STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING _____ B. WING _____	01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 8 R7's Incident Report, date 3-16-11, documented R7 was a cognitively impaired resident and observed on the floor after attempted self transfer and self toilteing. R7's Incident Repot, dated 4-6-11, documented R7 fell after self transfer. R7's Incident Report, dated 4-18-11, documented R7 was observed on the floor after attempted self transfer and self toileting. R7's Incident Report, dated 7-11-11, documented R7 received a laceration after attempting self transfer. R7's chart also documented he sustained a left hip fracture with his 7-11-11 fall. R7's Incident Report, dated 10-2-11, documented R7 fell after attempting self-transfer. The facility did not provide a fall prevention program and interventions addressing R7's repeated documented falls during self transfer prior to his 7-11-11 fall.	F 323		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.1210b) 300.1210d)3)5) 300.3240a) 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	F9999		

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F9999	Continued From page 9 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: 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidence by: Based on interviews and record review, the facility failed to adequately assess, monitor and	F9999		

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seek treatment for a declining painful lesion for 1 of 10 residents (R4) reviewed in a sample of 10. This failure resulted in R4 developing septic shock from a perirectal abscess requiring surgery.

Findings include:

1. The Minimum Data Set (MDS) dated 12/10/11 indicates R4 was admitted to the facility on 1/25/11 with diagnoses, in part, non-insulin diabetes, atrial fib, and multiple falls. According to nurses noted dated 11/4/11 at 11am, "CNA (Certified Nurses Aide) noted/reported 5cm L (centimeters long) x 6cm W (Wide) hard area Lt (left) lower buttock c (with) 0.1cm diam (diameter) raised red bump. O (no) warmth or other redness noted. T. (temperature) 98.1 c/o (complained of) tenderness c palpatation - states also c sitting. communication sent to Dr."

The next entry into the nurses notes is at 11:15am on 11/4/2011 when the Power of Attorney (POA) was notified and documentation that R4 has an appointment with the doctor on 11/8/11. There are no entries in the nurses notes that indicate the physician responded back. On 11/5/11 at 1700 (6pm), the nurses notes document R4 "had uncontrolled shaking all over. VS (Vital signs) are stable, BP (blood Pressure) 150/80. The note also documents R4 ate 50%of her dinner and then fell asleep. There is no documentation regarding the red area identified the day earlier on R4's buttock. At 2045 (8:45pm), the nurses notes documents her feeling warm with a temperature on 99.6. On 11/6/11 at 1am, her temperature was 98.7. The next entry is at 1800 (6pm) on 11/6/11 and documents "res (resident) shaking and c/o pain

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on L (left) buttock and anxiety. Temp in am was 99.1 and temp before supper was 100.5. Large lump still on buttox about 5 in (inch) and raised, warm + red."

On 11/7/11 at 4am, R4 is documented as having a 100.2 temperature with the left buttock red, firm, and tender to touch. At 6:50am, the noted indicates an update was sent to R4's physician which included new measurements of hard/firm raised area on left buttock 12/7cm long x 7 cm wide area firm/red/warm tender to touch "no specific" head area, 1 cm purple area. Running low grade temp 99.6 at this time." The next entry is at 1530 (3:30pm) and documents R4's appetite poor, "sleepy all day, has dr appt tomorrow. Have examine butt area. no c/os voiced at this time."

At 4pm, the nurses notes document R4's POA "came to writer stated res is down in her room moaning + I think she needs to be sent out to (hospital) for eval (evaluation) + tx (treatment). Writer went down to talk c res ask res if she wanted to go to hospital. Res said yes I need to get somewhere to get things taken care of so I get to feeling better." The note continues to document that the physician's office was called and told R4's POA wanted her sent to hospital. At 5:15pm, the physician responded with an order to send R4 out.

Hospital History and Physical dated 11/7/11 indicate R4 was admitted to the hospital with Septic Shock and Perirectal Abscess which requires incision and drainage on 11/8/11 and was admitted directly to Intensive Care from the emergency room. Physical exam at the time documents R4 being somnolent and lethargic and appeared to have a inflamed buttock with a black area present.

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F9999	Continued From page 12 According to R4's POA Z1 on 1/5/12 at 2:45pm, she was told the physician did not respond to the original faxed communication on 11/4/11 when she came in on 11/7/11 and thought she needed to be seen right away. Z1 stated she had thought they had probably gotten an order for an antibiotic or dressing but didn't think they would not have anything. On 1/5/11 at 3:45pm, E5 Licensed Practical Nurse (LPN) provided Fax Transmittal Forms dated 11/4/11 and 11/7/11 which shows the physician being faxed with information but was unable to provide any information/documentation that the facility received any response from R4's physician. E5 stated they did not follow up with a call nor did they contact the medical director until the evening of 11/7/11 when R4's POA came in and insisted she be sent to the hospital. E5 stated they assumed R4 would be seen in the office on 11/8/11 anyway. (A) 300.610a) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)3)6) 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	F9999		

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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 300.1210 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

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F9999	Continued From page 14 shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidence by: Based on record review and interview, the facility	F9999		

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failed to implement fall interventions for 2 of 6 residents (R7, R8) reviewed for falls in the sample of 10. This failure resulted in R8 sustaining a left femoral fracture during self ambulation and R7 sustaining a left hip fracture during self transfer.

Findings include:

1. R8's Incident Report, dated 12-8-11, documented R8 fell during self ambulation which resulted in a left femoral fracture. It was also noted R8 was admitted to a local hospital.

R8's Nursing Notes, dated 10-11-11 to 12-8-11, documented repeated incidents of confusion., attempted self ambulation and complaints of urinary discomfort. R8's Urinalysis, dated 10-6-11, documented R8 was positive for a Urinary Tract Infection.

E7, Licensed Practical Nurse (LPN), stated, on 1-5-12 at 12:50p.m., that R8 had been confused prior to her fall, required supervision and that R8 did not have safety awareness.

E8, Physical Therapy, stated, on 1-5-12 at 1:30p.m., that R8 was confused prior to her fall and that she had unsafe judgement.

R8's chart and Nursing Notes did not document the facility put in place fall preventive measurements or interventions to ensure R8's safety during R8's periods of confusion and self ambulation. It was also noted the facility did not document monitoring R8's complaints of urinary discomfort or urinary follow-up. R8's chart documented R8 was re-admitted to the facility on 12-14-11. R8's Urinalysis, dated 12-22-11, documented R8 was positive for a Urinary Tract Infection.

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F9999	Continued From page 16 The facility did not provide a fall prevention program and interventions addressing R8's periods of confusion and ambulation needs prior to R8's 12-8-11 fall. The facility's Resident Accident/Incident Prevention Program, dated 2-24-11, documented all resident's are assessed upon admission and every 90 days thereafter or as he residents condition warrants for their risk of accident/incidents to occur. 2. R7's Minimum Data Set (MDS), dated 4-11-11, documented supervision with assistance of one person physical assistance with ambulation and toileting and impaired balance. R7's Incident Report, date 3-16-11, documented R7 was a cognitively impaired resident and observed on the floor after attempted self transfer and self toilteing. R7's Incident Repot, dated 4-6-11, documented R7 fell after self transfer. R7's Incident Report, dated 4-18-11, documented R7 was observed on the floor after attempted self transfer and self toileting. R7's Incident Report, dated 7-11-11, documented R37 received a laceration after attempting self transfer. R7's chart also documented he sustained a left hip fracture with his 7-11-11 fall. R7's Incident Report, dated 10-2-11, documented R7 fell after attempting self-transfer. The facility did not provide a fall prevention program and interventions addressing R7's repeated documented falls during self transfer prior to his 7-11-11 fall. (B)	F9999		