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F 520	Continued From page 28 QA meetings, and if trends are identified, action plans are put into place, however has no documentation. She said that E5 (Wound Treatment Nurse) keeps QA wound summary reports. E5 stated on 1/24/12 at 3:15 PM, that she only keeps QA reports for pressure ulcers acquired at Stage 3 or 4, and that she does not have reports for the residents listed in this report.	F 520		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.1010h) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a	F9999		

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F9999	Continued From page 29 meeting. 300.1010h) Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 300.1210d)5) 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.	F9999		

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F9999	Continued From page 30 This Requirement is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to implement their skin care policy for facility acquired pressure sores, including early identification, and intervention monitoring of skin alterations, for 6 of 6 sample residents (R4, R15, R16, R5, R17, R18) reviewed for pressure sores in the sample of 18. Findings include: Facility policy titled, "Prevention of Pressure Ulcers", dated 8/08, requires, "6) The facility should have a system / procedure to assure assessments are timely and appropriate, and changes in condition are recognized, evaluated, reported to the practitioner..." "9) Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs or symptoms of irritation or breakdown. Immediately report any signs of developing pressure ulcer." "General Preventative Measures: For a person in bed; a) Change position at least every two hours or more frequently if needed. For a person in a chair; a) Change position at least every hour." 1) According to the face sheet, R15 is a 71 year old with diagnoses including Chronic Obstructive Disease and Cerebral Vascular Disease. The Minimum Data Sheet (MDS), dated 12/14/11, identified R15's Functional Status / Bed Mobility as "Extensive assistance with one person physical assist." R15's careplan, dated 11/11/11 and in place on 1/9/12, included the following instructions; "Conduct a systematic skin	F9999		

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inspection daily." "Skin check with ADL care, report any abnormality." "Report any alterations immediately to nurse".
The facility's Pressure Ulcer Report sheet, dated 1/14 - 1/20/12, documented that on 1/9/12, R15 acquired a Stage 3 pressure sore on his right heel.
According to the Wound Care Nurse's (E5) progress note, dated 1/9/12, at 12:24 PM, she was called to the shower room, where the Certified Nursing Assistant (CNA) said skin came off R15's heel when she took his sock off. The affected area measured 3 x 2 x 0.1 cm. A nurse's progress note, dated 1/10/12, documented, "Event day #1. Hospice CNA was removing pt's socks when a piece of dead skin came off with sock leaving an open wound."
E5 was interviewed on 1/24/12, at 1:15 PM. She confirmed the record findings and said R15's pressure ulcer was not discovered until it was a Stage 3. She stated she did not look into why his heel wound was not identified until already a Stage 3.

2) According to the face sheet, R4 is a 84 year old with diagnoses including Diabetes Mellitus, Atherosclerotic Heart Disease and Neurogenic Bladder. The MDS, dated 11/24/11, identifies R4's Functional Status / Bed Mobility as "Extensive assistance with two+ persons physical assist." The current careplan, updated 11/11, includes interventions for prevention of skin breakdown. These interventions were, "Encourage / assist [R4] to turn and reposition every 2 hours and as needed."
R4 was observed in her room, lying on her back in bed, at 10:15 AM, on 1/23/12. There were no positioning devices in her bed, except for one

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pillow under both heels. During this observation, R4 said she likes to have breakfast in bed, and can't walk. She stated she had been on her back since 7 AM, and complained that her "bottom was very sore", that she had "bedsores". R4 stated that staff doesn't turn her enough and she can't do it by herself. She said staff does not always answer her call light promptly when she needs to be turned or changed.

E8 (CNA) was interviewed on 1/23/12, at 10:25 AM. She said another CNA (E9) was assigned to R4, but they work together providing care. According to E8, she positioned R4 towards the right, with pillows, at approximately 8:30 AM, however she confirmed at 10:25 AM, that R4 was on her back without postioning devices in the bed.

E9 was interviewed at 10:35 AM, on 1/23/12, and said she was assigned to R4. E9 said she positioned R4 on her back at 8 AM, for breakfast, and had not turned her since that time,approximately 2.5 hrs ago.

E10, Agency RN, was interviewed on 1/23/12, at 2 PM. She said that she was assigned to care for R4, and that she was told that R4 had redness on her bottom, no breakdown.

The next morning, on 1/24/12, at 9 AM, R4's skin was assessed with E5 (Wound Care Nurse). R4 was lying in bed on her back, and said that her "bottom was sore". Upon turning R4, her buttocks was noted to be red, the area around her sacrum was moist and reddish-white in color, and there was an area of breakdown on the right side of her coccyx, approximately 1/2 inch in diameter. E5 said she was informed R4 had redness, but was not aware of breakdown, and that staff should immediately report any skin breakdown to her. According to E5, R4's

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breakdown is a stage 2, however the next days Bath and Skin report, dated 1/25/12, still identified only sacral redness, no breakdown.
R4's Treatment Flow sheets (TAR) include spaces for staff to initial each shift for "Turn and reposition every 2 hours, every shift". R4's TAR lacked shift documentation that this order was carried out for the following: 12/11 - 8 shifts missing, 1/12 = 19 shifts missing. E5 confirmed the TAR findings and stated on 1/24/12 at 1:15 PM, that nurses are to initial on the TAR that the residents are turned as ordered.
According to E5, on 1/24/12 at 9:30 AM, R4 gets up in a wheelchair for approximately 4 hours each day. She said that residents stay in wheelchairs/ adult reclining chairs for up to 4 hours at one time. They are encouraged to shift their weight in the chair, and if they cannot, the CNA's lift and shift the residents weight for them. Residents are not routinely taken out of recliners or wheelchairs unless they request it, or have above Stage 2 breakdown on pressure areas. This was confirmed by E2, the Director of Nursing on 1/24/12, at 2:15 PM.

3) According to the face sheet, R16 is a 80 year old with diagnoses including Multiple Sclerosis, Neurogenic Bladder and Dementia. The Pressure Ulcer Report, dated 1/14/12 to 1/20/12, documents that R16 developed a facility acquired pressure ulcer on her coccyx on 8/15/11. R16's MDS, dated 6/15/11 and 11/17/11, identifies her Functional Status / Bed Mobility as "Extensive Assistance with two persons physical assist." Her careplans, dated 7/1/11 and 8/25/11, included "Turn and reposition every 2 hours".
E5's progress notes document the following: "8/15/11 = Writer called to room noted right

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F9999	Continued From page 34 buttocks Stage 2..." "9/12/11 = Noted to coccyx red in color stage 2..." "9/15/11 = ...[urine catheter] to be inserted due to Stage 3 on right buttocks and coccyx..." "9/28/11 = right buttocks remains stable, coccyx has deteriorated." 12/13/11 - coccyx wound documented as Stage 4. 1/24/12 - Coccyx wound is still documented as "Stage 4". According to the Wound Care Specialist's (physician) Evaluation form, dated 8/30/11, the "Right upper buttocks wound is "Unstageable necrosis." On 9/13/11, the Specialist documented both the right buttock and coccyx ulcers as "Unstageable Necrosis". Nurses' progress notes, document that R16 was hospitalized on 9/30/11,and readmitted to the facility on 10/7/11. R16's Treatment Flow sheets (TAR) lacked documentation that the resident was turned every 2 hours as ordered, for the following months; 8/11 - 7 shifts missing, 10/11 - no documentation for 19 days, 12/11 - 14 shifts missing, 1/12 - 22 shifts missing . R16's record findings were confirmed by E5 on 1/24/12, at 1:15 PM. E5 was interviewed on 1/24/12, at 1:15 PM, and said she reports on pressure ulcers at the daily management meetings, and at the Quality Assurance meetings. E5 stated she thought the Director of Nursing (E2) investigates pressure ulcer incidents. E2 (Director of Nursing) was interviewed on 1/24/12, at 2:15 PM, and stated she thought the Wound Care Nurse looked into contributing factors of pressure ulcers, such as the lack of turning documentation on the TARs. E2 said she does not, and has no documentation of,	F9999		

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investigations regarding pressure ulcer developments. According to E2, there is no policy and procedure for investigating the cause of acquired pressure ulcers.
E1 (Administrator) was interviewed on 1/24/12, at 3:15 PM, and said that she is a member of the Quality Assurance (QA) Team, however E5 is QA Coordinator. She stated E5 only investigates the cause of acquired pressure sores that are Stage 3 and above.

According to the Pressure Ulcer Report, dated 1/14/12 to 1/20/12, the following are additional residents with facility acquired pressure ulcers: R5 - bilateral heel wounds acquired on 11/8/11 at Stage 2. E5 (Wound Care Nurse) confirmed on 1/24/11, at 11:20 AM, that R5 is in isolation for Methicillin Resistant Staphylococcus Aureus in her heel wounds. R17 - bilateral heel wounds acquired on 1/9/12 at a Stage 2. R18 - bilateral heel wounds acquired on 1/16/12 at Stage 2.

(B)

300.1210a)

300.1210b)

300.1220b)3)

300.3240a)

300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the

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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.

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:

300.1220b)3) Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as

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F9999	Continued From page 37 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. 300.3240a) Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. This Requirement is not met as evidenced by: Based on interview and record review the facility failed to appropriately supervise 1 resident with a history of falls, and failed to implement targeted, appropriate interventions, to reduce the risk of future falls. These failures resulted in 1 resident (R1) sustaining a hip fracture after falling in his room at the nursing home. R1 expired on 1/10/12 due to complications of right hip fracture. This is for 1 resident out of 2 reviewed for falls in the sample of 18. The findings include: R1 was re-admitted to the nursing home on 11/8/11 with multiple diagnoses including Dementia and Difficulty in Walking, according to the diagnosis list in the electronic medical record. R1 was admitted to Hospice care on 11/18/11, according to hospice documentation in the electronic medical record. R1 requires extensive assistance for bed mobility, transfers and toilet use, according to the Minimum Data Sets (MDS) dated 11/25/11. R1 has intermittent confusion,	F9999		

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impaired balance during transition, decreased safety awareness, and is prescribed medication with possible side effects that could increase fall risk, according to the Care Area Assessment (CAA) for Falls dated 11/30/11. R1 was assessed at high risk for falls according to a fall assessment dated 11/8/11. Social Service progress notes dated 11/26/11 document that R1 is alert and oriented with forgetfulness, confusion with impaired decision making ability. The note also states that R1 is considered a fall risk and has a history of removing his chair alarm and bed alarm so that he can care for himself.

R1 sustained falls in his room on 12/9/11 (12:59 AM), 12/22/11 (3:00 AM), 12/24/11 (12:55 AM), 12/27/11 (1:02 AM) and 1/4/12 (1:30 AM), according to progress notes and Fall Event reports. The care plan did not reflect specific interventions to supervise or monitor R1 to minimize the risk of further falls between 12:55 AM and 3:00 AM. There is no documentation to support that R1 was monitored appropriately during the night. On 1/4/12 R1 sustained a hip fracture when he fell in his room after attempting to take himself to the bathroom.

On 1/24/12 at 3:35 PM E7 (Restorative Nurse) stated that there were no targeted care plan interventions in place to minimize the risk of R1 ' s early morning falls. E7 stated that trends in falls are identified and documented on the Comprehensive Fall Review Reports.

The Comprehensive Fall Review Reports identified that most of R1 ' s falls are related to him trying to get out of bed without assistance to use the toilet. On 12/9/11 an intervention was

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F9999	Continued From page 39 added to the care plan to " review toilet schedule. " On 12/22/11 an intervention was added to " provide bolsters and concave mattress. " On 12/24/11 an intervention was added to the care plan to " educate staff to follow toilet schedule. " On 12/27/11 an intervention was added for " Hospice to evaluate. " There were no care plan interventions related to monitoring R1 more frequently between 12:55 AM and 3:00 AM and no documentation to support that R1 was monitored during the night. On 1/25/12 at 9:15 AM E3 (Assistant Director of Nursing) stated that interval rounding checks, i.e., every 15 minutes, are not done on residents with a known history of falls. (B)	F9999		