

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

PRINTED: 03/06/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2008
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NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF MAUMELLE	STREET ADDRESS, CITY, STATE, ZIP CODE 103 ALEXANDRIA DRIVE MAUMELLE, AR 72113
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F 000	INITIAL COMMENTS Complaints #13282, #13312 and #13340 were substantiated (all or in part) with a deficiency cited at F323. Complaint #13310 was substantiated (all or in part) with a deficiency cited at F314. Complaint #13271 was substantiated (all or in part) with a deficiency cited at F248. Complaint #13269 was substantiated (all or in part) with a deficiency cited at F309.	F 000		
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint #13271 was substantiated (all or in part) with these findings. Based on observation, record review and interview, the facility failed to ensure a program of activities was developed and implemented in accordance with the interests, physical, mental and psychosocial well-being of each resident for 2 (Residents #4 and #6) of 5 case mix residents who currently resided in the facility and required an ongoing program of activities (Residents #1, #2, #4, #6 and #8). The facility also failed to ensure one-to-one activities programs were developed and implemented for residents who would not or could not effectively plan their own	F 248		

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 248	<p>Continued From page 1</p> <p>activity pursuits. The failed practices had the potential to affect 61 residents who required an ongoing program of activities, as documented by the Director of Nursing (DON) on 2/15/08 at 11:05 a.m. The findings are:</p> <p>1. Resident #6 was admitted to the facility on 1/28/08 and had diagnoses of Osteoporosis, Sleep Disturbance, Malignant Neoplasm - Breast, Knee Joint Replacement and Osteoarthritis. As of 2/15/08 at 10:00 a.m., no Minimum Data Set (MDS) assessment was available for review.</p> <p>a. The Immediate Plan of Care dated 1/28/08 documented: "At risk for elopement related to wandering with no rational purpose, seemingly oblivious to safety needs ... Involve resident in facility activities of their liking." There was no other documentation in the Plan of Care regarding activities.</p> <p>b. On 2/14/08 at 11:43 a.m., the resident stated, "I don't go to any of the parties [activities] here. I haven't met the Activities Director."</p> <p>2. Resident #4 was admitted to the facility on 1/30/08 and had diagnoses of Osteoporosis, Insomnia and Cerebrovascular Accident. As of 2/15/08 at 10:00 a.m., no MDS assessment was available for review.</p> <p>a. The Immediate Plan of Care dated 1/30/08 did not include any documentation regarding the resident's activity needs.</p> <p>b. On 2/15/08 at 10:17 a.m., the resident stated, "I don't know anything about activities. No one has asked me to attend any."</p>	F 248			

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F 248	<p>Continued From page 2</p> <p>3. The facility's posted February 2008 Activity Calendar documented the following:</p> <p>a. Only one planned activity on Sundays - 10:00 a.m. Church Services.</p> <p>b. Mondays: 10:00 a.m. Music and Exercise and 2:00 p.m. Bingo.</p> <p>c. Tuesdays: 10:00 a.m. Storytime alternating every other week with Beauty Time and 2:00 p.m. Bible Study.</p> <p>d. Wednesdays: 10:00 a.m. Music and Exercise and 2:00 p.m. Crafts.</p> <p>e. Thursdays: 10:00 a.m. Popcorn and Movie and 2:00 p.m. Dominos, except on 2/14/08 when a Valentine's Day Party was planned.</p> <p>f. Fridays: 10:00 a.m. Music and Exercise and 2:00 p.m. Bingo.</p> <p>g. Saturdays: 10:00 a.m. Sing-a-long and 2:00 p.m. Coffee Social.</p> <p>Of the 50 scheduled activities 35 activities were repetitive representing 8 church services or bible study, 13 music with exercise, 9 bingo sessions and 5 coffee socials, inclusive of 1 party.</p> <p>4. On 2/12/08 at 10:08 p.m., 4 non-case mix residents were observed with the Activity Director making Valentines. The Activity Director stated, "I'm not having Beauty Time as planned for this time, as I have no supplies."</p> <p>5. On 2/12/08 at 3:00 p.m., the planned activity for 2:00 p.m. was Bible Study and had been</p>	F 248		

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F 248	Continued From page 3 deleted from the calendar. A volunteer was observed reading 16 residents a story while the Activity Director served cookies. 6. On 2/14/08 at 1:00 p.m., the Activity Director stated, "We didn't do crafts at 2:00 p.m. on 2/13/08." The Activity Director stated that on 2/14/08 at 10:00 a.m., for the planned Storytime, "We had 6 people. That was all that was interested." The Activity Director was asked if one-to-one programming for residents who would not or could not effectively plan their own activity pursuits or who needed specialized programs had been planned. The Activity Director stated, "I have not started those yet." The Activity Director was asked about having only one activity on Sundays, which was documented as "Church Services." The Activity Director stated, "That's all I know right now."	F 248			
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272			

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F 272	<p>Continued From page 4</p> <p>Contenance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct an accurate comprehensive assessment for 1 (Resident #7) of 8 case mix residents who required comprehensive assessments in order to develop individualized plans of care (Residents #1 through #8), as evidenced by failure to include accurate information regarding the presence of pressure ulcers and indicators for impending dehydration. The failed practices had the potential to affect 61 residents who required accurate comprehensive assessments to facilitate appropriate care planning, as documented on a list provided by Registered Nurse (RN) #1 on 2/15/08 at 11:35 a.m. The findings are:</p> <p>Resident #7 had diagnoses of Diabetes Mellitus, Alzheimer's Disease, Cerebrovascular Accident and Advanced Dementia.</p> <p>a. The Laboratory Report dated 11/15/07 documented: "Total Protein 6.1 g/dl [grams per deciliter] (Range: 6.1 g/dl-7.9 g/dl), Serum</p>	F 272			

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F 272	<p>Continued From page 5</p> <p>Albumin 2.6 g/dl (Range: 3.5 g/dl-4.8 g/dl) and Glucose 220 mg/dl [milligrams per deciliter] (Range: 74 mg/dl-118 mg/dl)."</p> <p>b. The Laboratory Report dated 11/15/07 documented: "BUN [blood urea nitrogen] 32 mg/dl (Range: 8 mg/dl-20 mg/dl) and BUN/Creatinine Ratio 27 (Range: 6-20)."</p> <p>c. The Laboratory Report dated 12/3/07 documented: "Total Protein 4.9 g/dl (Range: 6.1 g/dl-7.9 g/dl), Serum Albumin 2.1 g/dl (Range: 3.5 g/dl-4.8 g/dl) and Glucose 351 mg/dl (Range: 74 mg/dl-118 mg/dl)."</p> <p>d. Nurse's Notes dated 12/12/07 at 6:30 a.m. documented: "Skin concern per C.N.A. [Certified Nursing Assistant] and nurse. Observed Stage III x [times] 3 along L [left] buttock periarea. One area size of silver dollar on coccyx, one elongated and irregular on L medial gluteal cleft and another one on L lower 'seat' area."</p> <p>e. The Plan of Care dated 12/12/07 documented: "Wounds to Sacral area and heel ... Approaches ... Tx [treatment] as ordered, weekly body audit, lab as ordered, assess for s/s [signs/symptoms] of infection, booties of Podus boot to heel and wound clinic."</p> <p>f. Physician Orders dated 12/13/07 documented: "Vitamin C 500 mg qd [every day], Zinc 220 mg qd, Diabetic Ensure Pudding BID [twice daily] at lunch and supper and Prosource 1 package q [every] day at 8:00 a.m."</p> <p>g. The Laboratory Report dated 12/13/07 documented: "Total Protein 7.1 g/dl (Range: 6.7 g/dl-8.2 g/dl) and Serum Albumin 3.1 g/dl (Range:</p>	F 272			

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F 272	Continued From page 6 3.4 g/dl-5.0 g/dl)." h. The Laboratory Report dated 12/3/07 documented: "BUN 30 mg/dl (Range: 8 mg/dl-20 mg/dl) and BUN/Creatinine Ratio 27 (Range: 6-20)." i. Nurse's Notes dated 12/17/07 at 6:40 a.m. documented: "R's [Resident's] daughter [with] R at this time expressing concern about pressure sores to buttocks and L heel. Dsg [dressing] to L heel noted to be displaced at this time [with] gauze wrapping around ankle. R noted to be in W/C [wheelchair] [without] air cushion in place. [Daughter] requests that R not be out of bed until immediately before breakfast. [Daughter] took photos of L heel. Dsg changed at this time. R placed on air cushion [with] assistance from [Licensed Practical Nurse]. [Daughter] also requests the use of a lap belt while R is in W/C. [CNA.] and [CNA Supervisor] inserviced about air cushion and instructed to allow R to remain in bed until after 7:00 a.m."	F 272			
F 273 SS=E	483.20(b)(2)(i) RESIDENT ASSESSMENT- WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of	F 273			

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F 273	<p>Continued From page 7</p> <p>this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure an initial comprehensive assessment was conducted with 14 days of admission to facilitate the development of an individualized plan of care for 2 (Residents #6 and #4) of 2 case mix residents who were recent admissions to the facility. The failed practice had the potential to affect 12 residents who were new admissions to the facility from 1/15/08 through 2/15/08, as stated by the Director of Marketing on 2/19/08 at 8:19 a.m. The findings are:</p> <p>1. Resident #6 was admitted to the facility on 1/28/08 and had diagnoses of Osteoporosis, Sleep Disturbance, Constipation, Malignant Neoplasm Breast, Knee Joint Replacement, Osteoarthritis, Hypertension, Normocytic Anemia, Parkinson's, Osteoarthritis, Vertebroplasty, Osteopenia, Seizures, Coronary Artery Disease and Gastroesophageal Reflux Disorder.</p> <p>a. The Pressure Ulcer Risk Assessment dated 1/28/08 documented the resident's pressure ulcer risk score as "10" with a score of 8 or more indicating that the resident was at high risk for pressure ulcers.</p> <p>b. On 2/13/08 at 2:00 p.m., RN #2 conducted a body audit in the presence of the Surveyor. There was a 0.3 centimeter (cm) by 0.5 cm dark purple area to the left great toe tip and a 4.3 by 3</p>	F 273			

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F 273	<p>Continued From page 8</p> <p>cm weeping, Stage II pressure sore with a 0.3 cm dark center to the right heel.</p> <p>c. On 2/12/08 at 3:35 p.m., after being asked for documentation of an Initial Minimum Data Set (MDS) Comprehensive Assessment for this resident, the Director of Nursing provided a copy of one page (the identification information page), which documented the resident's name, date of birth, race, gender and other identifying information. No assessment information was included. A handwritten statement by the DON was written on this page which documented: "This is all that is available 2/12/08 @ [at] 1535 [3:35 p.m.]."</p> <p>d. As of 2/15/08 at 10:00 a.m., there was no Initial Minimum Data Set (MDS) available for review in the MDS section or elsewhere in the clinical record.</p> <p>2. Resident #4 was admitted to the facility on 1/30/08 and had diagnoses of Hypothyroidism, Unspecified Vitamin Deficiency, Constipation, Osteoporosis, Insomnia, Glaucoma, Hypertension, Sarcoidosis, Cerebrovascular Accident and Parkinson's Disease.</p> <p>a. A Braden Scale dated 1/30/08 documented the resident's pressure ulcer risk score was 16, with a score of 15 to 18 indicating the resident was at mild risk for pressure ulcer development. A facility form titled, "Pressure Ulcer Risk Assessment" dated 1/30/08 documented the resident's pressure ulcer risk score was 10, with a score of 8 or above indicating the resident was at high risk for pressure ulcer development.</p> <p>b. As of 2/15/08 at 10:00 a.m., there was no</p>	F 273			

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F 273	Continued From page 9 Initial Minimum Data Set (MDS) available for review in the MDS section or elsewhere in the clinical record.	F 273			
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Complaint #13269 was substantiated, all or in part, with these findings. Based on observation, record review and interview, the facility failed to ensure the necessary care and services were provided in a timely manner to 1 of 1 case mix resident who experienced an acute change of condition and had physician orders for STAT laboratory services and subsequent transfer to the hospital (Resident #1). The failed practice had the potential to affect all 61 residents (who could potentially experience an acute change in their medical condition), as documented on the Census List dated 2/11/08. The findings are: Resident #1 had diagnoses of History of Deep Vein Thrombosis, Atrial Fibrillation, Coronary Artery Disease, History of Carotid Stenosis and Congestive Heart Failure. The Quarterly Minimum Data Set (MDS) dated 12/15/07 documented the resident was independent in cognitive skills for daily decision making and	F 309			

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F 309	Continued From page 10 required limited assistance with activities of daily living. a. Nurse's Notes dated 1/23/08 at 11:20 a.m. documented, "R [resident] had emesis X [times] 2. V/S [vital signs] 114/70, P [pulse] 111, 18 [respirations], 97.6 [temperature]. [Physician] notified. New orders received. Lab called." b. A Physician's Telephone Order dated 1/23/08 (not timed) documented: "1. Phenergan 25 mg. [milligrams] PO [by mouth] or PR [per rectum] Q [every] 6 hours PRN [as needed]. 2. STAT [immediate] BMP [Basic Metabolic Panel], CBC [complete blood count]." c. The Daily Lab Draw Log provided by the Director of Nursing on 2/13/08 at 10:00 a.m. documented the STAT BMP and CBC were not drawn until 2:20 p.m., a period of 3 hours after the physician had specified that they were to be drawn STAT. The Laboratory Results Report documented the specimen was collected "by nurse" on 1/23/08 at 2:45 p.m., received by the diagnostic laboratory at 3:34 p.m. and results faxed back to the facility at 4:24 p.m. d. Nurse's Notes dated 1/23/08 at 2:00 p.m. documented, "Nursing Note: C/O [complained of] difficulty breathing. [Elevated] HOB [head of bed]. Lung fields diminished at bates W/ [with] crackles. SPO2 [Saturation of Peripheral Oxygen] 84% on RA [room air]. Started O2 [oxygen] at 2L [2 liters] per protocol. Informed [physician] at this time by message. Awaiting STAT [immediate] Labs from 11:30 [a.m.] order." e. Nurse's Notes dated 1/23/08 at 2:20 p.m. documented, "Nursing Note - MD called at this	F 309			

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F 309	<p>Continued From page 11</p> <p>time w/ [with] concern about pt. [patient] esp [especially] RE: [regarding] CHF [Congestive Heart Failure] (exacerbation?) SPO2 % 94% at this time. Pulse 92. Order received to transfer pt. to [Hospital #1]. Daughter informed of transfer. Will continue to monitor."</p> <p>f. A Physician's Telephone Order dated 1/23/08 at 2:30 p.m. documented, "Transfer to [Hospital #1] due to decreased SPO2 and difficulty breathing, N/V [nausea/vomiting], w/ [with] hx [history] CHF [Congestive Heart Failure]."</p> <p>g. Nurse's Notes dated 1/23/08 at 3:00 p.m. documented, "Nsg. [Nursing] Note - Dtr. [daughter] to meet pt. at ER [Emergency Room] Dept. [Department] [Hospital #1]. V/S [vital signs] 136/72, 92 [pulse], 94% SPO2, Afebrile."</p> <p>h. The Record of Assessment from Hospital #1 documented the resident arrived at the hospital on 1/23/08 at 5:29 p.m. The vital signs upon arrival were blood pressure - 123/74, pulse - 76, respiratory rate - 18, temperature - 97.5 degrees Fahrenheit (F.) and oxygen saturation of 98%. The diagnosis was documented as, "CHF [Congestive Heart Failure]."</p> <p>i. On 2/14/08 at 11:00 a.m., RN #3 was interviewed regarding the laboratory order. RN #3 stated, "The lab was drawn about noon. I was on the phone to the lab several times asking about my lab. They finally came about 3 hours later. They drew the lab."</p> <p>j. On 2/14/08 at 11:00 a.m., RN #3 was also interviewed regarding the resident's transfer to the hospital. RN #3 stated, "I took the order from the doctor to find out what hospital the family</p>	F 309			

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F 309	<p>Continued From page 12</p> <p>used and to transfer the resident. The resident was having some difficulty breathing - about 84-85% O2 [oxygen] sat [saturation]. I put O2 on her. In seconds to 1 minute it increased to 93-94-95%. Her lungs were clear and vital signs stable. I called the doctor about her change of condition. He expressed concern about exacerbation of her Congestive Heart Failure. I asked what hospital the family used - they said [Hospital #1]. That's where I made my mistake. I didn't know how to transfer - I thought it was more sub-acute than an emergency 911 case. The facility van driver was [CNA #3]. I spoke to the family and told them I would call them when the resident left here. In about 20-30 minutes the family called back and said she had not arrived at [Hospital #1]. I called the transport CNA [CNA #3] - she was going to [Hospital #2] not [Hospital #1]."</p> <p>k. On 2/14/08 at 3:47 p.m., CNA #3 was interviewed. CNA #3 stated, "I made it back here after getting another resident. I was parking the van and was told there was another resident that needed to go to the hospital. When I got up the street near [street name], I called to see where to drop her off. [RN #3] said [Hospital #1]. He must have told me [Hospital #1] and I just heard [Hospital #2]. I turned around on [street name] and came back. It was getting dark. When I got there, her daughter and son-in-law were waiting. She [daughter] was upset because she wasn't transported by ambulance. I took her by wheelchair. She had a blanket and her oxygen was attached to her wheelchair. She had the oxygen thing that goes in her nose and wraps around the ears. I left her in her wheelchair with oxygen at the ER with her family. I told the Receptionist my telephone number in case they</p>	F 309			

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F 309	Continued From page 13 needed to call me if she needed to be transferred back by the nursing home van."	F 309			
F 314 SS=H	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 #13310 was substantiated (all or in part) with these findings. Based on observation, record review and interview, the facility failed to ensure necessary care and treatment to promote healing of pressure ulcers and prevent development of new pressure ulcers was provided to 2 (Residents #7 and #6) of 2 case mix residents with pressure ulcers (Residents #6 and #7), as evidenced by failure to conduct weekly skin assessments in accordance with the Plan of Care, failure to document measurements of pressure ulcers to allow healing or deterioration to be accurately assessed, failure to implement care planned or physician-ordered pressure relief interventions immediately upon discovery of pressure ulcers and consistently thereafter, failure to reassess the resident's nutrition and hydration needs in a timely manner after pressure ulcers were identified, failure to consistently document the resident's nutritional intake and the provision of	F 314			

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F 314	<p>Continued From page 14</p> <p>snacks/supplements and failure to apply a pressure ulcer dressing in accordance with the physician order. The failed practices resulted in a pattern of actual harm to Residents #6 and #7, who developed pressure ulcers and had the potential to affect 30 residents in the facility who were at risk for pressure ulcer development and 8 residents with existing pressure ulcers, as documented on a list provided by Registered Nurse (RN) #1 on 2/15/08 at 11:35 a.m. The findings are:</p> <p>1. Resident #7 had diagnoses of Pressure Sores, Diabetes Mellitus, Alzheimer's Disease and Dehydration.</p> <p>a. The Braden Scale dated 10/26/07 documented the resident's pressure ulcer risk score was 18, with a score of 15-18 indicating that the resident was at mild risk for pressure sores. The score of 18 had been calculated by coding the resident's sensory perception as not impaired, exposure of skin to moisture as "occasionally moist," degree of physical activity as "walks occasionally," mobility as "slightly limited," nutrition as adequate and friction/shear as "potential problem."</p> <p>b. The Plan of Care dated 10/28/07 documented: "Resident is at risk for complications related to dx [diagnosis] of Diabetes... Approaches... monitor skin integrity weekly..."</p> <p>As of 2/15/08 at 10:00 a.m., there was no documentation that weekly skin assessments were conducted from 10/28/07 through 12/12/07.</p> <p>c. A Laboratory Report dated 11/15/07 documented: "Total Protein 6.1 g/dl [grams per deciliter] (Range: 6.1 g/dl-7.9 g/dl), Serum</p>	F 314			

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F 314	<p>Continued From page 15</p> <p>Albumin 2.6 g/DL (Range: 3.5 g/dl-4.8 g/dl) and Glucose 220 mg [milligrams]/dl (Range: 74 mg/dl-118 mg/dl)."</p> <p>d. The November 2007 Physician Orders sheet documented an order dated 10/18/07 for the resident to receive: "Prosource 1 pkg [package] PO [by mouth] qd [every day] as directed."</p> <p>Nurses' Notes dated 11/22/07 at 9:00 a.m. documented the resident was transported to the hospital to rule out sepsis after the resident's daughter expressed concern regarding the resident's urine color and clarity, "yellow in color, milky consistency." Nurses' Notes dated 11/26/07 at 5:00 p.m. documented the resident returned to the facility after being hospitalized with a Urinary Tract Infection (UTI) and Pulmonary Embolus."</p> <p>The Admission Orders dated 11/26/07 upon the resident's return from the hospital did not include an order to continue the Prosource. The diet order documented: "Mech. [mechanical] soft. Ground meat." The section of the physician order form designated for documentation of nutritional supplements was blank.</p> <p>A Laboratory Report dated 12/3/07 (7 days after the resident's return from the hospital) documented: "Total Protein 4.9 g/dl, Serum Albumin 2.1 g/dl and Glucose 351 mg/dl." This was a 1.2 g/dl decrease in Total Protein, a 0.5 g/dl decrease in Serum Albumin and a 131 mg/dl increase in Glucose since the labwork completed on 11/15/07 (18 days prior). There was no documentation that the resident's diet was changed until 12/13/07 and no documentation that the Registered Dietician re-evaluated the</p>	F 314			

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F 314	<p>Continued From page 16</p> <p>resident's nutritional needs until 12/19/07.</p> <p>e. Nurse's Notes dated 12/12/07 at 6:30 a.m. documented: "Skin concern per C.N.A. [Certified Nursing Assistant] and nurse. Observed Stage III x [times] 3 along L [left] buttock periarea. One area size of silver dollar on coccyx, one elongated and irregular on L medial gluteal cleft and another one on L lower 'seat' area." There was no documentation these pressure ulcers were measured (including depth) until 12/28/07.</p> <p>f. Physician's Orders dated 12/12/07 documented: "Clean buttock, sacral wounds [with] NS [normal saline], apply Collagenase Santyl to wounds, Cover [with] Allevyn qd [every day] and PRN [as needed] and reeval [re-evaluate] on 12/24/07."</p> <p>g. A Plan of Care update dated 12/12/07 documented: "Wounds to Sacral area and heel ... Tx [treatment] as ordered, weekly body audit, lab as ordered, assess for s/s [signs/symptoms] of infection, booties of Podus boot to heel and wound clinic."</p> <p>h. Nurse's Notes dated 12/13/07 at 8:45 a.m. documented: "Air mattress put on bed at this time, air mattress in w/c [wheelchair]." This was a period of over 25 hours after the Stage III pressure ulcers were identified.</p> <p>i. Physician Orders dated 12/13/07 documented: "Vitamin C 500 mg [milligrams] qd [every day], Zinc 220 mg qd, Diabetic Ensure Pudding BID [twice daily] at lunch and supper and Prosource 1 package q day at 8:00 a.m."</p> <p>j. A Laboratory Report dated 12/13/07</p>	F 314			

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F 314	<p>Continued From page 17</p> <p>documented: "Total Protein 7.1 g/dl, Serum Albumin 3.1 g/DL.</p> <p>k. Nurse's Notes dated 12/17/07 at 6:40 a.m. documented: "R's [Resident's] daughter [with] R at this time expressing concern about pressure sores to buttocks and L [left] heel. Dsg [dressing] to L heel noted to be displaced at this time [with] gauze wrapping around ankle. R noted to be in W/C [wheelchair] [without] air cushion in place. [Daughter] requests that R not be out of bed until immediately before breakfast. [Daughter] took photos of L heel. Dsg changed at this time. R placed on air cushion [with] assistance from [Licensed Practical Nurse]... [CNA] and [CNA Supervisor] inserviced about air cushion and instructed to allow R to remain in bed until after 7:00 a.m."</p> <p>l. The Minimum Data Set dated 12/18/07 documented the resident was moderately impaired in cognitive skills for daily decision-making, required set up assistance only for meals, required extensive assistance of two or more persons for all other activities of daily living, was incontinent of bowel, had an indwelling catheter, had no weight changes and inaccurately documented that the resident had no pressure ulcers or other skin problems.</p> <p>m. Dietary Progress Notes dated 12/19/07 and signed by the Registered Dietitian (RD) documented: "Dec [December] wt [weight] 137 # [pounds], not sig [significant] change in wt but decreased some. R does have a decub [decubitus] to sacral area. Diet: Mechanical Soft. PO [oral] intake is fair. Receiving Vit [vitamin] C, Zinc and Prosource to aid in wound healing. No current labs. Observed R at lunch today.</p>	F 314			

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F 314	<p>Continued From page 18</p> <p>Appears to drink really well, better than eating solid foods. Est [estimated] needs: 2170 Kcal [kilocalories], 87 g [grams] Protein, 2170 cc [cubic centimeters] H2O [water]. Plan: Change diabetic Ensure pudding to Boost diabetic or Glucerna shake TID [three times daily] b/t [between] meals. Cont [continue] [with] Prosource for wound healing. Suggest check albumin and prealbumin." As of 2/15/08 at 10:00 a.m., there was no documentation in the clinical record that the physician had been contacted regarding the RD's recommendation to recheck the albumin and prealbumin and to change supplements and no documentation that the resident's daily fluid intake was monitored.</p> <p>n. A Braden Scale assessment dated 12/27/07 documented the resident's pressure ulcer risk score was 18, with a score of 15-18 indicating that the resident was at mild risk for pressure sores. The score of 18 had been calculated by coding the resident's sensory perception as not impaired, exposure of skin to moisture as "occasionally moist," degree of physical activity as "walks occasionally," mobility as "slightly limited," nutrition as adequate and friction/shear as "potential problem."</p> <p>o. As of 2/15/08 at 10:00 a.m., there was no documentation that weekly skin audits were conducted from 12/12/07 through 12/28/07.</p> <p>p. A Weekly Body Audit dated 12/28/07 documented: "...pale, dry, scattered ecchymosis and numerous moles ..." The anatomical posterior illustration was marked at the mid-center of the back as: "Stage II .25 cm [centimeter] x [by] 1 cm." The right lateral back was marked and documented: "Abrasion [with]</p>	F 314			

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F 314	<p>Continued From page 19</p> <p>scab." The coccyx region was marked and documented: "Stage III 3.0 cm necrotic x 2.5 cm slough x 0 [zero]." The right buttock was marked twice and documented: "Stage I .5 cm x .25 cm. [and] 1 x 0.25."</p> <p>q. There was no documentation on the December 2007 Treatment Administration Record that the treatments were provided as ordered on 12/15/07, 12/16/07, 12/22/07, 12/23/07, 12/29/07 and 12/30/07, all of which were weekend days.</p> <p>r. A Wound Clinic Physician's Note dated 12/31/07 documented: "The patient has multiple wounds, most of which are small and of little significance. This includes 2 or 3 small abrasions on the back. It also includes 2 or 3 small lesions on his feet. He has bruising and tenderness of the posterior aspect of the right heel. His most significant wound is a sacral decubitus. This wound has a wound bed filled with slough and there is surrounding redness suggesting cellulitis. Please see nurse's note for measurements of all wounds."</p> <p>s. The Wound Clinic Nurse's Notes dated 12/31/07 documented:</p> <p>1.) "Coccyx - 4.5 cm x 3.5 cm x 0.2 cm with serosanguineous exudate, erythematous, painful, wound bed devitalized and odorous." [This was an increase of 1.5 cm by 1.0 cm by 0.2 cm from the measurements taken at the facility 3 days prior].</p> <p>2.) "Right back posterior - 1.3 cm x 0.5 cm x 1 cm with serous exudate, erythematous and eschar." [This wound was documented as an</p>	F 314			

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F 314	Continued From page 20 abrasion with scab and not measured on the 12/28/07 body audit documented by the facility]. 3.) "Midline back - 1.5 cm x 1.2 cm x 0.1 cm with serous exudate, erythematous, wound bed with granulation and pink." [This was an increase of 0.5 cm by 0.2 cm by 0.1 cm from the measurements taken at the facility 3 days prior]. 4.) "Left heel - 1.3 cm x 1.5 cm x 0.1 cm with no exudate, erythematous and wound bed with granulation and pink." [This wound was not documented on the facility's 12/28/07 body audit]. 5.) "Left 5th toe - 1 cm x 0.7 cm x 0.1 cm with eschar." [This wound was not documented on the facility's 12/28/07 body audit]. 6.) "Right 5th toe - 0.2 cm x 0.2 cm x 0.2 cm with serous exudate, granulation of pink wound bed and erythematous." [This wound was not documented on the facility's 12/28/07 body audit]. t. Physician Orders dated 1/2/08 documented: "DC [discontinue] previous tx [treatment] orders and start orders from [Hospital] Wound Clinic." Physician Orders dated 1/2/08 documented: "Clorpactin Solution wet to dry to sacral area daily and Xenaderm applied to 2 ulcerations of groin area daily." u. The Wound Clinic Nurse's Notes dated 1/7/08 documented: 1.) "Coccyx - 9.5 cm x 5.0 cm x 0.1 cm with serous, bloody exudate, erythematous, wound bed devitalized."	F 314			

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F 314	<p>Continued From page 21</p> <p>2.) "Right back posterior lateral side - 1.5 cm x 0.5 cm x 0.1 cm with serous yellow exudate, and wound bed with slough."</p> <p>3.) "Midline back - 1.5 cm x 1.2 cm x 0.1 cm with serous exudate, erythematous, wound bed with granulation and pink."</p> <p>4.) "Left heel - 2.8 cm x 1.7 cm x 0.1 cm with eschar."</p> <p>5.) "Left 5th toe - 1 cm x 0.7 cm x 0.1 cm with eschar."</p> <p>6.) "Right 5th toe - 0.3 cm x 0.3 cm x 0.1 cm with eschar."</p> <p>v. Physician Orders dated 1/7/08 documented: "Change Clorpectin Solution to Gentamycin 332 mg/Clindamycin 332 mg/Polymixin 166 mg plus Nystatin Solution for WTD [wet to dry] dressing qd to sacral area."</p> <p>w. The January 2008 Meal Consumption Percentage Record had no documentation of the resident's breakfast meal consumption on 1/1/08, 1/7/08 and 1/8/08, lunch meal consumption on 1/6/08, 1/7/08 and 1/8/08 and dinner meal consumption on 1/5/08, 1/6/08, 1/7/08, 1/8/08 and 1/9/08. There was no documentation of between meal or bedtime snacks provided to the resident from 1/1/08 through 1/9/08.</p> <p>x. Nurse's Notes dated 1/10/08 at 5:00 a.m. documented: "FSBS [finger stick blood sugar] was taken at 4:15 a.m. Results were > [greater than] 600... Ambulance arrived at 5:00 a.m. and removed resident from facility with 5 EMT's [Emergency Medical Technicians]. FSBS at the</p>	F 314			

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F 314	<p>Continued From page 22</p> <p>time of the calls was > 600. Resident was very lethargic."</p> <p>y. The Consultant Physician's Note dated 1/10/08 documented: "Impression ... Acute Renal Failure with prerenal presentation, Hypovolemia secondary to free water deficit, Hypernatremia secondary to free water deficit, Hyperchloremia, Metabolic Acidosis, Hyperkalemia, Hypotension, Insulin-Dependent Diabetes Mellitus with poor control, Alzheimer's type Dementia, Urinary Tract Infection with probable Sepsis and Decubitus Ulcers which appear infected."</p> <p>z. The hospital Laboratory Report dated 1/10/08 at 6:40 a.m. documented: "Glucose 782 mg/dl (Normals: 75 mg/dl-110 mg/dl), Total Protein 6.2 g/dl (Normals: 6.3 g/dl-8.2 g/dl) and Albumin 2.4 g/dl (Normals: 3.4 g/dl-5.1 g/dl)."</p> <p>aa. A hospital Laboratory Report dated 1/10/08 at 12:57 p.m. documented: "Glyco Hgb [Glycolated Hemoglobin] 9% (Normals: 4.1 %-6.5%)."</p> <p>2. Resident #6 was admitted to the facility on 1/28/08 and had diagnoses of Osteoporosis, Malignant Neoplasm Breast, Osteoarthritis, Knee Joint Replacement, and Hypertension. As of 2/15/08 at 10:00 a.m., the Initial Minimum Data Set (MDS) had not been completed for this resident.</p> <p>a. A Pressure Ulcer Risk Assessment dated 1/28/08 documented the resident's pressure ulcer risk score was 10, with a score of 8 or greater indicating the resident was at high risk for pressure ulcers.</p> <p>b. An Assessment for Potential of Unavoidable</p>	F 314		

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F 314	<p>Continued From page 23</p> <p>Pressure Ulcer Development dated 1/28/08 documented no primary risk factors, no lab indicator values and the presence of poor skin turgor. The assessment documented under Pre-existing Signs that the resident had skin discoloration "Bruises BLE [Bilateral Extremities], - post [posterior], ant [anterior], abdomen, thigh." The interventions for preventive measures was documented as "good skin care, cushion and positioning device."</p> <p>c. A Braden Scale assessment dated 1/29/08 documented the resident's pressure ulcer risk score was 16, with total score of 15-18 representing mild risk for pressure ulcer development.</p> <p>d. The Immediate Plan of Care dated 1/28/08 documented: "Pressure Ulcer sites - Bruising ... bed mobility problem ... Implement skin protocol where available ... implement treatments: ...application of dressing with or without topical medication other than to feet, prevention or protective skin care and application of dressing to feet with or without topical medication." The care plan did not document interventions for pressure relieving devices.</p> <p>e. Nurses Notes dated 2/6/08 at 7:08 p.m. documented: "Assisting R [Resident] to bathroom and to bed noticed a blister (closed) to R [right] heel size: 4x4, bridged R foot off bed [with] pillow. Will continue to monitor."</p> <p>f. Physician Orders dated 2/7/08 documented: "Cleanse R [right] heel [with] NS [normal saline]; apply Santyl Collagenase to blistered area; cover with Allevyn Foam Heel. Change dressing qd [every day] x [times] 10 days. Monitor for healing</p>	F 314			

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F 314	<p>Continued From page 24</p> <p>or complications. Blue Boots for heel off loading at all times."</p> <p>g. On 2/13/08 at 2:00 p.m., Registered Nurse (RN) #2 removed an Ace wrap from the resident's right foot/heel. There was no underlying Allevyn Foam Heel dressing as ordered by the physician. A skin audit was conducted in the presence of the Surveyor at this time and the following skin conditions were observed:</p> <p>1.) Left great toe tip - dark purple 0.3 cm x .5 cm.</p> <p>2.) Right heel - 4.3 cm x 3 cm Stage II pressure sore with 0.3 cm dark center, unstageable. Wound weeping."</p> <p>h. On 2/14/08 at 8:36 a.m., the resident was sitting in a wheelchair in the dining room. The bilateral off loading booties were not applied as ordered by the physician.</p> <p>i. On 2/14/08 at 10:25 a.m., the resident was sitting in a wheelchair near the activities area. The bilateral off loading booties were not applied.</p> <p>3. The facility's policy and procedure titled, "Prevention, Chapter 2, Prevention of Pressure Sores & [and] Other Ulcers" was provided by the Director of Nursing (DON) on 2/15/08 at 12:00 p.m. and documented the following:</p> <p>"...Skin integrity assessments are performed weekly by nurses on all residents paying particular attention to all pressure points. The Weekly Skin Integrity Assessment form is used. Treatment is initiated immediately... Resident admitted to the facility free of pressure sores but identified as at risk on the Braden Scale with a</p>	F 314			

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F 314	Continued From page 25 score of 14 or below will be placed on aggressive prevention interventions... All individuals at risk should have a systematic skin inspection at least once a day, paying particular attention to the bony prominences. Results of skin inspection should be documented... When apparently well nourished individuals develop an inadequate dietary intake of protein or calories, caregivers should first attempt to discover the factors compromising intake and offer support with eating. Other nutritional supplements or support may be needed. If dietary intake remains inadequate and inconsistent with overall goals of therapy; more aggressive nutritional interventions such as enteral or parenteral feedings should be considered. For nutritionally compromised individuals, a plan of nutritional support and/or supplementation should be implemented that meets individual needs. Residents identified at risk for skin breakdown will have a dietary consultation and be reviewed weekly at the NAR (Nutrition At Risk) committee meeting. Weekly weight may be recommended... INTERVENTIONS and OUTCOMES should be monitored and documented... Individuals in bed who are completely immobile should have a care plan that includes the use of devices that TOTALLY RELIEVE PRESSURE on the heels, most commonly by raising the heels off the bed. Do not use donut-type devices..."	F 314			
F 323 SS=G	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.	F 323			

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F 323	Continued From page 26 This REQUIREMENT is not met as evidenced by: Complaint #13282 was substantiated (all or in part) with these findings. Based on observation, record review and interview, the facility failed to ensure interventions were developed and implemented to prevent further falls for 4 (Residents #5, #6, #2 and #8) of 4 case mix residents with a history of falls (Residents #5, #6, #2 and #8). The facility failed to ensure planned interventions to prevent falls were consistently implemented and that the use of a personal alarm was evaluated for effectiveness when the resident continued to experience falls with the alarm in use for 1 (Resident #6) of 4 case mix residents with a history of falls (see identifiers above). The facility failed to ensure a fall was investigated for causative factors to facilitate the development of appropriate interventions to prevent further falls and failed to ensure staff members responsible for the resident's care were informed of the resident's fall risk status for 1 (Resident #8) of 4 case mix residents with a history of falls (see identifiers above). The failed practices resulted in actual harm to Resident #5, who sustained femoral and humeral fractures as a result of a fall, and had the potential to affect 52 residents who were at risk for falls, as documented on a list provided by Registered Nurse (RN) #1 on 2/15/08 at 11:35 a.m. The findings are: 1. Resident #5 had diagnoses of Alzheimer's Disease, Dementia, Seizures, Degenerative Joint Disease, and Cerebrovascular Accident. The Minimum Data Set (MDS) dated 11/7/07	F 323			

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F 323	<p>Continued From page 27</p> <p>documented the resident was moderately impaired in cognitive skills for daily decision-making, required extensive assistance of one person for transfers and limited assistance of one person for locomotion, had no functional limitations in range of motion and fell in the past 30 days.</p> <p>a. The Plan of Care dated 11/16/07 documented: "Resident is at risk for falls related to dependence of staff ... Call bell in reach answer promptly; ...encourage to areas of increased visibility lounge, common areas, dining room; ...Note any contributing factors to decrease likelihood of reoccurrence. ...chair alarm."</p> <p>b. An Incident/Accident Report dated 6/24/07 at 7:20 p.m. documented: "Pt [patient] slid oob [out of bed]. Received an abrasion to L [left] flank/back with no open areas. LPN [Licensed Practical Nurse] found pt sitting beside bed. Pt has been known to remove clip from bed alarm. Pt was in bed [with] alarm before incident." The steps to prevent recurrence documented: "Ensure body alarm in place at all times ... place body alarm clip in place where R [resident] cannot easily reach to undo."</p> <p>c. An Incident/Accident Report dated 8/9/07 at 7:00 p.m. documented: "When I walked into R's room [with] [another staff person] R is on the floor and [with] 3 cm [centimeter] x [by] 2 cm skin tear to rt [right] forearm noted. Hard to understand R's verbalization about what happened. R's roommate stated that R try to get up from w/c [wheelchair] and slid [sic] down on the floor." The steps to prevent recurrence documented: "Body alarm at all times and keep in visible area while up in w/c."</p>	F 323			

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F 323	Continued From page 28 d. The Fall Risk Assessment dated 8/17/07 documented the residents fall risk score was 16, with a score of 10 or greater indicating that the resident was at high risk for falls. e. An Incident/Accident Report dated 8/26/07 at 9:45 a.m. documented: "Responded to chair alarm. Upon entering R room, R was found on floor by bed. R has c/o [complaint of] pain at L [left] buttocks." The steps to prevent recurrence documented: "Continue body alarm while up in w/c and keep R in visible area while up in w/c." f. An Incident/Accident Report dated 9/16/07 at 6:15 a.m. documented: "Fell from wheelchair trying to get up and sit on couch. Had no injuries apparent noted." The steps to prevent recurrence documented: "Bed alarm/chair alarm and keep in visual area." g. An Incident/Accident Report dated 9/23/07 at 6:30 a.m. documented: "R fell out of chair trying to sit on couch. Left hip aches, R states, did not see any bruises or injuries noted from this accident." The steps to prevent recurrence documented: "Continue chair alarm. Assist resident to couch PRN [as needed]." h. An Incident/Accident Report dated 10/30/07 at 10:30 a.m. documented: "R was trying to sit in chair near nurse's station/DON [Director of Nursing] door and slid to floor during attempt. No bruising noted upon immediate assessment." The steps to prevent recurrence section of the form was not completed. i. An Incident/Accident Report dated 10/30/07 at 2:30 p.m. documented: "R attempted to get out of	F 323			

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F 323	<p>Continued From page 29</p> <p>w/c to try and get in the bed and fell. R has a light redness in color on R [right] hip. R has no complaints of pain. R laughing about it when C.N.A.'s [Certified Nursing Assistants] got her up." The steps to prevent recurrence documented: "Keep resident in sight until ready to be put in bed."</p> <p>j. An Incident/Accident Report dated 12/22/07 at 2:30 p.m. documented: "R was found yelling for help on the bathroom floor at shift change at 7:00 a.m. R had no c/o pain and R was taken to BR [bathroom] then to breakfast. Possible scratch to L [left] knee noted." The steps to prevent recurrence documented: "Resident is to have chair alarm at all times and not left in room when up in w/c."</p> <p>k. An Incident/Accident Report dated 1/3/08 at 5:15 a.m. documented: "Found pt lying in floor supine in common area at nsg [nursing] desk. Pain [with] ROM [range of motion] of LUE [left upper extremity]. No ST [skin tear], lacerations or obvious injury observed." The steps to prevent recurrence documented: "Chair alarm on w/c but turned off."</p> <p>l. The Emergency Room Physician's Progress Record dated 1/3/08 documented: "Femoral neck fx [fracture] L [left] displaced and impacted fx L humeral neck."</p> <p>m. A hospital Radiology Report dated 1/3/08 documented: "...Impression ... left hip fracture, new fracture deformity at the pubic symphysis and pelvic ring primarily intact ... proximal left humerus fracture."</p> <p>2. Resident #6 was admitted to the facility on</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>1/28/08 and had diagnoses of Osteoporosis, Knee Joint Replacement, Osteoarthritis, Parkinson's Disease, Osteoarthritis, Vertebroplasty, Osteopenia, Seizures and Coronary Artery Disease. As of 2/15/08 at 10:00 a.m., the Initial Minimum Data Set (MDS) for this resident had not been completed.</p> <p>a. The Immediate Plan of Care dated 1/28/08 documented: "At risk for falls R/T [related to] fell in past 30 days, fell in past 31-180 days, wandering and use of anti-anxiety drugs, use of hypnotics, use of anti-psychotics and use of anti-depressant ... Gather and document information if resident does fall: time of day, what activity was resident involved in, was resident reaching, was there glare on the floor, furniture in path, foreign objects in walkway, low lighting and what medications were taken ... Institute fall precautions. Evaluate need for bed alarm and chair alarm ... Resident unaware of person safety R/T full bed rails on all open sides ... Bed alarm/Chair alarm least restrictive in bed." As of 2/15/08 at 10:00 a.m., the Plan of Care had not been revised to include any additional fall prevention measures.</p> <p>b. The Fall Risk Assessment dated 1/28/08 documented the resident's fall risk score was 17, with a score of 10 or greater indicating the resident was at high risk for falls.</p> <p>c. An Incident/Accident Report dated 1/29/08 (not timed) documented: "R tried to get herself from w/c to bed and slipped down to floor between bed and wheelchair ... Type of injury: none apparent ..."The section of the form designated for documentation of additional steps taken to prevent recurrence was not completed.</p>	F 323			

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F 323	Continued From page 31 d. An Incident/Accident Report dated 2/2/08 at 1:30 a.m. documented: "R found in floor at foot of bed. States 'I just slipped. I need to go to the bathroom'. Denies pain, denies hitting head. Good ROM x [times] 4 extremities. No neurological deficits noted ... Type of injury: none apparent ..." The steps taken to prevent recurrence documented: "Advised R to call for assistance [with] all ambulation. Bed and w/c alarm in place." e. An Incident/Accident Report dated 2/5/08 at 5:30 a.m. documented: "Resident found in bathroom door opening. States she was trying to help her roommate to bathroom. No apparent injury." The section of the form designated for steps taken to prevent recurrence was not completed. f. An Incident/Accident Report dated 2/6/08 at 7:45 p.m. documented: "Called to R's room by C.N.A.'s. R lying on R [right] side on floor between the 2 beds and next to w/c. Assessment showed no open areas, no reddened areas, head not touching floor, no pain noted." The section designated for documentation of steps taken to prevent recurrence was not completed. g. An Incident/Accident Report dated 2/8/08 at 8:50 a.m. documented: "C.N.A. came and told me she found resident on floor. No bruises. C/O [complaint of] pain. PRN [as needed] med [medication] given ... Type of injury: none apparent." The Additional comments and/or steps taken to prevent recurrence section documented: "Advised R to get help before transferring, new battery on alarm and non skid pad."	F 323			

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F 323	Continued From page 32 h. On 2/12/08 at 10:30 a.m., Certified Nursing Assistant (CNA) #1 was observed exiting the resident's room. The resident was in bed. The safety alarm was not activated. CNA #1 verified that the alarm was not activated. i. On 2/13/08 at 2:00 p.m., RN #2 conducted a body audit in the presence of the Surveyor. The following bruises (which were a mixture of purple, blue and green bruises in various stages of healing) were observed: 1.) Right upper extremity: 2.0 centimeter (cm) by 1.4 cm bruise to upper arm. 1.0 cm by 1.3 cm bruise to outer antecubital space. 4.0 cm by 2.0 cm bruise to posterior upper arm. 0.7 cm by 0.6 cm bruise to anterior forearm. 1.4 by 1.4 cm bruise to posterior forearm. 1 cm circular bruise to lateral aspect of forearm. 0.6 cm by 0.8 cm bruise to inner aspect of upper arm. 2.) Left upper extremity: 1.4 cm x 1.6 cm bruise to inner aspect of upper arm. Five bruises to anterior upper arm measuring 0.7 cm x 5 cm, 2.6 cm x 0.8 cm, 4.0 cm x 2.0 cm, 0.8 cm x 0.4 cm and 1.0 cm x 0.9 cm. 0.7 cm x 1.3 cm and 0.3 cm x 0.3 cm bruises to anterior section of forearm above the wrist. 3.) Torso/Hips/Buttocks: 2.3 cm x 2 cm bruise right lower quadrant of abdomen. 4 cm x 0.8 cm bruise of top of left hip posteriorly. 5-5/8th inch by 3-5/8th inch bruise to left lateral	F 323			

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F 323	Continued From page 33 hip. 1.0 cm x 2.0 cm bruise left hip near sacrum. 3.0 cm x 2.0 cm and 2.0 cm x 0.4 cm bruises to right buttock. 4.0 cm x 3.7 cm and 2.0 cm x 1.0 cm bruises to right hip. 4.) Left lower extremity: 2.1 cm x 1.4 cm bruise upper lateral leg. 1.6 cm x 1.2 cm, 2.5 cm x 1.4 cm and 1.4 cm x 2 cm bruises to lateral aspect of knee. 4.3 cm x 2.4 cm, 4.0 cm x 1.6 cm, 1.0 cm circular, 2.5 cm x 0.6 cm, 3.0 cm x 1 cm and 4.5 inch x 3 inch bruises to lower anterior leg. 8.25 inch x 3.75 inch bruise from posterior aspect of ankle to first toe. 2.25 inch x 2 inch bruise to inner aspect of foot. 2 x 2 inch and 5.75 x 3 inch bruises to anterior aspect of lower leg. 5.) Right lower extremity: 1.4 cm x 1.4 cm and 2.3 cm x 1.8 cm bruises to lateral aspect of upper leg. 2.4 cm x 1.2 cm, 3-3/8th inch x 2.5 inch, 2.0 cm x 1.4 cm and 2.5 cm x 1.0 cm bruises to anterior aspect of upper leg. 0.8 cm x 0.6 cm and 0.7 cm x 1.0 cm bruises to anterior lower leg. 2.6 cm x 2.6 cm, 3.4 cm x 2.8 cm and 3.5 inch x 3 inch bruise to top of foot. 3. Resident #2 had diagnoses of Dehydration, History of Falls, Peripheral Edema, Depression, Peripheral Neuropathy, Pain and Hypertension. a. The Admission Assessment Minimum Data Set (MDS) dated 12/8/07 documented the resident had short and long-term memory problems, was moderately impaired with cognitive	F 323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/04/2008
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF MAUMELLE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 ALEXANDRIA DRIVE MAUMELLE, AR 72113		
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F 323	<p>Continued From page 34</p> <p>skills for daily decision making, required extensive assistance of one or more for the completion of activities of daily living, had limitation on one side with partial loss of voluntary movement of an arm and a hand, and had fallen in the past 30 days.</p> <p>b. The "Fall Risk Assessment", undated, documented Resident #2 had a fall score of 11 (Total Score of 10 or more represents high risk).</p> <p>c. An Incident/Accident Report dated 12/6/07 at 11:35 a.m. documented: "R [resident] slid from w/c [wheelchair] and into floor. Redness noted to R [right] hip + [and] R knee... X-ray ordered..." The section of the form designated for documentation of steps taken to prevent recurrence was not completed.</p> <p>d. The Plan of Care dated 12/13/07 documented: "At risk for falls related to frequent falls... Approaches: Alarm when in chair and when in bed... Remind resident to ask for assistance with transfer or ambulation as needed."</p> <p>e. An Incident/Accident Report dated 1/9/08 at 5:45 p.m. documented: "CNA [Certified Nursing Assistant's Name] held chair alarm in feeder room. Upon entering found R on floor. R lying on back [with] head on floor." The section of the form designated for documentation of steps taken to prevent recurrence was not completed. The Plan of Care did document an update dated 1/9/08: "Fall hematoma to head... Chair alarm, bed alarm, low bed."</p> <p>f. An Incident/Accident Report dated 1/12/08 at 1:00 p.m. documented: "Client found sitting @ [at] end of floor pad [after] checking R over, [no] apparent injury noted." The section of the form</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>designated for documentation of steps taken to prevent recurrence was not completed.</p> <p>g. An Incident/Accident Report dated 1/19/08 at 9:00 p.m. documented: "R found in bathroom floor by [CNA]. R denies pain. Good ROM. Neuro [neurological] checks normal." The section of the form designated for steps taken to prevent recurrence documented: "Alarms to be in place, advised R not to ambulate [without] assistance."</p> <p>h. There were no new interventions incorporated into the resident's plan of care after the falls on 1/12/08 at 1:00 p.m., and 1/19/08 at 9:00 p.m.</p> <p>4. Resident #8 had diagnoses of Parkinson's Disease, Diabetes and Wound Infection. The Medicare 5 day Minimum Data Set dated 2/18/08 documented the resident was independent in cognitive skills for daily decision-making, required partial physical support while standing and had no accidents in the past 30 days.</p> <p>a. The Plan of Care dated 2/14/08 documented: "At risk for falls R/T Orthopedic - L TKA [left total knee arthroplasty]... Intervention... Call lights available... Assisted with mobility... Gather and document information if resident does fall - Time of day. What activity was resident involved in? Was resident reaching? Was there a glare on the floor? Furniture in path. Foreign objects in walkway. Low lighting. What medications were taken?... Institute fall precautions..."</p> <p>b. The Fall Risk Assessment dated 2/14/08 documented a score of "12" with a total score of 10 or more indicating that the resident was at high risk for falls.</p>	F 323			

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F 323	<p>Continued From page 36</p> <p>c. Nurse's Notes dated 2/21/08 at 5:30 a.m. documented, "To resident room at this time. She has fallen. Given assistance up to her feet. V/S [Vital signs] 97.6, P [Pulse] 84, 20, 165/84. She is oriented to self. She has received several skin tears to left forearm. Message left on husband phone. [Physician] and Assistant DON [Director of Nursing] called and information given to her. Skin tears cleaned with NS [Normal Saline]. Non-adherent dressing applied, wrapped with Kerlix to secure."</p> <p>d. On 3/3/08 at 3:00 p.m., the Assistant Director of Nursing (ADON) was asked to provide the Incident and Accident (I/A) report for the fall on 2/21/08. On 3/4/08 at 1:00 p.m., the ADON stated she spoke to the nurse who was on duty at the time of the incident and that the nurse stated she forgot to fill out an I/A.</p> <p>e. On 3/4/08 at 2:00 p.m., CNAs #2 and #4 were asked who on their hall was at risk for falls. They named several residents, including Resident #8. They stated they felt she was at risk for falls due to her having a brace on her leg. The CNAs were asked if anyone had come to them and informed them that Resident #8 was at risk for falls and how to intervene specifically with her. They stated no. They were both asked what kind of system the facility had in place to inform staff of who was at risk for falls. CNA #2 stated, "We had big yellow stars on the back of the wheelchair, or stars placed outside resident's doors on their name plates, but they're not there anymore." At this time, the surveyor walked with the 2 CNAs down 100 hall to look for the yellow stars. No yellow stars were found for any residents on the 100 hall.</p>	F 323			

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F 323	Continued From page 37 f. On 3/4/08 at 2:35 p.m., the ADON was asked how the facility informed staff which residents were at risk for falls. She stated, "We had stars; big stars, that we put on back of their wheelchairs. They must have taken them off when they washed the wheelchairs." g. On 3/4/08 at 2:40 p.m., the Restorative CNA was asked if she was aware that Resident #8 had recently fallen. She stated, "No." She stated every morning the staff had a meeting in which they discussed I/As [Incidents and Accidents] and if anyone had fallen. She stated she was informed at that time and instructed on what interventions to implement. The RCNA was asked if Resident #8 was on her list of residents who were at risk for falls. She stated, "No." h. On 3/4/08 at 3:23 p.m., The RN Consultant was asked if she could provide documentation to indicate the fall had been investigated and that interventions had been implemented to prevent recurrences. She stated, "I'll investigate it and enter it into her record because there's nothing documented."	F 323			
F 325 SS=H	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: Based on observation, record review and interview, the facility failed to ensure interventions	F 325			

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F 325	<p>Continued From page 38</p> <p>to prevent nutritional deficits and weight loss were implemented for 2 (Residents #7 and #2) of 2 case mix residents who experienced unplanned weight loss (Residents #7 and #2), as evidenced by failure to reassess nutritional needs when nutritional laboratory values declined or pressure ulcers were identified, failure to communicate the Registered Dietician's recommendations to the physician and failure to implement the recommendations and failure to consistently monitor and document nutritional intake. The failed practices resulted in a pattern of actual harm to Resident #7, who experienced a severe weight loss and was hospitalized with a Stage III decubitus, uncontrolled Diabetes Mellitus and Acute Renal Failure, and had the potential to affect 7 residents who experienced weight changes, as documented on the Roster/Sample Matrix provided by the Director of Nursing (DON) on 2/11/08 at 3:10 p.m. The findings are:</p> <p>1. Resident #7 had diagnoses of Pressure Sores, Diabetes Mellitus, Electrolyte Abnormality, Hyponatremia, Hypochloremia, Renal Insufficiency, Urinary Tract Infection, Alzheimer's Disease, Dehydration, Cerebrovascular Accident and Advanced Dementia.</p> <p>a. The Plan of Care dated 10/28/08 documented: "Potential for weight loss related to therapeutic ... diet as ordered, meds [medications] as ordered and determine food preferences ... Resident is at risk for complications related to dx [diagnosis] of Diabetes ... Approaches ... monitor blood sugars, diet: RCS [Reduced Concentrated Sweets], monitor for s/s (signs/symptoms) high blood sugars: drowsiness, thirst, rapid pulse, deep respirations, monitor for s/s hypoglycemia: irritability, confusion, shallow respirations,</p>	F 325			

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F 325	<p>Continued From page 39</p> <p>bounding pulse and notify MD [Medical Doctor] of problems, changes, concerns, chart accordingly."</p> <p>b. A Laboratory Report dated 11/15/07 documented: "Total Protein 6.1 g/dl [grams per deciliter] (Range: 6.1 g/dl-7.9 g/dl), Serum Albumin 2.6 g/dl (Range: 3.5 g/dl-4.8 g/dl) and Glucose 220 mg/dl (Range: 74 mg/dl-118 mg/dl)."</p> <p>c. The November 2007 Physician Orders sheet documented an order dated 10/18/07 for the resident to receive: "Prosource 1 pkg [package] PO [by mouth] qd [every day] as directed."</p> <p>Nurses' Notes dated 11/22/07 at 9:00 a.m. documented the resident was transported to the hospital to rule out sepsis after the resident's daughter expressed concern regarding the resident's urine color and clarity, "yellow in color, milky consistency." Nurses' Notes dated 11/26/07 at 5:00 p.m. documented the resident returned to the facility after being hospitalized with a Urinary Tract Infection (UTI) and Pulmonary Embolus."</p> <p>The Admission Orders dated 11/26/07 upon the resident's return from the hospital did not include an order to continue the Prosource. The diet order documented: "Mech. [mechanical] soft. Ground meat." The section of the physician order form designated for documentation of nutritional supplements was blank.</p> <p>A Laboratory Report dated 12/3/07 (7 days after the resident's return from the hospital) documented: "Total Protein 4.9 g/dl, Serum Albumin 2.1 g/dl and Glucose 351 mg/dl." This was a 1.2 g/dl decrease in Total Protein, a 0.5 g/dl decrease in Serum Albumin and a 131 mg/dl</p>	F 325			

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F 325	<p>Continued From page 40</p> <p>increase in Glucose since the labwork completed on 11/15/07 (18 days prior). There was no documentation that the resident's diet was changed until 12/13/07 and no documentation that the Registered Dietician re-evaluated the resident's nutritional needs until 12/19/07.</p> <p>d. Nurse's Notes dated 12/12/07 at 6:30 a.m. documented: "Skin concern per C.N.A. [Certified Nursing Assistant] and nurse. Observed Stage III x [times] 3 along L [left] buttock periarea. One area size of silver dollar on coccyx, one elongated and irregular on L medial gluteal cleft and another one on L lower 'seat' area."</p> <p>e. The Plan of Care dated 12/12/07 documented: "Wounds to sacral area and heel ... Approaches ... Lab as ordered ..."</p> <p>f. Physician Orders dated 12/13/07 documented: "Vitamin C 500 mg [milligrams] qd [every day], Zinc 220 mg qd, Diabetic Ensure Pudding BID [twice daily] at lunch and supper and Prosource 1 package q [every] day at 8:00 a.m."</p> <p>g. A Laboratory Report dated 12/13/07 documented: "Total Protein 7.1 g/dl, Serum Albumin 3.1 g/dl."</p> <p>h. The Minimum Data Set dated 12/18/07 documented the resident was moderately impaired in cognitive skills for daily decision-making, required set up assistance only for meals, had no weight changes and inaccurately documented that the resident had no pressure ulcers or other skin problems.</p> <p>i. Dietary Progress Notes dated 12/19/07 and signed by the Registered Dietitian (RD)</p>	F 325			

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F 325	<p>Continued From page 41</p> <p>documented: "Dec [December] wt [weight] 137 # [pounds], not sig [significant] change in wt but decreased some. R [resident] does have a decub [decubitus] to sacral area. Diet: Mechanical Soft. PO [oral] intake is fair. Receiving Vit [vitamin] C, Zinc and Prosource to aid in wound healing. No current labs. Observed R at lunch today. Appears to drink really well, better than eating solid foods. Est [estimated] needs: 2170 Kcal [kilocalories], 87 g [grams] Protein, 2170 cc [cubic centimeters] H2O [water]. Plan: Change diabetic Ensure pudding to Boost diabetic or Glucerna shake TID [three times daily] b/t [between] meals. Cont [continue] [with] Prosource for wound healing. Suggest check albumin and prealbumin." As of 2/14/08, there was no documentation in the clinical record that the physician was contacted and informed of the RD's recommendations for lab services or a change in supplements.</p> <p>On 2/14/08 at 2:07 p.m., the Director of Nursing (DON) stated, "I can't find anything in the chart to show that the RD's recommendations were forwarded to the doctor or acted upon."</p> <p>j. The Monthly Weight Record documented the following weights:</p> <p>7/20/07 - 143.9 pounds (lbs.). 8/7/07 - 144.2 lbs. 9/7/07 - 135.8 lbs. 10/3/07 - 143.8 lbs. 11/6/07 - 137.8 lbs. 12/6/07 - 137 lbs. 1/9/08 - 118.6 lbs.</p> <p>This was a 13.43% weight loss for one month, 17.52% weight loss for 3 months and 17.48% weight loss for 6 months.</p>	F 325			

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F 325	Continued From page 42 k. A Weekly Body Audit dated 12/28/07 documented: "...pale, dry, scattered ecchymosis ..." The anatomical posterior illustration was marked at the mid center of the back as: "Stage II .25 cm [centimeters] x [by] 1 cm." The right lateral back was marked as: "Abrasion [with] scab." The sacral region was marked as: "Stage III 3.0 cm necrotic x 2.5 cm slough x 0 [zero]." The right buttock was marked twice and documented: "Stage I .5 cm x .25 cm. [and] 1 x 0.25." l. Wound Clinic Physician Notes dated 12/31/07 documented: "...His most significant wound is a sacral decubitus. This wound has a wound bed filled with slough and there is surrounding redness suggesting cellulitis. Please see nurse's note for measurements of all wounds." m. Wound Clinic Nurse's Notes dated 12/31/07 documented: 1.) Coccyx - 4.5 cm x 3.5 cm x 0.2 cm with serosanguinous exudate, erythematous, painful, wound bed devitalized and odorous. 2.) Right back posterior - 1.3 cm x 0.5 cm x 1 cm with serous exudate, erythematous and eschar. 3.) Midline back - 1.5 cm x 1.2 cm x 0.1 cm with serous exudate, erythematous, wound bed with granulation and pink. 4.) Left heel - 1.3 cm x 1.5 cm x 0.1 cm with no exudate, erythematous and wound bed with granulation and pink. 5.) Left 5th toe - 1 cm x 0.7 cm x 0.1 cm with	F 325			

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F 325	Continued From page 43 eschar. 6.) Right 5th toe - 0.2 cm x 0.2 cm x 0.2 cm with serous exudate, granulation of pink wound bed and erythematous. n. The January 2008 Meal Consumption Percentage Record documented 100% consumption for breakfast on 1/6/08; lunch on 1/2/08, 1/3/08, 1/4/08 and 1/5/08; and dinner on 1/1/08, 1/2/08 and 1/3/08. The record documented 75% consumption for breakfast on 1/3/08 and 1/5/08. The record documented breakfast consumption of 80% on 1/2/08, 70% on 1/4/08 and 30% on 1/9/08. The record documented 50% consumption for dinner on 1/4/08. Consumption of meals was not documented for breakfast on 1/1/08, 1/7/08 and 1/8/08. Consumption of meals was not documented for lunch on 1/6/08, 1/7/08 and 1/8/08. Consumption of meals was not documented for dinner on 1/5/08, 1/6/08, 1/7/08, 1/8/08 and 1/9/08. There was no documentation of between meal or bedtime snacks provided from 1/1/08 through 1/9/08. o. On 1/7/08 the Wound Clinic Nurse's Notes documented the resident's pressure ulcers had deteriorated as follows: 1.) Coccyx - 9.5 cm x 5.0 cm x 0.1 cm with serous, bloody exudate, erythematous, wound bed devitalized. 2.) Right back posterior lateral side - 1.5 cm x 0.5 cm x 0.1 cm with serous yellow exudate, and wound bed with slough. 3.) Midline back - 1.5 cm x 1.2 cm x 0.1 cm with	F 325			

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F 325	Continued From page 44 serous exudate, erythematous, wound bed with granulation and pink. 4.) Left heel - 2.8 cm x 1.7 cm x 0.1 cm with eschar. 5.) Left 5th toe - 1 cm x 0.7 cm x 0.1 cm with eschar. 6.) Right 5th toe - 0.3 cm x 0.3 cm x 0.1 cm with eschar. p. Nurse's Notes dated 1/10/08 at 5:00 a.m. documented: "FSBS [finger stick blood sugar] was taken at 4:15 a.m. Results were > [greater than] 600... Ambulance arrived at 5:00 a.m. and removed resident from facility with 5 EMT's [Emergency Medical Technicians]. FSBS at the time of the calls was > 600. Resident was very lethargic." q. The Physician's Emergency Room Admission Report dated 1/10/08 documented: "Presumed sepsis secondary to Urinary Tract Infection, Diabetes poorly controlled, Hypernatremia, Hyperchloremia, Dehydration, History of Atrial Fibrillation and History of Hypertension though patient is now Hypotensive." r. The hospital Consultant Physician's Note dated 1/10/08 documented: "Impression ... Acute Renal Failure with prerenal presentation, Hypovolemia secondary to free water deficit, Hypernatremia secondary to free water deficit, Hyperchloremia, Metabolic Acidosis, Hyperkalemia, Hypotension, Insulin-Dependent Diabetes Mellitus with poor control, Alzheimer's type Dementia, Urinary Tract Infection with probable Sepsis and Decubitus Ulcers which appear infected."	F 325			

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F 325	<p>Continued From page 45</p> <p>s. Hospital Laboratory Reports dated 1/10/08 at 6:40 a.m. documented: "Glucose 782 mg/dl (Normals: 75 mg/dl - 110 mg/dl), Total Protein 6.2 g/dl (Normals: 6.3 g/dl-8.2 g/dl) and Albumin 2.4 g/dl (Normals: 3.4 g/dl-5.1 g/dl)."</p> <p>t. A hospital Laboratory Report dated 1/10/08 at 12:57 p.m. documented: "Glyco Hgb [Glycolated Hemoglobin] 9% (Normals: 4.1 %-6.5%)."</p> <p>2. Resident #2 had diagnoses of Dehydration, Peripheral Edema, Depression, Abdominal Pain, Parkinson's Disease, Peripheral Neuropathy, Pain, Urinary Tract Infection, Reflux Esophagitis and Hypertension. The Admission Minimum Data Set (MDS) dated 11/23/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with most activities of daily living, but only set-up assistance with eating, had no nutritional problems and had partial loss of voluntary movement in one arm and hand.</p> <p>a. The Malnutrition Risk Assessment (not dated) documented the resident's malnutrition risk score was 15, with a score of 10 or greater indicating that the resident was at high risk for malnutrition.</p> <p>The Plan of Care dated 12/13/07 documented: "At risk for wt [weight] loss and malnutrition related to mechanical altered diet and resident needs assistance with most meals... Approaches... Mechanical soft diet... Encourage resident to consume food served at mealtime... Watch for appetite deterioration and report to MD [Medical Doctor]."</p> <p>b. Nutritional Progress Notes dated 1/12/08 documented, "Jan [January] weight is 129.6 #</p>	F 325			

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F 325	<p>Continued From page 46</p> <p>[pounds] wt. [weight] loss since admit. Diet: Mech [mechanical] soft. PO intake is fair. R [resident] out to hospital this month. 12/17/07 albumin 2.2 down. Est [estimated] needs 1770 - 2065 kcal, 71 - 83 g [grams] protein, 2065 cc H2O [water]. Plan: Rec [recommend] fort [fortified] foods at all meals; Rec 30 cc Prosource TID [three times daily] with med [medication] pass." As of 2/14/08, there was no documentation in the Nurse's Notes, Physician's Orders or elsewhere in the clinical record that the RD's recommendations had been communicated to the physician or initiated for the resident.</p> <p>The February 2008 Physician Orders sheet documented the resident remained on a mechanical soft diet. There were no orders documented for nutritional supplementation via fortified foods or Prosource with med pass as recommended by the RD on 1/12/08.</p> <p>On 2/14/2008 at 2:07 p.m., the Director of Nursing stated, "I can't find anything in the resident's chart that indicates the physician was notified or the dietary recommendations were followed for [Resident #2] on 1/12/08."</p> <p>c. The January 2008 Meal Consumption % [Percentage] Record did not document the resident's meal consumption percentage for the breakfast meals served on 1/6/08, 1/20/08, 1/26/08 and 1/27/08. There was no documentation of the resident's meal consumption percentage for the lunch meals served on 1/5/08 through 1/8/08, 1/20/08, 1/26/08, 1/27/08 and 1/31/08. There was no documentation of the resident's consumption of the dinner meals served on 1/1/08, 1/2/08, 1/6/08 through 1/12/08, 1/14/08 through 1/28/08 and</p>	F 325			

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F 325	Continued From page 47 1/31/08. d. The Weight Change History form provided by the Director of Nursing on 2/14/08 at 2:07 p.m. documented the following weights: 11/12/07 - 137 pounds (lbs.). 12/5/07 135.8 lbs. 1/10/08 - 129.6 lbs. 2/6/08 - 124.2 lbs. This was a 9.14% weight loss in a 3-month period. e. On 2/15/08 at 11:00 a.m., the February 2008 Meal Consumption % Sheet for this resident could not be located by the Surveyor. Registered Nurse (RN) #2 stated, "[CNA #1] is responsible for taking care of documenting the meal and fluid consumption." f. On 2/15/08 at 11:27 a.m., CNA #1 stated, "The CNA's write the amount consumed on the meal tickets. I document what they wrote on the meal ticket onto the Meal Consumption % Sheet." The CNA was asked if the other CNA's always gave the meal tickets to her. CNA #1 stated, "Not always. Not for November, December, January and February. I have not received any meal tickets for the evening meal - some along - but not for February. I have 2/1/08 breakfast and lunch. I have none for any of the meals on 2/2/08 or 2/3/08. I have 2/4/08, 2/5/08, and 2/6/08 for breakfast and lunch only. None for 2/7/08, 2/8/08, or 2/9/08 for any of the meals. On 2/10/08 I have breakfast and lunch. On 2/11/08 I have breakfast only. On 2/12/08 I have no tickets. On 2/13/08 I have breakfast only. On 2/14/08 I have none for any meal."	F 325			
F 514	483.75(l)(1) CLINICAL RECORDS	F 514			

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F 514 SS=E	<p>Continued From page 48</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure wound care records were accurate and complete for 1 (Resident #8) of 3 case mix residents who required wound care (Residents #6 through #8). The failure to ensure that the provision of wound treatments was consistently documented had the potential to affect the facility's ability to monitor and ensure that wound care was being consistently provided as ordered by the physician for 13 residents who received wound care, as documented on a list provided by Registered Nurse (RN) #1 on 3/4/08 at 3:52 p.m. The findings are:</p> <p>1. Resident #8 had diagnoses of Diabetes and Knee Wound Infection. The Medicare 5 day Minimum Data Set dated 2/18/08 documented the resident was independent in cognitive skills for daily decision-making and had a wound infection.</p> <p>a. The Admission Physician Orders dated 2/14/08 documented: "Dressing changes to left</p>	F 514			

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F 514	Continued From page 49 knee w/ [with] immobilizer. 4x4's [4 by 4-inch gauze pads], Kerlix, gauze stocking BID [twice daily] and PRN [as needed]." b. The February 2008 Treatment Administration Record (TAR) documented, "Dressing change to left knee suture line BID/PRN." The treatments were documented as scheduled for 6:00 a.m. and 6:00 p.m. As of 3/3/08 at 2:00 p.m., there was no documentation on the TAR or in the Nurse's Notes to indicate the resident's 6:00 a.m. treatments were completed on 2/17/08, 2/18/08, 2/19/08, 2/20/08, 2/21/08 and 2/28/08. There was no documentation the resident's 6:00 p.m. treatments were completed on 2/15/08, 2/17/08, 2/18/08, 2/20/08, 2/24/08, 2/25/08 and 2/29/08. c. On 3/3/08 at 1:39 p.m., the resident was in bed. Licensed Practical Nurse (LPN) #5 raised the resident's pant leg and loosened the leg brace at the Surveyor's request. There was a clean, dry dressing dated 3/3/08 at 6:10 a.m. on the resident's knee. d. On 3/3/08 at 3:50 p.m., the Assistant Director of Nursing (ADON) was asked if wound treatments would be documented anywhere other than the TAR or the Nurse's Notes. She stated, "No." e. On 3/3/08 at 4:10 p.m., Licensed Practical Nurse (LPN) #3 was asked if she had performed any of the treatments on this resident's knee. She stated, "Yes. At the beginning of my shift, I flip through the book to see what kind of treatments need to be done." She was asked why she did not initial the TAR to indicate she had provided the treatments. She stated, "I get kinda busy and forget to go back and initial the TAR."	F 514			

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F 514	Continued From page 50 f. On 3/3/08 at 4:15 p.m., RN #3 was asked if he had performed any of the treatments on this resident's knee. He stated, "Yes. I've done it at least 3 times, but I didn't document it." g. On 3/4/08 at 12:28 p.m., LPN #4 was asked if he had performed any of the treatments on this resident's knee. He stated, "Oh yes, nearly every evening. There's been a couple of times I've been tied up and the 7:00 p.m. person got it for me." He was asked why he did not initial the TAR to indicate he had provided the treatments. He stated, "I have no excuse, other than I just didn't." h. On 3/4/08 at 12:50 p.m., the resident's dressing was again observed. It was clean, dry and dated 3/4/08. The resident was asked, "Do you get your knee dressing changed twice a day?" The resident stated, "Yes. They did it early this morning." i. On 3/4/08 at 1:20 p.m., LPN #2 was asked if she had performed any of the treatments on this resident's knee. She stated, "Yes, I've done them." She was asked why she did not initial the TAR to indicate she had provided the treatments. She stated, "All I can tell you, is I failed to chart it." 2. Refer to F314 for details regarding facility failures to ensure the provision of wound care services.	F 514			