

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

PRINTED: 05/12/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045147</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/28/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>MORRILTON HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 BROOKRIDGE LANE</b> <b>MORRILTON, AR 72110</b>	
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F 000	INITIAL COMMENTS  Complaint #11526 was substantiated (all or in part) with a deficiency cited at F314.  Complaint #11535 was unsubstantiated.  Complaint #11561 was substantiated (all or in part) with deficiencies cited at F226.  Complaint #11565 was substantiated (all or in part) with deficiencies cited at F314.  Complaint #11635 was substantiated (all or in part) with deficiencies cited at F309 and F323.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		

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 164	<p>Continued From page 1</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure staff provided privacy during bathing for 2 (Residents #11 and #19) of 19 case mix residents who required assistance with bathing (Residents #1 through #13 and #15 through #20). The failed practice had the potential to affect 99 residents who required assistance with bathing, as documented on the facility's Resident Census and Conditions of Residents form dated 4/25/06. The findings are:</p> <p>Resident #11 had diagnoses of Alzheimer's Disease and Secondary Parkinsonism. The Quarterly Minimum Data Set (MDS) dated 4/20/06 documented the resident was severely impaired in cognitive skills for daily decision-making and totally dependent on staff for personal hygiene and bathing.</p> <p>Resident #19 had diagnoses of Cerebrovascular Accident and Genital Herpes. The MDS dated 3/3/06 documented the resident was moderately impaired in cognitive skills for daily decision-making and required extensive assistance with bathing.</p> <p>On 4/25/06, the following observations were</p>	F 164			

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F 164	<p>Continued From page 2 made:</p> <p>a. At 10:30 a.m., Certified Nursing Assistants (CNA's) #14 and #15 transferred the resident to a shower chair in the shower room. During the transfer, the CNA's pulled the resident's incontinent brief and pants down. After the transfer was completed, the remainder of the resident's clothes were removed. The resident was moved to the shower stall and CNA #14 began to bathe the resident. CNA #14 did not close the privacy curtain or drape any part of the resident's body.</p> <p>b. At 10:40 a.m., while Resident #11 was being bathed by CNA #14, Resident #19 entered the shower room with his walker and sat down on the shower chair. CNA #15 removed Resident's #19's clothes. CNA #15 did not close the privacy curtain around the resident. Residents #11 and #19 were each in the other's line of sight.</p> <p>c. At 10:45 a.m., a third CNA entered the shower room from the 400 Hall entrance without knocking. The CNA stood with the door open and 2 people were observed walking in the corridor at this time. The CNA entered the room then exited through the 300 Hall door on the other side of the room. Residents #11 and #19 remained nude and CNA's #14 and #15 made no effort to provide privacy to them during the third CNA's trip through the room.</p> <p>d. At 10:55 a.m., CNA #15 left Resident #19 sitting nude on the whirlpool chair with his underwear pulled up to the knees. The CNA left the room to get socks for the resident. The CNA did not cover the resident with a towel or sheet to protect his privacy during her absence from the</p>	F 164			

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F 164	Continued From page 3 room.	F 164			
F 221 SS=D	<p>483.13(a) PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure 1 of 1 case mix resident with a tray table restraint in use (Resident #9) did not have an additional waist restraint applied without care planning and obtaining a physician order for the additional restraint. The failed practice had the potential to affect 20 residents with physical restraints in use, as documented on a list provided by the facility's Nurse Consultant on 4/28/06 at 2:40 p.m. The findings are:</p> <p>Resident #9 had diagnoses of Anxiety Disorder, Dementia with Behavior Disturbance, Fractured Femur and Lack of Coordination. The Admission Minimum Data Set (MDS) dated 4/4/06 documented the resident was severely impaired in cognitive skills for daily decision-making and had a trunk restraint in use daily.</p> <p>a. A physician order dated 4/5/06 documented: "DC [discontinue] Lap Buddy, replace with lap tray..."</p> <p>b. The Care Plan dated 4/5/06 documented: "...Problem/need - At risk for falls due to poor safety awareness... Approach - Lap tray while up</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>in w/c [wheelchair]... D/C [discontinue] Lap Buddy..." Other than the lap tray and side rails, no other types of restraints were addressed on the Care Plan.</p> <p>c. On 4/26/06 at 11:00 a.m., the resident was sitting in a wheelchair. Two Certified Nursing Assistants (CNA's) prepared to transfer the resident out of the wheelchair. CNA #8 removed the lap tray. A seat belt restraint was also in place around the resident's waist and CNA #7 released the seat belt restraint at this time.</p> <p>d. On 4/27/06 at 3:10 p.m., CNA #8 was asked if the resident was supposed to be restrained in the wheelchair. The CNA stated, "Yes." The CNA was asked what type of restraint was used on the resident. She stated, "I guess the lap [tray] is a restraint." CNA #8 was asked if the lap tray was the only restraint in use for this resident. The CNA stated, "I didn't notice another one on her." The CNA was asked the purpose of the lap tray. She stated, "The resident had a fall and broke her hip. The restraint is to keep her from walking without assistance."</p> <p>e. On 4/27/06 at 3:15 p.m., CNA #7 was asked if the resident was supposed to be restrained. She stated, "Yes." The CNA was asked what type of restraint was in use. She stated, "She [Resident #9] had on a lap tray and a seat belt. She is not supposed to have a seat belt." The CNA was asked the purpose of the lap tray. The CNA stated, "The tray is to keep her from leaning over, jumping out of the seat and falling."</p> <p>f. On 4/28/06 at 10:35 a.m., the Director of Nursing (DON) was informed that Resident #9 had been observed with a lap tray and belt</p>	F 221			

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F 221	Continued From page 5 restraint applied at the same time. The DON was asked if the lap tray was considered a restraint. The DON stated, "Yes." The DON was asked if the seat belt was also considered a restraint. The DON stated, "Yes." The DON was asked if the resident was supposed to have 2 different types of waist restraints in use at the same time. The DON stated, "No, that should never have happened."	F 221			
F 226 SS=C	483.13(c) STAFF TREATMENT OF RESIDENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by:  Complaint #11561 was substantiated (all or in part) with these findings.  Based on record review and interview, the facility failed to ensure their abuse prohibition policy and procedure was implemented, as evidenced by failure to conduct State Employment Clearance Registry (ECR) checks on 2 of 6 employees whose personnel files were reviewed and failure to complete reference checks on 3 of 6 employees whose personnel files were reviewed. The failed practice had the potential to affect all 101 residents, as documented on the facility's Resident Census and Conditions of Residents form dated 4/25/06. The findings are:  1. The facility's "Abuse Policy" documented: "...Screening: All applicants for employment in the facility shall, at a minimum, have the following	F 226			

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F 226	Continued From page 6 screening checks conducted: 1. Reference checks with the current and/or past employer. 2. Appropriate licensing board or registry check..."  2. On 4/25/06 at 2:00 p.m., 6 employee files were reviewed with the following findings:  a. The employee file of Activity Employee #1 documented a hire date of 3/8/06. There was no documentation the State Employment Clearance Registry (ECR) had been checked for this employee and no documentation of reference checks completed with current or previous employers prior to hire.  b. The employee file of Dietary Employee #1 documented a hire date of 2/16/06. There was no documentation of reference checks with current or previous employers prior to hire.  c. Maintenance Employee #1's employee file documented a hire date of 3/20/06. There was no documentation that an ECR check or reference checks were completed for this employee.  3. On 4/26/06 at 8:40 a.m., the Business Office Manager was unable to provide documentation of reference checks on the above employees. She stated no such documentation was available.  4. On 4/26/06 at 8:40 a.m., the Administrator and Business Office Manager were both asked if the ECR had been called for the Dietary and Maintenance employees. They both stated they did not know they were supposed to complete ECR checks for those employees and thought ECR checks were only required for CNA's.	F 226			

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F 246 F 246 SS=D	Continued From page 7 483.15(e)(1) ACCOMODATION OF NEEDS  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by:  Based on observation and record review, the facility failed to ensure a wheelchair of proper size was provided, to meet the needs of 1 (Resident #17) of 12 case mix residents who used wheelchairs for mobility (Residents #2 through #7, #9, #10 and #16 through #19). The failed practice had the potential to affect 55 residents who used wheelchairs for mobility, as documented on a list provided by the facility's Nurse Consultant on 4/28/06 at 2:40 p.m. The findings are:  Resident #17 had diagnoses of Congestive Heart Failure and Musculoskeletal Disorder. The Minimum Data Set (MDS) dated 3/29/06 documented the resident was severely impaired in cognitive skills for daily decision-making, weighed 197 pounds and wheeled self in a wheelchair.  a. On 4/27/06 at 2:20 p.m., Certified Nursing Assistants (CNA's) #9 and #10 transferred the resident to a wheelchair. The wheelchair did not have full length armrests. Tissue on the hip area was protruding between the seat back and the armrest. The backs of the resident's knees were	F 246 F 246		

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F 246	<p>Continued From page 8</p> <p>8 inches from the edge of the seat and when the resident's feet were placed on the footrests, the resident's knees were above hip level. The backrest of the wheelchair was completely vertical, with no tilt and was pressing into the kyphotic area of the resident's thoracic spine area.</p> <p>b. On 4/27/06 at 3:45 p.m., the Physical Therapist was asked to describe the facility's protocol for providing appropriate equipment which met the needs of individual residents. She stated, "The physician would order for Therapy to evaluate and treat. Physical Therapy would evaluate and communicate needs to the physician, who would write the order. They would be submitted to the Administrator by PT [Physical Therapy]." When asked if Resident #17 had been evaluated for an appropriately sized wheelchair, the Physical Therapist stated, "No."</p> <p>c. On 4/28/06 at 7:55 a.m., the resident was sitting in a recliner in her room. An extra-wide wheelchair was parked beside the resident's bed. The resident stated, "That wheelchair is so much better. It's wider, so it doesn't hurt my hips."</p> <p>d. The facility's Policy and Procedure titled, "Equipment" was provided by the Nurse Consultant on 4/28/06 at 2:40 p.m. The policy documented: "...Our facility shall provide routine equipment for the general use of the resident population... Wheelchairs, walkers, crutches... are maintained by our facility for the general use of all residents... Equipment maintained for the general use of all residents may not be permanently assigned to any resident... Request or need for special equipment should be referred to the social services department..."</p>	F 246			

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F 253 F 253 SS=C	Continued From page 9 483.15(h)(2) HOUSEKEEPING/MAINTENANCE  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by:  Based on observation and interview, the facility failed to ensure walls were maintained in clean, intact condition, furniture was maintained in good repair, doors were free of scratches and chipped areas, floors were clean and free of damage, baseboard moldings were present and intact, air vents were clean and foul odors were removed. The failed practices had the potential to affect all 101 residents, as documented on the facility's Resident Census and Conditions of Residents form dated 4/25/06. The findings are:  1. On 4/27/06 at 10:00 a.m. during the environmental tour with the Maintenance Supervisor (MS), the following observations were made:  a. In the Main Dining Room:  1.) Both kitchen door jambs were scraped, exposing the metal surface underneath.  2.) The kitchen door on the left had several scratches halfway between the knob and the floor.  3.) The floor in the dish room had large pieces of linoleum missing in 3 different places, approximately 2 to 3 feet long by 6 inches wide.	F 253 F 253			

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F 253	<p>Continued From page 10</p> <p>A different pattern of linoleum was visible to the end of the wall. This piece of linoleum was raised on the edges and a sour smell emanated from the floor area.</p> <p>4.) The Private Dining Room door was scratched at the knob level.</p> <p>5.) One red dining room chair had multiple white, grey and black stained areas to the seat and back of the chair.</p> <p>6.) The entrance to the secondary dining room had a missing three inch corner piece of baseboard molding.</p> <p>b. On the 100 Hall:</p> <p>1.) Room #102 had scuff marks 12 inches from the floor on the bathroom walls directly in front of and perpendicular to the toilet, extending the entire width of the walls.</p> <p>2.) The double fire doors and doors to Rooms #102 through #115 had chipped edges on the hinge side and scratches on the door surfaces 5 inches from the floor.</p> <p>3.) Room #115 had a 19 by 1 inch scuff mark across two 12 by 12 inch floor tiles and the bathroom door was scratched 8 inches from the floor across its entire width.</p> <p>c. On the 200 Hall:</p> <p>1.) The hall floor near the fire doors had eight 12 by 12 inch tiles that were cracked in a spider web pattern.</p>	F 253			

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F 253	Continued From page 11 2.) The door surface to Therapy Tub Room #1 had scratches to the lower portion (below the knob).  3.) Room #201 had a yellow-brown discoloration on the bathroom floor and smelled of urine.  4.) The fire doors were scratched eight inches from the floor and the hinge side edges were chipped below the level of the door knob.  5.) Rooms #202 through #215 and #217 had chipped edges on the hinge side of the doors and scratched door surfaces five inches from the floor across the doors' width.  6.) Room #214 had scratches 8 inches from the floor on the inside of the bathroom door and scuff marks on the walls directly in front of and perpendicular to the toilet (12 inches from the floor), extending the entire width of the walls. There was also a 1.5 by 1 inch gouge to the bathroom door just below the knob.  d. On the 300 Hall:  1.) The hall floor near the fire doors had three 12 by 12 inch tiles with concave cracked areas.  2.) The fire doors were scratched eight inches from the floor and extended the entire width of the door.  3.) Rooms #301 through #314 and #316 had chipped edges on the hinge sides of the doors and scratched surfaces five inches from the floor across the doors' width.  4.) The closet door and adjacent wall in Room	F 253			

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F 253	Continued From page 12 #313 had scratches on the surfaces. There was a scuff mark 12 inches from the floor on the wall adjacent to the closet. The bathroom floor had a 1/2 inch rust ring around the toilet base.  5.) The paint on the hand rails at the exit door was chipped in several places.  6.) The restorative dining room air conditioner vents had debris behind the grid and there were six badly stained chairs in the dining room.  7.) The main dining room air conditioner vents had debris behind the grid and the paint on the door frames was chipped in several spots. The wall on the right of the dining room entrance had a scratch 42 inches from the floor which measured 44 by 1/2 inches.  8.) The paint on the bathroom and activity door frame was chipped in several places.  9.) The wall in front of the activity storage room had a scratch 42 inches from the floor which measured 21 by 1/2 inch.  10.) The paint on the dirty linen closet door was chipped in several places.  11.) The kitchen had two chairs with orange, brown and white stains at their bases.  12.) The wall between the dirty linen and medication room was scuff marked 12 inches from the floor.  13.) The bathroom floor had a 1/2 inch rust ring around the toilet base. The walls parallel to the toilet and next to the supply closet had chipped	F 253			

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F 253	<p>Continued From page 13</p> <p>paint and the shower floor entrance had a soap scum-like build-up.</p> <p>14.) Therapy Tub Room #2 had scratches across the width of the door which connected to the 400 hall. There were 10 rusted 6 by 6 floor tiles at the shower entrance under a metal plate. The bathroom wall parallel to the toilet had a 19 by 1.5 inch scuff mark above the molding.</p> <p>e. On the 400 Hall:</p> <p>1.) The entryway had eight 12 by 12 inch cracked/concave floor tiles.</p> <p>2.) Room #401 had scuff marks across the width of the closet door eight inches from the floor.</p> <p>3.) The wall directly across from Room #401 had a 4 by 3 inch tear to the wallpaper, below the hand rail.</p> <p>4.) The fire doors were scratched five inches from the floor and the hinge side edges were chipped below knob level.</p> <p>5.) Rooms #405 through #414 had scratched lower door surfaces and chipped hinge side door edges.</p> <p>6.) The main lobby had two couches with torn armrests, which exposed the yellow foam filling underneath the upholstery.</p> <p>2. On 4/26/06 at 9:40 a.m., the wall to the left of the door in Resident Room #305 was scraped at door knob level. The scrape extended around the room to the closet and stopped at the window. The bathroom wall had paint chipping in four</p>	F 253			

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F 253	<p>Continued From page 14</p> <p>places measuring from 1.5 by 1 inch to 6 by 3 inches.</p> <p>3. On 4/26/06 at 10:40 a.m., the wall opposite Bed A and the wall between the closet and window in Resident Room #316 was scraped at door knob level and extended across the width of the walls. The hinge side of the door was chipped in several places.</p> <p>4. On 4/26/06 at 3:00 p.m., the closet in Resident Room #209 was scratched at knob level on one door and 16 inches below knob level on the other door. The scratches extended across the entire width of the doors. The bathroom floor had yellow-orange stains behind the commode and the hinge side of the bathroom door edge was chipped below the knob.</p> <p>5. On 4/25/06 at 8:12 a.m., the following observations were made in Resident #11's room:</p> <p>a. The bathroom had 2 blue streaks and multiple spots on the wall. The streaks were approximately 3.5 inches long and 1/4 inch wide.</p> <p>b. The wall to the left of the bathroom entrance had gray scuff marks approximately 3 feet long and 1 inch wide approximately 1 foot above floor level.</p> <p>c. The outside of the bathroom door had an indentation and scuffed area approximately 1 foot above floor level which measured approximately 1 inch long and 1/4 inch wide.</p> <p>6. On 4/25/06 at 8:30 a.m., the following observations were made in Resident #3's room:</p>	F 253			

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F 253	<p>Continued From page 15</p> <p>a. The privacy curtain around Bed B had 4 brown-stained areas which ranged in diameter from approximately 1/4 inch to 1.5 inches.</p> <p>b. The base of the commode and the baseboard in the bathroom had a build up of dirt/dust.</p> <p>c. The wall on the right side of the bathroom had a gray scuff mark approximately 1 foot above floor level which measured approximately 4 feet long by 1 inch wide.</p> <p>7. On 4/25/06 at 9:55 a.m., the following observations were made in Resident #13's room:</p> <p>a. The wall under the bathroom sink had a 1 by 1 foot area that was bulging outward.</p> <p>b. The bathroom floor was sticky and had brown stains.</p> <p>c. The commode had dirt/dust on the base.</p> <p>d. The baseboards had a build-up of brown dust/dirt around the edges of the floor.</p> <p>8. On 4/25/06 at 10:30 a.m., Certified Nursing Assistants (CNA's) #14 and #15 transferred Resident #11 to a shower chair and undressed the resident. While waiting for Licensed Practical Nurse (LPN) #8 to remove the dressing, the resident was incontinent of stool. The fecal material dropped onto the floor. When the LPN removed the resident's dressings she stepped in the stool and left tracks across the shower room floor.</p> <p>On 4/25/06 at 11:05 a.m., the CNA's and Surveyor exited the shower room. There were 6</p>	F 253			

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F 253	<p>Continued From page 16</p> <p>small areas where fecal material had been tracked into the hall. CNA #14 stated, "It couldn't have been me that stepped in it, because there are spots out here and I haven't been in the hall since it happened." The fecal stains remained on the floor at 1:00 p.m., 3:00 p.m. and 5:30 p.m.</p> <p>9. On 4/25/06 at 11:10 a.m., the lower frame of Resident #11's geri-chair had multiple brown stains which measured approximately 1/4 to 1/2 inches in diameter on the right inner surface. There was a brown substance on the right outer frame and seat cushion had multiple yellow stains.</p> <p>On 4/27/06 at 10:15 a.m., the Director of Nursing (DON) was asked to check the resident's geri-chair. After the DON observed the chair, she was asked if the chair was dirty. She stated, "Yes, it needs to be cleaned."</p> <p>10. On 4/25/06 at 1:05 p.m., the following observations were made in Resident #15's room:</p> <p>a. The commode had multiple gray/brown stains on the base and sides of the bowl.</p> <p>b. There were 2 streaks of a brown/tan substance on the wall between the sink and commode. The streaks were 3 inches long and 1/4 inch wide.</p> <p>c. The right wall had black scuff marks and gouges in the drywall which measured 3 feet long by 1.5 inches wide.</p> <p>11. On 4/25/06 at 12:30 p.m., Resident #4's bed had the wood trim missing from the foot board.</p> <p>12. On 4/25/06 at 12:15 p.m., Resident #8's</p>	F 253			

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F 253	Continued From page 17 bathroom door had grooved marks approximately 1 inch from the floor.	F 253			
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:  Based on observation, record review and interview, the facility failed to ensure the physician's plan of care was implemented for 3 (Residents # 3, #11 and #13) of 5 case mix residents with physician orders for wound treatments/dressings (Residents #3, #4, #11, #13 and #15), for 1 of 1 case mix resident with physician orders for Fosamax (Resident #27), for 1 (Resident # 3) of 3 case mix residents with orders for a lap buddy/lap tray (Residents #3, #7 and #9), 1 (Resident #3) of 4 case mix residents care planned for the use of a body alarm (Residents #2, #3, #9 and #10) and for 1 (Resident #11) of 2 case mix residents with physician orders for Restorative Nursing services (Residents #11 and #13). The failed practice had the potential to affect 21 residents with physician orders for wound treatments, as documented on a list provided by the Nurse Consultant on 4/28/06 at 2:40 p.m., 3 residents with physician orders for Fosamax, as documented on a list provided by the Nurse Consultant on 4/28/06 at 9:00 a.m. and 9 residents with lap buddies/lap trays in use, 18 residents with body alarms in use and 16 residents with physician orders for Restorative	F 282			

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F 282	<p>Continued From page 18</p> <p>Nursing services, as documented on lists provided by the Nurse Consultant on 4/28/06 at 2:40 p.m. The findings are:</p> <p>1. Resident #3 had diagnoses of Heel and Midfoot Ulcers, Ankle and Buttock Decubitus Ulcers and Peripheral Vascular Disease. The Admission Minimum Data Set (MDS) dated 3/22/06 documented the resident had modified independence in cognitive skills for daily decision-making, had 4 Stage II and 2 Stage III ulcers and required limited assistance of two or more persons for transfers.</p> <p>a. A physician order dated 3/22/06 documented: "Xenaderm ointment to open areas Rt [right] lower buttock bid [twice daily] until healed."</p> <p>b. A physician order dated 3/31/06 documented: "Clean Rt lateral ankle W/NS [with normal saline], apply Xenaderm and cover QD [every day] x [times] 14 D [days]."</p> <p>c. A physician order dated 4/21/06 documented the Stage III ulcers to the resident's right lateral foot, left medial heel and left lateral foot were to be scrubbed twice with Betadine, treated with Panafil and covered daily.</p> <p>d. On 4/26/06 at 10:15 a.m., Licensed Practical Nurse (LPN) #10 set up a clean field with 8 gauze sponges, 1 medapore dressing, 5 packages of Q-tips, three 30-milliliter (ml) medication cups of normal saline, one 30-ml medication cup of Xenaderm, one 30-ml medication cup of Panafil, two packages of alcohol pads and tape. No Betadine scrub solution was prepared. The following observations were made after the supplies were in place:</p>	F 282			

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F 282	Continued From page 19  1.) LPN #10 used normal saline instead of Betadine to cleanse the ulcers on the right lateral foot and both ulcers on the left foot. The normal saline was poured into the wound beds, which were then patted dry with gauze. No Betadine scrub was provided at any time during the procedure.  2.) LPN #10 cleansed and applied Xenaderm to the ulcer on the right lower buttock as ordered, then applied a medapore dressing which was not ordered.  e. On 4/28/06 at 12:20 p.m., LPN #10 was asked why the Betadine scrub was not provided as ordered. The LPN stated, "I got interrupted and I guess I didn't look to see what I was supposed to do."  f. The Care Plan dated 3/22/06 documented: "Problem/Need: At risk for falls R/T [related to] generalized weakness... Approaches: ... 4/10/06 Body alarm on at all times..."  g. A physician order dated 4/12/06 documented: "Lap buddy on when up in W/C [wheelchair]..."  h. On 4/25/06 at 9:55 a.m., 11:45 a.m., 12:55 p.m., 1:15 p.m., 2:50 p.m., 5:25 p.m. and 6:40 p.m. and 4/26/06 at 6:40 a.m. and 8:45 a.m., the resident was sitting in a wheelchair with no lap buddy in use.  i. On 4/26/06 at 12:15 p.m., 2:30 p.m. and 4:15 p.m., the resident had no body alarm in use.  j. On 4/28/06 at 8:30 a.m., the Director of Nursing (DON) was asked if the resident should	F 282			

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F 282	<p>Continued From page 20</p> <p>have a lap buddy when up in the wheelchair and a body alarm on at all times. The DON stated "Yes."</p> <p>2. Resident #13 had diagnoses of Cerebral Palsy and Persistent Vegetative State. The Quarterly Minimum Data Set (MDS) dated 3/8/06 documented the resident was severely impaired in cognitive skills for daily decision-making and had a feeding tube.</p> <p>a. A physician order dated 3/21/03 documented: "Clean GT [Gastrostomy Tube] site with soap and H2O [water] and apply dry dressing Q [every] day." This was documented as a current physician order on the April 2006 Physician Orders Sheet.</p> <p>b. On 4/25/06 at 8:00 a.m., 9:55 a.m., 10:02 a.m., 1:25 p.m., 3:00 p.m. and 5:20 p.m. and 4/26/06 at 6:45 a.m., there was no dressing on the GT site.</p> <p>c. On 4/28/06 at 8:30 a.m., the Director of Nursing (DON) was asked to review the physician orders dated 3/23/03 for a gastrostomy dressing. The DON was informed that there had been no gastrostomy dressing present during observations on 4/25/06 and 4/26/06. The DON stated, "It should have been on."</p> <p>3. Resident #11 had diagnoses of Alzheimer's Disease and Secondary Parkinsonism. The Quarterly Minimum Data Set (MDS) dated 4/20/06 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for transfers, locomotion, personal hygiene and bathing and did not receive Physical Therapy or</p>	F 282			

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F 282	Continued From page 21 Nursing Restorative care during the 7 days preceding the assessment date.  a. Wound Treatment Findings:  1.) A physician order dated 2/13/06 documented: "Xenaderm oint [ointment] to right hip bid until healed."  2.) A physician order dated 4/10/06 documented: "Xenaderm to right buttock bid x 14 days."  3.) A physician order dated 4/11/06 documented: "Xenaderm to low back bid x 14 days or healed."  4.) The April 2006 Treatment Kardex documented: "Xenaderm to right hip and telfa pad to cover area. Fold 2 - 4x4 in half and place over top of telfa pad - bid till healed."  5.) On 4/25/06 at 10:30 a.m., LPN #8 removed the resident's wound dressings. The dressing removed from the right hip was dated: "4/24/06 3-11 [3:00 p.m. to 11:00 p.m. shift]." The dressings removed from the resident's back and buttocks were dated: "4/24/06 7-3 [7:00 a.m. to 3:00 p.m. shift]." LPN #8 stated the dressings she removed from the resident's back and buttocks were the ones she had applied on the day shift the day before. The back and buttock treatments had not been provided again on the evening shift, in accordance with the physician order to provide the treatments twice daily.  b. Restorative Care Findings:  1.) A physician order dated 2/10/06 documented: "Ambulate in unit and up and down hallway 1 x [time] daily with contact guard assistance and min	F 282			

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F 282	<p>Continued From page 22</p> <p>[minimal] assistance to direct R/W [rolling walker].</p> <p>2.) The Restorative Nursing Plan of Care dated 2/10/06 documented: "Discharged from PT [Physical Therapy]... Treatment: Amb [ambulate] in unit, up and down hallway 1 x daily... Frequency: 5 x wk [5 times per week]. Duration: ongoing..."</p> <p>3.) The Restorative Care Flow Record entries from 3/1/06 through 4/7/06 were reviewed. Of the 28 days when Restorative Care should have been provided (according to the physician order), there was documentation for only 15 dates when Restorative Care was provided. (During the week of 3/5/06 to 3/11/06, Restorative Care was documented only 4 days, instead of 5. During the week of 3/12/06 to 3/18/06, Restorative Care was documented only on 2 days, instead of 5 times per week as specified on the Restorative Nursing Plan of Care. During the week of 3/19/06 to 3/25/06, Restorative Nursing Care was documented on only 3 days, instead of 5. During the week of 3/26/06 to 4/1/06, Restorative Care was documented on only 2 days instead of 5.)</p> <p>4.) On 4/26/06 at 2:35 p.m., Restorative Nursing Assistant (RNA) #1 was asked why the resident was no longer receiving Restorative Care. The RNA stated, "He was getting more difficult to walk by myself and I couldn't do him alone. I told Therapy about it when I stopped treatments on 4/7/06."</p> <p>5.) On 4/27/06 at 4:15 p.m., Physical Therapy Assistant #1 was asked if the Therapy Department had received notification on 4/7/06 that the resident was not able to ambulate with Restorative as ordered. The PTA stated, "We got</p>	F 282			

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F 282	Continued From page 23 an order for wheelchair positioning on 3/23/06. Maybe she thought we had picked him up again. I never got a referral or recall any conversation about the RNA services being stopped." When asked who was responsible for monitoring RNA services, PTA #1 stated, "At one time the Assistant Director of Nursing (ADON). Maybe it's [MDS Coordinator's name] now."  4. Resident #27 had diagnoses of Osteoporosis, Multi-Site Osteoarthritis and Joint Pain - Multiple Joints.  a. Physician orders dated 2/3/06 documented: "Fosamax tabs [tablets] 70 mg [milligrams] 1 PO [by mouth] weekly - Wednesday... Calcium 500 + [plus] D [Vitamin D] 1 by mouth twice a day: DO NOT TAKE ON DAY FOSAMAX IS TAKEN."  b. On 4/27/06 at 9:40 a.m., the April 2006 Medication Administration Record (MAR) was reviewed. The MAR documented the Fosamax tablets were scheduled (and each dose initialed as administered) on 4/5/06, 4/12/06, 4/19/06 and 4/26/06. The MAR also documented the Calcium 500 + D was administered twice daily on each of these dates. This was in violation of the physician order to withhold the Calcium +D on the dates when Fosamax was administered.  c. On 4/27/06 at 9:45 a.m., LPN #1 stated, "It does state 'do not give Calcium 500 + D on days of Fosamax,' but it looks like they are giving it."	F 282			
F 309 SS=J	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,	F 309			

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F 309	<p>Continued From page 24</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #11635 was substantiated (all or in part) with these findings.</p> <p>A. Based on observation, record review and interview, the facility failed to ensure necessary care and services were provided for 1 of 1 case mix resident who required emergency treatment (Resident #14). The facility failed to ensure respiratory support was provided during Cardiopulmonary Resuscitation (CPR) for Resident #14, who was found without a pulse or respirations. The facility failed to ensure emergency equipment was readily available to respond to the emergency situation for Resident #14. The failed practices resulted in immediate jeopardy, which caused or could have caused serious harm, injury or death to Resident #14 and had the potential to affect 29 residents with physician orders for full code status, as documented on a list provided by the Director of Nursing (DON) on 4/26/06 at 3:40 p.m. The facility was informed of the immediate jeopardy condition on 4/26/06 at 11:25 a.m. The findings are:</p> <p>1. Resident #14 had diagnoses of Diabetes Mellitus and Chronic Renal Failure. The Admission Minimum Data Set (MDS) dated 1/2/06 documented the resident was independent in cognitive skills for daily decision-making.</p>	F 309			

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F 309	Continued From page 25  a. A physician order dated 12/20/05 documented: "CPR in facility/Full Code for EMS [Emergency Medical Services] and hospital."  b. The Care Plan dated 1/2/06 documented: "Problem Onset: 12/21/05. CPR - Cardiopulmonary Resuscitation. Follow Physician's orders, initiate CPR, open airway, check to see if resident is breathing, assess resident circulation, start chest compressions, continue CPR until EMS arrive and start ACLS [Advanced Cardiac Life Support]... In the event that the resident is found unresponsive and has Cardiac or Respiratory arrest, provide CPR to maintain life until advanced cardiac life support is available."  c. Nurses' Notes dated 4/12/06 on the 11:00 p.m. to 7:00 a.m. (11/7) shift and signed by Licensed Practical Nurse (LPN) #6 documented: "While making rounds on residents at approx [approximately] 2335 [11:35 p.m.], beginning of shift I entered [Resident #14's] room to say hi and found resident lying off side of bed pinned between bed rail and mattress... neck was pinned with rail across neck. Resident was unresponsive. Skin warm and pale. Yelled for help... put pt [patient] back into bed. Assessed for pulse and respirations. None present. Instructed someone to call 911 and initiated chest compressions. Sent for O2 [oxygen] and backboard while continuing to perform chest compressions. Hooked O2 at 5 liters per Ambu bag. [LPN #1] provided O2 with Ambu bag while I continued compressions... Ambulance arrived, transferred resident to gurney..."  d. The hospital History and Physical dated	F 309			

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F 309	<p>Continued From page 26</p> <p>4/13/06 documented: "...During the night, the nursing personal [personnel] at the nursing home found her on routine patient checks to be wedged between the mattress and the bed rail, and apneic, unconscious, and unresponsive... The ambulance personnel intubated the patient at the nursing home, and at the time of intubation, found a large amount of gastric contents and material in her posterior pharynx. When arriving in the emergency room, she was apneic, unresponsive, and hypotensive... She was found to be suffering from brain damage and that her pupils were unequal, unresponsive to light, and had disparate movements." A hospital Progress Note dated 4/15/06 documented the resident expired 4/15/06.</p> <p>e. The facility's policy and procedure for Cardiopulmonary Resuscitation dated March 2005 documented: "With arms straight, elbows locked and shoulders over your hands (over resident's sternum), perform 15 compressions at a rate of 80 to 100 per minute. Open the airway and deliver two rescue breaths. Repeat cycle of 15 compressions to two breaths, performing four cycles before you evaluate the resident."</p> <p>f. On 4/26/06 at 7:05 a.m., Licensed Practical Nurse (LPN) #6 was asked how long it was from the time she initiated CPR until respiratory support was provided to the resident. She stated, "I don't know for sure... probably a couple of minutes. Everything went so fast." She was asked if, during the timeframe between when she started chest compressions and the ambu bag arrived, did she consider providing mouth-to-mouth respirations. She stated, "No. I've been told not to do that. The thing that bothers me is when I sent for the O2, the 'E' cylinder didn't have a valve on it and we couldn't</p>	F 309			

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F 309	<p>Continued From page 27</p> <p>find one. So we had to use a concentrator, but the tubing on the ambu bag wasn't for the concentrator... it wouldn't fit, so [LPN #7] had to hold the tubing onto the concentrator."</p> <p>g. On 4/26/06 at 7:30 a.m., the facility's emergency equipment was inspected. On the secure unit, LPN #5 was asked if the unit had an ambu bag. She stated, "Yes I do." It took approximately 45 seconds for the LPN to open the supply room door, after going through several keys. Another staff person had to open the door. No ambu bag could be found in the room. She stated, "I did have an ambu bag at one time." At this time, the Surveyor prompted LPN #5 to look in the medication room for an ambu bag. The medication room contained an ambu bag in the cabinet below the countertop, and the face apparatus with tubing was hanging in a bag on the wall.</p> <p>h. On 4/26/06 at 2:25 p.m., the Immediate Jeopardy was removed and the scope/severity reduced to "E" when the following plan of removal was implemented:</p> <p>1) Two identical crisis carts to include: a designated 'E' tank of Oxygen with a regulator and wheeled dolly, an Ambu bag with oxygen tubing, a back up/spare Ambu bag, a mechanical suction machine, and a CPR board will be maintained within the facility. One crisis cart will be kept in the Medication room on the Medical Model, and the other cart will be kept in the activity closet located within the Special Care Unit. The Executive Director will ensure compliance beginning at 12:00 noon 4/26/06 and to be completed by 6:00 p.m. on 4/26/06.</p>	F 309			

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F 309	<p>Continued From page 28</p> <p>2) Nursing staff will be inserviced to the location and contents of the crisis carts, the proper use and maintenance of all equipment contained on the cart by April 27, 2006 at 3:00 p.m. by the DON/Designee.</p> <p>3) The crisis cart will be monitored daily by the DON/Designee on daily nursing start up on an ongoing basis for appropriate equipment and cleanliness.</p> <p>4) If the crisis cart is used, the licensed staff involved in the use of the crisis cart is responsible for replacing all items used, cleaning the appropriate equipment and ensuring correct placement back to the original location.</p> <p>5) Nursing staff will be inserviced on CPR Policy and Procedure to include identifying the need to initiate CPR by 3:00 p.m. on 4/27/06 by the DON/Designee.</p> <p>B. Based on observation, record review and interview, the facility failed to ensure urinary catheter tubing was properly positioned to facilitate drainage for 1 (Resident #13) of 6 case mix residents with urinary catheters (Residents #6, #7, #13, #17, #18 and #24). The facility also failed to ensure urinary catheter tubing and collection bags were kept off of the floor to prevent potential contamination for 1 (Resident #6) of 6 case mix residents with urinary catheters (see identifiers above). These failed practices had the potential to affect 8 residents with indwelling catheters, as documented on the facility's Resident Census and Conditions of Residents form dated 4/25/06. The facility also failed to ensure stasis ulcer care was provided in a manner to prevent possible infection for 1</p>	F 309			

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F 309	<p>Continued From page 29</p> <p>(Resident #3) of 5 case mix residents who received wound care (Residents #3, #4, #11, #13 and #15). The failed practice had the potential to affect 21 residents who received wound care, as documented on a list provided by the Nurse Consultant on 4/28/06 at 2:40 p.m. The findings are:</p> <ol style="list-style-type: none"> <li>1. The facility's policy and procedure titled, "Dressing Change (Clean)" documented: "...Put on first pair of disposable gloves... Remove soiled dressing and discard in plastic bag... Put on second pair of disposable gloves... Pour prescribed solution onto gauze to be used for cleaning, if required... Cleanse wound with prescribed solution... Apply prescribed medication if ordered... Apply dressings and secure with tape... Remove gloves and discard with all unused supplies in plastic bag..."</li> <li>2. The facility's policy and procedure titled, "Catheter Care, Urinary" documented: "...Be sure the catheter tubing and drainage bag are kept off the floor... Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site... Ensure that there is no disconnection or leaking of urine from the system (except into the drainage bag)... Check drainage tubing and bag to insure that the catheter is draining properly."</li> <li>3. Resident #3 had diagnoses of Ulcer of Heel and Midfoot, Decubitus Ulcers of the Ankle and Buttock and Peripheral Vascular Disease. The Admission Minimum Data Set (MDS) dated 3/22/06 documented the resident had modified independence in cognitive skills for daily decision-making and had 4 Stage II and 2 Stage III ulcers.</li> </ol>	F 309			

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F 309	Continued From page 30  a. A physician order dated 3/22/06 documented: "Xenaderm ointment to open areas Rt [right] lower buttock bid [twice daily] until healed."  b. A physician order dated 4/21/06 documented the Stage III ulcers to the resident's right lateral foot, left medial heel and left lateral foot were to be scrubbed twice with Betadine, treated with Panafil and covered daily.  c. On 4/26/06 at 10:15 a.m., Licensed Practical Nurse (LPN) #10 provided wound care to the resident. The LPN changed gloves after cleaning two ulcers on the right lateral foot and before cleaning the ulcer on the right ankle. The LPN completed the treatment to the right foot then measured, cleaned and patted dry the ulcer on the buttocks before changing gloves. There was fecal material on the sheet next to the resident's buttocks. The LPN applied Xenaderm ointment and a Medapore dressing to the buttock area, then wearing the same gloves, began the treatment to the left medial heel and left outer ankle. The LPN completed the treatment and applied new dressings with the same pair of gloves she had on when she was completing the treatment to the resident's buttocks.  d. On 4/28/06 at 8:30 a.m., the Director of Nursing (DON) was asked when a Nurse should change gloves, if providing wound care to a resident with multiple wounds. The DON stated, "Between different decubitus. Between removing soiled dressings and applying clean dressings."  e. On 4/28/06 at 12:20 p.m., LPN #10 was asked to describe this facility's protocol for cleansing wounds/ulcers. The LPN stated, "Clean with	F 309			

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F 309	<p>Continued From page 31</p> <p>normal saline. Take gauze and clean from the inside out in a circular motion." When asked when a Nurse should change gloves, the LPN replied between dirty and clean and between different wounds or ulcers.</p> <p>4. Resident #13 had diagnoses of Cerebral Palsy, Urinary Tract Disorder and Persistent Vegetative State. The Quarterly Minimum Data Set (MDS) dated 3/8/06 documented the resident was severely impaired in cognitive skills for daily decision-making and had an indwelling urinary catheter and a feeding tube.</p> <p>a. A physician order dated 10/12/00 documented: "Suprapubic catheter for obstruction of penis prn [as needed] 28 Fr [French] 30 cc [cubic centimeters] cath [catheter]..."</p> <p>b. On 4/25/06 at 10:02 a.m., Certified Nursing Assistants (CNA's) #10, #11 and #12 turned the resident to his left side. The suprapubic catheter drainage bag remained on the right bed frame. The catheter tubing went up over the resident's right hip and then down into the collection bag. At 11:50 a.m., the resident remained on his left side with the catheter tubing positioned over the his right hip and the collection bag hanging on the right bed frame.</p> <p>c. On 4/25/06 at 3:00 p.m., CNA's #10 and #13 positioned the resident on his left side. The catheter tubing extended up over the right hip and the collection bag was hanging on the right bed frame.</p> <p>d. On 4/27/06 at 10:15 a.m., CNA #10 was asked where the urine collection bag should be positioned when this resident was positioned on</p>	F 309			

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F 309	Continued From page 32 his left side. The CNA stated, "On the left side, so it can drain."	F 309			
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interview, the facility failed to ensure perineal care was provided in a manner to maintain good personal hygiene for 1 (Resident #11) of 12 case mix residents who required assistance with activities of daily living (Residents #1 and #3 through #13). The failed practice had the potential to affect 99 residents who required assistance with bathing, as documented on the facility's Resident Census and Conditions of Residents form dated 4/25/06. The findings are:  Resident #11 had diagnoses of Alzheimer's Disease and Secondary Parkinsonism. The Quarterly Minimum Data Set (MDS) dated 4/20/06 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for personal hygiene and incontinent of bowel and bladder.  a. On 4/25/06 at 10:30 a.m., Certified Nursing Assistant (CNA) #14 provided a shower to the resident. The CNA did not retract the resident's foreskin or cleanse the urinary meatus at any time	F 312			

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PRINTED: 05/12/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045147</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/28/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>MORRILTON HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 BROOKRIDGE LANE</b> <b>MORRILTON, AR 72110</b>	
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F 312	Continued From page 33 during the resident's shower.  b. The facility's policy and procedure titled, "Perineal Care" documented: "...For a male resident: ...wet washcloth and apply soap or skin cleansing agent... Wash perineal area starting with urethra and working outward... Retract foreskin of the uncircumcised male... Wash and rinse urethral area using a circular motion..."	F 312		
F 314 SS=E	483.25(c) PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by:  Complaint #11565 was substantiated (all or in part) with these findings.  Based on observation, record review and interview, the facility failed to ensure pressure ulcer care was provided in a manner to prevent potential infection or deterioration, failed to ensure pressure ulcers were correctly staged in order to accurately assess healing progress or deterioration and failed to ensure interventions were implemented to prevent further skin breakdown for 1 (Resident #11) of 3 case mix residents with pressure ulcers (Residents #3, #11 and #13). The failed practice had the potential to	F 314		

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F 314	Continued From page 34 affect 10 residents with pressure ulcers, as documented on the facility's Resident Census and Conditions of Residents form dated 4/25/06. The findings are:  1. The facility's policy and procedure titled, "Skin Integrity/Pressure Ulcer Protocol" documented: "...review all at risk residents and those with wounds on a weekly basis. The DNS [Director of Nursing Services] or her designee will be responsible for ensuring that the skin integrity program is implemented and monitored for quality... The staging classification is as follows: ...Stage II: Partial thickness of skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. Stage III: Full thickness loss involving damage or necrosis of subcutaneous tissue which may extend down to but not through underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. Stage IV: Full thickness loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule, etc.) Undermining and sinus tracts may also be associated with Stage IV pressure ulcers. This definition recognizes the following limitation: 1. When eschar is present, accurate staging of the pressure ulcer is not possible until the eschar has sloughed or the wound has been debrided. The stage of the ulcer may be described as 'unable to determine' (UTD). For purposes of documentation on the MDS (Minimum Data Set) code the pressure ulcer(s) covered by eschar... as a Stage IV until the eschar has been debrided to allow staging... Care Interventions: ...Utilize pressure reducing devices."	F 314			

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F 314	<p>Continued From page 35</p> <p>2. Resident #11 had diagnoses of Alzheimer's Disease and Secondary Parkinsonism. The Quarterly Minimum Data Set (MDS) dated 4/20/06 documented the resident was severely impaired in cognitive skills for daily decision-making, had no skin ulcers, received pressure relieving devices to bed and chair and was on a turning/repositioning program.</p> <p>a. The Admission Nursing Assessment dated 12/15/05 documented: "Open areas 1/2 cm x 3" [one half centimeter by 3 inches] on left buttock."</p> <p>b. A Change in Condition - Altered Skin Integrity Report dated 2/13/06 documented: "Physical assessment: location - right hip, size - 1 inch diameter... At bed check - 1st rounds - found red area right hip - upon closer inspection - it looked like a blister type area that had opened - top skin area gone - no drainage - area clean - no infection noted - Baza - antifungal cream applied - turned to left side..."</p> <p>c. A physician order dated 2/13/06 documented: "Xenaderm oint [ointment] to right hip bid [twice daily] until healed."</p> <p>d. The Skin Conditions Report dated 3/1/06 with weekly evaluations dated 3/1/06, 3/8/06, 3/15/06, 3/2/06, 3/24/06, 3/29/06, 3/31/06, 4/5/06 and 4/10/06 had no documentation of the size or stages of the ulcer to the resident's right hip. The entries documented the wound was present and was receiving treatment, but no descriptions, measurements or stages were documented. The entry dated 4/10/06 documented: "Open area cont [continues] to left hip. New area on buttocks noted. Tx [treatment] as ordered." A physician order dated 4/10/06 documented: "Xenaderm to</p>	F 314			

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F 314	<p>Continued From page 36</p> <p>R [right] buttock BID [twice daily]..."</p> <p>e. The Plan of Care dated 4/10/06 documented: "Problem/concern: 1) Pressure area on lower spine. 2) Pressure area on right buttock. 3) Pressure area on right hip... Approach: 1) Treatment per Drs [Doctor's] orders. 2) Pressure reduction mattress... Problem/concern: At risk for skin breakdown R/T [related to] episodes of incontinence... 2/18/06 Open area found at bed check to right hip approximately 1 inch in diam [diameter]... 4/10/06 Two (2) Stage II to left buttock - One (1) to back Stage II... Approaches: T/R [turn/reposition] q [every] 2 hours. Apply Baza Cream... Treatment per MD [Medical Doctor] order. Turn/reposition freq [frequently]. Cushion in chair."</p> <p>f. The Weekly Skin Report dated 4/13/06 documented the following:</p> <p>1.) "Pres [pressure] - Stage I, Acqr'd [acquired] In house... Location - spine... Description - red 2 cm [centimeters] x [by] 4 cm... Treatment: Xenaderm... Ident [identified] 4/10 [4/10/06]."</p> <p>2.) "Pres Stage II, Acqr'd In house... Location - right buttock... Description - 1 cm x 3 cm... Treatment: Xenaderm... Ident 4/10 [4/10/06]."</p> <p>3.) "Pres Stage II, Acqr'd In house... Location - right hip... Description - 4 cm x 5 cm... Treatment: Xenaderm... Ident 2/15 [2/15/06]."</p> <p>g. Nurse's Treatment Notes dated 4/19/06 documented: "Right hip St [Stage] II 4.5 x 2 cm area with 3 x 1.5 dark necrotic tissue noted. Wound around necrotic tissue wound bed pink with granulation noted. Trochanter area. Ischium</p>	F 314		

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F 314	<p>Continued From page 37</p> <p>area Rt buttock wound bed pink and clean. Wound bed firm. Granulation noted."</p> <p>h. A physician order dated 4/25/06 documented: "Continue Xenaderm ointment to right buttock bid till healed."</p> <p>i. The April 2006 Treatment Kardex documented: "Xenaderm to right hip and telfa pad to cover area. Fold 2 - 4x4 in half and place over top of telfa pad - bid till healed... Cont [continue] Xenaderm oint [ointment] to right buttock bid until healed, clean with NS [normal saline] and cover with gauze."</p> <p>j. On 4/25/06 at 10:30 a.m., Licensed Practical Nurse (LPN) #8 removed the resident's dressings. The dressing removed from the right hip was dated "4/24/06 3-11 [3:00 p.m. to 11:00 p.m. shift]." The dressings removed from the resident's back and buttock were dated "4/24/06 7-3 [7:00 a.m. to 3:00 p.m. shift]." LPN #8 stated the dressings removed from the resident's back and buttock were the ones she had applied on the day shift the previous day. The dressings had not been changed on the evening or night shift.</p> <p>k. On 4/25/06 at 11:15 a.m., LPN #10 measured the pressure ulcer on the resident's right hip. The outer red area measured 3.5 by 2 cm. The inner area of the wound bed, which was yellow in color and had a gray/black center, measured 1.5 cm in diameter. When asked what stage the ulcer was, the LPN stated, "Stage II." When asked what was in the center of the ulcer, the LPN stated, "Slough." The LPN cleaned the ulcer, applied Xenaderm, covered the ulcer with Telfa and folded two 4x4 gauze pads in half. The folded gauze pads were placed over the pressure ulcer</p>	F 314			

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F 314	<p>Continued From page 38</p> <p>and covered with an Omnifix dressing. After changing gloves, the LPN cleaned the pressure ulcer to the resident's right lower buttock. The LPN used a 4x4 gauze pad moistened with normal saline to wipe across the pressure ulcer 3 to 4 times without changing to a clean area of the pad or using a new pad.</p> <p>l. On 4/25/06 at 11:45 a.m., LPN #10 was asked if the resident was on a pressure-reducing mattress. The LPN stated, "His mattress has a built-in egg crate. We use this mattress for all the residents." When asked how often measurements and staging of decubitus ulcers were completed and who was responsible for completing this, the LPN stated, "I do the treatment once a week and do measurements/staging then. We don't have a Treatment Nurse." When asked if the inner area of the right hip had slough present, the LPN stated, "Yes." When asked again what stage the ulcer was, the LPN stated, "With slough, it should be a III, not a Stage II."</p> <p>m. On 4/25/06 at 3:00 p.m. and 4/26/06 at 2:35 p.m., the resident was in bed on his right side with the head of the bed elevated 15 degrees. On 4/25/06 at 5:30 p.m. and 4/26/06 at 6:50 a.m., the resident was sitting in a geri-chair and was leaning to the right, placing pressure on the right hip.</p> <p>n. On 4/27/06 at 10:15 a.m., LPN #10 was asked what she used as a reference or tool to guide her in staging pressure ulcers. The LPN stated, "I have several books with pictures and I've done this Treatment Nurse stuff before." When asked what resource she used to assist her in staging Resident #11's hip wound, the LPN stated, "I</p>	F 314			

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F 314	Continued From page 39 think it was this one. I really need some help here. I've never had training for staging." When asked who was responsible for implementing interventions, the LPN stated, "I am." The Director of Nursing (DON) and LPN #10 were asked what was wrong with the way the resident leaned to the right in the geri-chair, the DON stated, "He needs to be kept off the right hip." The Surveyor accompanied the DON to the resident's room and asked what type of mattress the resident had. The DON stated the resident needed to be on an air mattress. The Surveyor asked the DON to find an order for the folded 4x4 dressing that was applied to the right hip. The DON stated the last order for the right hip was dated 2/10/06 and was only for Xenaderm ointment.  o. On 4/27/06 at 5:10 p.m., the Director of Nursing assessed the resident's right hip pressure ulcer. The DON stated, "It has eschar and you can't stage it, but for MDS purposes, it's a Stage IV."	F 314		
F 322 SS=B	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, record review and	F 322		

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F 322	<p>Continued From page 40</p> <p>interview, the facility failed to ensure soap was rinsed from a Gastrostomy Tube (g-tube) site after cleansing for 2 (Residents #4 and #13) of 3 case mix residents who received tube feedings (Residents #4, #6 and #13). The failed practice had the potential to affect 6 residents who received tube feedings, as documented on a list provided by the Nurse Consultant on 4/28/06. The findings are:</p> <p>1. Resident #4 had diagnoses of Dysphagia and Gastrostomy Status. The Admission Minimum Data Set (MDS) dated 3/24/06 documented the resident was moderately impaired in cognitive skills for daily decision-making and had a feeding tube.</p> <p>a. A physician order dated 4/21/06 documented: "Clean G/T [Gastrostomy Tube] site with soap and H2O [water]. Apply dry dressing QD [every day]."</p> <p>b. On 4/27/06 at 12:15 p.m., Licensed Practical Nurse (LPN) #3 provided G-tube site care to the resident. The LPN set up a basin which she stated contained, "soap from the bathroom and water." The LPN used a washcloth dipped into the soap and water solution to cleanse around the Gastrostomy site then placed a split gauze dressing around the G-tube. The LPN did not rinse the soap from the site at any time during the procedure, which increased the risk of irritation at the stoma site.</p> <p>2. Resident #13 had diagnoses of Cerebral Palsy, Urinary Tract Disorder and Persistent Vegetative State. The Quarterly Minimum Data Set (MDS) dated 3/8/06 documented the resident was severely impaired in cognitive skills for daily</p>	F 322			

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F 322	Continued From page 41 decision-making and had a feeding tube.  a. A physician order dated 3/21/03 documented: "Clean GT site with soap and H2O [water] and apply dry dressing Q [every] day."  b. On 4/26/06 at 12:15 p.m., Licensed Practical Nurse (LPN) #4 washed around the resident's Gastrostomy site with a washcloth moistened with water and hand soap. The LPN dried the site and applied a dressing without ever rinsing the soap from the resident's skin. Failure to rinse the soap from the resident's skin increased the risk of irritation at the stoma site.  3. On 4/27/06 at 4:50 p.m., the Director of Nursing (DON) provided the label from a container of the hand soap used to cleanse the G-tube sites of Residents #13 and #14.  a. The instructions on the soap label documented: "...rinse well."  b. The ingredients on the soap label documented the soap contained chloroxylenol, ammonium lauryl sulfate and fragrances, among other ingredients.  1.) Hazardous Chemical Data Volume II, Washington D.C., 1984-1985 documented prolonged contact with ammonium lauryl sulfate will cause skin irritation.  2.) The Diseases Database, 2006, documented chloroxylenol is a mild skin irritant which can cause allergic contact dermatitis.	F 322			
F 323 SS=J	483.25(h)(1) ACCIDENTS	F 323			

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F 323	<p>Continued From page 42</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #11635 was substantiated (all or in part) with these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure side rails were properly attached and/or fitted to prevent gaps between the mattress and side rails for 2 (Residents #14 and #7) of 16 case mix residents who used side rails (Residents #2, #3, #4, #6 through #14, #17, #18, #24 and #28). The failed practice resulted in immediate jeopardy, which caused or could have caused serious harm, injury or death to Resident #14, who was found wedged between the mattress and side rail with no vital signs. The failed practice also had the potential to cause more than minimal harm to 61 residents with side rails in use, as identified by the Interim Director of Nursing (DON) on 4/26/06. The facility was informed of the immediate jeopardy condition on 4/26/06 at 11:25 a.m. The findings are:</p> <ol style="list-style-type: none"> <li>1. The facility's Restraint Policy and Procedure, effective March 2005, documented "...The use of side rails will be evaluated in terms of risks and benefits for each individual resident... When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment."</li> <li>2. Resident #14 had diagnoses of Chronic Airway Obstruction, Diabetes Mellitus (DM) and Late</li> </ol>	F 323			

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F 323	<p>Continued From page 43</p> <p>Effect Motor Vehicle Accident (MVA). The Admission Minimum Data Set (MDS) dated 1/4/06 documented the resident was independent in cognitive skills for daily decision-making, required extensive assistance from one person for bed mobility, used bed rails for mobility or transfers and had full loss of voluntary movement in one leg and foot.</p> <p>a. The Pre-Restraining Assessment (not dated) documented the resident had paralysis/paresis in the right arm, right and left leg and left foot. There was no documentation on this assessment to indicate a determination was made regarding the use of side rails for this resident. The Referral/Recommendations section of the form was left blank.</p> <p>b. The Care Plan dated as revised 3/27/06 documented: "Problem Onset: 12/20/05 - Requires extensive assistance with all transfers d/t [due to] inability to move independently - Approaches: ...Side rails up while resident is in bed to help remind resident to call for assistance." There was no documentation anywhere in the clinical record that an assessment to determine the appropriateness of side rail use for this resident was completed until 4/12/06.</p> <p>c. The Side Rail Assessment dated 4/12/06 documented the resident had fluctuations in levels of consciousness/cognitive deficit related to a diagnosis of Diabetes, had problems with balance or poor trunk control and used the side rails for positioning or support. The assessment also documented: "Resident wants side rails for safety and assistance for turning."</p> <p>d. Nurse's Notes dated 4/12/06 on the 3:00 p.m.</p>	F 323			

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F 323	<p>Continued From page 44</p> <p>to 11:00 p.m. shift (3/11) documented: "VS [vital signs] 138/78, 76, 20, 98.6 - rec'd [received] resident up in G/C [geri-chair]. Resident out several times to smoke. FSBS [fingerstick blood sugar] at 4 pm [4:00 p.m.] 132 [milligrams per deciliter]. Resident ate supper. Resident took meds [medications] without difficulty. FSBS at 8 pm [8:00 p.m.] was 231 with 5 units sliding scale regular insulin given alone with 11 units Lantus scheduled. C/O [complains of] generalized feeling bad. 2 ES [extra strength] Tylenol given at 9 pm [9:00 p.m.] for generalized discomfort. Resident was given peanut butter crackers at 10 pm [10:00 p.m.] and resident stated she wanted to get up. This nurse explained that the CNA's [Certified Nursing Assistants] were on their last bed check and would get her up when they finished on the hall... no distress noted at 10 pm."</p> <p>e. Nurse's Notes dated 4/12/06 on the 11:00 p.m. to 7:00 a.m. (11/7) shift and signed by Licensed Practical Nurse (LPN) #6, the oncoming 11/7 shift nurse, documented: "...while making rounds on residents at approximately 2335 [11:35 p.m.], beginning of shift I entered [Resident #14's] room to say hi and found resident lying off side of bed pinned between bed rail and mattress. Siderail was in an up position. Resident's neck was pinned with rail across neck. Resident was unresponsive. Skin warm and pale, yelled for help. Disconnected call light from side rail and took side rail off bed. With help of [LPN#1] and [CNA #5] put her back into bed. Assessed for pulse and respirations. None present. Instructed someone to call 911 and initiated chest compressions..."</p> <p>f. On 4/26/06 at 12:10 p.m., CNA #1 stated Resident #14 was placed in bed at approximately</p>	F 323			

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F 323	<p>Continued From page 45</p> <p>9:30 p.m. on the night of 4/12/06. She stated Resident #14's roommate (Resident #3) had a body alarm which sounded between 10:00 and 10:15 p.m. She stated as she and CNA #2 went in to check on Resident #3, Resident #14 stated she wanted to get up and go smoke. The CNA stated, "We told her we were in the middle of doing our bed checks and if we had time after we finished, we would come back and get her up. We just had to tell her we couldn't get her up at that time. We told the Nurse." CNA #1 indicated the resident understood and did not get upset about not getting up at that time. CNA #1 stated the resident had complained earlier in the shift that she was not feeling well. CNA #1 stated the last time she observed the resident was at 10:15 p.m.</p> <p>g. On 4/26/06 at 1:45 p.m., CNA #2 stated, "She [Resident #14] wasn't acting like herself. I messed up. I didn't say anything about it. I should've. She wasn't cheerful. That night [4/12/06], she was complaining she just wasn't feeling good. She had gone to bed a little after 9:00 p.m. We were doing our last bed check. Approximately 10:00 to 10:15 p.m., we went to check on [Resident #3's] body alarm. [Resident #14] said she wanted to get up to go smoke. We told her we were doing our last bed checks and if we had time, we would come back and get her up. If not, the 11 to 7 [11:00 p.m. to 7:00 a.m.] shift would get her up... I should've went back down there to check on her. I don't know what happened to her." The CNA also stated, "...I think she needed side rails, because she was one who would grab the side rail to help us roll her over." CNA #2 stated the last time he observed the resident was at 10:15 p.m.</p>	F 323			

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F 323	<p>Continued From page 46</p> <p>h. On 4/26/06 at 3:55 p.m., LPN #7 stated at approximately 10:00 to 10:10 p.m., she went into the resident's room to give her peanut butter crackers and explain to her that the CNAs were doing their rounds and she would report to the 11/7 shift to get her up to smoke. LPN #7 indicated this was the last time she observed the resident until LPN #6 observed the resident in bed with no vital signs.</p> <p>i. On 4/26/06 at 7:05 a.m., LPN #6 stated the resident needed side rails to help roll herself over. She stated the resident would sometimes pull herself over to throw up on the floor. She stated, "...her arm and head was more wedged between the mattress and side rail..." She was asked if there was padding placed between the mattress and the side rail. She stated, "No." LPN #6 demonstrated how Resident #14 was found at the time of the incident on 4/12/06. She stated, "I can't position my body down between the side rail and mattress like the resident was." As LPN #6 placed her neck against the side rail she stated, "Oh, that chokes!"</p> <p>j. A Witness Statement dated 4/19/06 at 1:20 p.m. and signed by LPN #1 documented: "...I saw her [Resident #14] lying between the mattress and side rail. [Resident #14] was lifted back into the mattress by myself who had her legs, [CNA #5] who had her stomach area and [LPN #6] who had her head and arms. [LPN #6] immediately gave orders to call 911..."</p> <p>k. The Police Report dated 4/13/06 documented: "...On Thursday morning at approximately 12:15 a.m., this officer was dispatched to [facility name]. ...the officer spoke with [LPN #7], she states that a resident in a [Resident #14's Room #] was</p>	F 323			

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F 323	<p>Continued From page 47</p> <p>found with her head lodged between the mattress and the bed railing face down... She had been transported to the [hospital]. This officer was directed to [room #]. I observed a silver bed railing lying on the floor next to the bed. [LPN #7] stated that the railing had been removed to treat [Resident #14]..."</p> <p>l. The Hospital's History and Physical dated 4/13/06 documented: "...Impression: Severe brain injury with possible seizure as an etiology, possible vomiting with aspiration, and acute airway obstruction secondary to aspiration of vomitus."</p> <p>m. On 4/25/06 at 10:35 a.m., LPN #1 was asked if the resident's neck was against the side rail. She stated, "Yes." At 10:51 p.m., the LPN stated, "...I thought to myself, how did she get that way... all the times I've taken care of her. I think she leaned over because she became sick to throw up in the trash can. That's what she would do when she was on 100 Hall when I took care of her..." As LPN #1 demonstrated how Resident #14 was found and positioned in bed, she stated the head of the bed had been elevated to a 45 degree angle. There was a gap of 5 inches observed from the mattress to the bottom side rail. As LPN #1 positioned herself in the bed, there was an 8 inch gap when the LPN's body pressed down on the mattress.</p> <p>n. On 4/25/06 at 2:00 p.m., LPN #3 was interviewed at the Nurses' Station. The LPN was asked if Resident #14's side rails were used as a restraint. She stated she didn't think so. She was asked if the resident could move herself in the bed. She stated, "Oh yeah." She was asked if the resident could get out of bed if the side rails</p>	F 323			

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F 323	<p>Continued From page 48</p> <p>were down. She stated, "Yes, but not safely. She could roll out of the bed if she wanted to." At 2:40 p.m., LPN #3 was asked when Resident #14 returned from the hospital on 4/12/06 if a side rail assessment had been done and if the gap between the side rail and the mattress had been assessed. She stated, "No. I just pulled the side rail up. I didn't measure." The facility's side rail policy was shown to LPN #3 at this time and she was asked if she had ever seen the policy and procedure. She stated, "No... if I've been shown that, it was when I first started." She was asked if anyone had ever told her to check the gap when a resident used side rails. She stated, "No." She was asked who determined whether side rails were a restraint. She stated, "The nurse who does the assessments." She also stated, "We were told that side rails require a physician's order, but we didn't know that until after the fact."</p> <p>o. On 4/25/06 at 1:06 p.m., Maintenance Supervisor was asked if the facility had a policy and procedure for the side rails to be checked on a routine basis. He stated, "No. I go through the halls each day. If I see one, then I'll do something about it. I don't go everyday to check. It's a hit and miss kinda thing..." He also stated the gap in Resident #14's side rail was not identified until after the resident was found trapped between the rail and the mattress.</p> <p>p. On 4/25/06 at 4:00 p.m., LPN #2 (the MDS Coordinator) stated she was supposed to do the side rail assessments on every resident on admission. She was asked if she assessed or measured the side rails prior to using them on a resident. She stated, "I've never done that... I assess to see if the resident uses them to help turn... I was told that there can't be more than a 2</p>	F 323			

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F 323	<p>Continued From page 49</p> <p>inch gap between the mattress and the side rail..." She stated the side rail assessment should trigger us to do a pre-restraining assessment.</p> <p>q. On 4/26/06 at 9:50 a.m., the Interim Director of Nursing (DON) was asked if she measured the space or gap between the mattress and side rails when she completed a side rail assessment. She stated, "...I never knew it was an issue." She indicated she was unaware of the restraint policy and procedure regarding the side rail usage and the appropriate assessment of the space between the mattress and the side rails to prevent entrapment.</p> <p>3. Resident #7 had diagnoses of Congestive Heart failure, Chronic Airway Obstruction and Dementia. The MDS dated 4/6/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, required extensive assistance from staff for bed mobility and transfers, experienced shortness of breath and inability to lie flat due to shortness of breath and had side rails in use daily.</p> <p>a. On 4/26/06 at 2:50 p.m., the resident was in bed with both side rails up. There was no padding on the side rails. There was a gap at the top left side of the bed which measured approximately 4.5 inches between the mattress and side rail. At 2:55 p.m., the DON was asked to come to the resident's room. After the DON observed the resident in bed and the gap between the mattress and side rail, the DON sent a staff member to get the Administrator. The DON stated, "I didn't want to leave him alone. We're going to take care of this."</p> <p>b. On 4/26/06 at 3:15 p.m., the Administrator</p>	F 323			

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F 323	Continued From page 50 stated, "This is the type of bed rails we got rid of." The Administrator was asked if this was the same type of side rail that had been on Resident #14's bed. The Administrator stated, "Yes and this one has been put on upside-down."  4. The immediate jeopardy was removed and the scope/severity reduced to "G" on 4/26/06 at 2:25 p.m. when the following plan of removal was implemented:  1.) All residents with siderails will be reassessed beginning 2:00 p.m. on April 26, 2006 for the need, safety and type of siderails by DON/Designee to be completed by 10:00 p.m. on April 26, 2006. (Any siderails identified to be a hazard will be replaced immediately).  2.) Nursing staff will be inserviced on the appropriate use of siderails to include safety and any hazards created by the use of the siderails. Nursing staff will be inserviced on the appropriate procedure to assess residents for the need, safety and type of siderails to be used by DON/Designee by 3:00 p.m. on April 27, 2006.  3.) All siderails will be assessed quarterly, on admission/readmission, and change of condition or as needed on an ongoing basis to determine any potential hazards pertaining to the use of siderails by the DON/Designee.  4.) DON/ADON [Assistant Director of Nursing] to ensure ongoing compliance with this plan of correction by monitoring daily on start up x [times] 1 month, then weekly x 3 months, then monthly x 6 months.	F 323			
F 328	483.25(k) SPECIAL NEEDS	F 328			

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F 328 SS=E	<p>Continued From page 51</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure sterile technique was maintained during tracheostomy care and nursing staff were trained to competently provide tracheostomy care for 1 of 1 case mix resident with a tracheostomy (Resident #16). The failed practice had the potential to affect only this resident, as documented on the facility's Resident Census and Conditions of Residents form dated 4/25/06. The facility also failed to ensure oxygen tubing was maintained in clean and sanitary condition for 2 (Residents #7 and #16) of 3 case mix residents who received oxygen therapy (Residents #7, #16 and #17). The failed practice had the potential to affect 7 residents who received oxygen therapy, as documented on a list provided by the Nurse Consultant on 4/28/06 at 2:40 p.m. The findings are:</p> <p>1. Resident #16 had diagnoses of Chronic Bronchitis, Chronic Airway Obstruction and</p>	F 328			

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F 328	<p>Continued From page 52</p> <p>Transient Cerebral Ischemia. The Minimum Data Set (MDS) dated 2/24/06 documented the resident was independent in cognitive skills for daily decision-making and required tracheostomy care.</p> <p>a. A physician order dated 4/14/06 documented: "Trach [tracheostomy] Care BID [twice daily] and prn [as needed]."</p> <p>b. On 4/27/06 at 2:50 p.m., Licensed Practical Nurses (LPN's) #1 and #8 set up supplies to provide tracheostomy care to the resident. LPN #1 opened the tracheostomy kit and spread the sterile paper cloth on the table, then set the kit on the right corner of the cloth, which contaminated that section of the cloth. The LPN donned sterile gloves then contaminated them by picking up a bottle of hydrogen peroxide. The resident asked, "Have you ever done this before?" The LPN stated, "I have watched it done a couple of times, but I haven't actually done it before. Are you going to be all right with this?" The resident stated, "It's okay." The LPN removed the inner cannula from the resident's tracheostomy and placed it into the container of peroxide. Instead of immediately cleansing, rinsing and replacing the inner cannula, the LPN moistened a gauze pad with the remaining hydrogen peroxide and cleaned the outside surface of the tracheostomy and the skin below the trach collar, further contaminating the sterile gloves. The LPN rinsed the areas with normal saline applied to another gauze pad. Without changing gloves, the LPN removed the inner cannula from the hydrogen peroxide and cleaned and rinsed the inner cannula with normal saline. The LPN dried the outer surface of the inner cannula with gauze and inserted the inner cannula into the tracheal</p>	F 328			

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F 328	<p>Continued From page 53</p> <p>stoma, but did not lock the cannula in place. The resident reached up and locked the inner cannula in place. LPN's #1 and #8 then discussed how to put on the trach ties, reading the instructions on the packet. LPN #8 stated, "Oh [Resident #16] can help if we need it."</p> <p>c. The Policy and Procedure titled "Tracheostomy Care," provided by the Nurse Consultant on 4/28/06 at 2:40 p.m., documented: "...Use sterile technique when suctioning the tracheostomy tube or cleaning the inner cannula... Open the sterile tracheostomy kit... Aseptically open the 3 4x4 gauze packages... Pour saline on one, peroxide on the second, and leave the third dry... Unwrap the basin and small brush from the dressing kit... Pour peroxide into the basin... Aseptically drop brush in basin... Apply sterile gloves. The dominant hand will remain sterile... With non-dominant hand, remove the oxygen source. Then unlock and remove inner cannula... Drop cannula into the basin containing peroxide and the brush... Place tracheostomy collar, T-tube or oxygen source over the outer cannula... Quickly clean the inside and outside of the inner cannula with brush... With sterile gloved hand hold the cannula over the basin. Pour saline over the cannula to remove hydrogen peroxide... Replace inner cannula and lock in place... Using sterile (dominant) hand, clean the outer cannula and stoma under the faceplate with peroxide-soaked 4x4 gauze pads and cotton swabs..."</p> <p>2. Resident #7 had diagnoses of Congestive Heart Failure and Chronic Airway Obstruction. The Minimum Data Set dated 4/6/06 documented the resident was moderately impaired in cognitive skills for daily decision-making and received</p>	F 328			

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F 328	<p>Continued From page 54 oxygen therapy.</p> <p>a. A physician order dated 12/20/05 documented: "O2 [oxygen] @ [at] 2-3L/min [2 to 3 liters per minute] per N/C [nasal cannula] if pulse ox [oximeter] below 90%."</p> <p>b. On 4/25/06 at 12:40 p.m., the resident was in bed with oxygen at 2 liters per minute via nasal cannula.</p> <p>c. On 4/25/06 at 4:27 p.m., Certified Nursing Assistant (CNA) #5 rolled the resident's oxygen tubing into a circular coil and placed the tubing on the oxygen concentrator without bagging or covering the tubing to prevent potential contamination.</p> <p>d. On 4/26/06 at 2:50 p.m., the resident was in bed with both siderails up. The oxygen tubing was coiled on the oxygen concentrator and was not bagged or covered to prevent contamination.</p> <p>e. On 4/26/06 at 4:00 p.m., CNA #6 was asked, "What type of training have you had on handling the oxygen and tubing for a resident who is on oxygen therapy?" The CNA stated, "I don't think we've had any training on oxygen. I guess we just know to take the tubing off and put it back on."</p> <p>f. On 4/26/06 at 4:05 p.m., CNA #5 was asked, "What training have you had on handling the oxygen and tubing for a resident who is on oxygen therapy?" The CNA stated, "I haven't actually had any training since I've been here." The Surveyor asked, "Could you tell me what you would do for a resident who is on oxygen therapy and needs to get out of bed and go to the dining</p>	F 328			

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F 328	Continued From page 55 room for a meal." The CNA stated, "I'd remove the tubing, wrap it up and place it in the handle to keep it from falling on the floor and turn it off." The Surveyor asked the CNA, "Are you saying that you would turn the oxygen concentrator off." The CNA stated, "Yes."	F 328			
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by:  Based on observation of the 8:00 a.m. and 12:00 p.m. medication passes on 4/27/06, record review and interview, the facility failed to ensure the medication error rate was less than 5%. Physician orders were not followed for 2 (Residents #25 and #26) of 10 residents observed during the medication passes, which resulted in medication errors. Medication errors were made by 2 Licensed Practical Nurses (LPN's) of 4 nurses who administered medications in the facility. The failed practice had the potential to affect 51 residents who resided on Halls 100 and 400, as documented on the facility's Roster/Sample Matrix dated 4/24/06 at 10:20 a.m. The medication error rate was 9.80%, based on observation of 50 medications administered, 1 medication ordered but not administered and a total of 5 errors detected. The findings are:  1. Resident #25 had a physician order dated 3/13/06 for Pantanol Ophthalmic Solution 0.1% 1 drop in both eyes twice daily and Systane	F 332			

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F 332	<p>Continued From page 56</p> <p>Ophthalmic drops 0.3 - 0.4% 2 drops in both eyes four times daily.</p> <p>a. On 4/27/06 at 8:34 a.m., LPN #8 entered the resident's room for the 8:00 a.m. medication pass. The LPN stated, "The residents can tell you that you need to wait 2 minutes between [eye] drops." At 8:35 a.m., LPN #8 administered Pantanol Ophthalmic Solution 0.1% 1 drop in both eyes. At 8:37 a.m., the LPN administered Systane Ophthalmic drops, 1 drop in both eyes. At 8:39 a.m., the LPN administered Systane Ophthalmic 1 drop in both eyes. This resulted in two medications errors.</p> <p>b. On 4/27/06 at 8:45 p.m., LPN #8 was asked how long she waited between the eye drops administered to Resident #25. The LPN stated, "Wait 2 minutes between each drop."</p> <p>c. The Centers for Medicare &amp; Medicaid Services (CMS) Interpretive Guidelines at F332 documented: "...Medications instilled into the eye: The drop must contact the eye for a sufficient period of time before the next eye drop is instilled. The time for optimal eye drop absorption is approximately 3 to 5 minutes.</p> <p>2. Resident #25 had a physician order dated 3/13/06 for Artificial Tears 1 drop in each eye 3 times daily.</p> <p>a. On 4/27/06 at 8:43 a.m., LPN #8 administered Artificial Tears 1 drop in each eye. The LPN waited 2 minutes, then administered a second drop of Artificial Tears in each eye.</p> <p>b. On 4/27/06 at 9:45 a.m., LPN #8 was asked how many drops of Artificial Tears had been</p>	F 332			

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F 332	Continued From page 57 administered to the resident. The LPN stated, "I gave 2 drops of the Artificial Tears."  3. Resident #26 had a physician order dated 3/29/06 for Simethicone tablets 125 milligrams (mg) by mouth three times a day after meals.  a. On 4/27/06 at 8:46 a.m., LPN #1 administered Simethicone 80 mg, instead of 125 mg as ordered by the physician.  b. On 4/27/06 at 10:10 a.m., LPN #1 stated, "The MAR [Medication Administration Record] says Phazyme. I just did not look at the strength."  4. Resident #26 had a physician order dated 4/4/06 for Multivitamin with minerals, 1 tablet by mouth daily.  a. The April 2006 MAR documented the multivitamin with minerals was to be administered at 8:00 a.m. daily.  b. On 4/27/06 at 8:46 a.m., LPN #1 administered the resident's 8:00 a.m. medications. The LPN failed to administer the multivitamin with minerals to the resident.	F 332			
F 372 SS=C	483.35(i)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by:  Based on observation, the facility failed to ensure garbage was properly contained within the	F 372			

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F 372	Continued From page 58 dumpsters to prevent potential pest infestation. The failed practice had the potential to affect all 101 residents, as documented on the facility's Resident Census and Conditions of Residents form dated 4/25/06. The findings are:  1. On 4/25/06 at 10:00 a.m., 2 trash dumpsters had partially closed bags of trash that extended above the top rim of the dumpsters. Large black birds were flying in and out of the dumpsters with particles of trash in their beaks. Trash was scattered around each dumpster. Water was standing between the dumpsters and there were flies swarming around the area.  2. On 4/27/06 at 8:40 a.m., the two dumpsters were uncovered. Lids were missing from 4 spaces on the second dumpster and 2 spaces on the first. Bags of trash were exposed and improperly tied. Used gloves, milk cartons, one soda bottle, a bag of garbage, debris and trash were on the ground around the dumpsters. One large white pool of a liquid substance, approximately 4 feet in diameter extended between the 2 dumpsters on the ground as flies landed on the spills and debris around both dumpsters. Brown spills were on the ground in front of the dumpsters.  3. On 4/27/06 at 10:00 a.m., one dumpster was missing the lid from the top of the dumpster. Cans, plastic gloves, bottles and paper were on the ground around the dumpsters. Garbage bags inside the open dumpster were exposed and flies were swarming around this area. A pool of dirty water stood between the 2 dumpsters.	F 372			
F 441 SS=E	483.65(a) INFECTION CONTROL	F 441			

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F 441	<p>Continued From page 59</p> <p>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure ice was passed in a manner to prevent the potential spread of infection to residents on the 200 Hall. The facility also failed to ensure medication was prepared for administration in a sanitary manner. The failed practices had the potential to affect 30 residents who resided on the 200 Hall and 25 residents who received medications from Licensed Practical Nurse (LPN) #1, as identified by the facility on 4/25/06. The findings are:</p> <p>1. The facility's policy titled, "Ice Machines and Ice Storage Chests" documented: "Methods of Contamination: 1. Ice-making machines, ice storage chest/containers, and ice can all become contaminated by: ...Unsanitary manipulations by employees, residents, and visitors... Improper storage or handling of ice... Preventing Contamination: ...Wash hands before obtaining ice... Keep the ice scoop on a clean, hard surface when not in use... If another receptacle such as a small chest or bin is used to transport ice from the</p>	F 441			

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F 441	<p>Continued From page 60</p> <p>source to another point of distribution, follow the same steps as above..."</p> <p>2. On 4/24/06 at 11:40 p.m., Certified Nursing Assistant (CNA) #3 entered Room #209 with gloves on, picked up the water pitcher from Bed A, emptied the pitcher in the bathroom and went to the ice chest in the hallway. The CNA lifted the ice chest lid, picked up the ice scoop from inside the ice chest, filled the pitcher, dropped the ice scoop back inside the ice chest and took the pitcher back to Bed A.</p> <p>a. On 4/24/06 from 11:41 a.m. to 11:45 a.m., the CNA repeated the above procedure for 4 other residents. The CNA did not change gloves at any time as she picked up the ice scoop with her contaminated gloves and dropped the scoop back into the ice each time.</p> <p>b. On 4/24/06 at 11:48 a.m., CNA #3 was asked, "When should you wash your hands?" The CNA stated, "Every time you deal with someone or their things." The CNA was asked, "Do you think you should wash your hands between changing water pitchers." The CNA stated, "Yes, but since I'm wearing gloves, I'm protected and I don't need to." When asked what about protecting the residents, the CNA stated, "I guess I should have changed the gloves." When asked where the ice scoop should be kept when not in use, the CNA stated, "In a plastic bag on the ice cart."</p> <p>3. On 4/27/06 at 8:04 a.m., Licensed Practical Nurse (LPN) #1 prepared a Colace 100 milligram capsule for administration to Resident #8 by cutting the capsule open with scissors that she removed from her pocket. The LPN did not clean the scissors before or after the capsule was cut.</p>	F 441			

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F 514 F 514 SS=B	Continued From page 61 483.75(l)(1) CLINICAL RECORDS  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interview the facility failed to ensure intake and output records were accurate and complete for 5 (Residents #4, #6, #7, #13 and #17) of 6 case mix residents who had urinary catheters and/or feeding tubes (Residents #4, #6, #7, #13, #17 and #18). The failed practice had the potential to affect 8 residents with catheters, as documented on the Resident Census and Conditions of Residents form dated 4/25/06 and 6 residents with feeding tubes, as documented on a list provided by the Nurse Consultant on 4/28/06 at 2:40 p.m. The findings are:  1. Resident #6 had diagnoses of Brain Laceration, Urinary Retention and Congestive Heart Failure. The Annual Minimum Data Set (MDS) dated 3/17/06 documented the resident was severely impaired in cognitive skills for daily decision-making, had an indwelling suprapubic	F 514 F 514			

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F 514	<p>Continued From page 62</p> <p>catheter and a feeding tube and required intake/output monitoring.</p> <p>a. A physician order dated 3/1/06 documented: "Diabetisource to run 16 HRS [hours] @ [at] 125 cc/HR [cubic centimeters per hour] via pump to provide 2016 KC [kilocalories] per day."</p> <p>b. The Care Plan dated 3/18/06 documented: "...At risk for complication r/t [related to] to G-tube [Gastrostomy Tube]... Approaches - Observe intake of feeding and record amount. Report any significant fluid balance discrepancy to M.D. [Medical Doctor]."</p> <p>c. The Intake and Output Summaries for February through April 2006 were reviewed. There were 30 shifts in February with no intake recorded, 22 shifts in March with no intake recorded and 21 shifts in April with no intake recorded. There were only 3 shifts in February when output was documented, 7 shifts in March and no shifts in April had documentation of output.</p> <p>2. Resident #17 had diagnoses of Congestive Heart Failure, Acute Respiratory Failure and Musculoskeletal Disorder. The Minimum Data Set (MDS) dated 3/29/06 documented the resident was severely impaired in cognitive skills for daily decision-making and had an indwelling catheter.</p> <p>As of 4/28/06, there was no Intake and Output Summary available for review in the resident's clinical record. The Activities of Daily Living (ADL) Flow Records for March and April 2006 were reviewed. There were 56 shifts in March with no documentation of catheter output and 67</p>	F 514		

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F 514	<p>Continued From page 63</p> <p>shifts in April with no documentation of catheter output.</p> <p>3. Resident #7 had diagnoses of Congestive Heart Failure, Impaired Renal Function and Gastrostomy Status. The MDS dated 4/6/06 documented the resident was moderately impaired in cognitive skills for daily decision-making and did not have a urinary catheter.</p> <p>a. On 4/24/06 at 9:35 p.m. during the initial tour of the facility, Certified Nursing Assistant (CNA) #16 stated the resident had an indwelling urinary catheter.</p> <p>b. On 4/28/06 at 11:00 a.m., the ADL Flow Record was reviewed. There were 39 shifts from 4/1/06 through 4/27/06 that had no output recorded.</p> <p>c. On 4/28/06 at 11:00 a.m., Licensed Practical Nurse (LPN) #9 was asked, "Do you have the output record for [Resident #7]? LPN #9 stated, "I don't have them." When asked, "Where do you usually record the output from the Foley catheter?," the LPN stated, "Its usually on the MAR [Medication Administration Record] but they're not here."</p> <p>4. Resident #4 had diagnoses of Gastrostomy Status and Impaired Renal Function. The MDS dated 3/24/06 documented the resident was moderately impaired in cognitive skills for daily decision-making and had a feeding tube.</p> <p>On 4/28/06 at 11:00 a.m., the April 2006 Intake and Output Summary was reviewed. There was no documentation of intake and output on 41</p>	F 514			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045147</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/28/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>MORRILTON HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 BROOKRIDGE LANE</b> <b>MORRILTON, AR 72110</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 64 shifts so far that month.</p> <p>5. Resident #13 had diagnoses of Cerebral Palsy, Urinary Tract Disorder and Persistent Vegetative State. The Quarterly Minimum Data Set (MDS) dated 3/8/06 documented the resident was severely impaired in cognitive skills for daily decision-making and had an indwelling catheter and a feeding tube.</p> <p>a. A physician order dated 1/14/06 documented: "H2O [water] flushes 280 cc [cubic centimeters] GT [Gastrostomy Tube] Q [every] 4 hrs [hours]."</p> <p>b. A physician order dated 3/1/06 documented: "Fibersource HN to run at 60 cc/hr [cubic centimeters per hour] via pump cont [continuous] over 23 hours..."</p> <p>c. The April 2006 Intake and Output Summary had no documentation of intake for 29 of 75 shifts and no documentation of output for 67 of 75 shifts.</p> <p>d. On 4/28/06 at 8:30 a.m., the Director of Nursing (DON) was asked to review the Intake and Output Summary. The DON stated, "It's incomplete. It should be filled out every shift."</p> <p>6. The facility's Policy and Procedure titled, "Intake, Measuring and Recording," provided by the Nurse Consultant on 4/28/06 at 2:40 p.m., documented: "...Verify that there is a physician's order for this procedure and/or that the procedure is being performed per facility policy... Review the resident care plan to assess for any special needs of the resident... At the end of your shift, total amounts of all liquids the resident consumed... Record all fluid intake and output in cubic centimeters..."</p>	F 514			