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F 514	Continued From page 52 E2 (DON) stated, on 2-16-12 at 9:55a.m. and 11:45a.m., that R6's food intake was not documented in any of the meal intake books during review of all the meal intake books with E2. E2 also stated R6's meal intake should have been documented. 2. Record review of R2's Physician Order Sheet (POS) shows an order on 2-17-12 for a treatment to his pressure sore on R2's coccyx. There is no documentation as to which Physician gave the order or where the order came from On 2-17-12 at 9:35AM, E1, Administrator, was shown the order and asked where the order came from. E1 stated she had told the Nurse to call Z2 to clarify orders for treatment to his coccyx. E1 confirmed there was no documentation on the POS as to who gave the order. E1 stated she would have the Nurse correct the POS.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210d)2)5) 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	F9999		

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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, seven-day-a-week basis:
2) All treatments and procedures shall be administered as ordered by the physician.
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

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F9999	Continued From page 54 pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new 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 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 ARE NOT MET AS EVIDENCED BY: Based on observation, record review and interview, the facility neglected to accurately assess; aggressively treat; follow physician orders; and follow their policy and procedure for pressure sore for 1 of 8 residents (R2) reviewed for pressure sores in the sample of 17. These failures resulted in a decline in a pressure sore on R2's coccyx from a stage II to unstageable. Findings include: Facility POLICY AND PROCEDURE for Pressure Ulcers, that is not dated, documents Pressure Sores are categorized by severity, from Stage 1 (earliest signs) to Stage IV (worst) and also	F9999		

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unstageable. The definition of a stage III is a deep crater; full thickness loss of skin tissue, also involving subcutaneous tissue down to the fascia. The definition of a stage IV is a full thickness skin loss, with damage to the bone, muscles, tendons, or joint capsules. May involve sinus tracts. The Policy documents that if a resident has a non-draining wound, the Physician may order a wet to dry dressing or follow the recommendations of the Wound Consultant Nurse. If there is moderate to heavy drainage, the Physician may order wet to dry dressings to be done more frequently.

R2's Physician Order Sheet (POS) dated 2/2012 shows R2 was a new admit with an order dated 10-19-11 to apply DuoDerm to R2's coccyx and change every 72 hours and prn (as needed). The POS and Treatment Administration Record (TAR) show R2's treatment was not changed until 1-8-12 even though Pressure Ulcer Reports showed a decline from admission from a stage 2 pressure sore to a stage 3 on 12-4-11. On 1-8-12 the facility obtained an order apply Aquacel and cover with dry dressing daily and prn and to refer to (special wound consult) for consult. E15, Licensed Practical Nurse (LPN)/Treatment Nurse stated on 2-17-12 at 9:30AM, she had called Z2, R2's Physician/Facility Medical Director on 1-8-12 to ask for a different treatment and a for a consultation to (special wound consult) because R2's pressure sore was getting worse. E16, Director of Nursing in training, provided a written statement on 2-17-12 during a meeting with the facility, documenting in part, E15 stated R2's treatment was DuoDerm and it needed to be changed everyday due to a lot of drainage. "During the treatment this writer noted that the

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wound to his coccyx was stage III and currently being treated with DuoDerm. E15 was educated on wound staging and informed that DuoDerm was not appropriate for R2's current wound status. E15 was informed to notify Z2, of R2's wound status and request new treatment order. E15 obtained new treatment orders and obtained (special wound consult) order from Z2."

A (special wound consult) Report of 1-12-12 documents unstageable pressure ulcer of the coccyx length 5.5 cm, width 2 cm, depth necrosis. Wound bed covered with yellow necrosis. Exudate moderate amount of yellow. Odor: none. Right buttock unstageable. Length: 1.5 cm, Width: 2cm Depth: necrosis. Wound bed covered with yellow necrosis. Exudate: scant yellow exudate. Odor: none. Recommendation was to change treatment and cleanse with wound cleanser, apply Santyl and Aquacel, cover with bordered gauze, change daily and prn. The POS shows the order was changed on 1-12-12. "Encouraged patient to off-load pressure, patient does have a J cushion in his wheel chair to help off- load pressure. I do recommend the patient gets up only for meals and turn side to side Q (every) 1 to 2 hours to promote healing...Fecal incontinence - toilet Q 1 to 2 hours. Urinary incontinence - Continue with condom cath as ordered..." R2's Care Plan does not address the recommendations from (special wound consult). (Special wound consult) report of 1-18-12 documents the coccyx is still unstageable 5cm x 2 cm and the right buttock now a stage 3 measuring 1.1 cm x 1cm x .03 cm depth.

R2's current Care Plan dated 11-8-11 documents R2 was admitted to the facility with a pressure

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ulcer to the coccyx. There is an undated hand written note documenting a stage 2 pressure sore to the left and right buttock. Care Plan approaches include in part: toilet every 2 hours and prn; reposition when in wheelchair and turn and position when in bed frequently and prn; Rounds ever 2 hours and prn.

On 2-14-12 at 2:30PM, R2 stated he was concerned that staff were not repositioning him timely and he has pressure sores.

On 2-15-12, R2 was observed from 9:30AM to 11:00AM to be up in a motorized wheel chair. During meeting on 2-17-12 at 10:45AM, E16, Director of Nurses (DON) in training, stated R2 had been up in his wheel chair since 7:30AM. At 11:55AM, R2 was in bed partially on his back and right side with his knees towards the door and a pillow between his knees. R2 remained in the same position until 3:20PM. At 3:05AM, R2 stated he had not been repositioned since he was put into bed that morning and he needed to be repositioned. R2 turned on his call light and asked to be repositioned. At 3:20PM, E13 and E14, Certified Nurse Aides (CNA) and E14, LPN, came into the room and and repositioned R2 for a skin check. R2 had a large bandage on his buttocks covering the coccyx that was saturated with yellow substance. E14 removed the dressing and R2 had blood tinged packing in the pressure sore to the coccyx. E14 removed the packing which revealed an open pressure sore the size of a golf ball and down to the bone. R2 also had DuoDerm on his left buttock and a dressing on his right buttock.

On 2-16-12 at 10:55AM, E19, CNA, stated she

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had no problems with R2, he is cooperative. He tells her what he needs, and is very pleasant. He does not refuse to reposition. At 10:58AM, E20, LPN, stated R2 sometimes gets a little smart, probably due to frustration. He's cooperative. No problem. He knows what's going on. At 11:10AM, E4, CNA, stated she hasn't had problems with R2. He is cooperative if you do things his way. He's cooperative with treatments and positioning.

Outside Consultant Physician progress note of 2-13-12, documents an order for Juven powder 1 pack TID (three times a day) with meals. Observation on noon meal on 2-14-12, 2-16-12 and breakfast on 2-17-12 showed R2 did not have Juven on his tray. Juven was also not on the Medication Administrator Record. E1 confirmed on 2-17-12 at 2:00PM, R2 was not getting the Juven. E1 stated the facility had missed the order.

During a meeting with E1, E2 and E16 on 2-17-12 at 11:00AM, they provided a written statement saying R2 refused to allow staff to provide care to treat and prevent complications of his sacrum pressure ulcer. R2 will not allow CNA's to turn him in a timely manner. Refuses repositioning or to be laid down after extensive amounts of time have elapsed since placed in his wheelchair. Refuses treatments. Has his family treat his wound inappropriately while in facility. Refuses to be laid down to rest and stays up in chair to socialize with other residents. After several attempts to educate and re-educate, resident continues to refuse care that places him at risk to develop pressure ulcers or worsen existing ones. "This resident is alert and oriented x 3 and is his

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own responsible person. He has a right to refuse and alter his care as long as he is educated on the risks associated with those care decisions. Facility has secured statements from several CNA's and Licensed Nurses as to witnessing this refusal of care. Resident has contributed to the worsening of his ulcer by exercising his rights in refusing and altering care prescribed by his physician. It has been care planned. The facility does re-approach and continue to deliver care when resident allows." E1 stated that when R2 first came to the facility he would request to be turned and repositioned hourly.
E1 stated that R2 is now noncompliant and even had his family change his dressing to DuoDerm while in the facility. There is nothing in the Nurses Notes that documents R2 having a DuoDerm dressing put on by his family. E1 stated R2 also goes on overnight home visits and they cannot control what he does or what kind of dressing treatment he gets there. On 2-17-12 the facility provided a hand written note documenting R2's last home visit was on 12-27-11. On 2-23-12 at 1:00PM, E1 confirmed that was the date of R2's last home visit.

Record review of Nurses Notes from 10-19-11 through 2-16-12 show Nurses documented 1 time in 4 months that R2 refused to lay in bed. On 12-23-11 at 2:30PM, Nurses Note documents, "Asked several times to lay in bed D/T (due to) areas on coccyx Refuses at this time & aware of consequences no distress noted." There is nothing in R2's Care Plan addressing his refusal for treatment to his pressure sore and repositioning.

On 2-21-12, the facility provided an undated list of

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Residents assessed for pressure sores and documented that R2's pressure sore on his coccyx is a Stage 4.

On 2-23-12 at 1:00PM, E1 stated she had a telephone meeting with Z2 and Z2 stated he would like the nurses to make sure that we follow up on the appointments recommended by the hospital when the residents go to ER or are re-admitted. He also stated he wanted the nurses to whenever there is a follow up appointment they should tell the clinic or office if the appointment was recommended by the ER so they will be more likely make the appointment within the specific time frame.

R2's Minimum Data Set (MDS) of 1-30-12 documents R2 has a diagnosis, in part, Paraplegia. R2 has no cognitive impairment and no behaviors. R2's MDS documents R2 requires extensive assistance of 2 or more staff for bed mobility, transfer and toileting; extensive assistance of 1 for hygiene; is frequently incontinent of bowel; and has a urinary condom catheter.

R2's BRADEN SCALE - For Predicting Pressure Sore Risk dated 10-19-11 and 1-27-12 documents a score of 14 which is moderate risk.

R2's Care Plan dated 11-8-11 documents R2 was admitted to the facility with a pressure ulcer to the coccyx and an unstageable pressure ulcer to the right great toe. There is an undated hand written note documenting a stage 2 pressure sore to the left and right buttock. Care Plan approaches include: Toilet every 2 hours and prn (as needed); Pressure relieving mattress to bed; Pressure

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reducing cushion in wheelchair; Reposition when in wheelchair and turn and position when in bed frequently and prn; Rounds ever 2 hours and prn; and weekly skin checks.

R2's ADMISSION NURSING ASSESSMENT of 10-19-11 documents a stage 2 pressure sore on the coccyx and right great toe, dark eschar, .5 cm. There is no documentation as to the size, drainage or odor to the stage 2 on the coccyx.

Nurses Notes of 10-19-11 document, "Noted open area to coccyx DuoDerm applied. Has small area R (right) Buttocks Barrier Cream applied, Has area to R (right) Grt (great) toe lateral Dark in Color." There is no assessment/measurements of the above areas.

On 2-16-12 at 3:00PM, E2, DON, stated R2's pressure sore assessments should be on the Treatment Administration Record (TAR). E2 was informed there were no assessment/measurements on the TAR for October, November, and December 2011 and nothing in the Nurses Notes. At 3:30PM, E2 provided Weekly Wound Assessment Reports and stated that was all she could find.

The first report documenting R2's pressure sores is dated 10-26-11 and documents a stage 2 pressure sore on the coccyx measuring 4 x 0.3 cm with scant amount of serosanguinous drainage with pink wound bed and an unstageable on R (right) 1st toe measuring 1 x .09 cm with eschar. The Report of 12-14-11 documents a stage 3 pressure sore to the coccyx measuring 6.5 x 2.5 x 1.3 cm and a stage 2 to right buttock measuring 5.6 x 3.0 x 0.2 cm. The

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report documents R2 was admitted to the facility with the pressure sore on the right buttock yet this is the first assessment of the pressure sore. There is no documentation on the report if there was drainage or odor to the pressure sores. The Report of 12-28-11 documents the pressure ulcer on the coccyx increased in size measuring 6.5 x 2.5 x 1.4 cm. The Report of 1-4-12 documents a new stage 2 on the left buttock measuring 6.2 x 1.7 x 0.2 cm. and documents that R2 was admitted with the pressure sore. There is no assessment of drainage or odor. The report of 1-11-12 identifies the pressure sore on the coccyx to be unstageable and measuring 5.5 x 2.0 cm, pink marbled with yellow slough. The right buttock was assessed as unstageable measuring 1.5 x 2.0 cm with yellow slough. The report of 2-8-12 documents the coccyx pressure sore is Stage 3 with 4.8 x 1.8 necrosis. Pink tissue buds with gray and yellow necrosis, exudate moderate amount of yellow, odor improved with increased granulation and decreased necrosis. Right buttock healed and left buttock a stage 2 measuring 3 x 2 x 0.3 cm with pink granulation tissue with diffuse yellow necrosis exudate moderate, sero - sanguinous with increased granulation.

R2's Emergency Department (ED) report of 2-7-12 documents that R2's pressure sore on his coccyx was down to the bone and was debrided by a Surgeon in the Emergency Room (ER). R2 had discharge orders for a wet to dry dressing twice a day and to make an appointment with the Wound Center to be seen that week. If facility had difficulty getting an appointment as ordered they were to call the ER immediately. A facility Resident Appointment form documents R2's

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appointment to the Wound Ostomy Center was made on 2-10-12. The appointment was made for 2-22-12 at 2:00PM. On 2-16-12, at 11:05AM, E15 stated R2 had not yet been to the Wound Ostomy Center and confirmed his appointment is for 2-22-12. There is nothing in R2's medical record that shows the facility called the ER department when they could not get an appointment until 2-22-12. E15 stated she was unaware of the orders of 2-7-12 for wet to dry dressing twice a day. E15 stated R2's pressure sore on his coccyx is currently a stage 3. Facility Wound Report of 2-8-11 also identifies R2's Pressure sore as a stage 3.

R2's February 2012 POS and Treatment Records shows the facility neglected to follow the Surgeon's orders and continued a previous order of 1-12-12 for Santyl and Aquacel dressing. On 2-16-12 at 2:05PM, E1, Administrator, stated a pressure sore to the bone would be staged as a stage 4. E1 was shown R2's POS and TAR and she confirmed the treatment had not been changed and stated, "Wet to dry dressings are not always the best treatment orders." E1 stated she would have to check with the Nurse who took the orders and confirmed there was nothing in R2's Medical Record that Z2 did not want to follow order from the ED.

On 2-17-12 at 10:00AM, Z2 stated he was called that morning for verification of treatment orders to R2's coccyx. They had also called him after Z2 went to the ER on 2-7-12 and Z2 told them then to follow the ER orders. Z2 stated they should follow the orders sent by the ED. Z2 stated a nurse from the facility had called him for verification orders for Santyl and Aquacel. Z2

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F9999	Continued From page 64 stated he did not realize this was not the treatment given by the ED department and stated he was going to call the facility back and tell them to follow the orders from the ED. (A) 300.1210b) 300.1210d)1)3) 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 care needs of the resident. 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. 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.	F9999		

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	145705	A. BUILDING _____ B. WING _____	02/24/2012

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F9999	Continued From page 65 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 REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on record review, interview and observation, the facility failed to provide timely pain monitoring, assessments and medication for pain management for 2 of 5 residents (R3, R6) reviewed for pain in the sample of 17. This failure resulted in R6 experiencing lower extremity pain during care. This failure resulted in R3 experiencing pain during wound care. Findings include: 1. R6's Minimum Data Set (MDS), dated 11-9-11, documented moderate cognitive impairment, total dependence on two plus persons physical assistant with mobility, transfer and locomotion, lower extremity functional limitation in range of motion and on a scheduled pain medication regimen with 1 to 2 days of possible pain observed. R6's Cognitive Loss/Dementia Care Plan, dated 5-12-11, documented R6 was confused with short and long term memory loss. The Care Plan documented R6 had expressive and receptive asphasia, was rarely understood and sometimes understood others. R6's Pain Management Care Plan, dated 5-12-11, documented R6 experienced	F9999		

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pain due to diagnoses of Arthritis, contractures of her knees and a pressure sore. It was also noted to monitor for adequate pain relief and to"give PRN (as needed) Vicodin for break through pain."

R6's Physician Order, dated 10-3-11, documented "Hydrocodone-APAP 5/500 mg 1 tablet by mouth every 12 hours." R6's Medication Record, dated 2-1-12 to 2-29-12, did not document R6 had a PRN order for "Vicodin." E2, Director of Nursing (DON), stated, on 2-17-12, that R6 did not have any PRN medication. E2 also stated there should be an assessment to determine the effectiveness of the R6's scheduled pain medication. E2 did not provide an assessment as to the effectiveness of R6's scheduled pain medication during the survey.

During observation of R6's incontinent care and positioning, on 2-15-12 at 12:00 noon, provided by E8, Restorative, and E9, Certified Nursing Assistant (CNA), R6 cried out and was tearful when E8 or E9 moved her lower extremities to provide perineal care.

E8 stated, on 2-15-12 at 12:00 noon, that R6 yelled when her legs were touched. E8 stated,on 2-16-12 at 11:00a.m., R6 cried out when her legs were touched.

R6's Pain Evaluation, in R6's current chart and dated 5-24-11, 8-15-11 and 11-9-11, documented, in part, that R6 "yells out and cries." R6's pain evaluations did not document a continued evaluation of non-verbal expressions of pain or R6's expression of pain when her legs were moved. It was also noted R6's pain evaluations, or chart, did not document assessments as to the

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effectiveness of her pain medications.

R6's Daily Pain Log for 12-1-11 to 12-14-11, documented "no pain." The facility provided an additional Daily Pain Log for December, 2011 dated 12-1-11 to 12-5-11 and 12-16-11 to 12-4 (12-24-11) and 1-1-12 to 1-3-12, documenting no pain. None of R6's Daily Pain Logs documented verbal and/or non-verbal signs and symptoms of pain. The facility did not provide additional Daily Pain Logs for February, 2012 during the survey.

The facility's Pain Procedure policy and procedure, not dated, documented, "Purpose: To assure that the resident is offered pain management and to ultimately control pain...3.) If the resident does have pain present, all medications will be reviewed with the Primary Care Physician/designee on admission. 4.) The resident's pain protocol will be monitored weekly for effectiveness. 5.) A resident's pain level will be assessed using a 0-10 verbalization scale. If the resident is unable to verbalized pain due to another predisposing factor, the assessing licensed nurse will utilize the Wong-Bake Facial Grimace Scale wit the corresponding numbers. 6.) All residents will have a pain assessment completed quarterly and/or PRN (as needed) to monitor for changes in status...9.) Residents with chronic/acute pain and/or residents on a pain protocol will have a plan of care documented."

2. On 02/15/12 at 11:00 AM, E17, Licensed Practical Nurse (LPN) was observed providing R3's wound care to R3's right heel ulcer. E17 removed the right heel boot, the sock and cut off and removed the soiled dressing. R3 had facial grimacing and pulled back his right leg, and said

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F9999	Continued From page 68 "ouch." E17 then asked if that hurt, and R3 replied "yes, when you touch it." No offer of pain medications at this time. R3 reported that his right knee had been hurting for a couple of weeks and the right heel would have a throbbing pain throughout the day. At 11:25 AM, E17 returned to the room and began to cleanse the wound. R3 displayed several episodes of facial grimacing and would pull back his right leg, complaining of pain. E17 completed the treatment and did not ask R3 if he wanted anything for pain until after the dressing change was completed, which was at 11:40 AM. R3 reported that E17 came to give pain medications a 1:15 PM. The medication administration record for 02/15/12 documents that R3 received one Tylenol 500 mg tablet at the 1:00 PM hour. R3 still reported having pain in his right knee and right heel. There is no documentation in the nurses notes regarding pain or R3 having pain during wound treatments. The care plan, dated 01/04/12, does not identify pain as a problem. According to R3's current POS does not get pain medications on a scheduled basis. (B) 300.1210b) 300.1210d)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 69 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. 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. THIS REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on observation, record review and interview, the facility failed to timely assess, care plan and obtain a urine specimen for culture and sensitivity resulting in delay of treatment for 1 of 2 residents (R2) reviewed for urinary tract infection (UTI) in the sample of 17. This failure resulted in a delay in treating R2's UTI.	F9999		

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Findings include:

R2's Physician Order Sheet (POS) for February 2012 documents R2 has a history of acute urinary retention and has a urinary condom catheter.

R2's Minimum Data Set (MDS) dated 1-30-12 documents R2 has no cognitive impairment; requires extensive of assistance of 2 for toilet use and is frequently incontinent of bowel.

R2 was observed on 2-15-12 at 3:20PM to have a urinary condom catheter.

Nurses Notes of 10-27-11 at 10:11PM document, "Resident (condom) catheter continues to leak with foul smelling white stuff Continues to charge he complains of pain prn (as needed) med is given with some relief.." This is the first Nurses Note documenting foul smelling urine. Note of 10-28-11 at 12:36PM documents condom catheter is draining dark amber color urine with foul odor. "MD (Medical Doctor) call awaiting return call for UA (Urinalysis) order." Nurses Notes of 11-1-11 at 1:45PM documents, "Res (resident) condom cath intact with amber color urine foul smell noted...Tylenol given per Temp 99.6. Will continue to monitor vs (vital signs) 102-20-104/70." Note at 5:15PM documents ambulance arrived to transport R2 to the hospital for treatment and evaluation. R2 alert and oriented x 3. Nurses Note of 11-2-11 at 12:30AM documents R2 returned to the facility with diagnosis of pain and UTI. POS shows an order of 11-2-11 for Oxycodone/Acetaminophen 5/325 mg and Ciprofloxacin 500 mg 1 tab twice a day for 7 days

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F9999	Continued From page 71 Nurses Note of 12-21-11 at 7:15AM documents R2 is in his room yelling, stating he needs to go to the hospital. MD was called and order given to send R2 to the ER (emergency room). Note at 7:30AM states R2 complained to the night Nurse that he needed a suppository and that he was having abdominal pain. The abdomen was soft to touch and not tender with hyperactive bowel sounds. There are no Nurses Notes written by the night Nurse concerning R2's complaints. The previous Nurse Note prior to the note of 12-21-11 was dated 12-14-11 at 11:25PM. Nurses Note of 12-2-11 at 5:00PM documents R2 returned from the ER with new order for Levaquin 500mg x 5 days and Pericolace at bedtime daily. Nurses Note of 12-22-11 at 3:00AM, documents R2 is on the antibiotic for a UTI. Record review of R2's most current Care Plan of 11-2-11 shows there is no mention of R2 having a history of UTI. On 2-22-12 at 3:00PM, E1, Administrator, confirmed there is nothing on R2's Care Plan addressing his history of UTI. (B)	F9999		