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F 000	INITIAL COMMENTS	F 000		
F 272 SS=D	Annual Recertification and Licensure 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		11/19/11

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

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This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the Facility failed to assess for the use of siderails and for the administration of medication ordered to suppress sexual behaviors for 1 of 7 residents (R6) reviewed for restraints, behaviors and medication in the sample of 21.

Findings include:

A) On 10/13/11, at 9:40 AM, R6 was lying in his bed with bilateral 1/2 side rails in the raised position in the center portion of his bed. E2, Director of Nurses, (DON) who was in R6's room at that time, stated that the bilateral siderails were applied after R6 returned to the Facility from the hospital with his fractured hip.

R6's clinical record was reviewed and no assessment for the use of the siderails was present. E10, Care Plan Coordinator, confirmed that the bilateral siderails were applied to R6's bed when he returned to the Facility from the hospital on 9/1/11. E10 stated that R6 uses the siderails for turning and positioning. E10 confirmed that the Facility does not have documentation showing the medical reason, how R6 uses the siderails or assessed risk versus benefit for the use of the 1/2 siderails in the center of the bed.

B) R6's clinical record documents that on 7/28/11, his physician ordered Provera 10

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F 272	Continued From page 2 milligrams orally three times a day due to elevated testosterone levels. On 10/11/11, at 2:10 PM, E2 and E11, Quality Assurance Nurse, were asked why R6 was receiving the Provera. Both E2 and E11 stated that R6 has sexual behaviors of grabbing both staff and resident's genitals and breasts. E2 said that R6's physician told her that R6's testosterone level was high for a man of his age. E2 confirmed that there is no documentation in R6's clinical record regarding this information. The Facility was unable to produce physician notes regarding the Provera. There is no assessment documentation in R6's clinical record regarding his sexual behaviors. There is no documentation assessing why behaviors occurred mainly on the night shift. There is no assessment documenting less restrictive methods attempted prior to utilizing the Provera. There is no documentation regarding assessing for adverse side effects when using Provera. .	F 272		
F 309 SS=G	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: Based on observation, interview and record review, the facility failed to provide appropriate	F 309		11/19/11

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treatment for wounds/ulcers for (1) of 7 sampled residents (R8) and 1 supplemental resident (R29) reviewed for wound care and failed to assess and monitor and Care Plan for Dialysis complications for 1 of 1 residents (R14) reviewed for Dialysis in the sample of 21. This failure resulted in R29 developing cellulitis, osteomyelitis and having her left great toe amputated.

Findings include:

1. R29's Physician Order (POS) Sheet of July 2011 documents R29 is a 50 year old female with a diagnosis, in part, Insulin Dependent Diabetes Mellitus, Hypertension, Crohn's Disease, Back Surgery, Cardiovascular Accident, Decubitus Ulcers, Wound Right Hip Closure and Blood Dyscrasia. R29 has a Physician order on 7-17-11 to give Rocephin 1 gram IM (intermuscular) qd (every day) x 2 days then start Keflex 500 mg by mouth 1 every 6 hours x 8 days for treatment to cellulitis of the left great toe. Cleanse area and apply Bactroban ointment and dry dressing q (every) day and PRN (as needed). POS documents an order of 7-19-11 "May send res (resident) to ER (Emergency Room). POS shows an order of 7-19-11 for Bactrin DS BID (twice a day) po (by mouth) x 10 days. It is documented on 7-21-11 on the POS to refer to a vascular surgeon to evaluate and treat left great toe. POS documents an order on 7-22-11 to send R29 to the ER for evaluation per family demand.

R29's Wound Culture of left great toe on 7-19-11 shows MRSA (Methicillin Resistant Staph Aureus) which was resistive to Bactrim DS. The culture does not identify sensitivity to Keflex.

NURSE/PHYSICIAN COMMUNICATION RECORD of 7-17-11 has documentation that

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reason for calling the physician is left great toe very red, swollen , hot to touch , nail bed above nail red and top of the toe is purple. Temperature is 99 degrees, pulse is 90, blood pressure is 110/68. Pain is 3 out of 5. Pain medication given for comfort. Physician called and gave order for Rocephin 1 gm IM qd x 2 days then start Keflex 500mg every 6 hours x 8 days. Record also shows the above order for cleaning and treating the wound. Note at 2PM states R29 states foot and even her leg hurt half way up her calf. No drainage.

NURSE/PHYSICIAN COMMUNICATION RECORD of 7-19-11 documents, "L (left) great toe declining". Time of Physician response states 12 noon with orders to send R29 to the ER for evaluation. Note at 10AM documents, "CNA (Certified Nurse Aide) came & told this nurse L toe looks worse very red & swollen hot to touch mushy on bottom & purple has yellow drainage coming out. Res was started on ABt (antibiotic) 7/17/11. Call placed to Dr. (Doctor) awaiting call back." Note at 12 noon documents, "Dr states send res to ER for eval. DON (Director of Nursing) states call Dr. back ask for culture order & ? about IV antibiotics. awaiting call back." (POS review shows no order was obtained for IV antibiotics.) Note at 3:20PM documents, "Spoke with Dr.-- at length re (regarding) res cond (condition), states to send res to ER if res chooses to go. This Nurse evaluated L great toe et (and) noted 0 increase in redness or swelling noted from eval on Sunday evening, res (resident) reassured and states does not want to go to ER..."

It is documented on 7-20-11 Nurses Notes that R29 left the facility with a family member at 8:30AM for a Doctor appointment. E1,

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Administrator, stated on 10-21-11 at 11AM, she could not find any information as to where R29 went on 7-20-11. She stated it is suppose to be documented in the Nurses Notes but it is not. E1 suggested to call R29's sister and she may know. On 7-20-11 at 12:40PM, Z4, R29's sister, stated she took R29 to the plastic surgeon who operated on her buttock wound and the Surgeon did not look at R29's toe.

It is documented in the Nurses Notes on 7-20-11 that R29's left toe continues to be swollen, red and purple with large amount of yellow slough noted, continues to have scant amount of serosanguinous drainage. R29 ambulates and full weight bearing to left lower extremity without difficulty. Left foot slight swollen inner arch and slight red in color. (Facility WEEKLY WOUND OR SKIN ABNORMALITY TRACKING LOG of 7-22-11 identifies left toe wound with treatment of Bactroban and dry dressing with no pain. ".2 slit on nail bed. 0 toenail. Just starting to grow from bottom of toe nail bed. There is no mention of color, swelling, slough or drainage.)

Z5, Nurse Practioner, documented on a progress note of 7-21-11, that R29 was seen to follow up on a Vascular Ulcer to great left toe. Onset 5-7 days ago on antibiotic therapy. Denuded skin up to 1st knuckle. A large piece debrided off with slight bleeding. Wound base white. Rest of toe mushy under skin. Plan to send to Vascular Surgeon.

Nurses Note 7-20-11 states R29 propels self around facility in wheel chair. Note of 7-22-11 states R29 has pain in left leg, 3 plus pitting edema noted in left leg and foot. It is documented on 7-22-11 at 12 noon, Z4 was called to tell her of appointment for vascular

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surgeon. Z4 stated, "I demand my sister be sent to hospital now!" It is documented at 6:25PM R29 was admitted to the hospital for IV antibiotic and MRSA to R (right) great toe. (Yet above medical records show it was the left great toe.)

It is documented in R29's Hospital History and Physical of 7-23-11, that R29 came to the hospital with chief complaint of having noted left toe pain and redness and swelling ongoing for a few days. She had broken her toe nail and started noticing that there was some redness in the beginning but no purulence or bleeding. Later on the toe started to swell and she had severe pain. Physical examine showed left foot great toe has significant edema and erythema. No open wounds or ulcers. No purulent discharge noted at this time. It is documented under Assessment and Plan: Left foot diabetic ulcer with cellulitis associated with leukocytosis, subjective fever. Culture is positive of MRSA. Continue vancomycin, obtain podiatry on consult, wound care on consult. Arterial Doppler negative for evidence for peripheral vascular disease. Continue bacitracin topically. Obtain X-ray of the foot for signs of osteomyelitis...

It is documented on the Hospital X ray of R29's left foot, on 7-22-11, Soft tissue swelling of the great toe is seen. Irregularity of the tuft of the distal phalanx of the great toe. This may be due to bony erosion as a result of osteomyelitis. This could be due to prior trauma. A small linear lucency in the area, possibly a more recent fracture. Mild degenerative osteoarthritic changes. Small posterior calcaneal spur.

It is documented on R29's Consultation Report of 7-24-11 by Z3, Podiatrist, R29 does have a large ulceration distal tip of the left hallux. There is exposed bone of the distal phalanx tip present.

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It is somewhat fibrotic and necrotic. X ray results are suspicious for osteomyelitis . There does appear to be some destruction about the distal tip of the distal phalanx...Assessment: Osteomyelitis of the left hallux distal phalanx with associated cellulitis and foot ulceration. Plan includes, in part, treat with amputation of the distal phalanx of the hallux...continue on current IV antibiotics...

Hospital Discharge Summary of 7-27-11 states discharge diagnoses, in part: Osteomyelitis of the distal phalanx of the left great toe; Status post amputation of the distal phalanx of the left great toe; Cellulitis of the ankle and left foot - significantly improved. Hospital Course: R29 came to the ER and admitted with severe pain in her right great toe and was admitted to the hospital She has a left diabetic foot ulcer and was diagnosed to have cellulites of the foot, and was started on IV antibiotics because of the wound and the leukocytosis and fever. R29 was diagnosed as having osteomyelitis and underwent amputation of the distal phalanx of the left great toe for the osteomyelitis.

During interview with E20, Licensed Practical Nurse (LPN) on 10-14-11 at 11:45AM, E20 stated on 10-19-11 she was told by a CNA that R29's toe was getting worse. E20 stated she had not seen the toe before. It was really big very swollen purple on bottom and the top was cracked with yellow drainage. It was crusty. E20 thought R29 needed to go to the hospital. She had been on antibiotic's for 2 days. It must not have been working. E20 called Z2, R29's Physician and told him of her concerns and he ordered for her to be sent to the hospital. E20 stated they have to let, E2, Director of Nursing (DON) know when they are sending a resident to the hospital. E20 stated

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she told E2 and E2 stated to call Z2 back and see if they could treat the toe at the facility. R29 was not refusing to go to the hospital. It was the end of the shift so E21, Registered Nurse (RN) took over.

On 10-19-11, E21 stated she was the Nurse who initially saw R29's toe on 7-19-11. Her great toe was red and swollen and real purple on the end with yellow drainage. It looked like a blister area on the end of the toe. She called Z2 and got an order for Rocephin IM and then Keflex. On 7-19-11, E20 stated R29's toe looked very bad and she had called Z2. It's the facility's Policy and Procedure to check with E2 or the Nurse on call, before sending residents to the hospital. E21 stated she thought E2 went and looked at the toe and thought they could treat it at the facility with IV antibiotics. E21 stated she was the one who had to call Z2 back and tell him E2 wanted to treat R29 in house. E21 stated Z2 was very upset. He wanted her sent to the hospital. He felt he was being seconded guessed. He asked E21 if she had seen the toe that day and she told him "NO", she had just come on duty. Z2 told her he did not understand why they did not want to send R29 out and said if she wants to go send her. E21 said she then looked at R29's toe and talked to R29. The toe didn't look any worse. Her accu check was good. E21 stated she told R29 the antibiotics had not had a chance to work. E21 states she felt she convinced R29 she didn't need to go the the ER. E21 stated she felt pressured not to send R29 to the hospital. E21 stated after R29 went to the hospital she talked to E1 and E2 of concerns of not doing what Z2 wanted. Facility Policy got in the way of good patient care. Z2 did not give an order to not send R29. He said she had just had 2 days of IM Rocephin. He wanted

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her to go to the hospital based on what the Nurse told him that morning. E21 stated at the time, there was no written order to send R29 to the ER. It was written on the Nurse communication record but not on the POS.

On 10-19-11 at 2:15PM, Z2 stated he had gotten a report from a Nurse that R29's wound on her toe was worse. He wasn't at the facility at the time. If the wound is not getting better in 2 days and is worse, someone needs to look at it. He ordered for R29 to be sent to the hospital. If he over reacted then the worse thing that happens is they send her back. If needed they would admit her. They called Z2 back and said E2 wanted to treat R29 at the facility. Z2 stated he had concerns and thought R29 should go to the hospital. Z2 stated he did not rescind the order to send R29 to the ER. The only reason not to send her is if she refused to go. Z2 stated if the toe was becoming gangrenous then waiting 2 days would not have made a difference. She probably would have lost the toe anyway. (There is nothing in hospital records that show R29's toe was gangrenous.)

E2 stated on 10-21-11 at 10:45 AM, she was not aware Z2 had ordered for R29 to go to the hospital. E20 had told her she was sending R29 out to the hospital and E2 told her she should ask for a culture and antibiotics and treat at the facility. E2 denied she told E20 not to send R29 to the ER. "If someone wants to go to the hospital it's her right." E2 stated she did not look at R29's toe before telling E20 to call Z2 and see if she could be treated at the facility. She stated there was no written Policy and Procedure that she or a charge Nurse had to approve before a resident was sent out to the hospital.

On 10-21-11 at 10:55PM, E22, LPN, stated it

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had been the rule around the facility that you had to get approval to send a resident to the hospital. They wanted residents to be treated in the facility unless it was an emergency.

On 10-21-11 at 11AM, E1, Administrator, stated there was no written Policy and Procedure to not send a resident to the hospital unless the DON or charge Nurse approves. The do want the Nurses to run it through the DON before sending out unless it's an emergency due to some Nurses getting carried away and sending a resident out when they could be treated at the facility.

On 10-20-11 at 3:05PM, Z3, R29's Surgeon/Podiatrist, stated trauma could have caused injury to R29's left great toe. Even rubbing shoe on toe could have caused the injury. She doesn't have much feeling in the toe and she could be doing damage without knowing it. Z3 stated they possibly could have saved the toe if it was treated earlier. When he saw it, bone was exposed and it was too late. Once bone is exposed it has to be amputated. Possibly with IV antibiotics and staying off her feet, the toe may have been saved. It could have healed. Two days could make a difference.

2. R8 was observed on 10-12-11 at 12:30PM, to have two ulcerated areas on her right foot and one on her left foot. E7, Treatment Nurse, was present and confirmed the areas and stated they were not pressure sores.

Record review of R8's Medical Record and Treatment Administration Record (TAR) show R8's ulcerated areas on her feet were not assessed. At 1:20PM, E1, Administrator, stated she had just looked at R8's feet and stated it looks arterial and R8 needs a doppler study. E1

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was informed there was a treatment order on the TAR for treatment to the left lower extremity but no assessment. At 1:50PM, E1 stated she could not find an assessment on R8's feet. E1 stated the policy is to do an initial assessment and document and then assess and document weekly.

3. The Admission sheet identifies R14 as being readmitted to the facility on 10/9/11. According to the Minimum Data Set (MDS) dated 10/4/11, R14 receives dialysis services. There are no orders for Dialysis services and no orders for the Dialysis catheter or shunt site on the Physician's Order Sheet (POS) for October, 2011. A "Dialysis Communication Form" dated 10/11/11 indicates R14 goes to Dialysis on Tuesday, Thursday and Saturday. The care plan dated 8/5/11 has dialysis identified only under Dehydration for fluids restriction. There are no directions and/or care interventions toward monitoring the catheter or shunt site or for intake/output regarding the fluid restriction in the care plan.

On 10/13/11 at 10:35am, R14 was in her room eating lunch. R14 stated she eats before she goes to Dialysis and is leaving for that around 11am. R13 had a dressing upper left arm. R14 stated she was on a special diet.

On 10/13/11 at 11:05am, E9, Licensed Practical nurse identified R14's shunt site as the left arm and stated "yea" when asked if she checked the site including Bruit/Thrill. E9 was unsure as to where the nurses charted the assessment then stated she thought they charted it on the daily Dialysis sheet. When asked how often, she hesitated and stated "daily." E9 also identified R14 as being on 1500cc fluid restriction

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but could find no order for it on the current physician's orders or on the hospital transfer sheet dated 10/9/11.

Dialysis Communication Reports are sent home with R14 and have a section to be completed post dialysis by the facility. The report is blank for "Vascular Access Condition" for her 10/11/11 visit. The only other daily sheets are dated 10/1/11, 9/29/11, 9/22/11, and 9/27/11. The Treatment Administration Records, Medication Administration Records and the nurses notes were all reviewed and found to be void of any information regarding R14's catheter or shunt site and/or Bruit/Thrill.

According to the facility's policy on Dialysis dated 11/1/07, residents receiving dialysis treatments will be appropriately assessed for complications and will together, with the dialysis treatment center, communicate and collaborate to assess, implement, evaluate, and revise the resident's plan of care. Under care of the shunt, it states care will be provided by a licensed nurse and include leaving dressing in place for 24 hours, closely inspect dressing for drainage and bleeding, sites are checked for patency and condition daily an upon return from dialysis "If a bruit changes in regularity or depth or if thrill is not able to be palpated, notify the physician immediately." The policy also indicates blood pressures or venous punctures will be not performed on the extremity where the shunt is located.

In addition, the policy states the residents plan of care will include the following: Dialysis order - There are no orders on the POS for dialysis. Monitor Intake and Output (I&0) - review of the I&0 sheet since her return from the hospital on 10/9/11 is incomplete. The COMPREHENSIVE

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F 309	Continued From page 13 INTAKE & OUTPUT RECORD (8 HOUR SHIFTS) has no 24 hour totals recorded and only 6 of 11 shifts completed. The policy also indicates common nursing practice will be implemented that includes shunt assessment and monitoring. The Contract for Outpatient Dialysis Services indicates they will provide information on all aspects of the management of the residents care related to the provision of dialysis services including but not limited to bleeding/hemorrhage, infection/bacteria, and care of the dialysis site and disinfection of dialysis access site.	F 309		
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 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 record review, observation and interview, the facility failed to provide timely turning and repositioning and pressure sore identification, monitoring and treatment for 1 of 7 residents (R16) in the sample of 21 and 1 resident (R28) in the supplemental sample reviewed for turning and reposition and pressure sore prevention. This failure resulted in R28 developing an unstageable left heel pressure	F 314		11/19/11

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sore.

Findings include:

1. R16's Minimum Data Set (MDS), dated 8-18-11, documented severe cognitive impairment, total dependence of two plus persons physical assistance with mobility and transfers, bilateral upper and lower extremity impairment and two Stage II pressure sores. R16's Care Plan, goal date 11-17-11, documented R16 was to be turned and repositioned every 2 hours and as needed.

During observation of R16's turning and repositioning, on 10-12-11 from 9:25a.m. to 12:20p.m., R16 was not timely turned and repositioned. Interview of E14, Registered Nurse (RN), on 10-12-11 at 9:25a.m., E14 stated R16 was"pulled up and switched her sides." R16's position was observed the same before and after her positioning with coccyx and buttock pressure remaining and unrelieved with being pulled up and sides switched. E13, Certified Nursing Assistant (CNA) and E5 (CNA), were observed checking R16 adult diaper for incontinence, on 10-12-11 at 11:40a.m., E5 and E13 did not reposition R16.

2. R28's MDS, dated 9-22-11,documented severe cognitive impairment, total dependence of one person physical assist with mobility and transfer, bilateral upper and lower extremity impairment and at risk for pressure sore development.

The facility's Weekly Wound or Skin Abnormality Tracking Log, week ending date 8-5-11, documented a 5.0cm x 4.0cm unstageable area was found on R28's left heel on

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F 314	Continued From page 15 8-1-11. Interview of E7, Treatment Nurse, on 10-13-11 at 1:40p.m., E7 stated she started as the Treatment Nurse on 8-5-11 and R28's entire left heel was very, very deep purple and boggy, mushy, when she saw it. E7 also stated she documented the measurements of R28's left heel on the Tracking Log, week ending date 8-5-11 and future Tracking Logs. R28's Weekly Wound or Skin Abnormality Tracking Log, week ending 8-12-11, documented R28's left heel as an unstageable 5.0cm x 4.0cm "escar (eschar)" area. Review of R28's chart did not document R28's left heel was monitored for pressure sore development until it was found on 8-1-11 as a 5.0cm x 4.0cm unstageable area. R28's MDS, dated 9-22-11, document she was at high risk for pressure sore development. R2's Skin Risk Evaluation and Plan of Care, goal date 12-25-11, documented R28 was at risk for skin breakdown. It was also noted R28's left heel pressure sore was not documented on her Care Plan with goals identified and/or interventions for her left heel. The facility's Wound Prevention/Skin and Wound Treatment policy and procedure, dated 10-1-08,documented, in part, residents will exhibit no evidence of sign breakdown or will regain skin integrity. It was also documented that all residents at risk will have skin condition checked and documented daily. Interview of E16, Medical Records, on 10-14-1 at 1:15p.m., E16 stated she was not finding Weekly Skin Condition Evaluation sheets for 7-11, 8-11 and 9-11. E16 then provided, on 10-14-1 at 1:50p.m., Weekly Skin Condition Evaluations, dated 2-11 to 10-11, which did not	F 314		

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F 314	Continued From page 16 document skin breakdown of R2's left heel until 8-15-11.	F 314		
F 322 SS=D	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 record review and observation, the facility failed to properly administer medications for 1 of 1 residents (R16) reviewed for enteral tube medication administration in the sample of 21. Findings include R16's Physican Order, dated 7-30-11, documented "Tramadol HCL 50mg tab (tablet) take 2 tablets by mouth or per tube every 6 hours." During observation of the medication pass, on 10-12-11 at 10:35a.m., E15, Licensed Practical Nurse (LPN), crushed two tablets of "Tramadol HCL 450mg" and placed each tablet in a separate plastic container. E15 did not dissolve the medication and poured the undissolved "Tramadol HCL" powder in R16's enteral tube syringe after filling the syringe with water. Each	F 322		11/19/11

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F 322	Continued From page 17 container was observed with remaining powder that was not administered. The facility's Medication Administered through an Enteral Tube policy and procedure, not dated, documented "3. Mix crushed medications with 15 ml of water."	F 322		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, the facility failed to provide a safe transfer for a resident with a history of falls; failed to ensure a resident's siderail was properly functioning; and failed to provide timely supervision, care planning and fall prevention for residents 4 of 10 residents (R2, R3, R8 and R15) reviewed for falls in a sample of 21. This failure resulted in R2 fall and fracturing his left hip. This failure also resulted in R15 falling and fracturing her right hip. Findings include: 1. R2's Investigation Report, dated 5-23-11, documented R2 was found, on 5-20-11, sitting on the floor, bedside. It was also noted R2 had a diagnosis of Dementia and was attempting to	F 323		11/19/11

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ambulate resulting in a fall. R2 complained of right ankle pain and edema. R2's Investigation Report, dated 6-17-121, documented R2 was found sitting on the floor in a puddle of urine. It was also noted R2 was attempting to ambulate unassisted. R2's Investigation Report, dated 7-11-11, documented R2 was found sitting on the floor in his room. It was also documented R2 was a risk factor for weakness and Dementia.

R2's Investigation Report,dated 10-3-11, documented R2 was found, on 7-11-11, leaning up against his roommates bed. It was also noted R2 sustained a left hip fracture.

R2's Fall Risk Assessments, dated 5-11 and 6-11, documented R2 was a high risk for falls. It was also noted R2 had a history of falls, impaired gait and balance and disoriented times three at all times.

R2's Plan of Care, current, did not document R2's falls or interventions to prevent further falls. R2's Behavioral Tracking, dated 7-11, 8-11 and 9-11,documented "Continuously getting out of wheel chair" with documented interventions. R2's Care Plan did not document R2's behavior or interventions documented on R2's Behavior tracking Sheet.

The facility's Fall Management policy and procedures, dated 11-07, documented "the facility will identify residents at risk for falls and implement interventions to minimize fall occurrences and injury real ted to falls." It was also noted A Fall Risk Evaluation and Care Plan will be completed when the resident is identified to be at risk for fall or has had a fall to ensure that appropriate interventions are put into place."

2. According to the Minimum Data Set (MDS) dated 03/18/11, R15 requires extensive assist of

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one staff for mobility, transfers, toilet use, hygiene and ambulation. The MDS also indicates that R15 has a moderate cognitive impairment and has sitting and standing balance deficits. The care plan dated 05/05/11 identifies R15 at high risk for falls requiring ADL assistance and supervision. A goal listed on the care plan dated 05/05/11 was listed as "resident will have fewer episodes of trying to get out of wheelchair."

On 06/08/11, a "Nurse/Physician Communication Record" indicated that R15 had "fallen forward from her wheelchair to the floor." The document indicated that R15 sustained a hematoma to the right side of the forehead. Further notations indicated that the physician was notified with no new orders. The care plan dated 06/08/11 listed interventions, in part as, "give verbal cues and offer to lay down after meals or when noted sleeping in wheelchair."

On 06/25/11 a "Resident Occurrence Report" indicated that R15 was found on the floor in her room next to her bed. It further indicated that R15 was complaining of right hip pain and pain to the right lower extremity. R15 was sent to the hospital where x-ray results showed a right subcapital femoral fracture resulting from trauma from a fall. Hospital records also indicated that a urine sample was obtained in the emergency department upon arrival indicating R15 also had an urinary tract infection. The only new intervention put into place was "Increase monitoring as needed."

On 07/18/11, documentation indicated that R15 had an unwitnessed fall from her bed with no injury noted. New interventions on R15's care plan, dated 07/18/11 were, in part as, "chair or bed alarm." On 10/13/11 at 11:00 am, R15 was observed standing in front of wheelchair at nurses

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station and took two steps forward. R15 was quickly assisted back to sitting position in wheelchair. There was no chair alarm that sounded. E7 was asked if R15 had a chair alarm, and her response was that she wasn't sure. There is no documentation in the medical record to indicate if a chair alarm was ever applied or in use as of this survey date.

3. R8's Physician Order Sheet for October 2011 documents a diagnosis, in part, Schizophrenia and Dementia. R8's most current Care Plan dated May 2010 identifies R8 as needing assistance of 1 staff for transfer using a gait belt.

R8's MDS of 9-1-11 identifies R8 as having disorganized thinking and a history of falls with injury. R8's Care Plan of May 2010 identifies R8 as being at risk for falls and having a history of a fracture of left hip. Care Plan approach includes in part, chair and bed alarm and remind to request assistance with transfers and toileting. Care plan also documents R8 is to be transferred with a gait belt.

On 10-12-11, at 12:30PM was observed to be transferred from her wheel chair to her bed by E17, CNA and Z1, Hospice CNA. E17 and Z1 failed to use a gait belt when transferring R8. R8 did not have a chair or bed alarm.

Facility Occurrence Report shows R8 had 7 falls between February 2011 and October 2011. Interventions for the falls include, in part; Provide safety education, ensure call light within reach, remind resident to request assist with toileting and transfer as needed. R8's current MDS shows disorganized thinking.

Occurrence Report of 8-17-11 documents R8 obtained a large hematoma to the right side of the forehead, abrasion to the bridge of the nose with

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F 323	Continued From page 21 a large amount bleeding from the nares and edema to nose/face and was sent to the hospital for evaluation. Occurrence Report of 10-9-11 reflects R8 fell out of her wheel chair and landed on her face. Recommendation is to increase monitoring as needed. Antibiotic, 3 day bladder tracking to be initiated on 10-17-11 when antibiotic completed. R8 was observed on 10-11-11 at 11:30AM to have a black and blue bruised face. 4. During the initial tour conducted on 10/11/11 of the 500 hall at 10:45 AM an air mattress was observed on the second bed in room 510 with side rails on both sides. The bed was occupied by R3. The head of the bed was elevated and there was a gap under the side rails of 4 inches at the point of where the bed was bent. When pressure was applied to the mattress edges where the bed bent a gap of 8 inches was measured. It was brought to the attention of E1, Administrator, at 10:55 AM on 10/11/11. An attempt was made to adjust the height of the side rails to eliminate the gap and it was determined the side rails could not be adjusted. At 11:30 AM the side rails were observed again and were found to have been replaced with adjustable side rails that could be adjusted to eliminate the gaps under the side rails.	F 323		
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	F 325		11/19/11

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F 325	Continued From page 22 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 interviews, observations and record review, the facility failed to follow their policy to provide assistance at meals and monitor meal intake for 2 of 7 residents (R5, R13) reviewed for nutritional status in a sample of 21. Findings include: 1. The Minimum Data Set (MDS) dated 9/2/11 identifies R5 to have had a decline in weight. The MDS indicates she requires set up/supervision for eating. The physician's Order Sheet (POS) for October 2011 identifies R5 to receives a mechanical soft diet with extra sauces/gravy and Med Pass 90cc three times daily (TID), all items cut up. The care plan dated 9/26/11 identifies R5 to have had a 6.5% weight loss within the past 30 days and 19.5% in the past 180 days. The care plan is to maintain weight. The problems/strengths indicates she is able to feed herself in the dining room with no noted difficulty swallowing or chewing. The care plan also identifies R5 to be on a restorative eating program. Interventions include selective menu, assist with tray set up, encourage resident to eat 75% or more of meals, offer alternates for food uneaten, record % eaten at each meal, if significant weight loss is determined, weigh weekly among others. Labs dated 7/20/11 show a	F 325		

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low Albumin 2.4 (normal 3/5 - 4/8) and a normal Prealbumin 23/6 (15-38).

On 10/11/11 at 11:30am, R5 was served her tray at bedside in her room. She had a large baked potatoes, ground meat, carrots, wheat bread, dessert and a container of skim milk. Staff set up her tray putting sour cream and butter on her potato. The bread was left in the bag. R5 fed herself very slowly and ate only 50% of her potato complaining that it was uncooked (testing showed it was hard), bites of her meat, 50% of her carrots, no dessert and 50% of her tea, 100% of her skim milk. No substitutes were offered for food uneaten. R5 stated she would have eaten the whole potato had it been cooked soft.

On 10/12/11 at noon, R5 received ground pork, baked beans, and pickled beets. She ate only bites of the meat, 100% of the baked beans and none of the beets. 50% of tea was drank. There was no milk on her tray. No staff were present once her tray was set up.

According to E3 Licensed Practical Nurse (LPN) on 10/12/11 at 1pm, R5 prefers to eat in her room.

Quarterly nutritional progress notes dated 9/2/11 indicates R5 tolerates her diet well, gets house supplements three times daily along with the med pass, and averages 50-75% meal intake.

Resident meal consumption records are incomplete with "hall" written in for 19 of 33 meals from 10/1/11 through 10/12/11 noon meal and no percentages recorded for any meals. The house supplement intake is also not monitored or recorded as well.

The facility's policy on "management of nutrition and hydration" indicates residents with unintentional weight loss with receive evaluation of weight loss and appropriate interventions

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F 325	Continued From page 24 implemented with the boundaries of the resident's wishes and/or health care directives. The facility did not take into account that eating in her room without staff encouragement could be a factor in her weight loss. The policy also indicates residents with significant weight loss are to be reviewed weekly at the standards of care committee meeting which is attended by the Registered Dietician or designee with each discipline prepared to discuss the cause for decline and risk factors. The policy also indicates the % of fortified supplements consumed will be recorded in the MAR (medication Administration Record) by nursing and reviewed/monitored by the RD. The policy also indicates all meal consumption will be reflected in percentage of food consumed. 2. The MDS dated 8/30/11 identifies R13 as being totally dependent on staff for eating. The October 2011 POS indicates R13 receives a pureed diet with house supplements and Med Pass 60cc three times daily. The POS also includes an order to "monitor intake." The Weight sheet shows a gradual weight loss from 134 pounds in April 2011 to 124.8 pounds in October. The care plan includes a goal to eat 75% of each meal. On 10/12/11 and 10/13/11 at noon showed R13 to receive a pureed diet and be fed. She ate only a small amount both on 10/12 and 10/13/11. Intake records show no intake recorded for 10/1 or 10/2 and blanks for 7 meals from 10/1 through 10/13 noon meal.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		11/19/11

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F 329	Continued From page 25 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assess for need, evaluate behavior tracking and plan for medication reduction for 3 of 11 residents (R6, R11 and R12) reviewed for medications in a sample of 21. Findings include: 1. R6's clinical record documents that on 7/28/11, his physician ordered Provera 10 milligrams orally three times a day due to	F 329		

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elevated testosterone levels. Laboratory analysis, dated 7/28/11 documents that R6's testosterone level was 5.31 nanograms per milliliter. This analysis documents that the normal range for testosterone in a male is 1.75-7.81 nanograms per milliliter. 5.31 nanograms per milliliter falls with the "normal" range.

On 10/11/11, at 2:10 PM, E2, Director of Nursing and E11, Quality Assurance Nurse, were asked why R6 was receiving the Provera. Both E2 and E11 stated that R6 has sexual behaviors of grabbing both staff and resident's genitals and breasts. E2 said that R6's physician told her that R6's testosterone level was high for a man of his age. E2 confirmed that there is no documentation in R6's clinical record regarding this information. The Facility was unable to produce physician notes regarding the Provera. E2 and E11 both stated that R6's Provera was discontinued when he was readmitted to the Facility from the hospital on 9/1/11. E2 said that R6 was in the hospital for a broken hip and the Provera was probably discontinued as it can increase bleeding.

R6's July 2011 behavior tracking documents a behavior of "Sexually Inappropriate (grabbing female resident and staff breasts and between legs)". The "Interventions" for this behavior is "1. Redirect and talk to resident about inappropriate behavior. 2. Report behaviors to physician. 3. Remove other residents from area of resident. 4. Medication as ordered by physicians". This document shows that from 7/1-7/31/11, this behavior occurred 18 times on the night shift, once on the day shift and once on the evening shift.

There is no other documentation in R6's clinical record regarding his sexual behaviors;

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why behaviors occurred mainly on the night shift; any less restrictive methods attempted prior to utilizing the Provera; and assessing for adverse side effects of using Provera in a male.

The Nursing 2011 Drug Handbook states that Provera "suppresses ovulation, possibly by inhibiting pituitary gonadotropin secretion, thus preventing follicular maturation and causing endometrial thinning". There is no documentation in the drug handbook regarding the use of Provera in males.

2. R11's October 2011, Physician Order Sheet (POS), documents R11 has a diagnosis, in part, Anxiety, depressive Disorder and Psychosis. R11 has an order of 10/31/09 for Risperdal .5 mg daily and an order Alprazolam 2.5 mg BID (twice a day) and .5mg HS (bedtime).

R11's Minimum Data Set (MDS) of 12/6/10, 5/3/11 and 7-13-11 documents no behaviors.

Record review of R11's Behavior Intervention forms from March, 2011 thru October 12, 2011 document R11 behaviors include: withdrawn due to mood; verbal distress/tearfulness; and decreased socialization (prefers to stay in room to crochet). Behavior Intervention forms show no behaviors during these months.

Record review of R11's medical record shows there is no comprehensive Physician note justifying the use of the Alprazolam and Risperdal and that a reduction would be contraindicated.

E19, CNA, stated on 10/13/11 at 12:45PM, R11 has no problems with behaviors. At 12:50PM, E8, Licensed Practical Nurse (LPN), stated R11 had no behaviors. At 1PM, E20, LPN stated she has never seen R11 have any behaviors.

Record review shows there is no evaluation of

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R11 not having any behavior and there is no plan in R11's most current Care Plan for a medication reduction.

E1, Administrator, stated on 10/12/11 at 2:20PM, Social Services department takes care of behavior tracking. On the afternoon of 10/13/11, E18, Social Service Director, stated she is new to the facility and confirmed Social Services should be evaluating behaviors and medications and confirmed there were no social service notes addressing R11 having no behaviors and addressing medication reduction.

3. The Admission sheet identifies R12 as being admitted to the facility on 11/5/10 with primary diagnoses of Ischemic Heart Disease and Chronic Obstructive Pulmonary Disease. The MDS dated 9/29/11 indicates R12 has no cognitive impairment and no behaviors/moods. .According to the Physician's Order Sheet (POS) for October 2011, R12 receives Abilify 5mg daily with Ativan .5mg twice daily and Lexapro. There is no justification for the use of this medication. On 10/11/11 during tour of the facility, E3, Licensed Practical Nurse identified R12 as having "panic attacks."

Review of the physician's orders indicate the Abilify was originally ordered on 9/1/11. The nurses notes reflect no behaviors and/or concerns that would justify the use of the Abilify. The physician progress note dated 9/1/11 written by the nurse practitioner documented "asked to see pt (patient) as she is upset that Dr did not see her yesterday. Pt states she is upset + thinks she is dying. She denies thoughts of suicide + states psych (psychiatrist) did not see her this month."

The physician progress notes dated 10/4/11 indicates R12 saw the nurse practitioner and is

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F 329	Continued From page 29 requesting the Ativan be scheduled due to anxiety when she uses the bathroom and at night. There is no documentation the facility identified this issue and assessed it prior to the increase in Ativan and no indication as to what interventions the facility attempted prior to the initiation of the Abilify. According to behavior sheets, R12 is being monitored for attention seeking and yelling at staff for the use of Lexapro. No behavior management program is evident for increased anxiety when using the toilet and at night or panic attacks identified by the facility and R12. On 10/11/11 at 11:15am, R12 stated she has "panic attacks" due to all the medication she takes and her inability to "draw a breath." R12 stated she gets really out of breath when ambulating to the toilet. R12 states if staff would just come in a sit with her until the attacks subside, she would be fine but staff don't/won't stay with her and the attacks are frightening. R12 had oxygen via nasal cannula and was slightly dyspneic while speaking.	F 329		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.615e) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction	F9999		

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Information Act [20 ILCS 2635] for all persons 18 or older seeking admission to the facility. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police.

This regulation was not met as evidenced by:

VIP Manor failed to follow their plan of correction for the survey of 09/16/2010.

Based on record review and interview the facility failed to initiate resident background checks within 24 hours for 6 of 10 residents (R22, R23, R24, R25, R26, R27) in the supplemental sample.

Findings include:

On 10/11/11 ten resident files were reviewed including their criminal background checks and the required website checks. Six of the ten background checks were not initiated within 24 hours.

Admitted	Background Check Initiated
R22 10/4/11	10/11/11
R23 9/27/11	10/3/11
R24 9/27/11	10/3/11
R25 8/30/11	9/2/11
R26 8/31/11	9/2/11
R27 9/8/11	9/15/11

On 10/13/11 at 10:35 AM, E1, Administrator, was asked about the criminal history checks that were not done within 24 hours of admission. She confirmed she had no questions about the dates the background checks

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F9999	Continued From page 31 were submitted. (Repeat B) 300.610a) 300.1210b) 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 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	F9999		

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F9999	Continued From page 32 care needs of the resident. 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 issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) 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 observation, interview and record review, the facility failed to provide appropriate treatment for wounds/ulcers for (1) of 7 sampled residents (R8) and 1 supplemental resident (R29) reviewed for wound care and failed to assess and monitor and Care Plan for Dialysis complications for 1 of 1 residents (R14) reviewed for Dialysis in the sample of 21. This failure resulted in R29 developing cellulitis, osteomyelitis and having her left great toe amputated. Findings include: 1. R29's Physician Order (POS) Sheet of July 2011 documents R29 is a 50 year old female with a diagnosis, in part, of Insulin Dependent Diabetes Mellitus, Hypertension, Crohn's	F9999		

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Disease, Back Surgery, Cardiovascular Accident, Decubitus Ulcers, Wound Right Hip Closure and Blood Dyscrasia. R29 has a Physician order on 7-17-11 to give Rocephin 1 gram IM (intermuscular) qd (every day) x 2 days then start Keflex 500 mg by mouth 1 every 6 hours x 8 days for treatment to cellulitis of the left great toe. Cleanse area and apply Bactroban ointment and dry dressing q (every) day and PRN (as needed). POS documents an order of 7-19-11 "May send res (resident) to ER (Emergency Room). POS shows an order of 7-19-11 for Bactrin DS BID (twice a day) po (by mouth) x 10 days. It is documented on 7-21-11 on the POS to refer to a vascular surgeon to evaluate and treat left great toe. POS documents an order on 7-22-11 to send R29 to the ER for evaluation per family demand.

R29's Wound Culture of left great toe on 7-19-11 shows MRSA (Methicillin Resistant Staph Aureus) which was resistive to Bactrim DS. The culture does not identify sensitivity to Keflex.

NURSE/PHYSICIAN COMMUNICATION RECORD of 7-17-11 has documentation that reason for calling the physician is left great toe very red, swollen , hot to touch , nail bed above nail red and top of the toe is purple. Temperature is 99 degrees, pulse is 90, blood pressure is 110/68. Pain is 3 out of 5. Pain medication given for comfort. Physician called and gave order for Rocephin 1 gm IM qd x 2 days then start Keflex 500mg every 6 hours x 8 days. Record also shows the above order for cleaning and treating the wound. Note at 2PM states R29 states foot and even her leg hurt half way up her calf. No drainage.

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NURSE/PHYSICIAN COMMUNICATION RECORD of 7-19-11 documents, "L (left) great toe declining." Time of Physician response states 12 noon with orders to send R29 to the ER for evaluation. Note at 10AM documents, "CNA (Certified Nurse Aide) came & told this nurse L toe looks worse very red & swollen hot to touch mushy on bottom & purple has yellow drainage coming out. Res was started on ABt (antibiotic) 7/17/11. Call placed to Dr. (Doctor) awaiting call back." Note at 12 noon documents, "Dr states send res to ER for eval. DON (Director of Nursing) states call Dr. back ask for culture order & ? about IV antibiotics. awaiting call back." (POS review shows no order was obtained for IV antibiotics.) Note at 3:20PM documents, "Spoke with Dr.-- at length re (regarding) res cond (condition), states to send res to ER if res chooses to go. This Nurse evaluated L great toe et (and) noted 0 increase in redness or swelling noted from eval on Sunday evening, res (resident) reassured and states does not want to go to ER..."

It is documented in 7-20-11 Nurses Notes that R29 left the facility with a family member at 8:30AM for a Doctor appointment. E1, Administrator, stated on 10-21-11 at 11AM, she could not find any information as to where R29 went on 7-20-11. She stated it is suppose to be documented in the Nurses Notes but it is not. E1 suggested to call R29's sister and she may know. On 7-20-11 at 12:40PM, Z4, R29's sister, stated she took R29 to the plastic surgeon who operated on her buttock wound and the Surgeon did not look at R29's toe.

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It is documented in the Nurses Notes on 7-20-11 that R29's left toe continues to be swollen, red and purple with large amount of yellow slough noted, continues to have scant amount of serosanguinous drainage. R29 ambulates and full weight bearing to left lower extremity without difficulty. Left foot slight swollen inner arch and slight red in color. (Facility WEEKLY WOUND OR SKIN ABNORMALITY TRACKING LOG of 7-22-11 identifies left toe wound with treatment of Bactroban and dry dressing with no pain. ".2 slit on nail bed. 0 toenail. Just starting to grow from bottom of toe nail bed. There is no mention of color, swelling, slough or drainage.)

Z5, Nurse Practioner, documented on a progress note of 7-21-11, that R29 was seen to follow up on a Vascular Ulcer to great left toe. Onset 5-7 days ago on antibiotic therapy. Denuded skin up to 1st knuckle. A large piece debrided off with slight bleeding. Wound base white. Rest of toe mushy under skin. Plan to send to Vascular Surgeon.

Nurses Note 7-20-11 states R29 propels self around facility in wheelchair. Note of 7-22-11 states R29 has pain in left leg, 3 plus pitting edema noted in left leg and foot. It is documented on 7-22-11 at 12 noon, Z4 was called to tell her of appointment for vascular surgeon. Z4 stated, "I demand my sister be sent to hospital now!" It is documented at 6:25PM R29 was admitted to the hospital for IV antibiotic and MRSA to R (right) great toe. (Yet above medical records show it was the left great toe.)

It is documented in R29's Hospital History and Physical of 7-23-11, that R29 came to the

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hospital with chief complaint of having noted left toe pain and redness and swelling ongoing for a few days. She had broken her toe nail and started noticing that there was some redness in the beginning but no purulence or bleeding. Later on the toe started to swell and she had severe pain. Physical examine showed left foot great toe has significant edema and erythema. No open wounds or ulcers. No purulent discharge noted at this time. It is documented under Assessment and Plan: Left foot diabetic ulcer with cellulitis associated with leukocytosis, subjective fever. Culture is positive of MRSA. Continue vancomycin, obtain podiatry on consult, wound care on consult. Arterial Doppler negative for evidence for peripheral vascular disease. Continue bacitracin topically. Obtain X-ray of the foot for signs of osteomyelitis...

It is documented on the Hospital X ray of R29's left foot, on 7-22-11, Soft tissue swelling of the great toe is seen. Irregularity of the tuft of the distal phalanx of the great toe. This may be due to bony erosion as a result of osteomyelitis. This could be due to prior trauma. A small linear lucency in the area, possibly a more recent fracture. Mild degenerative osteoarthritic changes. Small posterior calcaneal spur.

It is documented on R29's Consultation Report of 7-24-11 by Z3, Podiatrist, R29 does have a large ulceration distal tip of the left hallux. There is exposed bone of the distal phalanx tip present. It is somewhat fibrotic and necrotic. X ray results are suspicious for osteomyelitis . There does appear to be some destruction about the distal tip of the distal phalanx...Assessment: Osteomyelitis of the left hallux distal phalanx with associated

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cellulitis and foot ulceration. Plan includes, in part, treat with amputation of the distal phalanx of the hallux...continue on current IV antibiotics...

Hospital Discharge Summary of 7-27-11 states discharge diagnoses, in part: Osteomyelitis of the distal phalanx of the left great toe; Status post amputation of the distal phalanx of the left great toe; Cellulitis of the ankle and left foot - significantly improved. Hospital Course: R29 came to the ER and admitted with severe pain in her right great toe and was admitted to the hospital She has a left diabetic foot ulcer and was diagnosed to have cellulites of the foot, and was started on IV antibiotics because of the wound and the leukocytosis and fever. R29 was diagnosed as having osteomyelitis and underwent amputation of the distal phalanx of the left great toe for the osteomyelitis.

During interview with E20, Licensed Practical Nurse (LPN) on 10-14-11 at 11:45AM, E20 stated on 10-19-11 she was told by a CNA that R29's toe was getting worse. E20 stated she had not seen the toe before. It was really big very swollen purple on bottom and the top was cracked with yellow drainage. It was crusty. E20 thought R29 needed to go to the hospital. She had been on antibiotics for 2 days. It must not have been working. E20 called Z2, R29's Physician and told him of her concerns and he ordered for her to be sent to the hospital. E20 stated they have to let, E2, Director of Nursing (DON) know when they are sending a resident to the hospital. E20 stated she told E2 and E2 stated to call Z2 back and see if they could treat the toe at the facility. R29 was not refusing to go to the hospital. It was the end of the shift so E21, Registered Nurse (RN) took

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over.

On 10-19-11, E21 stated she was the Nurse who initially saw R29's toe on 7-19-11. Her great toe was red and swollen and real purple on the end with yellow drainage. It looked like a blister area on the end of the toe. She called Z2 and got an order for Rocephin IM and then Keflex. On 7-19-11, E20 stated R29's toe looked very bad and she had called Z2. It's the facility's Policy and Procedure to check with E2 or the Nurse on call, before sending residents to the hospital. E21 stated she thought E2 went and looked at the toe and thought they could treat it at the facility with IV antibiotics. E21 stated she was the one who had to call Z2 back and tell him E2 wanted to treat R29 in house. E21 stated Z2 was very upset. He wanted her sent to the hospital. He felt he was being seconded guessed. He asked E21 if she had seen the toe that day and she told him "NO", she had just come on duty. Z2 told her he did not understand why they did not want to send R29 out and said if she wants to go send her. E21 said she then looked at R29's toe and talked to R29. The toe did not look any worse. Her accu check was good. E21 stated she told R29 the antibiotics had not had a chance to work. E21 states she felt she convinced R29 she did not need to go the the ER. E21 stated she felt pressured not to send R29 to the hospital. E21 stated after R29 went to the hospital she talked to E1 and E2 of concerns of not doing what Z2 wanted. Facility Policy got in the way of good patient care. Z2 did not give an order to not send R29. He said she had just had 2 days of IM Rocephin. He wanted her to go to the hospital based on what the Nurse told him that morning. E21 stated at the time, there was no written order

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to send R29 to the ER. It was written on the Nurse communication record but not on the POS.

On 10-19-11 at 2:15PM, Z2 stated he had gotten a report from a Nurse that R29's wound on her toe was worse. He was not at the facility at the time. If the wound is not getting better in 2 days and is worse, someone needs to look at it. He ordered for R29 to be sent to the hospital. If he over reacted then the worst thing that happens is they send her back. If needed they would admit her. They called Z2 back and said E2 wanted to treat R29 at the facility. Z2 stated he had concerns and thought R29 should go to the hospital. Z2 stated he did not rescind the order to send R29 to the ER. The only reason not to send her is if she refused to go. Z2 stated if the toe was becoming gangrenous then waiting 2 days would not have made a difference. She probably would have lost the toe anyway. (There is nothing in hospital records that show R29's toe was gangrenous.)

E2 stated on 10-21-11 at 10:45 AM, she was not aware Z2 had ordered for R29 to go to the hospital. E20 had told her she was sending R29 out to the hospital and E2 told her she should ask for a culture and antibiotics and treat at the facility. E2 denied she told E20 not to send R29 to the ER. "If someone wants to go to the hospital it's her right." E2 stated she did not look at R29's toe before telling E20 to call Z2 and see if she could be treated at the facility. She stated there was no written Policy and Procedure that she or a charge Nurse had to approve before a resident was sent out to the hospital.

On 10-21-11 at 10:55PM, E22, LPN, stated it had

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been the rule around the facility that you had to get approval to send a resident to the hospital. They wanted residents to be treated in the facility unless it was an emergency.

On 10-21-11 at 11AM, E1, Administrator, stated there was no written Policy and Procedure to not send a resident to the hospital unless the DON or charge Nurse approves. The do want the Nurses to run it through the DON before sending out unless it's an emergency due to some Nurses getting carried away and sending a resident out when they could be treated at the facility.

On 10-20-11 at 3:05PM, Z3, R29's Surgeon/Podiatrist, stated trauma could have caused injury to R29's left great toe. Even rubbing shoe on toe could have caused the injury. She does not have much feeling in the toe and she could be doing damage without knowing it. Z3 stated they possibly could have saved the toe if it was treated earlier. When he saw it, bone was exposed and it was too late. Once bone is exposed it has to be amputated. Possibly with IV antibiotics and staying off her feet, the toe may have been saved. It could have healed. Two days could make a difference.

2. R8 was observed on 10-12-11 at 12:30PM, to have two ulcerated areas on her right foot and one on her left foot. E7, Treatment Nurse, was present and confirmed the areas and stated they were not pressure sores.

Record review of R8's Medical Record and Treatment Administration Record (TAR) show R8's ulcerated areas on her feet were not

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F9999	Continued From page 41 assessed. At 1:20PM, E1, Administrator, stated she had just looked at R8's feet and stated it looks arterial and R8 needs a doppler study. E1 was informed there was a treatment order on the TAR for treatment to the left lower extremity but no assessment. At 1:50PM, E1 stated she could not find an assessment on R8's feet. E1 stated the policy is to do an initial assessment and document and then assess and document weekly. (B) 300.610a) 300.1210b) 300.1210d)5) 300.1220b)3) 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	F9999		

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F9999	Continued From page 42 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 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)5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel,	F9999		

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representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3220 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 issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

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 record review, observation and interview, the facility failed to provide timely turning and repositioning and pressure sore identification, monitoring and treatment for 1 of 7 residents (R16) in the sample of 21 and 1 resident (R28) in the supplemental sample reviewed for turning and reposition and pressure sore prevention. This failure resulted in R28 developing an unstageable left heel pressure sore.

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F9999	Continued From page 44 Findings include: 1. R16's Minimum Data Set (MDS), dated 8-18-11, documented severe cognitive impairment, total dependence of two plus persons physical assistance with mobility and transfers, bilateral upper and lower extremity impairment and two Stage II pressure sores. R16's Care Plan, goal date 11-17-11, documented R16 was to be turned and repositioned every 2 hours and as needed. During observation of R16's turning and repositioning, on 10-12-11 from 9:25a.m. to 12:20p.m., R16 was not timely turned and repositioned. Interview of E14, Registered Nurse (RN), on 10-12-11 at 9:25a.m., E14 stated R16 was "pulled up and switched her sides." R16's position was observed the same before and after her positioning with coccyx and buttock pressure remaining and unrelieved with being pulled up and sides switched. E13, Certified Nursing Assistant (CNA) and E5, CNA were observed checking R16 adult's diaper for incontinence, on 10-12-11 at 11:40a.m. E5 and E13 did not reposition R16. 2. R28's MDS, dated 9-22-11, documented severe cognitive impairment, total dependence of one person physical assist with mobility and transfer, bilateral upper and lower extremity impairment and at risk for pressure sore development. The facility's Weekly Wound or Skin Abnormality Tracking Log, week ending date 8-5-11, documented a 5.0cm x 4.0cm unstageable area was found on R28's left heel on 8-1-11.	F9999		

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Interview of E7, Treatment Nurse, on 10-13-11 at 1:40p.m., E7 stated she started as the Treatment Nurse on 8-5-11 and R28's entire left heel was very, very deep purple and boggy, mushy, when she saw it. E7 also stated she documented the measurements of R28's left heel on the Tracking Log, week ending date 8-5-11 and future Tracking Logs. R28's Weekly Wound or Skin Abnormality Tracking Log, week ending 8-12-11, documented R28's left heel as an unstageable 5.0cm x 4.0cm "escar (eschar)" area.

Review of R28's chart did not document R28's left heel was monitored for pressure sore development until it was found on 8-1-11 as a 5.0cm x 4.0cm unstageable area. R28's MDS, dated 9-22-11, document she was at high risk for pressure sore development.

R2's Skin Risk Evaluation and Plan of Care, goal date 12-25-11, documented R28 was at risk for skin breakdown. It was also noted R28's left heel pressure sore was not documented on her Care Plan with goals identified and/or interventions for her left heel.
The facility's Wound Prevention/Skin and Wound Treatment policy and procedure, dated 10-1-08,documented, in part, residents will exhibit no evidence of sign breakdown or will regain skin integrity. It was also documented that all residents at risk will have skin condition checked and documented daily.

Interview of E16, Medical Records, on 10-14-1 at 1:15p.m., E16 stated she was not finding Weekly Skin Condition Evaluation sheets for 7-11, 8-11 and 9-11. E16 then provided, on 10-14-1 at

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F9999	Continued From page 46 1:50p.m., Weekly Skin Condition Evaluations, dated 2-11 to 10-11, which did not document skin breakdown of R2's left heel until 8-15-11. (B) 300.610a) 300.1210b) 300.1210d)6) 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 practicable physical, mental, and psychological	F9999		

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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)6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

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

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These Regulations were not met as evidenced by:

Based on record review, interview and observation, the facility failed to provide a safe transfer for a resident with a history of falls; failed to ensure a resident's siderail was properly functioning; and failed to provide timely supervision, care planning and fall prevention for 4 of 10 residents (R2, R3, R8 and R15) reviewed for falls in a sample of 21. This failure resulted in R2 fall and fracturing his left hip. This failure also resulted in R15 falling and fracturing her right hip.

Findings include:

1. R2's Investigation Report, dated 5-23-11, documented R2 was found, on 5-20-11, sitting on the floor, bedside. It was also noted R2 had a diagnosis of Dementia and was attempting to ambulate resulting in a fall. R2 complained of right ankle pain and edema. R2's Investigation Report, dated 6-17-11, documented R2 was found sitting on the floor in a puddle of urine. It was also noted R2 was attempting to ambulate unassisted. R2's Investigation Report, dated 7-11-11, documented R2 was found sitting on the floor in his room. It was also documented R2 had risk factors of weakness and Dementia.

R2's Investigation Report, dated 10-3-11, documented R2 was found on 7-11-11 leaning up against his roommate's bed. It was also noted R2 sustained a left hip fracture.

R2's Fall Risk Assessments, dated 5-11 and 6-11, documented R2 was a high risk for falls. It

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was also noted R2 had a history of falls, impaired gait and balance and was disoriented times three at all times.

R2's current Plan of Care did not document R2's falls or interventions to prevent further falls. R2's Behavioral Tracking, dated 7-11, 8-11 and 9-11, documented "Continuously getting out of wheel chair" with documented interventions. R2's Care Plan did not document R2's behavior or interventions documented on R2's Behavior tracking Sheet.

The facility's Fall Management policy and procedures, dated 11-07, includes, "the facility will identify residents at risk for falls and implement interventions to minimize fall occurrences and injury real ted to falls." It was also noted A Fall Risk Evaluation and Care Plan will be completed when the resident is identified to be at risk for fall or has had a fall to
ensure that appropriate interventions are put into place.

2. According to the Minimum Data Set (MDS) dated 03/18/11, R15 requires extensive assist of one staff for mobility, transfers, toilet use, hygiene and ambulation. The MDS also indicates that R15 has a moderate cognitive impairment and has sitting and standing balance deficits. The care plan dated 05/05/11 identifies R15 at high risk for falls requiring ADL assistance and supervision. A goal listed on the care plan dated 05/05/11 was listed as "resident will have fewer episodes of trying to get out of wheelchair."

On 06/08/11, a "Nurse/Physician Communication Record" indicated that R15 had "fallen forward

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from her wheelchair to the floor." The document indicated that R15 sustained a hematoma to the right side of the forehead. Further notations indicated that the physician was notified with no new orders. The care plan dated 06/08/11 listed interventions, in part as, "give verbal cues and offer to lay down after meals or when noted sleeping in wheelchair."

On 06/25/11 a "Resident Occurrence Report" indicated that R15 was found on the floor in her room next to her bed. It further indicated that R15 was complaining of right hip pain and pain to the right lower extremity. R15 was sent to the hospital where x-ray results showed a right subcapital femoral fracture resulting from trauma from a fall. Hospital records also indicated that a urine sample was obtained in the emergency department upon arrival indicating R15 also had an urinary tract infection. The only new intervention put into place was "Increase monitoring as needed."

On 07/18/11, documentation indicated that R15 had an unwitnessed fall from her bed with no injury noted. New interventions on R15's care plan, dated 07/18/11 were, in part as, "chair or bed alarm." On 10/13/11 at 11:00 am, R15 was observed standing in front of wheelchair at nurses station and took two steps forward. R15 was quickly assisted back to sitting position in wheelchair. There was no chair alarm that sounded. E7 was asked if R15 had a chair alarm, and her response was that she was not sure. There is no documentation in the medical record to indicate if a chair alarm was ever applied or in use as of this survey
date.

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3. R8's Physician Order Sheet for October 2011 documents a diagnosis, in part, of Schizophrenia and Dementia. R8's most current Care Plan dated May 2010 identifies R8 as needing assistance of 1 staff for transfer using a gait belt.

R8's MDS of 9-1-11 identifies R8 as having disorganized thinking and a history of falls with injury. R8's Care Plan of May 2010 identifies R8 as being at risk for falls and having a history of a fracture of left hip. Care Plan approaches include, in part, chair and bed alarm and remind to request assistance with transfers and toileting. Care Plan also documents R8 is to be transferred with a gait belt.

On 10-12-11, at 12:30PM was observed to be transferred from her wheelchair to her bed by E17, CNA and Z1, Hospice CNA. E17 and Z1 failed to use a gait belt when transferring R8. R8 did not have a chair or bed alarm.

Facility Occurrence Report shows R8 had 7 falls between February 2011 and October 2011. Interventions for the falls include, in part; Provide safety education, ensure call light within reach, remind resident to request assist with toileting and transfer as needed. R8's current MDS shows disorganized thinking.

Occurrence Report of 8-17-11 documents R8 obtained a large hematoma to the right side of the forehead, abrasion to the bridge of the nose with a large amount bleeding from the nares and edema to nose/face and was sent to the hospital for evaluation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145655	A. BUILDING _____ B. WING _____	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
V I P MANOR	**393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 52 Occurrence Report of 10-9-11 reflects R8 fell out of her wheelchair and landed on her face. Recommendation is to increase monitoring as needed. Antibiotic, 3 day bladder tracking to be initiated on 10-17-11 when antibiotic completed. R8 was observed on 10-11-11 at 10:30AM to have a black and blue bruised face. 4. During the initial tour conducted on 10/11/11 of the 500 hall at 10:45 AM an air mattress was observed on the second bed in room 510 with side rails on both sides. The bed was occupied by R3. The head of the bed was elevated and there was a gap under the side rails of 4 inches at the point of where the bed was bent. When pressure was applied to the mattress edges where the bed bent, a gap of 8 inches was measured. It was brought to the attention of E1, Administrator, at 10:55 AM on 10/11/11. An attempt was made to adjust the height of the side rails to eliminate the gap and it was determined the side rails could not be adjusted. At 11:30 AM the side rails were observed again and were found to have been replaced with adjustable side rails that could be adjusted to eliminate the gaps under the side rails. (B)	F9999		