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	145926	A. BUILDING _____ B. WING _____	C 09/14/2016

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GARDENVIEW MANOR	**14792 CATLIN TILTON ROAD DANVILLE, IL 61834**

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F 000	INITIAL COMMENTS Complaint 1665079/IL88264-F202, F203 Complaint 1665164/IL88366-F314, 300.1230 j)5)k) Complaint 1665197/IL88408-F225, F226, F309, F323 Complaint 1665259/IL88477-F225, F226, F309, F323	F 000		
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the	F 203		

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

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facility for 30 days.

The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to provide a written notice to the resident and/or legal representative that documented the reasons for an emergency involuntary discharge for one (R1) of three residents reviewed for discharge in the sample of 17.

The findings include:

R1's Physician Order Report (POR)dated 8/01/16 documents R1 was admitted on 6/21/16 from a hospital. R1's diagnoses included: Bronchitis, Metabolic Encephalopathy, Hypo-osmolality, Hyponatremia, Hypothyroidism, Alcohol use with Alcohol Induced Anxiety Disorder, Schizophrenia,

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Other Schizoaffective Disorders, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease with acute exacerbation, Acute Respitory Failure.

R1's Minimum Data Sheet (MDS) dated 6/28/16 documented R1 was cognitively intact per the BIMS (Brief Interview for Mental Status) assessment tool. R1 was assessed as having daily "other behaviors, and rejects care daily." R1 was assessed as being independent in Activities of Daily Living.

R1 had a Court Order dated 7/25/16 appointing The Office of State Guardian (OSG) "Plenary Guardian of Person of a Disabled Adult."

R1's Progress note dated 8/31/16 1:15 pm states "resident agitated and upset this am (morning). resident talking about guns and knives and informing this nurse that he has been thinking a lot about this...resident stated "I have had it. I can't take it anymore." this nurse contacted Physician. Physician ordered resident to ER. (emergency room)." Registered Nurse E5 made the notations. There was no other progress note or social service note after that date. There was no documentation of the actual resident discharge to the hospital.

There was no discharge order in the August 2016 physician order report (POR) in the electronic record for the 8/31/16 discharge to the hospital. The last order for discharge was dated 8/22/16 "Send to (acute care facility) ER for Eval (evaluation) of admission to (psychiatric care center)."

There was no Social Service documentation of a

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decision to involuntarily discharge R1 from the facility. The last social service progress note dated 8/22/16 had to do with the previous discharge to psychiatric care unit for evaluation.

The "Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents" dated 8/31/16 for R1 documents that an "Emergency Transfer or Discharge" was occurring.
The form did not include any documentation that stated why R1 was being discharged. The form was signed by Administrator E1 on 8/31/16. This form was faxed to R1's Guardian, Z1, and The Illinois Department of Public Health, on 8/31/16 between 12:37 pm and 12:42 pm and to Ombudsman, Z3 on 9/1/16 at 7:50 am according fax confirmation forms. A copy was also faxed to the admitting hospital on 8/31/16 according to interview with E3 MDS coordinator on 9/6/13 at 3:30 pm.

The Discharge notification form had prewritten statements to check to specify why R1 was being transferred, which were not completed, such as " Your welfare and needs cannot be met in this facility, as documented in the clinical record by your physician, 483.12 a)(2)(i). ...or "the safety of individuals in this facility is endangered, 483.12 (a)(2)(iii)..or "the health of individuals in the facility would otherwise be endangered, as documented by your physician in your clinical record. 483.12 (a)(2)(vi).." There were no checks next to these reasons.

E1 stated on 9/6/16 at 4:30 pm that he prepared the notice of emergency involuntary discharge for R1. E1 confirmed that he failed to check the boxes or include any documentation pertaining to

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the reason for R1's discharge. E1 also stated he had not documented anything in R1's record pertaining to the decision to do an emergency involuntarily discharge for R1.

Z4, Physician stated on 9/7/16 at 4:00 pm that the facility notified him on 8/31/16 of R1's behavior and he gave orders to send R1 out for evaluation. Z4 stated the resident had become a threat to other residents and staff.

R1's Admission Contract signed 6/21/16 by Z1 Guardian states under Transfer or Discharge "The facility may transfer or discharge the resident in compliance with Facility Standards: 1. If necessary for the resident's health, safety, or welfare or if the safety or health of other individuals in the facility would otherwise be endangered...residents health has improved sufficiently so resident no longer needs services..if the resident fails to pay any charges when due."

The undated facility policy for Involuntary Discharge states "Notice Before Transfer - A valid discharge notice must meet the following criteria: Be filled out properly and in its entirety; Be given to the resident and to the representative in manner that they understand; State the reason for the transfer or discharge; State the effective date of transfer or discharge;state the location to which the resident will be transferred or discharged..." Endangerment to self or others in facility; When residents are either a danger to themselves or others, a facility may immediately transfer them to the hospital or a psychiatric unit...If the nursing home states they will not take the resident back, they still must issue the notice as soon as the decision has been made to

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F 203	Continued From page 5 discharge the resident. The resident retains the right to appeal.."	F 203		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		

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F 225	Continued From page 6 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure an injury of unknown origin was immediately reported the administrator for one of four residents (R6) reviewed for resident injury in the sample of 17. Findings include: The Physician's Order Sheet (POS) dated 8/1/16 through 9/9/16 documents that R6 has diagnoses of Alzheimer's Disease, Psychotic Disorder, Agitation and Anxiety. The Care Plan revised 8/25/16 documents that R6 is at risk for abuse related to total dependence on staff for care, inability to make needs known, not easily redirected, repetitive verbalizations, psychosis with agitation, anxiety, dementia, obsessive compulsive disorder and depression. The Event Note dated 9/6/16 documents "6:10 am CNA (Certified Nurses Aide) notified nurse of (R6's) L (left) leg discomfort. Nurse noted a knot on L (left) knee. The knot on L (left) knee measures 5.5 centimeters (cm) x 3.5 cm and bruising behind L (left) knee 10.5 cm x 8.5 cm..... (R6) complain of pain upon moving....." The Event Note documents that Z7 Physician and E2 Director of Nurse were notified of R6's left knee bruising and orders were received to X-ray R6's left knee on 9/6/16. The Nurses Note dated 9/6/16 at 6:00 PM documents "results of x-ray received (R6) has a	F 225		

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spiral fracture distal femur and superior displacement.....orders received to send (R6) to the hospital....."

E1 Administrator's Initial Report to the Illinois Department of public Health dated 9/7/16 documents that on 9/6/16 R6 " was noted to have bruising to (R6's) left knee, X-ray was obtained with abnormal results, (R6) was sent out to the hospital for further evaluation."

The Preliminary Radiology Report dated 9/6/16 documents findings of "Right femur - acute oblique fractures seen involving the distal right femur extending into the lateral condyle.....mild displacement of the distal fragments medially.....Left femur - oblique fracture of the distal left femoral shaft is present with medial displacement of the main distal fragment....."

On 9/8/16 at 1:15 PM E18 CNA stated that at 6:00 AM on 9/5/16 E18 was rolling R6 in the bed providing care and R6 was grimacing in pain and yelling louder than usual. E18 stated R6 was grabbing R6's right pelvic area during turning and R6 seemed more agitated than usual. E18 stated R6 had a bruise on the back of R6's left knee. E18 stated E18 did not report R6's pain and bruise to the charge nurse or anyone else except E15 CNA. E18 stated E18 told E15 that something was "not right with (R6), so much discomfort." E18 stated E18 should have reported R6's bruise and pain to the nurse that morning but the facility was short staffed and there was no nurse around for E18 to tell. E18 stated E18 transferred R6 back to bed the afternoon of 9/5/16 and R6 was still grimacing in pain. E18 stated E18 did not report R6's bruise or pain to anyone before E18 left the facility for

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the day.

On 9/8/16 at 12:30 PM E16 CNA stated that on 9/5/16 at 4:30 PM E16 was providing care for R6 in the bed prior to getting R6 up for dinner. E16 stated R6 was moaning in pain and grabbing R6's right leg when E16 rolled R6 and pulled R6's pants down for incontinence care. E16 stated R6 is nonverbal but was making noises as if R6 was in pain. E16 stated E16 did not report R6's pain to the nurse because E16 could not find a nurse to tell.

On 9/7/16 at 2:50 PM E23 Licensed Practical Nurse (LPN) stated that E23 was scheduled to work the evening shift on 9/5/16. E23 stated E11 (night shift Registered Nurse) called E23 and asked E23 to come in early because two day nurses called off. E23 stated E23 arrived at the facility around 9:40 am and worked on the unit where R6 resides. E23 stated no one reported to E23 that R6 had a bruise or pain with repositioning.

On 9/13/16 at 5:05 AM E13 LPN stated that E13 worked the night shift on 9/5/16 and that in the morning (9/6/16) a CNA (E15) told E13 about an area on R6's left knee. E13 stated R6's left knee was swollen and painful.

On 9/8/16 at 2:50 PM E17 LPN stated after the bruise and swelling was noted on R6's left knee (on 9/6/16) an X-ray was obtained and R6 was admitted to the hospital with a fractured left leg. E17 stated E17 was later notified by hospital staff that R6 had bilateral spiral femur fractures. E17 stated that on 9/7/16 E18 told E17 that E18 noted a bruise on the back of R6's left knee and that R6 was in pain during care on 9/5/16. E17 stated

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F 225	Continued From page 9 E17 told E18 that E18 should have reported the information to the nurse on 9/5/16 and instructed E18 to write a statement and give the statement to E2 Director of Nurses. E18's statement dated 9/7/16 documents "when I came in at 4:00 am on Monday morning (9/5/16) I noticed (R6) had a bruise on the back of her left leg. (R6) would grimace with pain when you turned (R6) grabbing (R6's) pelvis area." On 9/8/16 at 4:00 PM E2 stated R6's bruise and pain should have been reported to the charge nurse on 9/5/16. On 9/14/16 at 9:30 am E2 stated E2 does not know how R6's femurs were fractured. On 9/14/16 9:45 am E1 Administrator stated E1 conducted an investigation but does not know how R6's legs were fractured. The Abuse Prevention Program Facility Policy revised 3/7/13 states "Nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator."	F 225		
F 226 SS=D	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.	F 226		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to operationalize their abuse prevention policy by failing to ensure an injury of unknown origin was immediately reported to the administrator for one of four residents (R6) reviewed for resident injury in the sample of 17.

Findings include:

The Abuse Prevention Program Facility Policy revised 3/7/13 states "Nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator."

The Physician's Order Sheet (POS) dated 8/1/16 through 9/9/16 documents that R6 has diagnoses of Alzheimer's Disease, Psychotic Disorder, Agitation and Anxiety.

The Event Note dated 9/6/16 documents that at 6:10 am a CNA (E15) reported to the nurse (E13) that R6 had left leg discomfort. The Report documents that R6 was assessed and the nurse noted a knot on R6's left knee measuring 5.5 centimeters (cm) x 3.5 cm, bruising behind R6's left knee measuring 10.5 cm x 8.5 cm and pain upon movement. The Event Note documents that Z7 Physician and E2 Director of Nurse were notified of R6's left knee bruising and orders were

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received to X-ray R6's left knee on 9/6/16.

The Nurses Note dated 9/6/16 at 6:00 PM documents "results of x-ray received (R6) has a spiral fracture distal femur and superior displacement.....orders received to send (R6) to the hospital....."

On 9/8/16 at 1:15 PM E18 CNA stated that at 6:00 AM on 9/5/16 E18 was rolling R6 in the bed providing care and R6 was grimacing in pain and yelling louder than usual. E18 stated R6 was grabbing R6's right pelvic area during turning and R6 seemed more agitated than usual. E18 stated R6 had a bruise on the back of R6's left knee. E18 stated E18 did not report R6's pain and bruise to the charge nurse or anyone else except E15 CNA. E18 stated E18 told E15 that something was "not right with (R6), so much discomfort." E18 stated E18 transferred R6 back to bed the afternoon of 9/5/16 and R6 was still grimacing in pain. E18 stated E18 did not report R6's bruise or pain to anyone before E18 left the facility for the day.

On 9/8/16 at 12:30 PM E16 CNA stated that on 9/5/16 at 4:30 PM E16 was providing care for R6 in the bed prior to getting R6 up for dinner. E16 stated R6 was moaning in pain and grabbing R6's right leg when E16 rolled R6 and pulled R6's pants down for incontinence care. E16 stated R6 is nonverbal but was making noises as if R6 was in pain. E16 stated E16 did not report R6's pain to the nurse.

On 9/7/16 at 2:50 PM E23 Licensed Practical Nurse (LPN) stated E23 arrived at the facility around 9:40 am and worked on the unit where R6 resides. E23 stated E23 also worked the

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evening shift on 9/5/16. E23 stated no one reported to E23 that R6 had a bruise or pain with repositioning.

On 9/13/16 at 5:05 AM E13 LPN stated that E13 worked the night shift on 9/5/16 and that in the morning (9/6/16) a CNA (E15) told E13 about an area on R6's left knee. E13 stated R6's left knee was swollen and painful.

On 9/8/16 at 2:50 PM E17 LPN stated after the bruise and swelling was noted on R6's left knee (on 9/6/16) an X-ray was obtained and R6 was admitted to the hospital with a fractured left leg. E17 stated E17 was later notified by hospital staff that R6 had bilateral femur fractures.

E17 stated that on 9/7/16 E18 told E17 that E18 noted a bruise on the back of R6's left knee and that R6 was in pain during care on 9/5/16. E17 stated E17 told E18 that E18 should have reported the information to the nurse on 9/5/16 and instructed E18 to write a statement and give the statement to E2 Director of Nurses.

E18's statement dated 9/7/16 documents "when I came in at 4:00 am on Monday morning (9/5/16) I noticed (R6) had a bruise on the back of (R6's) left leg. (R6) would grimace with pain when you turned (R6) grabbing (R6's) pelvis area."

On 9/8/16 at 4:00 PM E2 stated R6's bruise and pain should have been reported to the charge nurse on 9/5/16.

On 9/14/16 at 9:30 am E2 stated E2 does not know how R6's femurs were fractured.

On 9/14/16 9:45 am E1 Administrator stated E1

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F 226	Continued From page 13 conducted an investigation but does not know how R6's legs were fractured.	F 226		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to timely report and assess pain for one of four residents (R6) reviewed for pain/injury in the sample of 17. This failure resulted in R6 experiencing pain that went untreated for over 24 hours before R6 was diagnosed with a fractured femur. Findings include: The Minimum Data Set for R6 dated 08/22/16 documents that R6 requires extensive assistance of two staff members for bed mobility and total assistance of two staff members for transfers. The Restorative Progress Notes for R6 dated 08/22/16 documents that R 6 usually speaks a "word salad" and is unable to communicate needs. this same progress note also documents that R6 is transferred by mechanical lift and requires extensive assistance of two staff members with bed mobility and toileting.	F 309		

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The facility Care Plan for R6 dated 08/25/16 documents that R6 is dependent on staff for care, is unable to make needs known.

On 09/08/16 at 1:15PM E18 C.N.A. (Certified Nurse Aid) stated that at 6:00AM on 09/05/16 at E18 was rolling R6 in the bed providing care and R6 was grimacing in pain and yelling louder than usual. E18 stated that R6 was "grabbing" R6's right pelvic are during turning and seemed more agitated that usual. E18 verified that she did not report this to the charge nurse but instead reported it to E15 C.N.A. stating that something was "not right" with R6, so much discomfort. E18 stated she transferred R6 back to bed the afternoon of 09/05/16 and R6 was still grimacing in pain. E18 stated she did not report R6's pain to anyone before leaving the facility for the day.

A statement dated 09/07/16 and signed by E18 documents the following: "When I came in at 4:00AM on Monday morning (09/05/16) I noticed R6 had a bruise on the back of (R6's) leg. (R6) would grimace with pain when you turned (R6) grabbing the pelvic area."

On 09/07/16 E17 L.P.N. (Licensed Practical Nurse) stated that on 09/07/16, E18 reported to her that R6 had a bruise on the left knee and that R6 was in pain during care on 09/05/16. E17 stated she told E18 that this should have been reported to the charge nurse on 09/05/16.

ON 09/07/16 at 2:50PM E23 L.P.N. stated that she arrived at the facility around 9:40AM and worked on the unit where R6 resides. E23 verified working the evening shift on 09/05/16 and stated that no one reported that R6 had a bruise or pain with repositioning.

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On 09/08/16 at 12:30 PM E16 C.N.A. stated that on 09/05/16 at 4:30PM she was providing care for R6 in the bed prior to getting R6 up for dinner and that during care R6 was moaning in pain and grabbing R6's right leg when E16 rolled and pulled R6's pants off to do incontinence care. E16 stated R6 is nonverbal but was making noises as if R6 was in pain. E16 verified that this was not reported to the nurse in charge.

The facility Event Note dated 09/06/16 at 6:10 AM documents that E15 C.N.A reported to the nurse (E13) that R6 had left leg discomfort. This same report documents that R6 was assessed and found to have a knot on the left leg measuring 5.5 by 3.5 centimeters (cm) with bruising behind R6's left knee measuring 10.5 by 8.5cm and pain upon movement. This same noted documents that Z7 Physician and E2 D.O.N. (Director of Nursing) were notified. and orders were received to x-ray R6's left knee.

The facility nurses notes for R6 dated 09/06/16 at 6:00PM document "result of x-ray received. (R6) has a spiral fracture distal femur and superior displacement. Orders received to send (R6) to the hospital."

The hospital Preliminary Radiology Report dated 09/06/16 documents findings of "right femur-oblique fractures seen involving the distal right femur extending into the later condyle...mild displacement of the distal fragments medially. Left femur-oblique fracture of the distal left femoral shaft is present with medial displacement of the main distal fragment..."

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F 309	Continued From page 16 On 09/08/16 E2 DON stated R6's bruise and pain should have been reported to the charge nurse on 09/05/16. On 09/14/16 at 10:00 AM Z8/Orthopedic Surgeon for R6 stated that after performing surgeery on R6's fractured femurs on 09/13/16 that Z8 believes that R6's left femur was fractured approximately three weeks earlier and R6's right femur was fractured within a week.	F 309		
F 314 SS=E	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 interview and record review the facility failed to ensure pressure sore treatments were administered for four of four residents (R9,R10,R11 and R16) reviewed for pressure sore care in the sample of 17. Findings include: 1. The Pressure Wound Report dated 9/6/16 documents R9 has an unstageable pressure sore on R9's right ischium measuring 8.8 centimeters (cm) x 10.0 cm and an unstageable pressure	F 314		

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sore on R9's coccyx sacral area measuring 15 cm x 15 cm.

The Physicians Order Sheet dated 9/1/16 through 9/7/16 documents orders for R9 to have the following pressure sore treatments: "Right Ischium, cleanse surrounding tissue with wound cleanser, apply (sodium hypochlorite) moistened wet to dry dressing, cover with (absorbent dressing) once a day and coccyx, apply (sodium hypochlorite) moistened kerlix, cover with (absorbent dressing) three times daily."

R9's Treatment Administration Records (TAR) dated 8/1/16 through 8/31/16 and 8/28/16 through 9/7/6 document R9's coccyx pressure sore treatment was not administered 8/17/16 evening shift "comment: drug/item not available", 8/17/16 night shift "comment:drug/item not available", 8/19/16 evening shift "comment: 2nd shift", 8/29/16 "comment: not done", 9/5/16 day shift "comment: med pass", 9/5/16 evening shift "comment: no staff."

The TARs dated 8/1/16 through 8/31/16 and 8/28/16 through 9/7/6 document R9's right ischium pressure sore treatment was not initialed as being completed on 8/20/16 and documented as not administered on 9/5/16 day shift "comment: medpass."

On 9/12/16 at 11:00 AM E11 Registered Nurse stated that on 9/5/16 E11 only had time to pass medications and did not complete R9's pressure sore treatments.

2. The Pressure Wound Report dated 9/6/16 documents R11 has a stage three pressure sore on R11's coccyx measuring 6.6 cm x 9.2 cm x 0.2

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cm.

The Physician's Order dated 8/1/16 documents instructions for staff to cleanse R11's coccyx pressure sore with "wound cleanser, skin prep around peri wound, allow to dry, cover with calcium alginate and a foam dressing daily."

The TARs dated 8/1/16 through 8/31/16 and 9/1/16 through 9/12/16 document R11's coccyx pressure sore treatment was not administered 8/5/16 "comment: (R11) not lying down", 8/11/16 "comment: due 1st shift", 8/14/16, 8/23/16, 8/27/16 and 9/3/16 "comment: no staff", and 9/9/16 "comment: previous shift".

3. The Pressure Wound Report dated 9/6/16 documents R10 has an unstageable pressure sore on R10's left heel measuring 3.4 cm x 4.0 cm.

The Physician's Order Sheet dated 9/1/16 through 9/7/16 documents instructions for staff to cleanse R10's left heel pressure sore with "(sodium hypochlorite) cover with calcium alginate, then cover with a foam dressing and wrap with bulky gauze daily."

The TAR dated 9/1/16 through 9/12/16 documents R10's left heel pressure sore treatment was not administered 9/3/16 "comment : no staffing" and is not initialed as being completed on 9/4/16.

On 9/13/16 at 11:00 am E9 Registered Nurse stated when E9 is assigned to R11 and R10's unit E9 usually only has time to pass medications and often can not complete the dressing changes. E9 stated a few weeks ago E9 contacted E3

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F 314	Continued From page 19 Assistant Director of Nurses and informed E3 that E9 did not have time to complete dressing changes. E3 instructed E9 to documents that the treatments were not administered due to no staff. 4. The Pressure Wound Report dated 9/6/16 documents R16 has a stage two pressure sore on R16's sacrum (buttocks) measuring 9.0 cm x 7.2 cm x 0.1 cm. The Physician's Order Sheet dated 9/1/16 through 9/13/16 documents instructions for for staff to cleanse R16's buttocks pressure sore with "wound cleanser, cover with moistened collagen, then cover with bordered gauze daily." The TAR dated 9/1/16 through 9/13/16 documents R16's buttocks pressure sore treatment was not administered on 9/4/16 "comment: not completed". On 9/13/16 T 2:00 pm E17 Licensed Practical Nurse confirmed that R16's buttocks pressure sore treatment was not completed on 9/4/16. On 9/13/16 at 11:00 AM E3 reviewed R9, R11, R10 and R16's TARs. E3 could not provide documentation that R9, R11, R10 and R16's pressure sore treatments had been completed as ordered by their physicians. E3 stated staffing is a problem, the nurses do not have time to complete pressure sore treatments.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		

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adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to safely transfer and reposition two of four residents (R6 and R10) reviewed for resident injury in the sample of 17.

Findings include:

1. The Physician's Order Sheet (POS) dated 8/1/16 through 9/9/16 documents that R6 has diagnoses of Alzheimer's Disease, Psychotic Disorder, Agitation and Anxiety. The Care Plan revised 8/25/16 documents that R6 has agitation with potential for resisting care and that R6 has impaired cognition and communication related to severe advanced Alzheimer type Dementia.

The Minimum Data Set dated 8/22/16 documents that R6 requires extensive assistance of two staff members for bed mobility and total assistance of two staff members for transfers. E30 Restorative Nurse's Progress Note dated 8/22/16 documents that R6 is alert and responsive at times but usually speaks a "word salad" and is unable to communicate needs. The Progress Note documents that R6 is transferred by mechanical lift and requires extensive assistance of two staff members with bed mobility and toileting.

Z8 Orthopedic Surgeon's Clinical Consultation Report dated 9/10/16 documents that R6 was admitted to the hospital on 9/6/16 from the

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nursing home with increased pain. The Report documents an impression of "advanced dementia, osteopenia, unknown injury with bilateral femur fractures...."

On 9/12/16 at 10:10 am E15 Certified Nurses Aide (CNA) stated that during the night shift on 9/4/16 E15 rolled R6 back and forth in the bed twice by E15's self to provide R6 with perineal care and a bed bath. E15 stated that during the night shift on 9/5/16 E15 again rolled R6 in the bed to provide perineal care and a bed bath by 15's self. E15 stated on that on 9/4/16 and 9/5/16 E15 was the only CNA on R6's unit and that is why E15 did R6's care by E15's self.

On 9/8/16 at 1:15 PM E18 CNA stated that on the morning of 9/5/16 at approximately 6:00 am E18 pushed R6 from one side to the other in the bed to wash up R6 by E18's self.

On 9/8/16 at 12:30 PM E16 CNA stated that at approximately 4:30 PM on 9/5/16 E16 rolled R6 in the bed to remove R6's pants and provide perineal care for R6 and then placed the mechanical lift sling under R6 by E16's self. E16 stated E16 then asked an unknown CNA to assist with the mechanical lift transfer. E16 stated E16 expected the other CNA to at least help guide R6's feet during the transfer but the other CNA did not assist with the mechanical lift transfer at all or even stand by R6 during the transfer. E16 stated the other CNA stood by the room exit door with the CNA's back towards E16 and R6.

On 9/8/16 at 2:50 PM E17 Licensed Practical Nurse stated R6 is a big (resident) and requires two staff to assist with incontinence care.

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On 9/13/16 at 1:35 PM E3 Care Plan Coordinator stated that E3 would expect two staff to reposition and provide perineal care for R6 for R6's comfort and safety. E3 stated two staff should always assist with mechanical lift transfers.

On 9/13/16 ay 3:30 PM Z7 Physician stated Z7 would expect two staff to assist R6 with bed mobility.

On 9/14/16 at 10:00 AM Z8 Orthopedic Surgeon stated that after performing surgery on R6's fractured femurs on 9/13/16 Z8 believes that R6's left femur was fractured approximately three weeks earlier and R6's right femur was fractured within a week. Z8 stated R6 is demented, nonambulatory, osteopenic and requires a mechanical lift for transfers. Z8 stated R6 is "dead weight" and can not contribute to repositioning at all. Z8 stated Z8 would expect two staff members to reposition R6. Z8 stated R6's fractures could have occurred if R6 was not carefully positioned in the mechanical lift sling during a transfer or during repositioning.

2. The POS dated 9/1/16 through 9/7/16 documents that R10 has diagnoses of Dementia, Muscle Weakness and Anxiety. The Minimum Data Set dated 6/18/16 documents that R10 requires extensive assistance of two staff members for bed mobility and toileting. The Care Plan revised 8/18/16 documents that R10 has a history of being resistive of care and that R10's ability to complete activities of daily living has deteriorated.

On 9/13/16 at 9:15 am E31 CNA rolled R10 on to R10's side in the bed and then removed R10's incontinence brief and tucked the mechanical lift

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F 323	Continued From page 23 sling partially under R10. R10 did not reach for the side rail or assist with rolling on to R10's side. E31 stated R10 did not help with rolling. E31 then walked to the other side of R10's bed and used the sheet to push R10 over on to R10's other side and pulled the tucked mechanical lift sling out so the sling was completely under R10 and then pulled R10 onto R10's back. E31 stated E31 has always completed R10's care by E31's self. E31 stated R10 resists being rolled to R10's left side. E31 stated other staff are busy. On 9/13/16 at 1:35 PM E3 Care Plan Coordinator stated E3 would expect two staff members to reposition and provide incontinence care for R10 for R10's comfort and safety.	F 323		