

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

PRINTED: 01/31/2008  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>045422</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/16/2008</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRACE HEALTHCARE OF MAUMELLE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>103 ALEXANDRIA DRIVE</b><br><b>MAUMELLE, AR 72113</b> |
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| F 000         | INITIAL COMMENTS  | F 000 |  |  |
| F 282<br>SS=E | <p>Complaint #13202 was substantiated (all or in part) with a deficiency cited at F332.</p> <p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, record review and interview, the facility failed to ensure the physician's plan of care was implemented by qualified staff, as evidenced by a topical prescription medication application completed by an unlicensed staff member to 1 of 1 case mix resident with a physician order for Nystatin powder (Resident #3). The failed practice had the potential to affect 7 residents with physician orders for Nystatin powder, as identified by the Director of Nursing (DON) on 1/17/08. The facility also failed to ensure the physician-ordered therapeutic diet was provided for 1 of 1 case mix resident with a physician order for a no-added-salt diet (Resident #3). The failed practice had the potential to affect 11 residents with physician orders for no-added-salt diets, as documented on the Diet List dated 1/16/08. The findings are:</p> <p>1. Resident #3 had diagnoses of Edema and Deep Vein Thrombosis. The Initial Minimum Data Set dated 11/15/07 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent, had no skin ulcers</p> | F 282 |  |  |

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| 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 282   | <p>Continued From page 1</p> <p>or rashes and required extensive assistance with activities of daily living.</p> <p>a. The January 2008 Physician Orders sheet documented a physician order dated 12/27/07 for: "Nystatin powder to groin area BID [twice daily]."</p> <p>b. On 1/14/08 at 5:10 p.m., Certified Nursing Assistant (CNA) #1 provided incontinent care to the resident, then applied Nystatin powder to the resident's groin area. The bottle had a pharmacy label which documented: "Apply as directed."</p> <p>c. On 1/16/08 at 1:15 p.m., the facility's Nurse Consultant stated, "It is the LPN's [Licensed Practical Nurse's] responsibility to put the Nystatin powder on the resident. It is a prescription; therefore, it would fall to the nurse. The nurse would have to put it on and the monitoring would be signing of the MAR [Medication Administration Record] or TAR [Treatment Administration Record]." As of 1/16/08, there was no TAR available for review on this resident and the January 2008 MAR did not document an order for Nystatin powder.</p> <p>2. Resident #3 had diagnoses of Hypertension and Edema. The Initial Minimum Data Set dated 11/15/07 documented the resident was moderately impaired in cognitive skills for daily decision making, received a therapeutic diet and required supervision and set-up assistance for eating.</p> <p>a. The January 2008 Physician Orders sheet documented an order dated 7/10/07 for: "Diet: NAS [no added salt] 2 mg [milligrams] low salt."</p> <p>b. The Plan of Care dated 11/14/07 documented:</p> | F 282   |   |                      |   |

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| F 282   | Continued From page 2<br>"Problem Onset 11/14/2007 Edema and fluid in lungs secondary to anemia... Approaches: ...Medication as ordered: lasix 20 mg [milligrams] 1 PO [by mouth qd [every day]... Problem Onset 11/14/2007 At risk for dehydration with decreased fluids and poor skin turgor related to use of Lasix... Approaches: NAS diet."<br><br>c. On 1/12/08 at 6:09 p.m. and 1/13/08 at 8:47 a.m. and 12:35 p.m., the resident's meal trays contained a salt packet.<br><br>d. On 1/13/08 at 1:07 p.m., the resident's diet card documented: "Diet: Regular, RCS [reduced concentrated sweets]. Condiment: Salt, pepper, Sweet & [and] Low."<br><br>e. On 1/13/08 at 2:45 p.m., the Dietary Manager stated: "NAS means no added salt on the resident's meal tray. RCS means reduced concentrated sweets for Diabetics." | F 282   |   |                      |   |
| F 309<br>SS=D   | 483.25 QUALITY OF CARE<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and record review, the facility failed to ensure indwelling urinary catheters were secured to prevent potential pulling or trauma of the urinary meatus and failed to ensure urinary collection bags were kept off of   | F 309   |   |                      |   |

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| F 309   | <p>Continued From page 3</p> <p>the floor for 1 of 1 case mix resident with an indwelling urinary catheter (Resident #4). The failed practice had the potential to affect 6 residents with indwelling urinary catheters, as documented on a list provided by the Director of Nursing (DON) on 1/16/08 at 2:30 p.m. The findings are:</p> <p>Resident #4 had diagnoses of Fractured Hip and Presenile Dementia. The Minimum Data Set (MDS) dated 11/20/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance from staff for bed mobility and transfers, had a current diagnosis of Clostridium difficile infection and a Urinary Tract Infection in the last 30 days and had an indwelling catheter.</p> <p>a. The Plan of Care dated 11/9/07 documented: "Problem: Foley cath [catheter] related to urinary retention. Goal: Will have no s/s [signs/symptoms] of UTI [Urinary Tract Infection] this qrt [quarter]. Approaches: ...Leg strap to hold foley tubing in place..."</p> <p>b. A Urinalysis with Culture and Sensitivity Report dated 12/13/07 documented a urine specimen collected from the resident contained red and white blood cells too numerous to count and many bacteria. The culture results documented the urine specimen cultured growth of Proteus mirabilis.</p> <p>c. A Urinalysis with Culture and Sensitivity Report dated 12/26/07 documented the urine specimen cultured growth of greater than 100,000 colony-forming units of Eschericia coli and greater than 100,000 colony-forming units of Proteus mirabilis.</p> | F 309   |   |                      |   |

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| F 309   | Continued From page 4<br><br>d. A Urinalysis with Culture and Sensitivity Report dated 1/5/08 documented the resident's urine specimen contained white blood cells too numerous to count and 4+ bacteria. The report documented the urine cultured growth of greater than 100,000 colony forming units of Escherichia coli >100,000.<br><br>e. On 1/12/08 at 3:50 p.m., 4:25 p.m., 5:15 p.m., 5:35 p.m. and 6:43 p.m., the resident's urinary catheter collection bag was on the floor. At 3:50 p.m., there was no leg band or other means of securing the catheter in place. At 5:15 p.m., the resident's son was in the room and was standing on the catheter collection bag. At 5:35 p.m., Licensed Practical Nurse (LPN) #2 went into the resident's room and administered medication to the resident. The LPN did not pick the catheter bag up off of the floor.<br><br>f. On 1/13/08 at 10:30 a.m. and 1/14/08 at 8:30 a.m., there was no leg band or other means of securing the catheter in place. On 1/14/08 at 8:30 a.m., the resident was repositioned in bed by Certified Nursing Assistants (CNA's) #1 and #4. The catheter tubing was left positioned under the resident's right leg when the CNA's left the room.<br><br>g. The facility's policy and procedure for Urinary Catheter Care was provided by the Director of Nursing on 1/17/08 at 1:45 p.m. and documented: "Catheter Care, Urinary... Purpose: The purpose of this procedure is to prevent infection of the resident's urinary tract... General Guidelines... 11. Be sure the catheter tubing and drainage bag are kept off the floor... 15. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site..." | F 309   |   |                      |   |

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| F 312<br>SS=D   | <p><b>483.25(a)(3) ACTIVITIES OF DAILY LIVING</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation and record review, the facility failed to ensure urine was cleansed from all areas of the resident's skin during incontinent care for 1 (Resident #8) of 3 case mix residents who were incontinent of bowel and/or bladder (Residents #3, #4 and #8). This failed practice had the potential to affect 41 residents in the facility who were incontinent, as documented on a list provided by the Director of Nursing (DON) on 1/16/08 at 2:30 p.m. The findings are:</p> <p>Resident #8 had diagnoses of Dementia and Osteoarthritis. The Minimum Data Set (MDS) dated 12/18/07 documented the resident had modified independence in cognitive skills for daily decision making, required limited assistance with toilet use and personal hygiene and was occasionally incontinent of bladder.</p> <p>a. On 1/14/08 at 11:00 a.m., Certified Nursing Assistants (CNA's) #2 and #3 provided incontinent care to the resident, whose incontinent brief was wet and soiled with feces. The CNA's did not cleanse the resident's buttocks.</p> <p>b. The facility's policy and procedure titled, "Perineal Care" was provided by the MDS Coordinator on 1/16/08 and documented:</p> | F 312   |   |                      |   |

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| F 312   | Continued From page 6<br>"...Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition... Steps in the Procedure... Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks..."   | F 312   |   |   |
| F 314<br>SS=H   | 483.25(c) PRESSURE SORES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure skin was monitored for breakdown for residents with or at risk for pressure ulcers, failed to ensure identified skin breakdown was assessed, that areas of breakdown were monitored, that the physician was immediately consulted for treatment orders for each area of breakdown or when areas deteriorated or that planned interventions were implemented to ensure healing of pressure sores for 2 (Residents #4 and Resident #8) of 3 case mix residents with pressure ulcers (Residents #4, #8 and #9). The failed practices resulted in patterns of actual harm to Residents #4 and #8, who developed additional pressure ulcers or deterioration of existing pressure ulcers. The facility also failed to ensure clean technique was | F 314   |   |   |

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| F 314   | Continued From page 7<br>followed during wound care, to prevent potential infection of existing pressure ulcers for 2 (Residents #8 and #9) of 3 case mix residents with pressure ulcers (see identifiers above). The failed practices had the potential to affect 4 residents with pressure ulcers, as documented on a list provided by the Director of Nursing (DON) on 1/16/08 at 2:30 p.m. The findings are:<br><br>1. The facility's policy and procedure titled, "Pressure Ulcer Risk Assessment" was provided by the Minimum Data Set (MDS) Coordinator on 1/16/08 at 2:00 p.m. and documented:<br>"...Purpose: The purpose of this procedure is to provide guidelines for the assessment and identification of residents at risk of developing pressure ulcers... General Guidelines: ...If pressure ulcers are not treated when discovered, they quickly get larger, become very painful for the resident and often times become infected...<br>10. Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure ulcer to the supervisor. Assessment: ...2. Skin Assessment - Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. 3. Monitoring: ...c. Nurses will conduct skin assessments at least weekly to identify changes... Documentation: The following information should be recorded in the resident's medical record: 1. The type of assessment conducted... 6. The condition of the resident's skin (i.e. [that is], the size and location of any red or tender areas). Prevention of Pressure Ulcers. Purpose: The Purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and | F 314   |   |                      |   |

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| F 314   | <p>Continued From page 8</p> <p>interventions for specific risk factors. General Guidelines: ...6. The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family and addressed... Interventions and Preventive Measures: Residents with Risk Factors... 5. Risk factor - Immobility... c. When in bed, every attempt should be made to "float heels" (keep heels off of the bed) by placing a pillow from knee to ankle or with other devices as recommended by therapist and prescribed by the physician..."</p> <p>2. The facility's wound care policy and procedure was provided by the MDS Coordinator on 1/16/08 at 2:00 p.m. and documented: "Wound Care... Infection Control Protocol and Safety: 1. Wash your hands thoroughly with soap and water at the following intervals: ...before resuming the procedure after an interruption... Maintain clean technique and isolation precautions as indicated... Steps in the Procedure: 1. Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached... Use no-touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers... Pour liquid solutions directly on gauze sponges on their papers... Be certain all clean items are on clean field..."</p> <p>3. Resident #4 had diagnoses of Fractured Hip and Pre-Senile Dementia. The Minimum Data Set (MDS) dated 11/20/07 documented the resident was moderately impaired in cognitive skills for daily decision making, had short-term</p> | F 314   |   |                      |   |

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| F 314   | Continued From page 9<br>and long-term memory problems, required extensive assistance from staff for bed mobility and transfers, was incontinent of bowel, had no existing pressure ulcers and had a history of resolved pressure ulcers in the last 90 days.<br><br>a. An Immediate Plan of Care dated 9/13/07 documented: "Pressure Ulcer Risk... Interventions... Pressure relieving device on chair/bed... Daily skin inspection during care/bathing by CNA [Certified Nursing Assistant] with report to the nurse of any areas of skin breakdown or redness..."<br><br>b. The Resident Assessment Protocol (RAP) Worksheet dated 9/19/07 documented: "RAP Problem area: ...Pressure Ulcers... Staff Notes: Resident was admitted with blister to heel and several stage 2's to back. Also excoriation to buttocks. Proceed to care plan."<br><br>c. The Plan of Care dated 11/9/07 documented: "Problem: Incontinent of bowel related to dementia and recent illness. Goal: Will have no skin breakdown related to incontinence this qrt [quarter]. Approaches: ...Assess skin weekly and prn [as needed]." There were no specific interventions to address current skin breakdown.<br><br>d. Nurse's Notes dated 12/13/07 and signed by Licensed Practical Nurse (LPN) #3 documented: "7-3 [7:00 a.m. to 3:00 p.m.] N.O. [New Order] Xenaderm to coccyx on open area - leave open to air BID [twice daily]. This nurse reported to [physician's] Registered Nurse [Nurse's name] of an open area to R's [resident's] bottom & [and] ii [two] small black looking areas to R [right] outer foot and heel. Nurse stated she and doctor would be in on 12/14/07 and would look at R's foot. | F 314   |   |                      |   |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRACE HEALTHCARE OF MAUMELLE</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>103 ALEXANDRIA DRIVE</b><br><b>MAUMELLE, AR 72113</b>               |                      |   |
| (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 314   | <p>Continued From page 10</p> <p>Order noted." There were no Physician's Progress Notes or Nurses' Notes to indicate that the physician or Registered Nurse saw the resident on 12/14/07.</p> <p>1.) A Physician's Telephone Order dated 12/13/07 documented: "...Heel protectors @ [at] all times... Zinc 220 mg. [milligrams] q [every] day. Vitamin C 500 mg. q day. Prosource 1 packet q AM [morning]..."</p> <p>2.) There was no further documentation regarding the areas on the resident's right foot until 1/7/08.</p> <p>e. A Bath Body Check dated 1/7/08 documented the resident's bath was completed by Certified Nursing Assistant (CNA) #5 and: "...Comments: Soars [sores] on feet need banages [bandages]..." The form also documented there was redness to the resident's buttocks/coccyx area. The bottom of the form documented that the findings were reported to LPN #3. There was no description of the wounds in the resident's clinical record regarding the areas to the feet at this time nor were treatment orders documented in the physician orders to indicate that the LPN followed up on this information.</p> <p>f. A Bath Body Check dated 1/9/08 documented the resident's bath was completed by CNA #1 and: "...Describe skin condition: Blisters on both legs (ankles)..." The bottom of the form documented that the findings were reported to LPN #3. There was no description of these areas in the resident's clinical record, nor were treatment orders documented in the physician orders to address treatment of these areas.</p> | F 314   |   |                      |   |

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| F 314   | <p>Continued From page 11</p> <p>g. A Weekly Body Audit Form dated 1/10/07 documented 7 areas on the resident's legs and feet. The areas affected were marked on a body illustration and documented the following:</p> <ol style="list-style-type: none"> <li>1.) A mark to the back of the left lower leg just above the heel accompanied a note which documented: "Superficial ?shear red, SS [serosanguineous] drainage no odor." No measurements were documented for this wound.</li> <li>2.) A mark to the left outer ankle accompanied a note which documented: ".5 x [by] .4 x 0 black, 0 drainage, 0 odor."</li> <li>3.) A mark to the left outer ankle accompanied a note which documented: "pink surround 0 drainage black." No measurements were documented for this wound.</li> <li>4.) A mark to the lateral aspect of the right foot accompanied a note which documented: "unstageable pressure necrotic tissue no odor no drainage .3 in [inch] circumference .1 deep."</li> <li>5.) Right ankle area - "0.1 mm (millimeter) round 0 drainage no odor."</li> <li>6.) A mark to the right medial aspect of the lower leg accompanied a note which documented: "1.5 x .5 x 0 pink SS drainage 0 odor."</li> <li>7.) A mark to the medial aspect of the left ankle accompanied a note which documented: "healing with scab 2 x 0.4."</li> </ol> <p>There was no documentation of staging of these areas and no documentation regarding the condition of the open area to the coccyx. Wound</p> | F 314   |   |                      |   |

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| F 314   | <p>Continued From page 12</p> <p>care orders obtained on 1/10/08 documented the following:</p> <p>1.) "Outer aspect L [left] foot - instep area [and] outer aspect L ankle @ [at] bone - Cleanse [with] wound cleanser, apply Accuzyme; cover [with] Mepore drsg [dressing] (occlusive)..."</p> <p>2.) "Inner aspect L foot @ instep [and] posterior LL [left lower] leg behind ankle - Cleanse [with] wound cleanser, apply TAO [triple antibiotic ointment], Telfa, wrap foot + [and] ankle area [with] Kerlix, secure [with] tape..."</p> <p>3.) "Anterior R [right] L [lower] leg above ankle, cleanse [with] wound cleanser. Apply Zenaderm, cover [with] Mepore drsg..."</p> <p>4.) "Outer aspect of [right] ankle at bone [and] outer aspect of foot @ instep - Cleanse [with] wound cleanser, apply Accuzyme; cover [with] Telfa. Wrap foot and ankle area [with] Kerlix; Secure [with] tape."</p> <p>There was no documentation of a treatment order for the coccyx at this time.</p> <p>h. On 1/13/08 at 10:30 a.m., the resident was not wearing heel protectors as ordered and her heels were not floated off of the bed. At 3:35 p.m., the resident had a heel protector on the left foot, but did not have one on the right foot and her heels were not floated off of the bed.</p> <p>i. On 1/14/08 at 8:30 a.m., the resident was not wearing heel protectors and her feet were not floated off of the bed.</p> <p>j. Treatments were observed on 1/14/08 at 11:45</p> | F 314   |   |                      |   |

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| F 314   | <p>Continued From page 13</p> <p>a.m. During these treatments, the following wounds were observed:</p> <ol style="list-style-type: none"> <li>1.) Left outer foot - black pinpoint area.</li> <li>2.) Left outer ankle - black area approximately 0.5 centimeters (cm) by 1 cm.</li> <li>3.) Left inner foot at instep - Stage III area with a red center surrounded by a white area with surrounding redness.</li> <li>4.) Right front lower leg - Stage II approximately 0.1 cm x 0.5 cm.</li> <li>5.) Right outer ankle - Stage III approximately 2 cm x 2 cm circular. The center had yellow slough and the surrounding area was dark red, almost purple in color.</li> <li>6.) Right lateral foot at instep - Stage III approximately 2 cm x 2 cm circular with yellow slough in the center and dark red, almost purple surrounding area.</li> </ol> <p>k. On 1/14/08 at 4:55 p.m., the resident was in bed. She did not have heel protectors on and her heels were not floated off the bed. CNA's #1 and #2 entered the room to change the resident's incontinent brief. The resident's buttocks, coccyx area and perianal area were reddened.</p> <p>4. Resident #8 had diagnoses of Restless Leg Syndrome, Edema and General Osteoarthritis. The Quarterly Minimum Data Set dated 12/18/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required limited assistance of staff for activities of daily living, had two Stage II pressure</p> | F 314   |   |                      |   |

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| F 314   | Continued From page 14<br>ulcers and required pressure relieving devices for the bed and the chair.<br><br>a. A Physician's Telephone Order dated 12/17/07 documented: "Have Therapy order Heel Suspension boots for resident."<br><br>b. The Plan of Care revised on 12/17/07 documented: "Skin breakdown on heels measures [no measurements documented]... Approaches: Treatment as ordered... Check heels daily."<br><br>c. Nurses' Notes dated 12/17/07 documented: "Bilateral heels blisters noted. [Physician] nurse called & [and] notified, orders received & done... Also [name] in Therapy asked to get R [resident] Heel Suspension Boots, protecting feet from further breakdown. Area to R [right] foot/heel measures 5 cm X 5 cm X 6 inches, white non-blanching [no] odor noted or discharge. L [left] foot has 2 X 2 X 3 dark area. MD [Medical Doctor] notified & family aware. Allevyn heel protectors applied, secured with Kling, care given to assure [no] further pressure applied to already edematous legs & feet."<br><br>d. The 200 Hall CNA Worksheet was copied on 1/14/08 at 1:17 p.m. and documented: "...HAS WOUND TO HEEL. NEEDS TO WEAR SPECIAL BOOT - USE HEEL BRIDGE AT NIGHT." The bottom of the form documented: "Must turn into [in to] nurse at end of shift."<br><br>e. The Pressure Sore Record form documented: "12/17/07 R heel, Stage N/A [not applicable], size: 5 X 5 X 6 [no depth], Color: White, L Heel Stage: N/A, size: 2 X 2 X 3, Color: dark." The next entry was dated 1/9/08 and documented the following: | F 314   |   |                      |   |

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| F 314   | <p>Continued From page 15</p> <p>"R Heel, size: 5 X 5, Depth: 0.2, Drainage: Sero Sanguinous, Odor: mild, Color: Pink, Yellow, Slough Necrotic Center, Response to Treatment: Appears healing - Wound Clinic. L Heel, Stage: N/A, Size: 3 X 3, Color: Fluid Filled." There was no documentation of assessments/monitoring of the resident's heels from 12/17/07 to 1/9/08.</p> <p>On 1/14/08 at 2:05 p.m., the Director of Nursing (DON) stated there were no other body audit sheets on this resident and, "The only one we could locate was in the record, dated 12/17/07."</p> <p>f. A physician order dated 1/8/07 at 4:10 p.m. documented: "...Accuzyme to wound R [right] heel cover [with] Kerlix.</p> <p>f. On 1/12/08 at 3:50 p.m. and 6:03 p.m., the resident was in bed, positioned on her back, with no heel protectors on either foot.</p> <p>g. On 1/13/08 at 7:45 a.m., 10:18 a.m., 12:36 p.m. and 2:36 p.m., the resident had a heel protector on the right foot, but nothing on the left heel.</p> <p>h. The Pressure Sore Record entry dated 1/13/08 documented the left heel wound assessment as: "3X3, Depth 0.2, purulent drainage, mild odor, color pink under necrosis fluid..."</p> <p>i. A Physician's Telephone Order dated 1/13/08 at 3:30 p.m. documented: "Wound to L [left] heel: Cleanse [with] NS [normal saline]; Apply Accuzyme to wound bed, cover [with] dry drsg, wrap [with] Kerlix and secure [with] tape QD [every day]."</p> | F 314   |   |                      |   |

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| F 314   | <p>Continued From page 16</p> <p>j. On 1/14/08 at 8:26 a.m., the resident was sitting in the dining room with a heel protector on the right foot and a dressing with a Velcro slipper on the left foot. At 12:02 p.m., the resident was sitting in a wheelchair with a dressing on the left foot. The heel was resting on the foot pedal and the right foot had on a heel elevator boot.</p> <p>k. On 1/14/08 at 10:40 a.m., Licensed Practical Nurse (LPN) #1 performed treatments to the pressure ulcers on the resident's heels. She donned gloves, then gathered supplies and placed them on the resident's bed. No clean field was set up. She used a dry 4x4 gauze to wipe the wound on the right heel, removed the glove from her right hand only and placed a clean glove on that hand. She then used the gloved right hand to apply Accuzyme ointment to the resident's heel. The LPN then picked up a piece of Telfa from the resident's bed and placed it over the wound area. The LPN followed the same process to complete wound treatments on the resident's left heel.</p> <p>l. On 1/14/08 at 12:10 p.m., the DON was informed that this was the first day the heel elevator had been observed on the resident. The DON stated, "She is supposed to have it on everyday."</p> <p>m. On 1/14/08 at 12:22 p.m., the Minimum Data Set Coordinator stated, "We keep Podus boots in-house and the one [resident] has on is one that we had." The MDS Coordinator was asked if the resident needed a boot, would it be reasonable to expect that the boot should be applied to the resident by the next day. She stated, "Yes."</p> <p>n. On 1/14/08 at 1:05 p.m., the Administrator was</p> | F 314   |   |                      |   |

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| F 314   | Continued From page 17<br>shown the Nurses' Notes dated 12/17/07 and he stated, "It says boots. That means 2 and it says feet, not foot. I take it to mean boots to both feet."<br><br>5. Resident #9 had a diagnosis of Chronic Skin Ulcer. The MDS dated 11/21/07 documented the resident was independent in cognitive skills for daily decision making, had 2 Stage IV pressure ulcers and had a wound infection.<br><br>a. A physician order dated 12/20/07 documented: "Chlorapactin 2 GM [gram] powder with sterile water for irrigation, wet to dry dressing BID [twice daily]."<br><br>b. On 1/13/08 at 7:40 a.m., LPN #2 performed treatments to the wounds on the resident's left buttock and coccyx. The LPN removed the soiled dressings from both wounds, changed gloves and cleansed the wounds with normal saline. The LPN again changed gloves, but could not find 4x4 gauze pads to complete the care. The LPN removed his gloves and left the room to obtain more supplies. The LPN re-entered the room and without washing his hands, donned gloves then opened the treatment cart. The LPN dug around in the drawers of the treatment cart with his gloved hands, then obtained a pair of scissors, opened a package of roll gauze and cut 2 pieces of the gauze. Still wearing the same contaminated gloves, the LPN picked up a bottle of Chlorapactin 0.2% and used it to moisten the gauze. The moistened gauze was then used to pack the wound on the resident's buttock. The LPN changed gloves, cut off 2 pieces of the roll gauze, picked up the bottle of Chlorapactin with his gloved hands, moistened the gauze with the Chlorapactin and packed the wound on the | F 314   |   |                      |   |

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| F 314   | Continued From page 18<br>coccyx.   | F 314   |   |                      |   |
| F 315<br>SS=D   | <p>6. On 1/14/08 at 2:10 p.m., the DON stated:<br/>"Body audits are done by room number on Monday through Saturday by the LPN's [Licensed Practical Nurses]. They are done weekly on each resident. They are looked at weekly by the LPN and a CNA on every shower/bath day. We have a policy, but evidently it isn't working."</p> <p>483.25(d) URINARY INCONTINENCE</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation and record review, the facility failed to ensure incontinent care was provided in a manner to prevent potential urinary tract infections (UTI's) for 1 (Resident #8) of 3 case mix residents who were incontinent of bowel and/or bladder (Residents #3, #4 and #8). This failed practice had the potential to affect 41 residents in the facility who were incontinent, as documented on a list provided by the Director of Nursing (DON) on 1/16/08 at 2:30 p.m. The findings are:</p> <p>Resident #8 had diagnoses of Dementia and Osteoarthritis. The Minimum Data Set (MDS)</p> | F 315   |   |                      |   |

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| F 315   | Continued From page 19<br>dated 12/18/07 documented the resident had modified independence in cognitive skills for daily decision making, required limited assistance with toilet use and personal hygiene and was occasionally incontinent of bladder.<br><br>a. On 1/14/08 at 11:00 a.m., Certified Nursing Assistants (CNA's) #2 and #3 provided incontinent care to the resident. CNA #3 cleansed feces from the resident's anal area by wiping downward from the anal area toward the urinary meatus 3 times.<br><br>b. The facility's policy and procedure titled, "Perineal Care" was provided by the MDS Coordinator on 1/16/08 and documented: "...Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition... Steps in the Procedure... Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same washcloth or water to clean the labia..." | F 315   |   |                      |   |
| F 323<br>SS=E   | 483.25(h) ACCIDENTS AND SUPERVISION<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and record review, the facility failed to ensure transfer assistance was  | F 323   |   |                      |   |

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| F 323   | <p>Continued From page 20</p> <p>provided in a manner to prevent potential injury for 2 (Residents #4 and #8) of 3 case mix residents who required manual transfers (Residents #3, #4 and #8). The failed practice had the potential to affect 14 residents who were transferred manually, as documented on a list provided by the Director of Nursing on 1/16/08. The findings are:</p> <p>1. Resident #4 had diagnoses of Fractured Hip and Osteoporosis. The Minimum Data Set (MDS) dated 11/20/07 documented the resident was moderately impaired in cognitive skills for daily decision making and required extensive assistance with transfers.</p> <p>a. The Plan of Care dated as reviewed/revised 11/9/07 documented: "Potential for injury/fx [fracture] secondary to hx [history] of fx and hx of fall and dx [diagnosis] Osteoporosis... Approaches - Use care with transfers to prevent injury... Lift as needed for safety..."</p> <p>b. On 1/14/08 at 4:55 p.m., Certified Nursing Assistants (CNA's) #1 and #2 transferred the resident from the bed to the wheelchair. A gait belt was applied around the resident's waist. Each CNA placed an arm beneath one of the resident's arms and with their other hand grabbed the gait belt at the back. The resident was lifted off of the bed into the wheelchair. Her feet did not touch the floor during the transfer and no support was provided to her lower extremities.</p> <p>2. Resident #8 had a diagnosis of Osteoarthritis. The MDS dated 12/18/07 documented the resident had modified independence in cognitive skills for daily decision making and required limited assistance with</p> | F 323   |   |                      |   |

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| F 323   | Continued From page 21 transfers.<br><br>a. The Plan of Care dated as reviewed/revise on 12/17/07 documented: "Potential for injury related to fall risk... Approaches - Use care with transfers to prevent injury... Have therapy inservice staff on proper transfer or mobility techniques as needed..."<br><br>b. On 1/14/08 at 11:15 a.m., CNA's #2 and #3 transferred the resident from the bed to the wheelchair. A gait belt was applied around the resident's waist. Each CNA placed an arm beneath one of the resident's arms and grabbed the gait belt behind the resident's back with their other hand. The resident was lifted off of the bed and placed into the wheelchair. The resident did not bear any weight on her lower extremities.<br><br>3. The facility's transfer policy and procedure was provided by the MDS Coordinator on 1/16/08 at 2:00 p.m. and documented: "Moving a Resident, Bed to chair/Chair to bed... Steps in the Procedure: ...If the resident cannot stand alone, two persons (one on each side) should lock arms with the resident, gently stand and turn the resident and sit him/her in the chair... Support the resident by placing a belt around the resident's waist for you to hold and steady the resident..." This policy did not include information regarding how a non-weight-bearing resident should be transferred. | F 323   |   |                      |   |
| F 325<br>SS=H   | 483.25(i)(1) NUTRITION<br><br>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  | F 325   |   |                      |   |

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| F 325   | Continued From page 22<br>demonstrates that this is not possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure nutritional interventions were implemented to maintain nutritional parameters for 1 (Resident #4) of 1 case mix resident who experienced a weight loss. This failed practice resulted in a pattern of actual harm to Resident #4 who experienced a severe weight loss and had the potential to affect 12 residents who experienced significant weight losses, as documented on a list provided by the Director of Nursing (DON) on 1/16/08. The findings are:<br><br>1. A facility policy and procedure provided by the Director of Nursing (DON) on 1/17/08 at 1:45 p.m. documented: "Nutritional At Risk Program. Policy. A. Assessment identification of risk factors will be identified as such for clinical baseline data and/or investigative purposes based on the following criteria: ...Residents with admitting diagnosis (or has been assessed for such) of malnutrition or dehydration... Nutritional at risk committee (NAR) Standard: It is the practice of this facility to review and monitor residents who are at high risk for poor nutritional status or displaying weight loss at an interdisciplinary committee on a regular basis... Procedure: ...Director of Nursing and dietary will audit weekly weights, monthly weights and weight histories to determine residents showing significant and trending weight loss;/gain. These residents will be reviewed weekly or referred to the NAR committee..." | F 325   |   |                      |   |

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| F 325   | <p>Continued From page 23</p> <p>2. Resident #4 had diagnoses of Fractured Hip, Anorexia and Pre-senile Dementia. The Minimum Data Set (MDS) dated 11/20/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required set-up assistance only for eating, had a swallowing problem, had not experienced a weight loss or gain of 5% or more in the past 30 days or 10% or more in the past 180 days and had a history of resolved pressure ulcers in the last 90 days.</p> <p>a. The Plan of Care dated 11/9/07 documented: "Potential for weight loss related to hx [history] of weight loss... Goal: Weight will remain within normal limits this qrt. [quarter]. Approaches: ...Encourage resident to eat at least 50%..."</p> <p>b. A physician order dated 12/13/07 documented: "Ensure pudding at lunch and dinner qd [every day]."</p> <p>The January 2008 Medication Administration Record (MAR) documented the resident was to receive Ensure pudding at 12:30 p.m. and 5:30 p.m. daily. No initials were documented to indicate the resident was provided with the pudding as ordered for the 12:30 meals on 1/1/08 through 1/4/08 and 1/7/08 through 1/11/08, the evening meal on 1/12/08 and the noon and evening meals on 1/13/08.</p> <p>c. Weekly weights were documented on Weekly Weights forms for this resident from 9/13/07 to 12/21/07. The resident's weight on 12/7/07 was 140.8 pounds. On 12/13/07, the residents weight was 134.8 pounds, a 6 pound loss in one week. The resident's weight on 12/21/07 was 134.2. There was no documentation that the weekly</p> | F 325   |   |                      |   |

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| F 325   | Continued From page 24<br>weights were continued after 12/21/07.<br><br>1.) The Monthly Weight & Vital Sign Record documented the resident's weight on 1/2/08 was 127.8. The resident had a 9.23 % weight loss in one month (from 140.8 pounds on 12/7/07 to 127.8 pounds on 1/2/08). The section of the form designated for documentation that the physician and Dietary Department were notified of the weight loss had not been completed. There was no documentation that the weight loss was reported to anyone until 1/10/08 or that further interventions to prevent continued weight loss were implemented until 1/11/08 when the Registered Dietician reviewed the resident's clinical record.<br><br>2.) On 1/15/08 at 1:00 p.m., the MDS Coordinator stated the Restorative Nursing Assistant weighed the residents and she had until the tenth of each month to report the weights to her.<br><br>d. There were no documented Dietary Notes in the resident's clinical record from 9/13/07 through 1/11/08. A Nutritional Progress Note dated 1/11/08 by the Registered Dietician documented: "Jan [January] wt [weight] 127.8. (sig [significant] loss x 1 month). Diet: Mech [mechanical] soft, ensure pudding @ [at] L&D [lunch and dinner]. Receives Megace ES daily. Abx [antibiotics] started for UTI [urinary tract infection] on 1/6/07... Plan: Send Ensure [with] meals." There was already an order for Ensure pudding with lunch and dinner and no further recommendations were added at this time, other than to send Ensure with meals. As of 1/13/08, there was no documentation on the January 2008 Physician Orders or the January 2008 MAR to indicate that | F 325   |   |                      |   |

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| F 325   | <p>Continued From page 25</p> <p>the Registered Dietician's recommendation for Ensure with meals had been initiated.</p> <p>e. On 1/15/08 at 11:10 a.m., the Director of Nursing (DON) stated that weights were reviewed at the end of each week. If there was a weight loss, the Physician and Dietician would be notified and the resident would be put on weekly weights. She stated that Resident #4 should be on 2 Cal, 2 ounces, 2 to 3 times daily and vitamin supplements.</p> <p>1.) On 1/15/08 at 11:35 a.m., Licensed Practical Nurse (LPN) #3 stated she had no residents on the 100 Hall (where Resident #4 resided) who received 2 Cal with medication pass.</p> <p>2.) On 1/15/08 at 11:25 a.m., the Dietary Manager stated, "I do not have Ensure pudding. I had it in the past. I had one resident on it and they d/c'd [discontinued]. It has been weeks since I had [Ensure] pudding. I have cans of Ensure; it goes out on the trays if I have a Doctor's order. Our house supplement is Mighty Shake and most of the weight losses are getting Mighty Shake and ice cream and super cereal." When asked what interventions were in place for Resident #4, the Dietary Manager stated, "She gets a mechanical soft diet with a divided plate and gets super cereal. I have her on no supplements."</p> <p>f. On 1/12/08 at 5:15 p.m., the resident's son brought the resident a hamburger, French fries and a carbonated soft drink for dinner. The resident's son remained with the resident throughout the meal and at 5:45 p.m., the resident had consumed 100% of the hamburger, half of the French fries and 12 ounces of the soft</p> | F 325   |   |                      |   |

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| F 325   | <p>Continued From page 26</p> <p>drink.</p> <p>g. On 1/13/08 at 8:45 a.m., the resident's breakfast tray was taken into her room by Certified Nursing Assistant (CNA) #1. The CNA repositioned the resident and set up the tray, then left the room without encouraging the resident to eat or attempting to feed the resident. The tray contained pancakes, eggs, sausage, oatmeal, 4 ounces of juice, 5 ounces of coffee and 8 ounces of milk. There was no Ensure or any type of supplement on the meal tray. The tray remained in front of the resident until 9:05 a.m., at which time the resident's daughter-in-law entered the room and attempted to feed the resident. The resident consumed only the juice and coffee and left the food items uneaten.</p> <p>h. On 1/14/08 at 8:35 a.m., the resident's breakfast tray was taken into the room by CNA #1. The CNA repeatedly attempted to place the spoon in the resident's hand. The CNA stated, "You not going to eat. I'll get you a straw." The resident was attempting to feed herself as the CNA left the room without ever making an attempt to feed the resident.</p> <p>i. On 1/15/08 at 10:35 a.m., the Speech Language Pathologist (SLP) was interviewed. She stated she worked with the resident for, "about a week in December [2007]. I did not see that she needed to be fed at that time. She will not let just anyone help her." When asked if she was aware of the resident's 9.2% weight loss from December 2007 to January 2008, the SLP stated she was not. She also stated, "If a resident has had significant loss, the resident is usually referred to me... If she is [eating] in her room, I would want someone to assist her or at</p> | F 325   |   |                      |   |

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| F 325   | Continued From page 27<br>least stay with her and make sure she eats. Fifty percent consumption is a good amount for her."  | F 325   |   |                      |   |
| F 332<br>SS=E   | 483.25(m)(1) MEDICATION ERRORS<br><br>The facility must ensure that it is free of medication error rates of five percent or greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation of the 12:00 p.m. and 4:00 p.m. medication passes on 1/14/08, record review and interview, the facility failed to ensure the medication error rate was less than 5%.<br>Physician orders were not followed for 5 (Residents #5, #16, #11, #17 and #18) of 21 residents observed during the medication passes, which resulted in medication errors. Medication errors were made by 3 Licensed Practical Nurses (LPN's #1, #2 and #3) of 5 licensed nurses observed administering medications in the facility. The failed practice had the potential to affect 60 residents who received medications, as identified by the Administrator on 1/12/08. The medication error rate was 12.76% based on observation of 46 medications administered, 1 medication ordered but not administered and a total of 6 medication errors detected. The findings are:<br><br>1. Resident #5 had a physician order dated 12/20/07 for Combivent 14.7 grams 2 puffs three times a day.<br><br>a. On 1/14/08 at 12:11 p.m. during the 12:00 | F 332   |   |                      |   |

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| F 332   | <p>Continued From page 28</p> <p>p.m. medication pass, LPN #1 administered Combivent 14.7 grams 2 puffs consecutively, without allowing any time between puffs.</p> <p>b. The Centers for Medicare &amp; Medicaid Services (CMS) Interpretive Guidelines at F332/F333 documented the following regarding administration of medication via metered dose inhalers (MDI): "If more than one puff is required, (whether the same medication or a different medication) wait approximately a minute between puffs."</p> <p>2. Resident #5 had a physician order dated 12/20/07 for Depakote Sprinkles 500 milligram (mg) by mouth (PO) with lunch.</p> <p>On 1/14/08 at 12:13 p.m. during the 12:00 p.m. medication pass, LPN #1 administered Depakote Sprinkles 500 mg to the resident. According to the facility's meal time schedule, lunch was not scheduled to be served until 12:30 p.m.</p> <p>3. Resident #16 had a physician order dated 12/26/07 for Neurontin 100 mg po three times a day (tid) at 9:00 a.m., 3:00 p.m. and 9:00 p.m. (which would result in the resident receiving a dose every 6 hours).</p> <p>a. The January 2008 Medication Administration Record documented the physician's order for the Neurontin to be administered at 9:00 a.m., 3:00 p.m. and 9:00 p.m.; however, the Time Codes on the MAR documented the administration times as 8:00 a.m., 12:00 p.m. and 5:00 p.m., instead of 9:00 a.m., 3:00 p.m. and 9:00 p.m. as ordered by the physician.</p> <p>b. On 1/14/08 at 12:23 p.m. during the 12:00</p> | F 332   |   |                      |   |

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| F 332   | <p>Continued From page 29</p> <p>p.m. medication pass, LPN #1 administered Neurontin 100 mg to the resident.</p> <p>c. On 1/15/08 at 1:05 p.m., the Registered Nurse Consultant stated, "The facility has not been able, until just recently, to make medications times specific times."</p> <p>4. Resident #11 had a physician order dated 12/28/07 for Artificial Tears 1 drop to both eyes every 2 hours as needed for dry eyes.</p> <p>On 1/14/08 at 4:10 p.m. during the 5:00 p.m. medication pass, the resident requested of LPN #2, "Can I have my eye drops?" LPN #2 looked for the Artificial Tears in the medication cart and the medication room. At 4:14 p.m., LPN #2 informed the resident, "I can't find the eye drops and I will have to call the pharmacy to order them."</p> <p>5. Resident #17 had a physician order dated 3/29/07 for Wellbutrin SR (sustained release) 100 mg 1 po twice a day (bid).</p> <p>a. On 1/14/08 at 4:45 p.m. during the 5:00 p.m. medication pass, LPN #3 administered Wellbutrin 100 mg instead of Wellbutrin SR.</p> <p>b. On 1/15/08 at 12:50 p.m., the Director of Nursing (DON) stated, "The pharmacy said that the insurance company would not pay for the Wellbutrin SR 100 mg, so they called the physician. They just did not let us know it changed and they just started sending the plain Wellbutrin 100 mg."</p> <p>6. Resident #18 had a physician order dated 10/26/07 for Ferrous Sulfate 325 mg 1 po every</p> | F 332   |   |                      |   |

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| F 332   | Continued From page 30<br>day with meals.   | F 332   |   |                      |   |
| F 333<br>SS=E   | <p>On 1/14/08 at 4:58 p.m. during the 5:00 p.m. medication pass, LPN #3 administered the Ferrous Sulfate 325 mg with 3 ounces of water and no food. According to the facility's meal time schedule, the resident's evening meal was not scheduled to be served until 5:30 p.m.</p> <p>483.25(m)(2) MEDICATION ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, record review and interview, the facility failed to ensure physician orders were implemented to prevent significant medication errors for 3 (Residents #4, #17 and #18) of 15 case mix residents with physician orders for medications (Residents #1 through #12 and #16 through #18). The failed practice had the potential to affect 60 residents with physician orders for medications, as identified by the Registered Nurse Consultant on 1/15/08. The findings are:</p> <p>1. Resident #4 had a diagnosis of Anorexia.</p> <p>a. A physician order dated 9/19/07 documented the resident was to receive Megace ES (extra strength) 625 milligrams (mg) by mouth (po) every day. This was documented on the January 2008 Physician Orders sheet as a current order.</p> <p>b. A physician's telephone order dated 10/8/07 at 10:00 a.m. documented: "D/C [discontinue] Megace."</p> | F 333   |   |                      |   |

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| F 333   | Continued From page 31<br><br>c. On 1/15/08 at 11:10 a.m., the Director of Nursing (DON) reviewed the resident's medications and stated, "The resident's on Megace."<br><br>d. The January 2008 Medication Administration Record (MAR) documented Megace ES 625 mg was administered twice daily at 8:00 a.m. and 5:00 p.m. every day from 1/1/08 through 1/13/08, with the exception of the 8:00 a.m. doses on 1/2/08 and 1/4/08 and the 5:00 p.m. doses on 1/2/08 and 1/9/08. This was a total of 21 doses of Megace administered during the month of January 2008 without a physician order to do so.<br><br>e. This medication error was significant due to the frequency of the error.<br><br>2. Resident #17 had a diagnosis of Unspecified Antidepressant Abuse.<br><br>a. A physician order dated 3/29/07 documented the resident was to receive Wellbutrin SR (sustained release) 100 mg 1 po twice a day (bid).<br><br>b. On 1/14/08 at 4:45 p.m. during the 5:00 p.m. medication pass, Licensed Practical Nurse (LPN) #3 administered Wellbutrin 100 mg to the resident, instead of Wellbutrin SR as ordered by the physician.<br><br>c. On 1/15/08 at 12:50 p.m., the Director of Nursing (DON) stated, "The pharmacy said that the insurance company would not pay for the Wellbutrin SR 100 mg, so they called the physician. They just did not let us know it changed and they just started sending the plain | F 333   |   |                      |   |

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| F 333   | Continued From page 32<br>Wellbutrin 100 mg."<br><br>d. The medication bubble pack of Bupropion (Wellbutrin) 100 mg tablets was copied on 1/15/08. The tablets had been punched out of the bubble pack from 1/10/08 through 1/15/08, a total of 6 doses of the drug.<br><br>e. This medication error was significant due to the frequency of the error.<br><br>3. Resident #18 had a physician order dated 1/13/08 at 6:55 a.m. which documented:<br>"Tobradex TID [three times daily] x [times] 7 days - until cracked left eye has cleared."<br><br>a. On 1/15/08 at 1:05 p.m., the Registered Nurse Consultant stated, "The medication was received 1/13/08 at 4:25 p.m."<br><br>b. The January 2008 MAR was reviewed on 1/15/08 at 10:00 a.m. and documented the Tobradex ophthalmic suspension was to be administered at 8:00 a.m., 4:00 p.m. and 12:00 a.m. (midnight) daily. The MAR documented the Tobradex was not initiated until 1/14/08 at 8:00 a.m. The Tobradex ophthalmic suspension was available in the facility by 1/13/08 at 4:25 p.m.; but no 4:00 p.m. dose or midnight dose was administered that day. A dose of the Tobradex was documented at 8:00 a.m. on 1/14/08; however, there were no initials documented on the MAR to indicate that the 4:00 p.m. and midnight doses were administered on 1/14/08. A total of 3 doses were missed, excluding the 4:00 p.m. dose that could have been administered when the medication was received by the facility at 4:25 p.m. on 1/13/08. | F 333   |   |                      |   |

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| F 333   | Continued From page 33   | F 333   |   |                      |   |
| F 363<br>SS=F   | <p>c. This medication error was significant due to the frequency of the error.</p> <p>483.35(c) MENUS AND NUTRITIONAL ADEQUACY</p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, record review and interview, the facility failed to ensure the planned, written menu and recipes were followed to ensure nutritional adequacy for the residents who received meals from the kitchen. The failed practice had the potential to affect 58 residents who received meals from the kitchen and were not tube fed, as documented on the Resident Census and Conditions of Residents dated 1/12/08. The findings are:</p> <p>1. On 1/15/08 at 10:20 a.m., 5 of 5 alert and oriented residents who participated in the group interview made the following statements:</p> <p>a. "The portions are small."</p> <p>b. "The sandwiches are skimpy... only get one thin slice of meat on a sandwich."</p> <p>2. On 1/15/08, the facility's menu for the evening meal documented the residents were to receive a Reuben sandwich with 2 ounces of meat and 2 slices of bread, a 2 by 3 inch slice of strawberry</p> | F 363   |   |                      |   |

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| F 363   | Continued From page 34<br>pound cake and 1 cup of beverage.<br><br>a. On 1/15/08 at 5:15 p.m., the following observations were made:<br><br>1.) The Dietary Manager was asked to separate the meat from the bread and weigh only the protein foods from several of the Reuben sandwiches. The ham and cheese were removed and weighed by the Dietary Manager. The weights ranged from 1.5 to 1.75 ounces.<br><br>2.) The Dietary Manager was asked to measure a few portions of the strawberry pound cake. Using a ruler, the Dietary Manager measured several of the smaller pieces of the cake. The measurements ranged from 1.5 by 2 inches to 2 by 2 inches, instead of 2 by 3 inches as specified on the menu.<br><br>b. On 1/15/07 at 5:21 p.m., 2 trays of glasses were filled with between 4 and 6 ounces of tea, instead of 8 ounces as specified on the menu. | F 363   |   |                      |   |
| F 364<br>SS=E   | 483.35(d)(1)-(2) FOOD<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure meals were palatable, served promptly and at temperatures that were acceptable to the residents. The failed practice had the potential to affect 58 residents  | F 364   |   |                      |   |

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| F 364   | Continued From page 35<br>who received meals from the kitchen and were not tube fed, as documented on the Resident Census and Conditions of Residents form dated 1/12/08. The findings are:<br><br>1. The facility's meal schedule documented breakfast was to be served at 7:30 a.m. daily, lunch was to be served at 12:30 p.m. daily and dinner was to be served at 5:30 p.m. daily.<br><br>2. Resident #2 had a diagnosis of Weight Loss.<br><br>a. On 1/12/08 at 1:08 p.m. during the initial tour of the facility, Licensed Practical Nurse (LPN) #7 stated that the resident received meals in her room.<br><br>b. On 1/12/08, the resident received her evening meal on a Styrofoam plate at 6:47 p.m., 1 hour and 17 minutes past the scheduled meal time.<br><br>3. Resident #3 had a diagnosis of Weight Loss.<br><br>a. On 1/12/08 at 1:47 p.m., LPN #1 stated the resident received most meals in the dining room.<br><br>b. On 1/13/08, the resident received a breakfast tray in his room at 8:44 a.m., 1 hour and 14 minutes past the scheduled meal time.<br><br>4. Resident #4 had a diagnosis of Anorexia.<br><br>a. On 1/12/08 at 1:44 p.m., LPN #7 stated that the resident received meals in her room.<br><br>b. On 1/12/07, the resident did not receive a breakfast tray until 8:45 p.m., 1 hour and 15 minutes past the scheduled meal time. | F 364   |   |                      |   |

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| F 364   | <p>Continued From page 36</p> <p>6. Resident #8 had diagnoses of Dementia and Vitamin Deficiency.</p> <p>a. On 1/12/08 at 1:10 p.m., LPN #1 stated that the resident received most meals in the dining room.</p> <p>b. On 1/13/07, the resident did not receive a lunch tray until 1:43 p.m., 1 hour and 13 minutes past the scheduled meal time.</p> <p>7. On 1/15/07 at 10:40 p.m., 5 of 5 alert and oriented residents who participated in the group interview made the following comments:</p> <p>"The meals are always cold."</p> <p>"Meals are not hot and are always late."</p> <p>8. On 1/15/08 at 5:52 p.m. during the supper meal observation, a tray containing a Reuben sandwich, broccoli slaw, fried corn nuggets, strawberry pound cake and tea was placed on a utility cart outside the kitchen serving window by nursing staff for a resident who was not in the dining room. The tray remained on the cart until after the residents in the dining room were served. At 6:10 p.m., when the hall trays were being placed on the cart, the Administrator removed the tray from the cart and took the tray down the hall to the resident's room. There was no attempt by nursing staff to in inform the Administrator of the length of time the tray had been sitting on the cart; nor were there any attempts by the staff to warm the tray or obtain another tray from the kitchen.</p> <p>9. On 1/15/08 at 6:06 p.m., a non case mix resident was served a tray in the dining room.</p> | F 364   |   |                      |   |

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| F 364   | Continued From page 37<br>The resident tasted the food on the tray and asked the Certified Nursing Assistant to get her another tray because the food on the tray was cold.   | F 364   |   |                      |   |
| F 371<br>SS=F   | 483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE<br><br>The facility must store, prepare, distribute, and serve food under sanitary conditions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, the facility failed to Dietary Employees washed their hands between dirty and clean tasks to prevent potential cross-contamination and failed to ensure food items were stored/coded in a manner to facilitate first-in/first-out stock rotation. The failed practices had the potential to affect 58 residents who received meals from the kitchen and were not tube fed, as documented on the Resident Census and Conditions of Residents form dated 1/12/08. The findings are.<br><br>1. On 1/15/08 at 5:00 p.m., the Morning Cook picked up sandwiches with her bare hands and placed them on the grill. After the first batch of sandwiches was grilled, the Cook removed the sandwiches from the grill, wiped her hands on a dirty, wet dish cloth then continued grilling more sandwiches without washing her hands.<br><br>2. On 1/15/07 at 5:13 p.m., Dietary Aide #1 disposed of paper in the garbage can by lifting the lid with her bare hands, then without washing her hands, filled tea glasses to be served to residents | F 371   |   |                      |   |

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| F 371   | Continued From page 38 with their evening meal.<br><br>3. On 1/15/08 at 5:40 p.m., the storage room shelves contained the following items which were not coded for first-in/first-out stock rotation:<br><br>a. Five cases of concentrated juice.<br><br>b. Six 5-pound boxes of carrot cake mix.<br><br>c. Four 4-pound boxes of cream cheese frosting.<br><br>4. On 1/16/07 at 1:05 p.m., Dietary Aide #2 went from the dirty side of the dish room to the clean side on 2 occasions, without washing her hands between dirty and clean tasks. | F 371   |   |                      |   |