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F 516	Continued From page 68 medical records were observed either stacked on top of metal filing cabinets and/or on a metal cart. The card board boxes were also observed stored under the water sprinkler system and not cover with a protective covering. 2. E1, Administrator, stated, on 1-125-12 at 10:30a.m., the medical records were both resident and employee records. E1 confirmed the observation. 3. The Resident Census and Conditions of Residents, CMS 672 dated 1/23/12 documents 109 residents in the facility.	F 516		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.615e) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act [20 ILCS 2635] for all persons 18 or older seeking admission to the facility. This requirement was NOT MET as evidenced by:	F9999		

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Based on record review and interview the facility failed to submit a request for a criminal history for 7 of 10 (R21, R23, R24, R25, R26, R11, R27) files reviewed of new residents admitted to the facility.

The findings include:

On 1/25/12 the files of ten new residents were requested to review the screening that was done prior or at the time of admission. Seven of the requests for criminal histories of the residents had not been requested within 24 hours.

R21 was admitted on 1/6/12 and the request for a criminal history was submitted on 1/9/12.
R23 was admitted on 1/24/12 and the request for a criminal history was submitted on 1/26/12.
R24 was admitted on 12/9/11 and the request for a criminal history was submitted on 12/12/11.
R25 was admitted on 1/2/12 and the request for a criminal history was submitted on 1/4/12.
R26 was admitted on 1/18/12 and the request for a criminal history was submitted on 1/26/12.
R11 was admitted on 1/13/12 and the request for a criminal history was submitted on 1/17/12.
R27 was admitted on 1/2/12 and the request for a criminal history was submitted on 1/4/12.

Interview with E1, Administrator, on 1/26/12 at 1:45 PM the Administrator was asked if the admission and submission dates were correct for the 10 files reviewed. We reviewed the dates and E1 confirmed the dates were correct. He stated he realized that some of the criminal history checks had not been submitted within the 24 hours after admission.

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F9999	Continued From page 70 (AW) 300.610a) 300.1210a) 300.1210b) 300.1210d)1)2)3)5) 300.1220b)2)3) 300.3220f) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.	F9999		

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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. (Section 3-202.2a of the Act)

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:

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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.

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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.

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F9999	Continued From page 73 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 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 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new	F9999		

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F9999	Continued From page 74 physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, record review and interview, the facility failed to identify and assess pressure sores; failed to turn and reposition residents; failed to monitor for drainage and intact pressure sore dressings; failed to follow physician orders for pressure sore treatment; and failed to follow interventions for pressure sores for residents (R3, R8, R9, R14, R17, R18) reviewed for pressure sores. This failure resulted in R3, R9 and R18 developing avoidable pressure sores and having a decline in the pressure sore. R18 developed an in house avoidable stage 2 pressure sore that declined to a stage 4 with infection and Osteomyelitis.	F9999		

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Findings include:

The facility Policy And Procedure titled PREVENTION OF PRESSURE ULCERS that is undated documents, in part: "Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decreased of circulation (blood flow) to that area, which destroys the tissues. The most common site of a pressure ulcer is where the bone is near the surface of the body including the ...backbone...For a person in bed: change position at least every two hours; use a special mattress that contains foam, air, gel, or water, as indicated...Persons confined to chairs should be repositioned at least every two hours. Persons confined to chairs who are unable to shift their own weight may need repositioning more frequently...Infection Control Protocol and Safety...Maintain clean technique and isolation precautions as indicated...

The facility documented on their NON-PRESSURE SKIN CONDITION REPORT of 10-24-11 through 11-27-11 that R18 had an excoriated open area on his coccyx. It is documented under comments, "Resident with excoriated @ intervals since 10-1." The facility 's documentation on the report shows a decline from 10-24-11 to 11-27-11. The facility failed to assess and identify the ares on the bony prominence as a pressure sore until 12-5-11 at which time the "excoriated open area" was now a stage 4.

Facility WEEKLY PRESSURE ULCER LOG of

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12-5-11 documented the coccyx as being a stage 4 pressure sore measuring 1 x .5 x 1 cm with odor and drainage with documentation the Physician and family were notified on 10-24-11. The Pressure Sore Logs show the facility assess the pressure sore to be a stage 4 from 12-5-11 through 1-6-12 with deterioration on 1-6-12 to 1.5 x .8 x 1 cm with no odor or drainage. Report of 1-12-12 does not assess stage of the pressure sore but shows measurements of 1 x .5 x .5 cm with small amount of drainage and odor.

Record review shows R18 was first seen in the wound clinic for the pressure sore on his coccyx on 11-29-11. The Wound Clinic Report of 11-29-11 shows an order for a special mattress. Z5, Wound Clinic Nurse, stated on 1-27-11 at 3:10AM a special mattress is an air flow mattress of a higher quality for pressure relieving. The report shows an order for treatment to cleanse the coccyx and apply Puracol Plus AG and cover with foam dressing every other day. Facility December 2011 Treatment Administration Record (TAR) shows treatment order was not documented to be done every other day as the Doctor had ordered on 11-29-11 and there is document that the treatment was done daily until 12-7-11. There is documentation on the TAR that states new order 12-6-11 for the treatment to be done every other day even though it was originally ordered on 11-29-11.

The Wound Clinic Report of 12-13-11 documents an order for Purocal Plus AG, 4 x 4 and tape every 2 days and to keep pressure off R18's sacrum. Facility TAR shows the order was documented on 12-13-11. The Treatment Record documents the treatment was done on 12-14-11, 12-15-11, 12-17-11, and then every 3rd day from 12-17-11 through 12-29-11, not every second day

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as ordered by the Physician, and with no treatment documented as being done from 12-30-11 through 1-5-12.

The Wound Clinic Report of 1-3-12 shows a treatment change to the coccyx to cleanse with wound cleanser and cover with collagen daily. On 1-30-12, the facility provided a TAR that is documented as being for the period of December 2011 with treatment order for January 2012 documented on the TAR. The TAR showed treatment change on 1-3-12 to clean coccyx wound with normal saline and apply collagen daily. Documentation shows the treatment was done starting on 1-5-12. There were initials of the treatment being done through 1-22-12 with scribble over the initials on 1-17-12 thru 1-22-12. There was a dash written on 1-23 and 1-24. A bracket was drawn below the initials that were scribble through from 1-17-12 through 1-24-12 and "hosp" written under the bracket. On the afternoon of 1-30-12, E3, Assistant Director of Nursing, E23, Corporate Nurse and E24, Corporate Marketing Director/Nurse all confirmed the TAR for January looked like staff had initialed they did the treatments on 1-17-12 through 1-22-12 and someone scribbled through the initials.

Wound Clinic Report of 1-17-12 documents an order again for a speciality bed "Roho Bed" and to provide appropriate chair. "This geriatric chair is not fit for patient to use."

Z6's Wound Clinic Progress Note written on 1-17-12, documents, "SUBJECTIVE: (Obtained from wife). Patient continues to be placed for hours on end seated or semirecumbent in a geri chair which probably dates back to the 1970s. A piece of equipment that he is transported in is the same as what is used at the nursing home. It

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appears to be quite dilapidated in condition. There is no support on the posterior seat or lower back. There is a large gap there. Patient is placed on his (special) cushion which does not nearly fill the seat of the chair and then allowed to fall back in such a way that his buttock does not contact the cushion. Wife also states that he is probably not being turned every two hours as he should be; when he is in the chair he is not turned at all. Patient's wife also states that his oral intake is hit or miss, depending on the aide who may or may not take the time to feed him. He is also not getting his (special) boots applied with any consistency despite the fact that they are supposed to be on his feet 24 hours per day. OBJECTIVE: Patient is afebrile. Temperature 97.3. Blood pressure however is 82/42. Pulse 53. Respirations 20. Patient is not responsive. He does moan in pain however. Examination of the wound shows that it has significantly deteriorated from last week...The wound now is down to tendon directly overlying bone. At 9 o'clock there is a tunnel that measures 2 cm. There is extensive ischemia along the right side of the wound...Our nurse contacted the nurse at (name of facility) and was told that the administrator there refused to order the mattress that we had requested because it was "not cost effective." I believe this is directly related to the worsening of this wound. Assessment: 1. Pressure ulcer of the coccyx stage 4 (patient was a stage 2 when he initially presented)..."

R18's Hospital History & Physical of 1-17-12 documents R18 was brought in from the Wound Care Center for hypotension. His Coccygeal ulcer had worsen significantly over the past two weeks.

Hospital Consultation Report by Z8,

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Consulting Physician for R18, of 1-20-12 documents, "The patient was initially evaluated in the Wound Care Center back on January 17 due to a pressure ulcer on the intergluteal area. The patient initially presented with a stage 2 ulcer, which has been progressing and became a stage 4 ulceration. When he was evaluated in that Wound Care Center the patient was found hypotensive and referred to the emergency room for evaluation, giving concern for sepsis. So tissue cultures were obtained that were reported positive for Proteus mirabilis and MRSA (Methicillin Resistant Staff Aureus) along with Streptococcus viridans...On examination there is no cellulitis, but the wound seems having quite amounts of drainage, most likely with bacteria overgrowth but cannot rule out underlying osteomyelitis. I suggest to obtain a bone scan to rule out this possibility..."

Hospital Bone Scan done on 1-23-12 documents, "IMPRESSION: 1. Focal fairly intense activity in the sacrum on all three phases that is suggestive of Osteomyelitis.

Nurses Notes document R18 was readmitted to the facility on 1-24-12.

R18's most current Minimum Data Set (MDS) of 11-19-11 documents R18 has severe cognitive impairment and is totally dependent on staff for transfer, bed mobility, dressing, eating, hygiene and bathing.

R18's most recent Care Plan of 8-24-10 documents R18 has a potential for skin breakdown related to incontinence with goal to have no skin breakdown. Note of 1-25-12 documents, "I am currently on IV antibiotics for coccyx wound...(Catheter due to Stage III on coccyx...)." Note is documented on 1-25-12 "on

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low air loss bed now. Turn every 1 hour." A note written on 1-27-12 documents, "I am to be turned/repositioned every hour. I am to be in bed only up for meals and therapy. I have a new order for Arginade three times daily with meals, for wound healing."

On 1-26-12, R18 was up in a geriatric reclining chair on his back from 8:30AM to 11:30AM. At 11:17AM, E16, Certified Nurse Aide (CNA) stated she got R18 up into the geriatric chair at 8AM. E16 and E19, CNA's, stated R18 had not been out of the reclining geriatric chair at all that morning. At 11:34AM, E16 and E19 stated they had just laid R18 down. R18 was in his bed and on his back. A skin check with E12, Licensed Practical Nurse (LPN) showed R18 had formed feces at his anal area and his pressure sore bandage was in his underwear and not on the pressure sore. There was a dried brownish/tan stain on the back of the underwear at the coccyx level the size of a silver dollar. R18's buttocks were deep creased and red and he had indentation around the waist that showed the plaid print of the elastic band on his pants. R18 had an irregular stage 2 pressure sore on his upper right inner buttock and no treatment on his coccyx. E19 got a wash cloth with bar hand soap and wiped the feces at the anal area up into the coccyx. E19 then dried the anal area with a dry wash cloth. After incontinent care was given, E12, brought in the treatment cart into R18's room to do a dressing change. E12 cleansed the pressure sore on the coccyx wiping lightly with normal saline and a gauze pad. E12 pulled out 2 empty packages of Aquacel Ag. E12 stated he would have to go down stairs to get another package. He put a piece of gauze with tape onto the coccyx pressure ulcer and left the room.

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On 1-26-12 at 11:55AM, E12 stated they were out of Aquacel so he called Z4, R18's primary physician/facility Medical Director. E12 stated Z4 stated it was OK to use PolyMem silver since they were out of the Aquacel. E12 proceeded to remove the gauze dressing and wiped the coccyx with gauze and normal saline. R18's buttocks were still deep creased. E12 was observed to use scissors that had been sitting directly on the top of the treatment cart to cut the PolyMem. He then placed a piece of PolyMem directly onto a piece of tape and placed the PolyMem and tape onto R18's coccyx. E12 did not put any gauze or padding in dressing to absorb the drainage. R18 was then repositioned so a skin check of his heels could be done. R18 had on heel protectors. E16 removed the heel protectors and it was noted R18's left inner heel had a golf ball size unstageable pressure sore. Z7, R18's wife, was present and stated he had it in the hospital before he was readmitted to the facility. There is nothing in R18's Admission Nursing Assessment of 1-24-12, in R18's Nurses Notes or on the Treatment Record that identifies the unstageable pressure sore on R18's left inner heel.

On 1-26-12, R18 was again observed at 10 to 15 minute intervals to be up in his geriatric reclining chair on his back from 12:11AM to 4:00PM without being repositioned and was still up in the geriatric reclining chair when observation was stopped.

On 1-27-12, R18 was observed at 10 to 15 minute intervals to be up in his geriatric chair on his back from 8:30AM to 10:15AM and then in bed laying on his back until noon. He was up in the geriatric chair for noon meal and then placed in bed on his back. At 3:00PM, E23, Corporate Nurse, was informed of concern that R18 had

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been on his back all day and has a Stage 4 Pressure Ulcer on his coccyx. E23 stated she would have staff reposition R18 immediately.

On 1-30-12 at 10AM, R18 was in bed. E24, Registered Nurse/Care Plan Nurse, was asked to do a skin check to see if he had a dressing on his coccyx. E24 was observed to have a dressing on his coccyx dated 1-30-12. The gauze was visible and had a brownish/tan drainage on the gauze and the tape was rolled up at the edges exposing the gauze. Nurses Note written by E24 on 1-30-12 at 10AM documents R18's dressing to his coccyx was intact and observed by Surveyor. At 2:05PM, another Surveyor checked the bandage and confirmed it was bunched up and needed to be changed and also confirmed the unstageable pressure sore on his left heel that was the size of a golf ball which now had an area the size and shape of a kidney that was dark brown. At 2:10PM, E23 was informed of concern that R18's dressing needed to be changed. The first time R18's pressure sore on his left heel is documented is in the Nurses Notes of 1-29-12 that documents a stage 1 pressure sore on the left heel 4 x 4 cm, red and soft. R18's WEEKLY PRESSURE ULCER RECORD of 1-29-12 that was provided on 2-1-12, documents date of onset as 1-29-12 left heel 4 x 4 cm unstageable DTI (Deep Tissue Injury) with preventative measures to turn q 2 hours, among others

On 1-27-12 at 9:00AM, Z5, Wound Clinic Nurse, stated Z6 had ordered an air flow mattress in November 2011 and the facility refused to provide the mattress and didn't get it. Z6 stated she had talked to a facility Nurse, E5, Licensed Practical Nurse (LPN) and was told R18 didn't need the air loss mattress/bed and that E1,

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Administrator, refused to get the bed. Z5 stated R18 was first seen in the wound clinic for a pressure sore on his coccyx on 11-29-2011. He was first seen with a Stage 2 pressure sore on his coccyx that progressed to a Stage 4. His cushion in his geriatric reclining chair was too small for the chair and pushes him back and has him sitting directly on his coccyx. Z5 stated R18 should be in bed off his coccyx and only up for meals. Z5 was told of the above observations on 1-26-12 and stated sitting up for extended time in his geriatric reclining chair is a problem and contributes to the decline in the pressure sore. Z5 stated moving the back or the chair up and down or the legs of the chair up and down does not relieve pressure off R18's coccyx. Z5 was told of the facility running out of Aquacel AG and the E12 calling Z4 for a different order for treatment. Z5 stated E12 should have called the Wound Clinic Physician for an order since R18 was being treated at the Wound Clinic. Z5 stated she believed R18's pressure ulcer on his coccyx declined due to neglect. On 1-27-12, Z5 stated the treatment E12 did on 1-26-12 was a totally inappropriate dressing change. There should be a dressing/gauze to absorb the drainage.

On 1-27-12 at 9:10AM, Z6, R18's Wound Clinic Physician, stated she had concerns that R18 was up for extended time in his geriatric reclining chair. Z6 stated she did not consider moving up and down the back of the chair or foot area as repositioning due to pressure is still on the coccyx. Z6 stated on November 29, 2011, R18 had a stage 2 pressure on his coccyx, it progressed to a stage 3 and then to a stage 4. When Z6 was asked if R18 sitting up for extended time in the geriatric reclining chair would contribute to the decline in his pressure

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F9999	Continued From page 84 sore, Z6 stated, "Absolutely. It would contribute to the decline." Z6 stated she wanted him to have an air flow mattress and the facility refused. Z6 stated she even called Z4 to try to get reinforcement that R18 needed the air flow mattress. Z4 refused stating maybe R18 needs to go to another facility. Z6 stated she was shocked at Z4's response. Z6 couldn't believe it. Z6 stated R18's pressure sore kept getting worse. That's why she called Z4. Z6 stated she considers it neglect. The facility had a direct order for the air flow mattress. Z6 stated she wrote the order and they refused to get it. Z6 stated R18's pressure sore and decline was avoidable. Every week the pressure sore kept getting bigger. Z6 stated the facility should have called the Wound Clinic when they ran out of the Aquacel AG and should not have ran out of it in the first place. Z6 stated she did have concerns if the facility was doing the pressure sore treatments as she had ordered. Z6 stated the decline in the pressure sore contributed to R18 developing Osteomyelitis. On 1-27-12 at 11:55AM, E12, and E11 (LPN/Wound Nurse) stated R18 did not get an low air flow bed until he was readmitted to the facility on 1-24-12. 2. A physician order dated 12-4-11 documents, DuoDerm to area on coccyx and change every 3 days and as needed. Care Plan approaches include, in part: Nursing will complete a pressure ulcer assessment upon admission, quarterly and prn (as needed) and will initiate appropriate interventions. Care plans will be updated accordingly; Skin will be checked daily.	F9999		

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A skin check on R8 with E17, LPN/Care Plan Coordinator, on 1-23-12 at 8:15AM showed R8 had a healed pressure sore on his right inner buttock/coccyx area the size of a quarter with a small open bleeding area within the healed pressure sore. A skin check was conducted again on 1-25-12 and the bleeding area on the right inner buttock/coccyx area was now scabbed over. R8 had dried feces on his buttocks that was stuck to the hair on his buttocks. His left outer heel had a stage 2 pressure sore irregular in size and larger than a dime. His right heel had a very small open area. E 31, CNA, was informed of concerns of the scab on R8's buttocks and the 2 open areas on his heels. E31 confirmed the areas and stated he had a bowel movement earlier in the morning and she must not have gotten it all cleaned and stated she would clean him. E17 came into the room to look at R8's heel and buttock and confirmed the areas and left the room.

Record review of R8's Nurses Notes from 1-23-12 through 1-28-12 does not mention anything about pressure sores on R8's heels or coccyx area. Note of 1-29-12 at 1210 documents, "Spoke with Z4 - NEW order for air mattress - Barractive Bed - Preventative Protective oint.(ointment) to coccyx EVERY shift and PRN. Nurses Note of 1-30-12 documents R8 was admitted to the hospital for Pneumonia.

On the morning of 2-1-12, E23 provided a copy of the facility WEEKLY PRESSURE ULCER LOG for 1-29-12. R8 was not on the list and this was confirmed by E23. E23 stated R8 was also not on their 1/29/12 skin non pressure ulcer list.

On 1-2-12 at 10:25AM, E17, stated when the skin check on R8 was performed on1/23/12, he did not have pressure sores, he had abrasions on

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his feet. E17 stated the areas were not open.

Facility undated Policy and Procedure for Pressure Sores documents, "Stage II - Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow center.

3. According to the MDS dated 11/30/11, R3 has cognitive impairment, requires minimal to extensive assist of one staff for all activities of daily living including mobility and transfers. Braden scale dated 9/3/11 identifies R3 to have no risk of pressure ulcers with a score of 19.

The care plan dated 11/30/11 documents R3 to have a potential for skin breakdown due to incontinence. Interventions include: skin check daily and report to nurse any red areas that won't go away, assist to turn and reposition at least every two hours, encourage good hydration and nutrition, and "feet are checked weekly by a nurse" due to diabetes.

The care plan dated 11/30/11 has a written statement (undated) "lt (left) heel - Apply Santyl per MD (Medical Doctor) orders - heel protectors in bed." added on in the margin.

The nurses notes dated 12/11/11 at 3:45pm document "res daughter from kitchen came to this writer stated "when I was getting mom ready to take her out she said ouch when I was putting her sock on her l foot. I noticed she has an area on her L heel." Upon assessment of area I noticed approx (approximately) 3cm circular area hard to touch c dry skin + deep purple in color - will apply protective barrier + slippy sock + float heels when in bed." Interview with R3's daughter, Z1, on 1/23/11 at 10am confirmed that she found the pressure ulcer and informed the staff. Z1 stated her mom had been complaining

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of her foot hurting the few days prior to 12/11/11 but she didn't look at it until 12/11/11.

Lab results dated 1/5/12 show normal Total Protein and Albumin levels and a Doppler done 11/14/11 showed "signals augmented well" with the findings being negative for deep vein thrombosis.

Weekly Pressure Ulcer QI Logs dated 12/16/11 identify R3's heel ulcer as in house acquired, stage II measuring 2 x 1.5cm, treatment - protective wipe. There is no depth, odor or drainage identified at the time. On 12/21/11, R3's ulcer was assessed by a wound specialist and was determined to be "unstageable", measuring 0.7 x 0.8 - "Woundbed : black center with pink edges." Scant exudate, sero-sanguinous is also identified with no debridement done. An order for Santyl and dry dressing was obtained.

On the 12/23/11, the facility's weekly skin log shows R3's heel wound has increased to 3 x 2cm with 0.5cm depth with odor and a small amount of drainage. There is no description of the ulcer by the facility. T

The facility's weekly log dated 12/30/11 indicates the measurements remained the same. However, measurements by the Wound care specialist dated 1/5/12 show another increase to 0.5cm x 1.3cm, unstageable, yellow woundbed, scant sero-sanguinous exudate.

On 1/8/12, the wound specialists measurements are as follows: L (length) 0.8cm Width 1.0 Depth 0.3cm unstageable" with yellow necrosis with minimal pink granulation with the same exudate as before. The wound is identified as "improved."

According to R3's daughter, Z1, on 1/23/12, the facility did not implement heel protectors until

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after the ulcer was found by family.

4. The Admission Sheet identifies R9 as a 69 year old male admitted to the facility with diagnosis of Cerebral Palsy and left arm paralysis.

The MDS dated 11/23/11 identifies R9 to require extensive assist of one staff for ADL. The MDS indicates he is "always incontinent" of bowel and bladder. According to the care plan dated 11/30/11, R9 has a potential for skin breakdown and history of same. Interventions include "The CNA's will assess my skin daily and with incontinence care and will report any red areas or skin breakdown to the nurse", reposition as least every 2 hours, external catheter for dignity, encourage/help me to drink adequate fluids and have good nutritional habits and put heel protectors on when in bed. The care plan indicates R9 has a history from 1/24/11 for coccyx pressure ulcers, in-house acquired. Weights are stable past year with a little weigh gain past month according to the weight sheets. Labs dated 3/4/11 documents normal Total Protein (7.5) and Albumin (3.8).

According to the Weekly Skin Logs, R9 is not identified as having a pressure ulcer until the week of 1/12/12 and indicates R9 acquired an in-house stage II to coccyx first identified on 1/6/12. Measurements are 1cm x .5cm and .2cm deep with a small amount of drainage. The nurses notes include no entry regarding this pressure ulcer until 1/11/12 even though the log indicates it was first identified on 1/6/12 and then only reflects the treatment order. On 1/11/12 at 10:25am, the nurses notes documents an order was received for Santyl to the Stage II pressure sore on R9's coccyx, cover with wet to dry

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dressing every day. The TAR shows no treatments done until after this order was received on 1/11/12 but have skin checks documented on the back which indicate on 1/7/12 - R9's skin was intact and on 1/14/12 - No new skin issues is documented.

On 1/23/12 at 8:25am, R9 was in bed on his back. He had 2 incontinent pads under him and he smelled of urine. He had heel protectors on bilaterally. R9 had a soaked dressing at the coccyx when he was rolled to his side.

5. R17's Nursing Notes, dated 11-23-11, documented R17 was admitted to the facility on 11-23-11. It was also noted "resident noted to have Allevyne on (R) (right) outer aspect of ankle she state her 'family member' ran it over. (R) ankle is larger than (L) (left) and tender to touch." R17's December 2011 Treatment Record documented "12-16-11 Cleanse inner outer (R) ankle wound with NS (noral saline) apply dry dresg (Dressing) qd (every day)" which was changed to "12-20-11 Cleanse two areas on (R) ankle with NS apply skin prep leave OTA (open to air)."

Weekly Pressure Ulcer Logs, from 11-11-11 to 11-25-11, did not document any areas of skinbreak down until the Weekly Pressure Ulcer Log, dated 12-20-11, which documented a right inner ankle unstaged pressure sore measuring 3.2cm x 2.5cm and a right outer ankle unstageable pressure sore measuring 3.7cm x 2.5cm. was identified on 12-16-11.

6. An additional example of not repositioning/turning timely according to the plan

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of care includes R14 who, according to her MDS dated 11/23/11, is totally dependent on staff for all activities of daily living and is always incontinent of bowel and bladder. R14's care plan dated 11/23/11 identifies her at risk for skin breakdown due to decreased mobility and incontinence with interventions that include: daily skin checks, turn and reposition at least every 2 hours, and encourage fluid and nutrition, in part. R14 was not repositioned timely. On 1/23/12 E6 and E9 CNA's both stated R14 was up in her wheelchair when they came in at 6:45am that morning as "nights" get her up before they leave.

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300.1210a)
300.1210b)3)4)
300.1220b)2)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

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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 300.696 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 (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). 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 (see Section 300.340):

1) Guideline for Prevention of Catheter-Associated Urinary Tract Infections

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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. (Section 3-202.2a of the Act)

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:

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F9999	Continued From page 93 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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	F9999		

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F9999	Continued From page 94 include medically defined conditions and medical 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 300.3240 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:	F9999		

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Based on observation, record review and interview, the facility failed to ensure residents are provided complete incontinent and catheter care for 2 residents reviewed for Urinary Tract Infection (UTI) and catheters. The facility failed to give appropriate and timely catheter care and failed to have a system in place for catheter replacement for 1 resident (R18). This failure resulted in R18 being hospitalized with an Indwelling Urinary Catheter Infection.

Findings include:

1. R18's Minimum Data Set (MDS) of 11-8-11 documents R18 is severely cognitively impaired and being dependent on staff for hygiene and toilet use.

R18's most current Care Plan of 8-24-10 documents R18 is total care for all personal care. Care Plan has a written note dated 12-1-11 stating R18 now has an indwelling urinary catheter...change catheter - bag - tubing per MD orders and prn (as needed). Catheter care every shifts and prn - 18 FR - 10 cc Balloon.

R18 has a Physician Order of 11-30-11 for a #18 French 10 cc indwelling urinary catheter. There is no order as to irrigation of the catheter or changing the catheter tubing and bag.

R18's Hospital History And Physical Examination report of 1-18-12 documents R18 was brought into the hospital from the Wound Care Center for hypotension with a blood pressure of 80/50. R18 has had an Indwelling Urinary Catheter at the nursing home. This one has been present definitely more that 30 days as per patient's wife (Z7). Under Assessment and

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Plan: "1. Foley Catheter infection in a patient from a nursing home with advanced dementia. Foley catheter placed in order to prevent worsening of decubitus ulcers from which the patient has been suffering. Status post discontinuation of the Foley catheter. Will start the patient of IV Zosyn and discontinue IV ceftriaxone for now for broad-spectrum coverage including Pseudomonas given the patient staying in a nursing home. Informed the patient's wife, and will give written instructions for the nursing facility to change the Foley at least once in 30 days."

R18's Discharge Summary of 1-24-12 documents as admitting diagnoses, in part, Indwelling Foley infection and Discharge Diagnoses, in part, Indwelling Foley infection, resolved with antibiotics.

Record review of R18's December 2011 and January 2012 Treatment Administration Record (TAR) on 1-26-11 showed there is no documentation concerning the care of R18's indwelling urinary catheter.

On 1-26-12 at 2:25PM, E12, Licensed Practical Nurse (LPN), E17, LPN/Care Plan Coordinator and E12, Registered Nurse (RN)/Care Plan Coordinator stated that catheter care is not documented on the TAR it is documented in the Nurses Notes.

Record review of R18's Nurse Notes November 30 2011 at 11:30AM confirms the order for the Indwelling Urinary Catheter. Note of 12-1-11 at 10:20AM documents a 18 FR 5 cc urinary catheter was inserted using sterile technique. Note of 12-12-11 states noted R18 pulling at catheter at times. Note on 12-13-11 states R18 returned from Wound Clinic and his wife states he needs to be seen by the doctor

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tomorrow related to blood in his urine. Note shows Z4, R18's Physician was called later on 12-13-11 due to urine in tubing and bag being burgundy in color with small clots noted. An order was obtained for stat PT and INR and CBC. Nurses Note of 1-15-11 documents R18 found with urine over clothes. Catheter appeared pulled out half way. Upon inspection noted 4 cc in bubble. Catheter replaced 20 Fr/10cc using sterile technique. This is the 1st documentation in the Nurses Notes that R18's indwelling urinary catheter was changed.

R18 was observed on 1-26-12 at 11:30AM to be in bed with an indwelling urinary catheter. E19, Certified Nurse Aide (CNA) was observed to clean a small amount of formed feces from the anal area using bar soap, no rinse and then dry R18's anal area. There was visible feces on the catheter tubing that was 1 inch from the tip of the penis. R18 did not get any catheter care. There was a puddle of liquid on the floor where R18 had been sitting in his reclining geriatric chair. E12 came into the room and stated there was urine on the floor. The gray cloth bag on the side of R18's reclining geriatric chair was soaked with urine from the bottom of the bag up to 4 inches. After care, E16 and E19, CNA's were observed to transfer R18 back into his reclining geriatric chair and placed his catheter bag into the soiled gray cover at the side of his chair.

Facility Policy and Procedure of August 2001 for "Catheter Care, Urinary" does not address how often the bag and tubing should be replaced or where it would be documented.

2. R8's Hospital Consultation report of 11-1-2011 R8 was brought to the hospital for gastric distention..."He was noted to have a rather

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F9999	Continued From page 98 severe urinary tract infection on his urinalysis." R8's MDS of 12-28-11 identifies R8 as being occasionally incontinent of bowel and frequently incontinent of urine and requiring extensive assistance with toileting and hygiene. R8's most recent Care Plan dated 11-3-09 documents R8 is continent of bowel and has a handwritten note undated that documents R8 can be incontinent of bladder. There is nothing on the Care Plan identifying R8 as having a history of UTI or the need for incontinent care. R8 was observed on 1-25-12 at 10:56AM to be transferred from his wheel chair to bed by E31, CNA. R8 had balls of dried feces on buttock hairs and dried feces smears on his buttocks. E31 confirmed and stated R8 had a bowel movement earlier in the morning and stated she must not have cleaned it all. (B) 300.610a) 300.1210b) 300.1210d)3)4)A)6 300.1220b)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and	F9999		

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F9999	Continued From page 99 procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal 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,	F9999		

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F9999	Continued From page 100 seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. 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:	F9999		

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F9999	Continued From page 101 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical 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 300.3240 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:	F9999		

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Based on record review, observation and interview, the facility failed to develop and implement effective interventions for repeated skin tears and an effective fall prevention program for 6 of 10 residents (R1, R6, R9, R14, R17 and R20) reviewed for injuries. This failure resulted in R6 fracturing her right hip after numerous falls.

Findings include:

1. R6's Incident/Accident Reports, dated 7-10-11 to 12-2-11, documented R6 fell five times prior to her 12-2-11 fall during which she incurred a right hip fracture. R6's Incident/Accident Report, dated 7-10-11, documented she was found on the floor and incontinent of stool. Fall intervention was to have physical therapy screen. On 8-16-11, R6 was found on the floor in the dining room. On 8-31-11, R6 fell to the floor during self ambulation. R6 hit head head incurring a small hematoma and complained of left knee tenderness. Fall intervention was to take her cane away and try a guad cane. O9-11-11, R6 tripped over a wheel chair in an activity area. On 10-6-11, R6 fell when walking in the 200 hallway. Fall intervention was to use appropriate foot wear. On 12-2-11, R6 was found lying with her back on the floor. R6's incurred a right hip fracture.

R6's Minimum Data Set (MDS), dated 7-2-11 to 10-3-12, documented declines and variances for cognition and ambulation which R6's Incident/Accident Reports fall prevention measurements did not address to prevent further falls. R6's MDS, dated 1-17-11, documented moderately impaired cognition and supervision with setup help only with walking in room and

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F9999	Continued From page 103 locomotion on unit. R6's MDS, dated 4-27-11, documented moderately impaired cognition and extensive assistance with one persons physical assistance with motion off unit. R6's MDS, dated 7-2-11, documented severe cognition impairment and supervision of set up with mobility, transfer, walking in corridor and locomotion off unit. R6's MDS, dated 12-6-11, documented severe cognitive impairment and limited assistance of one person physical assistance with mobility and supervision with transfer, walk in corridor and locomotion off unit. 2. The Admission Sheet identifies R69 as a 90 year old male admitted to the facility with diagnosis of Cerebral Palsy and left arm paralysis, in part. The MDS dated 11/23/11 identifies R9 to require extensive assist of one staff for ADL including transfers and mobility. According to the care plan dated 11/30/11, R9 has a potential for falls due to decreased mobility, altered thought process and left hemiparalysis. An Incident/Accident Report dated 12/4/11 indicates staff were "called into room by CNA state resident was struck in head by mechanical lift device attempting to put resident in w/c (wheelchair) - trying to move lift - went forward striking resident in L (left) eyebrow area." According to the report, this caused a 2cm x .5cm laceration of the eyebrow area on left side. There were no recommendations/interventions implemented as a result of this incident even though R9 sustained a laceration which had to be steristripped. The report section that asks how the resident sustained a skin tear and/or bruise documents "when putting resident in w/c attempted to move lift device jumped forward, lift	F9999		

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bar striking resident in left eyebrow area causing laceration." The staff failed to ensure that R9's transfer was safety done by ensuring the lift did not move/roll. The nurses notes dated 12/4/11 at 4pm reflects the same incident but adds that R9 also sustained a skin tear of the left elbow also which measured 2cm x .5cm which was closed with 2 steri strips. There is no indication the facility implemented anything to prevent this from occurring again.

3. The MDS dated 11/23/11 identifies R14 to have severe cognitive impairment and be dependent on staff for all activities of daily living including transfers. The care plan dated 11/23/11 documents that she is "non-ambulatory" and is transferred via a mechanical lift with a full body sling. Under skin, the care plan has identified that she is prone to skin tears easily. There are no interventions written to address a prevention plan for the skin tears.

According to INCIDENT/ACCIDENT REPORTs; on 11/12/11 at 9pm, the report documents that R14 "obtained a skin tear on her L (left) thigh aprox (approximately) 5cm long. CNA stated she doesn't know how it happened." The report states R14 was in her bed. There is no further investigation as to the causative factor.

On 11/20/11 at 1220pm, another Incident/accident report states a skin tear was found on R14's upper arm "possibly caught in gerichair." The tear was 3.5cm x 1/75cm on left upper arm. No further investigation was completed to determine the causative factor and no new interventions or revision added to the care plan to prevent further skin tears.

On 11/23/11 at 6:30pm, R14 sustained a skin tear to the left upper arm. This one measured

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4cm x 1cm and two other measuring 2cm x 1.5cm and 2cm x 1cm. The report states it was noted when R14's sheets were being changed and the CNA went to put a night gown on. Under RECOMMENDATIONS/INTERVENTIONS, it states "staff education on safety when transfers." There is, however, no new interventions and/or revisions done to the care plan in an effort to prevent further skin tears.

On 1/26/12 at 2:58pm, R14's skin was observed and scabbed skin tears were still evident on her upper left arm. R14 had on a short sleeve house dress and her arms were not covered. She had multiple scars over both arms from skin tears. E21, CNA, stated R14 gets skin tears very easily and they are probably done with transfers. E22, Licensed Practical Nurse stated they had not tried protective covering on R14's arms like special arm coverings. but stated they could and see how that went. E22 stated she thought the skin tears were from the lift sheet.

4. R1's MDS, dated 12-17-11, documented severe cognitive impairment, feeding tube for nutritional approach and total assistance with mobility and transfer. It was also noted R1 was not steady and only able to stabilize with human assistance from surface to surface transfer.

During observation of R1's transfer, on 1-23-12 at 12:00p.m., E15, CNA, and E16 CNA placed a transfer belt around R1's waist and stood her up from her reclining chair. R1 repetitively yawned, did not appear fully awake and did not bear weight as E15 and E16 dragged R1 backwards from her reclining chair to her bed.

R1's Care Plan, not dated, documented R1 was at risk for falls and "transfers: I use a

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F9999	Continued From page 106 mechanical lift." 5. R20's MDS dated 09/22/11, documents that R20 was cognitively impaired and was a total assist of 1-2 staff with all transfers, bed mobility, dressing, eating, hygiene and was always incontinent of bowel and bladder. The facility care plan last updated 08/10/11, documents that R20 is at risk for skin breakdown with potential for bruises and skin tears related to decreased elasticity of skin turgor. On 03/06/11, an incident/accident report documents that the Certified Nursing Assistant (CNA) was holding R20 on his side while changing him resulting in R20 sustaining a skin tear measuring 5cm x 6cm in the center of a purple bruise measuring 10cm x 7cm on R20's left posterior shoulder. Interventions documented that staff was educated on turning and repositioning. On 03/13/11, an incident/accident report documents that R20 had a 4.5cm x 3.5cm purple hematoma to inside right wrist. On 03/14/11 at 11:50 am, an interview note documents that R20 stated that he received the hematoma while "she was trying to get me out of the wheelchair and grabbed me by my wrist and pulled the skin too tight." On 03/14/11, an inservice documents that the CNA's were inserviced on R20's fragile skin precautions. On 03/14/11, an incident/accident report documents that R20 fell out of his wheelchair, unwitnessed, and sustained a 3cm gaping laceration to left eyebrow, a 1.2 cm skin tear to the right thumb and a 0.5cm skin tear to the left posterior forearm. Intervention was to place R20 in a high back wheelchair. On 03/23/11, an incident/accident report	F9999		

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documents that R20 had sustained a skin tear located under left arm in the center of a bruise. No measurements were documented. Documentation indicates that staff were unaware of how it happened. Another skin tear was noted on the second finger of the right hand. Documentation indicates that staff believe this might have occurred while trying to take R20's shirt off. No new interventions were put into place.

On 09/24/11, a nurses note documents that R20 sustained a skin tear while two CNA's were turning and repositioning R20 and he bumped his arm on the side rail between the left second finger and thumb. There was no incident report presented during the survey.

On 11/04/11, a nurses note documents that R20 sustained a skin tear on his left hand from a CNA pulling his shirt off measuring 4cm. There was no incident presented during survey.

On 11/23/11, an incident/accident report documents that R20 was being transferred via mechanical lift and sustained a skin tear to the right upper posterior back measuring 2cm x 1cm x 0.5cm. Interventions were to check the mechanical lift for areas of concern. No new interventions were added to the care plan at this time.

On 11/28/11, an incident/accident report documents that R20 sustained a 13cm x 15cm purple bruise with a small skin tear measuring 1cm x 0.5cm to the right forearm. The report documents that the incident was not witnessed and was speculated to be caused from R20's arm getting caught in the side rails. The intervention was to talk with Hospice about padding the side rails. There was no documentation in the care plan of adding padded side rails.

On 12/07/11, an incident/accident report

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documents that a CNA had removed an existing Band-Aid on the right forearm, had caused a new skin tear a couple of inches away from the old skin tear measuring 1.5cm x 0.5cm. There were no new interventions documented on the investigation report or the care plan.

On 12/12/11, an incident/accident report documents that a CNA was turning R20 and noted a skin tear to left upper arm measuring 2.1cm x 0.8cm x 0.5cm and left elbow measuring .05cm x 0.5cm. The report documents that there were no witnesses to the skin tears. There were no new interventions documented on the report or the care plan.

During an interview conducted on 01/27/12 at 9:40 am with E12, Licensed Practical Nurse, (LPN), he stated that he recalled taking care of R20, but only had him for about a month. He recalled R20 having multiple skin tears and bruises that happened when R20 was being transferred, and that some of the skin tears were unwitnessed. He did not recall R20 having any special arm sleeves, but stated R20 could have, he just couldn't remember.

During an interview conducted on 01/27/12 at 9:47 am with E11, LPN, she stated that she remembered working with R20 and stated "his skin was paper thin and he would get skin tears, bruises and pressure sores easily when doing care or if he was grabbed to tightly on the arm." When asked what fragile skin precautions included, she responded, "staff is to use soft touch during care, the use of special mattresses, pillows to prop during turning and repositioning and special arm coverings." She recalled that R20 would have soiled arm sleeves often due to skin tears and the sleeves would be removed and had to laundered.

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6. R17's MDS, dated 11-30-11, documented extensive assistance of two plus persons physical assistance with transfer and one person physical assistance with mobility. It was also noted total dependence of one person physical assistance with toileting and limited assistance of one person physical assistance with eating.

R17's Incident/Accident Report, dated 11-24-11 at 1:50pm, documented R17 was found lying on the floor with a hematoma to her right forehead. It was also noted her alarm was sounding. R17's Incident/Accident Report and her Nursing Notes, dated 11-24-11 from 1:50p.m. to 1-25-11, did not document increased supervision and/or fall prevention monitoring after her fall. R17's Incident/Accident Report, dated 11-24-11 dated 2:30a.m., documented R17 was found lying on the floor with an additional large hematoma to her right forehead and swollen upper lip. R17 was sent to a local hospital for evaluation. R17's Incident/Accident Report did not document if her alarm was sounding or if the alarm was in place. R17's Incident/Accident Report, dated 12-22-11, documented R17 leaned forward during toileting and hit her right forehead on floor received another hematoma with an open area in the center. R17's Incident/Accident Report did not document if staff were in-serviced in providing toileting supervision. It was also noted R17's chart did not document addtitoinal assessments for her toileting needs.

R17's Care Plan, not dated, did not document R17's specific falls or interventions related to those falls.

Additional, R17's Incident/Accident Report, dated 1-21-12, documented R17 spilt hot coffee in her lap during dining. R17's 11-24-11

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F9999	Continued From page 110 Incident/Accident Reports and her Nursing Notes, dated 11-24-11, did not document increased supervision for her dining. 7. R18 was observed on 1-27-12 to have an air flow mattress and 1/4 side rails. On the morning of 1-3-12, E1, Administrator, was asked for manufactures recommendations for the use of the low air loss mattress. On the morning of 2-1-12 at 9:30AM, R18 was observed to be in another bed that was low to the ground and had a mat by the side of the bed. E1 and E23, Corporate Nurse, were asked if R18 had fallen and they said he had slid out of the bed to his knees and they had changed R18 to another air loss mattress. The manufactures information on the first air flow mattress shows full side rails on the bed. During interview with Z9, a representative from the 1st air flow mattress, on 2-1-12 at 9:55AM, Z9 stated they recommend full side rails be used with the bed due to safety issues. They keep the resident from falling out of the bed. (B) 300.1210a) 300.1210b)4) 300.1210d)3 300.1220b)2)3) 300.3240a)	F9999		

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F9999	Continued From page 111 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. (Section 3-202.2a of the Act) 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: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities	F9999		

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F9999	Continued From page 112 in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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	F9999		

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F9999	Continued From page 113 include medically defined conditions and medical 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 300.3240 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 interviews, observations and record review, the facility failed to provide adequate	F9999		

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assistance and monitoring of meals for 1 resident reviewed for weight loss. This failure resulted in R14 losing 11.86% of her weight within 4 months (8/11-1/12/12).

Findings include:

1. The Minimum Data Set (MDS) dated 11/23/11 identifies R14 to have severe cognitive impairment and be dependent on staff for all activities of daily living including eating. The Physician's Order Sheet (POS) for January 2012 indicates R14 receives a pureed diet with thickened liquids, supercereal at breakfast along with double portions and "May have snacks between meals." The care plan dated 11/23/11 documents R14 "needs to be fed" and her appetite is good. The care plan also documents R14 has no teeth and on 11/18/11, R14 was placed on Remeron for "wt (weight) loss."

On 1/23/12 at 1:09pm, R14 received her tray in the assisted feeding dining room. She was fed by a volunteer. She received meat, spinach, potatoes and applesauce along with a small glass of water and a small glass of milk thickened. She took very small bites and ate <25% with no fluid intake. No substitutes were offered and/or tried before taking R14 from the dining room. No intakes were observed to be recorded at the time that the food plates were discarded. The intake records recorded on 1/23/12 for the noon meal that day documented R14 took 240cc of fluids and at 100% of her meal. .

On 1/25/12 at 1:22pm, R14 received her pureed diet which was mashed potatoes, meat, vegetables and apricots along with a shake type drink and water. E6 was feeding R14 along with 3 other totally dependent residents at a 1/2 moon

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table. E6 repeatedly gave R14 small bites of potatoes but no meat, vegetables or apricots. At 1:50pm, R14 was still being given small bites of potatoes only. At 2pm, E6 stated she didn't know why R14 wasn't eating anything and discarded the entire plate of food along with the full glass of milk and water which she failed to offer/encourage at all. The intake recorded for that day was 25% of food and 0 fluid intake. This was recorded in error as observations showed R14 only ate approximately 25% of her potatoes only and not of the whole meal.

According to monthly weight records, R14 weighted #118 in August 2011 and on 1/12/12 weighed 104 pounds. Other than the Remeron being added to the care plan, the facility failed to develop a plan of care directly toward increasing R14's intake amount. The Registered Dietician's (RD) assessment dated 11/29/11 indicates R14's "meal intake varies" and she has no pertinent labs. There is no indication the RD attempted any supplements if meals were not consumed or that additional interventions were added to the care plan in an effort to increase her meal intake and daily caloric amounts. There is no indication R14 gets a snack between meals as ordered when appropriate.

On 1/30/12 at 12noon, the Dietary manager E20 stated R14 gets only milk and no supplements. She confirmed that the intakes recorded may not be accurate and that no intake for supplements and/or shakes were recorded at this time if residents do have them ordered.

(B)