STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045267	A. BUILDING ____ B. WING ____	C 12/15/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEALTH AND REHABILITATION CENTER	**3310 NORTH 50 STREET** **FORT SMITH, AR 72904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #12206 was substantiated (all or in part) with deficiencies cited at F309 and F314.	F 000		
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: Complaint #12206 was substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure assessment/monitoring for complications related to catheter use was conducted for 1 (Resident #1) who had a blocked urinary catheter, catheter tubing was secured with a leg band or by looped/fastened tubing for 1 (Resident #3) and output was monitored for 2 of 2 (Residents #1 and #3) case mix residents who had an indwelling urinary catheter. This failed practice had the potential to affect 12 residents in the facility who had an indwelling urinary catheter, according to the Administrator on 12/18/06 at 10:10 a.m. The findings are: 1. Resident #1 had diagnoses of Dementia, Cerebrovascular Accident and Pneumonia. An Annual Minimum Data Set (MDS) dated 11/3/06 documented the resident had an indwelling urinary catheter and had not had a urinary tract	F 309		

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

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

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F 309	Continued From page 1 infection in the past 30 days. a. A Physician Order dated 7/28/06 documented, "Output every shift." b. The Care Plan dated 11/29/06 documented, "F/C [Foley catheter] 15 Fr [French] 10 cc [cubic centimeter] balloon. Change every month and prn [as needed]. Educated staff on providing proper cath care every 2 hours and prn, use of leg, privacy bag and positioning of F/C. Empty every shift and prn, observe for color, odor and report to nurse any observations of concern." c. An Emergency Clinical Record documented the resident arrived at the hospital 12/4/06 at 12:10 a.m. The record documented, "Rectal temperature - 101.1... Responsive to touch by moaning... B/P [blood pressure] - 68/26, Pulse 133, Respirations 40. Attempted to irrigate Foley. Unable to irrigate. Foley removed. Output when removed 3000 cc urine then Foley reinserted. Thick flesh colored urine draining. Urine sample collected..." d. A hospital urine culture dated 12/4/06 at 2:11 a.m. documented, "Colony Count: >100,000 - Proteus mirabilis. Also present, greater than 100,000 Enterococcus faecalis." e. A Hospital Emergency Room Report dated 12/4/06 documented, "A Foley catheter was changed and showed 3000 ml [milliliters] out with an apparently obstructed Foley catheter. Assessment: 1. Hyponatremic dehydration. 2. Urosepsis." f. As of 12/14/06 at 1:00 p.m., the section on the December 2006 Medication Administration	F 309		

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F 309	Continued From page 2	F 309		

Record (MAR) labeled for output was blank for 12/1/06, 12/2/06 and 12/3/06.

2. Resident #3 had diagnoses of Urinary Tract Infection (UTI), Dementia and Diabetes Mellitus. A Quarterly MDS dated 12/12/06 documented the resident had an indwelling urinary catheter and was severely impaired in cognitive skills for daily decision-making.

a. A Physician Order dated 3/15/06 documented, "Catheter Foley may use leg band..."

b. A Physician Order dated 3/15/06 documented, "Output every shift."

c. On 12/13/06 at 4:22 p.m., the resident was observed in bed. The resident had no leg band on to secure the Foley tubing and the tubing was not looped to ensure proper flow of urine.

d. As of 12/14/06 at 1:00 p.m., the section on the December 2006 MAR labeled for output was blank for the 11/7 shift on 12/1/06 through 12/7/06, 12/10/06, and blank for the 3/11 shift on 12/2, 12/3, 12/6, 12/7, and 12/10/06.

e. On 12/15/06 at 8:40 a.m., Licensed Practical Nurse (LPN) #2 stated, "We record out put every shift and put it on the MAR. The CNAs (Certified Nursing Assistants) write it down on paper and take it to the nurse's station. We write it down in the MARs." LPN #2 was asked if there was any other place it may be documented. She stated, "No, just in the MAR, or if we do a weekly summary."

f. The facility's Policy for Urinary Catheter Care dated 12/1/06 documented, "Secure the catheter

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F 309	Continued From page 3 with a leg band or loop to the bed sheet in a comfortable position for the resident." g. The facility's Policy for Intake and Output Measurement of Fluids dated 12/1/01 documented, "Intake and Output should be measured when ordered by the attending physician, or as indicated, and may be recorded on the MAR."	F 309		
F 314 SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Complaint #12206 was substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure wound care was performed as ordered by the Physician so that deterioration of a pressure sore could be identified for 1 (Resident #1) of 3 (Residents #1, #2 and #6) case mix residents who had pressure sores. The facility further failed to ensure weekly body audits were conducted for 2 (Residents #2 and #6) of 6 (Residents #1 through #6) case mix residents who were identified as being at risk for pressures sores. This failed practice had the potential to affect 30 residents in the facility who	F 314		

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F 314	Continued From page 4	F 314		

were assessed as being at risk for pressure sores, according to the Administrator on 12/18/06 at 10:10 a.m. The findings are:

1. Resident #1 had diagnoses of Cerebrovascular Accident, Pneumonia and Dementia. An Annual Minimum Data Set (MDS) dated 11/3/06 documented the resident had a Stage II and a Stage IV pressure ulcer and was totally dependent on staff for activities of daily living.

a. The facility's Wound Record for the resident documented the following wound characteristics:

Site: Mid coccyx

Treatment: Wound vac

11/2/06 - Stage 3 - 2.2 cm [centimeters] x 1.6 cm x 0.9 cm.

11/9/06 - Stage 3 - 2.2 cm x 1.5 cm x 0.9 cm.

11/20/06 - Stage 3 - 2.2 cm x 1.5 cm x 0.9 cm.

11/27/06 - Stage 3 - 2.2 cm x 1.5 cm x 0.9 cm.

b. A Physician Order dated 11/27/06 documented, "D/C [discontinue] wound vac to coccyx. Cleanse coccyx with w/c [wound cleanser], pack wound with Aquacel rope. Cover with 4x4's and ABD [abdominal] pad. Change M-W-F [Monday, Wednesday, Friday] and prn [as needed]." As of 12/15/06 at 10:00 a.m., there was no documentation to indicate the dressing change on the coccyx had been done for 11/27/06 (Monday) and 11/29/06 (Wednesday).

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F 314	Continued From page 5 c. A Nurse's Note dated 12/3/06 at 11:15 p.m. documented, "Upon entering res [resident's] room noted audible crackles, rapid resp [respirations], pulse ox at 80% on RA [room air], non rebreather placed, pulse ox up to 82%, physician paged at this time... send res to ER [emergency room] for evaluation and possible admit." d. A Hospital Progress Note dated 12/4/06 documented, "In to assess wounds of sacrum and right outer knee. Coccyx ulcer is a Stage 4 that is clean with small amt [amount] serosanguinous exudate. Wound is 6 cm x 4 cm x 1.5 cm with 1 cm undermining from 9 o'clock to 12 o'clock. No odor with the wound pink and fairly dry..." e. On 12/15/06 at 9:25 a.m., Registered Nurse (RN) #1 stated she had done the resident's treatment to the coccyx 3 times on 12/3/06 due to the resident having diarrhea. "I was the weekend nurse and did the treatment... I had not seen it in a couple of months and it looked about the same as it did 2 months ago." RN #1 was shown a measuring tool that showed how big a wound would be if it measured 2.2 cm x 1.5 cm, the last documented measurement by the facility. She stated, "I'm positive it was much bigger than that. I didn't see it before they took the wound vac off, but it probably increased in size after the wound vac was removed." f. As of 12/15/06 at 12:00 p.m., there was no documentation in the clinical record to indicate the physician had been notified that the wound progressed from 2.2 cm x 1.5 cm x 0.9 cm on 11/2706 to 6 cm x 4 cm x 1.5 cm on 12/4/06. As of 12/15/06 at 12:00 p.m., the resident remained in the hospital.	F 314		

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F 314	Continued From page 6 g. The facility's Policy for Pressure Ulcers dated 2/15/04 documented, "The physician should be informed of the presence of a pressure ulcer, or the failure of an ulcer to respond to treatment." 2. Resident #2 had diagnoses of Renal Failure and Congestive Heart Failure. The Quarterly MDS dated 10/23/06 documented the resident had a Stage 2 pressure ulcer and was modified independent in cognitive skills for daily decision-making. a. The Care Plan dated 10/11/06 documented the resident was at risk for skin breakdown. b. The facility's Wound Record dated 12/13/06 documented the resident had a Stage 3 pressure ulcer that measured 1.3 cm x 0.5 cm x 0.4 cm. c. As of 12/13/06 at 6:00 p.m., the Licensed Nurse Weekly Body Audit sheet documented the last body audit was conducted 12/4/06. The resident's Weekly Body Audit sheet also documented "Date: 12/11/06" in the next space on the form for documentation of a body audit; the date was the only documentation and there was no further documentation that the audit was actually done. 3. Resident #6 had diagnoses of Cerebrovascular Accident, Chronic Obstructive Pulmonary Disease and Diabetes Mellitus. The Quarterly MDS dated 12/6/06 documented the resident had a Stage 2 pressure ulcer and was totally dependent on staff for bed mobility. a. The Care Plan dated 12/6/06 documented the	F 314		

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F 314	Continued From page 7 resident was at risk for skin breakdown. b. The facility's Wound Record dated 12/6/06 documented the resident had a Stage II pressure ulcer that measured 1.1 cm x 1.2 cm x 0.4 cm. c. As of 12/13/06 at 6:00 p.m., the Licensed Nurse Weekly Body Audit sheet for the resident documented the last full body audit was conducted 11/28/06. The body audit form contained no documentation of the resident's body audits that were due on 12/5/06 and 12/12/06. d. On 12/13/06 at 6:45 p.m., the Director of Nursing stated it was the facility's policy to do weekly skin audits on every resident in the building. "We had a wound care nurse who did all our body audits, but she went back to work on the floor recently." e. On 12/15/06 at 12:10 p.m., the Administrator was asked if the skin audit problems had been discussed in the Quality Assurance meetings. He stated, "No. I was unaware we were behind on the skin audits."	F 314		