

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

PRINTED: 01/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/20/2007
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NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904
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{F 000}	INITIAL COMMENTS	{F 000}		
{F 314} SS=E	<p>483.25(c) PRESSURE SORES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: REWRITTEN DEFICIENCY</p> <p>Based on observation and record review, the facility failed to ensure all areas of the skin were cleansed of urine to prevent potential skin breakdown/promote healing of current skin breakdown for 2 (Residents #5 and #12) of 11 case mix residents who had or were at risk for pressure ulcers (Residents #1 through #7 and #9 through #12). The failed practice had the potential to affect 74 residents who were at risk for pressure ulcer development, as documented on a list provided by the Administrator on 12/20/07. The findings are:</p> <p>1. Resident #5 had diagnoses of Peripheral Vascular Disease and Protein-Calorie Malnutrition. The Quarterly Minimum Data Set (MDS) dated 9/28/07 documented the resident was incontinent of bowel and bladder, dependent</p>	{F 314}		

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 314}	<p>Continued From page 1</p> <p>on staff for personal hygiene and had two Stage II pressure ulcers.</p> <p>a. The Plan of Care update dated 11/19/07 documented the resident had a Stage II pressure ulcer to the coccyx which healed on 11/27/07.</p> <p>b. On 12/20/07 at 10:07 a.m., Certified Nursing Assistant (CNA) #2 provided incontinent care to the resident, whose incontinent brief was heavily saturated with urine. CNA #2 used a wet washcloth to wipe down the resident's buttocks, without spreading the buttocks to wash in the anal area, inner buttock folds or coccyx area. The CNA then turned the resident over and washed down each side of the groin twice, refolding the cloth each time. She then wiped downward over the vaginal area twice. On the second swipe over the vaginal area, most areas of the cloth had been used, so the cloth was rolled into the shape of a ball and the CNA wiped once more over the vaginal area. The CNA did not separate and cleanse between the labia.</p> <p>2. Resident #12 had diagnoses of Acute Renal Failure and Chronic Airway Obstruction. The MDS dated 11/26/07 documented the resident was incontinent of bowel and had a Stage II pressure ulcer to his sacrum.</p> <p>a. The Plan of Care dated 6/5/07 documented: "Incontinent bowel/bladd [bladder] r/t [related to] immobility, debility... Approach: ...Pericare after each episode to be done by CNA's x 2."</p> <p>b. On 12/20/07 at 10:45 a.m., CNA #1 provided incontinent care to the resident. The CNA used a wet washcloth with Aloe Vesta body wash to cleanse the resident's buttocks. The resident had</p>	{F 314}			

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{F 314}	Continued From page 2 a DuoDerm on his sacral area and there were 2 excoriated, scabbed areas approximately 0.5 centimeters each in the crease of the coccyx just above the DuoDerm. The CNA stated she thought the resident was getting another open area. The area of skin around the 2 scabbed areas was pink in color and looked moist and excoriated. The total area was approximately 1.5 centimeters in diameter. The CNA used the washcloth to wipe from the resident's anal area, across the DuoDerm and over the excoriated area twice without changing to a clean area of the washcloth. The CNA did not cleanse the resident's scrotum.	{F 314}			
{F 323} SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: REWRITTEN DEFICIENCY Based on observation, record review and interview, the facility failed to ensure a restraint was applied in accordance with the manufacturer's guidelines to minimize the potential for injury for 1 (Resident #1) of 2 case mix residents with physical restraints in use (Residents #1 and #6). The facility also failed to ensure a personal wheelchair alarm was attached to the resident's clothing to enable the alarm to function in accordance with the Plan of Care to	{F 323}			

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{F 323}	Continued From page 3 prevent further falls for 1 (Resident #3) of 4 case mix residents with physician orders for personal alarms (Residents #1, #2, #3 and #6). The facility also failed to ensure a partial-weight-bearing transfer was performed in a manner to minimize the potential for injury for 1 (Resident #7) of 3 case mix residents who required staff assistance with transfers (Residents #2, #5 and #7). The failed practices had the potential to affect 7 residents with physical restraints in use, 7 residents with physician orders for personal alarms and 27 residents who required staff assistance with transfers, as documented on lists provided by the Administrator on 12/20/07. The findings are: 1. Resident #1 had diagnoses of Advanced Severe Osteoporosis and History of Falls. The Minimum Data Set dated 11/11/07 documented the resident had modified independence in cognitive skills for daily decision-making, required limited assistance with transfers and ambulation, had an unsteady gait and had fallen in the past 30 days. a. The Plan of Care dated 12/1/07 documented: "Falls. 12/1/07. Restraint changed to non-self release." b. On 12/20/07 at 9:25 a.m., Certified Nursing Assistants (CNA's) #3 and #4 transferred the resident to a wheelchair. The resident's hips and back were forward in the seat approximately 4 to 5 inches from the back of the wheelchair. CNA #3 applied a brown, soft belt restraint by placing the restraint across the front of the resident's abdomen, pulling the left strap down between the back and the seat and the right strap between the side of the wheelchair and the back. The straps	{F 323}			

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{F 323}	Continued From page 4 were then crossed and ran over the back foot posts. The straps were not secured to a junction of the frame and the right strap was able to slide up. The strap ends were brought together and tied in a bow and then the ends of the bow straps were tied in a hard knot over the crossed straps in the back. CNA #4 told CNA #3, "That's supposed to be tied where you can undo it quick." The CNA's did not release the restraint and tie it properly. c. The Application Instruction Sheet for the Posey Soft Belt Restraint documented: "Hips should be held securely against the back of the chair whenever any type of restrictive product is used. The straps should be at 45 degrees over the hips and secured under the seat out of the patient's reach. Make sure straps are secured at a junction of the frame and will not slide in any direction, changing position of the device. Secure them out of the patient's reach with a quick release tie or buckle. Snug up tightness by pulling strap around back post, cross and twist before securing. The patient's hips should be against the back of the chair. Monitor to make sure the patient is not able to slide down or fall off a chair seat. If their body weight becomes suspended off the chair seat, chest compression and suffocation could result..." 2. Resident #3 had diagnoses of Pathological Fracture of the Neck of the Femur, Closed Fracture of the Humerus and Dementia without Behaviors. The Annual Minimum Data Set (MDS) dated 11/7/07 documented the resident was moderately impaired in cognitive skills for daily decision making, fell in the last 31-180 days and had a hip fracture within the last 180 days.	{F 323}			

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{F 323}	Continued From page 5 a. Nurses' Notes dated 12/14/07 documented: "2000 [8:00 p.m.]... found resident lying in floor on back in front of chair + [and] beside w/c [wheelchair]... Resident states, "I was trying to get in my chair + I got weak + sat in the floor..." b. The Care Plan dated 7/17/07 documented: "...Problem/Needs: Fall Potential for falls r/t [related to] past hx [history] + [and] immobility, weakness, [decreased] safety awareness... 12/14/07 Found in floor... Approach: Apply w/c alarm on w/c..." c. On 12/19/07 at 11:50 a.m. and 12:08 p.m., the resident was sitting in a wheelchair in the dining room with the string to the chair alarm unclipped from the resident and dangling behind the back of the wheelchair; however staff were in attendance at this time. d. On 12/19/07 at 12:55 p.m., Certified Nursing Assistant (CNA) #5 rolled the resident in the wheelchair to the resident's room. The string to the chair alarm remained unclipped from the resident and was dangling behind the back of the wheelchair. CNA #5 left the resident alone in the room with the wheelchair facing the bed and the alarm unclipped. e. On 12/19/07 at 1:03 p.m., the MDS Coordinator walked into the room. The resident remained in the wheelchair with the string to the chair alarm unclipped and dangling behind the back of the wheelchair. The MDS Coordinator was asked, "Is that a chair alarm?" The MDS Coordinator stated, "Yes, it is." The MDS Coordinator was asked if the alarm was operational in its current state. The MDS Coordinator stated, "No, it isn't hooked to her."	{F 323}			

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{F 323}	<p>Continued From page 6</p> <p>CNA #5 returned to the room at this time and was asked, "Are you the one who got the resident up in the wheelchair?" CNA #5 stated, "Yes." CNA #5 was asked, "What time was that?" CNA #5 stated, "Right before lunch." CNA #5 was asked, "Do you remember putting the chair alarm on the resident?" CNA #5 stated, "No, I didn't put it on."</p> <p>3. Resident #7 had diagnoses of Diabetic Foot Ulcer and Peripheral Vascular Disease. The Quarterly MDS dated 10/12/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required limited assistance of 1 person for transfers and was unable to attempt a standing balance test without physical help.</p> <p>a. The Care Plan dated 4/25/06 documented: "Problem/Need... Potential for falls R/T [related to] BKA L [Below Knee Amputation - left leg]... Approach: ...X1 [one person] assist [assistance] always using a gait belt. Partial wt. [weight] bearing..."</p> <p>b. On 12/19/07 at 9:10 a.m., CNA #5 transferred the resident from the bed to the bedside commode. CNA #5 grabbed under the resident's right arm and pulled the resident to a standing position, with no support to the middle or lower torso during the transfer. CNA #5 did not use a gait belt.</p> <p>c. On 12/20/07 at 11:35 a.m., CNA #6 transferred the resident from bed to the bedside commode. CNA #6 took the resident by the arms and pulled the resident from a lying to a sitting position. CNA #6 then pulled the resident's arms forward to the arms of the bedside commode. The CNA pulled the resident to a standing</p>	{F 323}			

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{F 323}	Continued From page 7 position by holding to the back of the resident's pants and pulling the resident upward, providing no support to the upper torso. The resident wobbled on one leg and was swivelled by the seat of the pants to the bedside commode. No gait belt was used. CNA #6 was asked, "Do you ever use a gait belt with this resident?" The CNA stated, "No, we don't ever use one."	{F 323}			