

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

PRINTED: 10/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2008
NAME OF PROVIDER OR SUPPLIER OZARK HEALTH NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 HIGHWAY 65 SOUTH CLINTON, AR 72031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 157 SS=E	<p>Complaint #13933 Substantiated (all or in part) with deficiencies cited at F157, F167, F221, FF241, F314, F323, F329, F428, and F514.</p> <p>483.10(b)(11) NOTIFICATION OF CHANGES</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 157			

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 157	<p>Continued From page 1</p> <p>by:</p> <p>Complaint #13933 was substantiated (all or in part) with these findings:</p> <p>Based on record review and interview the facility failed to ensure that the physician was consulted when a medication that had been ordered was unavailable for 1 (Resident #21) of 4 case mix resident's (Resident's #1, #18, #21, and #26) who had physician orders for antibiotic therapy. This failed practice had the potential to affect 7 resident's in the facility who were taking antibiotics in July as documented in the July 2008 infection control log received from the Secretary to the Administrator on /22/08 at 2:00 p.m.. The finding are:</p> <p>1. Resident #21 had diagnoses of Bipolar Disorder, and Alzheimer's Disease. This was a closed record.</p> <p>a. A Physician's order dated 6/27/08 documented "Penicillin G 4,000,000 units IM (Intramuscular) QID (four times a day) X (times) 7 days Dx (Diagnosis) UTI start when available. Bactrim DS 1 PO (by mouth) BID (twice a day) X (times) 10 days start when available Dx (Diagnosis) UTI".</p> <p>b. As of 9/23/08 the clinical record had no documentation of this drug being given. A Facsimile dated 6/27/08 at 4:35 p.m., was obtained from a local pharmacy of an attempt by the LPN (Licensed Practical Nurse) to order the drug.</p> <p>c. Nurses Notes dated 7/1/08 at 11:15 a.m. documented, "This nurse was asked by [Name] APN (Advanced Practiced Nurse) to track down what happened c (with) Penicillin 4,000,000 units</p>	F 157			

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F 157	Continued From page 2 IM (Intramuscular). This nurse called all Pharmacies in county and also our Medicare Pharmacy PSI none carry Penicillin IM will be couple of weeks before they can get it." d. On 9/23/08 at 1:05 p.m., APN stated that 7/1/08 was the first time she was aware the resident had not received the medication. e. The original order for the medication was dated 6/27/08, ordered per Advanced Practice Nurse. The medication had not been obtained by 7/1/08 when the APN made rounds and due to the decrease in status the resident was admitted to the hospital. As of 9/23/08 there was no documentation found in the clinical record that the APN or Physician was consulted about the inability to obtain the Penicillin drug. f. A Nurses Note dated 7/1/08 time 1500 (3:00 p.m.), documented, " Resident admitted to [name of hospital] for pneumonia and possible sepsis. "	F 157			
F 167 SS=B	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by:	F 167			

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F 167	Continued From page 3 Complaint #13933 was substantiated (all or in part) with these findings: Based on observation and interview the facility failed to ensure survey results were available for examination and readily accessible to residents This failed practice had the potential to affect 12 residents residing in the facility wearing Wanderguard devices according to a list provided by the DON on 9/19/08. The findings are: 1. On 9/22/08 at 5:00 p.m., the notebook containing the most recent survey of the facility and any plan of correction was located on the wall near the door to the office. This location was in an area where the 12 residents wearing Wanderguard devices could not enter without setting off an alarm and limited their access to the information without asking for assistance. 2. On 9/22/08 at 5:00 p.m., the DON was asked if the book was accessible to all residents in the nursing home. The DON acknowledged the residents wearing Wanderguard devices did not have access to the information unless someone brought it to them.	F 167			
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS 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. This REQUIREMENT is not met as evidenced by: Complaint #13933 was substantiated (all or in part) with these findings:	F 221			

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F 221	Continued From page 4 Based on observation, record review, and interview the facility failed to ensure that a physician order, consent, and assessment was completed before using a self release seat belt as a restraining device for 1(Resident #5) of 1case mix residents who had a self release belt. This failed practice had the potential to affect 3 residents in the facility that had self release seat belts as documented by a list provided by the Director of Nursing on 9/19/08. The findings are : 1. Resident # 5 had a diagnosis of Alzheimer's Disease. The significant Minimum Data Set documented the resident had short and long term memory problems, had severely impaired cognitive skills for daily decision making, and used a trunk restraint daily. a. On 9/16/08 at 10:05 a.m., and 3:10 p.m., on 9/17/08 at 9:30 a.m., and 3:40 p.m., and on 9/18/08 at 3:40 p.m. the resident was observed sitting in a wheelchair with a seat belt on. b. On 9/18/08 at 10:00 a.m., Licensed Practical Nurse (LPN) #2 asked the resident to "undo" the belt. The resident was not able to release the belt. The resident stated that she couldn't release the seat belt. LPN # 2 stated, "Don't have a consent for it because it is a self release seat belt." There was no order, consent ,or assessment for the seat belt observed in the resident's clinical record.	F 221			
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241			

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F 241	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # 13933 was substantiated (all or in part) with these findings:</p> <p>Based on interview and record review the facility failed to ensure that staff spoke to residents respectfully and/or did not yell at residents for 2 (Resident # 18 and # 35) of 2 (Resident # 18 and#35) case mix residents that had made accusations of verbal abuse. The failed practice had the potential to affect all 100 residents as documented on the Resident Census and Conditions of Residents form dated 9/17/08. The findings are:</p> <p>1. Resident # 35 had diagnoses of Debility and Myocardial Infarction. The Quarterly Minimum Data Set (MDS) dated 8/15/08 documented the resident had no short or long term memory problems and had moderately impaired cognitive skills for daily decision making.</p> <p>a. On 9/24/08 at 5:15 p.m., Licensed Practical Nurse (LPN) #1 was asked if [Resident #35] had ever told her of someone telling her not to use the call light. LPN #1 stated, "[Resident #35] told me that someone had really hurt her feelings. She was balling for 2 hours. [Resident #35] said I got on my call light during a fire alarm and someone came into the room, and was rude. I told the charge nurse and called the (Director of Nursing). The (Director of Nursing) told me to call the (Social Worker)."</p> <p>1). On 9/24/08 at 5:30 p.m., the resident was observed in bed. The resident's daughter was also in the room at the time. The resident stated," A young lady came in and told me they were</p>	F 241			

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F 241	<p>Continued From page 6</p> <p>having a tornado drill. After so long of time then there was something I couldn't reach, so I used the call light. This nurse talked terrible. Made me angry." The daughter stated, "[LPN # 3] did most of the talking."</p> <p>b. On 9/24/08 at 11:45 a.m., the Director of Nursing was asked if there was a complaint report that was signed by the Administrator that hasn't been worked yet. The Director of Nursing stated, "We found one in [previous Social Worker] desk this morning that the Administrator had initialed but hadn't been worked yet."</p> <p>d. On 9/25/08 at 1:35 p.m., the DON presented typed document dated August (Aug.) 27, 2008 Regarding (Re.) [Resident # 35] that documented, "[LPN #1] reported about 4 p.m. 8/27/08 that [Resident #35] was crying and upset over an incident Tuesday night. I went to [Resident #35's] room and asked about it. [Resident # 35] said sometime after supper, the facility had a tornado drill. [Resident #35] said she thought the drill was over, so she put on her call light for someone to come get her supper tray. She said a nurse came in and was "really mad." She said the nurse asked her, "Why did you put on that call light during a drill? Do you think that it [is] more important than finishing this drill? ... [Resident # 35] said she believes the nurse's name is [LPN #3]. ... [Resident # 35] cried for about an hour after the incident." The report was signed by the [previous Social Worker] and dated 8/27/08. There were initials observed at the bottom of the page.</p> <p>e. On 9/26/08 at 8:30 a.m. the DON stated that yesterday she asked both of the nurses that were on [Resident # 35's] hall to write a report about</p>	F 241			

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F 241	Continued From page 7 the incident. The DON was then asked if this was the first action taken concerning the incident. The DON responded that it was the first action taken. 2. Resident # 18 had diagnoses of Anxiety and Depression. The Quarterly MDS documented the resident had no short or long term memory problems and had moderately impaired cognitive skills for daily decision making. a. On 9/18/08 at 11:20 a.m., the resident was interviewed. The resident stated that about 4 weeks ago LPN # 4 had yelled at her and told her, "You don't do nothing right." The Administrator was notified of this interview by the surveyor on 9/18/08 at 12:50 p.m. b. On 9/24/08 at 3:30 p.m., the resident was interviewed again. The resident stated that [LPN #4] had accused the resident of lying. The Resident also stated, "Next day I went to [Director of Nurse's] office. I started crying. [The Director of Nursing] asked me if I wanted LPN #4 as a nurse anymore. I said no." c. On 9/25/08 at 12:10 p.m., the Director of Nursing was asked if LPN # 4 had been monitored with interactions with other residents. The Director of Nursing stated, "I haven't purposely monitored LPN #4 with other residents." The Director of Nursing was asked if any other residents had been interviewed about LPN #4. The Director of Nursing stated, "No other residents had been interviewed." The Director of Nursing was asked if any other staff had been interviewed about LPN #4. The Director of Nursing stated, "No other staff had been interviewed."	F 241			
F 312	483.25(a)(3) ACTIVITIES OF DAILY LIVING	F 312			

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F 312 SS=E	Continued From page 8 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 the penis and mons pubis was cleansed when providing incontinent care, the anal area was not cleansed using a back to front motion and a clean incontinent brief was used after incontinent care had been provided for 1 (Resident #2) of 7 (Resident #2, #3, #5, #8, #20, #25, and #26) case mix residents that were incontinent and resided on the 800 Hall, failed to ensure that incontinent care and/or toileting was provided at least every two hours and cleansed the mons pubis, labia, buttocks, and thighs when providing incontinent care for 2 (Resident #6 and #24) of 5 (Resident #4, #6, #10, #24 and #36) case mix residents that were incontinent and resided on the Purple Hall, and failed to ensure that nail care was performed for 2 (Resident # 9 and #12) of 8 (Resident # 3, #4, #9, #12, #17, #18, #20, and #36) case mix residents that received diabetic nail care from a Registered Nurse or a Licensed Practical Nurse. The failed practices had the potential to affect 29 residents that were incontinent and resided on the 800 Hall and Purple Hall and 18 residents in the facility that received diabetic nail care by a Registered Nurse or a Licensed Practical Nurse, as documented on lists provided by the Director of Nursing on 9/19/08 at 2:30 p.m. The findings are:	F 312			

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F 312	Continued From page 9 1. Resident # 2 had diagnoses of Alzheimer's Disease and Dementia With Behavior. The Quarterly Minimum Data Set (MDS) dated 7/11/08 documented the resident had severely impaired cognitive skills for daily decision making, was frequently incontinent bowel, and frequently incontinent urine and required limited assistance of 1 person with personal hygiene. a. The Resident Plan of Care dated reviewed 7/9/08 documented, "At risk for pressure areas secondary to incontinence of bowel and bladder" and "keep skin clean and dry." b. On 9/17/08 at 3:05 p.m. the resident was sitting on the side of the bed without any pants on. The resident was wearing a brief. Certified Nursing Assistant (CNA) #1 entered the room and stated that the resident's sweat pants had a "smear of BM (bowel movement) on them." The CNA cleansed the resident's rectal and buttock area. The CNA first cleansed the areas wiping from front to back, then cleansed the areas from back to front. The CNA did not cleanse the penis or front of the resident. The CNA then found a brief in the resident's bathroom trash can. The CNA took the brief out of the trash can and stated, "It is a little bit wet. He just took it off to use the bathroom." 2. Resident # 12 had a diagnosis of Diabetes Mellitus. The Quarterly MDS dated 7/31/08 documented the resident had moderately impaired cognitive skills for daily decision making and was totally dependent for personal hygiene. a. A Physician's Order dated 5/29/08 documented for Diabetic nail care every (Q) week	F 312			

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F 312	Continued From page 10 by Licensed Practical Nurse (LPN) / Registered Nurse (RN). b. On 9/16/08 at 12:05 p.m., the resident's fingernails were long, and ragged extending approximately 1/4 inch past the end of the finger pads. c. On 9/18/08 at 8:30 a.m., the resident's fingernails were long, ragged and had a brown substance under the nail extending approximately 1/4 inch past the end of the finger pads. 3. Resident #9 had diagnoses of Non-Insulin Dependent Diabetes Mellitus, and Vascular Dementia. The Significant Change MDS dated 6/18/08 documented the resident was severely impaired in cognitive skills for daily decision making, was dependent on staff for activities of daily living, and had partial loss of her hands due to contractures a. On 9/16/08 at 9:44 a.m. and 12:50 p.m., and on 9/17/08 at 8:30 a.m., the resident fingernails were rough, jagged, thick, unkept and extended approximately 1/8th inch beyond the end of her finger pads. 4. Resident #6 had diagnoses of Alzheimer's Dementia with Behavior Problems, Recent Fall with Injury, and Hip Fracture. The Annual MDS dated 6/20/08 documented the resident had severely impaired cognitive skills for daily decision-making, required extensive assistance with one to two persons for bed mobility, transfers, and toileting, had inadequate control of bladder and bowels with multiple daily episodes all or most of the time and required extensive assistance and require extensive assistance of	F 312			

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F 312	Continued From page 11 one person for personal hygiene. a. The Plan of Care dated 6/20/08 documented, "Provide incontinent care following each episode. Keep [resident's name] clean, dry and odor free. Maintain dignity." b. On 9/18/08 at 2:30 p.m., the resident was taken in her wheelchair to the toilet in her room by CNA #2. CNA #2 applied a gait belt, assisted the resident to hold onto the hand rails and raised the resident to a standing position. CNA #2 then pulled the resident's incontinent brief (dated and timed 9/18/08, 9:30 a.m.) and pants down to just above the resident's knees. The incontinent brief was dark yellow, heavily saturated, and there was an area approximately 6 inches in diameter of dark brown feces in the center. The CNA assisted the resident to sit onto the commode, and then removed the soiled brief. The resident urinated and had a bowel movement. When the resident was ready to get off the commode she patted the seat of the wheel chair with her left hand. The CNA then lifted the resident, who was holding onto the hand rail, to a standing/leaning position in which the CNA was holding much of the resident's weight and wiped the resident's rectal area with disposable wipes. The CNA wiped until the wipes came back with no feces on the paper and then set the resident back down onto the commode. A clean incontinent brief was positioned between the residents knees and the tabs were affixed to the sides. The resident was again assisted to a leaning/standing position in which the CNA was supporting most of the resident's weight while the CNA pulled up the incontinent brief. The CNA was unable to safely manipulate the resident using a pivot transfer back into the wheelchair and pulled the	F 312			

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F 312	Continued From page 12 emergency cord in the bathroom and requested assistance from another CNA. Two CNA's assisted the resident to a standing position, pulled up the sweat pants the residents had been wearing before she was toileted and sat her down into the wheel chair. There was a wet area approximately 6" in diameter on the posterior left leg of the pants. The resident was wheeled back into the hall and the CNA washed her hands and disposed of the soiled brief. The CNA failed to clean the resident's buttocks, inner thighs, mons pubis, and the labia. The resident was seated back into the wheel chair in urine-saturated pants. CNA #2 was asked if this resident was on a toileting program. The CNA stated, "[Resident's name] is toileted every two hours. The incontinent brief that had been removed was dated and timed, 9/18/08 , 9:30 a.m., was removed at 2:30 p.m., five hours later.	F 312		
F 314 SS=H	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Complaint #13933 was substantiated (all or in part) with these findings:	F 314		

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F 314	Continued From page 13 Based on observation, record review and interview the facility failed to ensure that ace wraps were removed and the skin integrity assessed at least daily to prevent the potential for deterioration in skin integrity for 1 (Resident #9), whose legs were wrapped with ace bandages and was at risk for skin breakdown. The facility also failed to ensure incontinent care was provided at least every 2 hours to prevent the potential for skin breakdown for 2 (Resident #6 and #24) who had a pressure sore on the sacrum, and failed to ensure wound care was provided consistently as ordered for 3 (Residents #9, and #12 and 22) of 8 case-mix residents (Resident's #1, #4, #6, #9, 12, #22, #24, and #25) who had pressure sore treatments and 10 case mix residents (Resident's #2, #3, #5, #7, #11, #26, #27, #33, #35, and #36) at risk for pressure sores. The failed practice caused a pattern of actual harm for Resident #9 who developed a stage II pressure ulcer on the left knee, a stage III on the right knee, and deterioration in other pressure ulcers and had the potential to affect 43 residents who were at risk for pressure sores as documented on a list provided by the Director of Nursing dated 9/19/08 at 2:30 p.m. The findings are: 1. On 9/16/08 at 11:30 a.m., LPN #1, the treatment nurse, stated that the floor nurses do their own treatments on weekends and that she often finds skips on the treatment record. She further stated that sometimes the dressings were not being done because the products were still in the cart on Monday morning and the dates on the dressings that were on the resident were the same dressings she dated from the Friday before when she did the dressing change.	F 314			

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F 314	Continued From page 14 On 9/16/08 at 3:30 p.m., the Director of Nurses was interviewed. When asked if she was aware of the skips in the Treatment Record documentation the DON stated that she was aware that the weekend nurses were not getting the dressings done. The DON was asked if she knew this had been happening for a long time. The DON responded that she had looked back as far as April 2004 on another resident's treatment record and the pattern was obvious. The DON stated that they had inserviced and inserviced concerning this matter. 2. Resident #9 had diagnoses of Decubitus Ulcers and Traumatic Fractures of the Right and Left Hip. The Significant Change Minimum Data Set (MDS) dated 6/18/08 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for all activities of daily living, had an indwelling catheter, was incontinent of bowel, used Oxygen continuous, had 1 stage II and 2 stage IV pressure sores with Methicillin Resistant Staph Aureus (MRSA) in the wounds. a. Nurses Notes dated 8/10/08 at 5:30 a.m. and signed by Licensed Practical [LPN] #3 documented, " Staff requested I examine resident 'stated her leg looked crooked.' On exam I observed [right] femur appears separated. From 6 to 8 inches above [right] knee leg bends easily [and] grating can be felt. Called phys. [physician], unable to reach. Left message [and] asked for orders. Resident denies pain. Will inform day nurse of condition. Resident has history of separation of [right] femur. Will retry to reach phys." Nurses Notes at 6:30 a.m. documented, "Contacted [physician] [and] received order for	F 314			

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F 314	<p>Continued From page 15</p> <p>x-ray of [right] thigh femur. He stated he remembered previous injury [and] that [right] femur was never reattached, that it probably had formed grisile between bones, that it looked bad but not painful when it bends. Stated to get a x-ray to be sure"</p> <p>b. Nurses Notes dated 8/10/08 LE [Late Entry] at 9:00 a.m. documented, "ADON (Assistant Director of Nursing) [and] 4 CNAs (Certified Nursing Assistants) accompanied [resident] to outpt [outpatient]for x-ray. When [resident] returned nurse now received report from [physician] in radiology. [Resident] has comunating (comminuted) fx (fracture) distal femur call [and] report to [physician]. Nurse now reported to ADON [and] M. D. (medical doctor). [Physician] ordered 1) Continue pain management as ordered. 2) Consult [with] [physician] on Monday. 3) Continue to immobilize [right] leg as much as possible. 4) Call M. D. [and] notify of any [changes] in [resident's] status" Nurses Notes at 11:10 a.m. documented that the family refused the consult because the consulting physician had already told them previously that the fracture was not fixable and that all that could be done was support it with pillows.</p> <p>c. The September 2008 Physician Orders documented, "08/14/2008 Splint [right] leg with pillows [and] wrap with 6" [inch] ace bandage for transfers [and] positioning" and "08/25/2008 Cleanse [and] rinse reddened blistered areas to inner bi-lateral knees with NS (normal saline), Apply Xenaderm to areas, cover with foam pad and secondary drsg (dressing) qd (every day) until healed."</p>	F 314			

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F 314	<p>Continued From page 16</p> <p>d. The care plan updated 8/19/08 [hand written] documented, " Has [fracture] to shaft (same as 2 [years] ago) Risk of pain/complications. ... 6). Splint [right] leg [with] pillows [and] wrap [with] 6 [inch] ace bandage for transfers [and] positioning (8/14/08) ... "</p> <p>e. On 9/17/08 at 8:30 a.m., the resident received treatments per LPN #1, the treatment nurse, to multiple pressure sores:</p> <p>1) Right inner knee Stage III measuring 3.0 cm [centimeters] in length x 3.5 cm in width x 0.5 cm in depth (per Weekly Skin Report dated 9/18/08).</p> <p>2) Left inner knee Stage II measuring 3.0 cm in length x 4.0 cm in width (per Weekly Skin Report dated 9/18/08) x 0.2 cm in depth.</p> <p>LPN #1, was asked how the resident got a Stage II pressure sore on the inside of the left knee and a Stage III on the inside of the right knee. LPN #1 stated, "She [resident] had pillows between knees and on sides and they were ace wrapped because both legs were broke and [staff] never took the ace wraps off. I assumed the night shift was unwrapping them, relieving the pressure and in reality no one was. It was a week before the wraps came off and it was red [with] a fluid filled blisters and went down from there. I feel real bad about that." (The physician order for the pillows and ace wrapping was dated 8/14/08 and the treatment order for the pressure sores to both inner knees was dated 8/25/08 - a period of 11 days.)</p> <p>3) Left hip [ischium] Stage IV measuring 3.2 cm in length x 1.8 cm in width x 1.5 cm in depth with tunneling 6.0 cm at 5 o'clock and 4.2 cm at 3 and</p>	F 314		

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F 314	<p>Continued From page 17</p> <p>12 o'clock (per Weekly Skin Report dated 9/18/08). The dressings that were removed were saturated with drainage that had a foul odor. The September 2008 Treatment Administration Record did not document the daily treatment was performed on the weekend of 9/13/08 and 9/14/08. The Weekly Skin Report dated 9/12/08 documented tunneling 6.5 cm at 3 and 12 o'clock only.</p> <p>4) Right hip [ischium] Stage IV measuring 1.2 cm in length x 1.0 in width cm x 2.0 in depth with tunneling 5.5 cm. at 1 o'clock and 6.5 cm at 3 o'clock (per Weekly Skin Report dated 9/18/08). The September 2008 Treatment Administration Record did not document the daily treatment was performed on the weekend of 9/13/08 and 9/14/08.</p> <p>LPN #1 stated the resident was admitted to the facility with the pressure sores to the ischium and has had them for years.</p> <p>5) Right lower ankle Stage II measuring 1.5 cm in length x 1.0 cm in width x 0.2 cm in depth (per Weekly Skin Report dated 9/18/08) with redness 2.6 x 2.5. The September 2008 Treatment Record documented 1st treatment order dated 9/16/08.</p> <p>6) Right lower leg Stage II measuring 1.0 cm in length x 2.0 cm in width x 0.2 in depth. The September 2008 Treatment Record documented 1st treatment order dated 9/16/08.</p> <p>7) Right elbow Stage II measuring 2.4 cm in length x 1.5 cm in width x 0.2 cm in depth (per Weekly Skin Report dated 9/18/08). The September 2008 Treatment Administration</p>	F 314			

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F 314	<p>Continued From page 18</p> <p>Record did not document the daily treatment was performed on the weekend of 9/13/08 and 9/14/08. The Weekly Skin Report dated 9/12/08 documented wound measurements as 1.8 cm in length x 1.0 cm in width x 0.1 cm in depth. The Weekly Skin Report dated 8/15/08 first noted this pressure sore as Stage II measuring 1.4 cm in length x 0.8 in width cm x 0.2in depth.</p> <p>8) Right lateral back Stage III measuring 3.6 cm in length x 3.0 cm in width x 0.4 cm in depth. The September 2008 Treatment Administration Record did not document the daily treatment was performed on the weekend of 9/13/08 and 9/14/08. The Weekly Skin Report dated 9/12/08 documented wound measurements as 3.5 cm in length x 2.5 cm in width x 0.3 cm in depth. The Weekly Skin Report dated 8/1/08 first noted this pressure sore as a Stage II measuring 1.0 cm in length x 1.4 cm in width x 0.1 cm in depth.</p> <p>9) The weekly skin report dated 9/18/08 also documented a Stage II to the right top of ear as resolved.</p> <p>3. Resident #22 had diagnoses of Infectious Diarrhea and Debility. A Significant Change MDS dated 8/12/08 documented the resident had moderately impaired cognitive skills for daily decision making, and had one stage II pressure ulcer.</p> <p>a. An Interdisciplinary Narrative Note dated 7/14/08 at 2:00 p.m. documented, "Treatment (Tx) nurse reported Stage II on patient (pt) coccyx.</p> <p>b. The Weekly Skin Report dated 7/18/08 documented, "Site sacrum, stage II, size 6.0 X</p>	F 314			

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F 314	Continued From page 19 4.0, depth 0.1, odor foul, drainage moderate." c. A Physician's Telephone Order dated 7/22/08 documented, "Cleanse and rinse stage II decubitus (decub) to sacrum [with] normal saline (NS), pat dry [with] 4 X 4s, apply allanderm ointment to wound, cover with foam dressing (drsg) and secure [with] secondary dressing (drsg) twice a day (BID) until healed." d. The July 2008 Treatment Administration Record had no initials indicating that the treatment was performed on the 7p to 7a shift on 7/22/08, 7/25/08, 7/30/08, and 7/31/08. e. The Weekly Skin Report dated 7/25/08, 8/1/08, and 8/8/08 documented, "Odor foul." f. A Wound Clinic Physician order sheet dated 8/13/08, documented, " Admit to wound clinic per [name of physician]. " f. The Wound Clinic documented, "Drainage: Color is green, yellow and large amount. There is an odor and no gluteal edema. ... Wound progress note: length centimeter (cm) 12.0, width (cm) 13.5, depth (cm) obscured. ...Clinical Notes: New patient (pt) [with] a likely stage IV decubitus, but unable to accurately stage due to eschar. ... " g. A Physician's Telephone Order dated 8/13/08 documented, "Ciprofloxacin 500 milligrams (mg.) 1 by mouth (po) twice a day (BID) X 3 weeks." h. On 8/20/08 the wound clinic documented, "Wound Description: Sacral decubitus ulcer, 13 x 5 x 13 centimeters (cm). Depth is obscured. ... Drainage Color is tan, green red, and copious, foul odor. No gluteal edema ... Clinician Notes:	F 314			

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F 314	<p>Continued From page 20</p> <p>This wound is larger in dimensions, but has less eschar. There is an extremely foul odor. MD removed quite a bit of non-viable, but still lots left. Culture and sensitivity (C&S) done due to increased odor."</p> <p>i. A Nursing Home Progress Note dated 8/22/08 documented, " Sacral stage 3 to 4 decubitus ulcer ... We are going to continue with the Cipro until the wound cultures are returned."</p> <p>An Anaerobic and Aerobic Sample Type tissue Culture Collect Date 8/20/08 documented," Result 1 Escherichia coli 4+ and Result 2 Enterococcus species 4+" and "Ciprofloxacin resistant (R)." The form had a print date at the bottom of the from of 8/24/08 at [6:07p.m.</p> <p>j. A Physician's Orders from the local hospital dated 8/24/08 documented, "Admit ... Diagnosis Septic, Sacrum Wound positive (+) Eschericia (E.) coli and Enterococcus."</p> <p>4. Resident #12 had a diagnosis of Decubitus. A Quarterly Minimum Data Set dated 7/31/08 documented the resident had moderately impaired cognitive skills for daily decision making and 2 stage 2 pressure ulcers.</p> <p>a. The Resident Plan of Care updated 2/20/08 documented, "Problem Identify Date: 6/20/07 At risk for further skin breakdown" and "Provide skin care, i.e., as ordered per physician."</p> <p>b. The July 2008 Treatment Record documented, "5/29/08 Cleanse stage II (R) [right] buttock with N/S [normal saline] pat dry apply Xenaderm barrier, Prisma cover with gauze QD [every day] until healed." There were no initials documenting</p>	F 314			

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F 314	<p>Continued From page 21</p> <p>the treatment was performed on 7/19/08, 7/26/08, 7/27/08, and 7/28/08.</p> <p>1). The Pressure Ulcer Record form documented wound measurements as follows: 7/4/08 stage II, size in cm (length x width) 0.6 x 0.6; depth 0.1; exudate type/amount [none]. 7/11/08 stage II, size in cm (length x width) 0.5 x 0.4; depth 0.1; exudate type/amount [none].</p> <p>The July 2008 Treatment Record documented, "5/29/08 Apply Xenaderm and then Prisma to coccyx, cover with dry dressing QD until healed." There were no initials documenting the treatment was performed on 7/6/08, 7/13/08, 7/19/08, 7/26/08, 7/27/08, and 7/28/08 .</p> <p>1). The Pressure Ulcer Record form documented wound measurements as follows: 7/4/08 stage II, size in cm (length x width) 1.5 x 0.4; depth 0.1; exudate type/amount [none]. 7/11/08 stage II, size in cm (length x width) 1.6 x 0.3; depth 0.1; exudate type/amount [none].</p> <p>c. The August 2008 Treatment Record documented, "5/29/08 Cleanse stage II (R) buttock with N/S, pat dry with 4X4, apply barrier, prisma cover with gauze QD until healed. There were no initials documenting the treatment was performed on 8/2/08, 8/13/08, 8/14/08, and 8/15/08.</p> <p>1). The Pressure Ulcer Record form documented wound measurements as follows: 8/1/08 stage II, size in cm (length x width) 0.6 x 0.6; depth 0.1; exudate type/amount [none].</p> <p>The August 2008 Treatment Record documented, "5/29/08 Apply Xenaderm and then Prisma to</p>	F 314			

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F 314	<p>Continued From page 22</p> <p>coccyx, cover with dry dressing QD until healed." There were no initials documenting the treatment was performed on 8/2/08, 8/13/08, 8/14/08, and 8/15/08.</p> <p>1). The Pressure Ulcer Record form documented wound measurements as follows: 8/1/08 stage II, size in cm (length x width) 1.0 x 0.2; depth 0.1; exudate type/amount [none].</p> <p>d. The September 2008 Treatment Record documented, " 8/28/08 Cleanse stage II on right (R) buttock, left (L) buttock, and coccyx with normal saline (N/S), apply Polymem, cover with dry dressing every day (QD) until healed." There was not any initials documenting the treatment was performed on 9/14/08.</p> <p>e. The Pressure Ulcer Record form dated 12/13/07 documented a stage 2 pressure ulcer on the right inner buttock measuring 1.5 centimeter by 1.0 centimeter and 0.5 centimeter depth. The Weekly Skin Report form dated 9/17/08 documented a stage 2 pressure ulcer continued on the right buttock measuring 2 centimeters by 1 centimeter and 0.1 centimeter depth.</p> <p>The Pressure Ulcer Record documented the date of onset of a stage 2 pressure ulcer on the coccyx as 2/5/08. The size of the pressure ulcer on 2/5/08 was documented as 1 centimeter by 1 centimeter and 0.2 centimeter deep. The Weekly Skin Report dated 9/17/08 documented that a stage 2 pressure ulcer continued on the coccyx measuring 0.5 by 0.5 and 0.2 centimeter depth.</p> <p>5. Resident #24 had diagnoses Dementia with Behavior (End Stage), Failure to Thrive, Hx (history) Fracture (R) leg, Hx Fracture (R) Arm,</p>	F 314			

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F 314	<p>Continued From page 23</p> <p>Decubitus Ulcer, Non-Insulin Dependent Diabetes Mellitus and Infection (wound). A Quarterly MDS dated 7/18/08 documented the resident had severely impaired cognitive skills for daily decision-making, was totally dependent on staff for activities requiring two-person assistance with transfers/mobility, had inadequate control of bladder and bowel with multiple daily episodes all or most of the time, had one Stage II pressure ulcer, and had skin tears.</p> <p>a. A care plan dated 4/23/08 documented, "Check q (every) 2 hrs (hours) and prn (as needed). Provide incontinent care following each episode. Keep [resident's name] clean, dry and odor free. Maintain dignity.</p> <p>b. On 9/23/08 at 5:45 p.m., CNA #3 and CNA #4 explained to Resident #24 it was time for supper and made preparations to get the resident out of bed. CNA #3 removed a saturated incontinent brief dated 9/23/08 1:41 p.m., and placed it into a plastic bag. There was a dressing on the resident's coccyx dated 9/23/08. CNA #3 failed to clean the resident's buttocks, mons pubis, groin, labia and thighs. CNA #3 was asked why there was a white patch on the resident's coccyx. CNA #3 stated, "[resident's name] has a bed sore there."</p> <p>On 9/23/08 at 5:45 p.m., CNA #3 and CNA#4 was asked how often incontinent care was provided for incontinent residents, both stated, "We change them every 2 hours." The incontinent brief which was removed was dated 9/23/08 and timed 1:41 p.m., indicating that it had been 4 hours since incontinent care had been provided for the resident.</p>	F 314			

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F 314	<p>Continued From page 24</p> <p>6. Resident #6 had diagnoses of Alzheimer's Dementia with Behavior Problems, Recent Fall with Injury, and Hip Fracture. The Annual MDS dated 6/20/08 documented the resident had severely impaired cognitive skills for daily decision-making, required extensive assistance with one to two persons for bed mobility, transfers, and toileting, had inadequate control of bladder and bowels with multiple daily episodes all or most of the time and required extensive assistance and require extensive assistance of one person for personal hygiene.</p> <p>a. The Plan of Care dated 6/20/08 documented, "Provide incontinent care following each episode. Keep [resident's name] clean, dry and odor free. Maintain dignity."</p> <p>b. On 9/18/08 at 2:30 p.m., the resident was taken in her wheelchair to the toilet in her room by CNA #2. CNA #2 applied a gait belt, assisted the resident to hold onto the hand rails and raised the resident to a standing position. CNA #2 then pulled the resident's incontinent brief (dated and timed 9/18/08, 9:30 a.m.) and pants down to just above the resident's knees. The incontinent brief was dark yellow, heavily saturated, and there was an area approximately 6 inches in diameter of dark brown feces in the center. The CNA assisted the resident to sit onto the commode, and then removed the soiled brief. The resident urinated and had a bowel movement. When the resident was ready to get off the commode she patted the seat of the wheel chair with her left hand. The CNA then lifted the resident, who was holding onto the hand rail, to a standing/leaning position in which the CNA was holding much of the resident's weight and wiped the resident's rectal area with disposable wipes. The CNA</p>	F 314			

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F 314	Continued From page 25 wiped until the wipes came back with no feces on the paper and then set the resident back down onto the commode. A clean incontinent brief was positioned between the residents knees and the tabs were affixed to the sides. The resident was again assisted to a leaning/standing position in which the CNA was supporting most of the resident's weight while the CNA pulled up the incontinent brief. The CNA was unable to safely manipulate the resident using a pivot transfer back into the wheelchair and pulled the emergency cord in the bathroom and requested assistance from another CNA. Two CNA's assisted the resident to a standing position, pulled up the sweat pants the residents had been wearing before she was toileted and sat her down into the wheel chair. There was a wet area approximately 6" in diameter on the posterior left leg of the pants. The resident was wheeled back into the hall and the CNA washed her hands and disposed of the soiled brief. The CNA failed to clean the resident's buttocks, inner thighs, mons pubis, and the labia. The resident was seated back into the wheel chair in urine-saturated pants. CNA #2 was asked if this resident was on a toileting program. The CNA stated, "[Resident's name] is toileted every two hours. The incontinent brief that had been removed was dated and timed, 9/18/08 , 9:30 a.m., was removed at 2:30 pm, five hours later.	F 314			
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323			

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F 323	Continued From page 26 prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #13933 was substantiated (all or in part) with these findings: Based on observation, record review and interview the facility failed to ensure that residents received adequate supervision, assistive devices to prevent accidents and failed to assess and evaluate interventions to ensure they were effective to prevent accidents for 3 (Residents #7, #24, and #25) of 15 (Residents #1, 5, 6, 7, 8, 10, 11, 12, 24, 25, 26, 27, 33, 34, and 35) case mix residents who require assistance from staff for transfers. This failed practice had the potential to affect 14 residents dependent on staff for transfers and 40 residents who require the assistance of 1-2 persons for transfers according to the Resident Census and Conditions of Residents form dated 9/17/08. The facility also failed to identify, evaluate, implement, monitor and modify appropriate interventions to prevent falls for 1 (Resident #1) of 17 case mix residents (Residents #1, 2, 3, 4, 5, 6, 7, 10, 19, 24, 26, 27, 33, 34, 35, 36 and 37) who were at risk for falls. The failed practice had the potential to affect 57 residents according to a list provided by the Director of Nursing (DON) on 9/19/08. The facility failed to ensure an electrical cord with multiple outlets was not used and hazardous materials were stored to prevent them from being assessable to cognitive impaired mobile residents. The failed practice had the potential to affect 18 cognitively impaired residents who	F 323			

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F 323	Continued From page 27 reside on the 800 Hallway according to a list provided by the Director of Nursing (DON) dated 9/19/08. The finding are: 1. Resident #24 had diagnoses Dementia with Behavior (End Stage), Failure to Thrive, Hx (history) Fracture R (right) leg, Hx Fracture (R) Arm, Decubitus Ulcer, and Infection (wound). A Quarterly Minimum Data Set (MDS) dated 7/18/08 documented the resident had severely impaired cognitive skills for daily decision-making, was totally dependent on staff for activities of daily living requiring two-person assistance with transfers/mobility, had inadequate control of bladder and bowel with multiple daily episodes all or most of the time, had one Stage II pressure ulcer, and had skin tears. a. A care plan dated 4/23/08 documented, "Check q (every) 2 hrs and prn (as needed). Provide incontinent care following each episode. Keep [resident's name] clean, dry and odor free. Maintain dignity. Also, Attempt to not bump skin during transfers. Observe closely to ensure resident's safety and Transfers [times] 2 staff. ... Frequent skin tears ... Attempt to not bump skin during transfers. b. On 9/23/08 at 5:45 p.m., Certified Nursing Assistant (CNA) #3 and CNA #5 informed the resident it was supper time and they were going to get the resident out of bed and transfer the resident into a geri-chair. The resident (with legs contracted at approximately almost 90 degrees at the hips and knees) was rolled back and forth by CNA (#3) without the use of a draw sheet to assist and a sling pad that was to be used with a mechanical lift for transfer was put into place. CNA #4 assisted CNA #3 attach the sling to the	F 323			

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F 323	<p>Continued From page 28</p> <p>mechanical lift and CNA#3 raised the resident with the lift and told CNA #4 to move the gerichair from the corner of the room to the center of the room. CNA#4 independently moved the resident in the mechanical lift from the bed to the gerichair while CNA #4 remained behind the gerichair. During the transfer the resident's feet were noted to be out of the view, behind the curtain, of CNA #3 as the lift was manipulated between the beds and over to the gerichair. The resident was lowered to the geri-chair by CNA#3 and guided by CNA #4, positioned comfortably with pillows and positioning devices and moved into the hall. The CNA failed to keep the resident in full view during the transfer to prevent the potential for injury.</p> <p>b. The Occurrence/Analysis Report forms documented: 4/29/08 the resident's toe was injured in the shower during a transfer; 5/5/08 the resident received a skin tear during a transfer from bed to gerichair; 5/17/08 the resident received a skin tear and CNA was instructed on "gentle transferring"; 5/23/08 the resident received a skin tear and CNA was instructed to "protect resident's legs during transfers"; 8/11/08 the resident received a skin tear during a transfer to the gerichair; and 8/23/08 the resident received a skin tear during a transfer to the gerichair.</p> <p>The Occurrence/Analysis Reports documented the following interventions: "Remind staff to be very gentle, ... Take extra care with transfers, ... Instruct CNA's to be more aware." On 5/5/08 the report documented, "pad arms of geri-chair." On 6/17/08 the report documented, "could use padded bed rails."</p> <p>d. As of 9/26/08 at 12:45 p.m., the care plan, in the clinical record did not reflect any of the</p>	F 323			

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F 323	Continued From page 29 interventions identified on the occurrence reports. 2. Resident #25 had diagnoses of Hydrocephalus, Seizure Disorder and Dysphagia. An Annual Minimum Data Set dated 8/21/08 documented the resident had severely impaired cognitive skills for daily decision-making and was totally dependent upon staff for personal hygiene, transfers and nutrition. a. The care plan dated 8/20/08 documented, "At risk for fall or injury related to severe cognitive and mobility impairments secondary to traumatic brain injury. ... Interventions ... Transfers are a 2 person assist with mechanical. Observe closely to ensure resident's safety. ... Risk of frequent skin tears or bruising ... Interventions ... Attempt to not bump during transfers, Minimize skin to skin contact as much as possible, Protective sleeves for arms and legs." b. The facility's Occurrence/Analysis Reports documented the resident incurred 17 injuries between March and September 2008. Skin tears (11) related to transfers were documented as occurring on the following dates: 3/27/08, 5/4/08, 5/31/08, 6/12/08, 6/16/08, 6/19/08, 7/19/08, 7/27/08, 8/11/08, 8/27/08, and 9/17/08. On 3/15/08 the resident received a bruise while being turned in bed; 3/29/08 the resident received a skin tear while gown was being changed; 4/30/08 the resident received a skin tear ' cause unknown ' ; 5/15/08 the resident returned from surgery with bruise on arm and hand; 5/16/08 the resident received a skin tear while gown was being changed; 7/16/08 the resident received a skin tear, cause not noted on report; and on 9/23/08 the resident received a skin tear, cause not noted on report.	F 323			

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F 323	Continued From page 30 c. The March through September 2008 facility's "Occurrence/Analysis Reports" documented the following as Corrective action/Interventions: 1) Remind CNA ' s ... to make sure and watch all limbs and to get assistance when needed: intervention was documented on occurrence reports dated 6/19/08; 2) Reinforce or instruct CNA's on proper transfer techniques, intervention was documented on occurrence reports dated 8/27/08, and 9/19/08; 3) Arm protectors/geri-sleeves, intervention was documented on occurrence reports dated 7/16/08/27/08, and 8/11/08; 4) Use proper technique while repositioning, intervention was documented on occurrence reports dated 4/30/08, and 6/12/08 5) Instruct/Remind CNA's to be more careful/caution, intervention was documented on occurrence reports dated 3/15/08, 3/29/08, 5/4/08, 5/16/08, 5/31/08, 7/19/08, and 6/16/08. No interventions were documented for the report generated on 5/15/08, 9/23/08. d. On 9/24/08 at 2:00 p.m., the Charge Nurse, LPN #5, was interviewed and questioned about the resident's repeated skin tears. The LPN stated, " [Resident's name] has no control of her limbs and they just flop down out of the sling when they transfer her. And when they turn her they just bump the rails. We have put geri-sleeves on her and we remind the CNA's to be very careful with [the resident]. [The resident]'s skin is very fragile. " e. On 9/26/08 at 9:30 a.m., the Director of Nursing was asked what other intervention was put in place to prevent the potential for more skin tears for this resident. The DON stated, None.	F 323			

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F 323	<p>Continued From page 31</p> <p>The DON was asked if she felt that the current plan of prevention of skin tears was working, and she stated no. The DON was asked what could the facility have done further to help prevent the potential for more skin tears for the resident, the DON stated that additional padding could have been added. The DON was asked if this had been done and the DON stated no.</p> <p>3. Resident #1 had diagnoses Osteoarthritis (right hip/knee) and Total Right Hip Replacement. A Quarterly MDS dated 6/26/08 documented the resident had moderately impaired cognitive skills for daily decision-making, required extensive assistance of one-two persons for transfers and mobility, and was occasionally incontinent of bowel and bladder.</p> <p>a. The care plan dated 4/4/08 documented, Problem: Risk of ongoing decline/pain/falls [secondary] to CVA (Cardiovascular Accident) [with] [right] side residual [related to] degenerative arthritis. ... approaches: Transfers x 2 staff, [side rails] x 2 to aid in turning [related to] repositioning. ... updates: 4/30/08 FWB (full weight bearing on [right] leg. 6/25/08 pressure alarm in bed. 6/25/08 Body alarm while in [wheelchair]. 7/21/08 Remind [resident] to ask for assist. 8/3/08 Remind to use [call light]. Remind staff to monitor. 8/15/08 moving closer to nurses station to better be able to watch/listen for alarms.</p> <p>b. The facility's Occurrence/Analysis Reports dated 6/2/08 documented, " Resident found lying on mat beside bed. Stated, ' I thought it was time to get up. I sat on side of bed and slide off. ' No pain or distress voiced when asked. No redness or bruising found on body. ... Corrective action/intervention: Resident was helped off floor</p>	F 323			

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F 323	Continued From page 32 and returned to bed then into wheelchair. ... Full side rails ... " c. The facility ' s occurrence/analysis report dated 7/21/08 documented, " [Resident] put self on toilet and fell between wall and toilet. Back [at] [resident] shoulder slightly reddened. [No [complaint] pain [at] site or elsewhere. Bears [weight] without complaint [of] pain. Resident laughing denies pain. ...Corrective action/intervention: Remind [resident] to wait for assistance. ... Briefly describe any follow up actions required: Ask [resident] if needs to go to toilet frequently to prevent attempts [at] self transfers. ... " d. The facility ' s occurrence/analysis report dated 8/3/08 time of occurrence: [2:00 p.m.] documented: " Aides walked into room [and] found [resident] on floor. [Resident] states she was trying to get in bed. ... Corrective action/Intervention: " [Resident] is reminded to use call light when in need of assistance. Aides reminded to monitor. Briefly describe any follow up actions required: [Resident] monitored closely [every] 2 [hours] post fall. She has fallen in past trying to get [out of bed] or back to bed. Will instruct staff to put [resident] back to bed [after] lunch. " e. The facility ' s occurrence/analysis report dated 8/12/08 time: [3:50 p.m.] documented " Attempted to transfer self from recliner to [wheelchair] Apparently removed body alarm. Fell on knees. [Left] knee [with] slight abrasion, both knees reddened. [Complaint of] [right] knee pain. Gave Tylenol 325 [milligram] [by mouth] for pain. Bear [weight] well. ...Corrective action/Intervention: Reinforce importance	F 323			

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F 323	<p>Continued From page 33</p> <p>[resident] not transferring alone. Check often to ensure body alarm in place. ... Briefly describe any follow up actions required: Informed PT (Physical Therapy). Monitor closely. [Resident] refuses to participate in PT. Recent [diagnosis] of pneumonia. [Resident] takes bed alarm off herself. Will talk to husband about option of moving [resident] closer to desk. "</p> <p>f. The facility ' s occurrence/analysis report dated 8/18/08, timed: [12:50 p.m.] documented, " Fell out of [wheel chair], and was found sitting on foot pedals. CNA came and got nurse. ...Corrective action/Intervention: Apply alarm [and] [continue] to monitor. Alarms to chair. Wedge cushion to [wheel chair] removed the gel pad. Notified restorative dept [and] PT. ... Briefly describe any follow up actions required: Gel cushion to be put back on [wheel chair] per resident ' s request, removed wedge cushion per resident ' s request. Will talk to resident to family about self release seat belt [with] alarm.</p> <p>g. The facility ' s occurrence/analysis report dated 9/4/08, timed: [2:40 p.m., documented " [Resident] in shower [with] shower aide. Shower aide assistance [with] standing to pull her pants up [and] [resident] feet started to slide out from under her. CNA caught [resident] [and] slid her to floor. Gait belt was in use. CNA called for help. Nurse came to help. [No] apparent injury. [No] redness. [Resident denies pain. ... Corrective action/Intervention: CNA to be sure floor clean [and] dry [and] be sure [resident] ready to stand before [resident] standing. " document the resident fell 12 times between 4/6/08 and 9/4/08.</p> <p>h. On 9/22/08 at 5:00 pm., the DON was asked if facility had looked at history of the residents falls</p>	F 323			

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F 323	<p>Continued From page 34</p> <p>and found a pattern. The DON stated no. The surveyor and the DON reviewed the residents history of falls. The DON agreed there was a trend that could be identified in the residents history of falls. The DON stated that since the facility now have all the information on the computer that it will be easier to identify patterns.</p> <p>4. Resident #7 had diagnoses of Fractured Neck of Femur, Debility, Osteoporosis, and Bilateral Edema. The Quarterly MDS documented the resident had modified independent cognitive skills for daily decision making, required limited to extensive assistance for activities of daily living and was continent of bowel and bladder.</p> <p>a. The care plan dated 1/23/08 documented, " At risk for injury/falls, related to decreased mobility. ...</p> <p>b. The care plan dated 7/9/08 documented, Physical Therapy to evaluate and treat as indicated.</p> <p>c. An Occurrence/Analysis Report dated 7/12/08 documented, " [Resident was being transferred from wheel chair to toilet and struck [right] leg and on wheel chair. ... skin tear to [right] shin. ... Corrective action/Intervention: ... C.N.A. and N.A. to be more careful with transfers.</p> <p>d. An Occurrence/Analysis Report dated 7/29/08 documented, " During transfer to toilet to [wheel chair] [resident] bumped her elbow on the [wheel chair] arm [and] caused a minor [skin tear] ... The intervention was to inservice the CNA's on transfers.</p> <p>e. An Occurrence/Analysis Report dated 9/20/08</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>documented, "R (resident) become toddery, aide assisted R (resident) to floor at that time R (resident) struck R (right) hand against w/c (wheel chair) causing large bruise. The only apparent injury was her right hand which was totally black and blue from finger tips to wrist and was swollen. The family was notified and the physician consulted and told LPN to monitor as long as there wasn't pain, and if the resident complained of pain to have it x-rayed. "</p> <p>f. On 9/23/08 at 2:10 p.m., the MDS Coordinator, and LPN #6, was asked if there were any interventions. LPN #6 stated that it had been talked about in the daily stand up meeting and gave this surveyor a copy of the falls discussed at the meeting. Under interventions it states: "R (resident) is a 1 person assist [and] proper procedures were followed."</p> <p>d. The Fall Risk Assessment dated 9/22/08 documented the resident was a 16. The form documented a score of 12 or greater, the resident was considered at high risk for falls and placed on Fall Prevention Program immediately. The Resident Care Guide posted on the closet door of the resident room for staff information documented, "Transfer Skills with 1 assist."</p> <p>5. On 9/18/08 at 5:00 p.m., during General Observations, of the facility the shower room door, room 862 was observed to be unlocked. There was no one in the room at the time. A bottle of Aloe Vesta 3-N-1 Cleansing Foam was observed in the unlocked shower room. The label on the back of the bottle documented, "Warning: For external use only. May cause eye irritation."</p> <p>6. On 9/18/08 at 5:15 p.m., during General</p>	F 323			

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F 323	Continued From page 36 Observations of the facility, a multiple outlet extension cord was observed in the day room on the 800 hall. A television, video cassette recorder, and a digital video disc player were plugged into the multiple outlet extension cord. There was only 1 electrical receptacle, allowing two devices to be plugged in, were in the area of the multiple outlet extension cord. 7. On 9/18/08 at 5:30 p.m., during General Observations of the facility the door to the beauty shop was observed to be unlocked. There was no one in the room at this time. There were 5 bottles, containing different products, with warnings documented on their labels observed on the counter next to the sink. A bottle of T Gel shampoo, with "for external use only" documented on its label was observed on the counter. A bottle of Therapro was observed on the counter. The label on the Therapro documented, "For external use only avoid contact with eyes. In case of accidental ingestion seek professional assistance or contact a Poison Control Center immediately. "A bottle of Curl it Up was observed on the counter. The label on the Curl it Up documented, " Avoid contact with eyes. For external use only. "A bottle of Scruples V2 was observed on the counter. The label on the bottle of Scruples V2 documented, "For external use only. "A bottle of Aquage Texturizing Spray was observed on the counter. The label on the bottle of Aquage Texturizing Spray documented, "Avoid getting in eyes. For external use only."	F 323			
F 329 SS=E	483.25(I) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329			

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F 329	<p>Continued From page 37</p> <p>duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13933 was substantiated (all or in part) with these findings:</p> <p>Based on interview and record review the facility failed to ensure that Prilosec (omeprazole) was not used past the manufactures recommendation without a risk versus benefit statement documentation the clinical rationale for it continued use for 1 (Residents #4) of 1 case mix residents who had physician orders for the medication Prilosec, and a dose reduction attempt had been attempted, a risk versus benefit statement documenting the clinical rationale for continued use or why a dose reduction would be</p>	F 329			

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F 329	<p>Continued From page 38</p> <p>contraindicated for 3 (Residents #4, #6, and #8) of 7 case mix residents (Residents #1, #3, #4, #6, #8, #10 and #12) who had orders for antidepressants. The failed practices had the potential to affect 12 residents who had physician orders for the medication omeprazole and 39 residents who had physician orders for antidepressants according to lists provided by the DON (Director of Nursing) on 9/19/08. The findings are:</p> <p>1. Resident #4 had the diagnoses Alzheimer's Dementia with Delirium and Gastritis. A Significant Change in Status Assessment Minimum Data Set (MDS) dated 8/15/08 documented the resident had moderately impaired cognitive skills for daily decision-making.</p> <p>a. A Physician order dated 1/22/07 documented Celexa 20 mg (milligram) daily. A Physician order dated 4/28/08 documented Celexa 20 mg to be continued daily with a readmit date to the facility from a hospitalization.</p> <p>b. A Drug Regimen Review dated 7/31/08 documented a recommendation for a reduction evaluation for Celexa and a reassessment for Prilosec (omeprazole) had been sent to the physician by the facility's pharmacy consultant.</p> <p>c. The September 2008 physician orders sheet documented for Celexa 20 mg (milligram) 1 tab PO (by mouth) QD (every day) .</p> <p>d. On 9/16/08 after review of the, September 2008 Medication Administration Record (MAR), Celexa had been continued at the same dose (20 mg PO (by mouth) daily), without documentation of a clinical rationale why a dose reduction would</p>	F 329			

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F 329	<p>Continued From page 39</p> <p>be clinically contraindicated or a failed dose reduction attempt.</p> <p>e. A physician's order dated 4/28/08 documented, "Omeprazole 20 mg PO q (every) a.m., at 0600 (6:00 a.m.)."</p> <p>f. The September 2008 Physician order sheet documented for Omeprazole (Prilosec) 20 mg 1 tab PO Q AM at 0600.</p> <p>g. On 9/16/08 after review of the, September 2008 MAR, Prilosec had been continued past the manufacturers recommendation for use, without documentation of a clinical rationale for the continued use of the medication past the manufacturer recommendation.</p> <p>h. The Geriatric Dosage Handbook 12th Edition page 1137 documented "Omeprazole" and "USE: Short-term use (4-8 weeks) treatment . . . of active benign gastric ulcers . . ."</p> <p>i. On 9/15/08 the facility could not provide documentation the pharmacy consultant's recommendations dated 7/31/08 for the reduction evaluation of Celexa and/or the reassessment of the use of Prilosec had been acted upon.</p> <p>2. Resident #6 had a diagnosis of Alzheimer's Dementia with Behavioral Problems. An Annual MDS dated 6/20/08 documented the resident had severely impaired cognitive skills for daily decision-making.</p> <p>a. The September 2008 Physician's Orders sheet documented an order dated 8/25/08 for "Zoloft (sertraline) 75 mg give 1 [and] 1/2 tabs of a 50 mg tabs = 75 mg PO QD".</p>	F 329			

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F 329	Continued From page 40 b. A Drug Regimen Review form dated 8/31/08 included documentation by the facility's pharmacy consultant dating back 1 year. There was no recommendation for the tapering of the Zoloft documented in the monthly reviews. c. On 9/16/08 after review of the September 2008 MAR documented Zoloft had been continued at the same dose (75 mg daily), without documentation of a clinical rationale why a dose reduction would be clinically contraindicated or a failed dose reduction attempt. 3. Resident #8 had diagnoses of Alzheimer's Disease and Depression. An Annual MDS dated 8/14/08 documented the resident had severely impaired cognitive skills for daily decision making. a. A Physician's Order dated 10/10/03 documented, "Remeron (Mirtazapine) 45 milligrams 1 tablet (tab) via percutaneous enteral gastrostomy (PEG) tube at bedtime (HS)." b. As of 9/19/08 at 11:25 a.m., there was no documentation on the Drug Regimen review that the Consultant Pharmacist had identified a need for the physician to evaluate the continued use of the drug Remeron, the need for a dose reduction in the absence of a clinical rationale to continue at the present dosage and the need to document a risk versus benefit statement if the need to continue at the present dose. c. On 9/22/08 after review of the September MAR, Remeron had been continued at the same dose (45 mg at HS), without documentation of a clinical rationale why a dose reduction would be clinically contraindicated or a failed dose	F 329			

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F 329	Continued From page 41 reduction attempt. d. On 9/22/08 at 5:00 p.m., the Director of Nursing was informed that no documentation had been found in the resident's clinical record regarding possible dose reduction of the Remeron. There was no documentation provided by the facility as of the time of exit from the facility on 9/26/08. 4. On 9/22/08 the facility's pharmacy consultant and stated she was confused about tapering the dosage on antidepressants and had not made recommendations to the physicians for re-evaluating the use of antidepressants on all the residents.	F 329			
F 333 SS=E	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to follow physician orders to ensure the residents were free of any significant medication errors for 1 (Resident #23) of 4 case mix residents (Residents #23, 27, 31 and 32) resulting in a significant medication error. The failed practice had the potential to effect 25 residents on the Southwest hall (rooms 728-730 and 850 - 896) according to a list provided by the DON on 9/26/08. The findings are: Resident #23 had the diagnoses Angina, Dysrhythmia (Cardiac), Congestive Heart Failure, Arteriosclerotic Heart Disease and Renal Failure. A Quarterly Minimum Data Set dated 5/27/08	F 333			

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F 333	<p>Continued From page 42</p> <p>documented the resident was moderately impaired in cognitive skills for daily decision-making.</p> <p>a. A letter dated 4/25/08, entitled Drug Regimen Review documented, "Amioderone eval (evaluation) [sent to] [Physician]" from the facility's pharmacy consultant.</p> <p>b. A letter dated 4/25/08 entitled "Note to Attending Physician/Prescriber" documented, "The resident is receiving Amiodarone. The only approved indication for use of this agent is the treatment of recurrent life-threatening ventricular arrhythmias used when the resident cannot tolerate or has not responded to other medications because it is associated with QT interval problems and carries a risk of provoking Torsades de pointes with a lack of efficacy in older adults. ... If the use of this medication is necessary, CMS requires an assessment of risk vs benefit. Please indicate which of the following apply. . ." The letter was signed by Consultant Pharmacist.</p> <p>c. A Drug Regimen Review form dated 5/30/08 documented, "No response from Amiodarone eval."</p> <p>d. A physician's order to discontinue (DC) the Amiodarone dated 6/2/08 was documented on the bottom of the letter entitled "Note to Attending Physician/Prescriber" which had an original date of 4/25/08.</p> <p>The same letter documented the order to D/C the Amiodarone was noted on 6/16/08, and the medication was actually stopped 14 days after the physician wrote the order to DC it.</p>	F 333			

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F 333	Continued From page 43	F 333			
F 428 SS=E	<p>e. This was a significant medication error due to the classification of the drug (Anti arrhythmic) and the frequency of the error.</p> <p>483.60(c) DRUG REGIMEN REVIEW</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13933 was substantiated (all or in part) with these findings:</p> <p>Based on observation, record review, and interview the facility failed to ensure the consulting pharmacy identified irregularities for 1 (Resident #4) and the consulting pharmacy identified irregularities and reported those irregularities to the attending physician and Director of Nursing (DON) and they were acted upon for 3 (Residents #4, 6, and 8) case mix residents. This failed practice had the potential to affect 12 residents who have physician order for antidepressants and/or omeprazole according to lists provided by the DON on 9/19/08. The findings are:</p> <p>1. Resident #4 had the diagnoses Alzheimer's Dementia with Delirium and Gastritis. A</p>	F 428			

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F 428	<p>Continued From page 44</p> <p>Significant Change in Status Assessment Minimum Data Set (MDS) dated 8/15/08 documented the resident had moderately impaired cognitive skills for daily decision-making.</p> <p>a. A Physician order dated 1/22/07 documented Celexa 20 mg (milligram) daily. A Physician order dated 4/28/08 documented Celexa 20 mg to be continued daily with a readmit date to the facility from a hospitalization.</p> <p>b. A Drug Regimen Review dated 7/31/08 documented a recommendation for a reduction evaluation for Celexa and a reassessment for Prilosec (omeprazole) had been sent to the physician by the facility's pharmacy consultant.</p> <p>c. The September 2008 physician orders sheet documented for Celexa 20 mg (milligram) 1 tab PO (by mouth) QD (every day) .</p> <p>d. On 9/16/08 after review of the, September 2008 Medication Administration Record (MAR), Celexa had been continued at the same dose (20 mg PO (by mouth) daily), without documentation of a clinical rationale why a dose reduction would be clinically contraindicated or a failed dose reduction attempt.</p> <p>e. A physician's order dated 4/28/08 documented, "Omeprazole 20 mg PO q (every) a.m., at 0600 (6:00 a.m.)."</p> <p>f. The September 2008 Physician order sheet documented for Omeprazole (Prilosec) 20 mg 1 tab PO Q AM at 0600.</p> <p>g. On 9/16/08 after review of the, September 2008 MAR, Prilosec had been continued past the</p>	F 428			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/26/2008
NAME OF PROVIDER OR SUPPLIER OZARK HEALTH NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 HIGHWAY 65 SOUTH CLINTON, AR 72031		
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F 428	Continued From page 45 manufacturers recommendation for use, without documentation of a clinical rationale for the continued use of the medication past the manufacturer recommendation. h. The Geriatric Dosage Handbook 12th Edition page 1137 documented "Omeprazole" and "USE: Short-term use (4-8 weeks) treatment . . . of active benign gastric ulcers . . ." i. On 9/15/08 the facility could not provide documentation the pharmacy consultant's recommendations dated 7/31/08 for the reduction evaluation of Celexa and/or the reassessment of the use of Prilosec had been acted upon. 2. Resident #6 had a diagnosis of Alzheimer's Dementia with Behavioral Problems. An Annual MDS dated 6/20/08 documented the resident had severely impaired cognitive skills for daily decision-making. a. The September 2008 Physician's Orders sheet documented an order dated 8/25/08 for "Zoloft (sertraline) 75 mg give 1 [and] 1/2 tabs of a 50 mg tabs = 75 mg PO QD". b. A Drug Regimen Review form dated 8/31/08 included documentation by the facility's pharmacy consultant dating back 1 year. There was no recommendation for the tapering of the Zoloft documented in the monthly reviews. c. On 9/16/08 after review of the September 2008 MAR documented Zoloft had been continued at the same dose (75 mg daily), without documentation of a clinical rationale why a dose reduction would be clinically contraindicated or a failed dose reduction attempt.	F 428			

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F 428	Continued From page 46 3. Resident #8 had diagnoses of Alzheimer's Disease and Depression. An Annual MDS dated 8/14/08 documented the resident had severely impaired cognitive skills for daily decision making. a. A Physician's Order dated 10/10/03 documented, "Remeron (Mirtazapine) 45 milligrams 1 tablet (tab) via percutaneous enteral gastrostomy (PEG) tube at bedtime (HS)." b. As of 9/19/08 at 11:25 a.m., there was no documentation on the Drug Regimen review that the Consultant Pharmacist had identified a need for the physician to evaluate the continued use of the drug Remeron, the need for a dose reduction in the absence of a clinical rationale to continue at the present dosage and the need to document a risk versus benefit statement if the need to continue at the present dose. c. On 9/22/08 after review of the September MAR, Remeron had been continued at the same dose (45 mg at HS), without documentation of a clinical rationale why a dose reduction would be clinically contraindicated or a failed dose reduction attempt. d. On 9/22/08 at 5:00 p.m., the Director of Nursing was informed that no documentation had been found in the resident's clinical record regarding possible dose reduction of the Remeron. There was no documentation provided by the facility as of the time of exit from the facility on 9/26/08. 4. On 9/22/08 the facility's pharmacy consultant and stated she was confused about tapering the dosage on antidepressants and had not made	F 428			

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F 428	Continued From page 47 recommendations to the physicians for re-evaluating the use of antidepressants on all the residents.	F 428			
F 514 SS=C	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: Complaint #13933 was substantiated (all or in part) with these findings: Based on record review and interview the facility failed to maintain accurate, complete and organized clinical information for 3 (Residents #6, 23 and 24) of 4 case mix resident (Residents #23, 27, 31 and 32) who reside on the Southwest hall and receive medication from LPN #5. The failed practice had the potential to effect 25 residents on the Southwest hall (rooms 728-730 and 850 - 896) according to a list provided by the DON on 9/26/08. The findings are: 1. Resident #23 had the diagnoses Angina, Dysrhythmia (Cardiac), Congestive Heart Failure, Arteriosclerotic Heart Disease and Renal Failure. A Quarterly Minimum Data Set dated 5/27/08	F 514			

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F 514	<p>Continued From page 48</p> <p>documented the resident was moderately impaired in cognitive skills for daily decision-making.</p> <p>a. Nurses Notes dated 6/23/08 documented the resident was having respiratory problems and oxygen saturation was 77-88%. A telephone order was received to administer 40 mg (milligrams) of Lasix and start oxygen at 2 liters per nasal canula (O2 @ 2lm/nc) at 0202 which was marked through and 0130 was written above 0202.</p> <p>b. A telephone order dated 6/23/08 documented O2 @ 2lm via nc prn to SOB (short of breath) Lasix 40 mg 1 X 1 now due to labor breathing. The number 3 was written over on the order as it was not originally a 3.</p> <p>c. The June 2008 Medication Administration Record (MAR) was hand written and on the MAR, LPN #5 initialed the Lasix and Oxygen were administered on 6/24/08 with no time documented; on the back of the MAR LPN #5 documented "Lasix 40 mg was give PO (by mouth) on 6/22/08 at 0130 for signs and symptoms of CHF labor breathing."</p> <p>d. In an interview on 9/25/08, LPN #5 stated "I wrote the orders for the O2 and Lasix. I wrote the wrong date on the back of the MAR. I started the O2 and gave the Lasix on the 23rd and not on the 22nd and initialed incorrectly on the front of the MAR."</p> <p>e. The March through June 2008 Treatment Administration Records documented a pattern of omitted initialed boxes for treatments of skin tears and diabetic nail care on weekends.</p>	F 514			

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F 514	Continued From page 49 1). The diabetic nail care was omitted as follows; There was not documentation indicating nail care had been done for March. Nail care was signed as being done on April 2nd , and 15th for the month of April. Nail care was signed as being done on May 10th and 27th for the month of May. For the month of June there was no documentation that nail care had been completed. 2). The Treatment Administration record documented 3 treatment regimens for the resident for March. Treatment for the skin tear on the resident lower leg documented QD (every day) dressing changes. For the month of March the form showed 7 days that the record had no documentation that treatment had been done. The form documented that the area was healed 3/14/08. Treatment for a skin tear on the back of the resident calf was to be done daily. For the month of March the form showed 8 days that the record had no documentation that the treatment had been done. The form documented the area was healed 3/14/08. The month of April the form show that documentation was not completed for 9 days. The May 2008 TAR documented the treatment discontinued on 5/1/08. Treatment for a skin tear to right shin to be done daily. The treatments started 3/21/08 and for the month of March the form had 3 days documentation was omitted. [There was no documentation for this treatment area on the April TAR]	F 514			

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F 514	<p>Continued From page 50</p> <p>Treatment for a skin tear on the right upper and lower shin to be completed daily. The form documented the treatment began on 3/24/08 and show 2 day that documentation for the treatment was omitted. [There was no documentation for this treatment area on the April TAR]</p> <p>Treatment to left lower leg began 5/26/08 and to left outer leg began 5/28/08. The TAR documented the care was to be provided daily. The June 2008 TAR showed 5 days that documentation for the treatment was omitted. The form documented the resident was in the hospital starting on 6/23/08.</p> <p>2. Resident # 24 had diagnoses Dementia with Behavior (End Stage), Failure to Thrive, Hx (history) Fracture (R) leg, Hx Fracture (R) Arm, Decubitus Ulcer, and Infection (wound). A Quarterly Minimum Data Set (MDS) dated 7/18/08 documented the resident had severely impaired cognitive skills for daily decision-making, was totally dependent on staff for activities requiring two-person assistance with transfers/mobility, had inadequate control of bladder and bowel with multiple daily episodes all or most of the time, had one Stage II pressure ulcer, and had skin tears.</p> <p>a. The Treatment Administration Records dated March through September 2008 documented a repeated omissions of initialed boxes for treatments. The omissions was as follows:</p> <p>March omitted documentation 29 of 31 times for the applications of Preparation H and 21 times for the treatment of skin tears.</p> <p>April omitted documentation 29 of 30 times for the</p>	F 514			

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F 514	<p>Continued From page 51</p> <p>applications of Preparation H and 33 times for the treatment of skin tears.</p> <p>May omitted 25 times for the applications of Preparation H, PEG tube site documentation omitted 9 times, treatment of skin tears documentation was omitted 16 times and twice for the treatment of a lesion on the residents nose.</p> <p>June omitted documentation 30 times for the applications of Preparation H,, 30 times for the treatment of a lesion on the residents nose and scalp, 8 times for treatment of incision on nose, PEG tube site care 9 times, and 8 times for the treatment of skin tears.</p> <p>July omitted documentation 2 times for the application of Preparation H, PEG tube site care 2 times, treatment for incision on nose 4 times, 8 times for the treatment of skin tears.</p> <p>August omitted documentation 4 times for the application of Preparation H, PEG tube site care 4 times, treatment for abrasion on head 5 times, 7 times for the treatment of skin tears; The August TAR also omitted 2 times documentation for PEG tube site care. An order for Alleвыen to be applied was discontinued in April, but continued to print out on the TAR through September.</p> <p>3. Resident #6 had a diagnosis of Alzheimer's Dementia with Behavioral Problems. An Annual MDS dated 6/20/08 documented the resident had severely impaired cognitive skills for daily decision-making.</p> <p>a. The Treatment Administration Records dated May through August 2008 documented a pattern</p>	F 514			

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F 514	<p>Continued From page 52</p> <p>of omitted initialed boxes. Documentation for May omitted initials in boxes for treatment to heels 13 times; June documented omitted treatment to heels 17 times and to "affected areas" bid 9 times; July documentation omitted initials 20 times; August documentation omitted initials 15 times for Polysporin and 5 times for barrier cream.</p> <p>4. On 9/23/08 at 3:05 p.m., the Medical Records (MR) Manager was asked if she audited the nurses assessments. The MR Manager stated, yes and she was aware that there were some missed. "I try to audit by the middle of the month so if some are missed they can get them in before that month is actually over."</p> <p>a. A schedule of resident's who had assessments due for the month of August for the 7:00 a.m. to 7:00 p.m. shift was obtained. It is broken down into 4 areas, Northeast Hall, Northwest Hall, Southeast Hall, and Southwest Hall.</p> <p>There were 21 assessment due and 4 LPN's on duty in the 4 areas. For the month of August 4 assessments were not done and 6 were incomplete.</p> <p>Even though the MR Manager audits in the middle of the month they still were not done by the end of the month.</p>	F 514			