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F 441	Continued From page 52 The label on the Super Sani Disposable Wipes does not list Clostridium difficile as one of the organisms which the wipes are effective against. The facility Infection Control Policy dated 6/2010 states, ""Reducing and/or preventing infections through indirect contact requires the decontamination (.....disinfecting an object to render it safe for handling) of resident equipment, medical devices and the environment..." 3. E29, Housekeeper was questioned as to what chemical agent was being used for general decontamination purposes on 1-10-12 at 9:40 a.m. at which time he indicated an unlabeled spray bottle containing a quaternary ammonia compound (Germakill) was being used. He indicated that a pail of water containing Germakill was used for floor treatment. At this time the contents of the unlabeled spray bottle and pail of mop water was tested using a quaternary ammonia test tape and a chlorine test tape. The tapes registered no discernable concentrations of quaternary ammonia or chlorine.	F 441		
F9999	FINAL OBSERVATIONS Subpart U - Alzheimer Unit LICENSURE VIOLATIONS Section 300.610a) Section 300.1210b)5) Section 300.3240a) Section 300.7040a)c)d)e) Section 300.610 Resident Care Policies	F9999		

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Continued From page 53

a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary 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:
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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or

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agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:

Based on observation, interview and record review, staff failed to utilize assessed and planned fall interventions for R14, who fell on 8/21/11 and sustained a left wrist fracture. R14 is one of 13 residents reviewed for falls with an injury in the sample of 30.

The facility failed to identify the root cause of falls and implement interventions to prevent recurrent falls for R9, R23, and R10. Staff failed to follow the transfer careplan of two assist which resulted in a fall for R18; the facility failed to identify and operationalize interventions to prevent recurrent falls for R17; and the facility failed to maintain supervision and intervene during R17's unsafe bed mobility to prevent a potential fall. R9, R23, R10, and R17 are four additional residents of 13 residents reviewed for falls in a sample of 30.

Findings include:

1. R14's Physician's Order Sheet (POS) dated 12/16/11 lists the following diagnoses: Alzheimer's Disease - Moderate Stage, Closed Fracture of Left Radius with Ulna and Osteoporosis. The Minimum Data Set dated 12/22/11 states R14 is cognitively impaired and requires extensive assistance with one person physical assist for transfers and toileting. R14's Morse Fall Assessment dated 12/16/11 states R14 is at high risk for falls.

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F9999	Continued From page 55 The facility Incident and Accident log dated March 2011 to August 2011 states R14 incidents resulting in falls on 3/25/11, 7/2/11, 8/1/11, 8/5/11 and 8/21/11. The fall intervention that was put into place for R14 from the 3/25/11 incident was to place a sensor floor mat at the bed side. The facility's fall investigation report for the incident on 8/5/11 states that R14 was found at the end of the bed , the fall investigation states R14 slipped and the fall intervention to prevent further falls was to obtain an order for sensor floor mat. The fall incident /investigation report for 8/21/11 states R14 had another fall, R14 climbed out of the bed on the opposite side of the bed that did not have a sensor floor mat. R14 fell and complained of left wrist pain and was sent to the emergency room for evaluation and treatment. The hospital Record dated 8/21/11 under Imaging Results states "Final Diagnostic Report" "There is a transverse fracture of the distal radial metaphysis without significant angulation or displacement. There is also a nondisplaced fracture of the ulnar styloid process." E2, DON (Director of Nurses) stated on 1/12/12 at 2:20 PM that R14 received a left wrist fracture and did not know why the sensor mat was removed from her bedside. The original order for the sensor mat was dated 3/30/11 and there should have been a sensor mat on the floor. 2. According to the facility resident roster, R9 resides on the specialized Alzheimer's Unit. R9's Minimum Data Sets (MDS) for both 8/22/11 and 1/6/12 show severe cognitive impairment and the need for assistance with transfers and	F9999		

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ambulation. The Morse Fall Scale dated 12/19/11 assesses R9 at high fall risk. R9's Physicians Order Sheet (POS) print date of 12/1/11 lists Physician Orders for a personal motion alarm while in bed to help prevent falls; safety mattress to prevent falls and a pull tab motion alarm in the chair for safety.

R9's Interdisciplinary Progress Notes and Resident Fall Investigation/Root Cause Analysis Reports document falls on 7/14, 7/15, 7/23, 10/21, 10/22, 11/17 and 12/13 of 2011. The investigation reports do not identify the root cause for each of the falls and fails to identify individualized interventions to prevent future falls. Comments under this section are: 7/14/11 - spend more time with resident and orient him more frequently; 7/15/11 - assist with all Activities of Daily Living; 7/23 - shoes tied; 10/21/11 and 10/22/11 - needs care plan review or therapy evaluation; 12/13/11 - monitor frequently.

R9's Care Plan available on the unit was dated 10/28/11 and lists fall interventions of supervision, a safety device appliance (motion alarm), safety mattress, call light within reach and verbal cueing to remind resident not to walk alone. The Care Plan for fall risk does not include interventions addressing his personal needs such as toileting, ambulation program or individualized Activities.

On 1/10/12 at 2:05 p.m. E6, Certified Nurse Assistant (CNA) walked R9 to a dining room table to sit with her while she charted. R9 was seated in a dining room chair with motion alarm in place where he remained until 2:55 p.m., when R9 stood up. At this time E6 walked R9 once around

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F9999	Continued From page 57 the unit and sat him in a chair in the living room next to R36. At 3:35 p.m. R9 stood up and activated his alarm. E13, CNA responded and walked R9 around the unit and returned him to his same chair at 3:38 p.m. At 4:05 p.m. R9 stood, activating the alarm and walked by himself across the room. E10, CNA who was providing one on one supervision for R31, called out for E13. E13 responded and returned R9 to his chair next to R36 stating to R36, "Will you do me a favor? Will you hold his hand so he'll stay here?" R36 and R9 then held hands. At 4:25 p.m. R9 stood up, activating the alarm. E14 CNA then walked R9 to the dining room and sat him in a chair stating it would soon be time for supper. At 4:35 p.m. R9 stood, the alarm sounded and E14 cued him to sit back down. At 5:00 p.m. R9 removed the motion alarm and E13, CNA reattached it. From 2:05 until 5:00 p.m. R9 was given a Health Shake and a glass of water; no attempt was made to engage R9 in planned individualized activities nor was R9 taken to the toilet. The unit was staffed with three CNAs on the day shift and three CNAs on the evening shift on 1/10/12. From 2:05p.m. until 5:00 p.m. one of the three CNAs was providing continuous one to one supervision for R31. 3. According to the facility resident roster, R23 resides on the closed Alzheimer's Unit. On 1/10/12 at 4:35 p.m. R23 walked independently with a walker from the living room to the dining room. R23 had a gait belt secured around her waist. E10, CNA,(who was providing one on one supervision for R31) gave verbal cues to R23 to stop and not walk alone but R23 continued. E10 then called out for E14, CNA to assist. E14 assisted R23 to a dining room chair. E14 stated	F9999		

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she was busy with another resident and did not see R23 get up. E14 stated R23 is to have a motion alarm in bed so staff know when she gets up; R23 doesn't use an alarm in the living room as staff usually supervise her.

R23's MDS dated 12/21/11 lists severe cognitive impairment. R23's Care Plan dated12/22/11 lists R23 at high risk for falls, and directs staff to use a bed motion alarm and to provide R23 with verbal reminders not to ambulate/transfer without assistance. A Resident Fall Investigation/Root Cause Analysis Report dated 12/14/11 documents R23 fell in the hallway while walking independently with her walker. The report indicates R23 was to have had staff assistance when walking. The measures listed to prevent further falls reads, "close and frequent monitoring of the resident."

4. According to the facility resident roster, R10 resides on the closed Alzheimer's Unit. On 1/10/12 at 3:20 p.m. R10 stood up from her chair in the living room. R10 had a gait belt around her waist and a motion alarm attached to her clothing. As R10 stood, the motion alarm pull tab did not pull out to activate the alarm, as the length of string was adequate to allow her to stand. R38 approached R10 and removed the motion alarm unit from the chair and started walking with R10 across the living room. A family member who was in the area alerted E10, CNA who was providing one on one supervision to R31. E10 called out for E14, CNA, who was busy in another resident's room. E10 then alerted E8, Licensed Practical Nurse, who intervened.

R10's MDS of 11/14/11 shows severe cognitive

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F9999	Continued From page 59 impairment and the need for staff assistance with transfers and ambulation. The Morse Fall Scale of 1/1/12 lists R10 at high fall risk. R10's POS, print date of 12/1/11, lists Physician Orders for a personal motion alarm while in bed and wheelchair for safety. Confidential family interview on 1/11/12 at 5:00 p.m. stated the unit is short of staff, and staff don't see everything that goes on because there is not enough of them. During tour on 1/10/11 at 8:40 a.m. 23 residents resided on the closed Alzheimer's unit. Staffing present on the unit on 1/10 and 1/11/12 consisted of three CNAs and one nurse on both the day and evening shifts. On 1/12/11 at 3:45 p.m. E5 stated she was not aware that R9 and R10 used motion alarms when up in a chair. 5. R18's January 2012 POS lists diagnosis which includes Progressive Nuclear Palsey, Paralysis agitans, Atrophy, Muscular disuse, and Osteoarthritis. R18's Minimum Data Set (MDS) dated 6/24/11 and 11/24/11 identifies R18 as severely cognitively impaired with decision making, requiring extensive physical assistance of two for mobility and transfers, has impaired upper extremities, balance is not steady, only able to stabilize with assistance. R18 is 77 inches tall and weighs 256 pounds. On 1/11/12 at 9:15 am R18 was transferred from the wheelchair to his bed by Certified Nurse Aides (CNAs) E42 and E43 using a sit to stand lift. R18 needed extensive assist of the two aides to place his feet on the platform, position his hands on the handles, apply the sling and bring the lift to the bed.	F9999		

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R18's Fall Risk Assessment and Physical Assessment dated 11/26/11 lists High Fall Risk with last fall occurring 9/05/11.

Nurses notes dated 9/05/11 7:00 am document a CNA reported she had R18 sitting on the bed, while she attempted to put the harness for the sit to stand lift on the resident. The resident leaned to the left and fell to the floor before she could catch him. R18 sustained bruising over the left eye and a skin tear to right hand and forearm.

The "Resident Fall Investigation/Root Cause Analysis Report" for the 9/05/11 incident documented "Equipment malfunction". The cause of incident says "CNA was attempting to use sit to stand", "lost balance". The report listed measures taken to prevent further falls documents ," Use two CNA and sit to stand lift." CNA E41 's written statement dated 9/5/11 confirmed that while E41 was applying the lift harness to R18, he started to lean towards the floor and E41 tried to hold him but she could not bear his weight to prevent the fall.

The root cause stated "CNA per statement failed to use 2 assist for transfer as plan of care directs. Will follow up with CNA per progressive disciplinary." The attached Door Sign/Care Plan for R18 dated 3/28/11 for transfers directs staff to use " (Sit to Stand) lift with 2 Assists.."

Unit 2 Nursing Supervisor E3 stated on 1/13/12 at 10:10 am that she investigated the 9/05/11 incident and interviewed E41. E3 stated that R18 required assist of two with the sit to stand lift because R18 was unpredictable. R18 would let

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F9999	Continued From page 61 go of the handle and would grab at staff. The care plan and door careplan guide at the time of the incident directed staff to use two assist with the lift. E3 stated that CNA E41 confirmed that she was aware that two staff were required but said she didn't have time to find someone to help. The undated (Sit to Stand) Lift Protocol states. "Type of transfer will be assessed by Skilled Therapy and Rehab staff. Information will then be processed...CNA will be informed and added to Care Plan and assignment sheet. The CNA's shall look at the Care Plan on back of door and assignment sheet to see type of transfer for resident and follow through with proper transfer." 6. R17's Physician Order Sheet dated 01/16/12 documents the following diagnoses: Dizziness, Hypertension, and Congestive Heart Failure for which R17 continuously uses oxygen. R17's Morse Fall Scale score dated 12/14/11 was 65, indicating high risk for falls. R17's Minimum Data Sheet (MDS) dated 12/14/11 documents moderate cognitive impairment and the ability to stabilize balance only with human assistance. The MDS dated 12/14/11 also indicates R17 has a history of falls. R17's Door Sign/Care Plan dated 12/05/11 indicates that R17's gait and balance are unsteady and that he is to have a personal sounding alarm when in the wheelchair. Resident Fall Investigation/Root Cause Analysis Reports dated 04/19/11, 09/27/11, and two separate reports dated 11/23/11 document R17's falls. The Resident Fall Investigation/Root Cause Analysis Report dated 11/23/11 at 2:15pm R17 fell while attempting to transfer himself from the	F9999		

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F9999	Continued From page 62 wheelchair to the recliner and sustained a bleeding abrasion. The investigation determined that the wheelchair was not locked and that the personal sounding alarm failed to sound. According to the report, the batteries were changed in the alarm, but no changes to resident care were implemented at this time. Another Resident Fall Investigation/Root Cause Analysis Report dated 11/23/11 at 3:15pm indicates R17 fell again. R17 was found between the recliner and wheelchair. The Root cause analysis indicated R17 was attempting to go to the restroom. The investigation determined that the personal sounding alarm again failed to sound. The Report of Investigation document for this fall indicated the following changes to resident care: staff were " instructed not to leave wheelchair within reach when (resident) in recliner, to utilize pull tab alarm, and make sure call light available. " R17's Care Plan dated 04/21/11 and reviewed 10/04/11 does not include the updated changes indicated on the Report of Investigation document dated 11/23/11. The Door Sign/Care Plan dated 12/5/11 (used by staff to alert them to residents ' needs) on R17's door does not include the changes to resident care indicated on 11/23/11. On 01/12/12 at 3:00 p.m. E3, Registered Nurse and Unit Supervisor confirmed that R17's Care Plan and Door Sign/Care Plan did not include the resident care changes indicated on the Report of Investigation document dated 11/23/11. 7. On 01/11/12 at 2:00p.m., R17 climbed out of his wheelchair and onto his bed and attempted to close the blinds on the window next to his bed. R17 ' s personal sounding alarm clipped to his shirt did not sound. R17 ' s oxygen tubing was in proper position in his nose, and was attached to	F9999		

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the portable oxygen supply secured to the back of his wheelchair. E24, Certified Nursing Assistant (CNA), saw R17 in this position and told him to wait there and she would get help. E24 then left R17 unsupervised on the bed and went for help. While E24 was gone, R17 backed himself off of the bed and sat in his wheelchair.
E24, CNA, returned with E25, CNA, at 2:04p.m. E25 checked the personal alarm and stated that it had been turned off. E24 and E25 assisted R17 to his recliner and then left without placing the call light within R17 ' s reach. The wheelchair was placed next to the recliner, unlocked, and the oxygen tubing remained connected to the portable oxygen unit on the back of the wheelchair.

(B)

Section 300.7040 Activities

a) The unit ' s activity program shall use ability-centered care programming.

c) Units with a census of more than 40 residents shall have a full-time activity professional who meets the requirements of Section 300.1410(c). Units with a census of 40 or fewer residents shall have an activity professional on duty at least 20 hours per week. This individual shall be responsible for providing activities and training staff in an ability-centered programming approach.

d) Activity programming shall be planned and provided throughout the day and evening, at least 7 days a week for an average of 8 hours per day.

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e) Activities shall be adapted, as needed, to provide for maximum participation by individual residents. If a particular resident does not participate in at least an average of 4 activities per day over a one-week period, the unit director shall evaluate the resident ' s participation and have the available activities modified and/or consult with the interdisciplinary team.

This requirement is not met as evidenced by:

Based on observation, interview and record review, staff failed to provide small and large group, planned activities based on the resident's current functional abilities and personal interests for R9, R10, R11, R27, R28 and R30. R9, R10, R11, R27, R28 and R30 are six of six residents reidents reviewed, who reside on the specialized Alzheimers unit, on the sample of 30.

Findings include:

During tour on 1/10/11 at 8:40 a.m. 23 residents resided on the closed Alzheimer's Unit. On 1/10/12 at 3:30 p.m. E5, Dementia Coordinator, stated the Activity responsibilities for the closed Alzheimer's Unit are shared by herself and two CNAs: E6 and E10. E5 stated E6 is the Team Leader on the day shift and E10 is Team Leader on the evening shift. E5 stated she is responsible for conducting the Activity assessments and quarterly Activity Progress Notes for the residents.

On 1/11/12 at 8:30 a.m. E6, CNA turned the news on the television (TV) in the living room and left the area. Three residents were seated in the viewing area and R9 was asleep in a recliner in

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F9999	Continued From page 65 the area. The TV remained on through 9:25 a.m. with staff clearing the breakfast dinnerware and toileting residents. Residents were taken from the dining room to their rooms and then to the living room, with 15 residents ending up in the living room. At 9:35 a.m. E6 told the residents, "Good Morning" and started to talk about the date and weather. E6 then started a sing-a-long with the residents. At 9:38 a.m. E6 was called away from the sing-a-long to assist with the care of R31. At 9:43 a.m. E5, Dementia Coordinator, entered the unit and started talking with the residents in the living room about the date and weather, then continued with reminiscing of things the residents use to do to keep from getting "bored" when it snowed. At 9:55 a.m. E5 announced to the residents that she needed to go to a Care Plan meeting, and left the unit. E6 then returned to the group and began reminiscing about cooking with the residents. At 10:00 a.m. E6 again left the living room to assist with R31's care. E6 returned to the living room at 10:05 a.m. as R10 was attempting to stand. E6 turned on music for the residents and then walked R10 around the unit and returned her to her chair. At 10:15 a.m. E6 turned off the music and started a sing-a-long. At 10:18 a.m. E6 left the living room to get snacks, then returned and at 10:25 a.m. and told the residents she was going to Dietary to get the snacks so would put a sing-a-long on; then stated she couldn't find a sing-a-long so turned on "Wheel of Fortune" on TV. The game show continued on TV with no staff in the area and nine of the fourteen residents in the living room were asleep. From 10:40 - 10:50a.m. E6 was passing out snacks with the game show on TV. At 12 noon residents were seated in the dining room awaiting lunch. Residents were still	F9999		

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F9999	Continued From page 66 eating lunch at 1:00 p.m. At 2:15 p.m. staff were taking residents to the living room; the TV was on. During this time there were no small group Activities offered and most residents did not actively participate in the reminiscing and sing-a-long. On 1/11/12 at 2:30 p.m. E6 stated she comes up with ideas for Activities at home each week and then has a list printed at work. E6 stated she bases the Activities on what the Activity Department use to do. When asked about small group or individual activities, E6 stated she usually tries to put out some clothing for residents to fold as they have a couple of residents who enjoy that, and she also tries to put out beads for individual activities. E6 stated she did not put them out today, and on days that she does put them out there is not time for one on one attempts to engage residents - this is only for residents who independently fold the clothing or work with the beads. E6 stated she was not able to provide the Kickball activity that was scheduled for after lunch, as she and the other two CNAs had just finished toileting the residents. E9 and E10 CNAs were included in the discussion, with all three CNAs stating the unit is staffed with three CNAs and a nurse on day shift. They explained that one CNA does showers and one CNA provides one on one continuous supervision of R31 when he is awake. This leaves only one CNA to provide care for the other 22 residents and conduct Activities. On 1/12/11 at 3:45 p.m. E6 stated maybe two days a week they are able to provide small group activities or organized Bingo. On 1/12/12 at 3:45 p.m. E5 confirmed the facility is not providing individualized ability based Activities for the residents in the closed	F9999		

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Alzheimer's Unit.

1. R9 was asleep in a recliner in the living room from 8:30 a.m. until 10:45 a.m. on 1/11/12. At 10:45 a.m. E6 woke R9 up and gave him a health shake. R9 drank the beverage and remained in the recliner. At 11:20 a.m., E6 walked R9 from his room to the dining room, stating she had just toileted him. At 12:50 p.m. R9 was still sitting at the dining table eating. No attempt was made to engage R9 in meaningful activity during this time period.

R9's most recent Activity Assessment and Activity Progress Notes are dated 5/31/11. On 1/11/12 at 12:25 p.m. E5, Dementia Coordinator, stated she might be behind on R9's assessments and notes. E5 was unable to provide additional Activity Assessments or Activity Progress notes beyond 5/31/11. R9's Care Plan dated 10/28/11 lacks Activities based on R9's individual functional level. The Care Plan states to "encourage participation of interest (music visual, intellectual discussion, religion, Bingo, table games, card game, jigsaw puzzles, intergenerational programs and pet visits)."

2. On 1/11/12 at 8:30 a.m. R10 was sitting in the dining room eating. At 8:50 a.m. R10 was seated in a chair in the TV room with her head down and eyes closed, along with a large group of residents. R10 remained in the chair asleep during the sing-a-long and TV programs. At 10:00 a.m. R10 awoke and started to stand up. At 10:08 E6, CNA assisted R10 to walk. At 10:15 a.m. R10 was seated in the same chair in the living room. R10 was asleep in the chair at 10:25 and 10:55 a.m. No attempt was made to engage

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R10 in any Activity.

R10's MDS dated 11/14/11 lists an admission date of 11/8/11 and severe cognitive impairment, with very important Activities listed as books, magazines, newspaper and music. R10's Care Plan dated 11/15/11 only addresses Activities under her risk for falls; with an intervention of "Occupy resident with meaningful distractions (e.g. music, companion, crafts, etc." R10's Initial Activities Assessment is dated 11/21/11. The sections entitled Activity Plan Box, Goal, and Approaches are blank. On 1/11/12 at 12:35 p.m. E5 stated she had gathered the initial Activity information from R10's husband, but has not yet developed an individualized Activity plan for R10.

3. On 1/11/12 from 8:50 -10:55 a.m. R28 was seated in the living room with a large group of residents. R28 actively participated in the two short sing-a-longs with E6, but did not engage in reminiscing. R28 was asleep in her chair at 10:35 a.m. At 11:20 a.m. R28 remained in the same chair in the living room holding a doll. At 2:15 p.m. on 1/10/12 R28 was seated in the living room; the TV was turned on. No attempts were made to engage R28 in individual Activities specific to R28.

R28's 3-1-11 Minimum Data Set reflects that R28 has severe cognitive impairment. The section on Activities Preferences is not completed. There were no Activities Progress notes in R28's clinical record nor were any provided from E5 as requested. R28's 1-5-12 Care Plan states that R28 is very active and enjoys helping assist staff with such activities as setting tables and cleaning up after activities. Her plan states to provide

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setup with independent tasks such as jigsaw puzzles. Her plan states she enjoys bingo, religious activities, and music programs. Her plan includes to introduce R28 to other residents to encourage socialization.

4. On 1//11/12 at 8:30 a.m. E6 CNA walked R27 from her room to the living room and assisted her into a chair in front of the TV. R27 remained in the chair at 8:50 through 10:15 a.m. At 10:35 a.m. R27 was asleep in the same chair. R27 was in the same chair at 10:55 and 11:20 a.m., and at 2:15 p.m. No attempts were made to engage R27 in individualized Activities.

R27's Minimum Data Set dated 3-21-11 reflects that she has severe cognitive impairment and no mood or behavioral issues. R27's activity preferences include snacks, family involvement, music, animals/pets, groups of people, and outdoors. R27's Care Plan states that R27 prefers small group settings for activities. Approaches include introducing R27 to other residents for socialization, invite/encourage R27 to activities including art, jazz band, and musical activities. There were no Activity Progress Notes in R27's clinical record nor were any provided by E5 upon request.

5. On 1/11/12 at 8:30 - 8:50a.m. R30 remained seated in a dining room chair although she was finished eating. At 8:50 a.m. R30 declined E6's offer to walk, remaining in the dining room chair with no meaningful activities until 9:15 a.m. At 9:25 a.m. R30 was seated in the TV/living room, where she remained through 10:35 a.m. R30's only interaction included random clapping of her hands. At 10:35 a.m. R30's head was tipped back

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F9999	Continued From page 70 and she was asleep. At 10:40 a.m. R30 was awoke for a snack, but remained in the same chair until 10:55 a.m. At 11:20a.m. R30 was talking on the phone at the nurse's desk. R30 was again in the same chair in the TV area at 2:15 p.m. No attempts were made to engage R30 in meaningful individualized Activities other than the telephone call. R30's MDS dated 4-6-11 reflects that she is moderately cognitively impaired, has no behaviors, and has activities preferences including caring for her belongings, snacks, staying up past 8 p.m., family involvement, music, animals/pets, keeping up with news, participation in favorite activities, groups of people, time away from the nursing home, outdoors, and participation in religious activities. R30's 12-13-11 Care Plan states that she does not speak the dominant facility language, rather she speaks Russian. R30's Care Plan does not address Activities. R30's clinical record contained no Activities Progress Notes and none were provided by E5 upon request. 6. R11's MDS dated 11/21/11 shows severe cognitive impairment, verbal and physical aggression and wandering. R11's POS (print date 12/02/11) includes an order of 12/20/11 for the antidepressant Celexa; an order dated 10/3/11 for Risperdal 0.25 milligrams twice daily, which was increased to 0.5mg twice daily on 12/20/11; and an order of Trazadone 50mg at bedtime, which was increased to 100mg at bedtime on 1/4/12. R11's Activities Progress Notes dated 6/16/11 documents R11 chooses to not participate in small groups. R11's most recent Activities	F9999		

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F9999	Continued From page 71 Progress Notes is dated 9/10/11 and shows R11 was moved to a single resident room due to behaviors. R11's most recent quarterly Activities Assessment is dated 9/10/11. On 1/11/12 at 12:35 p.m. E5 stated R11 should have had additional assessments and progress notes on 11/21/11, but she did not have them completed. R11's Care Plan dated 11/22/11 does not include an individualized Activity plan, rather it states to encourage activities of choice, encourage small group programs and "structure daily programs around the physical aspects of the resident life." (AW)	F9999		