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	14E342	A. BUILDING _____ B. WING _____	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK FALLS REHAB & HCC	430 MARTIN ROAD ROCK FALLS, IL 61071

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F 000	INITIAL COMMENTS Annual Licensure and Certification An Extended survey was conducted. Complaint Investigation #1112963/IL54635- See F246 & F323	F 000		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to release restraints while residents are supervised, failed to show a medical need for the use of a restraint, failed to conduct a restraint assessment, failed to attempt less restrictive devices before using a lap restraint and failed to follow their policy and procedure on restraints. This applies to 2 of 10 residents reviewed in the sample for side rail use (R3, R7) and 3 in the sample (R5, R6, R9). The findings include: 1. On 11/7/11 at 11:15am, R6 was observed sitting in her wheelchair with a seatbelt around her waist. R6 was seated at a dining room table next to a supervised activity that was in progress. At 11:29am, the activity ended and R6 remained in her wheelchair with a seatbelt intact around her waist. At 12:05pm, E6 (Certified Nursing Assistant - CNA), moved R6 in her wheelchair	F 221		11/29/11

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

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F 221	Continued From page 1	F 221		

from one side of the table to the other side of the table. E6 sat in a chair at the table next to another resident. E8 (CNA) was also at the table sitting between R6 and another resident. At 12:25pm, R6 remained at the dining room table for the lunch with a seat belt intact during lunch.

On 11/8/11 at 9:25am, R6 was observed at a supervised activity with her seatbelt intact around her waist. At 9:35am, R6 stated, "I want to go home." R6 was asked if she could remove the seatbelt around her waist. R6 attempted to release the seatbelt and then stated, "No, I can't. Can You?"

The Physical Restraint/Enabler Consent dated 8/23/11 for R6 showed, "Type of restraint: Self Release Seat Belt and low bed.; Reason for restraint: Safety from injury and family requests.; Benefits of restraints: Prevention of injuries to self and others. Reduced potential for falling. Enhancement of functional abilities." The Physical Restraint/Enabler Consent dated 8/23/11 for R6 showed no documentation in the area for "Potential Consequences" (Physical consequences or psychosocial consequences) on the form.

R6's Care Plan dated 8/30/11 showed, "Need for use of enabler does not limit movement/accessibility (does not meet definition of restraint). Device in place, self release belt.; Enabler type self release belt in use in wheelchair. Enables R6 to maintain mobility safely. Explanation of why enabler does not restrict - resident able to self release."

The facility's October 2007 Physical Restraint

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F 221	Continued From page 2 Policy showed, "Definition of Physical Restraint: Physical restraints is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body, which the individual cannot remove easily and which restricts freedom of movement or normal access to one's body. They include, but are not limited to: bed rails, self -release waist restraints, soft waist restraints....; Procedure: Release the physical restraint a minimum of every two hours. During this period the resident shall be ambulated (if applicable), repositioned, toileted or changed, and skin care and nursing care provided, as appropriate." R6's Minimum Data Set with an Assessment Reference Date of 8/11/11 showed cognitive impairment.; Extensive assistance needed for bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. The Range of Motion Assessment dated 8/9/11 for R6 showed a score of 6. The "Risk Score and Treatment Options" section on this form showed a score of 6 equals, "Treatment may include, but is not limited to basic range of motion, positioning, turning, ambulating, as indicated by individual resident needs." The Range of Motion assessment for functional ROM on the form dated 8/9/11 was not filled out for R6 and the area to check to proceed or not to proceed with Restorative programming was left blank. 2. R3's Physician's Order Sheet dated 11/2011 shows that R3 has diagnoses including Osteoporosis, Dementia and Depression. This same form shows that R3 has an order for "Side rails x2 when in bed for resident self mobility per resident's request".	F 221		

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F 221	Continued From page 3 R3's Minimum Data Set dated 8/31/11 shows that R3 requires extensive assist of 2 staff for bed mobility and that physical restraints are not used for R3. On 11/9/11 at 11:40 AM, E8 (CNA) was asked why R3 needed two full side rails in bed. E8 stated, "When she came in some years ago (R3 was admitted to the facility in 2007) she had a broken pelvis and she tried to get out of bed. So we put the side rails up. I believe she still at times tries to get up by herself. She also uses them to turn. I believe it is because the family wants them up. It is care planned like that." E8 was asked if R3 requested that her side rails be up. E8 stated, "I don't know, I've never asked her. I would assume that they (referring to administration) did." R3's undated Physical Restraint/Enabler Assessment does not assess R3's bed mobility or a reason for R3 to use two full side rails. On 11/9/11/ at 11:30 AM, R3 was asked if she liked the side rails up when she is in bed. R3 looked at surveyor with a blank expression and stated, "I sleep with my husband. So he is on one side and there is nothing on the other side." R3's Falls care plan dated 8/28/11 states, "Side rails in up position while in bed to facilitate safe and more independent bed mobility." During the survey, from 11/7-11/9, no evidence of attempted restraint reduction was found in R3's medical record. 3. R9's November, 2011, Physician's Order	F 221		

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F 221	Continued From page 4 Sheet documents that R9's diagnoses include Parkinson's Disease, Dementia, Anxiety and Aggression. The same Physician's Order Sheet shows an order for a self-release seat belt for safety. R 9' s' Physical Restraint/Enabler Consent documents that R9 uses the seat belt for safety and to prevent injury. The same document shows that redirection and cues were tried, no duration, circumstances or time of day were documented. The benefits of the safety belt were documented as prevention of injuries, reduced falling and enhancement of functional abilities. R9's Minimum Data Set (MDS) assessment of 9/2/11 documents that R9 can rarely/never express his needs and rarely/never understand others. R9 has short and long term memory problems and severely impaired cognitive skills for decision making. The same assessment shows that R9 is dependent on two or more persons for bed mobility, and for transfer. R9 is dependent on two or more persons for toilet use. R9 has impairment in range of motion of both lower extremities. R9 uses a wheelchair for mobility. The assessment does not show any physical restraint device. On 11/9/11 at 8:05 AM R9 was observed at the breakfast table. E2 Director of Nursing said that R9 wears a self releasing belt and that R9 can release it himself. (Belt was not fastened at this time by staff) E2 said the staff release the belt at meal times, toileting, and when he goes to bed. The same day R9 was observed at 11:15 AM in the dining room, when R9 was talked to he did not respond to the questions, he smiled and	F 221		

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F 221	Continued From page 5 mumbled incoherently. (Belt was not fastened at this time) R9's Care Plan for Enable/Physical Restraint dated through 11/28/11 documents that R9 will use the enabler to preserve proper alignment and ensure safety with no side effects. The same plan shows that R9 should wear the belt when up in the wheel chair. The October 2007 facility policy shows the following definitions: Physical Restraint: Physical restraints is an manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body which the individual can not remove easily and which restricts freedom of movement or normal access to one's body. The same document defines Adaptive equipment/ Physical Enabler as: a physical or mechanical device, material or equipment attached or adjacent to the resident's body that may restrict freedom of movement or normal access to one's body, the purpose of which is to permit or encourage movement, or to provide opportunities for increased functioning, or to prevent contractures or deformities. Adaptive equipment is not a physical restraint. 4. The Physician's Order Sheet dated November 2011 showed R5 has diagnoses to include: Dementia, Osteoporosis, Vision Loss and Spinal Stenosis. R5 has an physician's order dated 8/24/11, "Up in wheelchair ad lib with quick release seat belt with assist. Self-Release Belt for safety."	F 221		

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F 221	Continued From page 6 The Minimum Data Set (MDS) assessment reference date of 9/8/11 assessed R5 as having long and short term memory and requiring extensive physical assistance of one staff for all ADL's (Activities of Daily Living) except eating. R5 was assessed as having functional limitations on both sides in the lower extremities. R5 did not walk during the assessment period. R5 was able to propel self in the wheelchair after being transferred by staff. R5 was assessed to require the use of a restraint daily (categorized as "Other" on the MDS). R5's Physical Restraint Assessment dated 5/27/11 documented the following: Type: Lap belt; Reason: Safety. There was no documentation for duration of the restraint, alternatives tried or circumstances and time the restraint should be used. R5's Physical Restraint Assessment dated 8/25/11 documented the following: Type: Self release seat belt; Reason: Falls. Alternatives tried: Chair alarm/cues. There was no documentation for duration of the restraint, or what circumstances and time the restraint should be used. The restraint care plan dated 9/7/11 documented, "Consider removing device when under monitoring (i.e. meals, activities...) if safety can be maintained." On 11/7/11 at 10:15am, 11:10am and 11:30am, R5 was observed in the main dining room during supervised activities and lunch and on 11/8/11 at lunch with a CNA seated beside her. R5's self-releasing seat belt was not released during	F 221		

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F 221	Continued From page 7 these times. On 11/9/11 at 8:15am, E2 (RN-Director of Nursing) said that R5 has a self-releasing seat belt and may not do it on command but would undo it if she was feeling around and found the release. The facility's Physical Restraint Policy of October 2007 documented, "Physical restraints include, but are not limited to: bed rails, self-release waist restraints, soft waist restraints....; Procedure: Release the physical restraint a minimum of every two hours. During this period the resident shall be ambulated (if applicable), repositioned, toileted or changed, and skin care and nursing care provided, as appropriate."	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225		11/29/11

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F 225	Continued From page 8 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on Observation, Interview and Record Review the facility failed to investigate allegations of abuse and report the allegations of abuse within 24 hours and the results of the investigation within 5 days to Illinois Department of Public Health. This applies to 2 of 10 (R8 & R10) residents reviewed for abuse in the sample of 10 and 1 (R15) resident in the supplemental sample. The findings include: 1. On 11/7/11 at 11:44am, R8 was observed to walk over to another table in the dining room. R15 was seated at the table with her chair pushed out towards the wall behind her. R8 squeezed	F 225		

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behind R15's chair to sit at another chair at the table. R15 stood up, moved her chair out of the way, walked over and struck R8 on the arm 3 times. R15 looked up and looked around and then yelled, "Nurse."

On 11/9/11 at 9:50am, E2 (Director of Nursing - DON) stated, "R8 was sent out because she hit R15. You were all there and saw it. We had been looking for other placement for R8 before you (state survey team) came. So we did not drop the ball on R8." E2 was asked if an abuse investigation was done for the resident to resident altercation in the dining room on 11/7/11? E2 replied, "We did an incident report. We were already placing R8 somewhere so we didn't look at R15. The certified nursing assistants (CNA)didn't see anything." E2 was asked if abuse investigations are done at the facility for residents when they have altercations? E2 replied, "Yes. We didn't with this one because of everything going on and we had already made arrangements for R8 to go to the hospital because of her behaviors." E2 stated she was not aware that R15 had hit R8 first and R8 responded by trying to hit back at R15.

The facility's Abuse Prevention Program Policy (dated 11/4/2010) showed, "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment.; Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by

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F 225	Continued From page 10 accidental means in a facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.; Physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment.; Employees are required to immediately report any occurrences of potential/alleged mistreatment they observe, hear about, or suspect to a supervisor and the administrator. Supervisors shall immediately inform the administrator or designee of all reports of potential/alleged mistreatment. Upon learning of the report, the administrator or designee shall initiate an investigation. Residents who allegedly mistreat another resident will be removed from contact with that resident during the course of the investigation. The accused resident's condition shall immediately be evaluated to determine the most suitable therapy, care approaches and placement considering his or her safety, as well as safety of other residents and employees of the facility.; The facility must ensure all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with state law. The report shall be made as soon as possible, but ought not exceed 24 hours after discovery of the incident. A written report shall be sent to the Department of Public Health. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health."	F 225		

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The Psychosocial Social Service Progress Notes for R8 showed, "12/23/10 - R8 was in room 9 and male resident reported to staff that R8 had struck him. R8 denied accusation.; 4/7/11 - R8 was reported to struck another resident yesterday. R8 has been coming to other resident's rooms and laying on their beds. Future behaviors will be documented here.; 6/2/11 - R8 was reported to be hitting a staff member yesterday after lunch break. Staff was mopping the floor and told R8 to stay away from it. R8 became very resistive and agitated when staff was trying to redirect her to another spot. R8 hit staff on her face and staff informed nurse and administrator about it. Future behaviors/developments will be documented here.; 6/14/11 - R8 entered another residents room and laid on her bed. The peer was trying to get her out when this resident kicked her in her chest. R8 denied accusations and said that it was her room. The two residents were separated, DON, Administrator and family were notified about this incident.; 9/8/11 - R8 was transferred to the hospital to have medications evaluated. R8 has been exhibiting aggressive behaviors towards staff and other residents."

R8's Nurses Notes dated 5/23/11 showed, "It was reported by a male resident that R8 hit him in the mouth when he attempted to redirect her out of his room. Doctor notified.... Doctor returned call with no new orders at this time. If R8 keeps it up she will order something."

The Physician Progress Note dated 6/2/11 for R8 showed, "R8 has had worsening of her behavior. R8 has always wandered through the facility frequently and ordered food. At times she goes into other patients rooms. R8 borrows things.

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When they confront her, she becomes upset. R8 frequently swings at staff. The other day, R8 hit another resident in the face.; Plan: The staff tries to redirect R8, she becomes upset and tries to hit people. I had recommended that they increase her Haldol and give her 3 or 4mg orally every 4 hours as needed for agitation. There is a psychiatrist that comes to the facility and I wrote an order for her to be seen by him. I asked them to let me know if her behavior does not improve."

The Nursing Progress Review dated 8/19/11 showed, "Due to increased agitation towards peers and staff, Haldol as needed dose increased. Seroquel increased to 50mg twice a day. Does not redirect easily."

R8's Nurses Notes dated 9/7/11 at 9:30pm showed, "Tried to take food away from resident. Staff intervened and R8 became aggressive verbally and shoved the tray and table spilling food. Hard to redirect but didn't return to room after trying to take another resident's false teeth on the way to her room.

R8's Nurses Notes dated 11/7/11 showed, "R8 involved in altercation with another resident. Psychiatrist notified."

On 11/8/11 at 10:30am, E1 (Administrator) was asked for all Abuse Allegations Investigations since last survey. E1 stated, "I am not sure about the record keeping here. It is poorly done. There has been nothing since I have been here." E1 stated there were no record of any abuse allegations/investigations.

The Minimum Data Set (MDS) with an

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F 225	Continued From page 13 Assessment Reference Date of 11/2/11 for R8 showed cognitive impairment, inattention and disorganized thinking.; No physical behavioral symptoms and no verbal behavioral symptoms.; Other behavioral symptoms not directed towards others occurred daily.; Wandering occurred daily. The Mood Assessment for R8 dated 7/20/11 and 10/5/11 showed R8 has trouble concentrating on things such as reading the newspaper or watching television.; Is short tempered, easily annoyed. The Psychosocial Assessment dated 10/5/11 for R8 showed, "Mild/Minimal Impairment/Problem" for the following: Listens attentively, comprehends communication, orientation to person, cooperative, obsessions, steals, inappropriate comments, toilets inappropriate locals, refuses care/services, paces, rummages in other's space, angry/aggressive, negative statements and anxious.; "Moderate Impairment/Problem" for the following: responds appropriately, orientation to place, forgetful, short term memory, long term memory, attention seeking, wanders, enters bedrooms uninvited, socially inappropriate and agitated. The Psychosocial Assessment dated 10/5/11 for R8 showed she had behaviors of physical aggression (push, grab), physical abuse (hit, scratch) that occurred 4-6 days, but not daily - moderate impairment/problem. 2. The Nurses' Notes on 6/5/11 at 9:45 PM for R10 states, "Resident tried to choke staff, had staff by the neck with both hands. Staff waited for	F 225		

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F 225	Continued From page 14 other staff to give care." The medical record did not contain any documentation of further attempts of R10 choking staff or other abnormal behaviors. The care plan for R10 identifies he has impaired cognition related to dementia. According to the care plan, R10 requires the assistance of 2 staff for all ADL's (Activities of Daily Living). The care plan does not show R10 is uncooperative or disruptive. There are no interventions addressing R10 risk for abuse to others or being abused by others. On 11/9/11 at 2:15 PM, E1 was interviewed regarding an incident investigation, and if the precipitating factors that caused R10 to attempt to choke an employee had been identified and addressed. E1 responded, "That incident occurred before I started working here. There are not abuse allegations or investigations." The social service notes dated 9/1/11 for R10 states, "The resident is dependent on staff for his ADLs. R10 is cooperative and does not have any history of resisting care nor violent aggressive behaviors". The choking incident was not reported and an investigation into the incident was not conducted.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226		11/29/11

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by:
Based on Observation, Interview and Record Review the facility failed to implement the protection, investigation and reporting components of the Facility Policy Abuse Prevention Program for allegations of abuse.

This applies to 2 of 10 (R8 & R10) residents reviewed for abuse in the sample of 10 and 1 (R15) resident in the supplemental sample.

The findings include:

1. On 11/7/11 at 11:44am, R8 was observed to walk over to another table in the dining room. R15 was seated at the table with her chair pushed out towards the wall behind her. R8 squeezed behind R15's chair to sit at another chair at the table. R15 stood up, moved her chair out of the way, walked over and struck R8 on the arm 3 times. R15 looked up and looked around and then yelled, "Nurse."

On 11/9/11 at 9:50am, E2 (Director of Nursing - DON) stated, "R8 was sent out because she hit R15. You were all there and saw it. We had been looking for other placement for R8 before you (state survey team) came. So we did not drop the ball on R8." E2 was asked if an abuse investigation was done for the resident to resident altercation in the dining room on 11/7/11? E2 replied, "We did an incident report. We were already placing R8 somewhere so we didn't look at R15. The certified nursing assistants (CNA)didn't see anything." E2 was asked if abuse investigations are done at the facility for residents when they have altercations? E2 replied, "Yes. We didn't with this one because of

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everything going on and we had already made arrangements for R8 to go to the hospital because of her behaviors." E2 stated she was not aware that R15 had hit R8 first and R8 responded by trying to hit back at R15.

The facility's Abuse Prevention Program Policy(dated 11/4/2010) showed, "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment.; Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.; Physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment.; Employees are required to immediately report any occurrences of potential/alleged mistreatment they observe, hear about, or suspect to a supervisor and the administrator. Supervisors shall immediately inform the administrator or designee of all reports of potential/alleged mistreatment. Upon learning of the report, the administrator or designee shall initiate an investigation. Residents who allegedly mistreat another resident will be removed from contact with that resident during the course of the investigation. The accused resident's condition shall immediately be evaluated to determine the most suitable therapy, care approaches and

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placement considering his or her safety, as well as safety of other residents and employees of the facility.; The facility must ensure all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with state law. The report shall be made as soon as possible, but ought not exceed 24 hours after discovery of the incident. A written report shall be sent to the Department of Public Health. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health."

The Psychosocial Social Service Progress Notes for R8 showed, "12/23/10 - R8 was in room 9 and male resident reported to staff that R8 had struck him. R8 denied accusation.; 4/7/11 - R8 was reported to struck another resident yesterday. R8 has been coming to other resident's rooms and laying on their beds. Future behaviors will be documented here.; 6/2/11 - R8 was reported to be hitting a staff member yesterday after lunch break. Staff was mopping the floor and told R8 to stay away from it. R8 became very resistive and agitated when staff was trying to redirect her to another spot. R8 hit staff on her face and staff informed nurse and administrator about it. Future behaviors/developments will be documented here.; 6/14/11 - R8 entered another residents room and laid on her bed. The peer was trying to get her out when this resident kicked her in her chest. R8 denied accusations and said that it was her room. The two residents were

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separated, DON, Administrator and family were notified about this incident."

R8's Nurses Notes dated 5/23/11 showed, "It was reported by a male resident that R8 hit him in the mouth when he attempted to redirect her out of his room. Doctor notified.... Doctor returned call with no new orders at this time. If R8 keeps it up she will order something."

The Physician Progress Note dated 6/2/11 for R8 showed, "R8 has had worsening of her behavior. R8 has always wandered through the facility frequently and ordered food. At times she goes into other patients rooms. R8 borrows things. When they confront her, she becomes upset. R8 frequently swings at staff. The other day, R8 hit another resident in the face.; Plan: The staff tries to redirect R8, she becomes upset and tries to hit people. I had recommended that they increase her Haldol and give her 3 or 4mg orally every 4 hours as needed for agitation. There is a psychiatrist that comes to the facility and I wrote an order for her to be seen by him. I asked them to let me know if her behavior does not improve."

R8's Nurses Notes dated 11/7/11 showed, "R8 involved in altercation with another resident. Psychiatrist notified."

On 11/8/11 at 10:30am, E1 (Administrator) was asked for all Abuse Allegations Investigations since last survey. E1 stated, "I am not sure about the record keeping here. It is poorly done. There has been nothing since I have been here." E1 stated there were no record of any abuse allegations/investigations.

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The Minimum Data Set (MDS) with an Assessment Reference Date of 11/2/11 for R8 showed cognitive impairment, inattention and disorganized thinking.; No physical behavioral symptoms and no verbal behavioral symptoms.; Other behavioral symptoms not directed towards others occurred daily.; Wandering occurred daily.
2. The Nurses' Notes on 6/5/11 at 9:45 PM for R10 states, "Resident tried to choke staff, had staff by the neck with both hands. Staff waited for other staff to give care." The medical record did not contain any documentation of further attempts of R10 choking staff or other abnormal behaviors.

The care plan for R10 identifies he has impaired cognition related to dementia. According to the care plan, R10 requires the assistance of 2 staff for all ADL's (Activities of Daily Living). The care plan does not show R10 is uncooperative or disruptive. There are no interventions addressing R10 risk for abuse to others or being abused by others.

On 11/9/11 at 2:15 PM, E1 was interviewed regarding an incident investigation, and if the precipitating factors that caused R10 to attempt to choke an employee had been identified and addressed. E1 responded, "That incident occurred before I started working here. There are not any abuse allegations or investigations."

The social service notes dated 9/1/11 for R10 states, "The resident is dependent on staff for his ADL's. R10 is cooperative and does not have any history of resisting care nor violent aggressive behaviors". The choking incident was not reported and an investigation into the incident was not conducted.

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F 241 SS=F	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that residents were spoken to and treated with dignity by staff during care and meals. This applies to all 31 residents in the facility. The findings include: The facility Census and Condition of Residents shows 31 residents were in the facility on 11/7/2011. During confidential interviews conducted on 11/8/11 and 11/9/11. The following statements were made: 1. "They talk like we are an assembly line in a factory.' I did this one... and I did that one...'". "We are not. We are people." 2. "The CNA lied to me. I wanted to go to bed and it was just before the 10:00 PM shift came on. I put my call light on and she came in, turned it off and said she had to go to the dining room but she would be right back. She never came back. I know what she was doing, she wanted the other shift to take of me. I was tired." 3. "They say I can't go to the bathroom until all	F 241		11/29/11

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F 241	Continued From page 21 'the feeders' are finished eating. They are very slow. Now I not only have to wait for them to be done eating, but I also have to wait until they take them all back to their rooms." 4." They are not nice. I am told that I can't leave the dining room unless I ask permission." 5. "The staff never say please when they ask you to do something." 6. "The nurse acts like she is doing you a favor, she huffs and sighs and acts like she is mad."(The resident referred specifically to E10 (Licensed Practical Nurse -LPN). 7. "Every time I go up to get my medicine, E10 lets out a big sigh and stomps over to the medicine cart to get it. If she doesn't like her job, then she shouldn't be here." 8. "They announce my BM's (bowel movements) to everyone. They say how much I did. I know it is natural and everyone does it but it is still embarrassing." On 11/7/11 at 10:20 AM, a staff member was heard in the North hall speaking loudly to another staff member, "I have to take (resident's name) and (resident's name) to the bathroom." On 11/7/11 and 11/9/11, E7(CNA) and E10 (LPN) were observed as they passed out clothing protectors before the noon meal. E7 had the clothing protectors in a laundry cart and tossed one onto each resident's place at the table. One resident had their head resting on the table and was hit in the head when the clothing protector was tossed. E10 carried a large stack of clothing protectors in her arms and tossed clothing protectors on each table as she walked past.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		11/29/11

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F 246	Continued From page 22 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that a resident fit comfortably and safely in her wheelchair and failed to ensure that a resident's bathroom was fitted with a grab bar. This applies to 1 of 10 residents (R3) reviewed for assistive devices in the sample of 10 and 1 resident (R12) in the supplemental sample. The findings include: 1. On 11/1/11 at 9:30 AM, R3 was observed sitting in her wheelchair. R3's hips were pressed tightly into the sides of the wheelchair. R3 was slumped down in her chair and the seat of the wheelchair was pressed tightly into the back of R3's upper thighs. R3 was unable to obtain a fully upright position due to the poor fitting of the wheelchair. On 11/1/11 at 11:AM, E2 (Director of Nursing) stated, "R3 is one that I have the least worries about skin issues." R3 interjected, "My butt is just too big." E2 continued, "R3 is kind of a creature of habit but we can try a different chair and if she doesn't like it I am sure she will tell us and then	F 246		

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F 246	Continued From page 23 we can document that." E2 then stated to R3, "Can we try a different chair at lunch?" R3 replied, "What ever you want to do is fine with me." 2. On 11/8/11 at 10:30 AM, R12 stated, "They need to have more handicap bathrooms. The bathroom in my room doesn't have a (grab) bar so they take me to use the bathroom in the hall. They give a lot of showers (in the hall bathroom) so then I have to go to the other hall bathroom." On 11/8/11 at 2:00 PM, R12's bathroom was observed to have no grab bars in place. E9 (Maintenance) stated that there were already grab bars installed in the hall bathrooms and Room 10's bathroom and that they could put them in if R12 needed them, but she wasn't aware that R12 had asked for them.	F 246		
F 253 SS=F	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure dining room chairs were clean and free of food debris, liquid spills and bodily fluids. This has the potential to affect all 31 residents in the facility. The findings include:	F 253		11/29/11

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F 253	Continued From page 24 The facility Census and Condition of Residents shows 31 residents were in the facility on 11/7/2011. 1. On 11/7/11 twelve (12) of 27 dining room chairs used by the residents during meals and activities were soiled with dried on food and liquid spills. On 11/7 before the noon meal, the back of R8's pants were significantly wet. R8 moved to and from at least 3 to 4 chairs in the dining room. The chairs were not cleaned before other residents sat in the chairs. On 11/8/11 at 2:25pm, E9 (Environmental Services) said, "We buff [the floors] every Friday and that is when we clean the chairs and legs of the tables." On 11/9 at 10:15am during a confidential interview, it was stated, "They [staff] know she (R8) is wet. She tells them, "I'm not wet" even though she is. You can see the back of her pants are usually wet."	F 253		
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 observation, interview and record review the facility failed to ensure a resident was toileted as scheduled and failed to provide hand	F 312		11/29/11

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hygiene before and after meals for all residents in the facility.

This applies to 2 of 8 residents (R7, R10) reviewed for incontinence care in the sample of 10 and all other 29 residents in the facility.

The findings include:

The facility Census and Condition of Residents shows 31 residents were in the facility on 11/7/2011.

1. On 11/9/11 at 9:30 AM, R10 was observed in the dining room seated at the large dining room table in a reclining wheel chair. R10 was resting with his eyes closed. Staff were preparing residents and supplies for a scheduled activity at 10 AM. At 10:50 AM, R10 was observed in the same location in the dining room sleeping in the reclining wheel chair. The activity was in progress at the table. At 11:05 AM, R10 was awake, eyes open watching the activity, but no verbal participation was noted. At 11:20 AM, the activity concluded. Activity staff moved R10 from the position at the large dining room table to his assigned table for lunch. At 11:30 AM, the surveyor attempted to engage R10 in a conversation. R10 responded yes to two questions, then no further conversation was offered. At 12:05 PM, R10 remained at the table waiting for lunch. At 1:05 PM, R10 had finished eating and was sitting quietly.

On 11/9/11 at 1:10 PM, E13 (Certified Nursing Assistant-CNA) was asked when R10 was last toileted. E13 stated "Around 10:30". E13 stated she had not taken him, "They must have". E13

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was informed R10 had been observed in the reclining wheelchair in the dining room since 9:30 AM. E13 stated, "Oh" and proceeded to move R10 to the shower/toilet room in the hallway. E13 stated she was going to toilet him now.

The Hospice Aide Notes document she arrived at 8 AM and left at 9 AM on 11/9/11. The notes state, "R10 was shaved and pericare given. Brief changed. Resident relies on facility staff for all ADL's (Activities of Daily Living). Resident taken to activity upon departure."

R10's care plan dated 9/9/11 states, "Toilet and or change (incontinence) padding and give proper hygiene before/after meals, upon arising, upon request, before retiring for the evening, after napping and as needed for incontinence."

2. On 11/7/11 at 12:50 PM, R7 was sitting in a standard wheelchair in his room unattended. R7 was requesting to lie down. Facility staff were informed of R7's request. E6 and E7 (Certified Nursing Assistants - CNA) transferred R7 from the wheelchair into his bed. R7 was positioned for comfort in the bed with 2 full side rails up. R7 was left fully dressed. The staff (E6 and E7) did not offer R7 to use the toilet before lying down, or perform a skin check for the presence of incontinence.

Interview with E6 upon completion of care, E6 stated, "R7 does not use the toilet in his room, he has to use the hall bathroom." E6 stated, "R7 was changed before lunch around 11:00 AM." The surveyor requested the staff to check R7 for incontinence. R7's brief was soiled with urine.

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F 312	Continued From page 27 The Minimum Data Set of 8/14/11 assessed R7 as frequently incontinent of urine and occasionally incontinent of urine. R7 is totally dependent on staff to provide personal hygiene and toilet use. R7's care plan dated 8/16/11 states, "Toilet and or change (incontinence) padding and give proper hygiene before/after meals, upon arising, upon request, before retiring for the evening, after napping and as needed for incontinence." On 11/7/11 at 1:10 PM, E2 (Director of Nurses) stated, "R7 should have been toileted and or checked for incontinence when they laid him down." 3. The noon meal service in the dining room was observed by the survey team on 11/7/11 and 11/8/11. Hand hygiene was not offered to any residents before or after the meal service.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to evaluate the	F 314		11/29/11

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effectiveness of wound treatment. The facility failed to obtain a medical consult when R9's wound characteristics changed. The facility failed to identify specific risk factors and develop a treatment plan for a residents foot ulcers. These failures contributed to R9's wound worsening from 9/19/11 when the facility first became aware until 11/9/11 when R9's toe ulcer drainage increased, the wound increased in size, and the wound failed to show progress in healing.

This applies to 1 of 5 residents (R9) reviewed for pressure sores in the sample of 10.

The findings include:

R9's November, 2011, Physician's Order Sheet documents that R9's diagnoses include Parkinson's Disease, Dementia, Anxiety and Aggression.

R9's Minimum Data Set (MDS) assessment of 9/2/11 documents that R9 has short and long term memory problems and has severely impaired cognitive skills for decision making. The same assessment shows that R9 is dependent on two or more persons for bed mobility, and transfer. R9 is dependent on one person for dressing. R9 has Impairment in range of motion of both lower extremities.

On 11/9/11 at 9:55 AM, R9 was observed sitting in his wheelchair in the dining room. R9 was wearing a shoe on his left foot and a black sock on the right foot. E10 Licensed Practical Nurse (LPN) was asked about R9's left foot. E10 said that R9 had circulation problems and has vascular wounds on his toes. E10 assisted to

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observe R9's left foot. E10 removed R9's sock and a dry gauze to show R9's toes. E10 said that R9's "toes kept rubbing" .
R9's right lower leg was shiny, reddened, and tight. R9's wounds on his toes (Dorsal Metatarsals) were red, with yellow slough, (devitalized tissue) and the wounds were moist.

R9's Treatment Administration Records (TAR) showed the following:

9/19/11 Cleanse open area on top of 2nd toe of Right Foot and apply Triple Antibiotic Ointment and dressing daily until healed. The same sheet shows this order was discontinued on 10/19/11. (31 days later)
The daily skin check record showed "other" coded by placing a 0 on the TAR.
On 9/19/11 the wound on the Right foot toe is described as 0.1 cm x 0.1 cm, vascular ulcer, no drainage and pink in color.
9/26/11 the wound is described as 0.1 cm x 0.1 cm, pink, vascular, healing slowly.
10/5/11 the Right toe wound is described as 1 cm x .5 cm superficial, pink, red, vascular, and improving.
10/17/11 Right toe wound 1cm x 1cm x .05 cm, red, and minimal drainage.
10/25/11 Right toe 1cm x 1 cm x .05 cm, red, vascular, minimal drainage, wet to dry dressing.
11/3/11 Right toe wound , Vascular, pink/red, minimal drainage, no size documented.

R9's Nursing Notes showed the following:
10/19/11 Area on left foot not improving much, treatment changed. (31 days after same treatment)
11/1/11 10:00 AM, reported on resident foot

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F 314	Continued From page 30 again, Doctor said he will be in to check it out on rounds this Thursday. (11/3/11) 11/8/11 10:00 AM. reminded Dr. about resident's foot appointment for 11/9/11. Podiatry reports were reviewed for R9 for the dates of 5/3/11, 7/7/11, and 10/26/11. According to these reports R9 had a capillary refill time of less than 3 seconds. (In the presence of arterial occlusion, refill time will take longer than 2-3 seconds) No vascular abnormalities are documented. R9's current Care Plan for Pressure Ulcers documents R9's risk factors as decreased mobility, Hypertension, and Parkinson's Disease. (no vascular problems are identified) The goal shows: will have no new open areas related to pressure or friction for the next 90 days. The care plan does not document the presence of any wounds to R9's right foot. According to Bryant, R. Acute and Chronic Wounds, third edition, 2007, Mosby, pg. 167, Clinical Indications for wound infection include: change in wound exudate, and lack of healing after 2 weeks in a clean wound despite optimal treatment.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate	F 315		11/29/11

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F 315	Continued From page 31 treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on Observation and Record Review the facility failed to provide incontinence care by not washing 2 residents pubic area after incontinent episodes. This applies to 1 of 8 (R8) residents reviewed for incontinence care in the sample of 10 and 1 resident (R16) in the supplemental sample. The findings include: 1. On 11/7/11 at 11:15am, R8 was observed sitting in a chair at a dining room table by the wall of the entrance to the facility. R8 stood up and was observed wearing teal colored sweat pants that were visibly wet under both buttocks. R8 walked over to the activity table in the middle of the dining room and sat down in a chair at the activity table. At 11:27am, R8 stood up, walked over to a table near the kitchen and sat down in a dining room chair at the table. E2 saw R8 and told her that her pants were wet. R8 replied, "I am not wet." At 11:30am, R8 was taken to the bathroom by E6 (Certified Nursing Assistant). E6 pulled R8's pants and incontinence briefs down. R8's incontinence brief was visibly soiled with urine and feces (diarrhea). E6 applied soap to wet wash cloths and wiped R8's peri area from front to back while reaching between R8's legs from behind R8. E6 used the same procedure to rinse and dry R8's peri area using a wet	F 315		

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washcloth to rinse and a towel to dry her peri area. No incontinence care was provided to the anterior part of R8's groin.

The facility's Perineal Cleansing Policy showed, "Wash pubic area including the upper inner aspect of both thighs and front portion of the perineum. Use long strokes from the most anterior down to the base of the labia. Follow the same procedure for rinsing (if applicable). Dry thoroughly. Wash peri-anal area thoroughly with each stroke beginning at the base of the labia and extending up over the buttocks."

R8's Minimum Data Set (MDS) dated 11/2/11 showed cognitive impairment.; Incontinence of bowel and bladder.

The Physician Order Sheet (POS) dated 11/1/11 for R8 showed Diagnoses including Alcohol Dementia, Gastritis, Diverticulitis and Senile Psychosis.

The last Care Plans completed for R8 were dated 11/2/11. There were no Care Plans dated 11/2/11 for R8's problem of bowel and bladder incontinence.

R8's Care Plan dated 8/4/11 showed, "Alteration in Bladder Elimination as related to incontinence.; Toilet and/or change padding and give proper hygiene before/after meals, upon arising, upon request, before retiring for the evening, after napping, and as needed for incontinence.; Apply house stock barrier cream with every after incontinence care. Report to nurse in charge any skin concerns.
2. The Physician's Order Sheet dated 11/1/11

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F 315	Continued From page 33 shows that R16 has diagnoses including Diabetes, Ischemic Stroke and Anxiety. R16's care plan dated 8/5/11 states, "Alteration in Bladder Elimination as related to incontinence. The interventions include : Toilet and/or change padding and give proper hygiene....." R16's Minimum Data Set of 11/4/11 shows that R16 is totally dependent on one staff for toileting. On 11/7/11 at 2:10 PM, E14 (CNA) and E6(CNA) were observed as they assisted R16 to the bathroom. As soon as R16's brief was removed and she was placed on the toilet she started to scratch her pelvic area vigorously. When R16 was done, E14 did not have enough washcloths to complete pericare and asked E2 (DON) who was also observing the procedure to get another one. E6 then lifted R16 off of the toilet and E14 washed, rinsed and dried R16's rectal area and with the washcloth reached between R16's legs and swiftly pulled back. E14 pulled up R16's brief and pants and E6 placed R16 back into her reclining wheelchair. R16's front peri area/vaginal area was not washed.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		11/29/11

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F 318	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on Observation, Interview and Record Review the facility failed to provide proper body alignment of a resident to maintain his position in a specialized wheelchair. This is for 1 of 5 (R4) residents reviewed for positioning in the sample of 10. The findings include: On 11/7/11 at 11:15am, R4 was observed sitting in the dining room with his head and part of his upper body hanging over the right side of a specialized padded wheelchair. An activity was in progress in the dining room at this time. At 11:29am, 11:38am, 11:45am and 12:05pm R4 was observed to continue to sit in his specialized padded wheelchair with his head and upper body hanging over the right side of the chair. On 11/7/11 at 12:05pm, Z1 (Hospice Nurse) stated, "R4 was having a problem in his wheelchair. R4 needed to keep his legs elevated and didn't sit very well in his wheelchair. R4 couldn't keep his position in his wheelchair." Z1 was asked if the specialized padded wheelchair was needed for positioning of R4? Z1 replied, "Yes." The Fall Risk Assessment dated 10/12/11 for R4 showed a score of 21, high risk for falls. The Telephone Order dated 9/29/11 for R4 showed he was admitted to hospice services for End Stage Alzheimer.	F 318		

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F 318	Continued From page 35 R4's Care Plan dated 10/13/11 showed, "R4 has risk factors that require monitoring and intervention to reduce potential for self injury." The Care Plan had no approaches for body alignment/positioning of R4 while in his specialized padded wheelchair. R4's Care Plan dated 9/30/11 showed, "Has high risk factors for falls: Balance unsteady. Assistive devices wheelchair. Poor safety awareness, agitation and confusion." The Range of Motion Assessment dated 10/2/11 for R4 showed a score of 5 which equals moderate risk.; Treatment may include, but is not limited to basic range of motion, positioning, turning, ambulating, as indicated by individual resident needs.	F 318		
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 observation, interview and record review the facility failed to ensure a resident was supervised while eating to prevent choking (R7). The facility failed to provide a wheel chair to provide proper body alignment to prevent R3 from falling. The facility failed to have a safe	F 323		11/29/11

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environment including functioning windows to prevent a resident from becoming injured.

This failure resulted in the third finger of R8's left hand needing 7 sutures at a local emergency department and which became infected after a window in the dining room came down on her hand.

This applies to 3 of 7 residents (R7, R3, R8) reviewed for supervision and safety in a sample of 10

The findings include:

1. The Nurses Notes for R8 dated 10/9/11 at 5:50am showed, "Certified Nursing Assistant (CNA) called nurse to room. R8 had laceration on 3rd finger of left hand. Was told by R8 and another resident that R8 was playing with the window in the dining room and it came down on her. Area cleaned and wrapped x 4. R8 refuses to leave dressing alone.; 7:15am, Sent to emergency room for sutures."

The Hospital Discharge instructions for R8 dated 10/9/11 showed, "Diagnosis: Laceration of the upper extremity.; Return to Emergency Department in 2 days. Return for wound check.; Return to the Emergency Department in 8 days. Return for suture removal."

R8's Nurses Notes dated 10/11/11 showed, "Left finger has 7 sutures dry and intact."

R8's Nurses Notes dated 10/17/11 showed, "5:30am - Sutures intact, area red/yellow. No drainage noted.; 9:30am - Doctor notified of signs

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and symptoms of infection in finger. Has appointment at 3:30pm."

The Physician Progress Notes dated 10/17/11 showed, "Infected left third finger. Keflex 500mg three times a day for 10 days. Given Rocephin in office 10/17/11."

On 11/9/11 at 2:50pm, E9 (Maintenance) stated, "The windows are hard to open and shut. I hooked a spring back on the window. (Window by where the trays are placed in the dining room.) They told me to fix the window and I did. They didn't tell me someone got their finger smashed in the window."

R8's Care Plan dated 11/2/11 showed, "Resident requires use of Psychotropic Medication to manage mood and/or behavior issues. Related diagnosis Dementia, Psychosis and Depression.; Behaviors exhibited aggression to others, yelling out and wandering."

R8's Care Plan dated 11/2/11 showed, "Impaired cognition results in repetitive verbalizations and/or wandering behavior. Related diagnosis Dementia and Psychosis. Behavior exhibited wandering and aggressive behaviors." No approaches were listed to show how often R8 will be monitored due to wandering behaviors and need for safety/supervision.

R8's Care Plan dated 11/2/11 showed, "Risk factors that require monitoring and intervention to reduce potential for self injury.; Assess cognitive deficits and accommodate forgetfulness regarding safety devices and environmental risks.; Remind of safety precautions and

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F 323	Continued From page 38 limitations as necessary." R8's Physician Order Sheet (POS) dated 11/1/1 showed Diagnoses including Alcohol with Dementia and Senile Psychosis. 2. R3's Physician's Order Sheet dated 11/2011 shows that R3 has diagnoses including Dementia and Depression. The Minimum Data Set of 8/31/11 shows that R3 requires extensive assist of 1 staff for locomotion off of the unit. The Nurse's Notes(NN) dated 8/28/11 at 8:15 PM states, "Resident on floor from fall out of wheelchair. CNA was pushing resident down hall resident bent over to push laundry cart, CNA started to pull back and resident started to fall. CNA grabbed sweater to hold back- resident fell face first on floor. Awake, (No) loss of consciousness, (no)complaints of pain except head. Rolled over and assessed head, 2 1/2 centimeter laceration.... At 7:00 PM (R3) had been given Ativan (antianxiety) (ordered) PRN (as needed) to calm. Agitated and unable to redirect PRN. Then resident was repeatedly scooting forward in chair just prior to fall. CNA had just been repositioned in wheelchair prior to taking down the hall." The 11:00 PM NN states, "5 sutures above left eye, splint to little finger left hand- small fracture." The Investigation Report for Falls dated 8/28/11 states, "Initiate Chair Alarm." On 11/1/11 at 11:00 AM E2(DON) was questioned about the reason for chair alarm as staff was with resident when she fell. E2 stated,	F 323		

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"We put the alarm on with the hopes that if she leaned forward when we weren't with her, we would hear the alarm. Educating her is not an option because she won't remember." The DON was alerted to the way R3 was sitting in her wheelchair. R3's hips were pressed tightly into the sides of the wheelchair. R3 was slumped down in her chair and the seat of the wheelchair was pressed tightly into the back of R3's upper thighs. R3 was unable to obtain a fully upright position due to the poor fitting of the wheelchair. E2 stated, "We definitely can try a different chair."

R3's care plan dated 8/28/11 states, "Observe resident during chair movement. Note areas of concern that may cause injury to the resident. Note areas of friction."

3. The Nurses' Note for R7 dated 9/15/11 at 5:45 PM states, "Resident was choking at the supper meal. Lips blue, unable to breath, making the universal choking gesture. Heimlich (maneuver) was performed without success. Resident lowered to the ground. Chest thrusts completed 3 times. Resident expelled food. Normal skin color returned to lips. Breathing on own, returned to bed with monitoring. Physician on call notified and order received to transferred to hospital for chest x-ray." The Nurses' Notes document at 7:35 PM on 9/15/11, R7 was transported to the hospital by the ambulance.

The Physician Order Sheet (POS) dated 9/1/11 states R7's diet is pureed. R7's diagnoses include: Dysphagia, Gastric Esophageal Reflux Disease, and Dementia. R7's care plan dated 8/16/11 states the resident is able to feed self with cueing. R7's care plan had not been

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updated after 9/15/11 to show the interventions put into place to reduce R7's chance of choking again while eating.

On 11/8/11 at 3:35 PM, E1 (Administrator) stated, "I was here that evening. I called 911 and then I disconnected myself. R7 is able to feed himself sometimes, sometimes not." E1 was questioned regarding what type of food R7 was served that evening. E1 stated, "I think it was pureed, but it was not pureed correctly." Later in the discussion E1 reported, "R7 received the wrong tray, he choked on a piece of fruit." E1 stated, "No investigation was conducted" regarding the root cause of the choking incident. It was unclear with E1 and E2 (Director of Nurses) what type of food R7 was served. E2 reported she had conducted an inservice with the facility staff the importance of calling 911. The inservice contents included, "All Staff: If a resident is choking: 1 staff member is to perform the Heimlich while another staff member is to call 911 at the same time, Do Not Wait!".

The menu for the evening meal on 9/15/11, showed "Sunrise Fruit Salad" was served to the regular and puree diets.

On 11/9/11 at 9:30 AM, E2 (DON) stated, "R7 was served fruit cocktail that night." E11 (Dietary Manager) stated, "There is no recipe available for the Sunrise Salad, and that most likely fruit cocktail was served. E11 stated the menu change was not listed on the substitution list.

The recipe directions for puree fruit cocktail states to place food in a food processor and

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F 323	Continued From page 41 process until fine in consistency.	F 323		
F 365 SS=G	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a resident received their prescribed food texture. This failure resulted in R7 consuming a food texture that caused him to choke and required the intervention of the Heimlich maneuver to open a resident's airway. (R7) This applies to 1 of 7 residents (R7) reviewed for nutrition in a sample of 10. The findings include: The Nurses' Note for R7 dated 9/15/11 at 5:45 PM states, "Resident was choking at the supper meal. Lips blue, unable to breathe, making the universal choking gesture. Heimlich (maneuver) was performed without success. Resident lowered to the ground. Chest thrusts completed 3 times. Resident expelled food. Normal skin color returned to lips". The Physician Order Sheet (POS) dated 9/1/11 states R7's diet is pureed. R7's diagnoses include: Dysphagia, Gastric Esophageal Reflux Disease, and Dementia. R7's care plan dated 8/16/11 states the resident is able to feed self	F 365		11/29/11

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F 365	Continued From page 42 with cueing. On 11/8/11 at 3:35 PM, E1 (Administrator) stated, "R7 is able to feed himself sometimes, sometimes not." E1 was questioned regarding what type of food R7 was served that evening. E1 stated, "I think it was pureed, but it was not pureed correctly." Later in the discussion E1 reported, "R7 received the wrong tray, he choked on a piece of fruit." It was unclear with E1 and E2 (Director of Nurses) what type of food R7 was served. The menu for the evening meal on 9/15/11, showed "Sunrise Fruit Salad" was served to the regular and puree diets. On 11/9/11 at 9:30 AM, E2 (DON) stated, "R7 was served fruit cocktail that night." E11 (Dietary Manager) stated, "There is no recipe available for the Sunrise Salad, and that most likely fruit cocktail was served. E11 stated the menu change was not listed on the substitution list. On 11/7/11 at 11:40 AM, E12 (Cook) stated she was preparing 7 puree meals for lunch. E12 stated they recently received a new food processor. E12 stated, "I check the food for smoothness, if I see chunks in the food, I process it a little longer." The recipe directions for puree fruit cocktail states to place food in a food processor and process until fine in consistency.	F 365		
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS	F 498		11/29/11

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F 498	Continued From page 43 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that CNAs were proficient in methods used for transferring a non-weight bearing resident from one surface to another. This applies to 1 of 8 residents (R7) reviewed for transfers in a sample of 10 and 1 resident in the supplemental sample(R16) The findings include: The Physician's Order Sheet dated 11/1/11 shows that R16 has diagnoses including Diabetes, Ischemic Stroke and Anxiety. R16's Minimum Data Set of 11/4/11 shows that R16 is totally dependent on one staff for transfers. On 11/7/11 at 2:10 PM, E14 (CNA) and E6(CNA) were observed as they assisted R16 to the bathroom. E6 applied the gait belt around R16's waist and E6 and E14 lifted R16 out if the reclining wheelchair, pulled her pants down and placed her on the toilet. When R16 was done, E6 said to E14, "I'll hold her and you wash." E6 pressed her knees firmly against R16 and lifted her under her arms in a bear-hug style. As E14	F 498		

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washed R16, E6 repositioned her arms by taking hold of the gait belt. R16 was wearing soft padded heel protectors and made no attempt to bear weight on her legs. R16 was held in this position until she was washed and her pants were pulled up. E6 then swung R16 gently into her reclining wheelchair.

On 11/9/11 at 3:05 PM, Z1(physical therapist) stated, "If there is a risk of injury to either the staff or the resident then a mechanical lift should be used."

According to Mosby's Text Book for Nursing Assistants, 6th Edition, pps. 258, "Some residents can not assist in transfers to or from chairs or wheelchairs. For those residents a mechanical lift is used."

2. On 11/7/11 at 12:50 PM, E6 and E7 (Certified Nursing Assistants - CNA) were observed transferring R7 from a wheelchair into his bed. R7 was sitting in a standard wheelchair without leg rests; his legs were crossed. Using a gait belt, E6 and E7 used a swing motion to move R7 from the wheelchair onto his bed. R7 was unable to bear weight due to his feet and legs being in a crossed position. E6 (CNA) was questioned regarding R7's ability to bear weight. E6 responded "Not much". E6 stated R7 does not walk anymore, and they always transfer him using 2 people and a gait belt.

R7's Care Plan dated 8/16/11 states R7's has impaired physical mobility related to muscle weakness and has a history of falls. The care plan states R7 is able to self propel a wheelchair for short distances. The plan does not address the resident's method and ability to transfer.

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F 516 SS=C	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that current clinical records and closed clinical records were contained in a manner to prevent potential destruction and safe. This has the potential to affect all 31 residents in the facility. The findings include: The facility Census and Condition of Residents shows 31 residents were in the facility on 11/7/2011. On 11/8/11 at 2pm, E9 (Environmental Services) said clinical records were kept in E2's (Director of Nursing) office in a file cabinet and in the closet in E2's office. E9 said that records that were at least 5 years old were in an outside storage shed	F 516		11/29/11

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F 516	Continued From page 46 behind the facility. E2 confirmed and observation showed that current clinical records had been thinned and were kept in a file cabinet and in (8)cardboard boxes on shelves in a closet in her office. In the event the sprinkler located on the ceiling above the records was activated the records would not be protected. In the storage shed behind the facility, there were 12 or more cardboard boxes of resident files on metal shelves and 2 stacked cardboard boxes with resident file folders scattered on top. E9 said that some of the files may be older than 5 years and the area needed to be cleaned out and organized. The storage shed was locked with a padlock but was accessible from the parking lot of the facility	F 516		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1030d) Section 300.1030 Medical Emergencies d) When two or more staff are on duty in the facility, at least two staff people on duty in the facility shall have current certification in the provision of basic life support by an American Heart Association or American Red Cross certified training program. When there is only one person on duty in the facility, that person needs to be certified. Any facility employee who is on duty in the facility may be utilized to meet this requirement. This regulation is not met as evidenced by :	F9999		

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F9999	Continued From page 47 Based on interview and record review the facility failed to ensure that at least 2 staff, certified in CPR (cardiopulmonary resuscitation) were available on every shift. This applies to all 31 residents in the facility. The findings include: The facility Census and Condition of Residents shows 31 residents were in the facility on 11/7/2011. Review of staffing schedules from October 18-November 8, 2011 shows that there were was only 1 staff person certified in CPR on 15 evening shifts. (10/18,19,20,21,22,23,25,27,28,31 and 11/1,4,5,6,8) On 11/8/11 at 3:30 PM, E2 (DON) stated that she is available until 5:00 PM on most days. Review of the incident report dated 9/15/11 shows that a resident began choking at the evening meal and required the Heimlich Maneuver to clear the airway. The Nurses' Note for R7 dated 9/15/11 at 5:45 PM states, "Resident was choking at the supper meal. Lips blue, unable to breath, making the universal choking gesture. Heimlich (maneuver) was performed without success. Resident lowered to the ground. Chest thrusts completed 3 times. Resident expelled food. Normal skin color returned to lips. Breathing on own, returned to bed with monitoring. Physician on call notified and order received to transferred to hospital for chest x-ray." The Nurses' Notes document at	F9999		

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F9999	Continued From page 48 7:35 PM on 9/15/11, R7 was transported to the hospital by the ambulance. The facility was unable to provide additional information/staff certified in CPR on the evening shift for 9/15/11. (B) 300.1210d)5) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 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 are not met, as evidenced by the following: Based on observation, record review, and interview the facility failed to evaluate the	F9999		

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effectiveness of wound treatment. The facility failed to obtain a medical consult when R9's wound characteristics changed. The facility failed to identify specific risk factors and develop a treatment plan for a residents foot ulcers. These failures contributed to R9's wound worsening from 9/19/11 when the facility first became aware until 11/9/11 when R9's toe ulcer drainage increased, the wound increased in size, and the wound failed to show progress in healing.

This applies to 1 of 5 residents (R9) reviewed for pressure sores in the sample of 10.

The findings include:

R9's November, 2011, Physician's Order Sheet documents that R9's diagnoses include Parkinson's Disease, Dementia, Anxiety and Aggression.

R9's Minimum Data Set (MDS) assessment of 9/2/11 documents that R9 has short and long term memory problems and has severely impaired cognitive skills for decision making. The same assessment shows that R9 is dependent on two or more persons for bed mobility, and transfer. R9 is dependent on one person for dressing. R9 has Impairment in range of motion of both lower extremities.

On 11/9/11 at 9:55 AM, R9 was observed sitting in his wheelchair in the dining room. R9 was wearing a shoe on his left foot and a black sock on the right foot. E10 Licensed Practical Nurse (LPN) was asked about R9's left foot. E10 said that R9 had circulation problems and has vascular wounds on his toes. E10 assisted to

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observe R9's left foot. E10 removed R9's sock and a dry gauze to show R9's toes. E10 said that R9's "toes kept rubbing" .
R9's right lower leg was shiny, reddened, and tight. R9's wounds on his toes (Dorsal Metatarsals) were red, with yellow slough, (devitalized tissue) and the wounds were moist.

R9's Treatment Administration Records (TAR) showed the following:

9/19/11 Cleanse open area on top of 2nd toe of Right Foot and apply Triple Antibiotic Ointment and dressing daily until healed. The same sheet shows this order was discontinued on 10/19/11. (31 days later)
The daily skin check record showed "other" coded by placing a 0 on the TAR.
On 9/19/11 the wound on the Right foot toe is described as 0.1 cm x 0.1 cm, vascular ulcer, no drainage and pink in color.
9/26/11 the wound is described as 0.1 cm x 0.1 cm, pink, vascular, healing slowly.
10/5/11 the Right toe wound is described as 1 cm x .5 cm superficial, pink, red, vascular, and improving.
10/17/11 Right toe wound 1cm x 1cm x .05 cm, red, and minimal drainage.
10/25/11 Right toe 1cm x 1 cm x .05 cm, red, vascular, minimal drainage, wet to dry dressing.
11/3/11 Right toe wound , Vascular, pink/red, minimal drainage, no size documented.

R9's Nursing Notes showed the following:
10/19/11 Area on left foot not improving much, treatment changed. (31 days after same treatment)
11/1/11 10:00 AM, reported on resident foot

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F9999	Continued From page 51 again, Doctor said he will be in to check it out on rounds this Thursday. (11/3/11) 11/8/11 10:00 AM. reminded Dr. about resident's foot appointment for 11/9/11. Podiatry reports were reviewed for R9 for the dates of 5/3/11, 7/7/11, and 10/26/11. According to these reports R9 had a capillary refill time of less than 3 seconds. (In the presence of arterial occlusion, refill time will take longer than 2-3 seconds) No vascular abnormalities are documented. R9's current Care Plan for Pressure Ulcers documents R9's risk factors as decreased mobility, Hypertension, and Parkinson's Disease. (no vascular problems are identified) The goal shows: will have no new open areas related to pressure or friction for the next 90 days. The care plan does not document the presence of any wounds to R9's right foot. According to Bryant, R. Acute and Chronic Wounds, third edition, 2007, Mosby, pg. 167, Clinical Indications for wound infection include: change in wound exudate, and lack of healing after 2 weeks in a clean wound despite optimal treatment. (B) 300.1210d)6) 300.2040b) 300.2040e) 300.3240a)	F9999		

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F9999	Continued From page 52 Section 300.1210 General Requirements for Nursing and Personal Care 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: 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 300.2040 Diet Orders b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered. e) A therapeutic diet means a diet ordered by the physician as part of a treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet). 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 are not met, as evidenced by the following: Based on observation, interview and record review the facility failed to ensure a resident was supervised while eating to prevent choking (R7).	F9999		

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The facility failed to provide a wheel chair to provide proper body alignment to prevent R3 from falling. The facility failed to have a safe environment including functioning windows to prevent a resident from becoming injured.

This failure resulted in the third finger of R8's left hand needing 7 sutures at a local emergency department and which became infected after a window in the dining room came down on her hand.

This applies to 3 of 7 residents (R7, R3, R8) reviewed for supervision and safety in a sample of 10

The findings include:

1. The Nurses Notes for R8 dated 10/9/11 at 5:50am showed, "Certified Nursing Assistant (CNA) called nurse to room. R8 had laceration on 3rd finger of left hand. Was told by R8 and another resident that R8 was playing with the window in the dining room and it came down on her. Area cleaned and wrapped x 4. R8 refuses to leave dressing alone.; 7:15am, Sent to emergency room for sutures."

The Hospital Discharge instructions for R8 dated 10/9/11 showed, "Diagnosis: Laceration of the upper extremity.; Return to Emergency Department in 2 days. Return for wound check.; Return to the Emergency Department in 8 days. Return for suture removal."

R8's Nurses Notes dated 10/11/11 showed, "Left finger has 7 sutures dry and intact."

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	14E342	A. BUILDING _____ B. WING _____	11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK FALLS REHAB & HCC	430 MARTIN ROAD ROCK FALLS, IL 61071

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R8's Nurses Notes dated 10/17/11 showed, "5:30am - Sutures intact, area red/yellow. No drainage noted.; 9:30am - Doctor notified of signs and symptoms of infection in finger. Has appointment at 3:30pm."

The Physician Progress Notes dated 10/17/11 showed, "Infected left third finger. Keflex 500mg three times a day for 10 days. Given Rocephin in office 10/17/11."

On 11/9/11 at 2:50pm, E9 (Maintenance) stated, "The windows are hard to open and shut. I hooked a spring back on the window. (Window by where the trays are placed in the dining room.) They told me to fix the window and I did. They didn't tell me someone got their finger smashed in the window."

R8's Care Plan dated 11/2/11 showed, "Resident requires use of Psychotropic Medication to manage mood and/or behavior issues. Related diagnosis Dementia, Psychosis and Depression.; Behaviors exhibited aggression to others, yelling out and wandering."

R8's Care Plan dated 11/2/11 showed, "Impaired cognition results in repetitive verbalizations and/or wandering behavior. Related diagnosis Dementia and Psychosis. Behavior exhibited wandering and aggressive behaviors." No approaches were listed to show how often R8 will be monitored due to wandering behaviors and need for safety/supervision.

R8's Care Plan dated 11/2/11 showed, "Risk factors that require monitoring and intervention to reduce potential for self injury.; Assess cognitive

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deficits and accommodate forgetfulness regarding safety devices and environmental risks.; Remind of safety precautions and limitations as necessary."

R8's Physician Order Sheet (POS) dated 11/1/1 showed Diagnoses including Alcohol with Dementia and Senile Psychosis.

2. R3's Physician's Order Sheet dated 11/2011 shows that R3 has diagnoses including Dementia and Depression.

The Minimum Data Set of 8/31/11 shows that R3 requires extensive assist of 1 staff for locomotion off of the unit.

The Nurse's Notes(NN) dated 8/28/11 at 8:15 PM states, "Resident on floor from fall out of wheelchair. CNA was pushing resident down hall resident bent over to push laundry cart, CNA started to pull back and resident started to fall. CNA grabbed sweater to hold back- resident fell face first on floor. Awake, (No) loss of consciousness, (no)complaints of pain except head. Rolled over and assessed head, 2 1/2 centimeter laceration.... At 7:00 PM (R3) had been given Ativan (antianxiety) (ordered) PRN (as needed) to calm. Agitated and unable to redirect PRN. Then resident was repeatedly scooting forward in chair just prior to fall. CNA had just been repositioned in wheelchair prior to taking down the hall." The 11:00 PM NN states, "5 sutures above left eye, splint to little finger left hand- small fracture."

The Investigation Report for Falls dated 8/28/11

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states, "Initiate Chair Alarm."

On 11/1/11 at 11:00 AM E2(DON) was questioned about the reason for chair alarm as staff was with resident when she fell. E2 stated, "We put the alarm on with the hopes that if she leaned forward when we weren't with her, we would hear the alarm. Educating her is not an option because she won't remember." The DON was alerted to the way R3 was sitting in her wheelchair. R3's hips were pressed tightly into the sides of the wheelchair. R3 was slumped down in her chair and the seat of the wheelchair was pressed tightly into the back of R3's upper thighs. R3 was unable to obtain a fully upright position due to the poor fitting of the wheelchair. E2 stated, "We definitely can try a different chair."

R3's care plan dated 8/28/11 states, "Observe resident during chair movement. Note areas of concern that may cause injury to the resident. Note areas of friction."

3. The Nurses' Note for R7 dated 9/15/11 at 5:45 PM states, "Resident was choking at the supper meal. Lips blue, unable to breath, making the universal choking gesture. Heimlich (maneuver) was performed without success. Resident lowered to the ground. Chest thrusts completed 3 times. Resident expelled food. Normal skin color returned to lips. Breathing on own, returned to bed with monitoring. Physician on call notified and order received to transferred to hospital for chest x-ray." The Nurses' Notes document at 7:35 PM on 9/15/11, R7 was transported to the hospital by the ambulance.

The Physician Order Sheet (POS) dated 9/1/11

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states R7's diet is pureed. R7's diagnoses include: Dysphagia, Gastric Esophageal Reflux Disease, and Dementia. R7's care plan dated 8/16/11 states the resident is able to feed self with cueing. R7's care plan had not been updated after 9/15/11 to show the interventions put into place to reduce R7's chance of choking again while eating.

On 11/8/11 at 3:35 PM, E1 (Administrator) stated, "I was here that evening. I called 911 and then I disconnected myself. R7 is able to feed himself sometimes, sometimes not." E1 was questioned regarding what type of food R7 was served that evening. E1 stated, "I think it was pureed, but it was not pureed correctly." Later in the discussion E1 reported, "R7 received the wrong tray, he choked on a piece of fruit." E1 stated, "No investigation was conducted" regarding the root cause of the choking incident. It was unclear with E1 and E2 (Director of Nurses) what type of food R7 was served. E2 reported she had conducted an inservice with the facility staff the importance of calling 911. The inservice contents included, "All Staff: If a resident is choking: 1 staff member is to perform the Heimlich while another staff member is to call 911 at the same time, Do Not Wait!".

The menu for the evening meal on 9/15/11, showed "Sunrise Fruit Salad" was served to the regular and puree diets.

On 11/9/11 at 9:30 AM, E2 (DON) stated, "R7 was served fruit cocktail that night." E11 (Dietary Manager) stated, "There is no recipe available for the Sunrise Salad, and that most likely fruit cocktail was served. E11 stated the

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F9999	Continued From page 58 menu change was not listed on the substitution list. The recipe directions for puree fruit cocktail states to place food in a food processor and process until fine in consistency. (B)	F9999		