

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

PRINTED: 03/28/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/14/2008</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>
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F 000	INITIAL COMMENTS  Complaint # 13293 was substantiated, all or in part, with deficiencies cited at F312, F325 and F364.	F 000		
F 157 SS=E	483.10(b)(11) NOTIFICATION OF CHANGES  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 157	Continued From page 1 legal representative or interested family member.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the physician was consulted when Intravenous (IV) Therapy was not continuously provided for 1 (Resident #12) of 1 case mix resident with a Physician's Order for IV therapy and failed to ensure the physician was consulted regarding treatment for a Stage II decubitus and open lesions to the right hand and arm for 1 (Resident #21) of 7 (Residents # 1, #7, #9, #11, #12, #18 and #21) case mix residents with a Physician's Order for treatments. This failed practice had the potential to affect 2 residents that required IV therapy and 33 residents with orders for treatments as identified by lists provided by the Administrator on 3/14/08. The findings are:  1. Resident #12 had diagnoses of Chronic Ischemic Heart Disease and Methicillin Resistant Staphylococcus Aureus (MRSA) Surgical Wound Infection. The Minimum Data Set (MDS) dated 2/18/08 documented the resident had independent cognitive skills for daily decision-making and required limited assistance with ADL's.  a. The Plan of Care dated 2/18/08 documented, "MRSA in Surgical Wound. Vancomycin [for] 6 weeks for MRSA. Risk for dehydration related to recent UTI (Urinary Tract Infection)."  b. A Physician's Order dated 3/6/08 documented, "0.9 % Sodium Chloride (Normal Saline) at KVO (keep vein open) 25 cc/hr (cubic	F 157			

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F 157	<p>Continued From page 2</p> <p>centimeters per hour) per PICC (Peripherally Inserted Central Catheter) line."</p> <p>c. On 3/11/08 at 10 a.m., the resident's IV pump was beeping. Licensed Practical Nurse (LPN) #2 entered the room and turned the IV pump off.</p> <p>d. On 3/11/08 at 1:50 p.m., 2:10 p.m. and 3:40 p.m., the IV was observed to be off.</p> <p>e. On 3/11/08 at 4:00 p.m., six hours after the IV was noted to be turned off, LPN #2 was asked why the IV was turned off. She stated, "It's off right now because we have the meds on order and haven't gotten them yet. We might have Normal Saline (NS) in the ER (emergency) box, I'd have to look." When asked who was supposed to order the IV fluids, the LPN stated, "It's never ran out on my shift so I've never had to order it."</p> <p>f. On 3/11/08 at 4:00 p.m., the Director of Nursing (DON) stated she was aware the IV fluids had run out and had been ordered this morning but was not aware that the fluids were available in the ER box. Both the DON and the LPN stated the physician had not been notified that the IV fluids were not infusing as ordered.</p> <p>2. Resident #21 had diagnoses of Sepsis, Dehydration, Chronic Skin Ulcers, Prolapsed Uterus and Muscle Weakness. The Significant Change MDS dated 2/13/08 documented the resident was moderately impaired in cognitive skills for daily decision making and had 1 Stage I ulcer.</p> <p>a. The Plan of Care dated 2/13/08 documented, "... Problem: Prone to pressure areas related to</p>	F 157			

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F 157	Continued From page 3 incontinence, weight loss, impaired mobility, history of unresolved pressure ulcers. ... Approaches: Monitor skin for reddened areas, blisters, soft 'mushy' areas. Report to physician as needed. ... Use pressure reduction devices in chair and bed. ... "  b. A Physician's Order dated 3/12/08 documented, "Cleanse [Right] buttock with N/S. Apply Duoderm. [Change] q (every) 3 days [and] PRN (as needed). Apply Zinc Oxide to buttock qd (every day)."  c. On 3/13/08 at 10:45 a.m., the resident was in bed. The resident had gauze wrapped on both forearms from the wrists to 1 inch below the elbows. Both forearm dressings were covered with cotton sleeves. The resident had a large black lesion to right hand between the thumb and forefinger, and a large black lesion to the right upper arm and to the left upper arm that were not covered and that seeped liquid from the wounds. Multiple dark bruises and skin tears were noted on the arms and hands.  d. As of 3/13/08, there were no orders in the clinical record to treat the open lesions on the arms and hands.  e. On 3/13/08 at 11:00 a.m., Certified Nurses Assistant (CNA) #9 and CNA #8 entered the room to provide incontinent care. When the resident was turned to wash the perirectal and buttock area, there was an open Stage II ulcer approximately 0.5 centimeter (cm) in diameter located to the upper left inner buttock that was not covered. The heel of the left foot had a 1 inch circular area on the bottom of the heel that was dark red where the bottom of the heel touched	F 157			

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F 157	Continued From page 4 the mattress. The area did not blanch when CNA #9 touched the red area of the heel.  f. On 3/14/08 at 9:50 a.m., the resident was lying on the back in the bed. No dressings were on the lesions to the right hand between the thumb and forefinger, and no dressings were on the lesions to the left upper arm or to the right upper arm.  g. On 3/14/08 at 10:10 a.m., the DON was asked, "What kind of treatment is being done for the open lesion to the right hand and left arm?" The DON stated, "I'll check on that." The DON went to the nurse's desk and asked LPN #5, "What kind of treatments are you doing for the resident's arm and hand?" The LPN stated, "I'm not sure what you're saying." The DON asked the LPN, "Do you know about the uncovered Stage II decubitus on the buttock?" The LPN stated, "Yes, I saw that. But I don't have any orders to treat that." The DON, LPN #5 and the Director of Clinical Services (DCS) went to the resident's room. The LPN was shown the lesions to the right hand and left arm that were not covered. The DON pulled the covers from the resident's feet to look at the Stage I pressure area on the left heel. The lower legs were on pillows to keep the heels off the mattress. LPN #5 stated, "I had the hospice aides put that pillow there this morning after they gave the resident a bath."	F 157		
F 166 SS=D	483.10(f)(2) GRIEVANCES  A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.  This REQUIREMENT is not met as evidenced	F 166		

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F 166	Continued From page 5 by: Based on observation, interview and record review, the facility failed to ensure family grievances concerning catheter care and drainage bag placement were promptly resolved for 1 (Resident #15) of 2 (Residents #15 and #21) case mix residents with catheters. This failed practice had the potential to affect 5 residents with catheters as identified by a list provided by the Administrator on 3/14/08. The findings are:  Resident # 15 had diagnoses of Methicillin Resistant Staph Aureus (MRSA) and Urinary Tract Infection (UTI). The Minimum Data Set (MDS) dated 2/20/08 documented the resident had moderately impaired cognitive skills for daily decision making, was dependent on staff for toileting and personal hygiene, was incontinent of bowel and continent of bladder with an indwelling catheter and had a Urinary Tract Infection in the past 30 days.  a. The Care Plan Conference Summary form dated 10/30/07 documented the resident's spouse expressed the following grievance: "Concern: recurring UTI's not keeping [name of resident] clean and dry."  b. The Care Plan Conference Summary form dated 1/16/08 documented the resident's spouse expressed the following grievance: "Concerns with catheter placement and ensure proper placement of foley bag."  c. A laboratory report dated 2/21/08 documented, "Culture Discharge Penis. Light growth Pseudomonas Aeruginosa. Heavy Growth MRSA - Methicillin resistant Staph Aureus."	F 166		

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F 166	Continued From page 6  d. The Admission Physician's Orders dated 3/7/08 documented, "Will need skilled RN (Registered Nurse) for IV ABT (Intravenous Antibiotics). Continue Isolation for MRSA."  e. A Plan of Care dated 3/10/08 documented, "MRSA Urine. Contact Isolation. Observe Isolation Precautions. Recurrent UTI's. Foley Cath care q (every) shift and PRN (as needed)."  f. On 3/10/08 at 2:25 p.m. and on 3/11/08 at 10 a.m., there were no isolation barrels located in the resident's room or bathroom for contaminated linens or trash.  g. On 3/13/08 at 3:20 p.m., the resident stood up from his recliner and took 2 steps. His catheter was not secured with a leg strap and was pulled taut. CNA #11 picked up the drainage bag and hooked it on her shirt pocket, above the level of the bladder, while assisting the resident to ambulate to the bathroom. The CNA laid the drainage bag in the floor while the resident was sitting on the toilet. The resident's penis had a thick, gummy, dark yellow discharge around the urinary meatus and had wet and dried exudate covering the proximal 2 to 3 inches of the catheter. The resident's incontinent brief was soiled with a half dollar sized area of dark yellow exudate on the inside front panel. CNA #11 stated, "That's drainage from his penis - he has MRSA." The resident had a bowel movement in the toilet. The CNA assisted the resident to stand and wiped the anal area only. The CNA did not cleanse the penis, the catheter insertion site or the catheter. The soiled brief was reapplied to resident. The catheter bag was again held above the level of the bladder during the assisted	F 166			

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F 166	Continued From page 7 ambulation back to the resident's bed.	F 166			
F 221 SS=E	<p>h. Best Practices - A Guide to Excellence in Nursing Care, copyright 2003 by Lippincott Williams &amp; Wilkins, pages 437, 438 documented, "Hang the collection bag below bladder level to prevent urine reflux into the bladder, which can cause infection. Explain the basic principles of gravity drainage so the patient realizes the importance of keeping the drainage tubing and the collection bag lower than his bladder at all times. Tape the catheter to the male patient's thigh to prevent pressure on the urethra at the penoscrotal junction, which can lead to formation of urethrocutaneous fistulas. Taping also prevents traction on the bladder and alterations in the normal direction of urine flow in males".</p> <p>483.13(a) PHYSICAL RESTRAINTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a Physician's Order and consent for a soft belt restraint was obtained prior to the application of the restraint for 1 (Resident #3) of 1 case mix resident and failed to ensure pre-assessments and restraint reductions were completed for 3 (Resident #6, #7 and #8) of 4 (Residents #3, #6, #7 and #8) case mix residents with restraints. These failed practices has the potential to affect 24 residents with restraints according to the list provided by the Administrator on 3/12/08. The findings are:</p>	F 221			

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F 221	Continued From page 8  1. Resident #3 had diagnoses of Transient Cerebral Ischemia, Anorexia, Urinary Tract Infection, and Presenile Dementia. The Minimum Data Set (MDS) dated 12/12/2007 documented the resident was moderately impaired in cognitive skills for daily decision making and required no restraints.  a. A Physician's Order dated 1/12/08 documented, "PSA (Personal Safety Alarm) while in bed and up in w/c (wheelchair)."  b. On 3/11/08 at 8:50 a.m., 12:40 p.m., 1:35 p.m., and 2:10 p.m., the resident was in a wheelchair with a soft belt restraint applied across the resident's lap. There was no PSA.  c. On 3/12/08 at 8:55 a.m. and 4:40 p.m., the resident was in a wheelchair with a soft belt restraint applied across the lap. There was no PSA  d. As of 3/12/08, there was no order for the soft belt restraint.  e. On 3/13/08 at 4:30 p.m., the Director of Nurses (DON) was asked, "Where are the restraint orders and consents kept?" The DON stated, "On the chart." The DON was asked, "Can you find a consent for the soft belt on [Resident # 3]?" The DON stated, "I don't see a consent for a soft belt. Only for a PSA."  2. Resident #8 had diagnoses of Presenile Dementia, Diabetes Type II, Urinary Tract Infection, and Difficulty Walking. The quarterly MDS dated 1/16/08 documented the resident was moderately impaired in cognitive skills for daily	F 221			

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F 221	Continued From page 9 decision making and had a trunk restraint.  a. A Physician's Order dated 11/8/07 documented, "Lap Buddy while up in w/c to reduce risk of unassisted AMB (ambulation) or transfer."  b. The Physical Restraint Informed Consent form dated 11/8/07 documented, " ... Restraint Intervention Recommended ... Restraint Type, Frequency: Lap Buddy while arrow pointing up [up] in w/c. Specific Target Behaviors: To reduce risk of unassisted ambulation or transfer. Medical Symptoms: Dementia. ..."  c. The Plan of Care dated 1/16/08 documented, "... Problem: ... Risk for falls d/t (due to) weakness and cognitive impairment related to dementia and difficulty walking. ... Approaches: ... Lap Buddy while in wheelchair. ..."  d. On 3/10/08 at 6:15 p.m., the resident was in a wheelchair in the dining room with a Lap Buddy applied.  e. On 3/11/08 at 8:30 a.m., 12:50 p.m. and 1:20 p.m., the resident was in a wheelchair with a Lap Buddy applied.  f. On 3/12/08 at 8:40 a.m., the resident was in the day room in a wheelchair with a Lap Buddy applied.  g. On 3/13/08 at 4:20 p.m., the DON was asked, "Can you find a restraint pre-assessment for [Resident #8]? Is there any documentation of attempts to reduce restraints?" The DON stated, "I can't find that."	F 221			

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F 221	<p>Continued From page 10</p> <p>3. Resident #6 had diagnoses of Arteriosclerotic Dementia and Cerebral Artery Occlusion. The initial MDS dated 12/27/07 documented the resident was moderately impaired in cognitive skills for daily decision making and had a trunk restraint.</p> <p>a. A Physician's Order dated 12/14/07 documented, "Soft Waist Restraint while up in W/C."</p> <p>b. The Physical Restraint Informed Consent dated 12/14/07 documented, "... Restraint Type, Frequency: Soft Waist Restraint." The Specific Target Behaviors section and the Medical Symptoms section were left blank.</p> <p>c. The Plan of Care dated 12/27/07 documented, "... Problem: Due to history of multiple falls and attempts to ambulate without assistance related to dementia and depression requires restraints. ... Approaches: Soft waist belt while in wheelchair to prevent unassisted ambulation. ..."</p> <p>d. On 3/10/08 at 6:03 p.m. and 6:40 p.m., the resident was up in a wheelchair with a soft belt restraint applied across the lap.</p> <p>e. On 3/11/08 at 8:50 a.m., the resident was in a wheelchair in the dining room with a soft belt restraint applied.</p> <p>f. On 3/11/08 at 9:30 a.m., the resident was in a wheelchair in the hall with a soft belt restraint applied. The resident stated, "Do you have some scissors so I can cut these straps off so I can go to bed?"</p> <p>g. On 3/11/08 at 12:50 p.m., the resident was in</p>	F 221			

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F 221	<p>Continued From page 11</p> <p>a wheelchair in the dining room with a soft belt restraint applied.</p> <p>h. On 3/13/08 at 4:20 p.m., the DON was asked, "Is there a pre-assessment and documented attempts to reduce the restraint on [Resident # 6]?" The DON stated, "I can't find that." The DON was asked, "Are there any targeted behaviors or medical symptoms on the consent?" The DON stated, "I can't find that."</p> <p>4. Resident #7 had diagnoses of Cerebrovascular Accident (CVA), History of Depression and Breast Neoplasm. The Quarterly MDS dated 3/05/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, needed extensive assistance from the staff for Activities of Daily Living (ADL) and required full side rails on all open sides of the bed and a trunk restraint.</p> <p>a. The Pre Restraining Assessment for the side rails was dated 6/13/06. The consent was dated 5/31/06. The last Physical restraint elimination assessment was dated 2/28/08. There was no documentation that a reduction had been attempted or the reason why the side rails were needed.</p> <p>b. A Physician's Order dated 8/21/06 documented, "Soft belt Restraint while up in wheel chair to prevent getting up without assistance check Q (every) thirty minutes and release Q two hours [for] ten minutes for ROM (range of motion). Side rails X- four while in bed to promote self positioning."</p> <p>c. The Plan of Care dated 3/5/08 documented,</p>	F 221			

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F 221	<p>Continued From page 12</p> <p>"Potential for injury related to restraint use. Approaches: Discuss necessity of restraining device for resident with resident and family..... Soft belt restraint while up in wheelchair..... Remove restraint every two hours for fifteen minutes for toileting, and position change..... Monitor for any signs and symptoms of distress related to use of safety belt."</p> <p>d. On 3/10/08 at 2:07 p.m., the resident was in a wheel chair with a soft belt applied.</p> <p>e. On 3/11/08 at 8:35 a.m., the resident was in a wheel chair with a soft belt applied.</p> <p>f. As of 3/14/08, the clinical record had no documentation that a pre restraining assessment had been completed for the use of the soft belt restraint. The Informed Consent was dated 6/13/06. The Physical restraint elimination Assessment form documented that on 2/24/08, the resident score was 23 making the resident a good candidate for restraint reduction as documented on this same form. There was no documentation that a reduction had been attempted or as to why the restraint was to be continued.</p> <p>g. The Physical restraint elimination assessment form instructions documented, "Restrained individuals should be reviewed at least quarterly to determine whether or not they are candidates for restraint reduction, less restrictive restraining measures, or total restraint elimination. For each category listed below, assess the resident by circling the corresponding score (s) that best describe his/her current status in the appropriate column. Add the column of numbers to obtain the total score. Continue evaluation and review on</p>	F 221			

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F 221	Continued From page 13 the reverse. At the bottom of this form under comments for total score documented 0-20 Priority candidate....21-35 good candidate...35+ Poor candidate."	F 221			
F 241 SS=E	483.15(a) DIGNITY  The facility must promote care for residents in a manner and in an environment that maintains or 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, interview and record review, the facility failed to ensure dignity was maintained while a resident was in bed for 1 (Resident # 7) and while a resident received a shower for 1 (Resident # 6) of 23 case mix residents. These failed practices had the potential to affect all 112 residents as identified by the Resident Census and Conditions of Residents form dated 3/11/08. The findings are:  1. Resident #7 had diagnoses of Cerebrovascular Accident (CVA), History of Depression and Breast Neoplasm. The Quarterly MDS dated 3/05/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, needed extensive assistance from the staff for ADL'S and was	F 241			

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F 241	<p>Continued From page 14 incontinent of bowel and bladder.</p> <p>a. The Plan of care dated 3/5/08 documented, "Unable to provide ADL self care due to cognitive and physical impairments related to Dementia and CVA. Approaches: Provide assistance with ADL'S as needed ... Inability to sense need to urinate or have bowel movement due to cognitive impairments related to Dementia and depression. Approaches: Provide incontinent care as needed ... Provide incontinence briefs as needed."</p> <p>b. On 3/11/08 at 10:00 a.m., the resident was lying in bed on top of the bed spread. The resident was covered with a sheet. Licensed Practical Nurse (LPN) #5 lifted the top sheet off the residents legs. The resident was lying on a bed pad with out a brief and had gray slacks that had been pushed down around both ankles. The resident also had on white socks and black shoes. The LPN pushed the slacks upward on the left leg then provided wound care treatment. The LPN removed gloves and pulled the left leg of the gray slack down around the residents ankle area. A brief was not applied and the pants were not pulled up on the resident. The resident was left lying in that position until 12:35 p.m. when perineal care was provided.</p> <p>2. Resident #6 had diagnoses of Arteriosclerotic Dementia and Cerebral Artery Occlusion. The MDS dated 12/27/07 documented the resident was moderately impaired in cognitive skills for daily decision making and required extensive assistance of 1 person for bathing and grooming.</p> <p>a. The Plan of Care dated 12/27/07 documented, "... Unable to perform adequate self care with ADL's due to lumbar disc repair and history of</p>	F 241			

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F 241	Continued From page 15 CVA ... Assist with ADL's as needed. ..."	F 241		
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a resident was out of bed for meals for 1 (Resident #11) of 23 (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22 and #23) case mix residents, failed to ensure thickened liquids were provided for 1 (Resident #11) of 1 case mix resident who had a Physician's Order for thickened liquids and failed to implement the plan of care for warm packs for 1 (Resident #7) of 7 (Residents #1, #7, #9, #11,	F 282		

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F 282	<p>Continued From page 16</p> <p>#12, #18 and #21) case mix residents with orders for special treatments. This failed practice had the potential to affect 33 residents with orders for special treatments, 4 residents with thickened liquids and 112 residents currently residing in the facility according to a list provided by the facility on 3/14/08 and the Resident Census and Condition of Residents form dated 3/11/08. The findings are:</p> <p>1. Resident #11 had the diagnoses of Cerebrovascular Accident, Esophageal Reflux, and Dysphagia. The date of admission was documented as 2/28/08. The physician history and physical dated 1/29/08 documented, " ... Alert, confused, oriented [times] 1. ... "</p> <p>a. A Physician History and Physical dated 1/29/08 documented, " ... 1/11/08: OPV (Swallowing Study) ... With thin liquids there is a trace amount of penetration and aspiration. ... 11/29/07: OPV (Swallowing Study) ... Aspiration was observed [with] thin liquids. ..."</p> <p>b. The Admission Working Care Plan that was not dated documented, " ... Problem: Poor Intake Food, Choking Risk, Aspiration Risk, Feeding tube ... Follow TF (Tube Feeding) Protocol ... Tube Feedings as ordered. Flushes as ordered. ... "</p> <p>c. On 3/10/08 at 3:20 p.m., the resident was lying on the back in bed. A sign over the head of the bed documented, "Out of bed for all meals!! Honey Thick liquids only!! Please brush teeth every day. Thanks."</p> <p>d. On 3/10/08 at 5:45 p.m., CNA #4 brought the resident's tray into the room. The resident was</p>	F 282			

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F 282	Continued From page 17 lying in the bed with the head of the bed elevated to 30 degrees. The CNA fed the resident in the bed with the head of the bed elevated to 30 degrees. The resident was not out of bed for the meal. e. On 3/11/08 at 9:10 a.m., Licensed Practical Nurse (LPN) #3 entered the resident's room with medications inside a crushing sleeve. The LPN returned to the medication cart and poured the medication into a medicine cup without crushing the medication. The LPN poured thin water into a plastic cup, then returned to the resident's room. The resident was lying in the bed with the head of the bed elevated to 30 degrees. The LPN gave the resident the plastic cup with the thin water, then put the medicine tablets into the resident's mouth. The resident drank the thin water to swallow the pills and coughed twice during the process. The LPN was asked, "How much water was in that cup?" The LPN stated, "About 120 cc (cubic centimeters)."  e. On 3/11/08 at 12:30 p.m., Certified Nursing Assistant (CNA) #5 entered the resident room with the lunch tray. The resident was out of the bed in a reclining wheelchair. The CNA placed the tray on the overbed table and set the tray up for the resident to have lunch. The Director of Clinical Services (DCS) was in the room. The CNA began to offer food to the resident and the resident stated, "I don't like that." The DCS stated, "What would you like?" The resident stated, "Post Toasties." The DCS stated, "We can get that for you." The DCS left the room.  f. On 3/11/08 at 12:35 p.m., the Assistant Administrator came into the room with a covered bowl of cereal and a carton of unthickened whole milk. CNA #5 opened the carton of unthickened	F 282			

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F 282	<p>Continued From page 18</p> <p>milk, poured the milk over the cereal, then placed a straw in the carton. The resident drank the remaining unthickened milk in the carton and ate the cereal with the unthickened milk. The DCS entered the room and stated, "Your milk is empty, do you want some more?" The resident nodded. The DCS stated, "We'll get you some more." The DCS left the room.</p> <p>g. On 3/11/08 at 12:40 p.m., the DCS returned to the resident's room with a carton of unthickened whole milk. The DCS opened the carton of unthickened milk, placed a straw into the carton and gave the carton to the resident. The resident drank the unthickened milk through the straw.</p> <p>h. On 3/11/08, the DCS stated the facility posted the sign that was above the resident's bed that documented the resident was to be out of bed for all meals and was to receive honey thickened liquids.</p> <p>i. On 3/13/08 at 3:20 p.m., LPN #3 was asked, "Do you carry thickened liquids on your cart?" The LPN stated, "No." The LPN was asked, "If a resident has thickened liquids, how do you give the medications?" The LPN stated, "There is a cooler in the room with thickened drinks that we use."</p> <p>2. Resident #7 had the diagnoses of Cerebrovascular Accident (CVA), History of Depression and Breast Neoplasm. The Quarterly MDS dated 3/05/08 documented the resident had moderately impaired cognitive skills for daily decision-making, needed extensive assistance from the staff for Activities of Daily Living (ADL),</p>	F 282			

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F 282	Continued From page 19 was incontinent of bowel and bladder, had open lesions other than ulcers, rashes, cuts and application of ointments, medication and dressings other than feet.  a. The Plan of Care dated 3/5/08 documented, "At risk for skin breakdown due to impaired ability to reposition self adequately without assistance. Approaches: Treatment as ordered."  b. A Physician's Order dated 10/17/07 documented, "Warm Moist Heat to right lower leg bid (twice daily)."  c. The Treatment Administration Record for March 2008 documented, "Warm Moist heat to right lower leg bid." D/C (discontinue) was written in the time section and all areas were left blank.  d. On 3/11/08 at 4:30 p.m., Licensed Practical Nurse (LPN) #5, the treatment nurse, was asked about the Physician's Order for the warm moist heat to the right lower leg dated 10/17/07 and March 2008. The LPN stated, "I never checked that order, but that treatment has never been done."	F 282		
F 309 SS=E	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:	F 309		

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F 309	<p>Continued From page 20</p> <p>Complaint # 13371 was substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure a foley catheter was secured to prevent potential injury to the meatus for 2 (Resident #15 and #21), failed to ensure soap or other cleansing agent was used for foley catheter care, all areas of the perineum were cleansed and the catheter tubing was cleansed for 2 (Resident #15 and #21) and failed to ensure foley catheter bags were not placed above the bladder or on the floor for 1 (Resident #15) of 2 (Residents #15 and #21) case mix residents with a foley catheter. This failed practice had the potential to affect 5 residents with a Physician's Order for a foley catheter according to the list provided by the Administrator on 3/14/08. The findings are:</p> <p>1. Resident #21 had the diagnoses of Sepsis, Dehydration, Chronic Skin Ulcers, Prolapsed Uterus and Muscle Weakness. The Significant Change Minimum Data Set (MDS) dated 2/13/08 documented that the resident was moderately impaired in cognitive skills for daily decision making, was totally dependent on 2 or more persons for bathing and had a foley catheter.</p> <p>a. The Plan of Care dated 2/13/08 documented, " ... Has indwelling catheter with potential for injury, infection ... Approaches: Give perineal care when incontinent of bowel - Cleanse front to back to prevent contamination of urinary meatus. ... Secure catheter per facility protocol to prevent trauma. ... Provide catheter care and change catheter as ordered. ..."</p> <p>b. On 3/13/08 at 11:00 a.m., Certified Nurses</p>	F 309		

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F 309	<p>Continued From page 21</p> <p>Assistant (CNA) #9 and #8 provided care for the resident. CNA #8 pulled the covers back. The foley catheter tubing was not secured and was stretched tight across the top of the resident's right thigh. The labia had a thick purulent appearing substance visible around the foley extending down the entire fold of the pubic area. CNA #8 handed CNA #9 a bundle of wet wash cloths and CNA #9 washed the resident with the wash cloths. CNA #9 washed the left side of the labia. A brown substance was seen on the wash cloth. CNA #9 was asked, "What is that?" CNA #9 stated, "BM (bowel movement)." CNA #9 turned the wash cloth and washed the left side of the labia. CNA #9 spread the labia and the uterus was visible protruding out of the vaginal area about the size of a large lemon. CNA #8 handed a new wash cloth to CNA #9. The vaginal and inner labia area was washed front to back, turning the cloth after each wipe. The foley catheter tubing was not cleansed. CNA #9 was asked, "Was there any kind of cleansing agent on the wash cloths?" CNA #8 stated, "No, only water." CNA #9 was asked, "Did you clean the foley tubing?" CNA #9 stated, "No, only around the very closest part."</p> <p>c. On 3/13/08 at 4:20 p.m., the Director of Nursing (DON) was asked, "What is the process for providing pericare at this facility?" The DON stated, "Wash with Peri-Wash or soap and water." The DON was asked, "Is it appropriate to clean residents with catheters with wash cloths wet with water only?" The DON stated, "No, especially if they have a catheter."</p> <p>d. On 3/14/08 at 10:10 a.m., the Director of Nursing (DON) pulled the covers from the resident to assess the foley tubing. The right</p>	F 309		

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F 309	<p>Continued From page 22</p> <p>thigh had a square adhesive tape device with a Velcro strap wrapped around the foley tubing. The Y site of the foley catheter was not secured in the Velcro strap, allowing the foley catheter tubing to slip back and forth through the device causing a risk for trauma to the urethra. The DON fastened the foley catheter in the device securing the Y site of the catheter to prevent movement.</p> <p>2. Resident #15 had diagnoses of Methicillin Resistant Staph Aureus (MRSA) and Urinary Tract Infection (UTI). The MDS dated 2/20/08 documented the resident was moderately impaired in cognitive skills for daily decision making, dependent on staff for toileting and personal hygiene, incontinent of bowel and continent of bladder with an indwelling catheter and had a Urinary Tract Infection in the past 30 days.</p> <p>a. The Plan of Care dated 3/10/08 documented, "MRSA Urine. Contact Isolation. Observe Isolation Precautions. Recurrent UTI's. Foley Cath care q (every) shift and PRN (as needed)."</p> <p>b. On 3/13/08 at 3:20 p.m., the resident stood up from his recliner and took 2 steps. His catheter was not secured with a leg strap and was pulled taut. CNA #11 picked up the drainage bag and hooked it on her shirt pocket, above the level of the bladder, while assisting the resident to ambulate to the bathroom. The CNA laid the drainage bag in the floor while the resident was sitting on the toilet. The resident's penis had a thick, gummy, dark yellow discharge around the urinary meatus and had wet and dried exudate</p>	F 309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/14/2008</b>
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F 309	Continued From page 23 covering the proximal 2 to 3 inches of the catheter. The resident's incontinent brief was soiled with a half dollar sized area of dark yellow exudate on the inside front panel. The CNA stated, "That's drainage from his penis. He has MRSA." The resident had a bowel movement in the toilet. The CNA assisted the resident to stand and wiped the anal area only. The CNA did not cleanse the penis, the catheter insertion site or the catheter. The soiled brief was reapplied. The catheter bag was again held above the level of the bladder during the assisted ambulation back to the resident's bed.  c. Best Practices - A Guide to Excellence in Nursing Care, copyright 2003 by Lippincott Williams & Wilkins, pages 437, 438 documented, "Hang the collection bag below bladder level to prevent urine reflux into the bladder, which can cause infection. Explain the basic principles of gravity drainage so the patient realizes the importance of keeping the drainage tubing and the collection bag lower than his bladder at all times. Tape the catheter to the male patient's thigh to prevent pressure on the urethra at the penoscrotal junction, which can lead to formation of urethrocutaneous fistulas. Taping also prevents traction on the bladder and alterations in the normal direction of urine flow in males."	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	F 312			

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F 312	<p>Continued From page 24</p> <p>by:</p> <p>Complaint #13293 was substantiated (all or in part) in these findings. Complaint #13371 was substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure all areas of the perineum were cleansed when incontinent care was provided for 4 (Residents #7, #10, #14 and #15) of 14 (Residents #2, #3, #4, #6, #7, #8, #9, #10, #11, #14, #15, #17, #18, #21 and #22) case mix residents that required assistance with incontinent care, failed to provide assistance with eating for 2 (Resident #3 and #14) of 11 (Residents #2, #3, #4, #7, #9, #11, #12, #14, #16, #21 and #22) case mix residents who needed assistance with eating and failed to provide nail care for 1 (Resident #15) of 10 (Residents #2, #4, #9, #12, #14, #15, #16, #18, #21 and #22) case mix residents dependent for ADL's. These failed practices had the potential to affect 27 residents dependent for nail care, 69 residents dependent on staff for incontinent care, and 14 residents dependent on staff for assistance with eating as identified by lists provided by the facility on 3/14/08 . The findings are:</p> <p>1. Resident #7 had the diagnoses of Cerebrovascular Accident (CVA), History of Depression and Breast Neoplasm. The Quarterly Minimum Data Set (MDS) dated 3/05/08 documented that the Resident had moderately impaired cognitive skills for daily decision-making, needed extensive assistance from the staff for Activities of Daily Living (ADLs) and was incontinent of bowel and bladder.</p>	F 312			

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F 312	<p>Continued From page 25</p> <p>a. The Plan of care dated 3/5/08 documented Problem: Unable to provide ADL self care due to cognitive and physical impairments related to Dementia and CVA. Approaches: Provide assistance with ADL'S as needed.</p> <p>b. On 3/11/08 at 12:35 p.m., the resident was lying in bed on top of the bed spread on a pad and was covered with a sheet. Certified Nursing Assistant (CNA) #12 and #13 provided care for the resident. CNA #13 took moistened wipes from a container. With one wipe, the CNA cleansed front to back down the right groin and inner thigh area and placed the soiled wipe into a plastic bag. With a clean wet wipe, the CNA cleansed downward on the left groin area. The resident was positioned on her left side. The resident had a moderate brown soft bowel movement (BM). CNA #12 removed the BM with a wipe then placed the wipe in the plastic bag and changed gloves. Both CNA's removed the soiled bed pad and placed a clean incontinent brief on the resident. The front of the perineal area and the buttocks were not cleansed. The labia was not separated to cleanse the urinary meatus. The resident was dressed, assisted out of bed into the wheel chair, and wheeled to the dinning room for lunch.</p> <p>2. Resident #10 had diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension and Dementia. The MDS had not been completed. The admission date was 3/6/08 for Hospice comfort care.</p> <p>a. The admission working Plan of Care (not dated) documented, "At risk for skin breakdown. Approaches: Prevent infection ,promote comfort."</p>	F 312			

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F 312	Continued From page 26  b. On 3/12/08 at 11:20 a.m., the resident was lying in bed on her back. CNA #10 and #14 stated they were from Hospice and placed clean supplies on the bed. CNA #14 placed a pan of warm water on the bed side table. CNA #14 removed the urine saturated brief from the resident. CNA #10 took a wet soapy wash cloth and squeezed the soapy water over the top perineal area. The CNA then wiped both sides of the groin area back to front then front to back and across the top area with the same wash cloth area. The resident was placed on her left side. The same wash cloth that was used on the front of the perineal area was also used to clean the anal area back to front. The CNA dried the anal area with a clean towel. Both CNA'S placed a clean incontinent brief on the resident and secured at both sides. The labia was not separated to cleanse the urinary meatus. The buttocks were not cleansed. The soapy water was not rinsed from the entire perineal area.  3. Resident #15 had diagnoses of Coronary Artery Disease and Diabetes Mellitus. The Minimum Data Set (MDS) dated 2/20/08 documented the resident was moderately impaired in cognitive skills for daily decision making and was dependent on staff for personal hygiene.  a. The Plan of Care dated 3/10/08 documented, "Unable to provide appropriate self care with ADL's (Activities of Daily Living) due to cognitive and physical impairments."  b. On 3/13/08 at 3:20 p.m., the resident's fingernails on both hands extended 1/2 inch past	F 312			

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F 312	Continued From page 27 the ends of his fingers and thumbs with sharp, jagged edges and a dark substance beneath the nail beds.  4. Resident #3 had the diagnoses of Transient Cerebral Ischemia, Anorexia, Urinary Tract Infection, and Presenile Dementia. The MDS dated 12/12/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance of one person for hygiene and bathing and was totally dependent on staff for toilet use.  a. A Physician's Order dated 2/20/08 documented, "Needs to be in feeder room."  b. The Plan of Care updated 11/7/07 documented, " ... Problem: ... Impaired ability to provide appropriate self care in ADL's ... Continue to assist in ADL's as needed. ... Problem: At risk for weight loss and or dehydration related to history of anorexia and and reduced fluid intake due to history of weight loss and dehydration related to cognitive impairment due to dementia and depression. ... Approaches: ... 2/22/08: Feeder room. Supplements as ordered. ..."  c. On 3/10/08 at 3:10 p.m., Licensed Practical Nurse (LPN) #1 stated, " ... [Resident #3] requires assistance of 1 for ADL's ... eats at feeder table. ... "  d. On 3/10/08 at 6:15 p.m., the resident was sitting up in bed with the head of the bed flat. No lights were on in the room. The overbed table was across the foot of the bed. No staff were present in the resident's room to assist or feed the resident. The resident was not eating and stated, "They didn't bring me any silverware."	F 312			

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F 312	<p>Continued From page 28</p> <p>Facility Staff #1 entered the room and sat silverware wrapped in a paper napkin on the resident's tray. Facility Staff #1 did not open silverware for the resident.</p> <p>e. On 3/10/08 at 6:25 p.m., the resident was sitting up in the bed with the head of the bed flat, the supper tray on the overbed table at the foot of the bed. No lights were on in the room. No staff were present in the room to assist the resident.</p> <p>f. On 3/10/08 at 6:35 p.m., the resident was sitting up in bed with the head of the bed flat. The supper tray was on the overbed table across the foot of the bed. No lights were on in the room. No staff were present to assist the resident. The resident was not eating. The resident's roommate would prompt the resident to take a bite. The resident would pick up the sandwich when prompted.</p> <p>g. On 3/10/08 at 7:00 p.m., the resident pushed the tray on the overbed table back and laid down in the bed. Less than 25% of the meal was consumed.</p> <p>h. On 3/11/08 at 1:45 p.m., the resident was toileted by the Assistant Director of Nursing (ADON) and Certified Nursing Assistant (CNA) #2. The resident had a bowel movement, and was lifted up from the toilet by the ADON and the CNA. The ADON took two incontinent wipes and cleaned the resident's peri-rectal area wiping front to back. Brown bowel movement was visible on the incontinent wipes. Without turning the wipes or obtaining fresh incontinent wipes, the resident was wiped front to back again, introducing the bowel movement on the wipes into the urethra/vaginal area. The resident was unsteady</p>	F 312			

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F 312	<p>Continued From page 29</p> <p>and sat down suddenly on the toilet. No further cleaning of the peri-rectal area was observed.</p> <p>5. Resident #14 had the diagnoses of Parkinson's Disease, Alzheimer's, Dementia, Paralysis Agitans, and Polyneuropathy. The ADL Functional/Restorative Assessment (not dated) and Progress form documented the resident was totally dependent for personal grooming, dressing and toileting. The eating/feeding section was blank.</p> <p>a. The Admission Working Care Plan dated 3/11/08 documented, " ... Problem: Nutrition / Hydration [at] risk related to dementia. ... Intervention: Monitor Intake. Weekly Wts (weights) [times] 4. RD (Registered Dietician) Consult PRN (as needed). ... Problem: Incont. (Incontinent) of B+B (Bowel and Bladder). ... Intervention: Monitor for incont. Keep clean [and] dry. ..."</p> <p>b. On 3/12/08 at 10:20 a.m., the resident was in the bed with the head of the bed elevated 20 degrees. Both side rails were elevated. A strong urine odor was coming from the room. The resident was unshaven. CNA #6 entered the resident's room, pulled back the covers and looked at the incontinent brief. The CNA stated, "Yes, he's wet." The CNA unfastened the incontinent brief and rolled the resident to the left side to remove the brief. Dried bowel movement (BM) was on the resident's buttocks. The CNA was asked, "What is that?" The CNA stated, "Looks like dried BM." The CNA was asked, "Is there any BM in the brief?" The CNA stated, "No. That must be from some other time." The CNA was asked, "Was the brief wet?" The CNA stated, "It was completely soaked." The CNA</p>	F 312			

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F 312	<p>Continued From page 30</p> <p>removed the brief and discarded it in the bathroom. The CNA covered the resident with a sheet and left the room. The resident's breakfast tray sat on the overbed table near the bed curtain. The tray was uncovered and contained scrambled eggs, chopped sausage, toast, 1 bowl of oatmeal, 1 open carton of whole milk, and 4 ounces of cranberry juice opened. None of the tray had been consumed or disturbed.</p> <p>c. On 3/12/08 at 10:30 a.m., Licensed Practical Nurse (LPN) #2 came to the resident's room. The LPN was asked, "Is the resident going to get incontinent care?" The LPN stated, "They're making their rounds, they'll get to him soon." The LPN was asked, "What time is breakfast served?" The LPN stated, "8:30." The LPN was asked, "How much did he eat?" The LPN stated, "Looks like he's refusing breakfast. He's kind of a different person." The LPN left the room.</p> <p>d. On 3/12/08 at 10:35 a.m., CNA #6 came into the room and stated, "They haven't come to clean him?" The CNA left the room.</p> <p>e. On 3/12/08 at 10:39 a.m., CNA #6 and #7 entered the room. CNA #6 pulled back the covers and lifted the hospital gown. The resident had electrodes from an electrocardiogram adhered to the mid sternum and the left lower quadrant of the abdomen. CNA #6 was asked, "How long has he had these on?" The CNA stated, "I don't know."</p> <p>f. On 3/12/08 at 10:45 a.m., the Director of Nursing (DON) came into the room. A body audit was performed. The resident had a Band-Aid on the left upper arm with a cotton ball with dried blood on it. The resident had a hospital</p>	F 312			

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F 312	Continued From page 31 identification band on the right wrist. The resident had the electrocardiogram (EKG) electrodes on the chest and lower abdomen. The DON was asked, "How long have these (the EKG electrodes) been on?" The DON stated, "He was sent out the the ER (emergency room) on Monday and sent back." The DON was asked, "Does the breakfast tray look like it has been touched?" The DON stated, "No." The DON instructed the CNAs to take the resident to the shower room and give the resident a shower. The DON instructed the CNAs to shave the resident.  g. On 3/13/08 at 10:45 a.m., the resident was in the bed with the side rails up on both sides. There was a strong urine smell coming from the resident. CNA #8 entered the room and stated, "I'm going to change his brief." The CNA provided incontinent care with wet wash cloths. The buttocks were not washed. The CNA was asked, "Was that brief very wet?" The CNA stated, "It was bad wet." The CNA was asked, "Did you wash the buttocks?" The CNA stated, "No." The CNA was asked, "What was on the wash cloths?" The CNA stated, "Just water."	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.	F 314		

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F 314	<p>Continued From page 32</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure a Stage II decubitus was identified and treated, and failed to implement measures to prevent the development of pressure ulcers for 1 (Resident #21) of 4 (Residents #1, #2, #9 and #21) case mix residents with pressure ulcers. This failed practice had the potential to affect 8 residents with pressure ulcers according to the Resident Census and Conditions of Residents form dated 3/11/08. The findings are:</p> <p>Resident #21 had the diagnoses of Sepsis, Dehydration, Chronic Skin Ulcers, Prolapsed Uterus and Muscle Weakness. The Significant Change Minimum Data Set dated 2/13/08 documented the resident was moderately impaired in cognitive skills for daily decision making and had 1 Stage I ulcer.</p> <p>a. The Plan of Care dated 2/13/08 documented, " ... Problem: Prone to pressure areas related to incontinence, weight loss, impaired mobility, history of unresolved pressure ulcers. ... Approaches: Monitor skin for reddened areas, blisters, soft 'mushy' areas. Report to physician as needed. ... Use pressure reduction devices in chair and bed. ... "</p> <p>b. A Physician's Order dated 3/12/08 documented, "Cleans [Right] buttock with N/S (Normal Saline). Apply Duoderm. [Change] q (every) 3 days [and] PRN (as needed). Apply Zinc Oxide to buttock qd (every day)."</p> <p>c. On 3/13/08 at 10:45 a.m., the resident was in the bed with no pressure relieving device on the</p>	F 314			

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F 314	<p>Continued From page 33</p> <p>bed. No pillows were under the feet area to prevent heels from pressing into the mattress. Both heels were pressing on the mattress.</p> <p>d. On 3/13/08 at 11:00 a.m., Certified Nurses Assistant (CNA ) #9 and #8 entered the room to provide incontinent care. CNA #8 handed CNA #9 a bundle of wet wash cloths and CNA #9 washed the resident with the wash cloths. The resident had a bowel movement (BM). When the resident was turned to wash the perirectal and buttock area, a duoderm dressing was noted on the left buttock close to the coccyx area that was dated 3/11/08. There was an open ulcer approximately 0.5 centimeter (cm) in diameter located near the upper left corner of the duoderm that was not covered. CNA #9 washed the buttock area with a wet wash cloth. A body audit was performed. Both shoulder blade areas were red. The heel of the left foot had a 1 inch circular area on the bottom of the heel that was dark red where the bottom of the heel touched the mattress. The area did not blanch when CNA #9 touched the red area of the heel. CNA #9 was asked, "Was there any kind of cleansing agent on the wash cloths?" CNA #8 stated, "No, only water." CNA #9 was asked, "Would you say this was a pressure relieving mattress? CNA #9 stated, "No, it looks like a regular mattress to me."</p> <p>e. On 3/14/08 at 10:10 a.m., the Director of Nursing (DON) was asked, "What kind of pressure relieving mattresses are on the beds?" The DON stated, "They are not pressure relieving, they are pressure reducing." The DON was asked, "Did the CNAs say anything about the uncovered Stage II decubitus on [Resident #21]'s left buttock and the Stage I decubitus on the</p>	F 314			

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F 314	Continued From page 34 bottom of the left heel that we saw yesterday?" The DON stated, "No." The DON asked LPN #5 "Do you know about the uncovered Stage II decubitus on the buttock?" LPN #5 stated, "Yes, I saw that. But I don't have any orders to treat that." The DON, LPN #5 and the Director of Clinical Services (DCS) went to the resident's room. The DON was asked, "Do you think this mattress is appropriate given the condition of this resident's skin?" The DON stated, "No." The DON pulled the covers from the resident's feet to look at the Stage I pressure area on the left heel. The lower legs were on pillows to keep the heels off the mattress. LPN #5 stated, "I had the hospice aides put that pillow there this morning after they gave the resident a bath."	F 314			
F 315 SS=E	483.25(d) URINARY INCONTINENCE  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate 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 a back to front motion was not used and a clean area of the wipe/washcloth was used when care was provided for 3 (Resident #3, #6 and #10) of 14 (Residents #2, #3, #4, #6, #7, #8, #9, #10, #11, #14, #15, #17, #18, #21 and #22) case mix residents that required assistance	F 315			

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F 315	Continued From page 35 with incontinent care. This failed practice had the potential to affect 69 residents dependent on staff for incontinent care as identified by lists provided by the facility on 3/14/08. The findings are:  1. Resident #10 had diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension and Dementia. The MDS had not been completed. The admission date was 3/6/08 for Hospice comfort care.  a. The admission working Plan of Care (not dated) documented, "At risk for skin breakdown. Approaches: Prevent infection ,promote comfort."  b. The Laboratory report for a urine culture dated 3/9/08 documented greater then 1000,000 cfu/ml: Pseudomonas Aeruginosa.  c. A Physician's Order dated 3/10/08 documented, "Levaquin 250 mg (milligram) every day for 10 days Diagnoses: Urinary Track Infection."  d. On 3/12/08 at 11:20 a.m., the resident was lying in bed on her back. Certified Nursing Assistant (CNA) #14 placed a pan of warm water on the bed side table. CNA #14 removed the urine saturated brief from the resident. CNA #10 took a wet soapy wash cloth and squeezed the soapy water over the top perineal area. The CNA then wiped both sides of the groin area back to front then front to back and across the top area with the same wash cloth area. The resident was placed on her left side. The same wash cloth that was used on the front of the perineal area was also used to clean the anal area back to front.	F 315			

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F 315	<p>Continued From page 36</p> <p>The CNA dried the anal area with a clean towel. Both CNA'S placed a clean incontinent brief on the resident and secured at both sides. The soapy water was not rinsed from the entire perineal area.</p> <p>2. Resident #3 had the diagnoses of Transient Cerebral Ischemia, Anorexia, Urinary Tract Infection, and Presenile Dementia. The MDS dated 12/12/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance of one person for hygiene and bathing and was totally dependent on staff for toilet use.</p> <p>a. A Physician's Order dated 2/20/08 documented, "Needs to be in feeder room."</p> <p>b. The Plan of Care updated 11/7/07 documented, " ... Problem: ... Impaired ability to provide appropriate self care in ADL's ... Continue to assist in ADL's as needed."</p> <p>c. On 3/11/08 at 1:45 p.m., the resident was toileted by the Assistant Director of Nursing (ADON) and Certified Nursing Assistant (CNA) #2. The resident had a bowel movement, and was lifted up from the toilet by the ADON and the CNA. The ADON took two incontinent wipes and cleaned the resident's peri-rectal area wiping front to back. Brown bowel movement was visible on the incontinent wipes. Without turning the wipes or obtaining fresh incontinent wipes, the resident was wiped front to back again, introducing the bowel movement on the wipes into the urethra/vaginal area. The resident was unsteady and sat down suddenly on the toilet. No further cleaning of the peri-rectal area was observed.</p>	F 315			

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F 315	Continued From page 37 3. Resident #6 had the diagnoses of Arteriosclerotic Dementia and Cerebral Artery Occlusion. The MDS dated 12/27/07 documented the resident was moderately impaired in cognitive skills for daily decision making and required extensive assistance of 1 person for bathing and grooming.  a. The Plan of Care dated 12/27/07 documented, " ... Problem: Unable to perform adequate self care with ADL's due to lumbar disc repair and history of CVA. ... Assist with ADL's as needed. ..."  b. On 3/12/08 at 9:15 a.m., the resident received a shower by CNA #2 in the 300 hall shower room. The CNA washed the vagina, perineal and rectal area front to back then, without turning or rinsing the cloth, wiped back to front. The wash cloth was moved front to back and back to front several times without turning the cloth.	F 315			
F 318 SS=E	483.25(e)(2) RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure restorative nursing was provided to increase range of motion and/or prevent further avoidable decline in range of motion for 1 (Resident #9) of 3 (Residents #9,	F 318			

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F 318	Continued From page 38 #14 and #22) case mix residents with orders for restorative nursing. This failed practice had the potential to affect 9 residents with orders for restorative nursing as identified by a list provided by the Restorative Nursing Assistant on 3/14/08. The findings are:  Resident #9 had diagnoses of Cerebrovascular Accident (CVA), Paraplegia and Contractures. The Minimum Data Set dated 2/25/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, totally dependent on staff for bed mobility, had full loss functional limitation in range of motion of both legs and feet and experienced moderate joint pain daily.  a. A Plan of Care dated 2/25/08 documented, "Impaired mobility to BLE (bilateral lower extremities) due to CVA and Contractures."  b. A Physician's Progress Note dated 1/8/08 documented, "I think her problem is more of a neuropathy and pain from the muscle contractures due to her stroke."  c. A Physician's Progress Note dated 1/15/08 documented, "She has had a stroke, is in chronic pain, has terrible contractures."  d. A Physician's Order dated 1/31/08 documented, "Restorative for daily ROM (range of motion) 5 [times]/week [times] 8 weeks BLE."  e. On 3/14/08 at 9:45 a.m., the Restorative CNA (RCNA) provided a copy of the list of residents currently receiving restorative nursing services. The resident was not on the list. When asked about the 1/31/08 Physician's Order for the	F 318		

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F 318	Continued From page 39 Restorative program, the RCNA stated, "I didn't get this order. It was never started and she's not on my case load now."	F 318			
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES  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.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a feeding tube was flushed for 1 (Resident #11) of 1 case mix resident with a feeding tube. This failed practice had the potential to affect 2 residents with feeding tubes according to the Resident Census and Conditions of Residents form dated 3/11/08. The findings are:  Resident #11 had diagnoses of Cerebrovascular Accident, Esophageal Reflux and Dysphagia. The date of admission was documented as 2/28/08. The physician history and physical dated 1/29/08 documented, " ... Alert, confused, oriented [times] 1. ... "  a. A Physician's Order dated 2/29/08 documented, "... Flush G/Tube (Gastrostomy Tube) with 150 cc (cubic centimeters) H2O (water) q (every) 4 hours. Flush G/T with 60cc H2O pre/post meds (before and after medications) and bolus feedings."	F 322			

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F 322	Continued From page 40  b. A Physician's Order dated 3/4/08 documented, "Bolus feedings [after] each meal [with] Nutren Pulmonary. ..."  c. The Admission Working Care Plan (not dated) documented, " ... Problem: Poor Intake Food, Choking Risk, Aspiration Risk, Feeding tube. ... Approaches: ... Follow TF (Tube Feeding) Protocol ... Tube Feedings as ordered. Flushes as ordered. ... "  d. On 3/11/08 at 9:30 a.m., Licensed Practical Nurse (LPN) #3 was outside the resident's room with the medication cart. The LPN stated, "I'm supposed to flush his PEG tube but first I need to know how much he had for breakfast so I'll know whether to give him a bolus or not." The LPN was asked, "Are you going to go do that now?" The LPN stated, "I'm going to finish giving the meds on my hall before I take care of that."  e. On 3/11/08 at 12:05 p.m., LPN #3 was in the resident's room at the bedside. The LPN stated, "I'm needing to flush the PEG tube, and I'm going to feel real stupid because this is something I've never done before." The resident was sitting in a reclining wheelchair beside the bed. The Director of Clinical Services (DCS) entered the room. The LPN stated, "How do you flush a tube with an extension tube in the end of the peg tubing?" The DCS stated, "Look at the care plan and do what it tells you." The LPN stated, "I did. And it didn't have anything about that extended tube on there. I'm not going to do anything until I know what that tube is for." The Director of Nursing (DON) entered the room. The DCS stated, "Do you know what that tube is for?" The DON stated, "I'll check into it." The DON and LPN #3 left the	F 322			

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F 322	Continued From page 41 resident's room. No flush was given. No bolus was given.	F 322		
F 323 SS=E	<p>f. On 3/13/08 at 3:20 p.m., LPN #3 was asked, "Was the morning flush administered to [Resident #3]?" The LPN stated, "No, it wasn't."</p> <p>483.25(h) ACCIDENTS AND SUPERVISION</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure Personal Alarms were consistently and/or correctly implemented for 6 (Resident #2, #3, #4, #8, #14 and #16 ) of 15 (Residents #2, #3, #4, #6, #7, #8, #11, #12, #14, #15, #16, #17, #20, #21 and #22) case mix residents with personal alarms, failed to obtain a wedge cushion for a wheel chair and/or initiate a new intervention timely to prevent future falls for 1 (Resident #4) of 6 (Residents #2, #4, #14, #15, #20 and #21) case mix residents who required a positioning device, failed to ensure transfers were not completed by holding the axillae area for 1 (Resident #3) of 9 (Residents #2, #3, #4, #12, #14, #16, #17, #19 and #22) case mix residents that required weight bearing assistance with transfers, failed to ensure restraints were applied correctly for 3 (Residents #3, #6 and #7) of 4 (Residents #3, #6, #7 and #8) case mix residents with restraints and failed to</p>	F 323		

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F 323	Continued From page 42 ensure wheel chairs were locked when repositioning was performed for 1 (Resident #11) of 9 (Residents #2, #3, #4, #12, #14, #16, #17, #19 and #22) case mix residents who required assistance with positioning. These failed practices had the potential to affect 59 residents with personal alarms, 22 residents who required positioning devices, 24 residents with restraints and 45 residents requiring weight bearing assistance with transfers and/or positioning as identified by lists provided by the Administrator on 3/14/08. The findings are:  1. Resident #2 had diagnoses of Alzheimer's Disease, Cerebrovascular Accident (CVA) and Osteoporosis. The Minimum Data Set (MDS) dated 11/5/07 documented the resident was severely impaired in cognitive skills for daily decision-making, required extensive assistance for transfers, had partial loss of functional range of motion in one leg, did not ambulate, had fallen in the past 31-180 days and had a hip fracture in the past 180 days.  a. A Fall Risk Assessment dated 3/3/08 documented, "If total is 12 or greater the resident is considered to be at high risk for falls." The documented score was 14.  b. A Plan of Care dated 3/11/08 documented, "Risk for falls and Fx (fracture) due to cognitive and physical impairments related to Dementia, Alzheimer's and Osteoporosis. History of arm Fx. and history of hip Fx."  c. The Treatment Administration Record (TAR) for March 2008 documented, "Pressure PSA (personal safety alarm) in bed to alert staff of unassisted transfers" and "PSA while up in	F 323			

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F 323	Continued From page 43 wheelchair."  d. On 3/10/08 at 3:10 p.m., the resident was observed in bed. A magnet type personal alarm was in place instead of the pressure sensor pad alarm.  e. On 3/13/08 at 10:15 a.m., the resident was observed in bed. There was no alarm in place.  2. Resident #4 had diagnoses of Alzheimer's Disease, Organic Brain Syndrome and Osteoarthritis. The MDS dated 1/29/08 documented the resident was severely impaired in cognitive skills for daily decision-making, required extensive assistance with transfers, had functional limitation in range of motion in both legs and feet and had fallen in the past 30 days.  a. A Therapy Fall Screening Form dated 1/14/08 documented, "Resident slipped out of wheelchair in Dining room and fell to floor. Resident often sits on edge of wheelchair seat to propel self down hall with feet. Considered an isolated event. Encourage patient to scoot back in wheelchair to prevent patient from scooting out."  b. A Therapy Fall Screening Form dated 1/18/08 documented, "Date of fall 1/17/08. Slid out of wheelchair and sat on floor. Resident tends to sit on forward 1/2 of wheelchair seat. Recommend wedge cushion for resident. None in building. Will order."  c. An Interdisciplinary Therapy Screening form dated 2/17/08 documented, "Resident slid out of wheelchair 2/17/08 and landed on right side. Patient needs moderate assist to transfer. Talked with nursing about correct positioning device	F 323			

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F 323	Continued From page 44 placement on wheelchair and to monitor for increased fall risk."  d. The Plan of Care dated 2/18/08 documented, "Actual Fall on 2/17/08 with complaints of slight right shoulder pain and right hip pain with range of motion. Wedge cushion placed in wheelchair to assist [Resident #4] to sit back in wheelchair."  e. On 3/11/08 at 8:45 a.m., the resident was observed in the wheelchair with a 4 inch cushion that was not wedge shaped.  f. On 3/11/08 at 10:00 a.m., the resident was transferred from the wheelchair to the bed. The cushion in the chair was measured with the resident out of the chair to be 4 inches on all 4 sides.  g. On 3/13/08 at 11:30 a.m., the Corporate Director of Clinical Services stated that she had measured the cushion and it was a wedge cushion with a "very slight" incline.  h. On 3/14/08 at 10 a.m., the Physical Therapist stated the cushion in the wheelchair was the same one the resident had to begin with. He stated a Pommel cushion had been sent instead of a wedge cushion. It didn't work so they went back to the original cushion. A wedge cushion had not been obtained for this resident.  3. Resident #16 had diagnoses of Abnormal Gait and History of Falls. The MDS dated 1/23/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, was non-ambulatory, had functional limitation in range of motion in one leg, and had an unsteady gait.	F 323		

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F 323	Continued From page 45  a. A Plan of Care dated 1/11/08 documented, "At risk for continued falls due to cognitive and physical impairments. PSA on wheelchair and in bed to alert staff when attempting unassisted transfers and/or ambulation."  b. A Plan of Care dated 1/16/08 documented, "Actual fall. [Resident #16] removed PSA from chair. Change PSA to pressure PSA in bed and wheelchair. Call light in reach and encourage use."  c. A Physician's Order dated 1/16/08 documented, "Pressure pad PSA on when in bed and up in wheelchair."  d. The Plan of Care dated 3/8/08 documented, "Found on floor. Continue with pressure PSA in bed and wheelchair."  e. On 3/10/08 at 2:55 p.m., the resident was observed in bed with a regular PSA, not a pressure pad PSA, attached to the resident with the clip but the monitor box was not attached to the bed and was lying on top of the mattress.  f. On 3/11/08 at 9:45 a.m., the resident was observed in bed with a regular PSA, not a pressure pad PSA, attached to the resident with the clip but the monitor box was not attached to the bed and was lying on top of the mattress.  g. On 3/13/08 at 10:20 a.m., the resident was observed in bed with a regular PSA, not a pressure pad PSA, attached to the resident with the clip but the monitor box was not attached to the bed and was lying on top of the mattress.	F 323		

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F 323	<p>Continued From page 46</p> <p>h. On 3/11/08 at 9:45 a.m., the resident was in bed. The call light was lying in the floor on the foot of the bed, out of reach and out of sight of the resident.</p> <p>i. On 3/11/08 at 12:00 p.m., the resident was observed sitting in her wheelchair with a PSA, not a pressure pad alarm.</p> <p>4. Resident #7 had the diagnoses of Cerebrovascular Accident (CVA), History of Depression and Breast Neoplasm. The Quarterly MDS dated 3/05/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, needed extensive assistance from the staff for Activities of Daily Living (ADLS) and had a trunk restraint.</p> <p>a. A Plan of Care dated 3/5/08 documented, "Potential for injury related to restraint use. Approaches: Soft belt restraint while up in wheelchair ... Monitor for any signs and symptoms of distress related to use of safety belt."</p> <p>b. On 3/11/08 at 3:45 p.m., the resident was setting up in a wheelchair in the area near the nurses station watching television. A brown soft belt restraint was loosely placed at the residents waist area. There were no foot rests on the wheelchair and the wheels on the chair were not locked. The left restraint strap was placed under the wheelchair arm and looped two times around the post of the wheelchair. The loose restraint allowed the resident to move about in the unlocked wheelchair.</p>	F 323			

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F 323	Continued From page 47  5. Resident #3 had diagnoses of Transient Cerebral Ischemia, Anorexia, Urinary Tract Infection, and Presenile Dementia. The MDS dated 12/12/2007 documented the resident was moderately impaired in cognitive skills for daily decision making and required limited assistance of one person for transfers.  a. A Plan of Care dated 11/07/07 documented, " ... Problem: Potential for falls related to history of falls, dizziness and the use of psychotropic drugs [and] Hx (history) of [Left] Femoral neck fx. (fracture). ... Approaches: Assist with ambulation and transfers as needed. ... "  b. A Physician's Order dated 1/12/08 documented, "PSA while in bed and up in w/c."  c. On 3/10/08 at 3:10 p.m., the resident was in the bed asleep. No personal alarm was on the resident.  d. On 3/10/08 at 5:50 p.m., the resident was sitting on the side of the bed looking out of the window. No personal alarm was on the resident.  e. On 3/10/08 at 6:25 p.m., the resident ws sitting up in the bed with right leg off the side of the bed. No personal alarm was on the resident.  f. On 3/11/08 at 8:50 a.m., the resident sat in a wheelchair in the dining room. A soft belt restraint was applied across the resident's lap with the left strap located over the side bar of the wheelchair arm and the right strap located under the side bar of the wheelchair arm. The back straps were crossed in the back and looped over	F 323			

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F 323	Continued From page 48 the back frame of the wheelchair. No personal alarm was on the resident or the wheelchair.  g. On 3/11/08 at 9:30 a.m., the resident was in the bed lying on the right side with the eyes closed. No personal alarm was on the resident.  h. On 3/11/08 at 12:40 p.m., the resident sat in a wheelchair in the dining room. A soft belt restraint was applied across the resident's lap. No personal alarm was on the resident.  i. On 3/11/08 at 1:35 p.m., the resident was rolled in a wheelchair to the resident's room by CNA #2. The wheelchair was rolled beside the resident's bed. A soft belt restraint was applied across the lap. No personal alarm was on the resident. The CNA stated, "I'm going to make sure all the residents are out of the dining room before I start laying people down." The CNA left the room.  j. On 3/11/08 at 1:45 p.m., the Assistant Director of Nursing (ADON) entered the room and asked the resident, "Do you need to go to the bathroom?" The resident stated, "Yes." The ADON rolled the resident to the bathroom. CNA #2 entered the bathroom. The ADON stated, "Can she stand up by herself?" The CNA stated, "I don't know." The CNA rolled the resident next to the toilet and guided the resident's right hand to the safety bar on the wall by the toilet. The resident held the bar. The CNA guided the resident's left hand to the safety bar and the resident was unable to hold the bar. The CNA reached under the resident's right axilla and the ADON reached under the resident's left axilla. The resident was lifted up with most of the body weight bearing on the upper arms and shoulders. The resident was turned and the CNA lowered	F 323			

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F 323	Continued From page 49 the pants and removed the incontinent brief. The resident stated, "Don't let me fall, don't let me fall." The resident suddenly sat down hard on the very edge of the toilet seat. The resident stated, "You let me fall." The ADON stated, "No we didn't, that toilet seat is too low, that's all." When the toileting was complete, the ADON grabbed the resident under the right axilla and the CNA grabbed the resident under the left axilla and lifted the resident to allow the ADON to perform pericare. The resident wobbled and began to fall. The resident sat down hard on the edge of the toilet. The ADON and the CNA pulled the wheelchair next to the toilet. The ADON grabbed the resident under the left armpit and the CNA grabbed the resident under the right armpit. The resident was lifted with all the body weight on the upper arms and shoulders. The resident was swiveled to position for seating in the wheelchair. The ADON let go of the left axilla to reach to steady the wheelchair that was unlocked. The entire body weight was on the right upper arm and shoulder. The resident sat down hard on the edge of the wheelchair. The resident was unsteady on the edge of the wheelchair and leaned back in a semi-reclined position.  k. On 3/11/08 at 2:10 p.m., CNA #2 and CNA #3 lifted the resident up in the wheelchair by the axillae area. The resident was rolled to the bedside by CNA #3 to transfer to the bed. A body audit was performed. A bruised area was noted under the right armpit area. The ADON was asked, "What is that?" The ADON stated, "A bruise." The ADON was asked, "How big would you say that is?" The ADON stated, "About 1 cm (centimeter)." The resident was left in the bed. No personal alarm was on the resident.	F 323		

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F 323	Continued From page 50 l. On 3/12/08 at 8:55 a.m., the resident was in a wheelchair in the resident's room wearing a soft belt restraint across the lap. No personal alarm was on the resident.  m. On 3/12/08 at 4:40 p.m., the resident was in a wheelchair in the day room wearing a soft belt restraint across the lap. No personal alarm was on the resident.  6. Resident #6 had the diagnoses of Arteriosclerotic Dementia and Cerebral Artery Occlusion. The MDS dated 12/27/07 documented the resident was moderately impaired in cognitive skills for daily decision making and had a trunk restraint.  a. A Physician's Order dated 12/14/07 documented, "Soft Waist Restraint while up in W/C."  b. The Physical Restraint Informed Consent dated 12/14/07 documented, "... Restraint Type, Frequency: Soft Waist Restraint." There was no documentation under Specific Target Behaviors or Medical Symptoms.  c. The Plan of Care dated 12/27/07 documented, "... Problem: Due to history of multiple falls and attempts to ambulate without assistance related to dementia and depression requires restraints. ... Approaches: Soft waist belt while in wheelchair to prevent unassisted ambulation. ..."  d. On 3/10/08 at 6:03 p.m., the resident was up in a wheelchair in the dining room with a soft belt restraint across the lap. The left strap draped over the metal guard and under the armrest, the right strap behind resident wrapped around the	F 323			

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F 323	Continued From page 51 frame. The straps were crossed in the back and looped loosely on the back frame of the wheelchair.  e. On 3/10/08 at 6:40 p.m., the resident was in the hall in a wheelchair with a soft belt across the lap. The left strap was draped over the metal guard and under the armrest on the left side of the wheelchair. The right strap was behind the resident wrapped around the frame. The straps were crossed in the back and looped loosely on the back frame of the wheelchair.  7. Resident #8 had diagnoses of Presenile Dementia, Diabetes Type II, Urinary Tract Infection, and Difficulty Walking. The MDS dated 1/16/08 documented the resident was moderately impaired in cognitive skills for daily decision making and had a trunk restraint.  a. A Physician's Order dated 10/16/07 documented, "PSA while up in w/c to reduce risk of unassisted AMB (ambulation) or transfer."  b. A Physician's Order dated 11/8/07 documented, "Lap Buddy while up in w/c to reduce risk of unassisted AMB or transfer."  c. A Plan of Care dated 1/16/08 documented, "... Problem: ... Risk for falls d/t (due to) weakness and cognitive impairment related to dementia and difficulty walking. ... Approaches: ... Lap Buddy while in wheelchair. PSA in bed and wheelchair to alert staff of unassisted ambulation or transfer..."  d. On 3/10/08 at 2:50 p.m., the resident was asleep in the bed. No alarm was on the resident. The wheelchair was at the foot of the bed with the alarm attached to the back of the wheelchair and	F 323			

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F 323	<p>Continued From page 52</p> <p>the sensor string hanging down into the empty seat.</p> <p>e. On 3/13/08 at 4:45 p.m., the resident was in the day room out of the wheelchair walking around. The lap buddy was behind the wheelchair. The personal alarm was not attached to the resident, the alarm box was hanging on the back of the wheelchair with the sensor string hanging down into the empty seat. The resident bent over to pick up something off of the floor, stumbled, and nearly fell. LPN #4 assisted the resident back into the wheelchair, replaced the lap buddy and clipped the alarm's sensor string to the back of the resident's shirt.</p> <p>8. Resident #11 had diagnoses of Cerebrovascular Accident, Esophageal Reflux, and Dysphagia. The date of admission was documented as 2/28/08. The physician history and physical dated 1/29/08 documented, " ... Alert, confused, oriented x [times] 1. ... Maximum assist [with] toileting and transfers."</p> <p>a. An Admission Working Care Plan that was not dated documented, " ... Functional Status: Able to Transfer 2 person assist. W/C only. ... "</p> <p>b. A Physician's Order dated 3/1/08 documented, "[Up] in g/c (Gerichair) as tolerated."</p> <p>c. On 3/11/08 at 12:20 p.m., the resident was in a reclining wheelchair beside the bed in the room. Both legs were supported by the metal leg supports. Both legs were secured to the legs of the wheelchair with Velcro straps. The ADON and the Director of Clinical Services (DCS) removed the velcro straps from the resident's legs. The DCS rolled the wheelchair forward and</p>	F 323			

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F 323	<p>Continued From page 53</p> <p>stood on the resident's left side while the ADON stood on the resident's right side. The DCS and the ADON held the resident at the upper arm and hip level and pulled the resident up in the reclined wheelchair. The wheelchair tipped backward, lifting the front legs of the wheelchair off the floor about 12 inches. The DCS and the ADON stopped the transfer and caught the wheelchair before it completely tipped backward. The DCS was asked, "Are those wheels locked?" The DCS stated, "No, I unlocked them to roll him forward."</p> <p>9. Resident #14 had diagnoses of Parkinson's Disease, Alzheimer's, Dementia, Paralysis Agitans, and Polyneuropathy. The ADL (Activities of Daily Living) Functional/Restorative Assessment and Progress form documented the resident was totally dependent for personal grooming, dressing and toileting.</p> <p>a. A Physician's Order dated 2/28/08 documented, "PSA while in w/c and bed D/T poor gait, trunk control and Hx (history) of falls. "</p> <p>b. The Admission Working Care Plan dated 3/11/08 documented, " ... Problem: Safety Risk. Overestimates abilities. Lap buddy while up in w/c. ... Interventions: Alarm to bed. Alarm to chair. Toilet frequently. Do not leave unattended in BR (bathroom) / shower. Restraints / SRs (siderails) per order. Monitor closely."</p> <p>c. On 3/12/08 at 10:20 a.m., the resident was in the bed with the head of the bed elevated 20 degrees. No personal alarm was on the resident.</p> <p>d. On 3/12/08 at 12:55 p.m., the resident was in the bed asleep. No personal alarm was on the resident.</p>	F 323			

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F 323	Continued From page 54  e. On 3/13/08 at 10:45 a.m., the resident was in the bed with the head of the bed elevated 90 degrees. A personal alarm was attached to the collar of the resident's shirt, but not attached to the bed. The box laid on the bed next to the resident. The string was pulled and the box lifted from the bed. The magnet did not separate from the alarm. CNA #8 performed incontinent care on the resident, and moved the alarm box out of the way. The CNA stated, "I don't understand these [personal alarms]. If they're not attached to the bed, how do they work?"  f. On 3/13/08 at 3:00 p.m., the resident was in the bed with the alarm sensor clipped to the shirt and the alarm box laying on the bed beside the resident.  10. The Manufacturer's User Instructions for the Personal alarm provided by the Director of Nursing on 3/13/08 documented, "Attach the Sentry Monitor to a wheelchair, chair or bed using the attached metal clip. Other mounting options include an optional bracket extender and a chair strap for large side chairs."	F 323			
F 325 SS=D	483.25(i)(1) NUTRITION  Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.  This REQUIREMENT is not met as evidenced by: Complaint #13293 was substantiated (all or in	F 325			

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F 325	<p>Continued From page 55 part) in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure interventions were implemented for a significant weight loss for 1 (Resident #3) of 8 (Residents #3, #4, #7, #9, #17, #19, #21 and #22) case mix residents with weight loss. This failed practice had the potential to affect 18 residents with weight loss according to a list provided by the facility on 3/14/08. The findings are:</p> <p>Resident #3 had the diagnoses of Transient Cerebral Ischemia, Anorexia, Urinary Tract Infection, and Presenile Dementia. The Minimum Data Sets dated 12/12/2007 documented the resident had moderately impaired cognitive skills for daily decision making and had no weight loss.</p> <p>a. A Physician's Order dated 12/31/07 documented, "Diet: Regular-Supercal."</p> <p>b. A Physician's Order dated 2/20/08 documented, "Needs to be in feeder room."</p> <p>c. A Plan of Care updated 2/22/08 documented, "... Problem: At risk for weight loss and or dehydration related to history of anorexia and reduced fluid intake due to history of weight loss and dehydration related to cognitive impairment due to dementia and depression. ... Approaches: ... Feeder room. Supplements as ordered. ..."</p> <p>d. The Dietary Recommendations form dated 3/10/08 documented, "... Nutritional need(s) identified: wt. (weight) loss 9 # (pounds) or 6% in 1 wk (week), 12 # or 7.84% [times] 1 month, 26 # or 15.57% X 100 days. Recommendations: Notify Doctor. Taking Megace, healthshakes, ice cream</p>	F 325			

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F 325	<p>Continued From page 56</p> <p>[and] supercal diet already. ... What do you recommend?" The physician documented on the form on 3/10/08, "Continue treatment. This lady is on a downward curve."</p> <p>e. On 3/10/08 at 3:10 p.m., Licensed Practical Nurse (LPN) #1 stated, "[Resident #3] eats at feeder table. Mechanical Soft diet. No recent weight loss."</p> <p>f. On 3/10/08 at 6:15 p.m., the resident was sitting up in bed with the head of the bed flat. No lights were on in the room. The overbed table was across the foot of the bed. The supper tray containing a chopped turkey sandwich, mashed potatoes, tomato soup, a carton of milk and a healthshake was on the overbed table and was uncovered. No staff were present in the resident's room. The resident was not eating and stated, "They didn't bring me any silverware."</p> <p>g. On 3/10/08 at 6:20 p.m., the resident was sitting up in the bed with the head of the bed flat. No lights were on in the room. No staff were present in the room. The overbed table was across the foot of the bed with the uncovered supper tray on the table. Facility Staff #1 entered the room and sat silverware wrapped in a paper napkin on the resident's tray. Facility Staff did not open the silverware for the resident.</p> <p>h. On 3/10/08 at 6:25 p.m., he Dietary Manager was in the resident's room and stated, "I'll go get her some more mashed potatoes." The resident was left sitting up in the bed with the head of the bed flat, the supper tray on the overbed table at the foot of the bed. No lights were on in the room. No staff were present in the room to assist the resident.</p>	F 325			

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F 325	Continued From page 57  i. On 3/10/08 at 6:35 p.m., the resident was sitting up in bed with the head of the bed flat. The supper tray was on the overbed table across the foot of the bed. No lights were on in the room. No staff were present to assist the resident. The resident was not eating. The resident's roommate would prompt the resident to take a bite. The resident would pick up the sandwich when prompted.  j. On 3/10/08 at 7:00 p.m., the resident pushed the tray on the overbed table back and laid down in the bed. Less than 25% of the meal was consumed.	F 325		
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, interview and record review, the facility failed to ensure Intravenous (IV) Therapy was maintained continuously for 1 (Resident #12) of 1 case mix resident that required IV therapy, failed to ensure oxygen equipment tubing was changed per facility policy and/or stored in a clean and sanitary manner for	F 328		

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F 328	Continued From page 58 6 (Resident #5, #10, #13, #17, #18 and #19), failed to ensure oxygen concentrator filters were maintained lint free for 5 (Resident #5, #10, #13, #18 and #19) and failed to ensure oxygen was set at the rate ordered by the physician for 3 (Resident #5, #13 and #19) of 7 (Residents #5, #10, #13, #17, #18, #19 and #20) case mix residents with respiratory equipment. These failed practice had the potential to affect 2 residents with a Physician's Order for IV therapy and 26 residents with a Physician's Order for respiratory therapy as identified by lists provided by the Administrator on 3/14/08. The findings are:  1. Resident #12 had diagnoses of Chronic Ischemic Heart Disease and Methicillin Resistant Staphylococcus Aureus (MRSA) Surgical Wound Infection. The Minimum Data Set (MDS) dated 2/18/08 documented the resident was independent in cognitive skills for daily decision-making and required limited assistance with ADL's.  a. The Plan of Care dated 2/18/08 documented, "MRSA in Surgical Wound. Vancomycin [for] 6 weeks for MRSA. Risk for dehydration related to recent UTI (Urinary Tract Infection)."  b. A Physician's Order dated 3/6/08 documented, "0.9 % Sodium Chloride (Normal Saline) at KVO (keep vein open) 25 cc/hr (cubic centimeters/hour) per PICC (Peripherally Inserted Central Catheter) line."  c. On 3/11/08 at 10:00 a.m., the resident's IV pump was beeping. Licensed Practical Nurse (LPN) #2 entered the room and turned the IV pump off.	F 328			

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F 328	Continued From page 59  d. On 3/11/08 at 1:50 p.m., 2:10 p.m. and 3:40 p.m., the IV was observed to be off.  e. On 3/11/08 at 4:00 p.m., six hours after the IV was noted to be turned off, LPN #2 was asked why the IV was turned off. She stated, "It's off right now because we have the meds on order and haven't gotten them yet. We might have Normal Saline in the ER (emergency) box, I'd have to look." When asked who is supposed to order the IV fluids, the LPN stated, "It's never ran out on my shift so I've never had to order it."  f. On 3/11/08 at 4:00 p.m., the Director of Nursing (DON) stated she was aware the IV fluids had run out and had been ordered that morning but was not aware that the fluids were available in the ER box.  2. Resident #13 had diagnoses of Chronic Airway Obstruction and Pneumonia. The MDS dated 2/25/08 documented the resident was independent in cognitive skills for daily decision-making, required limited to extensive assistance with all ADL's and required oxygen therapy.  a. A Physician's order dated 2/11/07 documented, "O2 at 2 1/2 LPM (liters per minute) N/C (nasal cannula) continuous."  b. The Plan of Care dated 2/25/08 documented, "At risk for impaired air exchange related to COPD (Chronic Obstructive Pulmonary Disease) and history of Pneumonia. O2 (oxygen) as ordered."  c. The Treatment Administration Record for	F 328			

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F 328	<p>Continued From page 60</p> <p>March 2008 documented, "Change O2 tubing weekly and Humidifier bottle as needed."</p> <p>d. On 3/10/08 at 3:30 p.m., the resident's updraft mouthpiece was lying across the updraft machine open to air. The tubing and cup were marked by the surveyor with a black marker on the edge of the cup and the mouthpiece.</p> <p>e. On 3/10/08 at 3:30 p.m., the O2 tubing was dated 3/3/08 and the concentrator filter was covered with a layer of white lint.</p> <p>f. On 3/13/08 at 10:50 a.m., the O2 tubing was dated 3/3/08 and the concentrator filter was covered with a layer of white lint. The oxygen concentrator was set at 3 LPM. The updraft equipment still had the black mark on the mouthpiece and cup.</p> <p>3. Resident #5 had diagnoses of Chronic Airway Obstruction, History of Pneumonia, and Alzheimer Disease. The Significant Change MDS dated 12/05/07 documented the resident was moderately impaired in cognitive skills for daily decision-making, needed extensive assistance from the staff for Activities of Daily Living (ADLS) and received Oxygen therapy.</p> <p>a. A Physician's Order dated 3/1/08 documented, "Oxygen at 3 liters per n/c ..."</p> <p>b. The Plan of Care dated 11/28/07 documented, "Problem: Risk for altered respiratory function related to COPD and recent pneumonia. Approaches: Oxygen as ordered."</p>	F 328			

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F 328	<p>Continued From page 61</p> <p>c. On 3/10/08 at 2:30 p.m., the oxygen concentrator was setting on the floor with a black filter covered with white lint substance. The tubing and nasal canula were attached and the oxygen was on at 2 liters. The nasal canula and tubing dated 3/9/08 was lying on the residents bed with the nasal canula uncovered. LPN) # 6 picked up the nasal canula and placed it on the resident. The LPN stated, "She takes the oxygen off and does not remember."</p> <p>d. On 3/11/08 at 8:30 a.m., 10:00 a.m. and 1:30 p.m., the resident received oxygen per nasal cannula at 2 lpm.</p> <p>e. On 3/12/08 at 9:00 a.m. and 11:05 a.m., the resident's oxygen was set at 2 liters.</p> <p>4. Resident #10 had diagnoses of Chronic Pulmonary Obstruction with Exacerbation, Congested Heart Failure, Hypertension and Dementia. The Admission MDS had not been completed. The resident was admitted 3/6/08 and was receiving Hospice care.</p> <p>a. A Physician's Order dated 3/7/08 documented, "Updraft with Albuterol every 3 hours PRN (as needed)."</p> <p>b. On 3/10/08 at 3:49 p.m., the oxygen concentrator was setting on the floor beside the resident's bed with a black filter covered with white lint substance. The tubing and nasal canula were attached and the oxygen was on at 2 liters. The nasal canula and tubing were dated 3/9/08. Setting on the bed side table was a nebulizer machine with the tubing and mask attached. The mask was not covered.</p>	F 328			

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F 328	Continued From page 62  5. Resident #18 had diagnoses of Cardiac Dysrhythmias, Multiple Sclerosis and had a history of Bronchial Pneumonia. The Significant Change MDS dated 2/27/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, totally dependent on staff for Activities of Daily Living (ADL) and received Oxygen therapy.  a. A Physician's Order dated 2/11/08 documented, "Oxygen at 2 liters per n/c."  b. On 3/10/08 at 3:12 p.m., the oxygen concentrator was setting on the floor beside the residents bed with a black filter covered with a white lint type substance. The tubing and nasal canula were attached and the oxygen was on at 2 liters.  4. Resident #19 had diagnoses of Congestive heart Failure, Cardiomegaly, and Abnormal Respiratory Functions with a history of Pneumonia. The Quarterly MDS dated 2/8/08 documented the resident was independent in cognitive skills for daily decision-making, required extensive assistance from staff for ADL'S and received Oxygen therapy.  a. A Physician's Order dated 11/30/07 documented, "Oxygen at 2.5 liters per n/c PRN (as needed)."  b. The Plan of Care dated 2/8/08 documented, "Problem Onset: At risk for Abnormal Respiratory Functions due to Congestive Heart Failure and history of Pneumonia. Approaches: Oxygen as ordered."	F 328			

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F 328	<p>Continued From page 63</p> <p>c. On 3/10/08 at 3:20 p.m., the oxygen concentrator was setting on the floor beside the resident's bed with a black filter covered with a white lint type substance. The oxygen was on at 2 liters.</p> <p>d. On 3/14/08 at 8:30 a.m., 10:00 a.m. and at 11:20 a.m. the resident was receiving oxygen per nasal cannula at 2 liters per minute and the filter on the concentrator was covered with lint type substance.</p> <p>6. Resident #17 had diagnoses of Bronchitis, Pneumonitis, Fracture of Femur Head and Muscle Weakness. The quarterly MDS dated 1/9/08 documented the resident was independent in cognitive skills for daily decision making.</p> <p>a. A Physician's Order dated 2/26/08 documented, "O2 [at] 2 L/M N/C to keep Sat (saturation) [greater than] 92%. Albuterol / Atrovent neb (nebulizer) q (every) 4 hours. Albuterol neb q 2 hours prn SOB (Shortness of Breath)."</p> <p>b. On 3/10/08 at 2:37 p.m., the resident was in the bed with the oxygen on at 2 liters per minute. The updraft/nebulizer mouthpiece was uncovered and laying on top of the updraft machine. The mouthpiece was dated 3/3/08. The oxygen tubing and the humidifier were dated 3/9/08. The Updraft and oxygen tubing were marked by the surveyor with an ink line on the tubing near the connection end.</p> <p>c. On 3/11/08 at 10:00 a.m., the resident was in the bed with the oxygen on at 2 liters per minute. The updraft mouthpiece was inside a zip lock plastic bag with the date 3/11/08 written on the</p>	F 328			

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F 328	Continued From page 64  bag. The mouth piece was dated 3/3/08. The oxygen tubing and the humidifier were dated 3/9/08. The ink marks were present on the tubing near the connection site in the location that was marked on 3/10/08.  d. On 3/11/08 at 1:36 p.m., the resident was in the bed eating lunch with the oxygen on at 2 liters per minute. The updraft mouthpiece was inside a zip lock plastic bag with the date 3/11/08 written on the bag. The mouth piece was dated 3/3/08. The oxygen tubing and the humidifier were dated 3/9/08. The ink marks were present on the tubing near the connection site in the location that was marked on 3/10/08.  e. On 3/12/08 at 9:04 a.m., the resident was in the bed with the oxygen on at 2 liters per minute. The updraft mouthpiece was inside a zip lock plastic bag with the date 3/11/08 written on the bag. The mouth piece was dated 3/3/08. The oxygen tubing and the humidifier were dated 3/9/08. The ink marks were present on the tubing near the connection site in the location that was marked on 3/10/08.  f. On 3/13/08 at 10:25 a.m., the resident was in the bed with the oxygen on at 2 liters per minute. The resident stated, "I've been sick lately." The updraft mouthpiece was inside a zip lock plastic bag with the date 3/11/08 written on the bag. The mouth piece was dated 3/3/08. The oxygen tubing and the humidifier were dated 3/9/08. The ink marks were present on the tubing near the connection site in the location that was marked on 3/10/08.  g. On 3/13/08 at 4:20 p.m., the Director of Nursing (DON) was asked, "What's the facility's	F 328			

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F 328	Continued From page 65 policy about oxygen and updraft tubing change?" The DON stated, "Tubing and humidifiers are changed every Sunday." The DON was asked, "What does the facility do if the oxygen tubing is left uncovered?" The DON stated, "We change it."	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 8:00 a.m. medication pass on 3/12/08, the facility failed to ensure Physician's Orders were followed so that the medication error rate was less than 5 %. Physician orders were not followed on 2 (Resident #22 and #23) of 9 residents observed during the medication passes. Medication errors were made by 2 Licensed Practical Nurses (LPN #1 and LPN #2) of 4 nurses that administered medication. This failed practice had the potential to affect 56 residents that received medication from these nurses according to the DON (Director of Nursing) on 3/12/08. The medication error rate was 6.25% based on administration of 44 medications plus 2 medications ordered but not administered and observation of a total of 3 errors. The findings are:  1. Resident #22 had a Physician's Order dated 2/7/08 for Sinemet CR (continuous release) 25-100 mg 2 tabs QID (Four times a day) but Sinemet 25-100 2 tabs was administered on 3/12/08 at 7:48 a.m. by LPN #1.	F 332			

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F 332	Continued From page 66 2. Resident #23 had a Physician's Order dated 3/3/08 for Xopenex 25 mg/3 ml (milligrams/milliliters) solution inhalation and Atrovent 0.02% solution 2.5 ml inhalation every 6 hours but neither was administered on 3/12/08 at 8:13 a.m. by LPN #2. The March 2008 Medication Administration Record documented both medications but there were no times for administration and no initials that the medications had been administered since ordered.	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 8:00 a.m. medication pass on 3/12/08 and record review, the facility failed to ensure Physician's Orders were followed so that residents were free of significant medication errors for 2 (Resident #22 and #23) of 9 residents observed during the medication pass and 1 (Resident #7) through record review were found to have a significant medication error. A significant medication error was made by 2 Licensed Practical Nurses (LPN #1 and LPN #2) of 4 nurses that administered medication according to the DON (Director of Nursing). This failed practice had the potential to affect 56 residents that received medication from those nurses. The findings are:  1. Resident #22 had a diagnoses of Parkinson and had a Physician's Order dated 2/7/08 for Sinemet CR 25-100 mg 2 tabs QID (four times a day).	F 333			

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F 333	<p>Continued From page 67</p> <p>a. During the medication pass on 3/12/08 at 7:48 a.m. the resident was administered Sinemet 25-100 mg 2 tabs.</p> <p>b. On 3/12/08 at 9:40 a.m., the provider pharmacy stated that on 2/26/08 112 tablets of Sinemet 25-100 mg were dispensed and on 3/7/08 90 more tablets were dispensed. There were 2 tablets removed from the medication card filled on 3/7/08 for a total of 114 doses incorrectly administered.</p> <p>c. This was a significant medication error due to the class of medication (Dopamine Agonist), residents condition and frequency of the error.</p> <p>5. Resident #23 had a diagnoses of COPD (Chronic Obstructive Pulmonary Disease) and CHF (Congestive Heart Failure) and had a Physician's Order dated 3/3/08 for Xopenex 1.25mg/3 ml solution, 3 ml inhalation every six hours and Atrovent 0.02% solution updraft every six hours.</p> <p>a. During the medication pass in 3/12/08 a 8:13 a.m., the Xopenex inhalation and Atrovent updraft were not administered by LPN #2.</p> <p>b. The March 2008 Medication Administration Record (MAR) had the medications listed, but there were no times or initials documented that the medication had been administered since ordered.</p> <p>c. Reconciliation of the Xopenex and Atrovent boxes dated 3/3/08 reveled that 4 doses of Xopenex had been removed from the box and 2 doses of Atrovent had been removed from its box but no dosages charted on the MAR as</p>	F 333			

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F 333	<p>Continued From page 68 administered.</p> <p>d. From 3/3/08 thru 8:13 a.m. on 3/12/08, the resident did not receive approximately 66 doses of the physician ordered medication.</p> <p>e. This was a significant medication error due to the drug classes (Anticholinergic Beta 2), resident's condition and frequency of the error.</p> <p>3. Resident #7 had diagnoses of Cerebrovascular Accident (CVA), History of Depression and Breast Neoplasm. The Quarterly Minimum Data Set dated 3/05/08 documented the resident had moderately impaired cognitive skills for daily decision-making, needed extensive assistance from the staff for Activities of Daily Living (ADL,S).</p> <p>a. A Physician's Order dated 1/04/08 documented Coumadin 4 mg one po (By mouth) on Tuesday and Thursday.</p> <p>b. The Plan of Care dated 3/5/08 documented, "At risk for abnormal bruising and/or bleeding due to anticoagulant therapy related to CVA. Approaches: Medications as ordered."</p> <p>c. The Coumadin Administration Prothrombin Time Flow Sheet documented Tuesday 3/11/08 Coumadin dose/time 4 mg at 1700 initials LB.</p> <p>d. On 3/12/08, the medication card for coumadin 3 mg was reviewed and had no medication left in the card for 3/11/08. The medication card for Coumadin 1 mg was also reviewed and had one pill left for 3/11/08.</p>	F 333			

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F 333	Continued From page 69 e. On 3/12/08 at 11:00 a.m., the Director of Nurses stated, "The coumadin given on 3/11/08 was 3 mg not the 4mg that was ordered."  f. This was a significant medication error due to the drug class (anticoagulant) and the resident's condition.	F 333			
F 364 SS=E	483.35(d)(1)-(2) FOOD  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that meals reached the residents at a palatable temperature. This failed practice had the potential to affect all 108 residents who received meals from the kitchen according to the Diet List dated 3/12/08. The findings are:  1. On 3/11/08 at 9:30 a.m., 2 of 7 residents in the group meeting stated the food was cold, particularly eggs, oatmeal, gravy and biscuits. The residents stated it was mainly the morning meal and it was slow to be served.  2. On 3/10/08 at 6:15 p.m., Resident #3 was served dinner in her room. The resident's meal consisted of a turkey sandwich, mashed potatoes, fruit salad, tomato soup, milk and a healthshake. At 6:25 p.m., the resident's soup registered 120 degrees Fahrenheit and mashed potatoes registered 90 degrees Fahrenheit.	F 364			

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F 364	<p>Continued From page 70</p> <p>3. On 3/12/08 at 12:45 p.m., a cart of 11 trays, plus one test tray, for halls 300 and 400 was delivered to hall 300 in front of the nurse's station. The first tray was served at 12:48 p.m.</p> <p>a. On 3/12/08 at 1:20 p.m. after the last tray was served, a test tray registered the following temperatures:</p> <p>b. Pureed chicken, 118 degrees Fahrenheit</p> <p>c. Mechanical chicken, 116 degrees Fahrenheit</p> <p>d. Pureed green beans, 115 degrees Fahrenheit.</p> <p>4. On 3/13/08 at 7:30 a.m., the 100 hall cart left the kitchen at 7:30 a.m. with 18 trays. The oral page for the cart was announced at 7:35 a.m. The cart sat on the hall until 7:40 a.m. when agency nurse assistant #1 stated "This is my first day, I've gotta' find out if he's in his room."</p> <p>a. On 3/13/08 at 7:41 a.m., the 100 hall cart still sat in the hall with 17 trays.</p> <p>b. On 3/13/08 at 7:48 a.m., Certified Nurse Assistant (CNA) #1 came to help pass trays and stated, "I have to look for 'em, I don't know 'em."</p> <p>c. On 3/13/08 at 7:58 a.m. 11 trays were left on the 100 hall cart.</p> <p>d. On 3/13/08 at 8:00 a.m., CNA #1 stated "I'm the only one passing trays. Every time I walk away and come back, there are more trays on the cart."</p> <p>e. On 3/13/08 at 8:13 a.m., the Certified Dietary Manager (CDM) pushed a cart of 7 trays plus a</p>	F 364			

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F 364	Continued From page 71 test tray to 400 hall. The last tray was served at 8:17 a.m. Temperatures on this tray registered as follows:  1) Mechanical sausage, 106 degrees Fahrenheit.  2) Scrambled eggs, 118 degrees Fahrenheit.	F 364			
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure available Intravenous (IV) fluids were administered as ordered for 1 (Resident #12) of 1 case mix resident with a Physician's Order for IV therapy. This failed practice had the potential to affect 2	F 425			

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F 425	<p>Continued From page 72</p> <p>residents with Physician's Orders for IV therapy as identified by lists provided by the Administrator on 3/14/08. The findings are:</p> <p>Resident #12 had diagnoses of Chronic Ischemic Heart Disease and Methicillin Resistant Staphylococcus Aureus (MRSA) Surgical Wound Infection. The Minimum Data Set (MDS) dated 2/18/08 documented the resident was independent in cognitive skills for daily decision-making and required limited assistance with ADL's.</p> <p>a. The Plan of Care dated 2/18/08 documented, "MRSA in Surgical Wound. Vancomycin [for] 6 weeks for MRSA. Risk for dehydration related to recent UTI (Urinary Tract Infection)."</p> <p>b. A Physician's Order dated 3/6/08 documented, "0.9 % Sodium Chloride (Normal Saline) at KVO (keep vein open) 25 cc/hr (cubic centimeters/hour) per PICC (Peripherally Inserted Central Catheter) line."</p> <p>c. On 3/11/08 at 10:00 a.m., the resident's IV pump was beeping. Licensed Practical Nurse (LPN) #2 entered the room and turned the IV pump off.</p> <p>d. On 3/11/08 at 1:50 p.m., 2:10 p.m. and 3:40 p.m., the IV was observed to be off.</p> <p>e. On 3/11/08 at 4:00 p.m., six hours after the IV was noted to be turned off, LPN #2 was asked why the IV was turned off. She stated, "It's off right now because we have the meds on order and haven't gotten them yet. We might have Normal Saline in the ER (emergency) box, I'd have to look." When asked who is supposed to</p>	F 425			

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F 425	Continued From page 73 order the IV fluids, the LPN stated, "It's never ran out on my shift so I've never had to order it."  f. On 3/11/08 at 4:00 p.m., the Director of Nursing (DON) stated she was aware the IV fluids had run out and had been ordered that morning but was not aware that the fluids were available in the ER box.	F 425		
F 441 SS=E	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 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: Complaint #13371 was substantiated (all or in part) in these findings.  Based on observation, interview and record review, the facility failed to ensure isolation precautions were maintained by placing isolation barrels for linen and trash in the resident's room for 1 (Resident #15) of 2 (Residents #12 and #15) case mix resident with Methicillin resistant Staph Aureus (MRSA), failed to ensure soiled incontinent briefs were not left in a resident's bathroom or on a resident's bed to prevent offensive odors and minimize the potential for the spread of infection for 1 (Resident #4) of 14	F 441		

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F 441	Continued From page 74 (Residents #2, #3, #4, #7, #8, #9, #10, #11, #14, #15, #17, #18, #21 and #22) case mix residents who were incontinent and dependent on staff for care, failed to ensure bathing equipment was free of standing water to prevent the potential for infection, failed to ensure clean supplies were handled to prevent potential contamination for 1 (Resident #21) of 7 (Residents #1, #7, #9, #11, #12, #18 and #21) case mix residents who had orders for treatments and failed to ensure personal care equipment was maintained resident specific for 1 (Resident #6) of 7 (Residents #3, #6, #7, #8, #15, #17 and #22) case mix residents who utilized the shower on the 300 hall. These failed practices had the potential. to affect 2 residents in contact isolation, 69 residents who were dependent on staff for incontinent care, 33 residents with orders for treatments, and 59 residents who utilized the shower on the 300 hall as identified by lists provided by the Administrator on 3/14/08. The findings are:  1. Resident #15 had diagnoses of Methicillin Resistant Staph Aureus (MRSA) and Urinary Tract Infection (UTI). The Minimum Data Set (MDS) dated 2/20/08 documented the resident was moderately impaired in cognitive skills for daily decision making, dependent on staff for toileting and personal hygiene, incontinent of bowel and continent of bladder with an indwelling catheter and had a Urinary Tract Infection in the past 30 days.  a. The Care Plan Conference Summary form dated 10/30/07 documented the resident's spouse expressed the following grievance: "Concern: recurring UTI's not keeping [Resident #15] clean and dry."	F 441			

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F 441	<p>Continued From page 75</p> <p>b. The Care Plan Conference Summary form dated 1/16/08 documented the resident's spouse expressed the following grievance: "Concerns with catheter placement and ensure proper placement of Foley bag."</p> <p>c. The laboratory report dated 2/21/08 documented, "Culture Discharge Penis. Light growth Pseudomonas Aeruginosa. Heavy Growth MRSA - Methicillin resistant Staph Aureus."</p> <p>d. The Admission Physician's orders dated 3/7/08 documented, "Will need skilled RN (Registered Nurse) for IV ABT (Intravenous Antibiotics). Continue Isolation for MRSA."</p> <p>e. The Plan of Care dated 3/10/08 documented, "MRSA Urine. Contact Isolation. Observe Isolation Precautions. Recurrent UTI's. Foley Cath care q (every) shift and PRN (as needed)."</p> <p>f. On 3/10/08 at 2:25 p.m., there were no isolation barrels located in the resident's room or bathroom for contaminated linens or trash and no gowns available for staff/family use.</p> <p>g. On 3/11/08 at 10 a.m., there were no isolation barrels located in the resident's room or bathroom for contaminated linens or trash and no gowns available for staff/family use.</p> <p>2. Resident #4 had diagnoses of Alzheimer's Disease and Organic Brain Syndrome. The MDS dated 1/29/08 documented the resident was severely impaired in cognitive skills for daily decision-making, incontinent of bowel and bladder and was dependent on staff for toileting and personal hygiene.</p>	F 441		

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F 441	Continued From page 76  a. The Plan of Care dated 1/29/08 documented, "Unable to provide adequate self care due to cognitive and physical impairments".  b. On 3/13/08 at 11:00 a.m., the resident's bed had a urine saturated brief lying on top of the covers. There was a strong urine odor in the room. The resident was not in the room. There was no staff present.  c. On 3/14/08 at 10:15 a.m., a urine saturated brief was lying in the floor underneath the sink in the resident's bathroom. There was a strong urine odor in the room.  3. On 3/10/08 at 3:10 p.m., a blue and white shower Gurney was stored on the 200 hall near room 201 by the door. There was approximately 16 to 20 ounces of standing water at the bottom near the drain of the shower gurney.  4. On 3/12/08 at 11:00 a.m., the shower gurney remained stored on the 200 hall with water standing in the bottom open to facility air.  5. Resident #6 had the diagnoses of Arteriosclerotic Dementia and Cerebral Artery Occlusion. The initial MDS dated 12/27/07 documented the resident was moderately impaired in cognitive skills for daily decision making and required extensive assistance of 1 person for bathing and grooming.  a. The Plan of Care dated 12/27/07 documented, "... Problem: Unable to perform adequate self care with ADL's (Activities of Daily Living) due to lumbar disc repair and history of CVA. ... Approaches: ... Assist with ADL's as needed. ..."	F 441			

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F 441	Continued From page 77  b. On 3/12/08 at 9:25 a.m., Certified Nurse's Assistant (CNA) #2 performed a shower bath on the resident in the 300 hall shower room. After the shower, the CNA dried and dressed the resident, then reached up to the top shelf and took a round brush off the shelf. The brush had hair matted in the bristles. The CNA brushed the resident's hair with the brush then replaced the brush on the shelf.  c. On 3/12/08 at 9:38 a.m., CNA #2 was asked, "Did you bring all of the resident's belongings back to the room?" The CNA stated, "Yes." The CNA was asked, "What did you brush the resident's hair with?" The CNA stated, "A brush." The CNA was asked, "It wasn't the resident's brush?" The CNA stated, "No. It was a brush that was left in the shower room that we use on residents."  6. Resident #21 had diagnoses of Sepsis, Dehydration, Chronic Skin Ulcers, Prolapsed Uterus and Muscle Weakness. The Significant Change MDS dated 2/13/08 documented the resident was moderately impaired in cognitive skills for daily decision making and had 1 Stage I ulcer.  a. The Plan of Care dated 2/13/08 documented, " ... Problem: Prone to pressure areas related to incontinence, weight loss, impaired mobility, history of unresolved pressure ulcers. ... Approaches: Monitor skin for reddened areas, blisters, soft 'mushy' areas. Report to physician as needed. ... Use pressure reduction devices in chair and bed. ... "  b. A Physicians Order dated 3/12/08	F 441			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/14/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
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F 441	Continued From page 78 documented, "Cleanse [Right] buttock with N/S (Normal Saline). Apply Duoderm. [Change] q (every) 3 days [and] PRN (as needed). Apply Zinc Oxide to buttock qd (every day)."  c. On 3/13/08 at 11:40 a.m., Licensed Practical Nurse (LPN) #5 rolled the treatment cart into the resident's room. Certified Nursing Assistant (CNA) #1 assisted in turning the resident to the right side, and loosened the incontinent brief from the resident. The LPN removed the duoderm dressing from the resident and discarded the dressing. Two small areas to the lower right of the lesion covered by the duoderm began to bleed. The LPN changed gloves and brought 2 4 inch by 4 inch gauze pads to the bedside and blotted the blood. The LPN was asked, "How big are those areas that are bleeding?" The LPN changed gloves, got 2 more 4 inch by 4 inch gauze pads, returned to the resident, and laid the clean gauze pads on the incontinent brief that had been fastened to the resident, with the gauze on the brief near the buttocks. The LPN got a measuring device and took the gauze pads off the incontinent brief and held pressure against the bleeding areas, then measured the bleeding areas. The incontinent brief was soiled with a brown substance near the rectal area. The LPN was asked, "What is that?" The LPN stated, "That is BM (bowel movement)." The LPN was asked, "Where do you put your clean supplies when you take them into a resident's room?" The LPN stated, "I normally put them on a disposable plate to keep them clean. I didn't today because I was doing this to show you those lesions."	F 441			
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION  The facility must require staff to wash their hands	F 444			

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F 444	<p>Continued From page 79</p> <p>after each direct resident contact for which handwashing is indicated by accepted professional practice.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13371 was substantiated (all or in part) in these findings.</p> <p>Based on observation, interview and record review, the facility failed to ensure staff washed hands after providing incontinent care and before providing oral care for 1 (Resident #9) of 14 (Residents #2, #3, #4, #7, #8, #9, #10, #11, #14, #15, #17, #18, #21 and #22) case mix residents who were incontinent and dependent on staff for care. This failed practice had the potential to affect 69 residents who were incontinent and dependent for care as identified by a list provided by the Administrator on 3/14/08. The findings are:</p> <p>Resident #9 had diagnoses of Cerebrovascular Accident (CVA) and Paraplegia. The Minimum Data Set (MDS) dated 2/25/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, was incontinent of bowel and bladder and was totally dependent on staff for toileting and personal hygiene.</p> <p>a. The Plan of Care dated 2/25/08 documented, "Impaired ability to perform self care with ADL's due to cognitive and physical impairments related to Dementia, OBS (Organic Brain Syndrome) and CVA with bilateral contractures. Provide ADL care daily and as needed. Monitor frequently to ensure [Resident #9] is clean, dry and odor free."</p>	F 444			

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F 444	Continued From page 80 b. On 3/11/08 at 10:25 a.m., the resident had been incontinent of urine. Certified Nursing Assistant (CNA) #10 provided a bed bath which included incontinent care. The CNA did not wash her hands or change her gloves before picking up a toothette sponge, dipping it in water and providing oral care. When asked by the surveyor if she had changed gloves she stated, "Oh my gosh, I forget."	F 444			