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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Federal Oversight and Support Survey An extended survey was conducted.	F 000		
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and

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procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to provide complete written notice informing 5 of 5 Medicare residents of how to ask for an immediate appeal of their decision to discharge the residents from Medicare coverage (R12, R20, R21, R22, and R23). R12 is one of 14 sampled residents. R20, R21, R22 and R23 are on the supplemental sample. Staff failed to demonstrate knowledge regarding how the residents can request an immediate appeal.

Findings include:

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F 156	Continued From page 3 "Notice of Medicare Non-Coverage", Centers for Medicare and Medicaid Services (CMS) form 10123 were reviewed on 5-17-12 at 11:30 A.M. with the facility's Business Office Manager, E3. Copies of the six completed notices for R12, R20, R21, R22, and R23 were reviewed. R20 received two different notices on 2 different dates. The notice had a section on how to ask for an immediate appeal of the facility's decision to discharge the resident from Medicare covered services. The section states that a request of appeal can be made to the Quality Improvement Organization, (QIO) which is an independent reviewer authorized by Medicare. The notice states at the end of page one, "Call your QIO at: {insert QIO name and toll-free number of QIO} to appeal." The name and phone number of the QIO was not on any of the notices. At this time, E3 was asked who was the facility's QIO and why the name and phone number was not on the form. E3 stated she was not aware of the QIO and the QIO information had to be inserted on the "Notice of Medicare Non-Coverage" and she had failed to do so.	F 156		
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits	F 159		

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F 159	Continued From page 4 all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	F 159		

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F 159	Continued From page 5 failed to provide an ongoing balance for the resident funds quarterly statements for 44 of 55 residents managed by the facility. Findings include: R34's 3-31-12 Quarterly resident trust fund statement was reviewed on 5-17-12. The statement had a beginning and an ending balance. The statement did not have an ongoing balance after each transaction. The Business Office Manager, E3 stated on 5-17-12 at 11:25 A.M. that the current procedure does not provide for an ongoing balance on the statements. E3 stated that the facility manages funds for 44 of the facility's 55 residents. E3 acknowledged that the 44 residents had not received a quarterly statement with an ongoing balance since prior to 1-1-12.	F 159		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and	F 167		

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F 167	Continued From page 6 interview, the facility failed to ensure that the residents had access to the facility's most recent survey results without having to ask for it. This has the potential to impact all 55 residents. The finding is: During General Observation on 5-17-12 at 8:15 A.M., the most recent survey result documentation was not seen in the facility. A notice where the Certification survey results could not be found and was not posted. The survey results or a notice as to where the survey could be found were not available for residents' information. On 5-17-12 at 8:15 A.M., the Director of Nurses, E2 said "the survey results is in the front office and (one) would have to ask for it." The Center for Medicare and Medicaid Services, 672 form "Resident Census and Conditions of Residents", completed 5-16-12 reflects a census of 55 residents.	F 167		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to prevent the use of a	F 221		

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restraint for the purpose of convenience, use the least restrictive restraint, failed to have a restraint reduction program in place, failed to identify medical symptoms for the use of a restraint, and failed to assess for the use of a restraint for two of four residents (R12 and R18) reviewed for restraints in the sample of 14.

Findings include:

1. R12's Physician's Order Sheet (POS) dated May 2012 documents the following diagnoses: Muscle Weakness--Difficulty Walking, Obsessive Compulsive Disorder, and History of Falls.

R12's Minimum Data Set (MDS) dated 03/09/12 documents that R12's balance is unsteady at all times and that she requires human assistance to stabilize. The MDS dated 03/09/12 also documents that R12 requires limited assistance with bed mobility and transferring, has full use of her lower extremities, and full use of one upper extremity.

On 05/15/12 at 10:40am R12 was lying in her bed with bilateral bed bolsters and bilateral full side rails.

On 05/17/12 at 11:58am, the bilateral side rails were raised on R12's bed.

On 05/17/12 at 12:07pm, E16, Certified Nursing Assistant (CNA), confirmed that the rails on R12's bed were raised.

On 05/17/12 at 12:07pm, E16 stated that the bilateral full side rails were used to keep R12 in bed because she will try to get up and toilet

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herself and fall. E16 also stated on 05/17/12 at 12:07pm that bilateral full side rails are used in addition to bilateral bed bolsters because "(R12) will climb over the side rails." E16 also stated on 05/17/12 at 12:07pm that the bilateral full side rails were implemented after one of R12's falls.

On 05/23/12 at 1:00pm, E17, CNA, confirmed that she sometimes uses the bilateral full side rails to keep R12 in bed and prevent falls.

The Investigation Report for Falls documented that R12 fell 03/24/12, 03/25/12, 04/12/12, 04/20/12, and 04/23/12.

R12's Fall Risk Assessments dated 03/24/12, 03.25/12, 04/12/12, 04/20/12, and 04/23/12 documented that R12 was at high risk for falls.

R12's Side Rail Assessment dated 03/03/12 documented the recommendation that no side rails be used with R12's bed. The Side Rail Assessment dated 03/03/12 does not document any medical symptoms for the use of side rails.

R12's POS dated May 2012 did not include an order for bilateral full side rails for R12's bed or document any medical symptoms for the use of side rails.

R12's Care Plan dated 03/24/12 and updated 04/12/12, 04/20/12, and 04/23/12 does not document an intervention using bilateral full side rails due to R12's high fall risk or for any other use.

On 05/17/12 at 11:55am, E2, Director of Nursing (DON) stated that the side rails on R12's bed

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F 221	Continued From page 9 were zip-tied down to make them inoperable. On 05/23/12 at 12:30pm, E5, Maintenance Supervisor, confirmed that when he removed the bilateral full side rails from E12's bed after 05/17/12, the rails were not zip-tied down to make them inoperable. According to the Food and Drug Administration in a Safety Alert entitled "Potential Hazards with Restraint Devices," side rails can increase resident safety risk resulting in increased incidence of falls or head trauma due to falls (1992). The facility failed to identify and prevent bilateral full side rails being raised on R12's bed when she was in bed, even when contraindicated by the Side Rail Assessment dated 03/03/12, R12's Care Plan for Fall Risk interventions dated 03/24/12 and updated 04/12/12, 04/20/12, and 04/23/12, and the Investigation for Falls Report's new interventions to prevent falls dated 03/24/12, 03/25/12, 04/12/12, 04/20/12, and 04/23/12. The Facility's Physical Restraint Policy states that "Physical restraints shall not be used for the purpose of discipline or convenience (revised 07/12/10). 2. According to R18's May 2012 POS diagnoses include Stroke and Right body Cerebral Vascular Accident (CVA). Physician's Orders include Personal Safety Alarm in bed and wheelchair, bilateral full side rails for mobility, security and restraint purposes due to poor safety awareness and CVA per Healthcare Power of Attorney request.	F 221		

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R18's MDS dated 4-20-12 identifies R18's bed mobility, transfer and ambulation as limited assist/ one person physical assist. Range of motion was assessed as one side impairment for both upper and lower extremities.

The "Quality Care Reporting Form"dated 4-9-12 lists R18 had a fall on 4-9-12 at 3:15pm with identified bruises and pain to right upper arm and right hip. The review indicates "(R18) impulsive on walk to dine program fell did not inform anyone. (Wheelchair) alarm (added)."

R18's Fall Risk Assessment dated 4-17-12 identifies R18 as high risk for falls with one previous fall. The Physical Restraint/Enabler Consent dated 4-13-12 for R18 identifies the alternatives tried "Family refuses 1/2 side rails." The type of restraint is marked as " Full side rails bilaterally." No medical reason is given for the use of the restraint.

The Side Rail Assessment dated 4-17-12 for R18 shows R18 has "unsteady gait", "unable to ambulate without assistance". "Difficulty moving to a sitting position on the side of the bed, Currently using side rails for positioning or support, serves to remind resident to seek help- unaware of physical limits. Serves as Enabler to promote independence in bed mobility, Resident expresses desire to have the side rail for security."

On 5-22-12 at 9:10am R18 was in bed with bilateral full side rails.

On 5-17-12 at 12:10pm E16, CNA stated "(R18) uses the side rails to pull with the right hand (his

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F 221	Continued From page 11 good hand). To help get dressed, to help get up and to roll over in bed." On 5-23-12 at 9:10am (regarding R18's use of side rails) E8, CNA stated R18 "can't put side rail down (when) in bed." On 5-22-12 at 11:00am E9, Licensed Practical Nurse, Minimum Data Set, Care Plan Coordinator, stated she thought they had reduced or had tried smaller side rails at one time but was unable to provide documentation of a restraint reduction program. She stated R18's wife and R18 want the full side rails. R18's Care Plan dated 4-25-12 for restraint directs staff to use bilateral side rails when R18 is in bed. It does not address a restraint reduction plan.	F 221		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that staff are knowledgeable of all various types of abuse. This has the potential to affect all fifty five residents in the facility. Findings include: The facility's Abuse Prevention Program Facility	F 226		

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Policy dated 11/11/11 section II. "Orientation and Training of Employees" states employees will be trained during orientation and annually. The same policy under the section titled "Definitions" lists the following types of abuse with their individualized definitions: " Physical Abuse, Sexual Abuse, Verbal Abuse, Mental Abuse, Misappropriation of Resident Property, Involuntary Seclusion, Neglect and Serious Bodily Injury."

Nine of nine employees asked to list all the various types of abuse were unable to do so. E1, Administrator and Abuse Prevention Coordinator of the facility responded on 5/16/12 at 11:10 AM: Neglect, Verbal, Physical, Misappropriation of Property and Catastrophic Events. E25, LPN (Licensed Practical Nurse) responded on 5/16/12 at 11:50 AM : Financial, Neglect, Emotional, Physical, Verbal, and Resident to Resident abuse. E19, LPN responded on 5/16/12 at 1:50 PM: Physical, Verbal, Mental, Sexual, Misappropriation of Property and Resident to Resident Altercations. On 5/17/12 at 11:35 AM E16, CNA (Certified Nurses Assistant) responded: Verbal, Physical and Neglect. E12, LPN on 5/17/12 at 4:15 PM stated the types of abuse were: Physical, Emotional, Verbal, Sexual, Financial and Resident to Resident. E20, CNA stated on 5/17/12 at 4:35 PM : Physical and Emotional. E20 stated she only remembers this from her CNA training. E13, CNA stated on 5/18/12 at 9 AM the types she was trained in were: Physical, Mental, Verbal, Sexual and misappropriation of property. E8, CNA stated on 5/18/12 at 10 AM the types of abuse she was trained in were: Mental, Physical, Sexual, Financial, Verbal and

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F 226	Continued From page 13 Neglect. E22, CNA stated on 5/18/12 at 10:15 AM the types of abuse were: Physical, Mental, Sexual, Neglect, Verbal and Resident to Resident. The Resident Census and Conditions of Residents dated 5/16/12 list the total census for the facility is 55.	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify and seek ways to support one of four resident's (R17) concerns with her roommate. This failure has resulted in an ongoing, persistent feeling of dehumanization, embarrassment, loss of appetite, and nausea to the point of vomiting when exposed to her roommate's compulsive behaviors. R17 is one of four residents reviewed for infection control in the sample of 14.; Staff failed to identify and address R7's on going behaviors. R7 is one of five residents reviewed for behaviors on the sample of 14. Findings include: 1. R17's Physician's Order Sheet (POS) dated May 2012 documents the following diagnoses:	F 250		

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Coronary Artery Disease, Depression, Arthritis, and Asthma. R17's May 2012 POS indicates that R17 was admitted 04/23/09.

R12's POS dated May 2012 documents the following diagnoses: Obsessive Compulsive Disorder (OCD), Depression, and Methicillin Resistant Staphylococcus Aureus (MRSA) Infection of a Left Scapular Wound. R12's May 2012 POS documents that R12 was admitted 03/03/12.

R17 and R12 are roommates.

R12's Nurse's Notes dated 03/03/12, 03/05/12, 03/07/12, 03/08/12, 03/12/12, 03/13/12, 03/14/12, 03/17/12, 03/18/12, 05/10/12, and 05/13/12 document R12 picking dressings and scabs off of four abdominal wounds and one wound on her right breast and causing the wounds to bleed.

On 05/16/12 at 1:45pm, E10, Licensed Practical Nurse (LPN) stated that R12 picked off the four abdominal scabs and the scab on her right breast that morning and caused the wounds to bleed.

R12's POS dated May 2012 documented a MRSA infection of a wound on her left scapula, and Contact Precautions were ordered on the Referral Information Form dated 03/03/12, from a local hospital, to prevent the spread of the infection among other residents and staff.

On 05/15/12 at 10:40am; 05/16/12 at 10:20am, 11:30am, 12:50pm, and 1:40pm; 05/17/12 at 11:55am, 1:30pm, and 3:30pm; 05/18/12 at 10:00am; 05/22/12 at 11:00am and 2:30pm; and 05/23/12 at 10:00am, R17 and R12's room

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contained two large round isolation barrels: one for contaminated linens and one for contaminated disposable dressings and waste. The barrels sat on R17's side of the room directly in front of the closet doors, completely blocking R17's access to the closet. A portable commode was positioned next to R12's bed. R17 and R12's room contained no chairs for residents or visitors on which to sit.

On 05/22/12 at 9:30am, R17 stated that sharing her room with R12 "Keeps me upset all the time." R17 stated that after meals R12 returns to their room, strips off her clothes while in full view of R17 or anyone else in the room or hall, and picks the sores on her abdomen until they bleed. R17 stated that this behavior by R12 "makes me sick and almost vomit. Sometimes I can't eat. I feel upset all the time." R17 stated that she cannot have her family visit her in her room due to R12's behavior, and she must find another place in the facility to visit with her family. R17 is unable to access her closet when she wishes due to the isolation barrels placed in front of the closet doors.

On 05/22/12 at 9:30am R17 stated that she asked E18, Social Service Director (SSD), if she could move to another room and E18 showed her the available rooms. R17 stated that she told E18 that she would think about it.

On 05/22/12 at 9:30am R17 stated that she did not want to move to another room because she liked the view from the window. R17 stated that she has been living in this room for two years; R12 moved in 03/03/12.

R17's Social Service Progress Notes dated

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03/06/12 document "Has a new roommate as of 03/03/12, so far OK." Social Service Progress Notes dated 05/17/12 document "Resident asked what she needed to do to move to another room. I showed her what was available at this time, she said she would think about it." There was no documentation of any questioning of R17 as to her reasons for desiring a room change. There was no further documentation in the Social Service Notes.

On 05/22/12, E18, stated that she thought R17 was getting along OK with her roommate. E18 denied knowing that R17 was upset with her roommate's behavior to the point of vomiting or that R17 was "upset all of the time." E18 also stated that she did not know R17 could not access her closet, and that R17 was upset and embarrassed to have her family and friends visit due to R12's behavior. E18 stated that she does not spend a lot of time talking with R17 because R17 seems busy with family and friends.

On 05/23/12 at 10:00am, E18 stated that she had relayed R17's issues with her roommate's behavior to E1, Administrator, and that they would look into it later.

On 05/24/12 the Social Service Progress Notes contained additional entries dated 05/18/12 and 05/23/12. On 05/24/12 at 9:40am E18 stated that the 05/18/12 entry was a "probable late entry." E18 stated that she was unaware that she was required to write "Late Entry" on an entry entered after the stated date.

On 05/24/12 at 9:35am E2, Director of Nursing (DON), stated that she did not know when the

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additional entry was added.

2. R7's May 2012 POS includes diagnoses of Dementia, Aphasia and Left Cerebral Vascular Accident (CVA). R7's Minimum Data Set (MDS) for dates of 12-6-11 and 3-7-12 both indicated R7 does not have any problems with mood or behaviors.

R7's PsychoSocial Assessment dated 3-6-12 does not indicate any problems with behaviors or mood.

The Social Service Program Review on 3-6-12 indicates R7 is combative during showers.

On 5-15-12 at 2:10pm E8 and E16 both Certified Nurses Aides (CNAs) performed a transfer of R7 from the wheelchair to bed and then completed incontinence care. During this time of care R7 was combative, swinging her left hand/arm around while in the wheelchair. Once in the bed R7 grabbed at the staff, tried to hit and strike at E8 and E16. During this care R7 yells out and grabbed onto the front pocket of E8's uniform.

On 5-23-12 at 10:20am E8 stated R7 is combative during care. E8 said R7 grabs, pinches, hits and yells.

On 5-18-12 at 1:40pm E18 Social Service Director (SSD) was asked who reviews the residents with behaviors and she indicated that she did. When asked if "Combative during care" was a behavior E18 said "Yes".

R7's Behavior Monitoring Record forms for March 2012, April 2012 and May 2012 are all

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F 250	Continued From page 18 blank. The targeted behaviors are listed as irritability, crying and tearfulness. On 5-18-12 at 1:40pm E18 (SSD), verified R7's Behavior Monitoring Forms for March, April and May 2012 were all blank. E18 stated "the behavior documentation should be for the CNAs. If they didn't document then I can't put behaviors on the MDS or on the continued behavior forms at the next review." R7's Care Plan dated 3-4-12 was not written specific to R7's behavior of combative during care.	F 250		
F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272		

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F 272	Continued From page 19 Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete the Care Area Assessment (CAA) Summary by listing location and date of CAA information for 18 of 18 residents reviewed. Fourteen of fourteen sampled residents, (R1, R3, R6, R7, R10, R11, R12, R13, R14, R15, R16, R17, R18 and R19) and 4 residents on the supplement sample (R24, R25, R26 and R27). Findings include: The most recent full (Initial, Annual, or Significant Change) Resident Assessment Instruments (RAI) were reviewed for the 18 sampled residents. The RAI's Section V (Care Area Assessment Summary) did not include the location and date of the Care Area Assessment information for the following residents and the dates of their RAI's.	F 272		

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F 272	Continued From page 20 R1 1-31-12 R3 3-27-12 R6 2-24-12 R7 12-16-11 R10 10-12-10 R11 2-11-12 R12 3-9-12 R13 9-26-11 R14 11-16-11 R15 5-8-12 R16 6-5-11 R17 3-6-12 R18 1-24-12 R19 3-19-12 R24 5-4-12 R25 4-30-12 R26 5-14-12 R27 4-30-12 The Care Plan Coordinator, E9 stated on 5-18-12 at 1:45 P.M. that she does complete the resident RAIs. E9 stated she was not listing the location and dates on the Care Area Assessment information on the summary and that she was not aware that it was to done.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		

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F 279	Continued From page 21 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, intervention, and record review, the facility failed to address contact precautions on the care plan for one of four residents (R12) reviewed for infection control in the sample of 14. Findings include: R12's POS dated May 2012 documents the following diagnoses: Obsessive Compulsive Disorder (OCD), and Methicillin Resistant Staphylococcus Aureus (MRSA) Infection of a Left Scapular Wound. R12's May 2012 POS documents that R12 was admitted 03/03/12. R12's Referral Information Form dated 03/03/12, from a local hospital, documents that contact precautions are to be practiced to prevent the spread of the infection among other residents and staff. On 05/15/12 at 10:40am; 05/16/12 at 10:20am, 11:30am, 12:50pm, 1:40pm; 05/17/12 at	F 279		

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F 279	Continued From page 22 11:55am, 1:30pm, 3:30pm; 05/18/12 at 10:00am; 05/22/12 at 11:00am, 2:30pm; and 05/23/12 at 10:00am, R12's room contained two large round isolation barrels: one for contaminated linens and one for contaminated disposable dressings and waste. A table outside R12's door contained gloves, gowns, and masks to be used when caring for R12. R12's Care Plan dated 03/03/12, 03/8/12, 03/15/12, 03/21/12, and 03/24/12 does not address R12's care need for contact precautions or the measures that staff must follow to prevent cross-contamination and the spread of the MRSA infection to other residents and staff. On 05/17/12 at 11:00am E9, Licensed Practical Nurse (LPN), Minimum Data Set (MDS) and Care Plan Coordinator, confirmed that contact precautions were not addressed on R12's Care Plan.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280		

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F 280	Continued From page 23 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to revise the care plan for one of 14 residents (R14) in the sample of 14 residents. The facility failed to reflect R14's individualized repositioning schedule and R14's non-compliance with repositioning. Findings include: The Physician's Order Sheet (POS) dated May 2012 for R14 states the admission date for R14 to the facility was 11/10/11 with the following diagnoses: Pressure Ulcer Buttock Stage III, Multiple Sclerosis, Purpose of Foley Catheter due to Decubitus Ulcer Management. The MDS (Minimum Data Set) dated 4/30/12 states R14 is independent in his daily decision making skills. The November 2011 "Weekly Wound Tracking" shows R14 was admitted with an "unstageable pressure ulcer, size of 7.5 cm (centimeter) by 5.5 cm by 3.5 cm. of the right ischium on 11/10/11. The same form for the week of 2/12/12 shows R14 acquired two new pressure ulcers one located on the left buttock described as unstageable, and measured 1.8 cm by 0.6 cm., depth of the pressure ulcer reads N/A (not	F 280		

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applicable). The second pressure ulcer was located on the right buttock and was described as unstageable, and measured 4 cm by 2.5 cm. depth N/A. The right ischium on 2/12/12 was identified as Stage III measured at 4 cm by 1.8 cm by 3 cm. in depth.

Consultation Reports for R14 dated 1/11/12 from the Wound Clinic states: "Avoid pressure to ulcer. Turn every hour. Offloading with minimizing as much as possible time up in chair. Alternating low air loss mattress. Up in the chair only if cannot do tasks in bed (prefer he has meals in bed, ok to be up to toilet for BM's if needed.)" Consultation Reports for R14 dated 1/20/12 and 2/1/12 state the same information as the Consultation Report on 1/11/12 . Consultation Report dated 2/15/12 states the following information: " (R14) had developed new ulcers on his sacral area near his buttocks in a position that he is more likely to get them from lying." Consultation Report dated 2/29/12 for R14 reads: "(R14) wounds are looking worse. (R14) has more of an odor. There is black eschar over his right buttock wound. This is one that had developed that was new."

R14's Care Plan dated 5/9/12 under "Pressure Ulcers" states "Reposition per positioning schedule - See plan of care." The care plan did not provide a positioning schedule for R14 according to the Physician's Order to turn every hour and avoid pressure to the ulcer. R14's Care Plan did not address R14's noncompliance with turning and repositioning every hour as directed by the Physician's Order of 1/11/12.

E16, CNA (Certified Nurses Assistant) on 5/17/12

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F 280	Continued From page 25 at 1:45 PM stated that R14 would not stay on his side if he was turned. E16 stated R14 would pull the pillow out from behind his back and would lie flat on his back and buttocks. E16 stated she was not aware of any turning schedule for R14. E19, LPN(Licensed Practical Nurse) stated on 5/17/12 at 1:57 PM that R14 was non-compliant with positioning /turning from side to side and confirmed R14 did acquire two new pressure ulcers. E19 stated she was the wound nurse for the facility and was the one who measured all pressure ulcers every week. E19 did acknowledge that the Physician's consultant report did state to turn R14 every hour and avoid pressure to the ulcer . E19 could not remember the date of the order. E20, CNA on 5/17/12 at 4:35 PM confirmed R14 was non-compliant with turning and positioning and stated she did not know of any specific turning schedule for R14. E2, Director of Nurses on 5/17/12 at 2:15 PM confirmed R14 did not have a turning schedule available to the staff. No turning schedule has been created for R14 to the best of E2's knowledge. E1, Administrator on 5/18/12 at 10:30 AM confirmed that the Care Plan did not address R14's non-compliance with turning and repositioning.	F 280		
F 311 SS=F	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities	F 311		

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F 311	Continued From page 26 specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to have a restorative program in place to ensure that residents were assessed for the need for restorative programs, and that restorative programs were developed, implemented and evaluated for effectiveness. The facility failed to ensure that the staff responsible for the restorative program was educated in restorative nursing. Two of 14 sampled residents (R7 and R6) and 23 residents in the supplemental sample (R3, R4, R20, R22, R23, R27, R29, R30, R32, and R35 through R48) who had been identified with Restorative Nursing needs did not have programs that were being implemented and monitored. These failures to identify, implement and monitor residents for restorative needs places all 55 residents at risk for decline. Findings include: The facility policy "Restorative Nursing Programs" states " . . . to facilitate resident independence in Activities of Daily Living and assist the resident reach and maintain his/her highest practicable physical, mental and psychosocial needs through the use of Restorative Nursing Programs where appropriate." This policy directs staff to do the following: 1. "Perform comprehensive assessment of each resident to establish needs and strengths to determine the resident's readiness/capacity to learn and physical ability to participate."	F 311		

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F 311	Continued From page 27 "Comprehensive Assessment will be performed within 14 days of admission to determine individual needs/preferences and as needed after to establish programs." 2. "Develop goals and objectives per individual resident needs." 3. "Writing the Program-once the need is identified." 4. "Implementing the Program" 5. "Evaluating the Program" On 5-17-12 at 1:20pm E9, Licensed Practical Nurse stated she was responsible for the facility restorative program. E9 stated she did not have any training as a Restorative Nurse; but someone from Corporate came and told her how to do it. E9 stated "All they told me was to fill out the paper for the nurses and the CNAs (Certified Nurses Aides) to do." E9 identified these papers as "Restorative Nursing Program Documentation" forms. E9 said "I was given some programs to use for residents and was told to follow these." On 5-19-12 at 11:10am E9 stated she just recently was assigned the Restorative Nurse position. When asked for a listing of residents currently on restorative programs she stated she didn't have a list of residents on restorative programs. E9 then opened her desk drawer and took out a stack of documents indicating they were individual residents' restorative programs. E9 stated, "I have not had time to do anything with them yet." E9 was asked to make a list of all these residents and their respective restorative programs. This list included programs for Walking, Active Range of Motion, Grooming, Passive Range of Motion, Transfers and Dressing, for R3, R4, R6, R7, R20, R22, R23,	F 311		

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R27, R29, R30, R32 and R35 through R48. Some residents were identified as needing two or three restorative programs.

On 5-17-12 at 4:00pm E1, Administrator identified E9 as the facility Restorative Nurse and stated he was not aware E9, did not have any Restorative Nurse training. E1 stated he was not sure who from Corporate was sent to give E9 her training.

On 5-19-12 at 11:25am E2, Director of Nursing, stated she does not have Restorative Nurse training and was not aware that E9 lacked Restorative Nurse training. E2 stated she was not aware that the Restorative Programs were not being implemented.

On 5-28-12 at 3:05pm E9 stated she began as the Restorative Nurse in mid December 2011. E9 stated "all residents have been reviewed at least one quarterly review since or unless they have had a significant change then they do them more often." When asked what about a change in a resident's ROM status and if qualitative measurements were done E9 stated " I see what the CNAs mark on their goal sheets. " E9 was asked how she is able to use the "yes" or "no" responses by the CNAs as quantitative findings for resident's decline. E9 stated " I do know if the Nurses or aides have seen any kind of a decline we contact therapy right away." E9 was asked if she had seen any decline in any resident since December? E9 stated "only the one that came in ill anyway and went on Hospice. Most are just maintaining." E9 was asked about R7's ROM observation of 5/18/12 and R7's right shoulder that doesn't move. E9 stated "I know (R7) has pain, I didn't know the shoulder didn't

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F 311	Continued From page 29 move, the aides didn't tell me. I need to go look at it." R7's ROM Assessment dated 3-10-12 identifies the right shoulder as minimal function of the joint. On 5-18-12 at 2:05pm when E21, CNA demonstrated Range of Motion on R7, E21 identified the shoulder as "frozen" this was something E9 said she was unaware of. E9's employee file did not include any documentation of any Restorative Nurse Training. The Resident Census and Conditions of Residents dated 5-16-12 lists a current census of 55 residents.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide pressure relieving interventions according to the Wound Clinic's plan of care, failed to inform the Wound Clinic of non-compliance with repositioning, failed to monitor effectiveness of pressure relieving interventions to determine the need for additional interventions and failed to address	F 314		

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repositioning and non-compliance in the care plan for R14. These failures resulted in R14 acquiring two additional unstageable pressure ulcers and experiencing decline in a third pressure ulcer. R14 is one of three residents reviewed for pressure ulcers in the sample of 14.

These failures resulted in an Immediate Jeopardy.

While the immediacy was removed on 5/22/2012, the facility remains out of compliance at a Severity Level 2 in that the facility is in the process of monitoring the effectiveness of staff retraining directed towards turning and repositioning of R14. The facility is in the process of implementing a new turning and repositioning schedule, maintaining documentation of compliance and non-compliance with the new schedule and monitoring effectiveness of a new wheelchair cushion provided for R14.

Findings include:

The Physician's Order Sheet (POS) dated May 2012 for R14 states the admission date for R14 to the facility was 11/10/11 with the following diagnoses: Pressure Ulcer Buttock Stage III, Multiple Sclerosis, Purpose of Foley Catheter due to Decubitus Ulcer Management. The POS continues to order for R14 as a treatment for the buttock wounds to pack 1/4 strength Dakins soaked Kerlix into buttocks wounds twice a day , then place ABD (abdomen) pad and tape. The POS also states to have an Alternating Low Air Loss Mattress, Avoid Pressure to Ulcer and Turn Side to Side in Bed, Avoid Back. The Minimum Data Set (MDS) dated 4/30/12 records

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R14 to be independent in daily decision making skills and requires extensive assistance of two staff for bed mobility and transfers. The "Braden Scale for Predicting Pressure Ulcer Risk" dated 11/11/11, 2/7/12 and 5/3/12 records R14 to be at high risk for pressure ulcers.

The November 2011 form titled "Weekly Wound Tracking" shows R14 was admitted with an "unstageable pressure ulcer, size of 7.5 cm (centimeter) by 5.5 cm by 3.5 cm. of the right ischium on 11/10/11. The same form for the week of 2/12/12 for R14 shows R14 acquired two new pressure ulcers one located on the left buttock described as unstageable, and measured 1.8 cm by 0.6 cm., depth of the pressure ulcer reads N/A (not applicable). The second pressure ulcer is located on the right buttock described as unstageable, and measured 4 cm by 2.5 cm. depth N/A. The right ischium on this date of 2/12/12 shows the following measurements for R14: Stage III measured at 4 cm by 1.8 cm by 3 cm. in depth.

Consultation Reports for R14 dated 1/11/12 from the Wound Clinic states: "Avoid pressure to ulcer. Turn every hour. Offloading with minimizing as much as possible time up in chair. Alternating low air loss mattress. Up in the chair only if cannot do tasks in bed (prefer he has meals in bed, ok to be up to toilet for BM's if needed.)" Consultation Reports for R14 dated 1/20/12 and 2/1/12 state the same information as the Consultation Report on 1/11/12 . Consultation Report dated 2/15/12 states the following information: " (R14) had developed new ulcers on his sacral area near his buttocks in a position that he is more likely to get them from lying."

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Consultation Report dated 2/29/12 for R14 reads: "(R14) wounds are looking worse. (R14) has more of an odor. there is black eschar over his right buttock wound. This is one that had developed that was new."

On 5/15/12 at 11:50 AM to 4:40 PM based on observations of 30 minutes or less intervals, R14 was sitting in his wheelchair (w/c) on a foam cushion that collapsed due to R14's weight. R14 was participating in lunch and Activities during this period of time. R14 confirmed at 4:40 PM on 5/15/12 he had been in the w/c without benefit of repositioning by staff since 11:50 AM. R14 continued to state that staff do not move him from the w/c until it is time to be transferred to his bed by the mechanical lift. During the same interview R14 demonstrated that he repositioned himself in the w/c by placing his hands on the w/c arm and lifting one side of his buttocks up to relieve the pressure then he would go to the other side and do the same thing. R14 stated he only could hold himself up for less than a minute. On 5/16/12 at 8:10 AM R14 was in bed eating breakfast sitting on his buttocks with the head of the bed elevated at a 45 degree angle, R14 was lying on his back at 10:15 AM watching television. On 5/16/12 at 11 AM E1, Administrator was asked for manufacturing information for R14's w/c cushion and was not able to provide any information. E1 stated R14's w/c cushion came from his home and the facility did not have any information on the w/c cushion.
At 11:25 AM on 5/16/12, R14 was still laying on his back and buttocks. R14 was transferred to his electric w/c at 11:55 AM. On 5/17/12 at 8:30 AM R14 was in bed lying flat on his back and buttocks, at 10:30 AM R14 was still in the same

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position. At 12:30 PM R14 was on his back and buttocks with the head of the bed elevated to a 45 degree angle eating his noon meal. At 4:30 PM on 5/17/12 R14 again was lying on his back and buttocks. R14 stated on 5/17/12 at 4:35 PM, " I am still waiting to get up. No one has came and got me up. I have been in this bed all afternoon, I want to get up and move around."

R14's Care Plan dated 5/9/12 under "Pressure Ulcers" states "Reposition per positioning schedule - See plan of care." The Care Plan did not provide a positioning schedule for R14 according to the Physician's order to turn every hour and avoid pressure to the ulcer. R14's Care Plan did not address R14's noncompliance with turning and repositioning every hour according to the Physician's Order of 1/11/12.

E16, CNA (Certified Nurses Assistant) on 5/17/12 at 1:45 PM stated that R14 would not stay on his side if he was turned, E16 stated R14 would pull the pillow out from behind his back and would lie flat on his back and buttocks. E16 stated she was not aware of any turning schedule for R14.

E19, LPN(Licensed Practical Nurse) stated on 5/17/12 at 1:57 PM that R14 was non-compliant with positioning /turning from side to side and confirmed R14 did acquire two new pressure ulcers since admission. E19 stated she was the wound nurse for the facility and was the one who measured all pressure ulcers every week. E19 did acknowledge that the Physician's consultant report did state to turn R14 every hour and avoid pressure to the ulcer . E19 could not remember the date of the order.

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E20, CNA on 5/17/12 at 4:35 PM confirmed R14 was non-compliant with turning and positioning and stated she did not know of any specific turning schedule for R14.

E2, Director of Nurses on 5/17/12 at 2:15 PM confirmed R14 did not have a turning schedule available to the staff. No turning schedule has been created for R14 to the best of E2's knowledge.

Z2, Program Manager Wound Clinic stated on 5/17/12 at 2:39 PM "After speaking with the Wound Specialist, he stated that the facility did not contact him regarding (R14's) non-compliance with being turned and repositioned as ordered..."

E1, Administrator on 5/18/12 at 10:30 AM confirmed that the care plan did not address R14's non-compliance with turning and repositioning.

The facility's policy titled "Decubitus Care/Pressure Areas" revised 5/07 states under number 6 "Reevaluate the treatment for response at least every two (2) to four (4) weeks. Most pressure areas will respond to treatment in this amount of time. If no improvement is seen in this time frame, contact the physician for a new treatment order." E2, DON on 5/18/12 at 10:18 AM stated after identifying the two new pressure ulcers on 2/12/12 the pressure prevention program did not get changed for R14 and the care plan was not revised, it remained the same as always. E2 confirmed she was not aware of the Physician's Order to turn R14 every hour.

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F 314	Continued From page 35 On 5/18/12 at 2:00 PM, an Immediate Jeopardy was identified to have begun on 2/12/12 when facility staff failed to implement repositioning every hour, keeping R14 off his backside as directed by the Wound Clinic 's physician on 1/11/12. Staff failed to care plan R14's non-compliance with repositioning, and failed to inform the Wound Clinic physician of R14's non-compliance with turning every hour and avoiding pressure to his wound areas. The staff also failed to implement any alternative pressure relieving measures once the two new unstageable pressure ulcers were identified. E1, Administrator and E2, Director of Nurses were notified of the Immediate Jeopardy on 5/18/12 at 2:00 PM. The surveyor confirmed through observation, interviews and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. R14's Wound Physician was contacted on 5/18/12 at 3:23 PM regarding R14's refusal to turn and reposition every hour. The Wound Physician changed the order to turn and reposition every two hours and to encourage compliance. 2. Care Plan review was held on 5/22/12 with R14 regarding his non-compliance with turning schedule and changing position out of the w/c. Staff explained the negative effect of non-compliance including worsening or development of new pressure ulcers to R14. R14 voiced understanding of the information and R14 would rather continue with his preferred activities despite negative effects of pressure ulcers but	F 314		

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F 314	Continued From page 36 agreed to interventions that meet R14's preference and needs and implemented a program for set up schedules. 3. On 5/22/12 R14's care plan with pressure relieving program was revised to reflect resident's preferences and needs. 4. All nursing staff were inserviced by 5/22/12 regarding R14's new order from the Wound Physician to reposition every two hours, R14's refusals to be reported to Nurse for follow up education, and the new sit up schedule/activity plan to meet R14's needs and preferences. 5. The facility implemented on 5/22/12 a battery operated alternating pressure relief wheel chair cushion for R14 to help reduce pressure while up. 6. All nursing staff were inserviced on R14's new alternating pressure relieving wheelchair cushion on 5/22/12. 7. On 5/22/12 the Wound Clinic was consulted regarding R14's preferences with turning and repositioning schedule to include times of being up in wheelchair and of R14's new alternating wheelchair cushion.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate	F 315		

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treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to prevent cross contamination during incontinent care for one of five residents (R7) reviewed for incontinent care in a sample of 14.

Findings include:

E8, CNA (Certified Nurses Assistant) on 5/15/12 at 2:10 PM provided incontinent care to R7, E8 used the same area of the washcloth to wipe the perineum with consecutive wipes. E8 positioned R7 on her left side and started washing the buttock area. R7 had a BM (bowel movement) and E8 started cleaning this area. Upon completion of cleaning the buttocks, E8 positioned R7 on her back and with a clean washcloth washed between the labia with an upward stroke toward the top of the perineum, smearing BM on the perineum. E8, repeated this procedure twice starting at the bottom of the labia and going upward toward the top of the perineum.

The Facility policy titled "Perineal Cleansing" dated 9/21/10 states " Use long strokes from the most anterior down to the base of the labia. After each stroke refold the cloth to allow use of another area."

E8, CNA on 5/16/12 at 9:45 AM stated "Yes I realize I did not do the procedure correctly. I

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F 315	Continued From page 38 went the wrong direction when cleaning (R7's) front peri area. (R7) had BM there and I wanted to get her clean."	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assess a hand contracture, failed to assess for postural repositioning, failed to assess the need for Range of Motion (ROM), failed to assess and implement ROM/positioning programs, and failed to demonstrate knowledge of ROM for three of six residents (R7, R13, R16) reviewed for ROM/positioning in the sample of 14. Findings include: 1. R7's May 2012 Physician's Order Sheet (POS) lists diagnoses of Dementia, Left Cerebral Vascular Accident, and Muscle Spasms. The POS also lists an order for Nursing Restorative Program and an order dated 12-28-11 "foam ball right hand". A progress note written by Z5, Nurse Practitioner on 12-28-11 describes R7's physical	F 318		

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musculoskeletal exam: "she has hemiplegia of the right arm and she is developing a contracture, her hand does resist opening. With her left arm, she has full range of motion and strong grip. Lower extremities: She is able to do range of motion with the right hip but she does grimace with this. She is a little stiff on the right lower leg. Her left leg, she has good range of motion without problem. " Under the Assessment and Plan . . . "I have written for foam ball to be placed in the right hand to keep her from getting worse contractions."

R7's Minimum Data Set (MDS) dated 3-7-12 identifies Range of Motion as "impairment on one side" for both upper and lower extremities. Staff did not code for Functional Rehabilitation Potential.

R7's Care Plan dated 3-14-12 includes a Restorative Nursing Eating/Swallowing Program and a Restorative Nursing ROM (Range of Motion) Program. Consisting of both Active Range of Motion exercises and Passive Range of Motion exercises. The Active Range of Motion was to the left shoulder and elbow joints for 10 repetitions two times a day for 12 weeks. The Passive Range of Motion was to the right shoulder, hand, hip and knee joints and leg joints and ankle for 10 repetitions for two times per day for 12 weeks.

On 5-18-12 at 1:45pm E9 Licensed Practical Nurse, Minimum Data Set/ Care Plan Coordinator, identified the documentation form for the Certified Nurses Aides (CNAs) to document residents progress on when completing the Restorative Programs. E9 stated

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they use the "Restorative Nursing Program Documentation" forms in the CNA book that have been filled out. R7 has one for eating program, and active and passive ROM. E9 stated the review of the programs is done using the Range of Motion form and E9 documents the review in the Nurses Notes.

R7's Range of Motion Assessment dated 3-10-12 assessed R7 at moderate risk for contractures which indicates treatment may include but is not limited to basic ROM, positioning, turning, and ambulation depending on individual resident needs.

On 5-18-12 at 2:05pm E21, CNA was asked to demonstrate R7's Restorative Active and Passive Range of Motion Programs. E21 did not lower the side rail to effectively do complete range of motion for R7's right arm at the elbow. E21 only barely moved the elbow and did not completely move the wrist. E21 attempted a few repetitions of what she did do. E21 did not do range of motion at the fingers. All E21 did was flatten out R7's fingers in her right hand. E21 said " I don't move her right shoulder." On the left arm E21 did 3 repetitions with raising the arm at the shoulder and did not attempt complete ROM with the other joints on this arm. On R7's lower extremities E21 only bent R7's right knee slightly and stated R7 doesn't bend at the hip. E21 did not perform ROM to any other joint.

On 5-17-12 at 2:00pm Z3, Physical Therapy Assistant stated "I don't have (R7) on my case load. We don't do an evaluation unless there is an order from the doctor. Therapy does a quick

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observation. Like for previous contracture or to prevent contractures. "

On 5-18-12 at 9:30am Z4, Program Director for Therapy Services stated they have not done any therapy evaluations for R7.

On 5-23-12 at 10:10am E8 CNA confirmed the information on the data cards with the residents name, room number and picture on them. R7's does not include any information about Restorative Programs, E8 said the restorative programs are kept in the CNA charting book.

On 5-17-12 at 1:20pm E9, MDS/CPC stated she was told she was the Restorative Nurse but was not trained. She said someone from Corporate came to give her some training. E9 said they showed her the papers to fill out and they told her to put the papers out for the nurses to do. A review of E9's personnel file on 5-23-12 showed there is no training to verify any Restorative Nurse Training Program.

On 5-28-12 at 3:05pm E9 stated she began as the Restorative Nurse in mid December 2011. E9 stated "all residents have been reviewed at least one quarterly review since or unless they have had a significant change then they do them more often." When asked what about a change in a resident's ROM status and if quantitative measurements were done, E9 stated " I see what the CNAs mark on their goal sheets. " E9 was asked how she is able to use the "yes" or "no" responses by the CNAs as quantitative findings for resident's decline E9 stated " I do know if the Nurses or aides have seen any kind of a decline we contact therapy right away." E9 was asked if

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she had seen any decline in any resident since December? E9 stated "only the one that came in ill anyway and went on Hospice. Most are just maintaining." E9 was asked about R7's ROM observation on 5/18/12 and R7's right shoulder that doesn't move. E9 stated "I know (R7) has pain, I didn't know the shoulder didn't move, the aides didn't tell me. I need to go look at it." R7's ROM Assessment dated 3-10-12 identifies the right shoulder as minimal function of the joint. On 5-18-12 at 2:05pm when E21, CNA demonstrated Range of Motion on R7, E21 identified the shoulder as "frozen" this was something E9 said she was unaware of.

2. R13's POS dated May 2012 documents the following diagnoses: Dementia, Left Below the Knee Amputation, Cerebral Vascular Accident, Gastrostomy Tube, and Severe Peripheral Vascular Disease.

R13's Minimum Data Set (MDS) dated 09/26/11 and 03/12/12 document that R13 is severely cognitively impaired, has no impairment of upper extremity range of motion, has impairment of one lower leg's range of motion (due to amputation), is unable to balance without human assistance, and requires extensive assistance with bed mobility.

R13's Nursing Admission Assessment dated 09/14/11 documents "(Left) hand contracted."

R13's Medical Record contained no Physical Therapy or Occupational Therapy records.

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F 318	Continued From page 43 On 05/15/12 at 1:00pm R13's hand appeared contracted. On 05/23/12 at 10:02am, E13, Certified Nursing Assistant (CNA), stated that she does some exercising/stretching of R13's limbs when giving care, but not ROM or any number of repetitions of exercises. E13 stated that R13's contracted left hand was very painful with any movement. On 05/23/12 at 10:02am, E13 and E8, CNAs, stated that they do not perform ROM for R13. On 05/23/12, Z4, Occupational Therapist, stated that there was no record of an assessment or treatment for R13's left hand contracture. 3. The POS (Physician's Order Sheet) dated May 2012 states the following diagnoses for R16: Severe Dementia, Chronic Kidney Disease Stage 3 and Arthritis. The same POS has an order for a soft cervical collar when up in chair and a treatment order to place a rolled cloth to protect the palm of the right hand. The MDS (Minimum Data Set) dated 3/6/12 shows R16 is unable to speak, is moderately impaired in daily decision making skills and requires extensive assist with two or more staff for bed mobility, transfers and toileting. The same MDS states R16 has a limitation in range of motion (ROM) of upper and lower extremities on both side of the body. R16's Range of Motion Assessment dated 12/6/11 and 3/7/12 shows R16 is at moderate risk for contractures. On 5/15/12 at 12:50 PM R16 was being fed in the dining room by E15, CNA (Certified Nurses Assistant). R16 was not wearing her soft neck	F 318		

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F 318	Continued From page 44 collar, R16's head was bent down to her shoulder and her feet were off the wheelchair (w/c) foot rests her legs were extended straight out. On 5/16/12 at 8:30AM and 11:25 AM R16 was in the hallway slumped down in the w/c. No foot rests were on w/c. R16's legs were extended straight out. R16's soft neck collar was on and her head was bent down toward her right shoulder. On 5/17/12 at 10:20 AM R16 was seated in the w/c in the hallway with her legs extended straight. R16 was slumped in the w/c, with the soft neck collar on and R16's head was down to her right side. On the same day at 11:15 AM R16 was in the dayroom sitting next to the Business Office slumping in her w/c, legs extended straight, no foot rests attached to the w/c, with the soft neck collar on. R16's Care Plan dated 3/14/12 does not address any issues with R16's poor sitting posture, wheelchair positioning or range of motion exercises to be done . E9, Care Plan Coordinator and Restorative Nurse confirmed on 5/17/12 at 12:48 PM that R16 does not have any positioning programs, or range of motion programs addressed in the care plan. E9 continue to state R16 had not been assessed by therapy for proper wheelchair position, range of motion or for the soft neck collar. E10, LPN (Licensed Practical Nurse) confirmed on 5/17/12 at 12:30 PM that R16 has had no assessments for range of motion or positioning programs.	F 318		
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F 323	Continued From page 45 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, and record review, the facility failed to thoroughly investigate circumstances related to a fall and failed to assess the risk for entrapment and falls in the use of an air flow mattress and side rails for one of four residents (R13) reviewed for side rails in the sample of 14. These failures put the resident at risk for further falls with injury and entrapment, strangulation, or suffocation if she became lodged between the mattress and the rails. These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 05/22/12, the facility remains out of compliance at a severity level two as the facility is in the process of evaluating the effectiveness of new safety interventions for R13. Findings include: R13's Physician Order Sheet (POS) dated May 2012 documents the following diagnoses: Dementia, Left Below the Knee Amputation, Cerebral Vascular Accident, Gastrostomy Tube, and Severe Peripheral Vascular Disease.	F 323		

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R13's Minimum Data Set (MDS) dated 09/26/11 and 03/12/12 document that R13 is severely cognitively impaired, has no impairment of upper extremity range of motion, has impairment of one lower leg's range of motion (due to amputation), is unable to balance without human assistance, and requires extensive assistance with bed mobility.

R13's Admission Fall Risk Assessment dated 09/14/11 documents that R13 was at high risk for falls.

R13's Interim Care Plan dated 09/14/11 documented R13's high risk for falls but did not document any safety precautions to be implemented by staff, nor did it direct the extent of assistance required for R13's bed mobility or transferring.

The Investigation Report for Falls dated 09/18/11 documents that on 09/18/11 at 2:15pm R13 was found lying on her left side on the floor,"left arm pinned under the left side of her body, screaming in pain with any body movement, and head in a pool of blood."

The Emergency Department Report dated 09/18/11 documents that R13 received 15 sutures to the left temporal laceration.

On 05/22/12 at 12:05pm, E10, Licensed Practical Nurse (LPN), stated that on 09/18/11 when she responded to R13's fall, bilateral full side rails were raised on the bed with the air flow mattress. E10 confirmed this statement on 05/22/12 at 3:50pm.

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F 323	Continued From page 47 The Investigation Report for Falls dated 09/18/11 fails to document use of side rails at the time of R13's fall, but does document the following interventions to be implemented: 15 minute checks, side rails, and "family requested possibly low bed." The Investigation Report for Falls documents the root cause of the fall to be "Resident attempted to change position and was unaware of her limitations." On 05/22/12 at 4:16pm Z1, family member, stated that R13's fall was caused by R13 hallucinating and trying to feed her dog. Z1 stated that to her knowledge side rails were not being used at this time (9/18/11) for R13. The Investigation Report for Falls dated 09/18/11 and R13's MDS dated 09-26-11 do not document R13's hallucination. On 05/22/12 at 1:05pm R13 raised her right leg, left stump, and both arms upon command while in bed. The Facility investigation failed to demonstrate knowledge of R13's hallucinations, an assessed ability of R13's purposeful movement, and the appropriateness of R13's full side rails used in conjunction with an alternating air mattress. The Side Rail Assessments dated 09/13/11, 09/19/11, and 03/13/12 do not address the use of full side rails in conjunction with an alternating air mattress. Use of the low bed was not implemented. On 05/15/12 at 1:00pm R13 was lying on a standard height bed on an air flow mattress with	F 323		

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bilateral three-quarter side rails in use. The side rails extended from R13's axilla to her ankle. The side rails extended four inches above the height of the mattress.

On 05/22/12 at 1:15pm, the foot and head of the air mattress was compressed (with the resident lying in the bed) to the bottom structure of the bed, approximately four and one-half inches using one hand. This compressible space was confirmed on 05/23/12 at 2:00pm with E5, Maintenance Supervisor. Including this compressible space and the four inch extension of the side rails above the mattress, there is an eight and one-half inch space along the side rails on both sides of the bed in which R13 could be entrapped or wedged.

This compressible space has the potential to cause entrapment or wedging of R13's limbs, head, neck, or chest between rails and the mattress, or spaces between side rails and the foot board of the bed and cause serious injury or death.

On 05/15/12 at 1:00pm and 3:30pm when R13 was positioned to her right and left sides, there was no padding between R13, the rail, and the mattress to prevent entrapment.

On 05/16/12 at 9:15am, 11:15am, 1:30pm, and 3:45pm, there was no padding between R13, the rail, and the mattress to prevent entrapment.

On 05/17/12 at 9:00am, 12:00pm, and 1:30 pm, there was no padding between R13, the rail, and the mattress to prevent entrapment.

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On 05/22/12 at 1:05pm there was no padding between R13, the rail, and the mattress to prevent entrapment.

On 05/22/12 at 1:05pm R13 demonstrated that she had the ability to raise her right leg, left stump, and both arms (purposeful movement). The four inches the raised side rails extend above the mattress could enable R13 to place her leg on the rail and roll over the side of the bed onto the floor and injure herself.

On 05/22/12 at 2:10pm, an Immediate Jeopardy was identified to have begun on 09/18/11 when facility staff failed to thoroughly investigate circumstances related to a fall with injury and failed to assess and mitigate the risk for entrapment and falls in the use of an air flow mattress and side rails for R13, who was assessed as a high fall risk on admission (09/14/11). E1, Administrator, was notified of the Immediate Jeopardy on 05/22/12 at 2:30pm.

The surveyor confirmed though observation and interview that the facility took the following actions to remove the Immediate Jeopardy:

1. R13 was moved to her reclining chair at approximately 2:45pm on 05/22/12 upon notification of the Immediate Jeopardy.

2. R13 was reassessed for side rail usage on 05/22/12.

3. Hospice was contacted on 05/22/12 at 2:45pm to provide a high low bed with half side rails for R13 and air mattress. These were delivered on

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05/22/12 at 6:10pm. R13 was placed in the bed in a low position.

B. Based on observation, interview, and record review, the facility failed to implement safety measures for five of eight residents (R7, R11, R12,R13, R18) reviewed for falls during personal care and transfers and failed to fully conduct an investigation of falls to prevent recurrent falls.

Findings include:

1. On R11's May 2012 Physician Order Sheet (POS) the diagnoses includes Syncope, Osteoporosis, Hypertension and Dementia. R11 was admitted on 2-2-12 and the initial Minimum Data Set (MDS) on 2-8-12 identifies R11 as independent with Bed Mobility; Supervision/set up help for transfers, toileting and personal hygiene; and Supervision/1 person physical help for ambulation on the unit.

The " Investigation Report For Falls" dated 2-22-12 documents R11 had a fall on 2-22-12 at 4:00 pm without injury from the wheelchair with the intervention added for a mobility monitor in the wheelchair.

The "Quality Care Reporting Form" dated 3-23-12 at 4:00pm documents R11 attempted to stand during an activity and the wheelchair rolled back allowing R11 to fall. The intervention was to add anti roll back brakes to R11's wheelchair.

The "Quality Care Reporting Form" dated 4-21-12 at 8:30pm documents R11 had a fall from her bed and the investigation indicated R11 had a Urinary Tract Infection. The Investigation

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Report dated 4-21-12 for R11's fall indicates the mobility alarm was on and working. The intervention indicates the facility would add 15 minute checks.

The "Quality Care Reporting Form"dated 5-8-12 documents R11's fall at 3:30pm from bed resulted in an injury to the right side of her head above the right eye and the right cheek was red. R11 also had a skin tear on the right hand near the first digit and a slight bruising noted on the right knee. R11 was sent to a local hospital emergency room and admitted for testing. According to Nurses Notes on 5-10-12 ". . .upon palpation to right forehead area states pain when touched, continued edema (below knee left extremity), multiple bruises over body none open."

On 5-22-12 at 9:20am E2, Director of Nursing (DON), stated the bed (pressure) alarm was implemented for R11 at the initial admission per her daughter's request.

On 5-15-12 at 1:46pm E7, Licensed Practical Nurse, (LPN) E7 stated R11 is not usually compliant with the alarms. E7 described R11 as removing the clip alarm and removing the battery case so staff have to hide it from R11.

On 5-17-12 at 11:55am E13, CNA stated R11 requires minimal assist to hold her just in case. E13 stated R11 is forgetful and said mentally she is about the same as she was at the time of the fall on 5-8-12. E13 verified she was the CNA taking care of R11 up to 2:00pm on the day of the fall. E13 stated R11 had a bed alarm and a chair alarm both on and staff had to hide them because

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she would turn them off.

On 5-17-12 at 5:05pm E12, LPN stated she was working the second shift on 5-8-12 and heard R11. E12 stated " I heard Help." E12 stated she ran to R11's door and it was shut, no alarms were activated. E12 stated R11 had the pressure alarm in the bed and the one clipped to the wheelchair. E12 stated R11 had been in bed but was found sitting on the floor close to and leaning up against the bed. E12 stated "(R11) can take the (alarm) device with her so we try to hide them. I found the device (bed) and tried it and it wasn't turned on. I turned it on and tried it and it worked."

On 5-20-12 at 9:40am E2, DON (regarding the investigation of R11's fall on 5-8-12) stated she had interviewed E21, CNA assigned to R11 at the time of the falls who wrote out a statement indicating R11 had been checked every 15 minutes while sleeping with the (personal safety alarm) attached to her clothing. E2 stated the alarm device was found on R11's nightstand and R11 had taken off the personal alarm. The "Investigation Report For Falls" indicated "bed alarm and alarm attached to resident". E2 was asked if she had interviewed E12, the nurse who first entered the room and tried the alarm devices. E2 stated "No, I interviewed the nurse assigned to that hall and the CNA. I obtained statements from both. They are attached." E2 verified the only new intervention added after this fall was a fall mat according to the Investigation Report. E2 stated they did change out the type of chair alarm to be a pressure alarm device. The Investigation Form does not document results of the "Root Cause Analysis" of R11's fall on 5-8-12

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to help them identify what interventions would be effective to help prevent future falls. At this time E2 stated "On this form we wrote (indicating Quality Care Reporting Form) "attempting to get out of bed."

2. R13's Physician Order Sheet (POS) dated May 2012 documents the following diagnoses: Dementia, Left Below the Knee Amputation, Cerebral Vascular Accident, and Gastrostomy Tube.

R13's Minimum Data Set (MDS) dated 09/26/11 and 03/12/12 document that R13 is severely cognitively impaired, has impairment of one lower leg's range of motion (due to amputation), is unable to balance without human assistance, requires extensive assistance with bed mobility, and is always incontinent.

On 05/15/12 at 1:35pm while assisting with incontinence care, E15, Certified Nursing Assistant (CNA), pulled R13 over to the side of the bed and hit R13's head on the wall. R13 yelled "Ouch!"

On 05/15/12 at 1:36pm E15 stated R13 should have been repositioned in bed in order to avoid hitting R13's head when turning her and asked E14, CNA, to assist her with repositioning R13 before continuing on with incontinence care.

3. R12's POS dated May 2012 documents the following diagnoses: Muscle Weakness--Difficulty Walking, Obsessive Compulsive Disorder, and History of Falls.

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R12's MDS dated 03/09/12 documents that R12's balance is unsteady at all times and that she requires human assistance to stabilize. The MDS dated 03/09/12 also documents that R12 requires limited assistance with bed mobility and transferring.

On 05/15/12 at 10:40am R12 was lying in her bed with bilateral bed bolsters and bilateral full side rails.

On 05/17/12 at 11:58am, the bilateral side rails were raised on R12's bed.

On 05/17/12 at 12:07pm, E16, CNA, confirmed that the rails on R12's bed were raised.

On 05/17/12 at 12:07pm, E16 stated that the bilateral full side rails are used to keep R12 in bed because she will try to get up and toilet herself and fall. E16 stated that bilateral full side rails are used in addition to bilateral bed bolsters because "(R12) will climb over the side rails." E16 also stated at this time that the bilateral full side rails were implemented after one of R12's falls.

On 05/23/12 at 1:00pm, E17, CNA, confirmed that she sometimes uses the bilateral full side rails to keep R12 in bed and prevent falls.

The Investigation Report for Falls documents that R12 fell 03/24/12, 03/25/12, 04/12/12, 04/20/12, and 04/23/12.

R12's Fall Risk Assessments dated 03/24/12, 03/25/12, 04/12/12, 04/20/12, and 04/23/12 document that R12 was at high risk for falls.

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R12's Side Rail Assessment dated 03/03/12 documents the recommendation that no side rails be used with R12's bed.

R12's POS dated May 2012 did not include an order for bilateral full side rails for R12's bed.

R12's Care Plan addressing Risk for Fall dated 03/24/12 and updated 04/12/12, 04/20/12, and 04/23/12 documents the following interventions: resident educated to use the call light when needing to transfer, bed alarm, medication review, medication reduction, urinalysis and culture, basic metabolic profile, complete blood count, nonskid footwear, staff educated on all interventions, resident turns off alarms, and bed bolsters. Side rails are not listed as an intervention on the Care Plan.

On 05/17/12 at 11:55am, E2, Director of Nursing (DON) stated that the side rails on R12's bed were zip-tied down to make them inoperable.

On 05/23/12 at 12:30pm E5, Maintenance Supervisor, stated that when he removed the bilateral full side rails from E12's bed after 05/17/12, the rails were not zip-tied down to make them inoperable.

According to State Operations Manual, Appendix PP (revised 01/07/11), the Food and Drug Administration in a Safety Alert entitled "Potential Hazards with Restraint Devices," side rails can increase resident safety risk resulting in increased incidence of falls or head trauma due to falls (1992). The facility failed to identify and prevent bilateral full side rails being raised on R12's bed when she was in bed, even when

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contraindicated by the Side Rail Assessment dated 03/03/12. R12's Care Plan for Fall Risk interventions dated 03/24/12 and updated 04/12/12, 04/20/12, and 04/23/12, and the Investigation for Falls Report's new interventions to prevent falls dated 03/24/12, 03/25/12, 04/12/12, 04/20/12, and 04/23/12 also contraindicated side rail use.

The Facility's undated Fall Prevention Policy does not address the use of side rails.
.

4. R7's POS includes the diagnoses of Dementia, Muscle Spasms, Left Cerebral Vascular Accident, Hypertension and Arthritis of the Knees.

R7's MDS of 3-7-12 identifies bed mobility, dressing, ambulation on/off the unit, and personal hygiene as extensive assistance with one person physical assist. This MDS identifies R7's transfer needs as extensive assistance with two plus persons physical assistance.

The "Quality Care Reporting Form" dated 3-10-12 documents R7's fall on 3-10-12 at 6:25am without injury. The "Investigation Report for Falls" dated 3-10-12 indicates the CNA was in the room with R7 sitting in bed. The report states R7 began sliding and CNA eased her to the floor. This form identifies the cause of the fall as "Inadequate footwear. "

On 5-23-12 at 9:40am E2, DON stated the investigation for R7's fall on 3-10-12 included the statement from E23, CNA ". . .went to get (R7) dressed. I sat her on the side of the bed. She started sliding so I eased her to the floor."

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On 5-23-12 at 9:40am E2, DON stated " I spoke to the CNA, (E23), she said she sat the resident up at the side of the bed to put on her shoes. She didn't know why she did that. She only had on regular socks and they slide on this floor. "

According to the Investigation Report for Falls dated 3-10-12 the intervention identified to prevent future falls was for R7 to have footwear before getting out of bed.
This intervention was verified with E2, DON on 5-23-12 at 9:40am.

5. R18's May POS includes the diagnoses of Stroke, Right Cerebral Vascular Accident with an order for Personal Safety Alarm in bed and wheelchair.

R18's MDS of 4-20-12 identifies bed mobility, transfers, ambulation on/off unit, dressing, toileting, and personal hygiene as limited assistance with one person physical assist.

The "Quality Care Reporting Form" dated 4-9-12 documents R18 had a fall at 3:15pm with identified bruises and pain to Right upper arm and right hip. The review indicates "(R18) impulsive on walk to dine program fell did not inform anyone. (Wheelchair) alarm (added)."

Nurses Notes on 4-9-12 of x-rays indicated no additional injuries were received.

The "Investigation Report For Falls" dated 4-9-12 only indicates there is a "mobility alarm on the bed" and that R18 has "Aphasia". Everything else is marked "unknown" under Prompts and

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F 323	Continued From page 58 Observations. The section marked for the cause of the fall states " unaware of limits - Stroke (right) body CVA unsteady gait, not seeking assistance." The only interview documented was from the attending nurse asking yes/no questions of R18, indicating R18 fell in his room without anyone present. On 5-23-12 at 9:30am E2, DON stated (regarding the investigation of R18's fall on 4-9-12) "(R18) was observed up earlier walking by himself in the hall. He did not have bruises then, they were found on his upper arm, you could see the one just below his shirt sleeve. It was reported by his wife when she came in." E2 verified this information was not in the report. E2 also verified that she did not interview any other staff to see if they noticed any bruising or redness earlier in the day when helping with R18's care.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that food	F 371		

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F 371	Continued From page 59 was prepared in a manner in which it could not be contaminated by physical contact, potential contamination and unclean equipment and surfaces. This has the potential to affect all 55 residents. Finding includes: A. During observation of the Dietary Department on 5-16-12 at 9:00 A.M. accompanied by the Dietary Manager (E4) the following observations were made. 1. The ventilation exhaust hood over the oven/range combination was constructed of galvanized metal. The inside of the hood had been painted black and there were areas where the paint had flaked off. Grease,dust and cooking debris were on the glass light shields, on the fire extinguisher system piping and sprinkler heads, the surface of the hood, on the filters and in the grease trough. Food is prepared on the burner and grill under the ventilation exhaust hood. The food could be contaminated by fallen debris. 2. The oven/range combination has a shelf attached to the back of it. The shelf hangs over the burners and the grill. The underneath side of the shelf had dried and moist cooking residue that could fall into food during cooking. 3. The food preparation area, the dishmachine area, and the food storage room were equipped with in the wall exhaust fans. According to E4, the fans are not used and are covered with black garbage bags. The bags were covered with dust, lint, and a grease residue. The residue could fall	F 371		

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F 371	Continued From page 60 into food being prepared on the west wall food preparation table. 4. Inside the 2 door reach in refrigeration unit, a black rubber hose was used as a replacement for the condenser line. The hose surface was not smooth and easily cleanable. The hose was not designed to be used in a food storage area. 5. The steamtable wet wells had food spills and residue in the water. The water was cloudy. E3 acknowledged that the wells had not been cleaned daily according to facility policy. 6. Dried and moist residue was present on the food contact surface of the table mounted mixer. The meat slicer had small meat particulars on the backside of the blade. These food contact surfaces were not clean. 7. The commercial coffee brewer with a direct water line was on the counter. E4 stated the brewer was not easily moveable. The brewer is not moveable to clean under the unit. 8. The non food contact surfaces of the metal storage rack in the dish washing room were dusty and rusty. The blue metal rack in the food storage room to the left of the freezer was dusty and greasy. The back side of the oven/range combination had grease residue and cleaning chemical residue deposits. The manual can opener brace had food spills and residue. Food and grease residue was present on the outside edge and the top of the dishmachine. 9. The soiled side of the dishmachine area back splash caulk was covered with slimy black	F 371		

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F 371	Continued From page 61 residue. 10. The Dietary Department has three in the wall air conditioning and heating units. The units are smaller than the opening. The facility used foam installation strips to fill the gaps. The strips were dusty and grease. The strips did not fill the entire opening, as a result there are gaps to the outside. 11. The floor in the Dietary Department was not clean and brown residue was along the floor wall junction, around equipment legs, and under equipment. E4 stated that Housekeeping scrubs the floor weekly. B. During the General Observation tour on 5-16-12 at 3:30 P.M. accompanied by the Administrator (E1), the Maintenance Supervisor (E5), and the Housekeeping Supervisor (E6), the ice scoop was hanging beside the ice machine. The ice machine was discharging air across the food contact area of the scoop. Dust and lint were attached to the discharge vent of the ice machine. C. On 5-17-12 at 10:30 A.M. and 10:50 A.M., E4 was placing raw hamburger patties on an outside gas grill. E4 was handling the raw hamburger patties with her bare hands. E4 did not use a method to minimize potential contamination. The Centers for Medicare and Medicaid Services, form 672 "Resident Census and Conditions of Residents", completed on 5-16-12 reflects a census of 55 residents.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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F 425	Continued From page 62 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, and record review, the facility failed to maintain control of a medication to be destroyed. This has the potential to affect one resident (R1) in the sample of 14 and three residents (R28, R33, R34) in the supplemental sample. Findings include: R1's Physician Order Sheet (POS) dated May 2012 documents the following diagnoses: Dementia and Depression. R28's POS dated May 2012 documents the	F 425		

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following diagnoses: Dementia and Alzheimer's Disease.

R33's POS dated May 2012 documents the following diagnoses: Alzheimer's Disease, Anxiety, Agitation, and Depression.

R34's POS dated May 2012 documents the following diagnoses: Dementia and Agitation.

On 05/22/12 E2, Director of Nursing (DON) provided a list documenting that R1, R28, R33, and R34 ambulate independently throughout the facility.

On 05/15/12 at 12:03pm, E7, Licensed Practical Nurse (LPN) placed an oral syringe containing Phenytoin in the open waste receptacle on the medication cart. E7 then pushed the medication cart to the Nurse's Station and walked away from the cart.

On 05/15/12 at 12:07, E7, stated that she needed to dispose of the medication in the syringe, returned to the medication cart, removed the oral syringe containing the Phenytoin, and squirted it down the medication room sink.

The five minutes the Phenytoin remained in the open waste receptacle on the medication cart unsupervised by E7 had the potential to allow R1, R28, R33, and R34 to access and ingest the medication.

The Facility's Oral Medication Administration Policy (Revised 04/04) and Drug Release/Destruction Policy (Revised 01/06/10) do not address maintaining control of a medication

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F 425	Continued From page 64 to be destroyed until it is destroyed. The Facility's Drug Release/Destruction Policy directs staff that "Liquid medication(s) to be destroyed are to be poured into a zip lock bag with cat litter, water added into the zip lock bag, seal and place (in) waste receptacle." B. Based on observation and interview, the facility failed to ensure that the environment of the medication room is maintained in such a way as to promote safe, sanitary handling of medications. This has the potential to affect all 55 residents in the facility who receive medications. On 05/23/12 at 1:30pm the medication room had 6 denture cups lying on a towel on the medication room counter top. All of the denture cups contained water and/or denture soaking preparations, and three of the cups also contained residents' dentures. In a plastic bag, also lying on the counter top was a cantaloupe and 2 used, empty, disposable coffee cups with lids. On 05/23/12 at 1:30pm, E10, Licensed Practical Nurse, stated that she was cleaning dentures for some of the residents. E10 stated at this time that the cantaloupe had been given to her by a resident, and that she was going to take the coffee cups home to recycle them. The Facility's undated Denture/Partial Care Policy directs staff to clean dentures/partials in the residents' rooms; dentures/partials that are soaking are to be "(Placed) in bedside cabinet drawer."	F 425		

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F 425	Continued From page 65 On 05/29/12 at 9:30am, E2, Director of Nursing, stated that the Facility has no policy regarding maintaining the Medication Room in a safe, clean, and sanitary manner. The Centers for Medicare and Medicaid Services, form 672 "Resident Census and Conditions of Residents", completed on 5-16-12 reflects a census of 55 residents.	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		

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ILLINI HERITAGE REHAB & HC	1315B CURT DRIVE CHAMPAIGN, IL 61820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 66 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to perform hand hygiene during medication pass and incontinence care, and failed to prevent possible cross-contamination of oxygen tubing, an indwelling urinary catheter, and a bedside commode for four of four residents (R7, R14, R15) in the sample of 14 and four residents (R30,R31, R32, R33) in the supplemental sample. Findings include: 1. E8, CNA (Certified Nurses Assistant) on 5/15/12 at 2:10 PM provided incontinent care to R7. E8 washed R7's buttocks and visible stool was seen on the washcloth. E8 had visible stool on her gloves and did not remove the gloves but continue to complete the incontinent care of R7. During this procedure E8 kept touching her uniform pants and pulling them up at the waist with the soiled gloves on her hands. The Facility policy titled "Standard Precautions" dated 12/09 states under the procedure	F 441		

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"Handwashing" "Wash hands after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn., Wash hands immediately after gloves are removed.....wash hands between tasks and procedures on the same resident to prevent cross-contamination of different body sites."

2. On 5/15/12 at 11:55 AM R14's catheter drainage bag was hanging on the towel rack in the bathroom adjoining to R14's room. The catheter drainage bag tubing was uncapped and the tubing was wrapped into a circle and exposed to air. The drainage bag contained 150cc of urine.

E2, Director of Nurses stated on 5/30/12 at 10:10 AM "I expect CNAs to empty the drainage bag, apply the cap or cover the end of the tubing and place in a plastic bag to be stored away until next use."

3. On 05/15/12 from 12:12 pm until 12:28pm, E19, Licensed Practical Nurse (LPN) administered medications to R15, R31, R32, and R33 without performing hand hygiene prior to passing medications to each of these residents. E19 touched the residents' dining tables, back of their chairs, and residents' arms.

On 05/15/12 at 12:30pm, E19 stated that she did not perform any hand hygiene prior to administering R15, R31, R32, and R33's medication. E19 stated that she usually does perform hand hygiene when administering medications.

The Facility's Oral Medication Policy (revised

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04/02) directs nursing personnel to "Wash your hands or use hand gel/foam wash" after administering medication to a resident.

4. R12's POS dated May 2012 documents the diagnosis of Methicillin Resistant Staphylococcus Aureus (MRSA) Infection of a Left Scapular Wound. A Referral Information Form dated 03/03/12, from a local hospital, documents that contact precautions are to be enforced due to R12's MRSA infection.

On 05/16/12 at 11:30am, E8, CNA, assisted R12 from the bedside commode to her wheelchair. E8 then carried the commode bucket with urine in it uncovered to the soiled utility room at the end of the hall.

On 05/16/12 at 11:40am E8 stated that she had carried the commode bucket out of R12's room to the soiled utility room uncovered to empty it and that she should have covered it before bringing it out into the hall.

According to State Operations Manual, Appendix PP (revised 01/07/11), the infection prevention practice of Standard Precautions "(Applies) to all residents, regardless of suspected or confirmed diagnosis or presumed infection status," and directs all body substances such as blood, urine, or feces to be isolated from possible contact with other residents.

5. On 5-15-12 at 10:45 A.M., R30's oxygen cannula and tubing was on the floor in front of the air conditioner and heating unit in her room. The cannula and tubing was not protected from potential contamination.

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F 455 SS=F	483.70(b) EMERGENCY ELECTRICAL POWER SYSTEM An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted. When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that 4 of 10 lighted exit signs were fully lit as designed to assist residents, staff, and visitors to a means of egress in an emergency in 4 of 4 resident care area. This has the potential to affect all 55 residents. Finding include: During General Observation tour on 5-16-12 between 3:15 P.M. and 5:30 P.M. accompanied by the Administrator (E1), the Maintenance Supervisor (E5), and the Housekeeping and Laundry Supervisor (E6), lighted emergency exit signs were observed. One of the 2 light bulbs inside the exit sign was not lit in the center of the back (East) corridor. Two bulbs were not lit in the exit sign in the South Corridor. The exit sign above the South Exit door in the living room was	F 455		

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F 455	Continued From page 70 not lit. One of the 2 bulbs were not lit in the exit sign in the center of the service corridor. At this time, E5 was asked the last time he checked the exit lights. E5 said he did not know. The Centers for Medicare and Medicaid Services 672 form, "Residents Census and Condition Report" completed on 5-16-12 reflects a census of 55 residents.	F 455		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure that 2 of 2 open flame gas dryers were free of lint that could constitute a fire hazard. Findings Include: 1. During the General Observation tour on 5-16-12 between 3:15 P.M. and 5:30 P.M. accompanied by the Administrator (E1), the Maintenance Supervisor (E5), and the Housekeeping Supervisor (E6), the following was present: a.) Two of two open flame gas dryers' heat exchangers were not free of dust and lint. The dust and lint creates a potential fuel for a fire.	F 456		

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F 456	Continued From page 71 The lint and dust were on the gas Venturi tubes, on the ignitor and in the heat exchanger cabinet on top of the dryers.	F 456		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure that effective maintenance and housekeeping services were provided for four of four resident care areas and one service area. This has the potential to affect all 55 residents. Based on observation the facility also failed to ensure the surfaces were free of sharp edges in the resident environment for 1 of 14 sampled residents (R11) Findings include: A. During the General Observation tour on 5-16-12 between 3:15 P.M. and 5:30 P.M. accompanied by the Administrator (E1), the Maintenance Supervisor (E5), and the Housekeeping Supervisor (E6), the following concerns were detected. 1. The Woman's shower room ceiling exhaust	F 465		

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was not functioning. The exhaust was not running. E5 was asked about the facility's exhaust ventilation system in the resident care areas. E5 stated that the facility has four roof top exhaust ventilation fans and 2 of the 4 were not working. E5 stated he ordered new motors and parts over 3 weeks ago. E5 stated he did request the equipment from the corporation Maintenance Director, E11. E11 stated on 5-17-12 at 8:30 A.M. that the new motors and parts had not been ordered from the supplier. As a result, the moisture and the humidity could not be controlled.

2. The Woman's shower room had a rusty metal cover on the in the wall electric heater. The bath tub was used to store commodes. The inside of the shower had a cove base along the floor wall junction of the shower. The base had separated from the wall and mold and mildew was between the base and the shower wall. Six pieces of corner wall tile were missing in the shower. Ceiling light shields were cracked and missing. The ceiling exhaust vents were covered with dust and lint. A musty odor was detected in the shower room.

3. The facility uses in the wall heating and cooling units. The units are smaller than the wall opening. As a result, the facility used foam strips to fill the gap. The gaps were not closed to the outside and insects and rodents could enter the facility through these gaps. The strips were not clean and did not fill the air gaps. These units were located in the living room, in the main dining room, in the back hall dining room, and in the beauty shop.

4. The floor wall junctions along the corridor base

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board and door jams had accumulation of encrusted wax residue and built up dirt. This was present in the four resident care areas and service corridor.

5. The corridor painted wooden base board was chipped and marred. The painted metal door jams were chipped and marred. This condition was present in all resident care areas and the service corridor.

6. In the main dining room, the four ceiling lights had accumulated dust, lint, and dead insects on the chandelier. The insects appear to be gnats. The visual control monitor had dust and lint on it.

7. Five of eight upholstered living room chairs had holes in the seats.

8. The Men's shower room shower had mold along the floor wall junction. One of the light shields was loose and hanging down. It was also cracked. A hard plastic holder for the shower handle wand was inside the Men's shower on the short wall (3 to 3.5 feet high). The holder was broken and it had sharp edges. The sharp edges create a potential of injury during a shower.

9. The Beauty Shop's left cabinet kick plate was missing and a portion of the corner had deteriorated.

10. The facility has four emergency exit doors. One of these, the South emergency exit door was stuck and very hard to open. The South emergency exit door is in the living room. In order to open the door, E5, a large man, had to force the door open by pushing his weight

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F 465	Continued From page 74 against the door. The door was not easy to open and a smaller framed person may not be able to open the door in case of an emergency. B. During initial tour on 5-15-12 at 10:45 A.M., R30's bed had two holes approximately 3 inches in diameter in the foot board. A metal piece was hanging in front and under R30's bed. C. During observation of a resident activity on 5-22-12 at 10:00 A.M. in the living room, residents were in their wheelchair with lap cushions in use. The resident wheelchair arms were torn and cracked. Lap cushions were torn. E5 was asked for a list of all residents whose wheelchair arms and lap cushion were damaged. According to the list provided by E5, R6, R7, R11, R12, R14, R16, R17, R22, R23, R24, R25, R31, R32, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R44, R45, R46, R47, R48, R49, R50, R51, R52, R53, R55, and R56's wheelchairs arms were cracked and or torn. R31 and R40's lap cushions were torn and cracked. D. On 5-15-12 at 12:30pm the heater unit in R11's bathroom was identified as having sharp edges. The front cover piece was off and laying on top of the unit. The Center for Medicare and Medicaid Services, 672 form "Resident Census and Conditions of Residents", completed 5-16-12 reflects a census of 55 residents.	F 465		
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM	F 469		

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F 469	Continued From page 75 The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to have an effective pest control program in place to control ants and gnats. This condition has the potential to affect all 55 residents. Finding includes: During the General Observation tour on 5-16-12 between 3:15 P.M. and 5:30 P.M. accompanied by the Administrator (E1), the Maintenance Supervisor (E5), and the Housekeeping Supervisor (E6), there was evidence that ants and gnats were in the facility. Dead gnats were on the dining room lights. Evidence of ant dirt (loose grains of soil) were along the west wall of the dining room and behind the ice machine. The air conditioning and heating unit for the dining room were on the west wall. Gaps to the outside were present around the unit. In the back independent dining room, the west wall had similar evidence of ants and gnats and the air conditioning and heating unit had gaps to the outside. Evidence was also present around and behind the vending machines in the independent dining room. Gnats were behind the linen barrel in the women's shower.	F 469		

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F 469	Continued From page 76 At the resident group meeting on 5-16-12 at 9:30 A.M., the residents stated that they have seen ants and small flies. The facility's pest control company reports for 4-18-12 and 3-17-12 state that ant activity was reported. The report did not list the location of activity or where or if treatment was provided. The Centers for Medicare and Medicaid Services, form 672 "Resident Census and Conditions of Residents" completed on 5-16-12 reflects a census of 55 residents.	F 469		
F 516 SS=C	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that residents' clinical records were stored in a matter to prevent water damage in 2 of 2 storage	F 516		

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F 516	Continued From page 77 locations. This has the potential to impact all 55 current resident and discharged residents. Finding include: During the General Observation tour on 5-16-12 at 5:00 P.M. accompanied by the Administrator, E1, cardboard boxes were stored in the clean linen room in the service corridor and in a room in the laundry building. E1 acknowledged that the boxes contained clinical medical records of discharged residents and thinned records of current residents. The clean linen room stored 23 boxes of records and the laundry building stored at least 70 boxes. Both locations are equipped with overhead sprinklers for fire suppression. The medical records would be water damaged if the sprinkler system was activated. The Centers for Medicare and Medicaid Services form 672 "Resident Census and Conditions of Residents" completed on 5-16-12 reflects a census of 55 residents.	F 516		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment	F 520		

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and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to have a functioning structured quality assessment and assurance committee. A Physician was not present during three of the four quarterly meetings. The facility failed to identify concerns and develop and implement structured action plans designed to meet the needs for the 55 residents in the building.

Findings include:

1. The Quality Assurance Committee Agenda form dated January, February, March 2011 indicates that Z6, Medical Director (MD) signed as attending the Quality Assurance Meeting. The other 3 quarterly meetings for the year were void of Z6's signature. This was verified by E1, Administrator on 5-23-12 at 5:00pm.

2. On 5-22-12 at 12:46pm E1, Administrator described the Quality Assurance Committee as

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meeting quarterly and stated "most has been on going projects. We try to stay in compliance with all past surveys." E1 stated, "(E2, DON) will do random monitoring with transfers and (mechanical lifts) to see if we need to re-educate for all or just one person."
E1 continued to describe the facility's Quality Assurance as also meeting daily, and when they review they look for patterns in areas of problems. Stating they do the same thing with Infection Control.

On 5-23-12 at 11:55am E1 stated during the morning meetings staff discuss the who, why, how and any interventions on the Incident Report for the Quality/Assurance Analysis Form.
E1 explained that any major issues are discussed in the quarterly QA meetings. When asked if the facility had developed an action plan for falls, E1 stated, "Well it's hard for me to think of falls as global in our facility. We follow falls every day, two times a day at daily meetings so we look at the number of falls with the time, what interventions, looking at staffing ratios and the times they fell. Also why they fell and see if there is a pattern. We evaluate daily and do walking rounds 2 times daily."

On 5-23-12 at 11:55am E1 was asked for the facility Q/A Action Plans for any areas of concern the facility had identified in the past 12 months. E1 produced blank forms titled "Plan of Correction and Follow-Up Record" on 5-23-12 at 11:55am stating these were his action plan forms. E1 stated, "I have just been instructed to start using them. Right now we put our action plans in narrative form in our Q/A minutes."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315B CURT DRIVE CHAMPAIGN, IL 61820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 80 The facility was unable to provide documentation to demonstrate they had identified problems, developed and implemented corrective goals and action steps (including staff training or revision of policy), and evaluated effectiveness of changes for the areas of non compliance identified during the survey: resident falls, restraints, pressure ulcers, and restorative nursing programs. The Centers for Medicare and Medicaid Services, form 672 "Resident Census and Conditions of Residents" completed on 5-16-12 reflects a census of 55 residents.	F 520		