STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145290	A. BUILDING ______ B. WING ______	C 11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	**727 NORTH 17TH STREET** **BELLEVILLE, IL 62226**

(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 000	INITIAL COMMENTS Complaint Investigation 1143049 (IL 54734) - No deficiencies 1142983 (IL 54657) - F224, F309, F314, F322 1142793 (IL 54453) - F157, F312, F325, F327 1143213 (IL 54910) - F157	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Continued From page 1
the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation, and interview, the facility failed to notify the Power of Attorney (POA) of a significant change in a resident's physical status, and subsequent hospitalization, and diet change for 2 of 7 residents (R4, R6) reviewed for significant changes in the sample of 7.

Findings include:

1. On 10/18/11 E3, Licensed Practical Nurse, (LPN) documented in R6's nursing notes 4:00 AM, that R6 was a trachea tube / ventilator dependent resident, and had vomited, had an elevated temperature and became lethargic. R6's physician was called at 4:10 AM, and orders were obtained for R6 to go to the local hospital Emergency Room for Evaluation. 911 was called for an ambulance at 4:18 AM, the EMT staff arrived at 4:24AM and took R6 to the hospital.

A note at 4:27 AM documents that E3 attempted to call R6's family members to inform them, and due to no answer, a message was left for the family. At 6:05 AM, E3 again attempted to call the family to notify them but was unable to reach them.

In an interview with E3 on 10/26/11 at 1:30 PM, she stated that when she could not reach the family, she left information with the day shift nurse to try and reach them. E3 stated that on 10/18/11 after R6 was sent to the hospital, the hospital staff did call to inform her that R6 had

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F 157	Continued From page 2 passed away, and the hospital was not able to reach the family. E3 stated she used, and had given the hospital the POA's phone number as listed on R6's Admission Record sheet. A review of R6's record documented on 5/07/10, Z1, POA of R6, had informed the facility that she had moved out of state, and had changed her number. Z1 had also left phone numbers of other family members to contact if the facility was unable to reach her for any reason. On 10/26/11 at 2:00 PM, E3 stated she was not aware of the letter from Z1, on R6's chart, had been attempting to contact the wrong number, and had given the wrong phone number to the hospital. On 10/28/11, at 11:00 AM, E1, Administrator, and E2, Director of Nursing, both stated that they had not been informed that R6's family was not able to be contacted after her transfer to the hospital. E1 and E2 were not aware that R6's contact information had not been updated on her Admission Sheet. E1 and E2 stated that staff should have immediately told them there was a problem, so that the family could have been properly informed of what was happening to R6. 2 The Annual Dietary Assessment dated 5/27/11 identifies R4 to be on a mechanical soft diet with double portions, supercereal every morning, whole milk all meals and snacks at bedtime (sandwich.) According to a Therapy Discharge Summary for Speech Therapy dated 8/19/11, R4 had a swallow evaluation completed with a diagnoses of Dysphagia given. R4's diet recommendation was pureed and following notification to the physician, R4's diet was changed to Pureed. Review of the nurses notes from 8/19/11 through 8/26/11 show no notification	F 157		

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F 157	Continued From page 3 to R4's POA. On 10/5/11 at 12:22pm, R4 was served a pureed diet for the lunch meal. On 10/7/11 at 11:35am, Z5, R4's POA stated she was not consulted or informed that R4's diet was being changed to a pureed diet.	F 157		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIAT N 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: A) Based on interview, observation and record review, the facility neglected to identify new pressure ulcers and or wounds and neglected to identify new pressure ulcers/wounds as ordered for 1 of 3 residents (R5) reviewed for pressure sores and/or wounds in the sample of 7. This neglect resulted in R5's developing pressure sores the facility was unaware of and having deteriorating sores they failed to identify, assess and treat. Findings include: According to nurses notes dated 9/26/11 at 2:30pm, R5 was sent to the emergency room after staff noted decreased alertness, increased blood sugars for 2 days and rapid progression of a sacral decubitus. Wound reports dated 9/26/11 indicate R5 was being seen by a wounds	F 224		

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F 224	Continued From page 4 specialist who identified 8 pressure sores. The facility's "Weekly Pressure Ulcer QI Log" dated 9/26/11 shows the facility identifying 6 pressure ulcers, not 8 as identified by the wound specialist that same day. The weekly pressure ulcer report dated 9/19/11 identifies that R5 had 3 areas. There is no indication until 9/26/11, that the facility identified decline in the wounds he was admitted with on 9/12/11. Treatment records from September 12 through the 26th, 2011, show treatments were documented as being done 9 of the 13 days, with an order for neosporin to R5's right medial ankle at bedtime documented as being done only 2 of 13 days. This is the time frame in which he developed additional wounds on his coccyx (7.5cm x 13cm), Right buttock (4 x 2.5), left hip (9x8cm) and left shin (1x1cm) according to the Weekly Pressure Sore Ulcer QI Log dated 9/26/11. Pictures and information obtained from the hospital, dated 9/26/11, indicate a wound consultant saw R5 due to numerous open areas on his skin. The areas were documented to include, "superficial blisters that have denuded revealing superficial pink open areas beneath on his right axilla, right lateral knee, right calf, left calf in several areas in addition to open sloughing areas on his right hip, coccyx that are very large, at leach 12-15cm each. The coccyx is butterfly shaped. The rt trochanter area is moist, sloughing and there is some purple discoloration around this. The left plantar foot has a pink, resolving area with scarring around it. The left heel has eschar that is coming off, removed. The rt (right) heel has some purple discoloration but intact skin at this time." The report continues to state that R5 "should be hospice and made	F 224		

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F 224	Continued From page 5 comfortable" with palliative wound care provided. The coccyx wound was identified as a Kennedy ulcer. Hospital photographs dated 9/26/11 show R5 to have an open area on his abdominal fold measuring 5cm long and 1/2 centimeters wide, fatty tissue/slough at the wound base, and an open sore at the urethra opening. According to an consultant report dated 9/27/11, R5 had sores on his rectum described as, "The rectum has water filled blistering all around and there is ulceration on the outside, extending up into the rectum that shows sloughing." None of these areas were evident in any facility documentation. According to facility admission records, R5 was readmitted to the facility on 10/5/11 and placed on Hospice services. On 10/7/11, R5's skin was checked with E21, Licensed Practical Nurse (LPN) at 10:54am. R5 had no dressings on his right hip sore, no dressing/treatment on his coccyx and his coccyx/buttocks wounds were actively bleeding. He had a hydrocolloid dressing on his right outer leg dated 10/5/11 The pads underneath him were soiled with bloody drainage and his lower extremities dressings were on but soiled with bloody drainage. None were dated. E21 looked through the bedclothes for the dressings but was unable to locate them. A Certified Nurses Aide (CNA), E13 stated she removed the dressings at 9:30am. Review of the Treatment Administration Record for (TAR) for November 2011, R5 had no treatments done to his pressure sores since his return from the hospital on 11/5/11 as it was blank with no initials documented. Review of the Physician Order Sheet, (POS) documented the treatments were ordered to be done at nightly and PRN (as needed).	F 224		

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F 224	Continued From page 6 On 11/1/11 at 12:30pm, E22 LPN stated she admitted R5 back into the facility on 10/5/11 and completed the TAR. E22 stated R5 returned from the hospital with no treatment orders. At that time E22 called and received orders for treatments. E2 stated she did the dressings the afternoon of 10/5/11 when she assessed R5's wounds but acknowledged that she didn't sign the TAR after completing them. E5 was asked why she didn't sign off the treatments and stated "sometimes she doesn't." On 11/1/11 at 11:55am, E4 LPN confirmed she worked on 10/6/11 and did not get R5's treatments done. E4 stated she "passed the information on to" the next nurse but did not document that R5's treatments were not done. This was confirmed in nurses notes written by E4 on 10/1/11. The first initials, on the TAR, for R5's treatments was on 10/7/11. On 10/28/11, a copy of R5's October 2011 TAR was obtained and noted to not only have the blanks for treatments done following his admission on 11/5/11 until 11/7/11, but to also have initials of treatments done on 10/3 and 10/4/11 when he was not in the facility. These initials were added after the first copy was obtained on 10/7/11. On 11/1/11, E2 Director of Nursing confirmed that documentation was a problem. E2 confirmed that treatments should be done as ordered by the physician and documented when done. E2 also stated that treatments not done should be initialed and circled. E2 confirmed that they have identified concerns with pressure ulcer treatment. In addition, Skilled Daily Nurses Notes for 9/23/11, 9/24/11, 9/25/11, 9/26/11, 10/5/11, 10/6/11 and 10/7/11 failed to identify any skin ulcers on R5. E2, E22, E4 and E19 were all	F 224		

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F 224	Continued From page 7 unable to explain why this assessment conflicts with weekly wound documentation and treatment records. B) Based on interview, observation and record review, the facility neglected to meet nutrition and hydration needs and neglected to revise the plan of care for 1 of 4 residents (R5) reviewed for tube feeding in a sample of 7. Findings include: The care plan dated 8/4/11 identifies R5 to require tube feedings with goals to meet his hydration needs and maintain his weight within 5% by next review on 11/4/11. Interventions indicate staff are to follow physician's orders for feedings/flushes, monitor and record Intakes and Outputs (I&O), monitor for signs of dehydration (skin turgor, mucous membranes, etc.), and position at 30 degrees minimum. The care plan does not reflect any weight loss although monthly weight records indicate R5 has had a substantial weight loss since his admission to the facility. R5's admission weight is recorded as 257.9 pounds on 5/5/11; his weight on 7/29/11 was 225.8; on 8/19/11, 245.7; and on 9/6/11, 226 pounds. E23, Registered Dietician's (RD), made a Note on admission in May 2011 that R5 had feedings set at 60cc/hr and flushes at 120cc every 4 hours. On 6/24/11, an RD note identified that his current flush rate did not meet his hydration needs and documented "wt (weight) (decreased), fluids do not meet needs but may not tolerate ^ (increase). Will suggest and monitor. Concur c (with) goal and plan." No changes were recommended. On 7/13/11, the	F 224		

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F 224	Continued From page 8	F 224		

RD assessment documents "6/28/11 flush ^ to 250cc q (every) 4 hours. Tube feeding the same." R5's weight is documented as 222.7 pounds. On 7/29/11, the RD again documents to increase R5's flushes to 250cc q 4 hours. R5 was not reviewed again by the RD until 8/4/11. At that time, no weekly weights were recorded and no additional interventions toward preventing further weight loss is noted or recommended by the nursing staff or the RD.

On 9/12/11, R5 was readmitted to the facility following a hospitalization for pneumonia. His tube feeding was ordered at 60cc/hour with 120cc flushes every 4 hours even though the RD has identified that 120cc every 4 hours does not meet his hydration needs previously. An RD note dated 9/14/11 reflects the TF at 60cc/hour with water flushes at 120cc every hours. The note states readmission weight "to be clarified." R5 did not have weekly weights done following his readmission. The next entry by the RD was not until 10/14/11.

Calculating intake for feedings at 60cc/hr, 12 hours shifts would be 720cc with 120cc flushes every 4 hours being 360cc per 12 hours shift. The I&O sheets for the feeding and flushes from 9/12/11 to 9/26/11 are inconsistently documented with many blanks. There is no intake documented on 9/12/11. On 9/13/11 for 7a-7p shift, 480cc is documented under "ORAL" even though R5 is NPO (nothing by mouth.) and 861cc for "OTHER." On 9/14/11, 240cc is documented for 3-11 shift, 491cc for feeding but has no documentation for the rest of the day. 9/15 has 240cc/flush for 7p to 7a, 570cc/feeding with 7a-7p 480cc and 936cc/feeding. On 9/16/11 7p-7a, R5 is recorded as only getting 240 cc flush and 580cc feeding with nothing recorded for 7a-7p

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F 224	Continued From page 9 shift. On 9/17/11, 7p-7a has 240cc recorded for flush and 500cc feeding, 7a-7p has 360cc recorded for flush and 702cc recorded for feeding. On 9/18/11, 7a-7p 408cc flush, 1330cc feeding and 7p-7a 240cc flush with 570cc feeding. From 9/19/11 through 9/25/11, documentation is absent for 6 of 15 shifts. According to nurses notes dated 9/26/11 at 2:30pm, R5 was sent to the emergency room after staff "noted decreased alertness, increased blood sugars for 2 days and rapid progression of a sacral decubitus." He was admitted with dehydration, sepsis and numerous pressure ulcers/wounds that included extreme excoriation and open wound surrounding the gastric tube (g-tube) insertion site. The facility did not have the G-tube site wound identified prior to discharge on 9/26/11. The care plan shows no revisions to R5's interventions toward fluid intake/dehydration and/or weight maintenance since 5/26/11 despite his continued weight loss. On 11/1/11 at 2pm, E15, LPN, stated she worked with R5 on 9/24, 9/25 and 9/26 on 7am to 7pm shift. E15 stated she didn't know why she didn't document R5's intake for 9/23/11 but cleared the pump and wrote the amount down. The ORAL intake is the section she documents the flushes in. E15 stated R5 had no vomiting and/or diarrhea in the days prior to his hospitalization. On 10/5/11, R5 was readmitted to the facility. His admission weight was recorded as 230.6 pounds although his weekly weight was recorded as 199.3. On 11/1/11, R5's weight was 196.4. On 10/7/11 at 10:52am, R5's Novasource 1000cc bag was hanging with 500cc left. The pump was running at 60cc/hour. The bag was	F 224		

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F 224	Continued From page 10 not labeled. R5's mouth was in need of oral care as he had white substance in the roof of his mouth with sores evident. Lips were dry and peeling. At 10:54am, E21, Licensed Practical Nurse (LPN) stated she did not know when the bag of Novasource was hung. R5's g-tube site was noted to have no open sores evident but dark brown crusted substance underneath it. E21 stated "It just needs to be cleaned." On 10/28/11 at 1:30pm, E23, RD stated she bases all her feedings on 23 hour infusion. E23 stated no weekly weights were done until his last hospitalization. E23 stated she will look at the intake sheets occasionally and last saw R5 on 10/14/11. R5 was readmitted on Novasource 60cc/hr and 250cc flush with med pass. The RD note dated 10/14/11 indicates R5's weights "fluctuate". On 10/12/11, an order to increase R5's flushes to 250cc with every med pass and every 4 hours was given. E23, RD, acknowledged on 10/28/11 at 1:30pm that the med passes would be every 4 hours so essentially, his flushes were not increased.	F 224		
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, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		

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F 309	Continued From page 11	F 309		

Based on interview, observation and record review, the facility failed to identify, assess and treat 3 open wounds for 1 of 3 residents (R5) reviewed for wounds in the sample of 7.

Findings include:

1. The Minimum Data Set (MDS) dated 9/26/11 identifies R5 to be totally dependent on staff for all activities of daily living (ADL's) and to have a gastrostomy tube, vent dependent, and urinary catheter. The MDS indicates R5 has severe cognitive impairment.

According to nurses notes dated 9/26/11 at 2:30pm, R5 was sent to the emergency room after staff noted decreased alertness, increased blood sugars for 2 days and rapid progression of a sacral decubitus. Wound reports dated 9/26/11 indicate R5 was being seen by a wound specialist who identified 8 pressure sores. The weekly wound reports from the facility dated 9/26/11 do not identify any wounds except the pressure ulcers identified by the wound specialist that day.

Hospital pictures dated 9/26/11, include an open area on R5's abdominal fold. The wound measured 5cm long and 1/2 centimeter wide, with fatty tissue/slough at the wound base. Hospital records also identify an open sore at the urethra opening. A consultant report dated 9/27/11 describes R5's sores on his rectum as "The rectum has water filled blistering all around and there is ulceration on the outside, extending up into the rectum that shows sloughing." The hospital records also indicate he had diarrhea since his admission.

According to facility admission records, R5 was readmitted to the facility on 10/5/11 and placed on Hospice services.

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F 309	Continued From page 12 On 11/1/11 at 3:45pm, Z4 Wound Specialist stated she treated R5's pressure sores on 9/26/11 and did not notice any open areas at the rectum, abdomen or penis but stated she does not do a head to toe exam but looks only at the areas already identified by the facility nurses. On 10/7/11 at 10:54am, R5's skin was checked with E21, Licensed Practical Nurse (LPN). R5 was observed to have no current open sores on his abdomen or penis but had a small open area to the right of his rectum. Recent healing was evident at both the penis and abdomen. On 11/1/11 at 2:50pm, E19, Registered Nurses (RN) stated she recalled sending R5 out to the hospital on 9/26/11. E19 stated she did not recall any treatments that R5 had and could not recall if he had any open sores outside of what the wound specialist had identified.	F 309		
F 312 SS=D	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 interview, observation and record review, the facility failed to provide timely/thorough incontinent care and hygiene for 2 of 5 residents (R2, R1) reviewed for incontinent care and hygiene in the sample of 7. Findings include:	F 312		

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F 312 | F 312

Continued From page 13

1. The Minimum Data Set, MDS, dated 8/3/11 identifies R2 to be totally dependent on staff for all activities of daily living including bathing and hygiene. The MDS indicates R2 is vent dependent, has a gastrostomy tube (g-tube). The Physician's Order (POS) Sheet for October 2011 indicates R2 has 2 pressure sores.
On 10/7/11 at 10:30am, R2 was in bed. He smelled strongly of urine and had dried urine on his top sheet. At 10:42, a skin check was done. R2 was laying on two incontinent pads that were saturated with urine and a brown ring of dried urine was evident on the edges. E24, Certified Nurses Aide (CNA) stated she "had just gotten to him" for morning care. R2's coccyx and right buttocks dressings were soaked with urine. During incontinent care E24 did not cleanse R2's hips, upper thighs, back or upper buttocks that were all in contact with urine. R2's fingernails and toenails were long.

2. According to the MDS dated 8/13/11, R1 is totally dependent on staff for all ADL's, including bathing and hygiene. The MDS indicates he is vent dependent and has a g-tube.
On 10/5/11 at 12:30pm, R1 was in need of oral care. His lips were dry and peeling. His fingernails were long.

F 314 SS=G | F 314

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

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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 interview, observation and record review, the facility failed to identify, monitor, and treat pressure ulcers for 1 of 3 residents (R5) reviewed for pressure sores in the sample of 7. This failure resulted in R5 having decline in his pressure sores and developing new pressure sores.

Findings include:

1. The Minimum Data Set (MDS) dated 9/26/11 identifies R5 to be totally dependent on staff for all activities of daily living (ADL's). The MDS also indicates R5 has a gastrostomy tube (g-tube) and is vent dependent., The MDS indicates R5 has severe cognitive impairment. According to Admission records, R5 returned from a hospitalization on 9/12/11 and had pressure ulcers identified on his left foot, right medial/lateral ankle and left heel on readmission. The care plan dated 5/12/11 identifies R5's risk of pressure ulcers with interventions indicating Certified Nurses Aides (CNA's) are to notify nurses immediately of any new areas of skin breakdown, redness, blisters. Lab reports dated 9/26/11 identify a high total protein, low albumin and Pre-albumin.

The Weekly Pressure Ulcer QI Log dated 9/19/11 is the first weekly wound report that has documentation of R5's wounds since his readmission on 9/12/11. The report identifies

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F 314	Continued From page 15 them as admission wounds: Left foot - stage II 3 x 4 cm and 0.3 depth; Left heel - unstageable measuring 6 x 7 cm; and Right ankle stage II 1 x 1cm 0.5 depth with small amount of drainage. The treatment sheets dated 9/12/11 reflect treatments for these wounds. The next weekly pressure ulcer QI log is dated 9/26/11 and identifies the three original sores from admission but an additional 3 areas including the coccyx which measured 7.5cm x 13cm; the left hip measuring 9x8cm; and right buttocks 4 x2.5cm which the facility has all identified as stage III. On 9/26/11, R5 was seen by a wound specialist who identified a total of 8 wounds. There was discrepancies between the facility's assessment of the wounds and the wound specialist. The facility's weekly documentation dated 9/26/11 describes R5's left heel as an unstageable stage III which the wound specialist identifies as "eschar". The facility identifies R5's coccyx wound as unstageable stage III. The wound specialist indicates it had black/yellow necrosis with serosanguinous exudate. Review of the nurses notes and/or Skilled Daily Nurses Notes for 9/23/11, 9/24/11, 9/25/11, 9/26/11, 10/5/11, 10/6/11 and 10/7/11 all fail to identify any skin ulcers on R5 at all and there is no indication the facility had identified the developing 13cm coccyx wound prior to 9/26/11. Treatment records from September 12 through 26, 2011 document treatments being done to the three original areas 9 of the 13 days with an order for neosporin to his right medial ankle at bedtime documented as being done 2 of 13 days. According to nurses notes dated 9/26/11 at 2:30pm, R5 was sent to the emergency room after staff "noted decreased alertness, increased	F 314		

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F 314	Continued From page 16 blood sugars for 2 days and rapid progression of a sacral decubitus." E19, Registered Nurse stated on 11/1/11 at 2:35pm that she discharged R5 to the hospital on 9/26/11. She could not recall R5 having any sores on discharge but did state if he had treatment orders, she would have done the treatments. E19 stated "sometimes you document if you don't get something done." Hospital records indicate R5 was admitted with dehydration and Sepsis along with numerous pressure ulcers. Hospital pictures/information obtained dated 9/26/11 indicate the Hospital wound consultant was requested to see R5 due to numerous open areas on his skin. The areas were documented as including "superficial blisters that have denuded revealing superficial pink open areas beneath on his right axilla, right lateral knee, right calf, left calf in several areas in addition to open sloughing areas on his right hip, coccyx that are very large, at leach 12-15cm each. The coccyx is butterfly shaped. The rt trochanter area is moist, sloughing and there is some purple discoloration around this. The left plantar foot has a pink, resolving area with scarring around it. The left heel has eschar that is coming off, removed. The rt (right) heel has some purple discoloration but intact skin at this time." The report continues to state that R5 "should be hospice and made comfortable" with palliative wound care provided. The coccyx wound was identified as a Kennedy ulcer. On 11/1/11 at 3:45pm, Z4 Wound Specialist stated she treated R5's pressure sores on 9/26/11. Z4 stated she does not do a head to toe exam but looks only at the areas already identified by the facility nurses. She was unsure as to why R5 would have more sores on	F 314		

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F 314	Continued From page 17 admission to the hospital that what she treated and was not sure as to why the facility's documentation would differ from hers. Z4 was also unsure as to why the facility would have documentation only on 6 areas. On 11/1/11 at 2pm, E15, LPN, stated she worked with R5 on 9/24, 9/25 and 9/26 on 7am to 7pm shift. E15 stated R5 only had areas on his buttocks, left heel and plantar area on his right ankle but nothing else in the days prior to his discharge. E21 states she always got her treatments done but is bad about documenting them. According to facility admission records, R5 was readmitted to the facility on 10/5/11 and placed on Hospice services. On 10/7/11 R5's skin was checked with E21, Licensed Practical Nurse (LPN) at 10:54am. R5 had no dressings on his right hip sore, no dressing/treatment on his coccyx or buttocks and his coccyx/buttocks wounds were actively bleeding. He had a hydrocolloid dressing on his right outer leg dated 10/5/11 The pads underneath him were soiled with bloody drainage and his lower extremities dressings were on and saturated through with bloody drainage. None were dated. E2 looked through the bedclothes for the dressings but was unable to locate them. E13, Certified Nurse Aid, (CNA) stated she removed the dressings at 9:30am. According to the treatment administration records (TAR) on 11/7/11 at 12:30pm, R5 had had no treatments documented as being done to his pressure sores since his return from the hospital on 11/5/11. The treatments were ordered to be done at nightly and PRN (as needed). On 11/1/11 at 12:30pm, E22 LPN stated she admitted R5 back into the facility on 10/5/11 and	F 314		

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F 314	Continued From page 18 completed the TAR. E2 stated she did the dressings the afternoon of 10/5/11 when she assessed R5's sores but acknowledged that she didn't sign the TAR as completing them. E5 was asked why she didn't sign off the treatments and stated "sometimes she doesn't." The treatments were not documented as being done by 7pm to 7am shift the evening of 10/5/11. On 11/1/11 at 11:55am, E4, LPN, confirmed she worked 7am to 7pm on 11/6/11 and did not get R5's treatments done. E4 stated she "passed the information on to" the next nurse but did not document that R5's treatments were not done. The first initials for R5's treatments to be done was on 11/7/11 following E21 when the skin observation was done at 10:54am even though it was ordered on "nights." On 10/28/11, another copy of R5's October 2011 TAR was obtained and noted to not only have blanks for treatments done following his admission on 11/5/11 to 10/7/11, but to also have initials of treatments filled in for 10/3 and 10/4/11 on nights when he was not even in the facility. These initials were added after the first copy was obtained on 10/7/11. Skilled Daily Nurses Notes for 10/5/11, 10/6/11 and 10/7/11 all fail to identify any skin ulcers on R7. E2, E22, E4 and E19 were all unable to explain why this assessment they completed conflicted with weekly wound documentation and treatment records. On 11/1/11, E2 Director of Nursing, DON, confirmed that documentation was a problem. E2 agreed that treatments should be done as ordered by the physician and documented when done. The facility's policy does not include frequency	F 314		

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F 314	Continued From page 19 of documentation of treatments. The policy does indicate wounds should have stages, location, size, appearance/wound bed, drainage, odor, inflammation, undermining/tunneling, skin report, treatments. 2. The MDS dated 8/3/11 identifies R2 to be totally dependent on staff for all ADL's.. The MDS indicates R2 is vent dependent, has a G-tube, and has a urinary catheter. According to the Weekly Pressure Ulcer QI Log dated 9/26/11, R2 is documented as having 2 sores facility acquired: Coccyx stage III 0.7cm x 0.3cm with no depth and right buttock stage III 2.5cm x 2.5cm, no depth. Treatment sheets for October 2011 show R5 is to have a dry dressing on his coccyx twice daily and right buttocks is to have Santyl and dry dressing done daily. Wound sheets also indicate R2 is to have weekly skin checks done. On 10/5/11 at 1:12pm, R2 was found to have no dressing on his pressure sores. There were no dressings in the bed sheets. The right buttock was circular with black/brown areas within the circumference of the wound bed and the outer edge was bloody and red with drainage present. In addition, he had two small areas to the left side of his rectum that were full skin thickness deep. R2 had two cloth incontinent pads under him over the air mattress. On 10/7/11 at 10:30am, R2 was in bed. He smelled strongly of urine and had dried urine on his top sheet. At 10:42, a skin check was done. R2 was laying on two pads that were saturated with urine and a brown ring of dried urine was evident on the edges. E24, CNA stated she "had just gotten to him" for morning care confirming that she had not turned/repositioned him since early morning. Both R2's coccyx and right buttock	F 314		

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dressings were soaked with urine. R2 had two cloth incontinent pads underneath him and nothing on his feet and/or in between his knees. Poor incontinent care was observed to be given with no cleansing to his hips, upper thighs, back or upper buttocks that were all in contact with urine.

According to wound sheets dated 10/10/11, R2's coccyx wound had healed but the right buttock sore had deteriorated and measured 3.0 x 2.7cm. On 10/18/11, the facility also received a physician order for a newly developed pressure ulcer R2's right hip. The care plan shows no revisions to the interventions for further preventative measures.

The facility's policy for Pressure Ulcer Care identifies a stage III ulcer as a "full thickness skin loss exposing subcutaneous tissue with distinct margins, presence of eschar or necrotic tissue is possible.
The last statement of the policy documents "The presence of eschar will immediately classify the pressure ulcer/wound as a stage IV. The policy also directs staff to apply medication and dressings as ordered by physician.

On 11/2/11 at 3pm, E2 Director of Nursing and E25, Corporate Nurse both stated eschar and/or necrotic tissue should be identified as "unstageable."

3. According to the POS for October 2011, R3 has diagnoses of tube feeder, Left basal ganglia hemorrhage and stroke. The POS indicates R3 has a g-tube and is vent dependent. The Weekly Pressure Ulcer QI reports dated 9/26/11 indicates R3 has wounds on his right foot and chest.

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F 314	Continued From page 21 On 10/5/11 at 1:20pm, R3 was in bed. He had a dressing on his foot and chest and had pressure ulcers on both knees. The right knee cap had a irregular shaped open area 1cm in circumference at the widest point through full skin thickness. The base was pinkish/grey with a large amount of slough. The outer edges were macerated. The appearance of the wound indicated it was not newly developed. The inner knee had a smaller open area that was scabbed over. It also was not a new wound. The policy for Pressure ulcer care directs staff to document stages, location, size, appearance/wound bed, drainage, odor, inflammation, undermining/tunneling, skin report, treatment and support surface.	F 314		
F 322 SS=G	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure adequate hydration through tube feedings and flushes for 3 of 4 residents (R1, R2, R5) reviewed for tube feedings in a sample of 7. This failure resulted in R5 being admitted to the hospital for dehydration	F 322		

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F 322	Continued From page 22 and Sepsis. Findings include: 1. The Minimum Data Set (MDS) dated 9/26/11 identifies R5 to be totally dependent on staff for all activities of daily living (ADL's). The MDS also indicates R5 has a gastrostomy tube, is vent dependent, and has a urinary catheter. The MDS indicates R5 has severe cognitive impairment. The care plan dated 8/4/11 identifies R5 requires tube feedings with goals to meet his hydration needs and maintain his weight within 5% by next review documented as being 11/4/11. Interventions indicate staff are to follow physician's orders for feedings/flushes, monitor and record Intakes and Outputs (I&O), monitor for signs of dehydration (skin turgor, mucous membranes, etc.), and position at 30 degrees minimum. The care plan does not reflect any weight loss. The weight record indicate R5 has had weight loss with his admission weight recorded as 257.9 pounds on 5/5/11; on 7/29/11 he weighed 225.8; on 8/19/11 he weighed 245.7; and on 9/6/11 he weighed 226 pounds. The Registered Dietician's (RD), E23, Note on admission had feedings set at 60cc/hr and flushes at 120cc every 4 hours. On 6/24/11, a dietary manager's note written by E3, Dietary Manager,documents "no dietary changes. TF (tube feeding)/flush order same." On 6/24/11, an RD note documented "wt (weight) (decreased), fluids do not meet needs but may not tolerate ^ (increase). Will suggest and monitor. Concur c (with) goal and plan." On 7/13/11, the RD assessment documents "6/28/11 flush ^ to 250cc q (every) 4 hours. Tube feeding the same." R5's weight is documented as 222.7 pounds. On	F 322		

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F 322	Continued From page 23 7/29/11, the RD again documents to increase R5's flushes to 250cc q 4 hours. R5 was not reviewed again by the RD until 8/4/11 and no weekly weights are recorded and no additional interventions toward preventing further weight loss is noted. On 9/12/11, R5 was readmitted to the facility following a hospitalization for pneumonia. His tube feeding was ordered at 60cc/hour with 120cc flushes. An RD note dated 9/14/11 reflects the tube feeding at 60cc/hour with water flushes at 120cc every hours. The note states readmission weight "to be clarified." R5 did not have weekly weights done following his readmission. The next entry by the RD is 10/14/11. Calculating intake for feedings at 60cc/hr, 12 hours shifts would be 720cc with flushes every 4 hours being 360cc per 12 hour shift. The I&O sheets for the feeding and flushes from 9/12/11 to 9/26/11 are inconsistently documented with many blanks. There is no intake documented on 9/12/11. On 9/13/11 for the 7a-7p shift, 480cc is documented under "ORAL" even though R5 is NPO (nothing by mouth.) and 861cc for "OTHER." On 9/14/11, 240cc is documented for 3-11 shift, 491cc for feeding but has no documentation for the rest of the day. 9/15 has 240cc/flush for 7p to 7a, 570cc/feeding with 7a-7p 480cc and 936cc/feeding. On 9/16/11 7p-7a, R5 is recorded as getting 240 cc flush and 580cc feeding with nothing recorded for 7a-7p shift. On 9/17/11, 7p-7a has 240cc recorded for flush and 500cc feeding, 7a-7p has 360cc recorded for flush and 702cc recorded for feeding. On 9/18/11, 7a-7p 408cc flush, 1330cc feeding and 7p-7a 240cc flush with 570cc feeding. From 9/19/11 through 9/25/11, documentation is absent for 6 of 15 shifts.	F 322		

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F 322	Continued From page 24 According to nurses notes dated 9/26/11 at 2:30pm, R5 was sent to the emergency room after staff "noted decreased alertness, increased blood sugars for 2 days and rapid progression of a sacral decubitus." He was admitted with dehydration, sepsis and numerous pressure ulcers/wounds that included extreme excoriation and open wound surrounding the gastric tube (g-tube) insertion site. The care plan shows no revisions to R5's interventions toward fluid intake/dehydration and/or weight maintenance since 5/26/11 despite his continued weight loss. On 11/1/11 at 2pm, E15, LPN, stated she worked with R5 on 9/24, 9/25 and 9/26 on 7am to 7pm shift. E15 stated she didn't know why she didn't document R5's intake for 9/23/11 but clears the pump and writes the amount down that is on the pump. The ORAL intake is the section she documents the flushes in. E15 stated R5 had no vomiting and/or diarrhea in the days prior to his hospitalization. On 10/5/11, R5 was readmitted to the facility. His admission weight was recorded as 230.6 pounds although his weekly weight was recorded as 199.3. On 11/1/11, R5's weight was 196.4. On 10/7/11 at 10:52am, R5's Novasource 1000cc bag was hanging with 500cc left. The pump was running at 60cc/hour. The bag was not labeled. R5's mouth was in need of oral care as he had white substance in the roof of his mouth with sores evident. Lips were dry and peeling. At 10:54am, E21, Licensed Practical Nurse (LPN) stated she did not know when the bag of Novasource was hung. R5's g-tube site was noted to have no open sores evident but dark brown crusted substance underneath it. E21 stated "It just needs to be cleaned."	F 322		

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F 322	Continued From page 25 On 10/28/11 at 1:30pm, E23, RD stated she bases all her feedings on 23 hour infusion. E23 stated no weekly weights were done until R2's last hospitalization. E23 stated she will look at the intake sheets occasionally and last saw R5 on 10/14/11. R5 was readmitted on Novasource 60cc/hr and 250cc flush with med pass. The RD note dated 10/14/11 indicates R5's weights "fluctuate". On 10/12/11, an order to increase R5's flushes to 250cc with every med pass and every 4 hours was given. E23, RD, acknowledged on 10/28/11 at 1:30pm that the med passes would be every 4 hours so essentially, his flushes were not increased. As of 11/2/11, R5's care plan had not been revised to reflect any changes since 5/26/11. 2. The MDS dated 8/3/11 identifies R2 to be totally dependent on staff for all activities of daily living. The MDS indicates R2 is vent dependent, has a G-tube, and has a urinary catheter. According to the monthly weight records, R2's weight is stable around 184 pounds. The Physician's Order Sheet for October 2011 indicates R2 is to receive Fibersource HN at 60cc/hour with a 300cc flush every 4 hours. The POS also includes an order "cleanse tube daily c (with) soap and H2O." The TARs also reflect this order to be done by evening staff. On 10/5/11 at 1pm, R2's tube feeding was running via a pump at 60cc/hour. He had 150cc left in his bottle of 1000cc. The bottle was labeled hung at 1pm on 10/4/11. According to calculations, R2's tube feeding was off by 275cc. R2 also was noted to have peeling skin on his tongue, inner cheeks with mucus membranes being dry, lips peeling. The pump was soiled with	F 322		

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F 322	Continued From page 26	F 322		

formula. R2's g-tube site had dried dark red crusty drainage present under it with some moisture noted at the inner area.

The TAR for October reflects the g-tube site cleansing order and has only 17 of 29 days documented as having done the treatment.

The Intake records were also noted to be inconsistently documented and incomplete.

3. According to the MDS dated 8/13/11, R1 is totally dependent on staff for all activities of daily living. The MDS indicates he is vent dependent and has a g-tube. According to the RD notes of 8/19/11, R1 has "fluctuating weights" and weighed 196.4 on 8/19/11 and on 10/25/11, weighed 176.4 pounds. The POS indicates R1 receives 200cc water flush every 4 hours and Diabetisource 80cc/hour/pump.

The dietary note dated 5/26/11 indicates R1 had a hospitalization for pneumothorax and also receives Lasix which could contribute to the fluctuating weights. On 8/19/11, the dietary note identifies a goal to maintain weight within 5% ongoing and listed R1's current weight at that time as 196.4 pounds. The dietary manager made no recommendation but indicated they would continue to monitor. On 10/25/11, R1's weight was recorded as 176.4 pounds. There is no indication the facility made revisions to R1's plan of care to address the weight loss in an effort to prevent further loss.

R1's tube feeding and flushes are inconsistently documented with many omissions present. Of 62- 12 hours shifts for October 2011, 18 shifts have no intake for formula or flushes recorded as occurring.

On 10/5/11 at 12:30pm, R1's g-tube site was noted to have dry drainage with chunks hanging

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F 322	Continued From page 27 around the tube. There was no dressing over the site. R1's pump was soiled with feedings. His lips were dry and peeling.	F 322		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure appropriate diets, feeding assistance and supplements were provided for 1of 2 residents (R4) reviewed for weight loss in a sample of 7. Findings include: 1. According to the Minimum data Set (MDS) dated 8/12/11, R4 has severe cognitive impairment and requires total assist of one staff for eating. The care plan dated 5/25/11 indicates R4 is at risk for weight loss due to dementia, traumatic brain injury, and having periods where he refuses to eat. The goal is to maintain weight within 5% of his current weight. Interventions include recording monthly weights, pureed diet	F 325		

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F 325	Continued From page 28 with double portions, super cereal at breakfast and whole milk with meals, encourage good food and fluid intakes, encourage to continue to eat at meals and offer alternatives when necessary, prepare meal tray, then hand feed using slow unhurried approach. The Annual Dietary Assessment dated 5/27/11 identifies R4 to be on a mechanical soft diet with double portions, supercereal every morning, whole milk all meals and snacks at bedtime (sandwich.) Eating ability is "fed per staff." with good intake of all meals + supplements documented. Supplements given was 8oz of Boost Plus TID (with meals.) R4 was documented at being 74% of his ideal body weight or "underweight." He was identified as having an 11.3 pounds weight loss within the past 180 days. According to a Therapy Discharge Summary for Speech Therapy dated 8/19/11, R4 had a swallow evaluation completed with a diagnoses of Dysphagia given. R4's diet recommendation was pureed. Staff education included positioning R4 at 90 degrees when eating, presenting small bites, and alternating solids and liquids. The note documents R4 demonstrated (decreased) pocketing and increased consumption once diet was changed to pureed. The Physician's order sheet for October 2011 indicates R4 receives a pureed diet double portions. An order for a supplement "Resource" 120cc qid (4 times a day) was given on 9/13/11 for "excessive weight loss" in addition to a modified barium swallow evaluation. There is no indication the facility continued with R4's bedtime snack after his diet was changed to pureed. This was confirmed in interview with the Registered Dietician, E23, on 10/28/11 at 1:30pm. E23	F 325		

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F 325	Continued From page 29 stated she "must have forgotten to reorder that." A Nourishment list of snacks provided by dietary does not have R4's name on it for a bedtime snack. Weight sheets for October show fluctuating weights as well. On 10/4/11 - 147.3, 10/11 - 139.4, 10/18/11 - 141.5 and 10/25/11 as 141.0 pounds. The monthly weights sheets indicate R4's September weight was 137 pounds. August weekly weights have R4's lowest weight recorded during the first week at 133.6 pounds. On 8/18/11, the dietary manager documents "good intake noted (100%), has potential for wt (weight) loss." and "has periods of agitation + will refuse to eat." documenting that he receives double portions, supplements, supercereal and whole milk. She recorded R4's current weight at that time as 139.3 to 145 pounds for past 9 months. On 10/5/11 at 12:22pm, R4 was given a small portion of mashed potatoes with nothing on them, pureed fish with no tartar sauce and vegetables. He had no tartar sauce, dessert or condiments. He was given a small glass of ice tea and a supplement. He was totally fed by E26, Certified Nurses Aide. He was not served double portions nor did he get whole milk. he drank the tea, drank 100% of the supplement and was not noted to be alternating food and fluids as E26 fed him. He ate 100% with no second helping offered. E26 was noted to be in conversation with other staff at the table and not be engaged with R4 as she fed him. According to the dietary spread sheet, R4 should have received in addition to the main entry, 1 tablespoon of mayonnaise and a 2 x 2 inch piece of Pound cake along with condiments. On 10/7/11 at the noon meal, he was noted to	F 325		

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F 325	Continued From page 30 yell profanities at the staff and push them away as they were attempting to feed him and was taken directly back to his room. He again had no double portions. On 10/7/11 at 3:30pm, E2 stated R4 was fed his lunch after he went back to his room and ate well. E2 was informed that his plate again was not double portions and did not include dessert. R4's wife, Z5, stated on 10/7/11 at 11:35am that R4 often complains of being hungry when she's here and she doesn't think they are giving him enough food. She also said condiments are not always available. She voiced concern they are feeding him quickly and not allowing enough time for him to eat. The facility failed to develop a plan of care towards increasing R4's intake based on the speech therapist recommendations. The care plan dated 5/25/11 has only one revision added in and that is dated 9/13/11 for Resource. The care plan fails to reflect R4's refusals to eat and how staff should intervene when behaviors occur that prevent him to eating at the time and the alternating food with fluids. In addition, his care plan for behaviors indicates staff are to offer food when he is behavioral. Review of the Resident Counsel minutes from August 2011, salt/pepper are not on the tables and condiments are not always being put on the table.	F 325		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	F 327		

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F 327	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on interview, observations and record review, the facility failed to provide fluids during care and at mealtime for 1 of 7 residents reviewed for fluids in the sample of 7. Findings include: 1. According to the Minimum data Set (MDS) dated 8/12/11, R 4 has severe cognitive impairment and requires total assist of one staff for eating. The care plan dated 5/25/11 indicates R4 is at risk for weight loss due to dementia, traumatic brain injury, and having periods where he refuses to eat. An intervention indicates staff are to encourage good food and fluid intakes. According to the Medication Administration Record (MAR) for October, staff are to "encourage fluids." The Registered Dietician's assessment dated 5/27/11 identifies R4's daily minimum fluid requirements as 1920cc/24 hours. The assessment notes he is fed by staff and staff are to encourage good intake of meals and fluids. On 10/5/11 at 11:50am, R4 was in his wheelchair at the nurses station. At 12:21pm, R4 ate lunch and was served a glass of ice tea which he drank 100% without stopping. He was also given a supplement but no other fluids. His room was checked from 1:05pm when staff laid him down until 3:30pm and had no water pitcher present. On 10/7/11 at 10:30am, R4 was in bed. He had a dirty water pitcher 1/2 full of water water sitting across the room by the television out of reach. There was no glass or straw present. R4 was taken to lunch and returned immediately due to behaviors and put to bed. His water pitcher	F 327		

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F 327	Continued From page 32 remained the same until 3pm when last observed. On 10/7/11 at 11:45am, R4's wife, Z5, stated she is concerned with R4 not being given adequate fluids and that he often does not have fresh water at bedside.	F 327		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.1210b) 300.1210d)2) 300.3220f) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures:
4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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:

2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.3220 Medical Care

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been

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issued to assure facility compliance with such orders.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidenced by:

A) Based on interview, observation and record review, the facility neglected to identify new pressure ulcers and or wounds and neglected to identify new pressure ulcers/wounds as ordered for 1 of 3 residents (R5) reviewed for pressure sores and/or wounds in the sample of 7. This neglect resulted in R5's developing pressure sores the facility was unaware of and having deteriorating sores they failed to identify, assess and treat.

Findings include:

According to nurses notes dated 9/26/11 at 2:30pm, R5 was sent to the emergency room after staff noted decreased alertness, increased blood sugars for 2 days and rapid progression of a sacral decubitus. Wound reports dated 9/26/11 indicate R5 was being seen by a wounds specialist who identified 8 pressure sores. The facility's "Weekly Pressure Ulcer QI Log" dated 9/26/11 shows the facility identifying 6 pressure ulcers, not 8 as identified by the wound specialist that same day. The weekly pressure ulcer report dated 9/19/11 identifies that R5 had 3 areas. There is no indication until 9/26/11, that the

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F9999	Continued From page 35 facility identified decline in the wounds he was admitted with on 9/12/11. Treatment records from September 12 through the 26th, 2011, show treatments were documented as being done 9 of the 13 days, with an order for neosporin to R5's right medial ankle at bedtime documented as being done only 2 of 13 days. This is the time frame in which he developed additional wounds on his coccyx (7.5cm x 13cm), Right buttock (4 x 2.5), left hip (9x8cm) and left shin (1x1cm) according to the Weekly Pressure Sore Ulcer QI Log dated 9/26/11. Pictures and information obtained from the hospital, dated 9/26/11, indicate a wound consultant saw R5 due to numerous open areas on his skin. The areas were documented to include, "superficial blisters that have denuded revealing superficial pink open areas beneath on his right axilla, right lateral knee, right calf, left calf in several areas in addition to open sloughing areas on his right hip, coccyx that are very large, at leach 12-15cm each. The coccyx is butterfly shaped. The rt trochanter area is moist, sloughing and there is some purple discoloration around this. The left plantar foot has a pink, resolving area with scarring around it. The left heel has eschar that is coming off, removed. The rt (right) heel has some purple discoloration but intact skin at this time." The report continues to state that R5 "should be hospice and made comfortable" with palliative wound care provided. The coccyx wound was identified as a Kennedy ulcer. Hospital photographs dated 9/26/11 show R5 to have an open area on his abdominal fold measuring 5cm long and 1/2 centimeters wide, fatty tissue/slough at the wound base, and an open sore at the urethra opening. According to an	F9999		

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F9999	Continued From page 36 consultant report dated 9/27/11, R5 had sores on his rectum described as, "The rectum has water filled blistering all around and there is ulceration on the outside, extending up into the rectum that shows sloughing." None of these areas were evident in any facility documentation. According to facility admission records, R5 was readmitted to the facility on 10/5/11 and placed on Hospice services. On 10/7/11, R5's skin was checked with E21, Licensed Practical Nurse (LPN) at 10:54am. R5 had no dressings on his right hip sore, no dressing/treatment on his coccyx and his coccyx/buttocks wounds were actively bleeding. He had a hydrocolloid dressing on his right outer leg dated 10/5/11 The pads underneath him were soiled with bloody drainage and his lower extremities dressings were on but soiled with bloody drainage. None were dated. E21 looked through the bedclothes for the dressings but was unable to locate them. A Certified Nurses Aide (CNA), E13 stated she removed the dressings at 9:30am. Review of the Treatment Administration Record for (TAR) for November 2011, R5 had no treatments done to his pressure sores since his return from the hospital on 11/5/11 as it was blank with no initials documented. Review of the Physician Order Sheet, (POS) documented the treatments were ordered to be done at nightly and PRN (as needed). On 11/1/11 at 12:30pm, E22 LPN stated she admitted R5 back into the facility on 10/5/11 and completed the TAR. E22 stated R5 returned from the hospital with no treatment orders. At that time E22 called and received orders for treatments. E2 stated she did the dressings the afternoon of 10/5/11 when she assessed R5's wounds but	F9999		

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F9999	Continued From page 37 acknowledged that she didn't sign the TAR after completing them. E5 was asked why she didn't sign off the treatments and stated "sometimes she doesn't." On 11/1/11 at 11:55am, E4 LPN confirmed she worked on 10/6/11 and did not get R5's treatments done. E4 stated she "passed the information on to" the next nurse but did not document that R5's treatments were not done. This was confirmed in nurses notes written by E4 on 10/1/11. The first initials, on the TAR, for R5's treatments was on 10/7/11. On 10/28/11, a copy of R5's October 2011 TAR was obtained and noted to not only have the blanks for treatments done following his admission on 11/5/11 until 11/7/11, but to also have initials of treatments done on 10/3 and 10/4/11 when he was not in the facility. These initials were added after the first copy was obtained on 10/7/11. On 11/1/11, E2 Director of Nursing confirmed that documentation was a problem. E2 confirmed that treatments should be done as ordered by the physician and documented when done. E2 also stated that treatments not done should be initialed and circled. E2 confirmed that they have identified concerns with pressure ulcer treatment. In addition, Skilled Daily Nurses Notes for 9/23/11, 9/24/11, 9/25/11, 9/26/11, 10/5/11, 10/6/11 and 10/7/11 failed to identify any skin ulcers on R5. E2, E22, E4 and E19 were all unable to explain why this assessment conflicts with weekly wound documentation and treatment records. (B)	F9999		

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F9999	Continued From page 38 300.1210b)4) 300.3220f) 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. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new	F9999		

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physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidenced by:

Based on interview, observation and record review, the facility neglected to meet nutrition and hydration needs and neglected to revise the plan of care for 1 of 4 residents (R5) reviewed for tube feeding in a sample of 7.

Findings include:

The care plan dated 8/4/11 identifies R5 to require tube feedings with goals to meet his hydration needs and maintain his weight within 5% by next review on 11/4/11. Interventions indicate staff are to follow physician's orders for feedings/flushes, monitor and record Intakes and Outputs (I&O), monitor for signs of dehydration (skin turgor, mucous membranes, etc.), and position at 30 degrees minimum. The care plan does not reflect any weight loss although monthly weight records indicate R5 has had a substantial weight loss since his admission to the facility. R5's admission weight is recorded as 257.9 pounds on 5/5/11; his weight on 7/29/11 was

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F9999	Continued From page 40 225.8; on 8/19/11, 245.7; and on 9/6/11, 226 pounds. E23, Registered Dietician's (RD), made a Note on admission in May 2011 that R5 had feedings set at 60cc/hr and flushes at 120cc every 4 hours. On 6/24/11, an RD note identified that his current flush rate did not meet his hydration needs and documented "wt (weight) (decreased), fluids do not meet needs but may not tolerate ^ (increase). Will suggest and monitor. Concur c (with) goal and plan." No changes were recommended. On 7/13/11, the RD assessment documents "6/28/11 flush ^ to 250cc q (every) 4 hours. Tube feeding the same." R5's weight is documented as 222.7 pounds. On 7/29/11, the RD again documents to increase R5's flushes to 250cc q 4 hours. R5 was not reviewed again by the RD until 8/4/11. At that time, no weekly weights were recorded and no additional interventions toward preventing further weight loss is noted or recommended by the nursing staff or the RD. On 9/12/11, R5 was readmitted to the facility following a hospitalization for pneumonia. His tube feeding was ordered at 60cc/hour with 120cc flushes every 4 hours even though the RD has identified that 120cc every 4 hours does not meet his hydration needs previously. An RD note dated 9/14/11 reflects the TF at 60cc/hour with water flushes at 120cc every hours. The note states readmission weight "to be clarified." R5 did not have weekly weights done following his readmission. The next entry by the RD was not until 10/14/11. Calculating intake for feedings at 60cc/hr, 12 hours shifts would be 720cc with 120cc flushes every 4 hours being 360cc per 12 hours shift. The I&O sheets for the feeding and flushes from	F9999		

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F9999	Continued From page 41 9/12/11 to 9/26/11 are inconsistently documented with many blanks. There is no intake documented on 9/12/11. On 9/13/11 for 7a-7p shift, 480cc is documented under "ORAL" even though R5 is NPO (nothing by mouth.) and 861cc for "OTHER." On 9/14/11, 240cc is documented for 3-11 shift, 491cc for feeding but has no documentation for the rest of the day. 9/15 has 240cc/flush for 7p to 7a, 570cc/feeding with 7a-7p 480cc and 936cc/feeding. On 9/16/11 7p-7a, R5 is recorded as only getting 240 cc flush and 580cc feeding with nothing recorded for 7a-7p shift. On 9/17/11, 7p-7a has 240cc recorded for flush and 500cc feeding, 7a-7p has 360cc recorded for flush and 702cc recorded for feeding. On 9/18/11, 7a-7p 408cc flush, 1330cc feeding and 7p-7a 240cc flush with 570cc feeding. From 9/19/11 through 9/25/11, documentation is absent for 6 of 15 shifts. According to nurses notes dated 9/26/11 at 2:30pm, R5 was sent to the emergency room after staff "noted decreased alertness, increased blood sugars for 2 days and rapid progression of a sacral decubitus." He was admitted with dehydration, sepsis and numerous pressure ulcers/wounds that included extreme excoriation and open wound surrounding the gastric tube (g-tube) insertion site. The facility did not have the G-tube site wound identified prior to discharge on 9/26/11. The care plan shows no revisions to R5's interventions toward fluid intake/dehydration and/or weight maintenance since 5/26/11 despite his continued weight loss. On 11/1/11 at 2pm, E15, LPN, stated she worked with R5 on 9/24, 9/25 and 9/26 on 7am to 7pm shift. E15 stated she didn't know why she didn't document R5's intake for 9/23/11 but	F9999		

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F9999	Continued From page 42 cleared the pump and wrote the amount down. The ORAL intake is the section she documents the flushes in. E15 stated R5 had no vomiting and/or diarrhea in the days prior to his hospitalization. On 10/5/11, R5 was readmitted to the facility. His admission weight was recorded as 230.6 pounds although his weekly weight was recorded as 199.3. On 11/1/11, R5's weight was 196.4. On 10/7/11 at 10:52am, R5's Novasource 1000cc bag was hanging with 500cc left. The pump was running at 60cc/hour. The bag was not labeled. R5's mouth was in need of oral care as he had white substance in the roof of his mouth with sores evident. Lips were dry and peeling. At 10:54am, E21, Licensed Practical Nurse (LPN) stated she did not know when the bag of Novasource was hung. R5's g-tube site was noted to have no open sores evident but dark brown crusted substance underneath it. E21 stated "It just needs to be cleaned." On 10/28/11 at 1:30pm, E23, RD stated she bases all her feedings on 23 hour infusion. E23 stated no weekly weights were done until his last hospitalization. E23 stated she will look at the intake sheets occasionally and last saw R5 on 10/14/11. R5 was readmitted on Novasource 60cc/hr and 250cc flush with med pass. The RD note dated 10/14/11 indicates R5's weights "fluctuate". On 10/12/11, an order to increase R5's flushes to 250cc with every med pass and every 4 hours was given. E23, RD, acknowledged on 10/28/11 at 1:30pm that the med passes would be every 4 hours so essentially, his flushes were not increased.	F9999		

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