STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145290	A. BUILDING _____ B. WING _____	C 01/31/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 47 133 residents.	F 514		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)2)3) 300.2900d)2) 300.3100d)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary	F9999		

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F9999	Continued From page 48 care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical	F9999		

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F9999	Continued From page 49 functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.2900 General Building Requirements Section 300.3100 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	F9999		

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These Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility neglected to identify, assess and implement interventions to prevent elopement for one resident (R1) reviewed for elopement. On 1/14/2012, R1 eloped from the facility between 7:30 PM and 8:15 PM. R1 was found by the police face down in a creek, expired, on 01/16/2012.

Findings include:

1. The facility's initial report to the Department dated 1/15/2012 documented "This letter is to inform you of an elopement of one our residents (R1), a 78 year old male with diagnosis of Dementia, Acute and Chronic Renal Failure, and Coronary Syndrome, and Hypertension. The resident was found missing from the facility at 8:15 PM. He had last been seen at 7:30 PM while he was watching a movie with a group of residents in the Dining/Living Room area. The staff searched the building, the outer parameter of the facility and other staff got in their cars and searched the area blocks around the facility. The (city) police were notified as well during this search. The police came into the facility and took the report. They came back to the building at midnight and searched the building and were unable to find the resident. They sent a helicopter up around 2:30 AM to search further.

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Ongoing search is continuing. Further investigation of the incident will continue and a follow up on the results will be provided."

The Coroner's Report dated 1/16/2012 documented the Deputy Coroner, Z3, was notified by the city police of the death of R1 on 1/16/12 at 10:50 AM. The Report documented "He then led me to the creek viaduct that goes under 17th St., where I observed (R1), floating, face down, in the center of the creek." The Report documented R1 was wearing pajama bottoms, white underwear, a t-shirt, a sweat shirt, white socks and slippers. The Report documented Z3 pronounced R1 dead at 12:05 PM. The Report documented the cause of death was accidental "Hypothermia".

The weather history from the wunderground.com website for the area on 1/14/2012 at 7:55 PM documented a temperature of 28.2 degrees Fahrenheit (F) with a wind-chill of 23.1 degrees F with no precipitation.

On 1/17/12 at 4:30 PM, the area around the facility and the site where R1 was found was observed. The facility was located on the west side of a three lane street. The speed limit on this street was 30 miles per hour. There were sidewalks located on each side of the street. R1 was found approximately one block south east of the facility in a creek which flowed through a viaduct under the street to the south of the facility.

The following are a history of R1's elopement attempts :

a. R1's Hospital Departure Summary dated 5/6/2011 documented "05/06/11 1725 Triage Assessment, Complaint Related Notes via EMS (Emergency Service) c/o (complained of) combative and screaming with roommate and staff.....Went on EMS stretcher ok. Believes he

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is here to be checked out. On Thursday 5/5 he decided he wanted to leave the facility and packed up his belongings and started to leave the facility."

b. R1's Interdisciplinary Progress Notes dated 6/6/11 documented "(R1) believes that he is going home, and that his house needs tending to, he does have a grandson who visits with him weekly. (R1) will become verbally abusive with staff and other residents. He will try to leave the facility. (R1) has poor decision making skills."

c. On 1/24/12 at 10:20 AM a telephone interview was conducted with E24, Certified Nurse's Aide (CNA). E24 stated he had taken care of R1 when R1 resided on the 100 hallway. E24 stated he caught R1 outside the facility in late October 2011. E24 stated he saw R1 outside the facility through the window. He stated R1 was walking outside the facility in the front courtyard towards the front parking lot. E24 stated R1 was carrying his pants and shirts on hangers. E24 stated he went outside to retrieve R1. E24 stated R1 was upset; however, E24 was able to redirect R1 back into the facility. E24 stated he had questioned how R1 had walked past the receptionist at the front desk and walked out the front door. E24 stated R1 had a history of packing his belongings and attempting to leave the facility.

E24 stated he was working at the facility on 1/14/2012 at the time R1 eloped from the facility. E24 stated he did not hear any door alarms sound indicating any resident was leaving the facility.

d. R1's Nurse's Note dated 1/2/12 at 8:45 PM documented R1 walked out the front door , was not wearing a (patient monitoring device) and was redirected back inside the facility. The Note documented "Nurse initiated 15 min (minute)

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checks until he was sleeping." R1's Nurse's Note, dated 1/14/12 at 8:00 PM documented "CNA was looking for him he was gone from D/R (Dining Room) no one could tell where he went. q (every) one staff in building went by car & (and) on foot looking for him no trace of him. q (every) hall was (checked) over (and) over s (without) result." 8:30 PM Police notified came in to get information."

On 1/17/12 at 3:25 PM an interview was conducted with E4, Licensed Practical Nurse (LPN). E4 stated she was R1's nurse on 1/14/12 when R1 eloped from the facility. E4 stated she went to give him his medications at 8:00 PM and he was not in his room. E4 stated she asked E28, (CNA) where he (R1) was and E28 said he was in the dining room watching a movie. E4 stated she looked in the dining room but he was not there. E4 stated that the staff in the building began to search for R1, but could not locate him. E4 stated the Administrator and Director of Nurses were notified and stated to call the police.

On 1/17/12 at 3:40 PM an interview was conducted with E7, CNA. She stated R1 could ambulate independently. E7 stated she did not work on 1/14/12 when R1 eloped from the facility. E7 stated she was aware R1 had a history of packing up his clothes and said he was leaving.

On 1/19/12 at 10:30 AM a telephone interview was conducted E28 (CNA). E28 stated she worked on 1/14/12 when R1 eloped from the facility. E28 stated at 5:30 PM R1 was in the dining room eating his dinner. E28 stated she was passing through the Dining Room at around 7:30 PM, and she saw R1 watching a movie. E28 stated at 8:00 PM, E4 asked if I had seen R1, and I told her I had seen him watching the movie. E28

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stated R1 had a history of packing his belongings and saying he was going to leave. E28 stated she was unsure if R1 wore a patient monitoring device.

On 1/24/12 at 3:50 PM a telephone interview was conducted with E29, CNA. E29 stated she worked on 1/14/12, the evening R1 eloped from the facility. E29 stated at around 7:00 PM she saw R1 sitting in his room. E29 stated she asked R1 if he wanted to watch a movie. E29 stated R1 agreed and walked with her to the dining room. E29 stated around 7:45 PM she noticed R1 was not in his room. E29 stated she did not hear any door alarms indicating a resident had left the building. E29 stated R1 was normally quiet but it depended on his mood. E29 said R1 had a history of packing up his belongings, putting his clothes in a bag and saying he was leaving.

On 1/17/12 at 12:05 PM an interview was conducted with E1, Administrator. E1 stated R1 was admitted to the facility in January 2008 with Dementia, Hypotension, Hypertension and Cardiac Issues. E1 stated R1 ambulated independently without assistive devices. E1 stated R1 had a history of packing up his belongings, saying he was going to leave the facility but never left the facility. E1 stated staff would intervene prior to him leaving. E1 stated R1 attempted to pack his belongings up and leave the facility in early January 2012.

E1 stated that on 1/14/12, R1 did not pack his belonging up prior to eloping the facility. E1 stated R1 was not wearing a patient monitoring device when he eloped from the facility on 1/14/12. E1 stated she had been told by staff that R1 would not leave the patient monitoring device on his person, and therefore it had been removed. E1 stated Z4, R1's Psychiatrist, had seen R1 a few

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days prior to his elopement and did not feel R1 was an elopement risk.

On 1/19/12 at 10:30 AM a telephone interview was conducted with Z4. Z4 stated he did not recall being told by the facility R1 had attempted to leave the building or had a history of gather his items to leave the building. Z4 stated he would have expected the facility staff to let him know if R1 was trying to leave the building. Z4 stated R1 was demented and didn't know what he was doing.

On 1/19/12 at 12:20 PM a telephone interview was conducted with Z5, R1's Primary Care Physician. When asked if he was aware R1 had a history of packing up his belongings and saying he wanted to leave, Z5 responded "Yes. He (R1) was not very happy with placement." Z5 stated R1 had dementia and his cognitive and mental abilities fluctuated.

R1's Physician's Order Sheet dated January 2012 documented he had partial diagnoses of Acute Renal Failure, Hypertension, Coronary Syndrome and Dementia with Behavioral Issues.

R1's Minimum Data Set, MDS, dated 11/23/2011 documented under Section G0300 Balance During Transitions and Walking R1 was not steady, but able to stabilize without human assistance when moving from seated to standing position, walking, turning around and surface to surface transfers. The MDS documented he required supervision of staff for transfers and walking.

R1's Fall Risk Assessment dated 10/6/11 documented R1 had a fall risk score of 55. The Assessment documented "IF FALL SCORE 40 OR MORE THAN THEY ARE CONSIDERED A HALL FALL RISK AND SHOULD BE CARE PLANNED FOR FALL RISK."

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F9999	Continued From page 56 R1's Care Plan updated 12/2/2011 documented under the Comment Section "(R1) tries to leave the facility frequently wears a (patient monitoring device)." The Care Plan does not address R1's exit seeking behaviors and elopement attempts, and goals and interventions to address these behaviors. On 1/20/12 at 8:30 AM an interview was conducted with E30, LPN/Care Plan/MDS Coordinator. E30 stated she started her position as Care Plan/MDS Coordinator the end of October 2011. E30 stated she was not aware of R1's previous attempts to elope the facility, his behavior of packing his belongings, and saying he was going to leave. E30 stated R1's Care Plan was never revised to address those behaviors. R1's Initial Wandering Assessment Guide reviewed and revised on 10/6/11 documented "No" to the question "7. Is resident a candidate for (patient monitoring device) bracelet?" The facility's policy "Wandering Residents" revised March 2004 documented the following under the section Policy Interpretation and Implementation: "1. All residents who are at risk for harm because of wandering (elopement) will be assessed by the interdisciplinary care planning team. 2. The resident's current MDS 3.0 will be reviewed to determine what changes have occurred that would trigger elopement episodes." 3. The resident's care plan will be modified to indicate the resident is at risk for elopement episodes. Staff will be informed at shift change of the modifications to the resident's care plan. 4. Interventions into elopement episodes will be entered onto the resident's care plan and medical record.	F9999		

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F9999	Continued From page 57 5. Should an elopement episode occur, the contributing factors, as well as the intervention tried, will be documented on the nurse's notes. 6. If a resident repeatedly wanders off the unit, a monitoring schedule will be implemented to ensure resident safety. The resident's care plan will be documented as to the implementation of the monitoring schedule." On 1/17/12 at 1:00 PM, E5, Maintenance Director, was observed checking all exit doors to ensure the door alarms were working properly. At 1:45 PM, there were double exit doors in the 500 Hall Solarium. When E5 opened the right side exit door, the alarm did not sound. E5 stated "I don't know why." The Door Alarm and Locks check sheet for the facility were reviewed for the dates 1/10/12 through 1/17/12. There were no Alarm check sheets for 1/14 and 1/15/12. At 2:00 PM, E5 stated the maintenance only conducts door alarm checks Monday thru Friday and that was why there was no door alarm check sheet for 1/14/12. 2) R9's Department of Health Services Assessment of Summary Information sheet, located in R9's medical record, dated 10/26/11, documented he was residing in a state operated mental hospital. The Summary documented prior to his admission to the state hospital "Reports walking away from a previous nursing home because ' people were talking about me.' The Behavior Assessment Summary section documented "(R9) has a history of impaired judgement, poor insight, substance use, and	F9999		

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behavior that place him at risk".

R9 was discharged from the state hospital on 11/1/11 and admitted to the facility. R9's POS dated December 2012 documented he had partial diagnoses of Schizophrenia, History of Alcohol Abuse, History of Drug Abuse. R9's physician's order dated 11/1/11 documented "(Patient Monitoring Device) for personal safety".

R9's Admission MDS dated 11/9/11 documented he had a BIMS (A brief screener that aids in detecting cognitive impairment) score of 15 (Score of 13-15: cognitively intact).

On 1/19/12 at 11:15 AM, R9 was pacing up and down the 500 hallway. At 11:20 AM, an interview was conducted with E36, LPN. E36 stated R9 had a history of elopement. E36 stated R9 had a (patient monitoring device), but had been taken off 15 minute checks on 1/16/12 by E2, Director of Nurses (DON).

On 1/19/12 at 3:30 PM an interview was conducted with E2. She said a facility-wide re-assessment of all residents had been completed on 1/16/12 to determine who required patient monitoring devices. E2 stated R9 was assessed as requiring a patient monitoring device, and therefore, he was taken off the 15 minute checks.

The following are a history of R9's wandering behaviors and elopement attempts:
a. R9's Nurse's Note dated 11/21/11, no time, documented "Res. (Resident) monitored by staff. Very sensitive. Sneaking up on elevator. Gait very rigid. Continues to want to leave to go to the Christian Center down the street. Adapt (On-Site Mental Health Care Provider) staff aware of behavior. Has (patient monitoring device) in place on arm." R9's Nurse's Note dated 11/22/11

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at 1:00 PM documented "Res up walking halls all day (patient monitoring device) remain in place. Being monitored closely for wandering behaviors." R9's Nurse's Note dated 11/23/11 documented "Requires close monitoring due to attempting to go to upper level to go out of facility. Adapt staff re-directed res."

b. R9's Nurse's Note dated 11/28/11 documented "Case Management: Transition Aftercare & Linkage, Chestnut Health Systems - Met w (with) client face to face, as well as staff of Adapt and (facility).....Staff report client continues to attempt to walk off the grounds. He will ask permission to attend activities upstairs then walk out the front door."

c. R9's Nurse's Note dated 11/29/11 at 1:00 PM documented "Res attempted to walk out the front door of the facility, was able to redirect."

d. R9's Nurse's Note dated 12/5/11 at 9:00 PM documented "Client noted not to be in room or sitting rooms. Search conducted throughout facility for client." R9's Nurses's Note at 9:15 PM documented " 911 called and staff dispatched to search for client on grounds and streets, on foot and in vehicle." R9's Nurse's Note at 9:55 PM "Client returned to facility c (with) police escort, ambulatory. Stated he had been @ (at) (local bar), approx (approximately) 15 blocks from facility drinking only H2O." R9 was sent to the hospital for evaluation. R9 returned to the facility that evening.

On 1/20/12, E32's, LPN, statement regarding R9's elopement on 12/5/11 was reviewed. The statement documented "Approximately 7:00 PM I did the treatment on his (R9's) left foot, on healing open areas, as he had requested bandage. Approx 8:45 PM I noticed the he was neither in his room nor the TV room. I alerted

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MIDWEST REHAB & RESPIRATORY	**727 NORTH 17TH STREET BELLEVILLE, IL 62226**

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one of my CNA's, (E33), who immediately went upstairs to look for him, returning back downstairs in 5-10 min., not having found him. After about 5 min further search in bathrooms and small rooms downstairs, I called (E3, Assistant Director of Nurse's), who affirmed that I should call 911, which I then immediately did."

On 1/20/12, E33's, CNA, signed statement regarding R9's 12/5/11 elopement was reviewed. The statement documented ".....my last time seeing (R9) was around 7:30ish walking down the hall.....(E32) was down on A hall passing meds. When she asked me have I saw (R9) I stated o not since earlier I preceded to look in his room then when I did not locate him I went upstairs to look for him. I started asking other co-workers have they seen him and they stated no. I looked down 100 hall. I searched all bathrooms down on 500 hall, from there the police was called in."

On 1/20/12, E34's, LPN, signed statement regarding R9's 12/5/11 elopement was reviewed. The statement documented "This nurse observed resident (R9) walking from the 300/400 nurses station towards the dining room past the front entrance @ (at) 7:30 PM. We were told he was missing around 9:20 PM."

On 1/20/12, a statement taken from R9 after he eloped from the facility on 12/5/11 was reviewed. The statement documented "He was asked which door did he leave out of. He stated 'The front door.' He also was asked did the alarm sound. He said 'No. I walked to (local bar) it took 30 minutes' and he stated he did not fall. He was asked if he drank anything He said water. He also was asked did he smoke anything. He said cigarettes. He stated Pam bought me a jacket. He stated he wanted to go to (local hospital) and wanted his medications."

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F9999	Continued From page 61 e. R9's Nurse's Note dated 12/8/11 at 1:45 PM documented "Resident attempting to elope from facility x 1 this shift. Resident redirected from front entrance walk per Adapt staff. 15 minute checks continued at this time. Will continue to monitor. 1 on 1 observation initiated." On 12/9/11, the facility provided the following letter to the Department: "This letter is a follow up letter in reference to (R9). (R9) eloped from our facility on 12/5/11 and walked 1.5 miles to (a local bar).....Our staff has decided that we can no longer meet (R9's) needs and has issued him an Involuntary Discharge Notice. We have provided (R9) with a one on one staff member and has implemented a 15 minute check list for any behavior issues that (R9) might encounter. In addition to that we have in-serviced our staff on residents that wander and the purpose of the (patient monitoring device)." R9's Care Plan dated 11/1/11 was not revised after his elopement attempts on 11/21 and 11/29/11 to provide interventions to assist staff in preventing R9's future attempts at elopements. R9's Care Plan was updated after he eloped from the facility on 12/5/11; however, his Care Plan was not revised after R9 was placed on 15 minute checks after his elopement attempt on 12/8/11. On 1/20/12 at 8:30 AM an interview was conducted with E30. E30 stated she was hired the last week of October as the MDS/Care Plan Coordinator. E30 stated she went through R9's chart and asked staff questions regarding R9. E30 stated she was not aware of R9's previous elopement attempts. She stated she revised R9's Care Plan after he eloped from the facility on 12/5/11. E30 stated it is the nurse's responsibility to let her know what is going on with the residents	F9999		

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F9999	Continued From page 62 so she can update their Care Plan. (AA) 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the

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F9999	Continued From page 64 nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, record review, and interviews, the facility failed to provide safe transfer technique and failed to assess for possible cause of fracture of unknown origin for one resident (R3) reviewed for a fracture of	F9999		

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unknown origin, and failed to provide progressive interventions for fall prevention of f five residents (R5) reviewed for fall risks in the sample of 9. This failure resulted in R3's fracture of distal left tibial and fibular shafts.

Findings include:

1. On 1/17/2012 E2, Director of Nursing (DON) sent a report to the IDPH office which stated (in part), "I have conducted an investigation following the letter...sent to you on 1/14/12. The report is in regard to R3, who was diagnoses with left tibial fracture on 1/14/12. I have interviewed staff....The injury was noted by a CNA...was reported to the Nurse on duty....there were no complaints of pain prior to this....She (R3) was returned to our facility on Monday 1/16/12 with a soft cast to her lower leg.....I have concluded my investigation. It is still unknown when or how this injury occurred....".

E2's report of 1/17/12 stated (in part), "...there were no complaints of pain prior to this." R3's Nursing Notes documented the following complaints of pain:

a) On 1/5/12 at 7:50 PM, E17, Registered Nurse (RN) documented in R3's Skilled Nurses Note, "Resident yelling...CNA reports resident is complaining of pain. Given 650 mg. Tylenol via jelly.....". The Skilled Daily Nurses Note described the pain as "generalized" and intensity (0 -10) "crying".

b) On 1/20/12 at 10:15 AM, E17 stated she remembered R3's complaint of pain on 1/5/12. E17 stated she was preparing for medication pass when the CNA informed her of R3's

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complaint of pain. E17 was asked what was the source of the pain and stated she could not say. E17 did not assess R3 for the location of the pain.

c) On 1/6/12 at 8:50 PM, E12, Licensed Practical Nurse (LPN), documented in R3's Skilled Daily Nurses Note, "Res. c/o (complaining of) pain in left leg. Gave PRN Tylenol....".

On 1/20/12 at 11:15 AM, E12 stated in a telephone interview that she gave R3 the pain medication on 1/6/12. E12 was asked if she looked at R3's legs and feet at that time. E12 stated R3's, "legs are always very swollen. I didn't see any difference".

d) On 1/7/12 at 5 PM, E11, LPN, documented in R3's Skilled Daily Nurses Note, "C/o leg pain - given PRN Tylenol with evening medication - taken without difficulty with assistance from CNA (Certified Nursing Assistant).

On 1/20/12 at 10 AM, E11 stated in a telephone interview that she remembered R3's daughter asked for the Tylenol for "pain in her legs" on 1/7/12. E11 stated she did not look at R3's legs when she gave the pain medication on 1/7/12.

e) During a confidential staff interview on 1/19/12, at 3:10 PM, staff stated that on the previous Sunday, January 8, R3's ankle was swollen and R3, "was definitely in pain. She was hollering out, voice was higher pitched than usual." Staff stated the nurse was informed on Sunday, January 8th, that R3's ankle was swollen and she was in pain.

The facility's Monthly Incident Tracking form for January 2012 listed R3's incident dated 1/14/12, "Left ankle found swollen, in pain..... Type of injury: Fx (fractured) ankle. Investigation: Res. transferred via (mechanical) lift. Possible hit leg during transfer. Intervention:

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pad pole during transfer.".

The Hospital Consultation Report dated 1/14/12 by Z6, Doctor of Osteopathy documented (in part), "She (R3)....evidently in the process of being transferred..The staff lost control of her and she struck the floor, sustaining an injury to her left ankle.....Radiographs....showed mildly angulated and displaced fractures of the distal left tibial and fibular shafts."

On 1/19/12 at 11:45 AM, E2, DON,stated that she was at the facility on 1/14/12, when R3's fracture was first reported. E2 was asked why the hospital report stated that R3's injury was a result of a fall. E2 stated she was unaware of the hospital report and had no idea where the hospital obtained that information.

On 1/24/12 at 12:10 PM, E1, Administrator, stated she had completed the January 2012 Accident Incident Log that attributed R3's cause as "...transferred via (mechanical lift) Possible hit leg during transfer." E1 stated, "That's my assumption of how the injury was caused. That was the only thing that I could think of - possibly she hit the lift. That is not a statement of fact.". E1 stated she had not reviewed the report that E2, DON, had sent to IDPH, which stated that the cause of injury was not known.

On 1/20/12 at 10:22 AM, R3 was transferred from her bed to a loveseat/chair at her bedside. E13, and E26, CNA's, E25, LPN, and E27, Respiratory Therapist, were in the room to assist with the transfer. R3 was placed on the lift pad for a large mechanical lift. E25 supported R3's legs. E13 operated the mechanical lift, and E26 assisted in guiding R3 towards the chair. E27 was holding the ventilator tubing. As the lift moved R3 towards the chair, the base of the lift did not spread widely enough to face the front of

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the chair. The lift base was positioned around the side of the chair, which would require the CNAs to swing R3 either to the right or left to position her in the chair correctly. As E13 was turning R3 to lower her into her chair, R3's left leg and cast were moving towards the center support pole of the lift. E13 moved the lift base back from the chair, turned the chair in the opposite direction so R3's feet could clear the lift pole, and guided her towards the chair. E27 had to move the ventilator down to the foot of the bed until R3 was positioned in the chair. The staff involved in the transfer had to move furniture around, reposition the lift, reposition the chair, move the ventilator around the foot of the bed, all while R3 was suspended from the mechanical lift.

R3 is assessed as totally dependent on staff for all Activities of Daily Living (ADL). R3's MDS dated 12/6/11 assessed her as totally dependent, requiring two or more staff for bed mobility, transfers, dressing, eating, toilet use, grooming. R3's Care Plan dated 12/12/11 identified Problem/Need: Total care for all ADL tasks and Fall risk r/t cognitive deficits.

2. R5's POS dated January 2012 indicated she had partial diagnoses of COPD, Hypertension and History of Seizure Disorder.

R5's MDS dated 9/24/11 documented she required limited assistance of two staff persons for transfers and was assessed as not steady, only able to stablize with human assistance when moving from seated to standing position.

R5's Nurse's Note dated 11/1/11 at 6:28 AM documented "found resident on floor in room in sitting position @ (at) foot of bed stated she bumped her head. 0 injuries noted".

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F9999	Continued From page 69 R5's Nurse's Note dated 11/11/11 3:50 AM documented "CNA went into res room @ 3:30 AM found resident in sitting position on floor beside the bed stated she was sitting on side of the bed and slid to the floor". R5's Nurse's Note dated 11/23/11 at 5:10 PM documented "Resident found on floor by this nurse sitting in front of w/c (wheelchair)on the floor on buttocks. Res denies having any pain. Res stating 'I was trying to go to the bathroom.' " R5's Fall Investigation Report dated 12/3/11 documented R5 was trying to get to the bed from her wheelchair and fell to the floor. R5's Care Plan dated 9/22/11 was not revised after R5 fell on 11/1/11, 11/11/11 and 11/23/11 to address R5's falls or progressive interventions to prevent R5 from future falls. On 1/19/, 1/20 and 1/24/12 the surveyor requested the Incident Reports regarding R5's falls on 11/1, 11/11 and 11/23/11. On 1/24/12 at 11:45 AM during an interview with E1 she stated no incident reports could be found regarding R5's falls on 11/1, 11/11 and 11/23/11. (A)	F9999		