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F 516	Continued From page 36 stored within under water sprinkler system in the basement. E2, Acting Director of Nursing, stated, on 3-7-12 at 9:20a.m., that observed medical records were stored unprotected from the facility water sprinkler system. E2 also stated that the records would be covered. 2. CMS 672, Resident Census and Condition of Residents dated 3/8/12 documented 44 residents in the facility.	F 516		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b) 300.1210d)2) 300.1210d)5) 300.3240 a) 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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F9999	Continued From page 37 300.1210 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician.	F9999		

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F9999	Continued From page 38 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. 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 observation, record review and interview, the facility failed to identify pressure sores; failed to accurately assess pressure sores; failed to turn and reposition residents; failed to monitor; and failed to provide interventions developed for pressure sores for 6 of 6 residents (R1, R2, R5, R6, R10 and R11) reviewed for pressure sores in the sample of 11. This failure resulted in R2 developing an avoidable unstageable pressure sore on his left heel; R5 developed multiple avoidable stage 2 and stage 3 pressure sores on his coccyx; R6 developed avoidable pressure sores on his heels; R10 developed multiple avoidable stage 2 pressure sores that facility was unaware; and R11 developed multiple avoidable pressure sores from a leg brace and pressure sore on the coccyx	F9999		

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that weren't identified until after she died.

Findings include:

1. R5's assessment of 2-6-12 documents R5 has no cognitive impairment; is totally dependent on 3 or more staff for transfer; requires extensive assistance with hygiene and toilet use; and is occasionally incontinent of bowel and bladder.

R5's Care Plan of 11-23-11 documents R5 is at risk for Pressure Ulcer per Braden Risk Assessment with interventions, in part; turn and position every 2 hours; maintain clean, dry, wrinkle free linens; monitor site for infection - redness, swelling, drainage, foul smell, decline in function, reduced mobility; toilet, change brief when wet and upon rising at bedtime and after meals; to lay down after meals per MD's order.

R5 was observed on 2-29-12 up in his wheelchair from 12:20PM to 2:05PM. At 1:00PM, R5 stated he had been up in his wheelchair all morning and stated he wears an incontinent brief. R5 stated he wanted to lay down. At 2:05PM, E6 and E7, Certified Nurse Aides (CNA's) stated they got R5 up at 7:30AM and that R5 had not been out of his wheelchair since then. E3, Registered Nurse (RN)/Acting Director of Nursing from a sister facility, came into the room. The CNA's transferred R5 to an air flow bed with 2 bed pads under him and removed his incontinent brief that was saturated with urine and the folded pad on the seat of his wheelchair was wrinkled and bunched up in areas. The back of R5's thighs and buttocks were deep creased and red. R5 had a bunched up 4 x 4 dressing on his coccyx that was 4 x 4 inches dated 1-29-12. R5 stated he was tired and his eye lids were heavy. The CNA's were observed to do incontinent care and

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by the time they were done, R5's dressing was loose and only adhering to his right buttock and partially to the left buttock. On 3-1-12 at 12:13PM, E3 was asked if anyone changed R5's dressing yesterday afternoon after he was transferred to bed. E3 stated treatments are done only one time a day. E3 stated she did not know if anyone changed the dressing, "probably not."

R5 was observed on 3-1-12 every 15 to 20 minutes up in his wheelchair from 10:30AM to 2:35PM. At 1:45PM, R5 stated that he wanted to go to bed. At 1:50PM, E21, RN/Assistant Director of Nursing from a sister facility was informed R5 wanted to go to bed. E21 stated E7, CNA, told her that when they got R5 up that morning, his pressure sore did not look good. At 2:05PM, E11, CNA, stated she was suppose to give R5 a shower the other day, but his pressure sore on his bottom did not look good and she was afraid it might become infected so she gave him a bed bath. At 2:15PM R5 was informed that staff would be in to lay him down and R5 stated, "Good." At 2:25PM, R5 was still up, had a visitor in his room and stated he wanted them to lay him down. E10, Licensed Practical Nurse (LPN) was informed that R5 wanted to lay down and that Surveyor wanted to see his pressure sore on his coccyx. At 2:35PM R5 was transferred to bed by E17 and E18, CNA's. R5's incontinent brief was saturated with urine and urine was at the crotch. R5's buttocks were deep creased and red along with the back of his thighs. R5 stated his bottom hurt. "They said it was healed but it's getting bad. It hurts." At 2:55PM, E21 removed the bandage on R5's coccyx/sacrum area. There was a large pressure sore irregular in shape the size of a quarter with slough along the right edge and

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multiple open pressure sores surrounding the larger pressure sore. There was macerated tissue surrounding the multiple pressure sores.

R5's Treatment Administration Record for February 2012 shows documentation on 2-24-12, "Coccyx cleansed and Island Drsg (dressing) applied til Multiplex come in. Doesn't appear to be opened skin red & irritated with old scar tissue 5.3 cm x 2.5 cm x 0.1 area" facility identifies depth but documents it is not open.

On 3/1/12:45PM and 3:40PM, E1 was asked for the assessment of R5's pressure sore on his coccyx. E1 stated E3 was working on it. On 3-2-11 at 9:45AM, E1 again was asked for the assessment on R5's coccyx. At 10:00AM, E3 provided a Shower Abnormal Skin Report dated 3-1-12 and signed by E3 documenting "Coccyx 5 x 1.5" At 10:07AM, E3 and another Surveyor looked at R5's pressure sore on his coccyx. There was a larger pressure sore on R5's coccyx with slough on the outer right edge and multiple open pressure sores surrounding the larger pressure sore with two having slough and one long thin scabbed area to the lower right. Surrounding skin of the coccyx area and the one to the immediate right was macerated. E3 stated the facility had the coccyx staged as a stage 3, but she would stage the area at the coccyx to be a stage 4. R5 stated the pressure sore hurt and it was from sitting on it to long. At 11:00AM, E3 stated she did not previously assess R5's pressure sore on his coccyx and the first time she saw it was today with the Surveyor. E3 stated the pressure sore was assessed by E25, Administrator from a sister facility on 3-1-12. E3 confirmed there was no staging of the pressure sore and that E25 failed to assess individual pressure sores and measured the whole area as

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one pressure sore. E3 stated she had signed the shower sheet because she filled it out. E3 stated E25 has told her the pressure sore measured 5 x 1.5 cm. E3 stated, "There is a system problem at this facility. No system in place for assessing pressure sores." E3 confirmed there is no assessment on R5's coccyx and stated she would do an assessment and measure today.

On 3-2-12 at 11:48PM, E3 provided a Weekly Wound Tracking form dated 3-2-12 documenting R5's pressure sores on the coccyx. The center of the coccyx was assessed as a stage 3 pressure sore measuring 4 x 3 x .2 cm minimal drainage and no odor. A pressure sore on the left of the coccyx was assessed as a stage 2 measuring .6 cm x .6 cm x .1 cm with minimal drainage and area for odor was left blank. A pressure sore to the right of the coccyx was assessed as a stage 3 measuring .5 x 3 x.2 cm with minimal drainage and the area for odor was left blank. Date of onset of the pressure sores was documented as 3-2-12.

The facility Policy and Procedure for Preventative Skin Care dated 10/06, documents: "Policy: To provide preventative skin care through repositioning and careful washing, rinsing, drying, and observation of the resident's skin condition to keep them clean, comfortable, well groomed, and free from pressure ulcers." Procedures, in part; "Any resident identified as being at high risk for potential skin breakdown shall be turned and repositioned at a minimum of every two (2) hours; Maintain wrinkle free, clean, dry bed linen; Keep incontinent residents clean and dry..."

2. R2's MDS, dated 1-17-11, documented R2 was extensive assistance of one person physical

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assistance with mobility and transfer and upper and lower extremity functional limitations in range of motion.

R2's Care Plan, start dated 11-2-11, documented R2 was at risk for skin breakdown related to decreased mobility. It was also noted the Nurse was to do skin check two times per week. R2's Care Plan, dated 12-12-11, documented "Area to (L) (left) heel (unstageable) eschar off 1-19-12 Stage II." It was also noted "12-14-11 refer to (wound management clinic)."

R2's Treatment Records and Weekly Skin Summaries, dated 10-11, 11-11 and 12-11, did not consistently document R2's skin was checked two times per week. R2's skin was documented as being checked on 10-3-11, 10-6-11 and 11-16-11 without skin breakdown. R2's skin check, dated 12-12-11, documented "weekly skin assessment re heels 4.3 x 5.5 x utd deep tissue injury/pressure area to left heel. Scrotum and groin excoriated. All (?) skin intact."

R2's Treatment Record, Weekly Skin Summaries and chart did not document his left heel pressure area was identified at lesser stage or alternative interventions were put in place to prevent his left heel from developing a pressure sore with deep tissue injury.

3. R11's MDS, dated 10-13-11, documented R11 was a cognitively impaired resident with upper and lower extremity functional limitation in range of motion and at risk for pressure sore development. R11's Care Plan, start dated 10-20-11, documented R11 was a potential for skin breakdown. It was also noted to assess skin and to do a skin check times twice per week.

R11's Treatment Records and Weekly Skin Summaries, dated 11-11, 12-11, 1-12 and 2-12,

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did not document R11's skin was consistently checked two times a day. It was also documented R11's skin was checked on 12-10-11, 12-12-11, 11-26-11, 2-2-12, 2-9-12 and 2-11-12. R11's Treatment Records and Weekly Skin Summaries did not document lower extremity skin breakdown

R11's Illinois Health Care Facility Report on Resident Death, dated 2-12-12, documented R11 had "(I) Pressure sores/Decub coccyx .5cm x 1.5 Stage II" and "Other conditions "(2) large st (skin tear) to left of coccyx 3.5 x 3cm, (3) (L) (left) inner knee 3 cm x 3 cm (4) small darken area (L) outer need/top length 1.2 x 2.5 not open." It was also documented on a pictorial of R11 that(1) was on her coccyx and (2), (3) and (4) were on her lower left extremity. R11's Treatment Sheet, dated 1-12, documented R11 wore a "(special) Boot" to her left foot at all times.

Z4 (R11's Power of Attorney) stated, on 3-1-12 at 8:45a.m., that the facility was not aware of R11's knee and leg area until Z4 instructed unidentified staff to check R11's left lower extremity. Z4 also stated R11 wore a left lower extremity brace, or boot, and that the brace was pressing against R11's skin.

4. The physician's order, dated 02/01/12, documents R10 has the following diagnoses, in part, of Traumatic Brain Injury resulting in Spastic Hemiplegia, Expressive Aphasia, Seizure Disorder and Quadriplegia. The MDS, dated 01/06/12, documents R10 as severely cognitively impaired and is total care requiring assist of at least two staff persons for locomotion, toilet use, hygiene and bathing; and requires extensive assist of at least 2 staff persons for all transfers with a mechanical lift, bed mobility, dressing and eating. The MDS also documents R10 has

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bilateral upper and lower extremity limitations and is always incontinent of bowel and has a urinary catheter. The care plan, dated last review 12/28/11, documents R10 is at risk for pressure ulcers related to decreased mobility, bilateral upper extremity contractures, PVD (Peripheral Vascular Disease) and Quadriplegia. The approach/interventions listed, in part, skin check with routine care by CNA - inform nurse of abnormal findings; nurse to do skin check two times per week, and turn and position every two hours and prn (as needed).

On 02/28/12 at 10:15 AM, R10 was observed sitting up in his high back wheelchair in his room. At 11:00 AM, R10 was still sitting in his high back wheelchair in his room. At 11:50 AM, R10 was observed in his high back wheelchair in the dining room. At 12:50 PM, R10 was back in his room in the high back wheelchair. At 1:35 PM, R10 was observed in his high back wheelchair in his room. At 2:20 PM, R10 was still in his room in the high back wheelchair. At 3:10 and 3:45 PM, R10 remained in his room in the high back wheelchair.

On 02/29/12, at 9:05 AM, R10 was observed to be at the nurses station in his high back wheelchair. At 9:15 AM, he was propelled to his room and left in the high back wheelchair. At this time, this surveyor asked E12 (CNA) to observe R10 transfer to bed and to do a skin check. At 10:55 AM, R10 was observed to already be in bed, transferred by E12 and E13 (CNA's). E14 (RN) and E23 (LPN) were observed coming out of the room. Upon entering R10's room, R10 was lying in bed with pants down at his ankles and side rails up. An area to the left hip was noted and appeared to be approximately pea sized with serosanguineous drainage with reddened edges, thick white cream was noted in and around the

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wound. E13 stated that the white cream was barrier cream that the CNA's had been putting on after showers. E13 also stated that the wound was noted to be opened today. Another open area was noted on the coccyx. This open area is in a linear shape directly between the folds of the buttocks approximately 3 cm in length. The wound had small amount of serosanguineous drainage with reddened edges. White cream was also noted around the wound. Multiple scabbed areas noted to bilateral lower legs.

On 03/01/12 1:20 PM, R6 was observed to be in his high back wheelchair in his room. At 2:30 PM, R6 was propelled to the activity area in his high back wheelchair. At 3:45 PM, R6 was observed in his high back wheelchair in his room.

On 03/01/12, a late entry nurses note from 02/29/12 at 4:40 PM, documents the physician called back with orders for wound treatments for R10. It also documents R10 had multiple skin concerns as follows; right medial shin scabbed area 2.2 x 1.1 cm, right superior shin scabbed area 2.4 x 1.1 cm and right upper shin scabbed area 0.5 x 0.5 cm. Also, on the left upper thigh/hip area measuring 0.6 x 2.4 cm open, and on the coccyx 1.0 x 0.5 cm open.

On 12/05/11, Laboratory Reports document R10 had Albumin of 3.8 (3.2-5.5 g/dl range) and Total Protein of 6.9 (5.5-8.3 g/dl range).
Treatment records for the months of December 2011, January and February 2012 indicate "skin check two times per week on shower days." There is nothing checked as being performed for the month of December or February and only January 24, 27 and 31 is checked as performed.

On 03/01/12 at 1:25 PM, Z3 stated "This is the first time in 31 years that he has had any pressure sores." When asked if she knew how

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R10 developed these pressure sores, she stated "obviously they leave him in his chair too long." She also stated that she has been complaining for months that his wheelchair needed some sort of footboards or a way to elevate his feet to help prevent him from sliding down too far in his chair.

5. The physician's order sheet, dated 02/01/12, documents R6 has the following diagnoses, in part, as CVA (Cerebral Vascular Accident), Diabetes Mellitus, Malnutrition, UTI (Urinary Tract Infection) and PVD (Peripheral Vascular Disease). The MDS, dated 01/16/12, documents R6 is severely cognitively impaired and requires extensive assist of at least two staff persons with all transfers, bed mobility, dressing and bathing. It also documents R6 is a total assist with at least two staff persons for toilet use and is frequently incontinent of bowel and bladder. It documents R6 to have both upper and lower extremity limitations and does not currently ambulate. The care plan, last updated 01/26/12, documents R6 is at risk for pressure ulcers and the approach/intervention listed, in part, as reposition every two hours and prn.

On 02/28/12 at 10:15 AM, R6 was observed to be sitting in a wheelchair in his room. At 12:12 PM, R6 was still sitting in his room in his wheelchair. At 12:25 PM, R6 propelled himself to the dining room for lunch. At 12:50 PM, R6 was observed to propel himself to the nurses station then outside to smoke. At 1:45 PM, R6 was observed in his wheelchair outside smoking. At 2:30 PM, R6 was observed in his room sitting in the wheelchair. At 3:15 PM, R6 was sitting in his wheelchair next to door to the outside smoking area.

On 02/29/12 at 9:05 AM, R6 was observed

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sitting in his wheelchair next to door to the outside smoking area. At 11:05 AM, R6 was observed in his room sitting in his wheelchair. At 11:30 AM, R6 was observed propelling himself down the hallway to the nurses station. At 1:30 PM, R6 was observed being propelled via wheelchair to his room. At 1:45 PM, R6 was observed propelling himself to the nurses station then outside to smoke. At 2:10 PM, R6 was observed propelling himself to the nurses station then back outside to smoke.

On 03/01/12 at 9:10 AM, R6 was observed to be sitting up in his wheelchair in his room. At 11:15 AM, R6 was observed to be out at the nurses station in his wheelchair.

R6 was not observed out of his wheelchair throughout the survey from 02/28/12 to 03/01/12.

A physician's note, dated 07/23/08, documents that R6 had a stage III decubitus ulcer on the left foot. R6 was admitted to the facility on 11/01/08. The physician's order, dated 11/01/08, documents wound treatments for left anterior foot only. A wound consultation report dated 09/24/09, documents that R6 had left and right heel ulcers. The wound tracking report for February 2012 documents R6's stage III left heel ulcer measured 0.7 x 0.8 x 0.3 cm and the right heel ulcer measured 2.0 x 4.4 x 0.3 cm and is determined to be unstageable. The wound consultation report for March 1, 2012 documents R6's left heel ulcer measured 0.7 x 1.7 x 0.3 cm and the right heel ulcer measured 1.7 x 4.5 x 0.3 cm, showing a decline in the wound status for both heels.

6. The MDS, dated 1/27/12, identifies R1 to have short/long term memory deficits with severe cognitive impairment and is totally dependent on staff for all activities of daily living including

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F9999	Continued From page 49 mobility and transfers. According to the care plan dated 2/9/12, R1 has a potential for altered skin integrity due to decreased mobility and incontinence. The interventions included turning/reposition every 2 hours and as needed (PRN), pericare after each inc (incontinent) episodes, pressure relief mattress, and skin check daily among others. The care plan indicates that R1 has no pressure ulcers at this time. On 2/28/12 at 12pm, R1 was in her wheelchair in the dining room preparing for lunch. R1 was observed to eat lunch in her wheelchair and then be moved to the television room where she remained in her wheelchair. At 3:45pm, the observation ended with R1 still in her wheelchair. R1 was observed at 15 minute intervals with no turning/repositioning or toileting being done as indicated in the care plan. R1 had no pressure relieving cushion in her wheelchair. On 2/29/12 at 12noon, R1 was again in the wheelchair in the dining room. At 1:43pm, R1 was transferred to the toilet and a urine soaked incontinent brief was removed. She had no pressure relieving cushion in her wheelchair. Her buttocks and gluteal folds were very red with deep creases throughout. E12 and E13, CNA's provided incomplete incontinent care and transferred her back into the wheelchair where she remained until the observation ended at 3:45pm. (A) 300.1210a) 300.1210d)6)	F9999		

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F9999	Continued From page 50 300.3240a) 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the 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. 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: 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. 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	F9999		

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resident.

THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:

Based on record review, observation and interview the facility failed to implement fall interventions for 2 of 6 residents (R1, R2) reviewed for falls in the sample of 11 and 1 resident (R38) in the supplemental sample. This failure resulted in R1 incurring a fractured right femoral head after unsupervised ambulation.

Findings include:

1. The assessment dated 1/27/12 identifies R1 to have short/long term memory deficits with severe cognitive impairment and is totally dependent on staff for all activities of daily living. According to the Care Plan dated 8/11/11, R1 was at risk for falls due to balance issues. The goal was to have no falls by 11/9/11. The interventions included assist with all transfers using a gait belt, use wheelchair for mobility, self release alarmed seat belt on when up, bed sensor when in bed, low bed and mat on floor. The fall risk assessment record documents repeated falls for R1 on 7/31/11, 8/2/11, 8/6/11 and again on 9/12/11.

According to an Incident Report dated 9/12/11, R1 attempted to stand up unassisted on 9/12/11 at approximately 7:15pm and was "redirected by staff with self releasing lap belt in place and working." The report indicates that approximately 10 minutes later, R1 took her belt off and attempted to stand again. The report documents "while staff was running to assist her, patient fell onto floor. Assessment revealed severe guarding of left hip and leg as well as 1.5cm x 2.5cm x

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0.2cm laceration to left temple." R1 was sent to the emergency room where she was diagnosed to have a fracture of the right femoral head. Surgery was not done and she returned to the facility. In addition, a CT Scan done 9/12/11 also revealed a small hemorrhage, left frontal lobe region.

The careplan has only one intervention dated 10/5/11 added following her fall/fracture/hemorrhage and that indicated staff was to "have her hold baby doll + care for it when she is agitated or attempts to stand." There is no further interventions added or deleted until 1/25/12 when an intervention "may use clip/tab alarm and/or lap alarm if indicated" was added.

On 1/27/12 at 2:20pm, a reporting form identified another fall for R1. The reports documents that R1 was "sleeping" at the time of the fall and was found sitting on the floor with her legs extended. A personal alarm was in place and sounding staff was unable to reach her before she hit the floor. The causative factor indicates R1 "slipped out of chair" but fails to identify any preventative measures to implement to prevent future falls. There are no new interventions added to prevent further falls.

On 2/28/12 at 10:00am, R1 was sitting in her wheelchair in a dark lounge by herself. Her back was to the door and she was slumped over to the right sleeping in her wheelchair. The television was on. At 1:30pm, she was back in the television room by herself . She remained there until 2:38pm when she was noted to be sleeping in her wheelchair in front of the piano. No staff was in the room. She had an alarm clipped to her shirt and another alarm attached to the back of her wheelchair.

On 2/29/11 at 1:43pm, R1 was transferred to

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the toilet by E12 and E13, Certified Nurses Aides. E12 identified that R1 had an alarm box on her wheelchair for the self release belt but that the alarm did not work and that was why she had a clip alarm on. E12 and E13 both stated R1 can self release the belt.

On 3/1/12 at 3:30pm, incident/fall reports were requested on R1's falls dated 7/31/11, 8/2/11, and 8/6/11 from E1, Acting Administrator. On 3/2/11 at 11:35am, E1 confirmed that she was unable to find any reports on falls for R1 on those dates.

According to the nurses notes dated 12/3/11, 12/29/11, 12/31/11 and 2/11/12, R1 sustained repeated skin tears on her upper arms and lower extremeties. The physician's order sheets show orders for treatments on 12/19/11 for a skin tear right lower extremities measuring 3cm. On 12/31/11, a skin tear to the right forearm was identified in addition to the right outer calf area of the leg. On 2/11/12, an order was documented for a skin tear on the left lower extremity. The facility has no reports on these injuries to determine causative factors according to E1 Acting Administrator on 3/2/12 at 10am. Review of R1's care plan dated 8/11/11 identifies pressure ulcer potential and includes the skin tears on 12/19/11 and 12/31/11 but fails to include any intervention to prevent future skin tears from occurring.

On 2/28/12 at 3:27pm, R1 was noted to have a dressing on her left lower leg that was pulled up/rolled up exposing a scabby area with some bright red blood present. R1 was observed pulling and scratching at it.

On 2/29/11 at 1:45pm, R1's left lower leg was again noted to have a gauze dressing on it. Interview with E10, LPN on 2/29/11 at 2:15pm indicates that the dressing is for a skin tear to her

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left shin area which she thinks she got from bumping into the wheelchair pegs. R1 was sitting across the hall in her wheelchair. She had no pedals on her wheelchair and the pegs to attach the pedals had no padding on them.

On 3/1/12, the facility completed a "Shower/Abnormal Skin Report" on R1 and noted the area on her left lower leg to measure 2.5cm x 1.6cm x 0.1cm "pink (not) open (no) bleeding." There is no explanation as to how R1's leg wound can have a depth of 0.1cm when there is no break in the skin. There is no documentation that indicates the facility identified the causative factors of R1's multiple skin tears and developed/implemented a prevention plan.

2. The MDS dated 11/19/11 identifies R3 to require stand by assist/supervision for transfers. The Falls Risk assessment dated 1/6/12 indicates R3 is high risk for falls and has occasional confusion. According to the care plan of 11/30/11, R3 is at risk of falls due to seizure activity, balance, CVA (cerebral vascular accident) and arthritis. The care plan for falls prevention indicates R3 uses a sensor alarm in bed and chair when up although the care plan also indicates R1 is "currently independent" in transfers.

According to the care plan, R3 had a fall on 12/5/11 at 11:30am and staff was educated to the alarms and functioning. The fall report dated 12/5/11 indicates R3 was "transferring self s (without) assist. No alarm in place. Re-educated staff regarding bed + chair sensor alarm c (with) periodic checks" in the bathroom. A fall risk assessment done at that time identify R3 to have balance problems with walking, needs assist to stand and is confused. The investigation

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indicates R3 was attempting to self transfer without assistance and was found on the floor. Alarm was not on.

On 12/24/11 at 11:15am, R3 was again found on the floor when staff found her. The causative factor is identified as "transferring self without assistance" wheelchair to bed. The fall prevention techniques identified in place at the time of the fall was "call light in reach." The report indicates R3 "needs to ask for assistance by using call light." However, the report doesn't indicate whether or not the alarm was in place and in working condition/sounding at the time. In addition, the risk assessment done at the time of the fall fails to indicate what R3's safety awareness is and whether she is capable/willing to use the call light.

On 2/11/12, R3 was found on the floor again at 8:55am when she was attempting a self transfer with "unsteady gait. Pt (patient) is a 1 assist c transfer." The report identifies the w/c alarm and grip socks in place as prevention techniques at the time of the incident.

Review of the care plan dated 11/30/11 fails to reflect R3's non-compliance to call for assistance prior to attempting self transfer and whether or not she can appropriately use the call light given her confusion. In addition, there is no documentation that shows the facility identified 2 of the 3 falls occurred when R3 was taking herself to the toilet, one after breakfast and one just prior to lunch. The care plan for falls prevention fails to reflect her toileting needs in an effort to prevent her from self transferring.

On 2/28/12 at 10:21am during the initial tour of the building with E8, Business Office manager, R3's alarm sounded. R3 had her room door shut and when E8 entered the room, R3 was already

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F9999	Continued From page 56 on the toilet and her wheelchair was sitting in the doorway of the bathroom. E8 had to call for assistance to help transfer R3 back to her chair. R3's room door was noted to remained closed throughout the survey making visual checks on R3 from the hallway for monitoring impossible unless her door was opened. This also is not reflected in the care plan. 3. According to the MDS dated 11/16/11, R38 has short/long term memory deficits with severe cognitive impairment and requires extensive assist of one to total assistance of staff for all activities of daily living including mobility and transfers. R38 is currently receiving Hospice Services. The physician's order sheet indicates R38 currently has a skin tear that is being treated on her right lower leg. On 3/1/12 at 1:48pm, R38 was observed being transferred to her bed from the wheelchair by E12 and E22, CNA's. She had a gauze dressing on her right lower extremeties with multiple bruises on her left shin. Review of the care plan dated 11/11 fails to reflect R38's skin tears. A Hospital History and Physical dated 11/3/11 identifies R38 to have "multiple skin tears and ecchymosis to bilateral upper and bilateral lower extremities"" when admitted through the emergency room. The facility has no skin tears for R38 identified on their incident/accident log provided on 2/28/12. According to the Treatment sheets weekly summary, R38 has a history of repeated skin tears that the facility has failed to identify and implement a prevention plan. (B)	F9999		