and conduct a thorough investigation for an incident of injury of unknown origin for 1 of 1 residents (R11) reviewed for injuries of unknown origin in a sample of 14. R11 sustained a Left Proximal Tibia and Fibula Fracture that was not found for days even though staff were aware an incident had occurred.

Findings include:

During a phone interview with Z2, family Member, on 9/9/11 at 8:50am, Z2 stated R11 informed her that on 8/1/11 R11 was sitting in a wheelchair in the activity room with her left leg around the leg of

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the table when a staff member pulled the wheelchair backward causing injury to R11's leg. Z2 stated that R11 informed the staff that her leg was caught in the table and told staff "you are breaking my leg." Z2 went on to say that R11 suffered a fractured left leg.

R11 is a 91 year old resident whose Minimum Data Set (MDS) dated 5/27/11 shows diagnoses that include Alzheimer's disease and Dementia. The MDS describes R11 as having no alterations in speech and hearing and is usually understood. Nurses notes dated 6/22/11 describe R11 as alert with confusion, participates in activities and socializes with peers.

An Incident/Accident Notification report dated 8/1/11 with time of occurrence as 7:45am states Certified Nurses Aide (CNA) on duty observed swelling on resident's (R11) left leg when she made her initial rounds and notified the nurse. Upon assessment by the nurse on duty, R11 was found with swelling below the left knee with reddish discoloration, warm to touch and tenderness upon palpation.

R11's nurses notes dated 8/1/11 at 4:18pm state observation of left lower extremity swelling, bluish, pain with movement, and resident sent out to hospital for evaluation.

E1 (Administrator) presented a Final Incident Investigation Report on 9/9/11 at 2:30pm completed by Z3 (former director of nursing), describing the discovery of the swollen leg by a certified nurses aide (CNA) occurring on 8/1/11 at 7:45am. The Report summarizes that R11 denied having an accident and denied inappropriate

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treatment, however there was no investigative statement from R11. The Report also states that Z2 (family member) was interviewed and agreed that R11 would be able to recall if any incident had occurred. However, there was no statement from Z2.found. The Report also states that all nurses and CNA's that took care of R11 on 8/1/11 and several days prior were interviewed.

Only three staff interviews were done. E10 (Certified Nurses Aide) stated on 9/9/11 at 11:40am that she was a witness to the initial discovery of the injury but was not interviewed during the investigation. E10 also said that all the staff on the 4th floor where R11 resided knew what had happened. E10 stated that R11's leg was injured on a Wednesday (7/27/11) when activity staff was transferring R11 from the activity room to the bedroom, and that she, E10, could not understand why nothing was done about it immediately. E10 was not able to identify the activity staff. E10 stated that the injury was not reported to the nursing staff until 8/1/11. E10 recalls that on 8/1/11 she was assisting E13 (CNA) with turning of R11 who was in bed, when R11 cried out complaining of pain in the left leg. E10 stated that R11, who is usually up in her wheelchair participating in activities on the unit, remained in bed from the day of the injury to the day the injury was reported.

During a phone interview with Z3 on 9/10/11 at approximately 2:30pm, Z3 stated that she conducted the investigation. Z3 confirmed that she did not record the interview conducted with R11 nor Z2. Z3 also confirmed that the only staff interviewed were 2 CNA s and 1 nurse. Z3 was not aware that E10 was a witness to the

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F9999	Continued From page 33 discovery of the injury. Z3 was not aware that an injury had occurred to R11 while being transported by an activity staff on 7/27/11. Z3's investigation conclusion states, "The allegation of abuse or neglect cannot be substantiated due to lack of evidence and factual information." The policy titled, "Abuse Prevention Program Facility Policy," states in part.....The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect, or abuse of our residents. This will be done by: -identifying occurrences and patterns of potential mistreatment; -implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively, and making the necessary changes to prevent future occurrences; and -filing accurate and timely investigative reports. (B)	F9999		