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F 520	Continued From page 147 development and implementation of policy and procedures. E4, Social Services Director, was interviewed on 11/2/11. She stated she does not determine issues for QA discussion. She stated department heads have daily meetings to discuss pertinent issues. E39, Food Services Supervisor, was interviewed on 112/11 at 11:00 AM. E39 stated the QA committee meets quarterly. E39 stated E1, Administrator, is the coordinator and submits an agenda for the meeting. E39 stated dietary issues such as weight loss, gain, thickened liquids, special diets are reviewed. E39 stated the Registered Dietician usually does not attend the meeting. E38, Maintenance Supervisor, was interviewed on 11/2/11 at 11:20 AM. E38 stated he attends the meetings. He stated, "I think they're held monthly." E38 stated the meeting, "go over nursing issues. I take notes if there are any environmental issues. If there is something I am responsible for, I contact th contractor, get bids and write it up.". E38 stated he did not attend the last QA meeting. 2. The facility's CMS-672, Resident Census and Conditions of Residents form dated 10/25/11 documented the facilty's census as 50.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.610a) 300.650a) 300.650d)	F9999		

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F9999	Continued From page 148 300.660a) 300.660d) 300.3240a) 300.3240b) 300.3240d) 300.3240e) 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 300.650 Personnel Policies a) Each facility shall develop and maintain written personnel policies that are followed in the operation of the facility. These policies shall include, at a minimum, each of the requirements of this Section. d) The facility shall check the status of all applicants with the Nurse Aide Registry prior to hiring. Section 300.660 Nursing Assistants	F9999		

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a) A facility shall not employ an individual as a nurse aide unless the facility has inquired of the Department as to information in the Registry concerning the individual. The Department shall advise the inquirer if the individual is on the Registry, if the individual has findings of abuse, neglect, or misappropriation of property in accordance with Sections 3-206.01 and 3-206.02 of the Act, and if the individual has a current background check.

d) The facility shall certify that each nursing assistant employed by the facility meets the requirements of this Section. Such certification shall be retained by the facility as part of the employee's personnel record.

Section 300.3240 Abuse and Neglect

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

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department.

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact

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with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee.

These Regulations were not met as evidenced by:

A. Based on record review and interview, the facility staff failed to operationalize the facility's abuse policy by failing to report an allegation of abuse to the administrator immediately, allowing a Certified Nursing Assistant to have direct contact with residents after a potential abuse incident, delaying the initial investigation of potential abuse for three residents reviewed for abuse investigations in the supplemental sample. This had the potential to affect all 50 residents in the facility.

B. Based on interview and record review, the facility failed to operationalize the facility's abuse policy by failing to conduct health care worker registry checks for potential abuse findings prior to hire for eight (E8,E15,E16,E17,E18,E19,E20, and E21) of 12 employee reviewed for pre-employment screening. This had the potential to affect all 50 residents in the facility.

Findings include:

A.
1. The facility's Incident Report - IDPH (Illinois Department of Public Health) Notification form, dated 10/24/11, documented an allegation of verbal abuse. The form documented "Resident report that CNA was rude to her and cursed at her. The staff member was suspended pending an investigation. A five day report to follow."

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F9999	Continued From page 151 On 10/25/11, at 12:20 PM, an interview was conducted with E1, Administrator. E1 stated she had been notified of the incident which occurred between R7 and E15, CNA on 10/24/11. E1 stated the Director of Nurse's had been notified by E7 via the telephone early morning on 10/23/11. E1 confirmed she had not been notified until the next day. E1 stated E15 was pulled off the set so she would not have to take care of R7. E1 confirmed R15 worked her entire shift on 10/23/11. 2. The facility's Incident Report Form -IDPH Notification form regarding R9, dated 9/7/11 was reviewed. The form documented "Two therapist overheard staff member speaking to the above listed resident in a louder than usual tone. They wrote statements and reported this alleged incident. The staff member was suspended pending an investigation. A five day report to follow." The form documented the date of the incident as 9/5/11. On 10/27/11 at 8:30 AM an interview was conducted with Z6. Z6 stated that Z5 wrote up a statement and placed it on E1's desk. On 10/26/11, at 2:25 PM, during an interview with E1 she stated that the incident regarding R9 occurred on 9/5/11 which was Labor Day weekend. E1 stated she was not notified until 9/6/11. E1 stated E30 was allowed to work her entire shift on 9/5 and until mid-afternoon on 9/6/11. E1 stated the report was not sent to IDPH until 9/7/11. E1 stated she failed to notify IDPH timely.	F9999		

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F9999	Continued From page 152 3. The facility's Incident Report Form - IDPH Notification form, dated 4/20/11 regarding R16 was reviewed. The report documented "Alleged patient report of hand slapping by unknown CNA (unidentified). Patient report hand was 'pushed away by a CNA one morning not long ago when it was dark outside.' No injuries noted @ (at) this time." There was no further investigation documented regarding this incident. On 10/26/11, at 2:25 PM, E1 stated "I never have seen this allegation. This is the first time I saw it." E1 stated there was no investigation conducted regarding this incident with R16. 4. The facility's Abuse Policy dated 7/29/10 documented, "Employees are required to immediately report any occurrences of potential/alleged mistreatment they observe, hear about, or suspect to a supervisor and the administrator." The policy continued to document "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." The policy did not document all employees shall report abuse immediately to the Administrator. The facility's Abuse Policy documented the following regarding "Protection of Residents": "Employees of this facility who have been accused of mistreatment will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee. Employees accused of alleged mistreatment shall not complete their shift as a direct care provider to residents."	F9999		

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F9999	Continued From page 153 On 10/27/11 during interviews with E10 (CNA), E17 (CNA), E22 (CNA), E23 (Restorative CNA), E24 (CNA), E33 (Activity Director) and Z6, Speech Therapist, they all stated they would report allegation of abuse to the nursing supervisor. None of these employees stated they would immediately report the allegation to the Administrator. B. 1. On 10/28/11, the facility's employee files were reviewed. The facility failed to check the Health Care Worker Registry prior to hire for E15, Certified Nursing Assistant (CNA), E16 (CNA), E17(CNA), E18 (CNA)E19 (CNA), E20 (CNA), E8, Registered Nurse (RN), and E21, Licensed Practical Nurse (LPN). All of these employees had been hired since September 2010. On 11/1/11, at 10:00 AM, an interview was conducted with E26, Office Manager. She stated some of the Registry Checks were missing and she reprinted them off the Registry on 7/4 and 7/5/11. She stated she never checks the Registry for the nurses. The facility's Abuse Policy dated 11/4/10 documented "Prior to a new employee starting a work schedule this facility will "Check the Illinois Health Care Worker Registry on any individual being hired for a position." 2. The facility's CMS-672, Resident Census and Conditions of Residents form dated 10/25/11 documented the facilty's census as 50.	F9999		

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300.696a)
300.696c)6)

Section 300.696 Infection Control

a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code and Control of Sexually Transmissible Diseases Code. Activities shall be monitored to ensure that these policies and procedures are followed.

c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services:
6) Guideline for Isolation Precautions in Hospitals

These Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to follow isolation precautions and failed to clean and disinfect environmental surfaces for one resident (R50) reviewed for Clostridium difficile (C. diff) infection in the supplemental sample. This has the potential to affect all 50 residents in the facility.

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F9999	Continued From page 155 Findings include: 1. R50 was transferred from the hospital to the facility on 10/27/11. The hospital's Patient Transfer Form dated 10/27/11 documented "Contact precautions (+ C-diff) ." The EMS, Emergency Medical Service, Patient Care Report dated 10/27/11 documented "RN (Registered Nurse) also states pt. (patient) is on isolation for C-diff." R50's nurse's note dated 10/27/11 documented "10 pm 47 y/o (year old) Caucasian female admitted to (Facility) from (Hospital) at 5:22 PM by (Ambulance).....Resident on contact isolation for c-diff in stool per nursing report and MRSA per EMT report (nares)." R50's Care Plan, revised on 10/27/11, documented "Returned from hospital c (with) diagnosis of Sepsis from UTI (Urinary Tract Infection) and C-diff. Resident now on contact isolation for C-Diff." On 10/28/11, at 8:49 AM, E2, Director of Nurse's was standing in front of R50's room. E2 stated "She is on isolation. I know I need to get her a sign." There was no isolation sign on R50's door. E7 and E34, Certified Nurse's Assistants (CNAs), were standing by R50's door. When asked why R50 was on isolation, E7 and E34 stated were not sure. On 11/1/11, at 9:10 AM, during an interview with E9 and E11, CNAs, both stated they were not sure why R50 was on isolation. E24, CNA, walked up and whispered "I know. She has	F9999		

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Hepatitis C." E9 and E11 nodded their heads in agreement. E9, E11 and E24 were caring for R50 on the 6 AM - 2 PM shift.

On 11/1/11, at 3:23 PM, E11, CNA, was interviewed regarding who was on isolation and for what reasons. E11 stated R50 was on isolation but she was not sure why.

On 11/1/11, at 3:40 PM, E12, CNA, was interviewed regarding infection control. E12 stated she was not sure what residents were currently on isolation. She stated "I would know due to sign on door or biohazard red barrels in room."

On 11/1/11, at 3:40 PM, E36, CNA, was interviewed regarding infection control. E36 stated he did not have anyone on his hallway who was in isolation.

The facility's policy "Isolation Room Set Up" dated 3/02 documents "It is the policy of this facility to set up isolation for communicable diseases, which so require this procedure based on the guidelines per the Center for Disease Control." The policy documented the procedure "7. Place sign on door to resident's room for visitor's to inquire at nurse's desk prior to entering room."

2. On 11/1/11, at 9:20 AM, E13, Housekeeping Supervisor, was interviewed. When asked how the facility cleans and sanitizes rooms where residents with C-diff reside, E13 responded "We use Clean Power Yellow on all surfaces in every room." E13 stated "It kills 99.1 % of germs."

On 11/1/11, at 2:45 PM, the Manufactures label

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on Clean Power Yellow was reviewed. The manufacture's label did not document the product kills C-diff.

The Center for Disease Control, CDC, guidelines states under 11.1 Environmental measures "Certain pathogens (e.g.....C. difficile) may be resistant to some routinely used hospital disinfectants....Also, since C. difficile may display increased level of spore production when exposed to non-chlorine based cleaning agents, and the spores are more resistant than vegetative cells to commonly used surface disinfectants, some investigators have recommended the use of a 1:10 dilution of 5/25%.....hypochlorite (household bleach) and water for routine environmental disinfection of rooms and with patients with C. difficile when there is continued transmission... In one study the use of (bleach) was associated with a decrease in rates of C. difficile infections."

On 11/8/11, the Material Safety Data Sheet for Clean Power Yellow documented the active ingredient for the solution was Ammonium Chloride. There was no hypochlorite or bleach ingredients in the solution.

3. E13, Housekeeping Supervisor, stated in an interview on 11/1/11 at 3:30 PM that she was not sure who was on isolation in the facility except for R50 and they had set up her room for isolation on Friday. E13 stated they use the same disinfectant, Power Yellow, in the mop water and spray bottles for cleaning all rooms. E13 stated she was not sure of the concentration and the disinfectant was dispensed already mixed. E13 stated the disinfectant "kills everything" and is

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F9999	Continued From page 158 "better than bleach." E13 stated they keep everything at "arms length" and have not had to use gowns when cleaning the rooms. Observation of the "Biohazard room" on 11/1/11 at 3:35 PM noted the biohazard barrel was overflowing and with red garbage bags and the lid was off. 4. The facility's CMS-672, Resident Census and Conditions of Residents form dated 10/25/11 documented the facilty's census as 50. (A) 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with	F9999		

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F9999	Continued From page 159 the active participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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 300.3240 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 and interview it was determined that the facility failed to assess, implement interventions and identify causative factors contributing to falls for 5 of 6 residents	F9999		

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(R13, R10, R9, R1, R3) reviewed for falls in the sample of 13. R13 fell and sustained a left hip fracture which required surgical intervention. R13 expired on 8/22/11.

Findings include:

R13 was admitted to the facility on 9/29/10 with diagnoses, in part, of dementia, psychosis, congestive heart failure, and chronic obstructive pulmonary disease. The Minimum Data Set (MDS) dated 7/15/11 assessed R13 with no wandering behaviors. The MDS assessed R13 as requiring extensive assistance of 1 person for transfer, dressing, toilet use and personal hygiene. R13's main mobility device was documented on the MDS as a wheelchair and once in the wheelchair required limited assistance with 1 person for locomotion. On 6/22/11 R13 was assessed as a high fall risk on the "Fall Risk Assessment." The fall assessment documented R13 needed assistance to stand and walk with loss of balance with both activities. R13's mental status was documented as "Occasional confusion." The MDS documented R13 had "two or more" falls with no injury since the prior assessment.

The care plan dated 7/28/11 documented under "Falls" that R13 had "risk factors that require monitoring and intervention to reduce potential for self injury." The goal for R13 was documented as "Resident will follow safety suggestions and limitations with supervision and verbal reminders for better control of risk factors thru next 90 days."

On 3/8/11 R13 was found in her room on the floor

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according to the "Investigation Report for Falls" report. The fall was not witnessed. The report documented that R13 was transferring independently from the bed to the wheelchair to go to the toilet. There were no injuries noted. The "Root Cause Analysis" section was not filled in nor was the "What new interventions was implemented to prevent further falls" section. The Interdisciplinary Team (IDT) review dated 3/9/11 recommendation documented "Pt (patient) self-reliant, non-compliant (with) care (at) (times). Pt education re: (regarding) use of call light (with) all transfers given. Pt verbalized understanding."

On 6/22/11 at 1:30 PM the "Investigation Report for Falls" documented R13 was at the nurses station and tried to get up unassisted and fell. R13 sustained a skin tear on the left third finger. The IDT recommended R13 to call staff for assistance when attempting to get up. The new intervention to prevent further falls was as "alarm in place."

On 7/29/11 R13 fell and sustained a left intertochanteric hip fracture. There is no incident report or investigation for this fall. E1, Administrator, confirmed in an interview on 11/3/11 at 2:45 PM that there was no incident report for the 7/29/11 fall.

The nurses notes dated 7/29/11 at 3:30 PM document R13 was found in her room on the floor. R13 stated she was trying to put a soda on the night stand when she fell. The nurses notes do not identify if the alarm was sounding. Staff were unable to perform range of motion to the left leg and lifted R13 back into bed. R13 was unable to move her left leg due to the pain. The

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physician was notified and R13 was sent to the emergency room. R13 underwent surgical repair of the hip and returned to the facility on 8/1/11. The nurses notes dated 8/1/11 documented a large bruise on her left hip and multiple bruises on her right and left arm. A skin tear was noted on her left elbow.

On 8/2/11 R13 was admitted to hospice services. On 8/9/11 R13's medications were discontinued. On 8/22/11 at 9:00 AM the nurses notes documented R13 was deceased with no pulse noted.

2. On 10/27/11 at 12:15 PM, E7 and E22, Certified Nursing Assistants (CNA) transferred R10 from the bed to a reclining geriatric chair using a mechanical lift. R10 was wearing geri-sleeves on both arms. Both arms had multiple fading purplish bruises noted. His legs were pulled up into a fetal position. R10 was apprehensive during the transfer, speaking loudly and repetitively.

R10's Care Area Assessment (CAA) dated 7/9/11 for falls stated (in part), "Will remain on high alert in regard to falls & incidents - resident is unable to recognize safety factors in general - so staff has to be on high alert @ all times in this regard."

R10's Care Plan reviewed on 10/7/11 identifies the Problem: "Resident is at risk for falls due to his extensive dementia & inability to recognize safety factors & his limited physical abilities - sometimes he still thinks he is capable of doing things independently." Interventions include: "His bed is to be in the lowest position.....he has bilateral side rails to help with turning &

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repositioning....Remove any environmental barriers from his room that may cause problems."

The facility's Fall Log and Investigations documented frequent falls and skin tears for R10. On 12/8/10 at 6:30 AM, R10 was found on the floor of his room. There are no new interventions listed on the incident investigation or Care Plan.

On 12/19/10 at 9:50 AM, the Incident Report stated R10's "skin came off with shirt" while CNA was undressing him. No new interventions were listed on the investigation or Care Plan.

On 12/29/10 at 5:00 PM, R10 sustained a skin tear due to "scratching himself." Geri-sleeves were placed on both arms and CNAs were directed to dress him in long sleeves.

On 12/30/10 at 9:55 PM, R10 sustained another skin tear to left upper arm due to scratching himself. There were no new interventions listed on the investigation or Care Plan.

On 3/30/11, R10 slid out of his chair onto the floor of the TV room. A personal alarm was added as a new intervention.

On 4/24/11 at 9:00 AM, R10 received skin tears on both left and right elbows from the mechanical lift pad during a transfer. No new interventions were listed.

On 5/2/11 at 4:30 PM, R10 received a skin tear to his right upper arm. No new interventions were listed.

On 6/18/11 at 4:25 PM, R10 slid out of the

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geriatric recliner onto the floor. No new interventions were listed.

On 7/9/11 at 5:50 AM, R10 was noted to have scratches to his right hip - no new interventions were listed.

On 7/6/11 at 4:30 PM, R10 obtained a skin tear during transfer from bed to chair. No new interventions were listed.

On 8/28/11 at 6:05 AM, R10, "was trying to get out of bed. Caught in between siderails." The investigation listed "Add padding to siderails" as a new intervention.

On 9/25/11 (time unknown), R10 was found "arm through side rails, knees on mat." R10 obtained skin tears to his right elbow and right forearm. There were no new interventions on either the Care Plan or investigation.

R10's Nursing Notes dated 8/29/11 at 2:10 AM documented (in part), "....res. was found on left side, caught in siderails. L.(left) arm caught under siderails."

The facility's Investigative Report for Skin Tears/Bruises dated 8/28/11 stated, "Res. was trying to get out of bed, was caught in between siderails and bed. That's how s/t (skin tear) occurred." The Root Cause with Recommendation dated 8/29/11 stated, "add padding to S/R (siderail) to prevent future S/T." The was no reassessment of the safety of siderail use following this incident.

The facility's Investigation Report for Falls dated

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F9999	Continued From page 165 9/25/11 documented another incident involving R10's siderails. This report documented "arm through side rails, knees on mat." Witness Reports attached to the investigation by E27, CNA, documented he, "Found res sitting on floor mat holding on to bed rail in upright position." There was no recommendation following this incident. On 10/27/11 at 10:40 AM, R10 was asleep in his bed, on his left side. He had a mat on the floor and 1/2 siderails up on both sides of the bed. On 10/27/11 at 11:00 AM, E2, Director of Nursing, confirmed that R10 continues to use side rails. E2 stated she has been DON since 9/16/11. She did not recall if there were re-assessments for safety of siderail use after the incidents on 8/29/11 and 9/25/11. 3. The MDS, dated 10/12/11, documents R1 is moderately cognitively impaired, and requires extensive human assistance to stabilize her balance for transfers. The Fall Assessment, dated 10/12/11, scores R1 as a high risk for falls. The Quality Care Reporting Form, dated 9/13/11, documents R1 was ambulating independently, went outside the facility, sounded the exit door alarm and fell at 4:30 PM. R1 suffered a spiral fracture of the left distal fibula. The intervention documented to prevent further falls is, "Any and everyone react and respond to door alarms." A treatment intervention ordered by the physician on 10/4/11 is, "Fitted with fracture boot, must wear at all times, and continue non weight bearing status."	F9999		

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F9999	Continued From page 166 On 10/25/11, at 9:40 AM, 10:57 AM, and 11:24 AM R1 was in bed with no personal safety alarm in place to the bed or to R1's clothing. At 11:37 AM, E9 and E19, CNA's applied fracture boot to R1's left lower extremity and transferred R1 from the bed to the wheelchair with the use of a gait belt. E9 and E10 allowed R1 to use full weight bearing to both lower extremities during the transfer. On 10/25/11, at 11:50 AM, E2, Director of Nursing, (DON) reported R1 is supposed to have a personal safety alarm when in bed and in the wheelchair. At 11:52 AM, R1 was wheeled into the dining room with a safety alarm attached to the wheelchair and clipped to R1's blouse. On 10/25/11, at 1:05 PM, R1 was seated in her wheelchair in the hall. R1 was trying to rise from the wheelchair, and the clip to the safety alarm came unclipped. The alarm did not sound. At 1:20 PM, E9 and E10 transferred R1 to bed and the alarm was not attached and did not sound. E10 clipped the safety alarm to R1's blouse, and placed the base of the alarm on the mattress, next to the pillow. E10 did not secure the base of the alarm to anything, making it impossible to sound if R1 tried to get out of bed. On 10/25/11, at 2:21 PM and 2:50 PM, the personal safety alarm remained on the mattress, unattached. On 10/26/11, at 8:53 AM, 9:20 AM and 10:00 AM, R1 was in bed on her back. The base of the safety alarm laid on the bed unattached or secured to the bed. The clip of the alarm was attached to R1's left shoulder. R1's Care Plan, dated 10/12/11, documents she is at risk for falls due to the diagnosis of dementia	F9999		

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and is receiving psychotropic medications. The Care Plan documents R1 is monitored for trying to get up unassisted since she is used to walking independently, and does not have the cognitive ability to realize her limitations. The Care Plan documents a personal safety alarm is to be present on the wheelchair and when R1 is in bed.

4. The Physician's Order Sheet for October 2011 documents R3 has diagnoses of Schizophrenia, Severe Mental Retardation, Seizure Disorder and Dementia. The Fall Risk Assessment, dated 9/2/11, documents R3 is a high risk for falls.

On 10/26/11, a review of the Nurses Notes document R3 was found on the floor after falling from his wheelchair on 2/13/11, 2/21/11, and 3/04/11. The Quality Care Reporting Form, dated 2/13/11, documents R3 slid out of the wheelchair onto the floor of the activity room, with the (soft lap cushion) on his upper torso, not connected to the wheelchair. The Prevention Plan, dated 2/13/11 documents, "Monitor resident closely, within sight at all times.

The Quality Care Reporting Form, dated 2/21/11, documents R3 slid from his wheelchair at 5:30 PM in the television room with the (soft lap cushion) next to him. The Investigation documents R3 was taken to the dining room where he tried to remove the (soft lap cushion), then tried to slide under the lap cushion. The analysis of the fall documents R3 took off (soft lap cushion). The prevention plan, dated 2/21/11, documented is to "find better lap buddy," and "to make sure resident lap buddy is attached."

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On 10/26/11, at 3:00 PM, E2, DON reported the fall investigation of 3/4/11 could not be located at the facility.

On 10/25/11, at 9:00 AM, 10:42 AM, 11:47 AM, 12:07 PM and 12:27 PM, R3 was up in his wheelchair with a (soft lap cushion) resting on his lap. The (soft lap cushion) was too small and did not attach effectively to the wheelchair. Only one side of the (soft lap cushion) was attached to the wheelchair.

On 10/25/11, at 4:25 PM, 4:38 PM, and 4:40 PM, R3 was up in the wheelchair. R3 was observed pulling on the (soft lap cushion).

On 10/26/11, at 8:30 AM, R3 was in the corner of the television room, with the soft lap cushion sitting on his lap. The lap cushion was completely unattached to the wheelchair. No staff were in the television room to monitor R3.

On 10/26/11, the Physical Restraint/Enabler Consent, undated, documents the reason for the (soft lap cushion) is, "to promote upright position and to remind resident not to get up unassisted." On 10/26/11, at 2:15 PM, E18 and E35, CNA's reported R3 takes off the soft lap cushion, and sometimes puts himself in bed. Both E18 and E35 confirmed R3 does not have a personal safety alarm on his bed or wheelchair. When E18 asked R3 to remove the lap cushion, R3 shook his head and refused.

R3's Care Plan to address falls, dated 9/02/11, documents R3 does remove the soft lap cushion and scoots out of his wheelchair onto the floor. An intervention, dated 3/3/11, is listed as "new

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chair cushion given and continue to place in high visibility areas, attend more activities." No other progressive interventions to prevent falls are documented. The Care Plan documents the soft lap cushion has been in place to R3's wheelchair since 6/10/08, and may be removed at meal times.

The facility's policy and procedure, entitled, 'Fall Prevention" does not address the use of a soft lap cushion as an intervention to prevent falls, but does document "Keep in visual when out of bed."

On 10/27/11, at 4:00 PM, E2, DON confirmed R3's soft lap cushion is too small to fit his wheelchair appropriately.

5. R9's physician's order sheet dated October 2011 documented he had a partial diagnoses of Huntington's Disease. In The Merck Manual of Geriatrics, Third Edition, 2000, Huntington's Disease is defined as "It is characterized by chorea (flowing continuous, random movements that flit from one part of the body to another), personality changes, cognitive impairment, and psychiatric signs (e.g., psychosis, depression)."

The facility's Investigative Report for Skin Tears/Bruises dated 6/2/11 documented at 3:50 AM R9 was getting up out of bed trying to walk and fell. The Report documented "Nursing measures to prevent: needs low bed/body alarm/chair alarm is used already." The Quality Care Reporting Form dated 6/2/11 documented "Root Cause with Recommendation by pt (patient) up s (without) assistance. Recommend checking on patient more frequently. R9's care

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plan was not revised after this fall with any new interventions to prevent him from falling in the future.

The facility's Quality Care Reporting Form dated 6/6/11 documented at 9:02 PM R9 fell in his room and sustained no injury. The Form documented "Root Cause with Recommendation by Resident up s (without) assistance remind of call light also monitor more frequently to have needs met."

The facility's Quality Care Reporting Form dated 6/7/11 documented at 12:35 AM R9 fell in his room. The intervention listed on the Form documented "Res (Resident to be assist x 2 to help c (with) unsteady gait." R9's Care Plan was revised on 6/7/11 and documented "No injuries sustained in fall." No new progressive interventions were implemented to prevent R9 from falling in the future.

The facility's Investigation Report for Falls form dated 6/21/11 documents at 3:00 PM R9 fell in his room trying to get into his wheelchair. There were no new interventions documented on the form to prevent R9 from future falls. The Report documented "What fall prevention techniques were in use prior to the fall? None. Were the fall prevention techniques in place? No." R9's Care Plan was not revised after this fall.

The facility's Investigation Report for Falls form dated 7/25/11 documented at 8:00 AM R9 fell in his room trying to transfer without assistance. There were no new interventions documented on the form to prevent R9 from future falls. The Report noted the chair alarm was in use prior to the fall ; however, the Report documented "Were

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the fall prevention techniques in place? No." R9's Care Plan was not revised after this fall.

The facility's Investigation Report for Falls form dated 8/2/11 documented at 12:35 AM R9 fell in his room trying to get into his wheelchair. The Report documented "May need low bed." The Report documented the body alarm was in place but did not document if the body alarm sounded. R9's Care Plan was revised on 8/5/11 and documented "Resident continued to have falls due to general further decline in motor skills and his inability to realize safety precautions any longer or to realize time factors of waiting for assistance. Staff tries to anticipate his needs. Keep in high visibility areas and 30 minute checks."

The facility's Investigation Report for Falls form dated 9/2/11 documented R9 was found face first on floor in front of the nurses station at 4:40 PM. R9 sustained a reddened area to his forehead. The Quality Care Reporting Form documented "Root Cause with Recommendation by resident attempting to get his glasses. Continue current interventions and monitor him outside of his room." The Report documented R9's chair alarm was in place but did not document if the chair alarm functioned.

R9's Care Plan was reviewed on 9/6/11 and documented "Staff continued c (with) 30 minute checks to be more aware of his whereabouts after meals, activities, etc. he continues to try to do things independently and due to his disease progress is not always aware of time frames, etc. Fortunately, his falls have not resulted in injuries thus far. As stated, he can't always (any longer)

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comprehend time frames. He may ask to go to bed, then shortly thereafter try to get up independently or vis versa." The Care Plan did not document any progressive interventions to prevent R9 from falling in the future.

The facility's Investigation Report for Falls form dated 9/10/11 documented R9 fell in his room at 8:30 AM. The Report documented "Transfer self without assistance." The Report and the Quality Care Reporting Form documented no new interventions to prevent R9 from future falls. The Report did not document if R9 was up in his wheelchair or in bed. The Report did not document if alarms sounded to notify staff of his movement.

The facility's Investigation Report for Falls form dated 9/18/11 regarding R9 documented "Getting up from w/c (wheelchair) to get into bed." The Report documented "Resident was in room/ found in sitting position." The Quality Care Reporting Form regarding this incident dated 9/18/11 documented "Root Cause with Recommendation by continuing 30 minute checks and monitor closely." The Report did not document if the alarms were sounding at the time of the falls. R9's Care Plan was not revised after this fall.

On 10/27/11 at 1:30 PM R9 threw his legs over the side of his bed, placed his feet on the floor and stood. There was a low muffled alarm sounding that was barely audible. R9 was unsteady and bent forward at the waist. R9 attempted to grab his wheelchair. E7 was walking down the hallway and observed R9. She went into the room to assist R9. E7 and E9,

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F9999	Continued From page 173 Certified Nurse's Aides (CNA) assisted R9 into his wheelchair. E7 removed and reset the alarm box that sounded the alarm. The alarm box had been placed under R9's bed linens causing the alarm to be barely audible from the hallway. (B) 300.1210a) 300.1210b) 300.1210c) 300.1210d)1) 300.1610a)1) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.	F9999		

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F9999	Continued From page 174 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. Section 300.3240 Abuse and Neglect	F9999		

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

Based on observation, record review, and interview, the facility failed to provide adequate comfort measures and coordinate hospice services and failed to timely obtain, correctly transcribe and administer medications as ordered for end of life comfort measures for one resident (R14) reviewed for Hospice care and medications on the supplemental sample. This failure resulted in increased fear, anxiety, and difficulty breathing due to delays in administration of medication for one Hospice resident (R14).

Findings include:

1. During initial tour of the facility on 10/25/11 at 9:20 AM, R14 was observed in bed, with the head of the bed elevated. He was calling "help, help," appeared anxious, was experiencing shortness of breath. R14's oxygen was running but had been removed and the tubing was laying on the floor. E24 and E23, Certified Nursing Assistants (CNA), were notified by this surveyor that R14 needed help.

On 10/25/11 at 1:00 PM, E25, Licensed Practical Nurse, documented (in part) in R14's Nursing Notes, "..C/O SOB (complaining of shortness of breath). Rhonchi noted on expiration. Respirations uneven & labored. MD called & notified of abnormal lung sounds not relieved with breathing TX (treatment). New orders received....." Z2, Physician, ordered an extra nebulizer treatment of Xopenex and Atrovent right

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now.

R14's Nursing Notes documented that after the treatment was completed, E25 notified Z2 that R14's breathing had not improved. Z2 ordered R14 to be sent to the hospital. E25 notified R14's POA (power of attorney) that R14 was being sent to the hospital. E25 called the ambulance service to transport R14 to the hospital. E25 then called Z4, Hospice Nurse to notify him of R14's change of condition and orders to send him to the hospital. E25 documented in the Nursing Notes, "POA called & notified, Hospice called & notified of orders to send to ER for TX (treatment) and evaluation. Hospice disagree, ordered Ativan, Scopolamine Patch, & Morphine. Call POA & informed him of Hospice orders. POA was o.k. with new ordered per (Z1 - Hospice Physician)."

On 10/25/11 at 4:00 PM, E28, Registered Nurse (RN), documented in Nursing Notes and was overheard as she talked on the telephone to Z4, Hospice Nurse. E28 informed Z4 that R14's condition continued to deteriorate, with pulse oximeter reading of 79% oxygen saturation. E28 notified Z4 the Scopolamine Patches were unavailable from the pharmacy. Z4 discontinued the Scopolamine Patches and ordered Atropine, 3 drops three times daily to decrease mucus secretions. E28 asked if Z4 would return and see R14. E28 called pharmacy and requested that all medications be sent stat (as soon as possible) and delivered in an e-run (emergency run).

At 5:00 PM R14 remained in bed. R14 was experiencing continued, increasing agitation. He was very short of breath, with moist respirations audible from the doorway of his room. He sat

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upright in bed, gasping for breath. E23, CNA, was in R14's room, holding his hand, attempting to comfort him, urging him to breathe slowly, to try to relax. The medication had not arrived in the facility at this time. E23 stated in an interview on 11/1/11 at 9:00 AM, that she heard R14 calling out for help on the 10/25/11 day shift. E23 stated, "He told me he was having a lot of trouble breathing. He didn't want to be left alone. He held my hand and asked me how much longer he had.". E23 stated she left the building around 6:00 PM that night. R14 had not received medication before she left.

E25, LPN, stated in an interview on 10/26/11 that the medications were not in the facility when she left around 4:30 PM. She ordered the medications and stated she had to change the scopolamine patches to Atropine drops because the scopolamine was not available.

E28, Registered Nurse (RN), working the evening shift on 10/25/11, documented in Nursing Notes at 4:00 PM, "Res (R14) very restless, Hospice called.....pulse ox 79%..... Called pharmacy to have them send Roxanol stat e-run...."

The following morning, on 10/26/11 at 6:20 AM, E29, LPN, night nurse, documented (in part) in Nursing Notes, "....Res. appears uncomfortable at this time. Wet coarse breathing heard upon exertion..... Res. remains on 02....After Roxanol given res appears a little bit @ ease."

Nursing Notes dated 10/26/11 at 8:00 AM, documented a note by E2, Director of Nursing, "Spoke with (Z4) hospice nurse. RC'd (received) order to suction PRN & he is calling the MD to

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increase Roxanol and atropine....he will be here to see res. this morning...." Nursing Notes at 9:40 AM documented that Z4 Hospice Nurse arrived in the facility, and at 9:48 AM, R14 died.

On 10/27/11, E28, RN, was interviewed regarding the delay in obtaining and administering the medications ordered to make R14 comfortable. E28 stated she had called the pharmacy to send medications stat at 4:00 PM. E28 stated the medications were sent in two different e-runs. The morphine (Roxanol) arrived around 8:00 PM. She stated she administered the first dose of Roxanol (morphine) around 8:00 PM. The Atropine arrived later. E28 stated she gave the first dose of Atropine drops at 9:00 PM.

On 10/27/11 at 11:00 AM, Z1, Hospice Physician, stated in a telephone interview that the purpose of hospice care is to treat any pain or other discomfort such as nausea and vomiting, shortness of breath, spiritual issues. Z1 was asked how soon medications should be given to ease the discomfort. Z1 replied, "Ideally, we should have a turn around within the first hour after being ordered. Some facilities don't have the narcotics on hand..... DEA (Drug Enforcement Agency) regulations have made it more and more difficult to obtain medications for end of life." Z1 stated many facilities obtain the medication in advance and have them available on an emergency basis to eliminate long delays.

On 10/27/11 at 1:35 PM, Z3, Pharmacist, was interviewed by telephone. He described the e-run delivery system to obtain emergency medication. Z3 stated the controlled substances such as Ativan, Vicodin, or Morphine must be

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accompanied by a signed prescription. If there are any questions regarding the order, the pharmacist must discuss questions with the physician personally. Telephone orders cannot be filled. Z3 stated, "We have a couple of facilities with narcotics available in their Emergency Kits." Z3 stated he has discussed the possibility with E2, Director of Nursing, but have not implemented having narcotics available in the facility's Emergency Kit.

On 10/28/11, Z3, Pharmacist, faxed documentation that the Roxanol (morphine) arrived at the facility on 10/25/11 at 6:12 PM. E28 had signed for the morphine at that time; however, the morphine was not administered until 8:00 PM. Z3 explained in a telephone interview at 2:37 PM, that 2 prescriptions were sent for Roxanol (morphine) and Scopolamine but the physician's signature had been covered with the other prescription. Z1, physician, refaxed the prescription at 3:45 PM but did not notify the pharmacy that it had been sent. The pharmacy found the prescription at 4:45 PM, had it ready to go at 5:00 PM, and it was received in the facility at 6:12 PM.

R14's Medication Administration Records (MAR) and Controlled Substance Records documented that the first dose of Morphine was administered by E28 at 8:00 PM, almost two hours after the pharmacy delivered the medication to the facility. R14's first dose of Atropine drops was administered at 9:00 PM, which had been delivered to the facility at 7:39 PM. Pharmacy records documented the Roxanol (morphine) had been delivered at 6:12 PM. The Atropine had been delivered at 7:39 PM.

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The MAR record for R14 transcribed by E28 listed the order for "Morphine 10 mg. P.O. Q 6 hours," however, the times to be administered were incorrectly listed at 0800 AM, 1600 (4:00 PM), 2000 (8:00 PM), and 0400 AM. Every 6 hours starting at 8:00 PM should be 8:00 PM, 2:00 AM, 8:00 AM, and 2:00 PM. The MAR documented that R14 did not receive a dose of Morphine at 2:00 AM; he received his next dose at 4:00 AM.

The MAR record transcribed by E28 for R14's Atropine drops TID (three times daily) listed the times as 9:00 PM, 3:00 AM, and 1:00 PM. R14 received his first dose at 9:00 PM, but did not receive any doses after. He missed the 3:00 AM dose.

On 10/27/11 at 3:00 PM, E28 reviewed the MAR and stated, "It looks like I wrote the wrong times on the MAR."

E25, LPN, was interviewed on 10/26/11 at 11:45 AM. E25 stated she had given R14 the extra breathing treatment on 10/25/11, but R14's condition did not improve. E25 stated she had notified Z2, physician, who ordered R14 to be sent to Emergency Room. E25 had initiated the transfer, called for an ambulance, notified POA and hospice. E25 stated that Hospice told her not to send R14 out. She stated Z4, Hospice nurse, stated Hospice would have to drop R14 if she sent him to the hospital. E25 stated Z4 is only to receive "Comfort Measures." E25 stated, "I said, 'but he's not comfortable, his anxiety is increasing, I can hear rhonchi in his respirations.' (Z4) put me on hold and another hospice nurse

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F9999	Continued From page 181 told me to cancel the ambulance." R14's record did not have a Hospice Care Plan. There were several Hospice Nursing Clinical Notes but no care plan. On 10/28/11, the facility received a faxed copy of R14's Hospice Care Plan. The Care Plan was dated 9/22/11. The Need/Problem was end-stage COPD (Chronic Obstructive Pulmonary Disease). Under the heading "Palliative care of symptoms, the symptoms are described as "SOB (shortness of breath), anxiety, pain." R14's current facility Care Plan updated on 9/30/11 stated, "All comfort and care measures provided per Hospice Protocol. Resident is a total care in all aspects of his ADLs (activities of daily living) and personal hygiene." There is no coordination of services from Hospice. There was no Hospice Care Plan available at the facility until 10/28/11, two days after he died. The Hospice Care Plan identified "Shortness of Breath" for symptom management. The goal listed is: 1. Patient Comfort, 2. Medication obtained if needed, 3. Medications/HME/Supplies obtained if needed. Interventions listed: 1. Evaluate medication needs 2. Obtain medications if applicable. R14's Hospice Care Plan for shortness of breath was not followed. Z4, Hospice Nurse, was interviewed by telephone on 10/27/11. Z4 stated R14 was receiving hospice care for end-stage COPD (chronic obstructive pulmonary disease). Z4 stated hospice goal is to provide comfort measure, pain management, and anxiety management. Z4 stated, "We ordered Roxanol to relieve his	F9999		

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F9999	Continued From page 182 shortness of breath." Z4 asked why the decision was made not to send R14 to the hospital when his condition deteriorated rapidly on 10/25/11. Z4 stated, "Because he is hospice, we don't send him out to the hospital. The hospital's goal is curative - not comfort measures. We try to ease his transition." Z4 was asked why he did not return to the facility on 10/25/11 when R14's condition deteriorated. Z4 stated he had seen R14 earlier that day and there wasn't much more he could do. (B)	F9999		