

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

PRINTED: 12/02/2008
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 11/14/2008
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF MAUMELLE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 ALEXANDRIA DRIVE MAUMELLE, AR 72113	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #14014 substantiated (all or in part) with deficiencies cited at F282, F309, F314, F315 and F325 and F520. Complaint #14036 substantiated (all or in part) with deficiencies cited at F282, F309, F314, and F315. Complaint #14023 substantiated (all or in part) with deficiencies cited at F282, F314, and F323.	F 000		
F 248 SS=D	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: Based on observation, interview and record review the facility failed to ensure that an ongoing program of activities based on the abilities, and cognitive level of functioning was developed based on assessed life-interests specifically for 1 (Resident #8) of 2 (Resident #8 and #12) case mix residents requiring one-on-one activities. The failed practice had the potential to affect 3 residents residing in the facility requiring 1:1 activities according to a list provided by the Activities Director on 11/12/08. The findings are: 1. Resident #8 had diagnoses of Oropharyngeal Dysphagia, Malnutrition, Intracranial Hemorrhage, Anxiety and Depression. The resident was admitted to the facility on 11/7/08. As of 11/11/08 there was no Minimum Data Set (MDS) available.	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 248	Continued From page 1 A History and Physical dated 10/07/08 documented the resident was [less than] 55 years old and non verbal. a. The Initial Activity Assessment dated 11/7/08 documented the resident's current interests were Bingo, Music, Spiritual/religious activities, walking/wheeling outdoors, parties/social events. Attitude (Psychosocial Well Being) was checked to indicate the resident was "willing to try " and Depression was not checked. b. An Activities Progress Note dated 11/10/08 documented the resident is "alert and seems to be oriented but she has a hard time right now speaking clearly. AD (Activities Director) will continue to invite and assist resident to all activities of her choice and monitor over the next quarter." c. On 11/11/08 at 8:50 a.m., CNA #1 stated, "[The resident] has been here since Friday afternoon (4 days) and no one has brought her anything to wear. She has no clothes or personal belongings here." d. On 11/12/08 at 8:30 a.m., the AD was asked what activities had been provided for the resident. The AD stated, "I visited with her, but she was too depressed to do 1:1 activities. " e. On 11/14/08 at 8:30 a.m., the resident was in bed with both side rails up. There was no television or radio available for the resident's audible stimulation. The resident's bed was against the wall nearest the hall. She did not have a view into the hallway. The privacy curtain was pulled the length of a bed obstructing the resident's view of the window. The TV was on	F 248			

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F 248	<p>Continued From page 2</p> <p>her roommates side of the room and not turned on. There was no radio provided. The resident was crying, "Get me out of here."</p> <p>g. The facility's Admission Agreement documented, "The facility agrees to furnish the Resident with routine nursing services and personal care, lodging, linen and bedding, meals, and other items as may be required by the Resident's known physical condition or by law for his or her health, safety, and well being."</p> <p>h. On 11/13/08 at 11:55 a.m., the facility Policy and Procedure entitled, ' Individual Activities and Room Visit Program ' documented, " Individual activities will be provided for those residents whose situation or condition prevents participation in other types of activities. . . Policy Interpretation and Implementation.</p> <p>1. Individual activities are provided for individuals who have conditions or situations that prevent them from participating in group activities, or who do not wish to do so.</p> <p>2. For those residents whose condition or situation prevents participation in group activities, and for those who do not wish to participate in group activities, the activities program provides individualized activities consistent with the overall goals of an effective activities program. The activities offered are reflective of resident's individual activity interests, as identified in the Activity Assessment, progress notes and the resident's Comprehensive Care Plan.</p> <p>3. It is recommended that residents on a full room visit program receive, at a minimum, 3 room visits per week. Typically a room visit is 10 to 15</p>	F 248			

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F 248	Continued From page 3 minutes at length. 4. Activities for residents with behavioral or emotional problem who cannot participate in group activities include. a. Uncomplicated activities that can be adapted to the level of the individual's attention span and function; b. Activities requiring short periods of concentration to reduce frustration; and c. Activities tailored to address specific underlying causes of the individual's behavioral or attention limitations (e.g., familiar occupation-related activities, exercise and movement activities, engaging the resident in conversation, and using 1:1 activities such as looking at familiar pictures and photo albums). 5. Residents who chose not to attend group activities will maintain an independent program. It is the responsibility of the facility and the activity staff to make regular contacts and offer supplies, as needed."	F 248			
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Complaints #14014, 14036, and 14023 substantiated (all or in part) with these finding: Based on observation and record review the facility failed to ensure that physicians orders	F 282			

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F 282	Continued From page 4 were followed for 4 (Residents #3, #6, #10, and #15) of 6 (Residents #1, #3, #6, #10, #11, and #15) case mix residents with physician orders for a therapeutic diet. The deficient practice had the potential to affect 22 residents with a physician order for a therapeutic diet according to the Diet Roster dated 11/10/08. The facility also failed to ensure a low air-loss mattress was in place for 1(Resident #6) of 2 (Residents #4 and #6) case mix residents with a physician's order for a low air-loss mattress. The failed practice had the potential to affect 3 residents with a physician order for a low air-loss mattress as documented by the Administrator on 11/14/08. The findings are: 1. Resident #3 had diagnoses of Anxiety, Depressive Disorder, and Stomach Ulcer. The annual Minimum Data Set (MDS) dated 10/2/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, required set-up only assistance for eating and had a chewing problem. a. A Physician's order dated 7/29/08 documented, "Regular Soft Diet." b. The Plan of Care updated 8/2/08 did not address her stomach distress or order for soft foods. c. A Physician's Progress Note dated 8/9/08 documented, "The patient continues to complain of intermittent abdominal pain." d. A Physician's Progress Note dated 8/21/08 documented, "The patient's abdominal pain has improved with the antibiotic therapy. She has peptic ulcer disease."	F 282			

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F 282	Continued From page 5 e. On 11/11/08 at 12:30 p.m., the resident received,"A Regular No Added Salt Diet." The Resident's diet card with the served tray documented, "Regular No Added Salt Diet." The resident received tamale casserole, creamed potatoes, pinto beans, sliced bread, 2% milk, and iced cake. The resident ate all of her food except the pinto beans. The Surveyor asked her if she did not like the beans. She stated, "Can't eat them. They hurt my stomach." There was no salt packet with her tray. g. On 11/11/08 at 6:20 p.m. the resident received: "A Regular No Added Salt Diet." She received no salt packet, 2 % milk, tea, 1 slice bread with jam, macaroni and cheese, corndog with catsup, fruit, and peanut butter cookie. The resident ate 70%. 2. Resident #6 had diagnoses of Reflux Esophagitis, Anxiety, Depressive Disorder, Vitamin Deficiency, Anemia, Nausea with Vomiting and Open Wound of Hip/Thigh. The initial MDS, dated 10/31/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required set-up only assistance for eating, required a therapeutic diet, a dietary supplement between meals and had a Stage 3 and a Stage 4 pressure ulcer. 1). Physician orders dated 10/24/08 documented: "Diet: Regular High Protein." a. The Plan of Care dated 10/24/08 documented, "Problem: Potential for further skin breakdown related to impaired mobility due to paraplegia. Approach: High protein diet as ordered."	F 282			

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F 282	<p>Continued From page 6</p> <p>b. A lab data sheet dated 10/17/08 documented, "Total protein low at 5.1 Gram/dl (6.4-8.3) and Albumin level low at 2.4 Gram/dl (3.5-5.2).</p> <p>c. On 11/11/08 at 12:45 p.m., and 6:00 p.m., the resident received a Regular Diet with a double portion of meat. No other protein source was served at the meals.</p> <p>d. The tray card documented a Regular Diet with Double Meat. It did not document a High Protein Diet.</p> <p>e. On 11/11/08 at 12:45 p.m., the resident was served, Tamale pie, mashed potatoes, pinto beans, 1 slice of bread, yellow cake, tea, and juice.</p> <p>f. On 11/11/08 at 6:00 p.m., the resident was served 2 corn dogs, macaroni and cheese, fruit and cumber salad and milk.</p> <p>g. On 11/12/08 at 7:50 a.m., the resident was served eggs, bacon, oatmeal, orange juice, milk, and coffee. The resident ate 50% of the eggs and 100% of everything else. The resident ate ½ of one corn dog and stated that was all she was going to eat because she was sick at her stomach.</p> <p>h. The Meal Consumption Sheet for November, 2008 with only 14 meals documented and average meal consumption of 40%. A double portion of meat would not be beneficial for a resident that was not eating even half of 1 portion served.</p> <p>2). A physician order dated 10/24/08 documented: "Low Air Loss Mattress."</p>	F 282			

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F 282	Continued From page 7 a. The resident's Care Plan dated 11/4/08 documented: "Problem/Need: Potential for further skin breakdown related to (r/t) impaired mobility r/t paraplegia ... Approaches: ... Low air loss mattress on bed. ...". b. On 11/11/08 at 11:40 a.m., the resident was in bed on a Pressure Relieving Mattress, but not a Low Air Loss Mattress. c. On 11/13/08 at 10:15 a.m. the Director of Nursing (DON) was asked if a Low Air Loss Mattress had been ordered since the resident had an order for one. The DON stated that she would find out. At 4:50 p.m. the DON stated that the resident had been on the Low Air Loss Mattress, but since 11/5/08 when the resident was discharged from Isolation and returned to her room, "the resident was placed on a pressure relieving mattress, but not the Low Air Loss Mattress. She was put back on the Low Air Loss Mattress right after I talked with you about it earlier." The resident was not on the special mattress ordered by the physician for 8 days. 3. Resident #10 had a diagnosis of Alzheimer's Disease. The quarterly Minimum Data Set (MDS) dated 8/1/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required limited assistance for eating, had a swallowing problem and did not have a weight loss. a. Physician orders dated 8/12/08 documented: "Diet: Regular Mechanical Soft Finger Foods." b. On 11/11/08 the following observation were made of the meal service:	F 282			

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F 282	<p>Continued From page 8</p> <p>1), In the dining room at 7:30 a.m., the resident received a Regular Soft Diet of bacon, biscuit, hash browns, scrambled eggs, 1 slice of bread, orange juice and water. Certified Nursing Assistant (CNA) #4 fed the resident with a fork and spoon with no interaction on the part of the resident. The resident ate 75%.</p> <p>The tray card documented, "Regular Diet, Regular Texture."</p> <p>2). At 12:45 p.m., in the dining room the resident received 1 slice bread, 1/2 cup of pinto beans in liquid, creamed potatoes, tamale casserole, solid cake with icing, water. This meal could not be eaten with her hands. The menu documented for finger foods: "Put entree between 2 slices of bread for a sandwich, serve food in strips, wedges, or chunks. serve soup and cereal in mugs and serve gravies and sauces on the side." CNA #4 fed the resident and the resident did not assist in the meal. She ate 50%.</p> <p>3). At 6:10 p.m., the resident received cucumbers in liquid, whole corn dog, catsup, macaroni and cheese, peanut butter cookie, undrained fruit chunks, 1 slice bread, water to drink. She was fed by CNA #8 who did not allow the resident to assist in feeding herself during the meal. The resident ate 25%.</p> <p>c. On 11/13/08 at 1:05 p.m., the resident received a fingerfood diet of cucumbers sliced and drained, sandwich cut in 4s, drained peach slices, tea and water. Resident was allowed to feed herself. The resident ate 75%.</p> <p>d. On 11/11/08 at 6:20 p.m., the Registered</p>	F 282			

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F 282	<p>Continued From page 9</p> <p>Dietitian (RD) stated that the Speech Therapist was working with the resident and that if the resident had finger foods she could hold them and still self-feed.</p> <p>4. Resident #15 had diagnoses of Congestive Heart Failure, Malnutrition and Open Wound Site. The quarterly MDS dated 8/14/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, required limited assistance for eating and had 1 Stage III pressure sore.</p> <p>a. A Physician's order dated 5/20/08 documented, "Diet: Low Sodium (Fortified Foods with every meal)."</p> <p>b. The Plan of Care updated 8/14/8 documented, "Problem: Decreased cardiac output due to diagnosis of Congestive Heart Failure for respiratory distress and fluid imbalance. Has Stage II to right lateral foot .8 x .9 x .2 centimeters. Potential for unintended weight loss/dehydration due to history of weight loss, cognitive disorder, and daily use of diuretic. -Approach, Provide diet and consistency as ordered Regular No Added Salt" [Low Sodium per MD (Medical Doctor) order] "Fortified foods with all meals."</p> <p>c. On 11/11/08 at the breakfast meal in the dining room at 7:40 a.m. the resident received a No Added Salt Diet with no salt packet on the tray, biscuit, gravy, scrambled eggs, sausage, regular oatmeal (it was not fortified as ordered) coffee, water, orange juice, the resident ate 25%.</p> <p>d. The Meal Consumption Sheet documented the resident's average intake for November, 2008</p>	F 282			

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F 282	Continued From page 10 was 45%. e. On 11/11/08 at 12:48 p.m., the resident received ,"A Regular No Added Salt Diet." She received tamale casserole, creamed potatoes, pinto beans, sliced bread, fortified milk shake [did not drink] coffee, iced cake, water margarine and no salt packet on try." f. On 11/11/08 at 5:30 p.m., the resident received: "A Regular No Added Salt Diet." She received no salt packet, coffee, tea, 1 slice bread, macaroni and cheese, chopped corndog with catsup, fruit and peanut butter cookie. The resident ate 10%. Certified Nursing Assistant (CNA) offered her substitutes and she accepted ice cream and ate (100%) 4 ounces of it.	F 282			
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Complaints #14014, and 14036 substantiated (all or in part) with these finding: Based on observation and record review the facility failed to ensure a urinary drainage bag and tubing were positioned lower than the bladder at all times for 1 (Resident #4) and a foley catheter tubing was secured to prevent the potential of trauma for 2 (Residents #1 and 4) or of 3	F 309			

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F 309	Continued From page 11 (Residents #1, 4, and 5) case mix residents with indwelling catheters. The failed practice had the potential to effect 7 residents in the facility with indwelling catheters as documented on the Resident Census and Conditions of Residents dated 11/10/08. The findings are: 1. Resident #4 had a diagnosis of Multiple Sclerosis and Pressure Ulcer. The Quarterly Minimum Data Set dated 9/30/08 documented the resident was severely impaired in cognitive skills for daily decision making and had an indwelling catheter. a. A physician order dated 6/17/08 documented: "Check Q (every) shift for leg band, privacy bag, and catheter bag placement and document." b. The resident's Care Plan dated 9/17/08 documented: "... Indwelling Foley catheter due to decubitus ulcer and UTI (Urinary Tract Infection). ... Leg strap to maintain catheter tubing ...". c. On 11/12/08 at 9:42 a.m., Certified Nurse Assistants (CNAs) #10 and 11 prepared to transfer the resident to the shower chair using the Hoyer lift by placing the lift sling under the resident. No leg band was present on the resident. There was cloudy, yellow urine visible in the catheter tubing. The urinary drainage (UD) bag was attached to the bar on the lift by CNA #10, causing the tubing and the bag to be above the level of the bladder for approximately 2 minutes and 15 seconds during the transfer. The resident was propelled to the shower room where at 10:05 a.m. the urinary drainage bag was again attached to the lift bar by CNA #10 causing the bag and the tubing to be above the level of the resident's bladder. After some problems with the	F 309			

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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 11/14/2008
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF MAUMELLE			STREET ADDRESS, CITY, STATE, ZIP CODE 103 ALEXANDRIA DRIVE MAUMELLE, AR 72113		
(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 309	<p>Continued From page 12</p> <p>whirlpool were solved and the resident was lowered into the tub, at 10:22 a.m., the UD bag was in the floor and the tubing draped over the tub, remaining above the level of the resident's bladder. After the resident was transferred back to the shower chair, at 10:31 a.m., the UD bag and the catheter tubing were lowered below the level of the resident's bladder and attached to the lower part of the shower chair. The catheter tubing remained above the level of the bladder for 26 minutes</p> <p>d. On 11/12/08 at 10:45 a.m. during wound care the foley catheter tubing was not secured.</p> <p>2. Resident #1 had diagnoses of Urinary Retention and Chronic Urinary Tract Infection (UTI). The Annual Minimum Data Set dated 10/12/08 documented the resident had modified independent cognitive skills for daily decision making and had an indwelling catheter.</p> <p>a. A physician order dated 1/24/08 documented: "LPN (Licensed Practical Nurse) assigned to resident is to check placement of leg band, catheter bag, and privacy bag Q shift and document."</p> <p>b. The resident's Care Plan dated 10//12/08 documented: "... At risk for complications/UTI r/t (related to) presence of indwelling catheter due to diagnosis Urinary Retention. ... Assure leg band is in place to prevent injury and assure placement, assure coiling to promote drainage ...".</p> <p>c. On 11/12/08 at 9:30 a.m. during a body audit performed by LPN #2, no the catheter tubing was not secured. The LPN stated, "I'll have to get a</p>	F 309			

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F 309	Continued From page 13 leg band. He didn't have one on."	F 309			
F 314 SS=E	<p>3. The Catheter Care, Urinary Policy provided by the facility on 11/13/08 at 12:30 p.m. documented: "... The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. ... Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.)"</p> <p>483.25(c) PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Complaints #14014, 14036 and 14023 substantiated (all or in part) with these finding:</p> <p>Based on observation, interview, and record review the facility failed to ensure all areas of the perineum and groin were cleansed, rinsed and dried after providing incontinent care for 1 (Resident #7) of 6 (Residents #2, #3, #4, #5, #7, and #8) case mix residents who were incontinent, at risk for skin breakdown, and dependent on staff for incontinent care. The facility also failed</p>	F 314			

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F 314	<p>Continued From page 14</p> <p>to ensure a skin condition change was reported to a nurse for 1 (Resident #2) and failed to provide a Low Air Loss Mattress per physician order to decrease the potential for skin breakdown for 1 (Resident #6) of 6 (Residents #1, #2, #4, #5, #6, and #7) case mix residents at risk for Pressure Ulcers. The failed practices had the potential to affect 10 residents on the 200 Hall that were dependent on staff for incontinent care, and 20 residents at risk for Pressure Ulcers in the facility as identified by lists provided by the Nurse Consultant on 11/14/08. The findings are:</p> <p>1. Resident #7 had diagnoses of Diabetes Mellitus Type II, and Pressure Sores on the Coccyx. The 14-Day Minimum Data Set dated 10/5/08 documented the resident had modified independent cognitive skills for daily decision-making, had inadequate control of bowel and bladder with multiple daily episodes, and required extensive, 2-person assistance for toilet use.</p> <p>a. The care plan dated 9/9/08 documented "Give perineal care when resident is incontinent."</p> <p>b. On 11/11/08 at 3:40 p.m., the resident had been incontinent of bowel and bladder. CNA (Certified Nursing Assistant) #2 and 3 provided incontinent care for the resident. CNA #2 used a dampened towel and cleansed the rectal area and placed the used towel in a plastic bag. The left groin area remained smeared with stool. CNA #3 left and returned to the room and handed CNA #2 a wash cloth. CNA #3 stated that the wash cloth was wet with soap and water. CNA #2 cleansed the resident with the wash cloth. The CNA 's did not rinse or dry the resident after completing incontinent care. Barrier cream was</p>	F 314			

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F 314	<p>Continued From page 15 applied. The CNA ' s put a clean brief on the resident. The stained linen was not changed.</p> <p>c. The facility's policy for Perineal Care provided by the Executive Director on 11/13/08 documented instructions which included "wash area downward from front to back" and "Gently rinse and dry the area." and "wash perineum moving from inside outward to and including the thighs, alternating from side to side, and using downward strokes. Do not reuse the same washcloth or water to clean the urethra or labia. ... Remove gloves and discard into designated container. Wash and dry your hands."</p> <p>2. Resident # 2 had a diagnosis of Presenile Dementia. The Quarterly MDS dated 10/28/08 documented the resident had severely impaired cognitive skills for daily decision making, and was incontinent of bowel and bladder.</p> <p>a. On 11/11/08 at 9:30 a.m., Certified Nursing Assistant (CNA) #4 and CNA #5 performed incontinent care. During incontinent care an open area was observed on the resident's buttock. CNA # 5 stated, "Looks like a blister that's opened."</p> <p>b. The November 2008 Treatment Administration Record, copied on 11/11/08 at 1:45 p.m., did not document any treatments for a pressure sore on the buttock.</p> <p>c. On 11/12/08 at 2:05 p.m., Licensed Practical Nurse (LPN) #3 was asked if the CNAs had told the nurse or Treatment Nurse if an open area was found." LPN #3 stated, "No one has told me of an open area on Resident #2."</p>	F 314			

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F 314	<p>Continued From page 16</p> <p>d. On 11/12/08 at 2:07 p.m., the Treatment Nurse, LPN #2, stated, "No one has told me of a new open area. There is no treatment for an open area on the buttock."</p> <p>e. On 11/12/08 at 2:40 p.m., the Treatment Nurse, LPN #2, assessed the resident. LPN # 2 measured the open area on the resident's buttock and stated, "1 1/2 by 3 1/2 centimeters, 3 centimeter diameter. Stage II area right there. I will get an order in place. See what (Resident #2 physician's name) wants to do."</p> <p>f. The Resident's Plan of Care dated copied 11/14/08 documented, "Problem Onset: 5/1/08 Resident is at risk for skin breakdown due to incontinence of bowel and bladder, needs assist with bed mobility, and pads and briefs used daily" and "CNA to inspect skin with daily care and report to Nurse any abnormal findings."</p> <p>3. Resident #6 was admitted on 10/24/08 with diagnoses of Open Wound of Hip/Thigh and Paraplegia. The Initial MDS dated 11/4/08 documented the resident was moderately impaired in cognitive skills for daily decision making and had 1 Stage III Pressure Ulcer and 1 Stage IV Pressure Ulcer.</p> <p>a. A physician order dated 10/24/08 documented: "Low Air Loss Mattress."</p> <p>b. The resident's Care Plan dated 11/4/08 documented: "Problem/Need: Potential for further skin breakdown related to [r/t] impaired mobility r/t paraplegia ... Approaches: ... Low air loss mattress on bed. ...".</p> <p>c. On 11/11/08 at 11:40 a.m., the resident was in</p>	F 314			

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F 314	Continued From page 17 bed and was lying on a Pressure Relieving Mattress, but not a Low Air Loss Mattress. d. On 11/12/08 at 4:00 p.m., the resident was not on a Low Air Loss Mattress, but did have a pressure relieving mattress. e. On 11/13/08 at 10:15 a.m. the Director of Nursing (DON) was asked if a Low Air Loss Mattress had been ordered since the resident had an order for one. The DON stated that she would find out. At 4:50 p.m. the DON stated that the resident was on the Low Air Loss Mattress, but since 11/5/08 when the resident was discharged from Isolation and returned to her room, "the resident was placed on a pressure relieving mattress, but not the Low Air Loss Mattress. She was put back on the Low Air Loss Mattress right after I talked with you about it earlier." The resident was not on the special mattress ordered by the physician for 8 days.	F 314		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Complaints #14014, and 14036 substantiated (all or in part) with these finding:	F 315		

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F 315	Continued From page 18 Based on observation and record review the facility failed to ensure that a front to back motion was used when cleansing the perianal area for 1 (Resident #7) of 6 (Residents #2, #3, #4, #5, #7 and #8) case mix residents who ere incontinent, and were dependent on staff for incontinent care. The failed practice had the potential had the potential to affect 10 residents on the 200 Hall that were dependent on staff for incontinent care as identified by a list provided by the Nurse Consultant on 11/14/08. The Findings are: 1. Resident #7 had diagnoses of Diabetes Mellitis Type II, and Pressure Sores on the Coccyx. The 14-Day Minimum Data Set dated 10/5/08 documented the resident had modified independent cognitive skills for daily decision-making, had inadequate control of bowel and bladder with multiple daily episodes, and required extensive, 2-person assistance for toilet use. a. The care plan dated 9/9/08 documented "Give perineal care when resident is incontinent." b. On 11/11/08 at 3:40 p.m., the resident had been incontinent of bowel and bladder. CNA (Certified Nursing Assistant) #2 and 3 provided incontinent care for the resident. CNA #2 used a dampened towel and cleansed the rectal area and placed the used towel in a plastic bag. The left groin area remained smeared with stool. CNA #3 left and returned to the room and handed CNA #2 a wash cloth. CNA #3 stated that the wash cloth was wet with soap and water. CNA #2 cleansed the resident with the wash cloth. Wipeing from front to back, then back to front when cleansing the labia of feces. The CNA 's	F 315			

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F 315	Continued From page 19 did not rinse or dry the resident after completing incontinent care. Barrier cream was applied. The CNA 's put a clean brief on the resident. The stained linen was not changed.	F 315			
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure that hand rolls were provided to decrease the potential for further contractures for 1 (Resident #4) of 1 case mix residents with a physician order for hand rolls and failed to provide a finger separator as ordered by a physician for 1 (Resident #12) of 1 case mix residents with a physician order for a finger separator. The failed practices had the potential to affect 1 resident in the facility with a physician order for hand rolls and 1 resident with a physician order for a finger separator as documented on lists provided by the Nurse Consultant on 11/14/08 and by the Director of Nursing (DON) on 11/16/08. The findings are: 1. Resident #4 had a diagnosis of Multiple Sclerosis (MS). The Quarterly Minimum Data Set dated 9/30/08 documented the resident was severely impaired in cognitive skills for daily decision making and had limitations in range of motion with full loss of voluntary movement in	F 318			

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F 318	Continued From page 20 both hands. a. A physician order dated 6/17/08 documented: "Hand Rolls bilaterally at all times." b. The resident's Care Plan dated 9/17/08 documented: "... Non-ambulatory secondary to MS and contractures. Provide comfort and repositioning ..." c. On 11/10/08 during the initial tour at 3:00 p.m., and again at 5:35 p.m. the resident was lying in the bed with a hand roll in the right hand, there was not a hand roll in the left hand. d. On 11/11/08 at 8:15 a.m., the resident was lying in the bed with a hand roll in the right hand and did not have a hand roll in the left hand. The same day at 8:55 a.m., following nail care, Licensed Practical Nurse (LPN) #1 replaced the hand roll in the resident's right hand and did not place a hand roll in the resident's left hand. e. On 11/12/08 at 10:45 a.m., following the resident's whirlpool bath and then wound care, no hand rolls were placed in either hand. The same day at 4:10 p.m., the resident was lying in the bed with no hand rolls in either hand. f. On 11/13/08 at 9:30 a.m., there were no hand rolls in either hand. At 9:40 a.m., LPN #2 was asked if hand rolls should be in the resident's hands. The LPN stated, "Yes, I will go get some." 2. Resident #12 had diagnoses of General Osteoarthritis, Alzheimer's, and Presenile Dementia. The Quarterly Minimum Data Set dated 8/21/08 documented the resident was severely impaired in cognitive skills for daily	F 318			

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F 318	<p>Continued From page 21</p> <p>decision making and had functional limitations in both arms and hands with partial loss.</p> <p>a. A physician order dated 7/28/08 documented: "Finger Separator to right hand at all times."</p> <p>b. The resident's Care Plan dated 8/21/08 documented: "Problem/Need: Self care deficit: Resident needs extensive to total assist with ADLs (Activities of Daily Living). ... Hand roll to right hand for contracture management D/C'd (discontinued) 7/28/08. 7/28/08 Finger Separator to [right] hand. ..."</p> <p>c. On 11/10/08 at 2:40 p.m., during initial rounds, the resident had on a restraint, a mitt to prevent chewing of the hand. The resident did not have on a finger separator.</p> <p>d. On 11/13/08 at 10:25 a.m., the resident had a mitt on the left hand. Nothing was on the resident's right hand. At 2:25 p.m. the resident had a mitt on the left hand, nothing was on the right.</p> <p>e. On 11/14/08 at 9:45 a.m. the resident was in the bed with both hands in fists. No mitt or a finger separator was on either hand. The Surveyor went to the Nurse's Station and asked the DON (Director of Nursing) if the resident should have a mitt on the left hand and a finger separator on the right. The DON stated, "I will have to ask, I am not sure." LPN #3 was asked and stated, "Yes, at all times." CNA (Certified Nursing Assistant) #12 came up and stated, "I took her mitt off a few minutes ago and put it in the wash. The DON asked the CNA about the separator. The CNA stated, "I usually put a cloth in the resident's other hand. The Surveyor, DON,</p>	F 318			

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F 318	Continued From page 22 and the CNA went to the resident's room again. The CNA looked in the resident's drawer and found the finger separator. The CNA began placing it on the left hand. The Surveyor asked if that was the correct hand. The CNA stated, "Well, I took the mitt off the right hand." The DON instructed the CNA to look in the ADL Book for the correct hand.	F 318		
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the feeding tube was connected continuously per physician's orders for 1 (Resident #8) of 2 (Residents #4 and #8) case mix resident who had gastrostomy tubes with orders for continuous feed. The failed practice had the potential to affect 4 residents in the facility with gastrostomy tubes and physician orders for continuous infusion according to a list provided by the Nurse Consultant on 11/14/08. The findings are: 1. Resident #8 had diagnoses Oropharyngeal Dysphagia, Malnutrition, and Intracranial Hemorrhage. The resident was admitted to the facility on 11/7/08. As of 11/11/08 there was no Minimum Data Set (MDS) available. A History	F 322		

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F 322	<p>Continued From page 23</p> <p>and Physical dated 10/07/08 documented the resident was [less than] 55 years old and non verbal and had a trach and a Dobbhoff tube for feeding.</p> <p>a. The admission orders dated 11/7/08 documented, "Nutren 2.0 [at] 35 cc/hr (cubic centimeters per hour) with H2O (water) 50 cc/hr per PEG (percutaneous esophageal gastrostomy) tube continuous.</p> <p>b. On 11/11/08 at 8:50 a.m., LPN (Licensed Practical Nurse) #1 disconnected the tubing from the feeding pump before CNA (Certified Nursing Assistant) #1 and CNA#2 took the resident to the shower.</p> <p>c. On 11/11/08 at 11:50 a.m., the resident was seated in a wheelchair beside the bed in the room the tubing was still disconnected and the pump was turned off. After the resident was assisted into the bed LPN #1 reconnected the tubing. The resident did not receive Nutren 2.0 for 3 hours.</p> <p>d. On 11/11/08 at 1:35 p.m., CNA #1 had provided care for the resident during the 7-3 shift was asked if the tubing had been reconnected at any time between 8:50 a.m., and 11:50 a.m. CNA #1 stated, "No. [the resident's name] went to the shower and then went to Therapy. It hadn't been reconnected."</p> <p>e. On 11/11/08 at 1:45 p.m., LPN #1 was asked if the feeding had been resumed since the tubing was disconnected for the shower . LPN #1 stated, "I disconnected it before the shower, but I connected it before lunch. She went to the shower and then to Therapy. We always disconnect it to take her to therapy."</p>	F 322			

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F 323 SS=E	<p>483.25(h) ACCIDENTS AND SUPERVISION</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #14023 was substantiated (all or in part) with these finding:</p> <p>Based on observation, record review, and interview the facility failed to ensure the axilla and waistband of a residents pants were not used to support a residents weight during a transfer to prevent the potential for injury for 1 (Resident # 2) of 2 (Resident # 2 and #4) non weight bearing case mix residents that resided on the 400 Hall, failed to ensure interventions were consistently implemented, for 1 (Resident # 3) of 6 (Residents # 2, #3, #10,#11, #13, and #16) case mix residents that were at risk for falls, and failed to ensure that an unsecured helium tank and a cookie oven plugged into an electrical outlet were not stored in an unlocked room. This failed practice had the potential to affect 5 non weight bearing residents on the 400 Hall and 25 residents in the facility that were at risk for falls as documented on a list provided by the Nurse Consultation on 11/14/08 at 8:30 a.m. and 8 residents in the facility that were ambulatory/ propel self in wheelchair and confused as documented on a list provided by the Medical Records Licensed Practical Nurse on 11/14/08 at 9:40 a.m. The findings are:</p>	F 323			

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F 323	Continued From page 25 1. Resident # 2 had diagnoses of Presenile Dementia and Osteoporosis. A Quarterly Minimum Data Set (MDS) dated 10/28/08 documented the resident had severely impaired cognitive skills for daily decision making, and was totally dependent for transfers. a. The Resident's Plan of Care dated copied 11/12/08 documented, "Problem Onset: 5/1/08 self care deficit: resident needs extensive to total assist of 1 - 2 staff for all activities of daily living (ADLS)." and "Mechanical lift with 2 staff for all transfers to promote safety." b. On 11/10/08 at 4:45 p.m., Certified Nursing Assistant (CNA) #6 and CNA #7 transferred the resident from the bed to a wheelchair. The CNAs lifted the resident up off the bed by lifting up on the resident's axilla and by the waist band of the resident's pants. The resident was then manually placed into the wheelchair. The resident's feet did not touch the floor during the transfer. A mechanical lift was not used during the transfer. c. On 11/12/08 at 4:15 p.m. the Executive Director stated, "[Resident # 2] is to be lifted with a mechanical lift." 2. Resident # 3 had a diagnosis of Muscle Weakness General. The Annual MDS dated 10/3/08 documented the resident had short term memory problems, moderately impaired cognitive skills for daily decision making, and had fallen in past 30 days. a. A Fall Risk Assessment was done on 10/3/08 that had a total score documented as 16. The Fall Risk Assessment documented, "Total score of 10	F 323			

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F 323	Continued From page 26 or more represents high risk." b. A Resident Incident Report form dated 11/2/08 documented, "Resident (R) on floor in bathroom (408) Attempting to get up off toilet without (w/o) assistance, lost balance fell to floor, assessed no injury noted. ... State immediate intervention implemented: assessed with help put resident (R) back into wheelchair (W/C) Stressed to resident (R) importance of waiting for assistance before ambulation." c. An Interdisciplinary Therapy Screening form dated 11/3/08 documented," 11/2/08 patient (pt) fell trying to transfer (t/f) from toilet without (s) assistance (A). Occupational Therapy (OT) recommends that Certified Nursing Assistant does not leave patient unattended." d. A Resident Incident Report form dated 11/4/08 documented, "Resident (R) found sitting in front of commode. No injuries noted. ... State immediate intervention implemented: Resident (R) will not be left alone in bathroom on this shift anymore. Someone will be in room until resident (R) is ready to go back to bed." e. An Interdisciplinary Therapy Screening form dated 11/4/08 documented, "11/3/08 Pt. fell in bathroom transferring (t/f) [without] assistance(A). OT recommends (rec) CNA to be present during toileting." f. The Resident's Plan of Care form documented," 11/4/08 resident (R) to have someone [with] her [at] all times when going to bathroom. CNA is to remain in room, then return resident to bed/ w/c (wheel chair)."	F 323			

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F 323	Continued From page 27 g. On 11/13/08 at 2:50 p.m., the Executive Director stated, "After concerns are identified with a resident regarding a transfer with a lift or a fall intervention, the Medicare Manager or Medical Records should put that information on the CNA Careplan in the resident's room." h. On 11/13/08 at 4:40 p.m., the Residents Care Needs forms located on the inside of the resident closet door was reviewed. There was no documentation concerning staying with the resident while the resident was toileting on the care plan in the residents room. i. On 11/13/08 at 11:30 a.m., CNA # 9 was pushing the resident in a wheelchair out of the bathroom in the resident's room. The CNA was asked if there were any special instructions concerning the resident using the commode. The CNA stated, "If I am not busy I will wait on her. If I am busy I will go help someone else and she will use the call light." 3. On 11/12/08 at 9:20 a.m., during General Observations of the facility, the door to the activity room was open with no staff present. A helium tank was in the room. The helium tank was not secured in any way. 4. On 11/12/08 at 9:22 a.m., during General Observations of the facility, the door to the activity room was observed open with no staff present. A cookie oven was observed in the room. The oven was plugged in to an electrical outlet.	F 323			
F 325 SS=H	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident -	F 325			

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F 325	<p>Continued From page 28</p> <p>(1) 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; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #14014 was substantiated (all or in part) with these findings:</p> <p>Based on observation, record review and interview, the facility failed to ensure that interventions to prevent continued weight loss and to promote weight gain were promptly developed, implemented, monitored, and re-evaluated for 4 of 4 case-mix residents (Residents #4, #10, #15, and #16), who experienced severe, unplanned weight losses. The failed practices resulted in actual harm for Residents #4, #10, #15, and #16 who experienced severe weight losses and had the potential to affect 7 residents who severe weight losses as documented on the facility's Weight Change History dated 11/10/08. The findings are:</p> <p>1. Resident #4 had diagnoses of Oropharyngeal Dysphagia, Pressure Ulcer, Reflux Esophagitis, Convulsions, Aphasia and Multiple Sclerosis. The quarterly Minimum Data Set (MDS) dated 9/29/08 documented the resident was severely impaired in cognitive skills for daily decision making, required total care for all Activities of Daily Living, had a swallowing problem, had a weight of 189 lbs, did not have a weight loss, had diarrhea, an</p>	F 325			

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F 325	Continued From page 29 indwelling catheter, an Ostomy, had a feeding tube, received 76 to 100% of daily nutrition from a tube feedings, and had a Stage II pressure sore. a. A physician order dated 6/24/08 documented, "Glucerna 50 ml (milliliters) per peg (percutaneous endoscopic gastrostomy) tube continuous." b. A lab data sheet dated 9/2/08 documented the resident's albumen level low at 3.2 g/dl (grams per decimeter), (normal range 3.5-4.8) and albumin/globulin ratio low at 0.7 (normal range 1-2.8). c. A physician order dated 9/16/08 documented, "Glytrol 50 cc (cubic centimeters) / hour (hr) when Glucerna depleted. d. The Plan of Care dated 6/17/08 and updated 9/17/08, documented, "Problem: Alteration in nutrition related to Dysphagia related to Multiple Sclerosis. Goal: Resident will maintain stable weight for 90 days. Approach: Tube feeding and supplements as ordered weekly wts (weights) until stable then monthly. Up as ordered when tube feeding is running. Notify MD (Medical Doctor) of weight loss or gain. Problem: Decubitus ulcer on right buttock. Approach: Observe nutrition and weights." e. The facility Weight Change History form dated 11/10/08 documented the resident's weight as follows: 6/17/08 192 lbs 6/23/08 192 lbs 7/1/08 193 lbs 8/1/08 191 lbs	F 325			

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F 325	<p>Continued From page 30</p> <p>9/1/08 189 lbs 10/1/08 186.6 lbs</p> <p>f. A physician order dated 10/9/08 documented, "Glytrol 55 cc/hr (cubic centimeter per hour), ProMod 1 scoop twice a day, Juven-1 package via peg twice a day for wound healing."</p> <p>g. A physician's Progress Note dated 10/11/08 documented, "She is on PEG tube feedings of Glucerna. We recently bumped it up to 55 an hour due to weight loss."</p> <p>h. Dietary Progress notes dated 10/14/08 and signed by the Dietary Manager, documented the October weight as 186.6 and noted no significant weight loss.</p> <p>i. Dietary note for recommendations dated 10/16/08 by the Registered Dietitian (RD) documented, "Tube feeding is under resident needs by 444 calories. Recommendation: Increase feeding to 75 cc/hr, decrease hourly flushes to 80 cc/l so that the volume will remain stable. This would provide 1800 calories, 81 grams protein and 3690 cc free water." The physician signed and dated on 10/21/08 to proceed with the order.</p> <p>j. A physician's telephone order dated 10/26/08 documented the order to increase the feeding, "Glytrol increase to 75 cc per hour and decrease hr flushes to 80 cc per hour."</p> <p>The RD recommendation dated 10/16/08 to increase the tube feeding due to the nutritional needs of the resident not being met was not initiated until 10/26/08 resulting in a loss in calorie intake for the resident. If the order had been</p>	F 325			

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F 325	<p>Continued From page 31</p> <p>initiated on 10/16/08 instead of 10/26/08, the resident would have received an additional 4,440 calories.</p> <p>k. The October Weekly Weights form for the 400 Hall dated 10/27/08 documented the resident's weight at 157.6 lbs. On 11/12/08 at 10:00 a.m., the Surveyor asked the Restorative Aide why she weighed the resident on 10/27/08. She stated, "Someone asked me to weigh Resident #4 because she looked like she had lost weight."</p> <p>l. A Dietary Progress Note dated 10/29/08 by the RD documented, " Resident is tolerating tube feeding at 75cc per hour. This should meet her needs. Will continue to follow."</p> <p>m. The November 2008 Physician orders sheet dated 11/1/08 documented, "10/26/08-Glytrol at 75 cc/hr per g-tube continuous. 80 cc/hr H2O (water) via peg tube. ... 6/25/08-Juven one package in 6-8 oz (ounces) H2O via peg tube twice a day wound healing. ... 10/9/08- Protein powder one scoop in H2O per G (gastrostomy) tube twice a day for wound healing."</p> <p>n. On 11/12/08 at 10:00 a.m., the Restorative Aide weighed the resident with the surveyor present. The resident's weight was 157.4 lbs. From 8/1/08 (Weight 191) to 11/12/08 (weight 157.4), the resident experienced a severe weight loss of 33.6 lbs. (17.6 %) in 104 days.</p> <p>n. On 11/10/08 at 3:00 p.m., on 11/11/08 at 8:15 a.m., at 4:30 p.m., 11/12/08 at 7:55 a.m., the resident's tube feeding was Glytrol infusing at 75 cc per hour.</p> <p>2. Resident #16 had diagnoses of Alzheimer's</p>	F 325			

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F 325	<p>Continued From page 32 Disease and Malnutrition.</p> <p>a. Physician orders dated 8/25/08 documented: "Diet: Regular Mechanical Meats Only."</p> <p>b. The Plan of Care dated 9/7/08 documented, "Problem-Resident has had a recent weight loss-with risk for additional nutrition and hydration problems. Goal: Gain at least 1 pound per month by next review date. Approach: Diet per MD (Medical Doctor), offer between meal snacks, encourage meals in dining room, dietary consult as needed."</p> <p>c. The admission MDS dated 9/8/08 documented the resident had short and long term memory problems, was moderately impaired in cognitive skills for daily decision making, required supervision only assistance for eating, weighed 138 pounds, had weight loss and left 25% or more uneaten.</p> <p>d. The Facility Weight Record documented the resident ' s weights as follows:</p> <p>9/1/08 - 138 lbs 9/18/08 - 137 lbs. 10/1/08 - 127.4 lbs. 11/3/08 - 127.3 lbs. 11/12/08 - 118.8 lbs</p> <p>From 9/1/08 thru 11/12/08 the resident experienced a severe weight loss of 19.2 lbs. (13.9 %) in the past 104 days.</p> <p>e. As of 11/11/08, the latest documented Dietary Assessment was dated 8/27/08 and was signed by the Certified Dietary Manager. The assessment documented the resident's August</p>	F 325			

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F 325	<p>Continued From page 33</p> <p>weight was 138 pounds, appetite information was blank, and daily caloric requirement was 1,618 calories.</p> <p>f. A Physician's Progress Note dated 10/23/08 documented, "Decreased nutritional status with an 11-pound weight loss despite Megace (8/25/08) and Eldertonc (Geritonic-10/9/08) I will have the family contact me to discuss PEG tube feedings."</p> <p>g. The resident's tray card for the breakfast meal dated 11/11/08 documented, "Regular Diet, Mechanical Soft Meat only." No likes, dislikes, special requests, or special notes were documented.</p> <p>h. On 11/11/08 in the private dining room at 8:00 a.m., 12:45 p.m. and 6:00 p.m., the resident received a Regular Mechanical Soft Diet. She was fed by the Social Worker and ate 100%. There were no fortified foods or other weight loss interventions on her tray.</p> <p>i. On 11/13/08 at 1:00 p.m., in the private dining room the resident received a regular tray of BBQ beef sandwich, potato salad, coleslaw, peaches, and tea. She was fed by staff but the CNA also let her use her hands for the sandwich. She ate 100%. There were no fortified foods or other weight loss interventions on her tray.</p> <p>j. The Meal Consumption Sheet for September, 2008 documented the resident's average daily meal intake was 73%.</p> <p>The Meal Consumption Sheet for November, 2008 had only 14 meals documented and the resident's average daily meal intake was 86%.</p>	F 325			

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F 325	Continued From page 34 k. On 11/13/08 review of the Meal Consumption Sheets for September 2008 and November 2008 [current] did not show documentation that the resident had received any between meal snacks as per the 9/7/08 plan of care. l. On 11/13/08 after review of the Clinical Record, dietary progress notes and nurses notes, no interventions to prevent further weight loss were documented from September 2008 through current November 2008. 3. Resident #10 had a diagnosis of Alzheimer's Disease. The quarterly Minimum Data Set (MDS) dated 8/1/08 documented the resident had short and long term memory problems, was moderately impaired in cognitive skills for daily decision making, required limited assistance for eating, had a swallowing problem and did not have a weight loss. a. Physician orders dated 8/12/08 documented: "Diet: Regular Mechanical Soft Finger Foods." b. The Vital Sign [and] Weight Flow Sheet form documented the resident had experienced continued weight loss since August, 2008. The Weight Record documented the following weights for the past 3 months: 8/3/08 - 142 lbs. 9/1/08 - 138 lbs 10/1/08 - 126.6 lbs. 11/3/08 - 125.4 lb 11/12/08 - 123.4 lbs. From 8/3/08 (weight 142 lbs.) to 11/12/08 (weight 123.4 lbs.), the resident experienced a severe	F 325			

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F 325	<p>Continued From page 35</p> <p>weight loss of 18.6 lbs. (13 %) in 101 days.</p> <p>c. The Plan of Care last updated 10/28/08 did not identify a weight loss and did not document any interventions to promote weight gain and prevent further weight loss.</p> <p>d. As of 11/11/08, the latest documented Dietary assessment for Resident #10 was signed by the Certified Dietary Manager and dated 8/27/08. The Assessment documented the resident's weight as 142 pounds, daily caloric requirements as 2, 053 calories, no information was provided regarding the resident's appetite.</p> <p>e. On 11/11/08 the following meal services were observed:</p> <p>1) On 11/11/08 in the dining room at 7:30 a.m., the resident received a Regular Solid Diet of bacon, biscuit, hash browns, scrambled eggs, 1 slice of bread, orange juice and water. The resident could have eaten this food easily with her hands but Certified Nursing Assistant (CNA) #4 would not allow her to try. She fed her with a fork and spoon with no interaction on the part of the resident. She ate 75%.</p> <p>The tray card documented, "Regular Diet, Regular Texture."</p> <p>2) On 11/11/08 at 12:45 p.m., in the dining room the resident received 1 slice bread, 1/2 cup of pinto beans in liquid, creamed potatoes, tamale casserole, solid cake with icing, water. This meal could not be eaten with her hands. The menu documented for finger foods: "Put entree between 2 slices of bread for a sandwich, serve food in strips, wedges, or chunks. serve soup and cereal</p>	F 325			

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F 325	<p>Continued From page 36</p> <p>in mugs and serve gravies and sauces on the side."</p> <p>She was fed by CNA #4 who would not allow her to feed herself and would not allow her to hold the food or drinks. She ate 50%.</p> <p>3) On 11/11/08 at 6:10 p.m., the resident received cucumbers in liquid, whole corn dog, catsup, macaroni & cheese, peanut butter cookie, undrained fruit chunks, 1 slice bread, and water to drink. She was fed by CNA #8 who refused to let her self-feed. The resident ate 25%.</p> <p>f. On 11/13/08 at 1:05 p.m., the resident received a finger food diet of cucumbers- sliced and drained, sandwich cut in 4s, drained peach slices, tea and water. The resident was allowed to feed herself. The resident ate 75%.</p> <p>g. The Meal Consumption Sheet for July, 2008 documented the resident's average daily meal intake was 70%.</p> <p>h. The Meal Consumption Sheet for August 2008 documented the resident ' s average daily meal intake was 62.6%.</p> <p>i. The Meal Consumption Sheet for September, 2008 documented the resident's average daily meal intake was 62.6%.</p> <p>j. The Meal Consumption Sheet for November, 2008 with only 14 meals documented, was 78%.</p> <p>j. The Meal Consumption Sheets did not document any snacks received from July 2008 through November, 2008.</p> <p>k. On 11/11/08 review of the Clinical Record did</p>	F 325			

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F 325	<p>Continued From page 37</p> <p>not show documentation of orders or recommendations for any interventions to promote weight gain or prevent further weight loss.</p> <p>I. On 11/11/08 at 6: 20 p.m., the Certified Dietary Manager (CDM) and the Registered Dietitian (RD) stated that they did not know of any intervention being in place for Resident #10. The RD stated that the Speech Therapist was working with the resident and that if the resident had finger foods she could hold them and still self-feed.</p> <p>4. Resident #15 had diagnoses of Congestive Heart Failure, Malnutrition and Open Wound Site. The quarterly MDS dated 8/14/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, required limited assistance for eating, weighed 158 pounds, had no weight loss and had 1 Stage 3 pressure sore.</p> <p>a. A Physician's order dated 5/20/08 documented, "Diet: Low Sodium (Fortified Foods with every meal.)"</p> <p>b. A Physician's order dated 5/20/08 documented, "Lasix 20 mg one by mouth daily. "</p> <p>c. The last Dietary assessment of needs was on 8/27/08.</p> <p>d. The Plan of Care updated 8/14/8 documented, "Problem: Decreased cardiac output due to diagnosis of Congestive Heart Failure for respiratory distress and fluid imbalance. Has Stage II to right lateral foot .8 x .9 x .2 centimeters. Potential for unintended weight loss/dehydration due to history of weight loss,</p>	F 325			

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F 325	<p>Continued From page 38</p> <p>cognitive disorder, and daily use of diuretic.</p> <p>-Approach, Provide diet and consistency as ordered Regular No Added Salt" [Low Sodium per MD order] "Fortified foods with all meals."</p> <p>e. A Dietary Progress Note by the CDM dated 9/5/08 documented, "Eating habits have changed from 75-100 % to 50 to 75%. Mechanical Soft diet No added salt with fortified foods. Ensure was discontinued. Will continue to monitor for any changes in weight and eating habits.</p> <p>f. A Dietary Progress Note by the RD dated 10/31/08 documented, "October weight-147.6 pounds, down 5.4 lbs (3.5%) in 30 days. She continues on Low Sodium fortified foods with 1 scoop protein powder each a.m. and 1 packet Juven twice a day. Will add snacks between meals to supplement fair intake."</p> <p>g. On 11/11/08 at the breakfast meal in the dining room at 7:40 a.m., the resident received a No Added Salt Diet with no salt packet on the tray, biscuit, gravy, scrambled eggs, sausage, regular oatmeal (the cereal was not fortified as ordered) coffee, water, orange juice. The resident ate 25%.</p> <p>The Resident's diet card with the served tray documented, "Regular No Added Salt Diet (NAS) Fortified Cereal."</p> <p>h. The November 2008 Meal Consumption Sheet documented the resident's average intake was 45%.</p> <p>i. On 11/11/08 at 12:48 p.m., the resident was served, "A Regular No Added Salt Diet." She received tamale casserole, creamed potatoes,</p>	F 325		

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F 325	<p>Continued From page 39</p> <p>pinto beans, sliced bread, fortified milk shake [did not drink] coffee, iced cake, water margarine and no salt packet on try." She fed herself and ate 25%.</p> <p>j. On 11/11/08 at 5:30 p.m., the resident was served: "A Regular No Added Salt Diet." She received no salt packet, coffee, tea, 1 slice bread, macaroni and cheese, chopped corndog with catsup, fruit and peanut butter cookie. The resident ate 10% of the meal. Certified Nursing Assistant (CNA) offered the resident substitutes and she accepted ice cream and ate 4 ounces of it.</p> <p>k. On 11/13/08 at 1:10 p.m., in the dining room, the resident received a Regular NAS diet. The resident fed herself a BBQ beef sandwich, coleslaw, potato salad, peaches, coffee, tea, water. There was no fortified food (applesauce with instant breakfast) on her tray.</p> <p>l. The November 2008 Meal Consumption Sheet showed no documentation that between meal snacks had been given as was recommended by the R.D.</p> <p>m. The facility Weight Change History form documented the resident's weight as follows: 8/1/08 158 lbs 9/1/08 153 lbs 10/1/08 143.6 lbs. 11/1/08 138.8 lbs. 11/13/08 133.9 lbs.</p> <p>From 8/1/08 (weight 158 pounds) to 11/13/08 (weight 133.9 pounds), the resident experienced a severe weight loss of 24.1 lbs (15.2%) in 114 days.</p>	F 325			

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F 332 SS=E	<p>483.25(m)(1) MEDICATION ERRORS</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview of the 8:00 a.m. and the 5:00 p.m. medication passes on 11/13/08 the facility failed to ensure that the medication error rate was less than 5%. Physician ' s orders were not followed on 4 residents (Residents #17, #18, #19, and #20) of 11 residents observed during medication passes resulting in medication errors. Medication errors were made by 2 Licensed Practical Nurse (LPN), (LPN #4 and #3) of 3 nurses who administered medications in the facility. This practice had the potential to affect 55 residents in the facility according to the Administrator on 11/10/08. The medication error rate was 11.36% based on administration of 43 medications and 1 omission for a total of 44 medications with 5 medication errors observed. The findings are:</p> <p>1. Resident #17 had a physician orders dated 9/5/08 for Vitamin D 1000 units po (by mouth) bid (twice a day).</p> <p>a. On 11/13/08 at 7:58 a.m. during the 8:00 a.m. medication pass LPN #4 administered Vitamin D 400 units.</p> <p>b. On 11/13/08 at 3:45 p.m., the surveyor asked LPN #4, "Do you have Vitamin D 1000 units?" LPN #4 looked in the medication cart and stated, "Guess we are out."</p>	F 332			

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F 332	<p>Continued From page 41</p> <p>2. Resident #18 had a physician orders dated 10/30/08 for Proventil updraft per nebulizer qid (four times a day).</p> <p>a. On 11/13/08 at 11:32 a.m., during the 12:00 p.m. medication pass, LPN #3 set up the updraft for Proventil 3 ml (milliliter). At 11:49 a.m., LPN #3 removed the nebulizer and bagged the updraft solution.</p> <p>c. On 11/13/08 at 5:22 p.m., the Director of Nursing (DON) was asked to measure the amount of solution left in the nebulizer. The DON measured and stated, "1.1 ml." This was liquid left in the nebulizer prior since the scheduled dose of medication at 12:00 p.m. and 5:00 p.m.</p> <p>3. Resident # 19 had a physician order dated 9/22/08 for Colace 100 mg 1 po bid. The Medication Administration Record (MAR) showed that the medication was scheduled for 8:00 a.m. and 5:00 p.m.</p> <p>a. On 11/13/08 at 4:12 p.m., during the 5:00 p.m. medication pass LPN #4 administered all scheduled medication except the Colace 100 mg.</p> <p>b. On 11/13/08 at 5:10 p.m., the surveyor asked LPN #4 have you administered all the medications that you have for the resident I watched with you? The LPN #4 stated, "Yes."</p> <p>4. Resident #19 had a physician order dated 9/22/08 for Niferex 150 mg Forte 1 po bid with meals.</p> <p>a. On 11/13/08 at 4:12 p.m., during the 5:00 p.m. medication pass, LPN #4 administered the Niferex 150 mg Forte with water. The resident</p>	F 332			

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F 332	Continued From page 42 had not been served a meal tray. b. According to the facility meal scheduled: 7:30 a.m., 12:30 p.m., and 5:30 p.m. 5. Resident #20 had a physician order dated for Ferrous Sulfate 325 mg po tid (three times a day) with meals. a. On 11/13/08 at 4:22 p.m., during the 5:00 p.m. medication pass, LPN #4 administered the Ferrous Sulfate 325 mg with water. The resident had not been served a meal tray. b. According to the facility meal scheduled: 7:30 a.m., 12:30 p.m., and 5:30 p.m.	F 332			
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure preplanned menus for all therapeutic diets for 3 (Residents #3, #6, and #15) of 6 (Residents #1, #3, #6, #10, #11, and #15) case mix residents with physician orders for a therapeutic diet . The failed practice had the potential to affect 22 residents with a physician order for a therapeutic diet according to the facility ' s Diet Roster dated 11/10/08. The findings are:	F 363			

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F 363	Continued From page 43 1. Resident #3 had diagnoses of Anxiety, Depressive Disorder, and Stomach Ulcer. The annual Minimum Data Set (MDS) dated 10/2/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, required set-up only assistance for eating and had a chewing problem. a. A Physician's order dated 7/29/08 documented, "Regular Soft Diet." b. A Physician's Progress Note dated 8/9/08 documented, "The patient continues to complain of intermittent abdominal pain." c. A Physician's Progress Note dated 8/21/08 documented, "The patient's abdominal pain has improved with the antibiotic therapy. She has peptic ulcer disease." d. The Plan of Care updated 8/2/08 did not address her stomach distress or order for soft foods. e. On 11/11/08 at 12:30 p.m., the resident meal tray served consisted of tamale casserole, creamed potatoes, pinto beans, sliced bread, 2% milk and iced cake. The resident ate all of her food except the pinto beans. The Surveyor asked her if she did not like the beans. She stated, "Can't eat them. They hurt my stomach." There was no salt packet with her tray. The diet card with the served tray documented, "Regular No Added Salt Diet." g. On 11/11/08 at 6:20 p.m., for the evening meal the resident was served 2 % milk, tea, 1 slice of bread with jam, macaroni and cheese, corndog	F 363			

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F 363	<p>Continued From page 44</p> <p>with catsup, fruit, peanut butter cookie and had no salt packet. The diet card with the served tray documented, "Regular No Added Salt Diet." The resident ate 70%.</p> <p>h. On 11/11/08 a review of the facility ' s menu revealed that there was no written menu for a Soft Diet.</p> <p>i. On 11/11/08 at 6:20 p.m. the CDM (Certified Dietary Manager) stated that there was not a written menu for a soft diet.</p> <p>2. Resident #6 was admitted to the facility on 10/24/08 with diagnoses of Reflux Esophagitis, Anxiety, Depressive Disorder, Vitamin Deficiency, Anemia, Nausea with Vomiting and Open Wound of Hip/Thigh. The initial MDS, dated 10/31/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required set-up only assistance for eating, required a therapeutic diet, had a dietary supplement between meals and had a Stage 3 and a Stage 4 pressure ulcer.</p> <p>a. A Physicians order dated 10/24/08 documented: "Diet: Regular High Protein."</p> <p>b. The Plan of Care dated 10/24/08 documented, "Problem: Potential for further skin breakdown related to impaired mobility due to paraplegia. Approach: High protein diet as ordered."</p> <p>c. A review of the menus revealed that there was not a written menu or a pattern for a High Protein Diet.</p> <p>d. On 11/11/08 at 6: 20 p.m., in an interview with</p>	F 363			

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F 363	Continued From page 45 the CDM and the RD, they stated that they did not have a menu in place for a high protein diet. 3. Resident #15 had diagnoses of Congestive Heart Failure, Malnutrition and Open Wound Site. The quarterly MDS dated 8/14/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, required limited assistance for eating and had 1 Stage 3 pressure sore. a. A Physician's order dated 5/20/08 documented, "Diet: Low Sodium (Fortified Foods with every meal)." b. The Plan of Care updated 8/14/8 documented, "Problem: Decreased cardiac output due to diagnosis of Congestive Heart Failure for respiratory distress and fluid imbalance. Has Stage II to right lateral foot .8 x .9 x .2 centimeters. Potential for unintended weight loss/dehydration due to history of weight loss, cognitive disorder, and daily use of diuretic. -Approach, Provide diet and consistency as ordered Regular No Added Salt" [Low Sodium per MD (Medical Doctor) order] "Fortified foods with all meals." c. On 11/11/08 at the breakfast meal in the dining room at 7:40 a.m. the resident received a No Added Salt Diet with no salt packet on the tray, biscuit, gravy, scrambled eggs, sausage, regular oatmeal, coffee, water, orange juice, the resident ate 25%. There was no fortified foods served. The Resident's diet card with the served tray documented, "Regular No Added Salt Diet (NAS) Fortified Cereal." d. On 11/11/08 at 12:48 p.m., the resident was	F 363			

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F 363	Continued From page 46 served, A Regular No Added Salt Diet as identified by the diet card that was on the tray. The resident was served tamale casserole, creamed potatoes, pinto beans, sliced bread, fortified milk shake [did not drink] coffee, iced cake, water margarine and no salt packet on try." f. On 11/11/08 at 5:30 p.m., the resident was served, A Regular No Added Salt Diet as identified by the diet card that was on the tray. The tray had no salt packet, coffee, tea, 1 slice bread, macaroni and cheese, chopped corn dog with catsup, fruit and peanut butter cookie. The resident ate 10%. Certified Nursing Assistant (CNA) offered her substitutes and she accepted ice cream and ate 4 ounces of it. g. On 11/11/08, a review of the facility ' s diet menus revealed that there was not a written diet menu for a Low Sodium Diet. h. On 11/11/08 at 6: 20 p.m. in an interview with the CDM and the RD (Registered Dietitian), they stated that they did not have a pattern or menu in place for a Low Sodium diet. The CDM stated to the RD, "That's the diet we were going to write."	F 363			
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure all soiled gloves	F 444			

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F 444	<p>Continued From page 47</p> <p>were removed after incontinent care before applying a clean brief, covering the resident with a sheet and pulling up the residents side rail for 1 (Resident #7) of 6 (Residents #2, #3, #4, #5, #7, and #8) case mix residents who were incontinent and dependent on staff for incontinent care. The failed practice had the potential to affect 10 residents on the 200 Hall that were dependent on staff for incontinent care as identified by a list provided by the Nurse Consultant on 11/14/08. The findings are:</p> <p>1. Resident #7 had diagnoses of Muscle Weakness, Pain, Diabetes Mellitus Type II, and a history of Urinary Tract Infections and Pressure Sores on the Coccoyx. A 14-Day Assessment Minimum Data Set dated 10/5/08 documented the resident had I modified independent cognitive skills for daily decision-making, had inadequate control of bowel and bladder with multiple daily episodes, and required extensive, 2-person assistance with toilet use.</p> <p>a. On 11/11/08 at 3:40 p.m., the resident was incontinent of bowel. Incontinent care was provided by CNA (Certified Nursing Assistant) #2. After CNA #2 had complete incontinent care, the CNA put a new brief on the resident, covered the resident with a sheet, replaced the resident's side rail, and touched the residents left shoulder. The CNA did not remove her gloves, and/or wash her hands prior to performing a different task.</p> <p>b. A copy of the Standard Precautions provided by the Nurse Consultant on 11/14/08 documented, "Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms." and "Remove</p>	F 444			

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F 444	Continued From page 48 gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environment."	F 444		
F 520 SS=H	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Complaint #14014 substantiated (all or in part) with these finding:	F 520		

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F 520	<p>Continued From page 49</p> <p>Based on observation, record review and interview, the Quality Assessment and Assurance Committee failed to ensure the timely development, implementation, and re-evaluation of corrective action to prevent continued weight loss and to promote weight gain for 4 of 4 case-mix residents (Residents #4, #10, #15, and #16), who experienced severe, unplanned weight losses. The failed practices resulted in actual harm for Residents #4, #10, #15 and #16, who experienced severe weight losses, and had the potential to affect 7 residents who had severe weight losses as documented on the facility's Weight Change History dated 11/10/08. The findings are:</p> <p>1. On 11/13/08 at 2:12 p.m., the Administrator stated the Quality Assurance Committee (QA) consisted of the Director of Nursing, Administrator, Medical Director, Medical Records, Social Services, Activities, Housekeeping Supervisor, Maintenance Supervisor and Restorative. She stated the full committee meets every three months. They have daily stand-up meetings, weekly At-Risk meetings and monthly Quality Assurance meetings.</p> <p>The Administrator was asked, " Did QA identify and develop an action plan for weight loss? She stated, " We discussed them on a weekly basis. There was no excuse on how it was missed. The Charge Nurses were supposed to monitor and change interventions. I conducted the last 2 weekly meetings myself because it wasn't being done right. "</p> <p>2. Four case-mix residents experienced severe weight losses:</p>	F 520			

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F 520	<p>Continued From page 50</p> <p>a. Resident #4 had diagnoses of Oropharyngeal Dysphagia, Pressure Ulcer, Reflux Esophagitis, Convulsions, Aphasia and Multiple Sclerosis. The quarterly Minimum Data Set (MDS) dated 9/29/08 documented the resident was severely impaired in cognitive skills for daily decision making, required total care for all Activities of Daily Living, had a swallowing problem, had a weight of 189 lbs, did not have a weight loss, had diarrhea, an indwelling catheter, an Ostomy, had ad a feeding tube, received 76 to 100% of daily nutrition from a tube feedings, and had a Stage II pressure sore.</p> <p>1) A physician order dated 6/24/08 documented, "Glucerna 50 ml (milliliters) per peg [percutaneous endoscopic gastrostomy] tube continuous."</p> <p>2) A lab data sheet dated 9/2/08 documented the resident's albumen level low at 3.2 g/dl (grams per deciliter) (normal range 3.5-4.8) and albumin/globulin ratio low at 0.7 (normal range 1-2.8).</p> <p>3) A physician order dated 9/16/08 documented, "Glytrol 50 cc (cubic centimeters) / hour (hr) when Glucerna depleted.</p> <p>4) The Plan of Care dated 6/17/08 and updated 9/17/08, documented, "Problem: Alteration in nutrition related to Dysphagia related to Multiple Sclerosis. Goal: Resident will maintain stable weight for 90 days. Approach: Tube feeding and supplements as ordered weekly wts (weights) until stable then monthly. Up as ordered when tube feeding is running. Notify MD (Medical Doctor) of weight loss or gain. Problem: Decubitus ulcer on right buttock. Approach: Observe nutrition and weights."</p>	F 520			

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F 520	Continued From page 51 5) The facility Weight Change History form dated 11/10/08 documented the resident's weight as follows: 6/17/08 192 lbs 6/23/08 192 lbs 7/1/08 193 lbs 8/1/08 191 lbs 9/1/08 189 lbs 10/1/08 186.6 lbs 6) A physician order dated 10/9/08 documented, "Glytrol 55 cc/hr (cubic centimeters per hour), ProMod 1 scoop twice a day, Juven-1 package via peg twice a day for wound healing." 7) A physician's Progress Note dated 10/11/08 documented, "She is on PEG tube feedings of Glucerna. We recently bumped it up to 55 an hour due to weight loss." 8) Dietary Progress notes dated 10/14/08 and signed by the Dietary Manager, documented the October weight as 186.6 and noted no significant weight loss. 9) Dietary note for recommendations dated 10/16/08 by the Registered Dietitian (RD) documented, "Tube feeding is under resident needs by 444 kcalories. Recommendation: Increase feeding to 75 cc/hr, decrease hourly flushes to 80 cc/l so that the volume will remain stable. This would provide 1800 kcalories, 81 grams protein and 3690 cc free water." The physician signed and dated on 10/21/08 to proceed with the order. 10) A physician's telephone order dated 10/26/08	F 520			

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F 520	<p>Continued From page 52</p> <p>documented the order to increase the feeding, "Glytrol increase to 75 cc per hour and decrease hr flushes to 80 cc per hour."</p> <p>The RD recommendation dated 10/16/08 to increase the tube feeding due to the nutritional needs of the resident not being met was not initiated until 10/26/08 resulting in a loss in calorie intake for the resident. If the order had been initiated on 10/16/08 instead of 10/26/08, the resident would have received an additional 4,440 calories.</p> <p>11) The October Weekly Weights form for the 400 Hall dated 10/27/08 documented the resident's weight at 157.6 lbs. On 11/12/08 at 10:00 a.m., the Surveyor asked the Restorative Aide why she weighed the resident on 10/27/08. She stated, "Someone asked me to weigh Resident #4 because she looked like she had lost weight."</p> <p>12) A Dietary Progress Note dated 10/29/08 by the RD documented, " Resident is tolerating tube feeding at 75cc per hour. This should meet her needs. Will continue to follow."</p> <p>13) The November 2008 Physician orders sheet dated 11/1/08 documented, "10/26/08-Glytrol at 75 cc/hr per g-tube continuous. 80 cc/hr H2O (water) via peg tube. ... 6/25/08-Juven one package in 6-8 oz (ounces) H2O via peg tube twice a day wound healing. ... 10/9/08- Protein powder one scoop in H2O per G (gastrostomy) tube twice a day for wound healing."</p> <p>14) On 11/12/08 at 10:00 a.m., the Restorative Aide weighed the resident with the surveyor present. The resident's weight was 157.4 lbs.</p>	F 520			

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F 520	<p>Continued From page 53</p> <p>From 8/1/08 (Weight 191) to 11/12/08 (weight 157.4), the resident experienced a severe weight loss of 33.6 lbs. (17.6 %) in 104 days.</p> <p>15) On 11/10/08 at 3:00 p.m., during the Initial Rounds of the facility, on 11/11/08 at 8:15 a.m., at 4:30 p.m., 11/12/08 at 7:55 a.m., the resident's tube feeding was Glytrol infusing at 75 cc per hour.</p> <p>b. Resident #16 had diagnoses of Alzheimer's Disease and Malnutrition. The re-entry MDS dated 9/7/08 documented the resident had short and long term memory problems, was moderately impaired in cognitive skills for daily decision making, required supervision only assistance for eating, weighed 138 pounds, had weight loss and left 25% or more uneaten.</p> <p>1) Physician orders dated 8/25/08 documented: "Diet: Regular Mechanical Meats Only."</p> <p>2) The Plan of Care dated 9/7/08 documented, "Problem-Resident has had a recent weight loss-with risk for additional nutrition and hydration problems. Goal: Gain at least 1 pound per month by next review date. Approach: Diet per MD, offer between meal snacks, encourage meals in dining room, dietary consult as needed."</p> <p>3) The Facility Weight Record documented the resident's weights as follows:</p> <p>9/1/08 - 138 lbs 9/18/08 - 137 lbs. 10/1/08 - 127.4 lbs. 11/3/08 - 127.3 lbs. 11/12/08 - 118.8 lbs</p>	F 520		

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F 520	<p>Continued From page 54</p> <p>From 9/1/08 thru 11/12/08 the resident experienced a severe weight loss of 19.2 lbs. (13.9 %) in the past 104 days.</p> <p>4) As of 11/11/08, the latest documented Dietary Assessment was dated 8/27/08 and was signed by the Certified Dietary Manager. The assessment documented the resident's August weight was 138 pounds, appetite information was blank, and daily caloric requirement was 1,618 calories.</p> <p>5) A Physician's Progress Note dated 10/23/08 documented, "Decreased nutritional status with an 11-pound weight loss despite Megace (8/25/08) and Eldertonic (Geritonic-10/9/08) I will have the family contact me to discuss PEG tube feedings."</p> <p>6) The resident's tray card for the breakfast meal dated 11/11/08 documented, "Regular Diet, Mechanical Soft Meat only." No likes, dislikes, special requests, or special notes were documented.</p> <p>On 11/11/08 in the private dining room at 8:00 a.m., 12:45 p.m. and 6:00 p.m., the resident received a Regular Mechanical Soft Diet. She was fed by the Social Worker and ate 100%. There were no fortified foods or other weight loss interventions on her tray.</p> <p>7) On 11/13/08 at 1:00 p.m., in the private dining room the resident received a regular tray of BBQ beef sandwich, potato salad, coleslaw, peaches, and tea. She was fed by staff but the CNA also let her use her hands for the sandwich. She ate 100%. There were no fortified foods or other</p>	F 520		

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F 520	<p>Continued From page 55 weight loss interventions on her tray.</p> <p>8) The Meal Consumption Sheet for September, 2008 documented the resident's average daily meal intake was 73%.</p> <p>The Meal Consumption Sheet for November, 2008 had only 14 meals documented and the resident's average daily meal intake was 86%.</p> <p>9) On 11/13/08 review of the Meal Consumption Sheets for September 2008 and November 2008 [current] did not show documentation that the resident had received any between meal snacks as per the 9/7/08 plan of care.</p> <p>10) On 11/13/08 after review of the Clinical Record, dietary progress notes and nurses notes, no interventions to prevent further weight loss were documented from September 2008 through current November 2008.</p> <p>c. Resident #10 had a diagnosis of Alzheimer's Disease. The quarterly Minimum Data Set (MDS) dated 8/1/08 documented the resident had short and long term memory problems, was moderately impaired in cognitive skills for daily decision making, required limited assistance for eating, had a swallowing problem and did not have a weight loss.</p> <p>1) Physician orders dated 8/12/08 documented: "Diet: Regular Mechanical Soft Finger Foods."</p> <p>2) The Facility Weight Record documented the resident had experienced continued weight loss since August, 2008. The Weight Record documented the following weights for the past 3 months:</p>	F 520			

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F 520	<p>Continued From page 56</p> <p>8/3/08 - 142 lbs. 9/1/08 - 138 lbs 10/1/08 - 126.6 lbs. 11/3/08 - 125.4 lbs. 11/12/08 - 123.4 lbs.</p> <p>From 8/3/08 (weight142 lbs.) to 11/12/08 (weight 123.4 lbs.), the resident experienced a severe weight loss of 18.6 lbs. (13 %) in 101 days.</p> <p>3) The Plan of Care last updated 10/28/08 did not identify a weight loss and did not document any interventions to promote weight gain and prevent further weight loss.</p> <p>4) As of 11/11/08, the latest documented Dietary assessment for Resident #10 was signed by the Certified Dietary Manager and dated 8/27/08. The Assessment documented the resident's weight as 142 pounds, daily caloric requirements as 2, 053 calories, no information was provided regarding the resident's appetite.</p> <p>5) On 11/11/08 the following meal services were observed:</p> <p>The tray card documented, "Regular Diet, Regular Texture."</p> <p>On 11/11/08 in the dining room at 7:30 a.m., the resident received a Regular Solid Diet of bacon, biscuit, hash browns, scrambled eggs, 1 slice of bread, orange juice and water. The resident could have eaten this food easily with her hands but Certified Nursing Assistant (CNA) #4 would not allow her to try. She fed her with a fork and spoon with no interaction on the part of the resident. She ate 75%.</p>	F 520			

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F 520	<p>Continued From page 57</p> <p>On 11/11/08 at 12:45 p.m., in the dining room the resident received 1 slice bread, 1/2 cup of pinto beans in liquid, creamed potatoes, tamale casserole, solid cake with icing, water. This meal could not be eaten with her hands. The menu documented for finger foods: "Put entree between 2 slices of bread for a sandwich, serve food in strips, wedges, or chunks. serve soup and cereal in mugs and serve gravies and sauces on the side."</p> <p>She was fed by CNA #4 who would not allow her to feed herself and would not allow her to hold the food or drinks. She ate 50%.</p> <p>On 11/11/08 at 6:10 p.m., the resident received cucumbers in liquid, whole corn dog, catsup, macaroni & cheese, peanut butter cookie, undrained fruit chunks, 1 slice bread, and water to drink. She was fed by CNA #8 who refused to let her self-feed. The resident ate 25%.</p> <p>6) On 11/13/08 at 1:05 p.m., the resident received a finger food diet of cucumbers- sliced and drained, sandwich cut in 4s, drained peach slices, tea and water. The resident was allowed to feed herself. The resident ate 75%.</p> <p>7) The Meal Consumption Sheet for July, 2008 documented the resident's average daily meal intake was 70%.</p> <p>8) The Meal Consumption Sheet for August 2008 documented the resident ' s average daily meal intake was 62.6%.</p> <p>9) The Meal Consumption Sheet for September, 2008 documented the resident's average daily meal intake was 62.6%.</p>	F 520			

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F 520	Continued From page 58 10) The Meal Consumption Sheet for November, 2008 with only 14 meals documented, was 78%. 11) The Meal Consumption Sheets did not document any snacks received from July 2008 through November, 2008. 12) On 11/11/08 the Clinical Record did not document any orders or recommendations for any interventions to promote weight gain or prevent further weight loss. 13) On 11/11/08 at 6: 20 p.m., the Certified Dietary Manager (CDM) and the Registered Dietitian (RD) stated that they did not know of any intervention being in place for Resident #10. The RD stated that the Speech Therapist was working with the resident and that if the resident had finger foods she could hold them and still self-feed. d. Resident #15 had diagnoses of Congestive Heart Failure, Malnutrition and Open Wound Site. The quarterly MDS dated 8/14/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, required limited assistance for eating, weighed 158 pounds, had no weight loss and had 1 Stage 3 pressure sore. 1) A Physician's order dated 5/20/08 documented, "Diet: Low Sodium (Fortified Foods with every meal.)" 2) A Physician's order dated 5/20/08 documented, "Lasix 20 mg one by mouth daily. " 3) The last Dietary assessment of needs was on 8/27/08.	F 520			

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F 520	Continued From page 59 4) The Plan of Care updated 8/14/8 documented, "Problem: Decreased cardiac output due to diagnosis of Congestive Heart Failure for respiratory distress and fluid imbalance. Has Stage II to right lateral foot .8 x .9 x .2 centimeters. Potential for unintended weight loss/dehydration due to history of weight loss, cognitive disorder, and daily use of diuretic. -Approach, Provide diet and consistency as ordered Regular No Added Salt" [Low Sodium per MD order] "Fortified foods with all meals." 5) A Dietary Progress Note by the CDM dated 9/5/08 documented, "Eating habits have changed from 75-100 % to 50 to 75%. Mechanical Soft diet No added salt with fortified foods. Ensure was discontinued. Will continue to monitor for any changes in weight and eating habits. 6) A Dietary Progress Note by the RD dated 10/31/08 documented, "October weight-147.6 pounds, down 5.4 lbs (3.5%) in 30 days. She continues on Low Sodium fortified foods with 1 scoop protein powder each a.m. and 1 packet Juven twice a day. Will add snacks between meals to supplement fair intake." 7) On 11/11/08 at the breakfast meal in the dining room at 7:40 a.m., the resident received a No Added Salt Diet with no salt packet on the tray, biscuit, gravy, scrambled eggs, sausage, regular oatmeal (the cereal was not fortified as ordered) coffee, water, orange juice The resident ate 25%. The Resident's diet card with the served tray documented, "Regular No Added Salt Diet (NAS) Fortified Cereal."	F 520			

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

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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 11/14/2008
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 520	Continued From page 60 9) The November 2008 Meal Consumption Sheet documented the resident's average intake was 45%. 10) On 11/11/08 at 12:48 p.m., the resident was served, "A Regular No Added Salt Diet." She received tamale casserole, creamed potatoes, pinto beans, sliced bread, fortified milk shake [did not drink] coffee, iced cake, water margarine and no salt packet on try." She fed herself and ate 25%. 11) On 11/11/08 at 5:30 p.m., the resident was served : "A Regular No Added Salt Diet." She received no salt packet, coffee, tea, 1 slice bread, macaroni and cheese, chopped corndog with catsup, fruit and peanut butter cookie. The resident ate 10% of the meal. Certified Nursing Assistant (CNA) offered the resident substitutes and she accepted ice cream and ate 4 ounces of it. 12) On 11/13/08 at 1:10 p.m., in the dining room, the resident received a Regular NAS diet. The resident fed herself a BBQ beef sandwich, coleslaw, potato salad, peaches, coffee, tea, water. There was no fortified food (applesauce with instant breakfast) on her tray. 13) The November 2008 Meal Consumption Sheet showed no documentation that between meal snacks had been given as was recommended by the R.D. 14) The facility Weight Change History form documented the resident's weight as follows: 8/1/08 158 lbs 9/1/08 153 lbs	F 520			

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F 520	<p>Continued From page 61</p> <p>10/1/08 143.6 lbs. 11/1/08 138.8 lbs. 11/13/08 133.9 lbs.</p> <p>From 8/1/08 (weight 158 pounds) to 11/13/08 (weight 133.9 pounds), the resident experienced a severe weight loss of 24.1 lbs (15.2%) in 114 days.</p> <p>3. Weights were difficult to find as evidenced by Resident #8. The Resident was admitted to the facility on 11/7/08 with diagnoses of Intracranial Hemorrhage, Craniotomy, Anemia, Depression, Anxiety and Malnutrition. She had a feeding tube of Nutren 2.0 at 35 cc per hour. She had a Temporary problem of alteration in nutritional status related to NPO status and tube feeding. Dietary was to screen feeding tube formula and rate per MD orders. On 11/12/08 at 4:15 p.m., the Nurse Consultant stated she had gone through the Resident 8's whole chart and did not find a weight.</p> <p>As of 11/13/08 at 3:00 p.m. a weight for this resident was not available.</p> <p>4. Weights were confusing. This was verified by the Certified Dietary Manager (CDM) on 11/12/08 at 2:30 p.m. In an interview with the CDM, she stated that the RD attended the last weight meeting in her place due to the staff changes in the kitchen. She stated that she had been with the facility for 3 months. When she 1st started the job she began to assess the residents' weights. She stated she found them confusing so she did reweights on all the residents she assessed. She said that 90 % of the time the reweight showed a loss from the documented weight she was given. She has not been able to</p>	F 520		

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F 520	<p>Continued From page 62</p> <p>get into directly working with the weights because her computer is locked with the last CDM's password and she has not been able to get action on this being corrected.</p> <p>5. Weights were not consistent. On 11/12/08 at 10:45 a.m., in an interview with the Restorative Aide, who is now weighing the residents, she stated that the facility had a turnover in Director of Nursing (DON) in the past. Each DON had the weights done differently. An example was the surface the scale was on. On 11/12/08 the scale set directly on carpet, which is a soft surface. She stated the DON before had the scale put on a hard surface only. She stated she noticed a difference in the weights.</p> <p>6. Weights were wrong with no way to identify why they were wrong. On the Weight Change History form, Resident #7's weight for August was 163 lbs. Her weight on 10/1 was 205 lbs and a reweight was 166.3. Surveyor asked the facility for the handwritten weights recorded at the time of weighing. On that document the resident's weight for November was recorded at 205.1 lbs.</p>	F 520			