

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/13/2009
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF BENTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 ALCOA ROAD BENTON, AR 72015		
(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 000	INITIAL COMMENTS	F 000			
F 164 SS=D	<p>Complaint #14182 was unsubstantiated.</p> <p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the staff failed to ensure laundry staff did not open privacy curtains during personal care for 1 (Resident #21) of 19</p>	F 164			
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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F 164	Continued From page 1 (Residents #1 through #13 and #16 through #21) case mix residents. This failed practice had the potential to effect all 96 residents in the facility as, documented on the Resident Census and Conditions of Residents form dated 1/9/09. The findings are: Resident #21 had a diagnosis of Urinary Retention. The Quarterly Minimum Data Set dated 10/27/08 documented the resident had moderately impaired cognitive skills for daily decision making and required extensive to total staff assistance for activities of daily living. On 1/8/09 at 9:48 a.m., while the resident was receiving Suprapubic catheter dressing care, Laundry staff person #1 knocked on the resident's door. After the nursing staff stated "Patient care," the laundry staff person entered the room and looked between the closed privacy curtain at the resident receiving his care.	F 164			
F 221 SS=E	483.13(a) 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, record review and interview, the facility failed to ensure a restraint was released every 2 hours, double restraints were not used and physician orders were obtained prior to the application of a restraint for 1 (Resident #10) and informed consent for was obtained prior to the application of a restraint for 2 (Residents #10 and #12) of 8(Residents #2, #5,	F 221			

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F 221	<p>Continued From page 2</p> <p>#6, #8, #10, #12, #18 and #20) case mix residents who had physical restraints. This failed practice had the potential to affect 21 residents in the facility who had physical restraints, according to the Resident Census and Conditions of Residents form dated 1/9/09. The findings are:</p> <p>1. Resident #10 had a diagnosis of Dementia. The Annual Minimum Data Set (MDS) documented the resident had modified independence in cognitive skills for daily decision making, required extensive physical assistance of one person for transfers and toileting, did not walk in the room or corridor, required limited physical assistance of one person for locomotion on and off the unit, had functional limitation in range of motion of one leg and one foot with partial loss of voluntary movement and had no restraint.</p> <p>a. The Physician Order dated 12/21/08 documented, "Soft waist restraint while up in W/C [wheelchair] d/t [due to] unassisted ambulation. Check q [every] 30 minutes and release q 2 hrs [hours]."</p> <p>b. The Physical Restraint Resident Informed Consent form dated 7/22/08 documented, "Low bed with mat on floor d/t fall risk r/t [related to] muscle weakness. Medical symptom muscle weakness and Dementia. Soft belt Restraint while up in W/C d/t muscle weakness and Dementia."</p> <p>c. The resident care plan dated 11/27/08 documented, "Soft waist restraint 7/23/08."</p> <p>d. On 1/6/09 at 8:30 a.m., 9:10 a.m. and 9:30 a.m., the resident was sitting up in a wheelchair at the nursing station with a soft belt restraint on and a black belt-type restraint around the chest area</p>	F 221		

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F 221	<p>Continued From page 3</p> <p>that was connected to the upper portion of the wheelchair back.</p> <p>e. On 1/6/09 at 10:20 a.m. and 10:42 a.m., the resident was in her room and remained sitting up in a wheelchair with a soft belt restraint on and a black belt-type restraint on around the resident chest, connected to the upper portion of the wheelchair back.</p> <p>f. On 1/6/08 at 11:10 a.m., the resident was sitting up in a wheelchair in the her room with a soft belt restraint in place and a black belt-type restraint around the chest area, connected to the upper portion of the wheelchair back. When ask if she could release the restraints around the chest or the soft belt the resident stated, "I can't get it off," pointing to the black belt-type restraint.</p> <p>g. On 1/6/09 at 11:20 a.m., the resident was in her room and remained sitting up in a wheelchair with a soft belt restraint on and a black belt-type restraint on around the resident chest, connected to the upper portion of the wheelchair back.</p> <p>h. On 1/6/09 at 11:53 a.m., the resident was in her room and remained sitting up in a wheelchair with a soft belt restraint on and a black belt-type restraint on around the resident chest, connected to the upper portion of the wheelchair back. Certified Nursing Assistant (CNA) #5 stated she had not had time to change the resident yet; the resident was taken to the dining room at 12:07 p.m., without being taken to the bathroom.</p> <p>i. On 1/6/09 at 1:30 p.m., the resident left the dining room with the soft belt restraint on and the black belt-type restraint around the chest area, connected to the upper portion of the wheelchair</p>	F 221			

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F 221	Continued From page 4 back. j. On 1/6/09 at 1:43 p.m., the resident was taken to the bathroom by CNA #5 and CNA #13. The resident sat up in the wheelchair with the soft belt restraint and the black belt-type restraint across the chest under constant observation by the surveyor from 8:30 a.m. until 1:43 p.m., approximately 5 hours and 13 minutes. k. On 1/6/08 at 4:27 p.m., the resident was sitting up in a wheelchair with a soft belt restraint on and a black belt-type restraint across the chest. l. On 1/7/08 at 7:30 a.m., the resident was in the dining room sitting at the dining room table with a soft belt restraint on and a black belt-type restraint around the chest. m. On 1/7/08 at 3:23 p.m., when asked about the resident having two restraints, the soft belt restraint and the black belt-type restraint around the chest, the Director of Nurses (DON) stated that the black restraint around the resident's chest was placed on by the therapist due to the resident slumping forward in the wheelchair. When asked if there was a order for the black restraint around the resident's chest, the DON reviewed the clinical record and was unable to find any documentation regarding the black restraint. The DON stated that she would have to check with therapy; there was no Physician order or informed consent for the black belt-type restraint. 2. Resident #12 had diagnoses of History of Falls, Presenile Dementia and Transient	F 221			

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F 221	Continued From page 5 Ischemic Attacks. The MDS dated 11/28/08 documented the resident had short/long-term memory problems, was moderately impaired in cognitive skills for daily decision making and had a trunk restraint. a. The Nurses note dated 11/20/08 documented, "D/C [discontinue] lap buddy d/t [due to] resident removing. Order for soft belt while in w/c [wheel chair] and pressure pad while in bed. Soft belt and pressure pad applied." b. On 1/5/09 at 2:00 p.m., the resident was up in a wheelchair with a soft belt restraint in place. c. On 1/6/09 at 4:05 p.m., the Assistant Director of Nursing (ADON) was asked if there was an informed consent for the resident's soft belt restraint and was unable to find one. She contacted the resident's family member; according to the ADON, the family member stated she had not signed a consent for the soft belt restraint. 3. The facility policy and procedure entitled Restraint Devices, Physical was received from the Administrator on 1/8/09 and documented, "Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The appropriate device, to meet the resident's needs, as ordered by a physician."	F 221			
F 241 SS=B	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241			

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F 241	Continued From page 6 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure staff knocked on doors prior to entering resident rooms. This failed practice had the potential to affect 96 residents in the facility, as per the Resident Census and Conditions of Residents form dated 1/9/09. The findings are: 1. The facility's Residents Rights documented, , "...19. [A resident has] The right to personal privacy." 2. On 1/6/09 at 8:48 a.m., 8:50 a.m. and at 9:01 a.m., Certified Nursing Assistant (CNA) #3 entered Resident Room #105, without first knocking on the door. 3. On 1/6/09 at 9:16 a.m., CNA #3 entered Resident Room #116, without first knocking on the door. 4. On 1/6/09 at 9:18 a.m., CNA #3 entered Resident Room #113, without first knocking on the door. 5. On 1/6/09 at 9:45 a.m., Registered Nurse (RN) #2 entered Resident Room #114, without first knocking on the door. 6. On 1/6/09 at 9:48 a.m., RN #2 and Licensed Practical Nurse (LPN) #3 entered Resident Room #110, without first knocking on the door. 7. On 1/6/09 at 9:49 a.m., CNA #1 entered	F 241		

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F 241	Continued From page 7 Resident Room #105, without first knocking on the door. 8. On 1/6/09 at 10:06 a.m., Laundry Staff #1 entered Resident Room #110, without first knocking on the door. 9. On 1/6/09 at 10:08 a.m., Laundry Staff #1 entered Resident Room #115, without first knocking on the door. 10. On 1/6/09 at 10:14 a.m., CNA #3 entered Resident Room #114, without first knocking on the door. 11. On 1/6/09 at 2:05 p.m., the door to Resident Room #314 was closed. Certified Nursing Assistant (CNA) #6 entered the resident's room, without knocking.	F 241		
F 309 SS=D	483.25 QUALITY OF CARE 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 observation, record review and interview the facility failed to ensure the indwelling urinary catheter insertion site was thoroughly cleansed to decrease the potential for infection for 1 of 1 (Resident #1) case-mix resident who had an indwelling urinary catheter. This failed practice had the potential to affect 4 residents in	F 309		

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F 309	Continued From page 8 the facility who had indwelling catheters, as identified on the Resident Census and Conditions of Residents form dated 1/9/09. The findings are: 1. Resident #1 had diagnoses of Mental Retardation, Paralysis, Pre-senile Dementia, Depressive Disorder, Convulsions, Aphagia, Chronic Urinary Tract Infections and Percutaneous Endoscopic Gastrostomy Tube Placement. The Significant Change Minimum Data Set dated 10/21/08 documented the resident was severely impaired in cognitive skills for daily decision making, had an indwelling catheter, was incontinent of stool and was totally dependent on staff for all activities of daily living. a. The Physician order dated 12/3/08 documented, "UTA 120 - 0.12 mg [milligram] cap[sule] P/T [per tube] Q [every] day" for urinary tract infection. b. The Urine Culture and Sensitivity results dated 12/30/08 documented growth of the micro-organism "Proteus mirabilis." c. On 1/6/09 at 9:55 a.m., Certified Nurse Assistant (CNA) #11 provided catheter care for the resident, following an incontinent episode of loose yellowish-tan stool. Upon completion of the incontinent care, the CNA was asked to remove the resident's disposable brief and re-cleanse the area of the urinary meatus. The CNA used an adult wipe to cleanse the resident's urinary meatus and was then asked to describe the used adult wipe; the CNA stated, "There is a yellowish-tan discoloration on the adult wipe [from the urinary meatus] on it." 2. The facility's policy titled, "Catheter Care,	F 309			

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F 309	Continued From page 9 Indwelling Catheter" under procedure documented... "Cleanse area well at catheter insertion site..."	F 309		
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure all soiled areas were cleansed during incontinent care for 2 (Residents #3 and #8) of 20 (Residents #1 through #13, #16, #18, #20, #21, #25 and #27) case mix residents who were incontinent and nails were kept trimmed for 2 (Residents #1 and #6) of 13 (Residents #1 through #13) case mix residents who required assistance with nail care. This failed practice had the potential to affect 57 residents who were incontinent of bowel and 58 residents who were incontinent of bladder, as documented on the Resident Census and Conditions of Residents form dated 1/9/09 and 51 residents who required assistance with nail care, according to the Director of Nursing on 1/9/09. The findings are: 1. Resident #3 had a diagnosis of Alzheimer's Dementia. The Quarterly Minimum Data Set (MDS) dated 10/22/08 documented the resident had severely impaired cognitive skills for daily decision making, was incontinent of bowel and bladder and required extensive assistance of staff for activities of daily living.	F 312		

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F 312	Continued From page 10 On 1/6/09 at 2:45 p.m., during incontinent care for liquid feces, Certified Nursing Assistant (CNA) #1 did not cleanse the resident's mons pubis or separate the labia for cleansing. 2. Resident #8 had a diagnosis of Cerebrovascular Accident. The Medicare 30-Day MDS dated 11/25/08 documented the resident had moderately impaired cognitive skills for daily decision making, was incontinent of bowel and bladder and required limited to extensive assistance for activities of daily living. On 1/6/09 at 1:10 p.m., CNA #1 removed the resident's urine soaked incontinent brief, and without performing incontinent care, placed a clean brief on the resident. 3. The facility's policy and procedure titled Incontinence Care documented, "...Procedure ...5. Wash all soiled skin areas, washing from front to back..." 4. Resident #1 had diagnoses of Mental Retardation, Paralysis, Pre-senile Dementia, Depressive Disorder, Convulsions, Aphagia, Chronic Urinary Tract Infections and Percutaneous Endoscopic Gastrostomy Tube Placement. The Significant Change MDS dated 10/21/08 documented the resident was severely impaired in cognitive skills for daily decision making, had an indwelling catheter, was incontinent of bowel and was totally dependent on staff for all activities of daily living. On 1/6/09 at 9:10 a.m., 11:45 a.m. and 2:40 p.m., the finger nails on the resident's contracted right and left hands extended approximately 1/4"	F 312			

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F 312	Continued From page 11 past the tips of the resident's fingers, touching the flesh of both palms. 5. Resident #6 had diagnoses of Insulin Dependent Diabetes Mellitus, Left Hemiplegia Post Cerebrovascular Accident, Dysphagia and Depressive Disorder. The Quarterly Minimum Data Set (MDS) dated 12/16/08 documented the resident was severely impaired in cognitive skills for daily decision making and was totally dependant on staff for personal hygiene. On 1/5/09 at 2:45 p.m. and 4:45 p.m. and on 1/6/09 at 8:50 p.m. and 10:30 a.m., the finger nails on the resident's contracted right and left hands extended approximately 1/4 inches past the tips of the fingers. 6. The facility's policy titled Care of Fingernails/Toenails and received on 1/8/09 documented, "...Purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections."	F 312			
F 314 SS=E	483.25(c) 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	F 314			

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F 314	Continued From page 12 interview, the facility failed to ensure repositioning was provided timely for 1 (Resident #10) and the nurse was immediately notified of redden areas on the skin for 1 (Resident #1) of 24 (Residents #1 through # 24) case mix residents at risk for pressure ulcers. This failed practice had the potential to affect 72 residents in the facility who were at risk for pressure ulcers, according to a list obtained from the Administrator 1/8/09. The findings are: 1. Resident #10 had diagnoses of Dementia, Peripheral Vascular Disease and Cerebrovascular Accident. The Annual Minimum Data Set (MDS) dated 11/27/08 documented the resident had a short-term memory problem, had modified independence in cognitive skills for daily decision making, had functional limitation in range of motion of one leg and foot with partial loss of voluntary movement and had a pressure relieving device for the chair and bed. a. The Physician order dated 12/21/08 documented, "Soft waist restraint while up in W/C [wheelchair] d/t [due to] unassisted ambulation. Check q [every] 30 minutes and release q 2 hrs [hours]." b. The resident careplan dated 11/27/08 documented, "Soft waist restraint dated 7/23/08... Risk for skin breakdown d/t (due to) decline in continence, mobility and limited rom (range of motion) d/t history of hip fx (fracture) muscle weakness and osteoarthritis... Assist and encourage frequent position changes." c. On 1/6/09 at 8:30 a.m., 9:10 a.m., 9:30 a.m., 10:20 a.m., 10:42 a.m. and 11:20 p.m., the resident was sitting up in a wheelchair with a soft	F 314			

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F 314	<p>Continued From page 13</p> <p>belt restraint on and a black belt-type restraint across the chest.</p> <p>d. On 1/6/09 at 11:53 a.m., the resident was sitting up in a wheelchair with a soft belt restraint on and a black belt-type restraint across the chest. Certified Nursing Assistant (CNA) #5 stated that she had not had time to change the resident yet; the resident was taken to the dining room at 12:07 p.m. without the restraints being released to reposition the resident.</p> <p>e. On 1/6/09 at 1:30 p.m., the resident was sitting up in a wheelchair with a soft belt restraint on and a black belt-type restraint across the chest.</p> <p>f. On 1/6/09 at 1:35 p.m., the resident left the dining room. At 1:43 p.m., the resident was taken to the bathroom. The resident had slight redness on the ischial area and the thighs. The resident sat up in the wheelchair with the soft belt restraint and the black belt-type restraint across the chest under constant observation by the surveyor from 8:30 a.m. until 1:43 p.m., approximately 5 hours and 13 minutes, without being repositioned.</p> <p>2. Resident #1 had diagnoses of Mental Retardation, Paralysis, Pre-senile Dementia, Depressive Disorder, Convulsions, Aphagia, Chronic Urinary Tract Infections and Percutaneous Endoscopic Gastrostomy Tube Placement. The Significant Change Minimum Data Set dated 10/21/08 documented the resident was severely impaired in cognitive skills for daily decision making, had an indwelling Foley catheter, incontinent of stool, totally dependent on staff for all activities of daily living and transfers.</p> <p>a. On 1/6/09 at 9:45 a.m., Certified Nurse</p>	F 314			

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F 314	Continued From page 14 Assistant (CNA) #11 was providing care after an episode of bowel incontinence; the resident had red bump-like areas along the inner folds of the right and left buttocks. The CNA stated, "I have not seen this on the resident before." b. On 1/6/09 at 1:50 p.m., Licensed Practical Nurse (LPN) #5 was asked, "Did any of your CNAs inform you that this resident had a bilateral reddened area on the inner folds of the buttocks?" The LPN stated, "No, they did not tell me... I would expect to be notified as soon as they found out." c. On 1/6/09 at 2:00 p.m., CNA #11 was asked, "Did you notify either the treatment nurse or the charge nurse that the resident had red areas on either side of the buttocks?" The CNA stated, "No... I guess I didn't tell either the charge or treatment nurse about the red areas on the resident." 3. The facility Pressure Ulcer, Prevention Policy received from the Administrator on 1/8/09 documented, "Assess for risk for pressure ulcer development and establish a turning and positioning schedule in bed and chair to meet the resident's needs. If a pressure ulcer is present, the licensed nurse is responsible to record condition of the skin, including stage, size, site, depth, color, drainage and odor as well as the treatment provided. Notification of the physician is required when a new pressure ulcer is identified as well as when treatment is not effective."	F 314			
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a	F 315			

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F 315	Continued From page 15 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 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 and record review, the facility failed to ensure all front to back cleansing motions were used during incontinent care to decrease the potential for urinary tract infections for 1 (Resident #3) of 20 (Residents #1 through #13, #16, #18, #20, #21, #25 and #27) case mix residents who were incontinent. This failed practice had the potential to affect 57 residents who were incontinent of bowel and 58 residents who were incontinent of bladder, as documented on the Resident Census and Conditions of Residents form dated 1/9/09. The findings are: Resident #3 had a diagnosis of Alzheimer's Dementia. The Quarterly Minimum Data Set (MDS) dated 10/22/08 documented the resident had severely impaired cognitive skills for daily decision making, was incontinent of bowel and bladder and required extensive assistance of staff for activities of daily living. On 1/6/09 at 2:45 p.m., during incontinent care for liquid feces, Certified Nursing Assistant (CNA) #2 wiped visible feces down the groin areas and across the vaginal areas 2 times.	F 315		
F 318 SS=E	483.25(e)(2) RANGE OF MOTION	F 318		

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F 318	<p>Continued From page 16</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure positioning devices were in place for 1 (Resident #1) of 2 (Residents #1 and #6) case-mix residents with contractures and postural positioning was provided for 1 (Resident #5) of 8 (Residents #1, #3, #5, #6, #7, #10, #18 and #20) case-mix residents who were dependent on staff for positioning. This failed practice had the potential to affect 3 residents in the facility with contractures, according to the Resident Census and Conditions of Residents form dated 1/9/09 and 46 residents dependent on staff for positioning, according to the Administrator on 1/27/09. The findings are:</p> <p>1. Resident #1 had diagnoses of Mental Retardation, Paralysis, Pre-senile Dementia, Depressive Disorder, Convulsions, Aphagia, Chronic Urinary Tract Infections and Percutaneous Endoscopic Gastrostomy Tube Placement. The Significant Change Minimum Data Set (MDS) dated 12/11/08 documented the resident was severely impaired in cognitive skills for daily decision making, was totally dependent on staff for all activities of daily living and had limitation in functional range of motion of both hands and arms with full loss of voluntary</p>	F 318			

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F 318	<p>Continued From page 17 movement.</p> <p>a. The Care Plan dated 12/15/08 documented, "Risk joint pain and discomfort d/t [due to] contractures to upper and lower extremities, muscle spasms and rigidity r/t [related to] cerebellar ataxia... Hand rolls to (B) [bilateral] hands contracture relief."</p> <p>b. On 1/6/09 at 9:10 a.m., there was not a positioning device in the resident's contracted right hand.</p> <p>c. On 1/6/09 at 10:05 a.m., 11:45 a.m. and 2:40 p.m., positioning devices were not in the resident's contracted right or left hand.</p> <p>d. On 1/8/09 at 11:10 a.m., positioning devices were not in the resident's contracted right or left hand. When asked to described the condition of the resident's hands, the Director of Nurses stated, "The resident's hands are contracted, handrolls are to be used to prevent further contraction."</p> <p>2. Resident #5 had diagnoses of Dementia, Brain Injury, Epilepsy and Osteoarthritis. The MDS dated 11/6/08 documented the resident had short/long-term memory problems, was moderately impaired in cognitive skills for daily decision making, was lifted mechanically and required extensive physical assistance of two persons for transfers.</p> <p>a. On 1/6/09 at 12:20 p.m., the resident was in the dining room at the feeding assist table, sitting in a wheelchair with a lap buddy in place. While feeding herself, the resident was leaning far to the left.</p>	F 318			

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F 318	Continued From page 18	F 318		
F 322 SS=D	<p>b. On 1/6/09 at 1:05 p.m., the resident was being propelled in the wheelchair from the dining room, per CNA #6. The resident was still leaning far to the left, with her head approximately 6-inches from touching the left armrest on the wheelchair.</p> <p>483.25(g)(2) NASO-GASTRIC TUBES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure only qualified personnel stopped and started Percutaneous Endogastrostomy (PEG) tube feeding pumps for 1 (Resident #1) of 2 (Residents #1 and #6) case-mix residents who had a gastrostomy tube for the administration of enteral feedings. This failed practice had the potential to affect 2 residents in the facility who had gastrostomy tubes, as identified by the Resident Census and Conditions of Residents form dated 1/9/09. The findings are:</p> <p>Resident #1 had diagnoses of Mental Retardation, Paralysis, Pre-senile Dementia, Depressive Disorder, Convulsions, Aphagia, Chronic Urinary Tract Infections and Percutaneous Endoscopic Gastrostomy Tube Placement. The Significant Change Minimum</p>	F 322		

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F 322	Continued From page 19 Data Set dated 10/21/08 documented the resident was severely impaired in cognitive skills for daily decision making, had an indwelling catheter, was incontinent of stool, had a feeding tube and was totally dependent on staff for all activities of daily living. a. On 1/6/09 at 9:55 a.m., Certified Nursing Assistant (CNA) #11 pushed the "HOLD" button on the resident's tube feeding pump, stopping the delivery of the resident's tube feeding formula. The CNA dressed the resident. Then, with the assistance of CNA #12, transferred the resident from the bed to a Geri-chair. b. On 1/6/09 at 10:05 a.m., CNA #11 pushed the "START" button to resume the delivery of the resident's tube feeding formula. The CNA stated, "CNAs can put the feeding pumps on hold and restart." c. On 1/9/08 at 9:45 a.m., when asked, "What is the policy of this facility for Certified Nurse Assistants to adjust the feeding pumps?" The Director of Nurses was stated, "Licensed nursing staff are to place continuous feeding pumps on hold while repositioning residents."	F 322			
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION 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	F 323			

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F 323	Continued From page 20 by: Based on observation, record review and interview, the facility failed to ensure transfers and repositioning were not performed using the axillae area, waistband or unsecured gait belts to decrease the potential for injury for 5 (Residents #1, #5, #10, #13 and #18) of 14 (Residents #1 through #8 and #10, #11, #12, #13, #18 and #20) case-mix who required staff assistance for transfers and the beauty shop was kept locked when staff was not in attendance to prevent access to chemicals. This failed practice had the potential to affect 81 residents who required assistance of staff for transfers, as documented on the Resident Census and Conditions of Residents form dated 1/9/09 and 23 cognitively impaired independently mobile residents, as documented by the Assistant Director of Nursing on 1/8/09. The findings are: 1. The facility's Transfer Policy documented, "Transfer activities: 4. Assist the resident to a sitting position on the side of the bed. 5. Apply transfer belt... 7. If resident is able to participate in transfer, have resident place strong leg and foot forward and weak foot back... 10. Hold the transfer belt from underneath, straighten your hips and legs slightly and lift the client to a standing position on a count of three." a. Resident #13 had diagnoses of Arthritis, Fractured Neck of Femur, Dizziness and Giddiness and Dementia. The Annual MDS documented the resident had short/long-term memory problems, had moderately impaired cognitive skill for daily decision making, required extensive physical assistance of two persons for transfers, was unable to attempt a test for balance while standing without physical	F 323			

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F 323	<p>Continued From page 21</p> <p>assistance, had functional limitation in range of motion in both legs with partial loss of voluntary movement.</p> <p>1) The Care Plan dated 10/27/08 documented, "Potential for falls related to history of falls, weakness and dementia..."</p> <p>2) On 1/6/08 at 9:37 a.m., CNA #5 placed a gait belt around the resident for transfer. During transfer, the gait belt slid up the resident's back; the resident was unable to stand and the CNA sat the resident in the floor. The CNA and Registered Nurse #2 used the resident's pants to lift the resident from the floor to the bed.</p> <p>b. Resident #10 had diagnoses of Muscle Weakness, Arthritis, Osteoporosis, Cerebrovascular Accident and Presenile Dementia. The Annual MDS dated 11/27/08 documented the resident had modified independence in cognitive skills for daily decision making, required extensive physical assistance of one person for transfers, was unable to attempt a test for balance while standing without physical assistance, had functional limitation in range of motion of one leg with partial loss of voluntary movement and had fallen in the past 31 to 180 days.</p> <p>On 1/6/08 at 1:43 p.m., CNA #5 and CNA #13 were transferring the resident from a wheelchair to the commode. The CNAs placed a gait belt around the resident waist. The gait belt was loose and when the CNAs were lifting the resident, the gait belt slid up the resident's back. The CNAs then used the resident's pants to assist the resident to stand. When transferring the resident back to the wheelchair, the CNAs used a gait belt</p>	F 323			

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F 323	<p>Continued From page 22 and the resident's pants to transfer the resident from the commode to the wheelchair.</p> <p>c. Resident #5 had diagnoses of Dementia, Brain Injury, Epilepsy and Osteoarthritis. The Significant Change MDS dated 11/7/08 documented the resident had short/long-term memory problems, was moderately impaired in cognitive skills for daily decision making, was lifted mechanically and manually, required extensive physical assistance of 2 persons for transfers, was unable to attempt a test for balance while standing without physical assistance, had fallen in the past 30 days and had fractured a hip in the last 180 days.</p> <p>1) The Care Plan dated 11/7/08 documented, "At risk for falls due to impaired mobility related to OA [osteoarthritis] and history of CVA [cerebrovascular accident]..."</p> <p>2) On 1/6/09 at 4:38 p.m. the resident was being transferred from the bed to a wheelchair by Certified Nursing Assistant (CNA) #7 and CNA #8. The resident was assisted to the bedside. The CNAs lifted the resident under each arm, while pulling up on the resident's pants in the back. The resident could not assist in the transfer at all.</p> <p>d. Resident #18 had diagnoses of Right Humeral Fracture, Dementia, Seizures, Percutaneous Endogastrostomy Tube, Cerebrovascular Accident, Osteoarthritis, Hypothyroidism and Hypertension. The Medicare 14-Day MDS dated 12/31/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive physical assistance of two persons for transfers and was unable to attempt a test for balance while</p>	F 323			

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F 323	<p>Continued From page 23</p> <p>standing without physical assistance.</p> <p>1) On 1/8/09 at 9:40 a.m., the resident was slumped down in a Geri-chair. CNA #2, CNA #9 and CNA #10 lifted and repositioned the resident by grabbing the resident on either side of the resident's pants and lifting the resident underneath the arms.</p> <p>2) On 1/8/09 at 9:50 a.m., CNA #2 and CNA #9 both stated that the resident was a total lift and unable to assist with transfers.</p> <p>e. Resident #1 had diagnoses of Mental Retardation, Paralysis, Pre-senile Dementia, Depressive Disorder, Convulsions, Aphagia, Chronic Urinary Tract Infections and Percutaneous Endogastrostomy Tube Placement. The Significant Change MDS dated 12/11/08 documented the resident was severely impaired in cognitive skills for daily decision making, had total dependence on two persons for transfers, was unable to attempt a test for balance while standing without physical assistance, had functional limitation in range of motion with total loss of voluntary movement in both arms and both hands and had functional limitation in range of motion in both legs and both feet with partial loss of voluntary movement.</p> <p>1) On 1/6/09 at 10:00 a.m., CNA #11 and CNA #12 transferred the resident from the bed into a Geri-chair by grabbing the resident's pants on either side and supporting the resident's weight underneath the resident's arms.</p> <p>2) On 1/6/09 at 10:05 a.m., CNA #11 stated, "The resident was unable to bear any weight during the transfer."</p>	F 323			

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F 323	Continued From page 24 2. On 1/5/09 at 5:21 p.m., the Beauty Shop door was unlocked, leaving the following items accessible: a. 1 bottle of Sani Care Restroom Cleaner spray labeled "May cause eye and skin irritation." b. 1 bottle of Fred's Window Cleaner spray labeled "Avoid eye contact. Immediately flush with large amounts of water for 15 minutes." c. 1 bottle of Dawn Dishwashing liquid Plus labeled "If swallowed drink glass of water to dilute. If gets in eyes rinse thoroughly." d. 1 can of ION Shaping Plus hair spray labeled "Avoid spraying in eyes. Misuse by deliberately ...inhaling the contents can be fatal." e. 1 can of Power House Antibacterial spray labeled "May cause eye irritation. Avoid contact with eyes and skin." f. 3 bottles of Fanci Full liquid hair color labeled "Keep out of eyes. If this product should accidentally get into eyes flush eyes. This product contains ingredients which may cause skin irritation." g. 1 can of Tresemmie volumizing mousse labeled "Avoid spraying in eyes ...Misuse by deliberately concentrating and inhaling contents can be harmful or fatal." h. 1 bottle of Personal Care Antibacterial hand sanitizer labeled "Warning-flammable, keep away from fire or flame. For external hand use only. Keep out of eyes. Avoid contact with broken skin.	F 323			

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F 323	Continued From page 25 Discontinue use and contact a doctor. In case of accidental ingestion, seek professional assist or contact a poison control center immediately>" i. 1 bottle of Kroger rubbing alcohol labeled "flammable. Do not get into eyes or mucous membranes. Do not apply over large areas of the body. If swallowed get medical help or contact poison control right away."	F 323			
F 328 SS=E	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure oxygen and updraft equipment was covered when not in use for 2 of 2 (Residents #1 and #3) case-mix residents who received oxygen and for 1 (Resident #3) of 3 (Residents #3, #7 and #17) case-mix residents who received updraft treatments. This failed practice had the potential to affect 21 residents who received oxygen and 13 residents who received updraft treatments, according to a list dated 1/8/09 received from the Director of Nursing. The findings are:	F 328			

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F 328	<p>Continued From page 26</p> <p>1. Resident #3 had a diagnosis of Alzheimer's Dementia. The Quarterly Minimum Data Set (MDS) dated 10/22/08 documented the resident had severely impaired cognitive skills for daily decision making, required extensive assistance of staff for activities of daily living and received oxygen therapy.</p> <p>a. The Physician order dated 10/6/08 documented, "O2 [Oxygen] at 2.5 L [liters] prn [as needed] sob [shortness of breath]."</p> <p>b. On 1/6/09 at 9:23 a.m., the resident's oxygen tubing and cannula was on the floor. This surveyor marked the tubing with red tape marked 1/6/09, 9:23 a.m.</p> <p>c. On 1/6/09 at 9:42 a.m., Registered Nurse #2 placed the oxygen tubing and cannula on the resident, after removing the marked red tape.</p> <p>2. Resident #1 had diagnoses of Mental Retardation, Paralysis, Pre-senile Dementia, Depressive Disorder, Convulsions, Aphagia, Chronic Urinary Tract Infections and Percutaneous Endogastrostomy Tube Placement. The Significant Change MDS dated 10/21/08 documented the resident was severely impaired in cognitive skills for daily decision making, had an indwelling catheter, was incontinent of bowel and was totally dependent on staff for all activities of daily living.</p> <p>a. The Physician orders dated 12/3/08 documented, "Xopenex 1.25 mg [milligram]/3 ml [milliliter] sol [solution] inhalation Q [every] 1 hr [hour] sob. Xopenex 1.25 mg/30 ml sol, 3 ml inhalation Q 8 hrs."</p>	F 328			

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F 328	Continued From page 27 b. On 1/6/09 at 9:10 a.m., 9:30 a.m. and 10:10 a.m., the Ventimask connected to the resident's updraft machine was unbagged and laying on the resident's bedside table. c. On 1/6/09 at 10:10 a.m., Licensed Practical Nurse (LPN) #5 picked up the unbagged Ventimask from the resident's bedside table placed the Ventimask over the resident's nose and mouth and began an updraft treatment for the resident. The LPN stated, "The Ventimask I used for the resident's updraft treatment was unbagged and laying on the resident's bedside table." 3. On 1/9/08 at 9:35 a.m., the Director of Nurses stated, "Oxygen nasal cannula, nebulizer and oxygen equipment are to be stored in plastic bag while not in use.."	F 328			
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the 5:00 p.m. medication pass on 1/5/09 and the 9:00 a.m. medication pass on 1/6/09, the facility failed to follow Physician orders to ensure that the medication error rate was less than 5%. Physician orders were not followed for 3 (Residents #1, #14 and #15) of 8 residents observed during the medication passes. Medication errors were made by 3 Licensed Practical Nurses (LPN) (LPN #1, LPN #2 and LPN #3) of 6 nurses that administered medication. This failed practice had	F 332			

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F 332	Continued From page 28 the potential to affect 95 residents who received medication from these nurses, according to Registered Nurse (RN) #1 on 1/6/09. The medication error rate was 10.20% based on administration of 49 medications and observation of a total of 5 errors. The findings are: 1. Resident #1 had a Physician order dated 12/3/08 for Colace 100 mg (milligrams) to be administered twice a day. On 1/5/09 at 4:40 p.m., LPN #1 administered Colace 40 mg to the resident. 2. Resident #1 had a Physician order dated 12/3/08 to, flush PEG [percutaneous endogastrostomy] tube with 60 cc [cubic centimeters] of water before and after medication administration of meds [medications]. a. On 1/5/09 at 4:40 p.m., LPN #1 did not flush the resident's PEG tube with water before medication administration. b. Federal Regulations require a flush of at least 30 cc of water before and after medication administration. 3. Resident #1 had a Physician order dated 12/3/08 that documented, "Xopenex 1.25 mg/3 ml [milliliter] sol [solution] inhalation q [every] 8 hours." a. The resident's January 2009 Medication Administration Record (MAR) documented the administration times for the resident's Xopenex 1.25 mg/3 ml solution as 9:00 a.m., 1:00 p.m., 5:00 p.m. and 9:00 p.m. (every 4 hours). The MAR further documented, by nurse initials, that	F 332			

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F 332	Continued From page 29 the resident received Xopenex at 1:00 p.m. on 1/5/09. b. On 1/5/09 at 4:40 p.m., LPN #1 administered Xopenex to the resident, 3 hours and 40 minutes hours after the resident's last dose was administered. 4. Resident #5 had a Physician order dated 2/27/08 for Timolol 0.5% Ophthalmic solution to use one drop in each eye twice a day and an order dated 2/27/08 for Brimzolamide 1% to use one drop in left eye twice a day. a. On 1/5/09 at 5:08 p.m., LPN #2 administered the eye drops only 30 seconds apart . b. Federal Regulations require at least 3 to 5 minutes between eye drops in the same eye. 5. Resident #14 had a physician's order dated 1/2/07 for Methylphenidate 5 mg to administer 3 tablets twice a day. On 1/6/09 at 8:14 a.m., LPN #3 administered only one tablet to the resident.	F 332			
F 333 SS=E	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation of the 5:00 p.m. medication pass on 1/5/09, the 9:00 a.m. medication pass on 1/6/09 and record review, the facility failed to ensure residents were free of significant medication errors for 2 (Residents #1 and #14) of	F 333			

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F 333	<p>Continued From page 30</p> <p>8 residents observed during the medication passes were found to have a significant medication error. A significant medication error was made by 2 Licensed Practical Nurses (LPN) (LPN #1 and LPN #2) of 6 nurses that administered medication. The facility further failed to ensure that Admission Physician Orders were transcribed accurately for 1 (Resident #20) of 2 (Residents #18 and #20) case mix residents who had admission orders. This resulted in a significant medication error. This failed practice had the potential to affect 58 residents who received medication from these nurses, according to Registered Nurse (RN) #1 on 1/6/09 and 18 residents in the facility who had admission orders, according to the admission list received from the Administrator on 1/5/09. The findings are:</p> <p>1. Resident #14 had a Physician order dated 1/2/09 for Methylphenidate 5 mg (milligrams) to administer 3 tablets twice a day.</p> <p>a. On 1/6/09 at 8:14 a.m., only one tablet was administered by LPN #3.</p> <p>b. On 1/6/09 at 11:45 a.m., review of the resident's January 2009 Medication Administration Record (MAR) and reconciliation of the facility narcotic sign out book and medication card revealed that only one tablet had been administered twice daily since the order started, rather than 3 tablets daily, as ordered.</p> <p>The medication was ordered on 1/2/09, but not started until 5:50 p.m. on 1/4/09, according to the January 2009 MAR, resulting in at least 3 missed doses, only one tablet administered on 1/4/09, two tablets on 1/5/09 and one tablet on 1/6/09, instead of the Physician ordered 6 tablets daily.</p>	F 333			

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F 333	Continued From page 31 c. This was a significant error due to the frequency of the error. 2. Resident #1 had a diagnosis of Pneumonia and a Physician order dated 12/3/08 for Xopenex 1.25 milligram/3 milliliter solution inhalation every 8 hours. a. The resident's December 2008 MAR documented the Xopenex was administered every 8 hours (3 times daily). b. The January 2009 MAR documented, starting 1/1/09, that the order for the resident's Xopenex continued to be every 8 hours, but was now scheduled four times a day and documented the Xopenex was administered four times daily from 9:00 a.m. on 1/1/09 through 9:00 a.m. on 1/6/09. c. This was a significant error due to the condition (Pneumonia) of the resident and frequency of the error. 3. Resident #20 had diagnoses of Pneumonia, Congestive Heart Failure and Chronic Airway Obstruction. The Medicare 5-Day Minimum Data Set (MDS) dated 1/5/09 documented the resident had severely impaired cognitive skills for daily decision making, required extensive assistance with activities of daily living, required oxygen therapy and had a recent infection of pneumonia. a. The resident's Admission Orders dated 12/31/08 documented, "Proventil 2.5 mg [milligram] inhalation QID [four times daily]." b. The resident's January 2009 MAR had been handwritten and documented, Proventil Inhaler	F 333			

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F 333	Continued From page 32 2.5 mg inhaler QID. On the MAR, the Proventil spaces for administration documentation had nurse's initials in each that were circled from 1/1/09 through 1/8/09. c. On 1/8/08 at 11:10 a.m., LPN #4 stated that the Proventil inhaler was not available. The LPN checked the medication cart and stated that the facility still did not have the inhaler. The LPN was asked if the Physician had been notified that the Proventil inhaler had not been available. The LPN stated, "No." d. On 1/6/08 at 11:48 a.m., Registered Nurse (RN) #2 provided the resident's computer generated Physician Orders for January 2009; the computer generated physician orders were not on the resident's clinical records. The computer generated Physician Orders documented, "12/31/08 Proventil 2.5 mg/3 ml inhalation updraft QID." The medication had been transcribed incorrectly on the handwritten MAR and the resident failed to receive 29 doses of the Proventil Updrafts 12/31/08 through 1/8/09, as ordered by the physician. e. This was a significant medication error due to the condition (Chronic Airway Obstruction) of the the resident and the frequency of the error.	F 333		
F 441 SS=B	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it	F 441		

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F 441	Continued From page 33 investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure an ice scoop was not placed back into the ice reservoir to decrease the potential for cross-contamination. This failed practice had the potential to affect all 95 residents in the facility, as documented on the Resident Census and Conditions of Residents form dated 1/9/09. The findings are: 1. On 1/7/09 at 3:21 p.m., Certified Nursing Assistant (CNA) #8 took the ice scoop from inside of the ice cart, filled 2 resident water pitchers and then placed the ice scoop back inside of the ice container. 2. The facility's policy and procedure "Serving Drinking Water" documented "...7. Maintain clean technique..."	F 441			
F 445 SS=E	483.65(c) INFECTION CONTROL - 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 and record review, the facility failed to ensure staff did not place linen against their uniforms to prevent the potential for	F 445			

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F 445	Continued From page 34 cross contamination. This failed practice had the potential to affect 95 residents in the facility, as per the Resident Census and Conditions of Residents form dated 1/9/09. This findings are: 1. On 1/6/09 at 2:05 p.m., Certified Nursing Assistant (CNA) #6 had just finished providing a shower for Resident #5. The dirty linen was removed from the resident's bed and the CNA held the linen close, touching her uniform, and placed the linens in a plastic bag. The facility's policy on "Making an Unoccupied Bed" documented, "3. Do not allow soiled linen to come in contact with your clothing." 2. On 1/6/09 at 8:43 a.m., CNA #1 carried clean linens against her uniform while walking down the hallway. 3. On 1/6/09 at 8:49 a.m., CNA #3 held clean linens against her uniform while taking plastic bags from the linen cart. 4. On 1/6/09 at 2:44 p.m., CNA #4 carried clean linens against her uniform while walking down the hall way. 5. On 1/8/09 at 10:22 a.m., the Assistant Director of Nursing held clean linen against her uniform while taking linen from the clean linen cart.	F 445			
F 514 SS=B	483.75(I)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514			

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F 514	<p>Continued From page 35</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure closed records were accurate and complete for 2 of 2 (Residents #22 and #23) case mix residents who were discharged. This failed practice had the potential to affect all 95 residents in the facility, according to the Resident Census of Conditions of Residents form dated 1/9/09. The findings are:</p> <p>1. The facility's policy on "Discharging the Resident" documented that the following information should be recorded in the resident's medical record, "1. The date and time the discharge was made. 2. The name and title of individual(s) assisting in the discharge. 3. All assessment data obtained during the procedure, if applicable. 4. The signature and title of the person recording the data."</p> <p>2. Resident #22 had diagnoses of Hypertension, Congestive Heart Failure and History of Constipation. The Minimum Data Set (MDS) dated 9/30/08 documented the resident was discharged with no return anticipated.</p> <p>a. As of 1/7/09, there was no Discharge Summary or Nurses Notes with documentation of what happened to the resident's medications on the date and time of discharge. At 12:03 p.m., the</p>	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/13/2009
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F 514	<p>Continued From page 36</p> <p>Director of Nurses (DON) stated the resident was transferred to [name of hospice facility], the non-narcotic medications were donated to the local community center and the narcotics had been sent to the health department.</p> <p>b. On 1/8/09 at 10:00 a.m., documentation on the cover of the manila folder that contained the residents clinical records noted an admit date of 12/15/06 and a discharge date of 1/2/07. The medical records director was asked if she would locate discharge information in the resident's closed records. She stated the records were spread out everywhere due to the last "...medical record director quit."</p> <p>c. Admission orders dated 4/22/08 documented the resident had been placed on hospice in the facility.</p> <p>d. The Plan of Care (POC) dated 9/30/08 documented hospice approaches for pain management and turning and repositioning of the resident.</p> <p>e. A hospital hospice Skilled Nurse Visit Note dated 9/30/08 documented that the resident's family had agreed to move the resident to [name of hospice facility] and a call was made to request an isolation room.</p> <p>f. A Discharge Summary was not available for the discharge date of 9/30/08 nor did the last Nurse's Note dated 9/30/08 contain information of the facility's discharge requirements.</p> <p>3. Resident #23 had diagnoses of Dementia and Renal Insufficiency. The MDS dated 11/6/08 documented the resident was severely impaired</p>	F 514			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	Continued From page 37 in cognitive skills for daily decision making and was totally dependent on staff for activities of daily living, had deteriorated and was on hospice. a. The Nurses Note dated 11/17/08 at 11:00 a.m. documented, "[name] in from Hospice... R [resident] having periods of apnea... need to send to in [name of in house hospice facility] for comfort care..." b. The Nurses Note dated 11/17/08 at 1:00 p.m. documented, "[name of ambulance company] her to transport R." c. The Activity Progress Notes dated 11/18/08 and untimed documented, "R has been admitted to [name of in house hospice facility] on 11/17/08..." d. On 1/8/09 at 10:00 a.m., the Medical Records Director stated the resident had been in and out of the hospital and hospice a lot and that she had died out of the facility, "...she was at hospice." She could not locate a physician's discharge summary. e. On 1/8/09 at 11:30 a.m., the Regional Director of Clinical Services and the Director of Nursing (DON) were asked for a discharge summary for the resident's discharge in November 2008. Both were unfamiliar with the form and asked the surveyor if it was on the Nurses Notes. f. On 1/8/09 at 3:00 p.m., the DON was asked again for the physician discharge summary; she showed the surveyor the Nurses Notes. g. On 1/9/09 at 8:30 a.m., the DON stated that the resident's non-narcotic medications were donated	F 514			

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F 514	Continued From page 38 to the local community center and the narcotics were sent back to the state.	F 514			