

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

PRINTED: 12/28/2007
FORM APPROVED
OMB NO. 0938-0391

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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 12/14/2007 |
| 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 157 SS=E | <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 by: Based on observation and record review, the facility failed to ensure the physician was consulted regarding abnormal blood sugars for 1 (Resident #3) of 2 (Resident #1 and #18) case</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 | Continued From page 1 mix residents with Physician's Orders for Accuchecks. This failed practice had the potential to affect 6 residents with Physician's Orders for Accuchecks according to documentation received from the Director of Nursing (DON) on 12/14/07. The findings are: Resident #3 had diagnoses of Insulin Dependent Diabetes Mellitus and Parkinson's Disease. The Quarterly Minimum Data Set dated 10/9/07 documented the resident was moderately impaired in cognitive skills for daily decision making. a. A Physician's Order dated 7/29/2006 documented, "Accuchecks AC (before meals) [and] HS (bedtime) If [less than] 80 give 8 oz (ounces) OJ (orange juice) and recheck in 45 min. (minutes). Call if [less than] 80 or [greater than] 300." b. The Care Plan dated 10/3/07 documented, "...At risk for hyper/hypoglycemia, and other complications, related to diabetes mellitus, ...Report abnormal results promptly. Accuchecks as per order." c. The Medication Administration Record (MAR) dated 9/1/07 thru 9/30/07 documented the following accucheck results: 9/1/07 69 orange juice given, 9/2/07 58 orange juice given, 9/8/07 77, 9/14/07 45, 9/15/07 64, 9/16/07 77, 9/20/07 64, 9/21/07 36 orange juice given, 9/22/07 74, 9/27/07 66, 9/28/07 36 orange given, 9/28/07 74, 9/30/07 64 orange juice given. All results occurred at 6:00 a.m. and one occurrence on 9/28/07 at 11:00 a.m. The MAR had no documentation of abnormal glucose levels being rechecked or the physician being consulted. | F 157 | | | |

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| F 157 | <p>Continued From page 2</p> <p>Eight abnormal glucose results had no interventions documented.</p> <p>d. The MAR dated 10/1/07 thru 10/31/07 documented the following at 6:00 a.m.: accucheck 10/5/07 49 orange juice given recheck 133, 10/13/07 36, 10/18/07 65 orange juice given recheck 94, 10/21/07 54 orange juice given, 10/21/07 at 11:00 a.m. 79, 10/27/07 78 orange given, 10/28/07 77, 10/29/07 56. One occurrence was documented on 10/12/07 at 8:00 p.m. with a result of 326. The MAR documented the glucose levels were rechecked on 2 occasions and there was no documentation that the physician was consulted. Five abnormal glucose results had no interventions documented.</p> <p>e. The MAR dated 11/1/07 thru 11/30/07 documented the following results at 6:00 a.m.: 11/1/07 55 no intervention, 11/2/07 68 no intervention, 11/8/07 67 no intervention. The following results were documented at 11:00 a.m. 11/10/07 68 orange juice times 2 given, 11/10/07 75 no intervention, 11/12/07 75 no intervention. The MAR had no documentation of abnormal glucose levels being rechecked or the physician being consulted. Five abnormal glucose results had no interventions documented.</p> <p>f. The MAR dated 12/1/07 thru 12/31/07 documented the following; 12/1/07 77 orange juice given/MD (Medical Doctor) notified, 12/7/07 31 orange juice times 2 given with sandwich, 12/8/07 68 MD notified. There was no documentation that the physician was consulted regarding the glucose result of 31 on 12/7/07 and no documentation of the glucose level being rechecked following the intervention.</p> | F 157 | | | |

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| F 157 | Continued From page 3 g. On 12/12/07, the clinical record was reviewed. There was no documentation in the Nurse's Notes dated 9/15/07 through 11/30/07 of interventions implemented (give orange juice 8 ounces, recheck glucose level) and no documentation that the physician was consulted regarding the abnormal glucose levels from the accuchecks. | F 157 | | |
| 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: Based on interview and record review, the facility failed to ensure their Abuse and Prohibition Policy and Procedure included the required prevention, identification and reporting components and failed to ensure the licensing registry was checked for 1 Licensed Practical Nurse (LPN #2). These failed practices had the potential to affect all 102 residents according to the Resident Census and Conditions of Residents form dated 12/11/07. The findings are: 1. On 12/14/07 at 10:30 a.m., the Abuse and Prohibition Policy and Procedure was reviewed. The following requirements were not documented in the policy: a. There was no documentation on how and to whom families and residents may report concerns, incidents and grievances without the fear of retribution, nor how the facility would provide feedback regarding the concerns that | F 226 | | |

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| F 226 | Continued From page 4 have been expressed. b. There was no documentation on how the facility would identify, correct and intervene in situations in which abuse, neglect and or misappropriation of resident property is more likely to occur. c. There was no documentation on how the facility would identify events or track and trend events that may constitute abuse and determine the direction of the investigation. d. There was no documentation that indicated the times to fax and mail events that are to be reported to the Office of Long Term Care. e. There was no documentation in the policy regarding the immediacy of notification to the administrator and law enforcement of suspected abuse or neglect. 2. On 12/14/07 at 11:10 a.m., the personnel record of LPN #2 was reviewed. The date of hire was documented as 8/10/07. There was no documentation that a licensure check had been completed. a. On 12/14/07 at 12:23 p.m., the staff coordinator stated the LPN began work with a temporary license and they were unable to place a temporary license number in an automated phone recording used to verify licensure of this LPN. b. The LPN had worked from 8/10/07 to 12/14/07 with no verification of licensure. | F 226 | | | |
| F 282 SS=E | 483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS | F 282 | | | |

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| F 282 | Continued From page 5 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 therapeutic diets and supplemental feedings were served for 3 (Resident #1, #12 and #14) of 3 case mix residents with a Physician's Order for a therapeutic diet and supplemental feedings , failed to ensure compression stockings were applied for 1 (Resident #9) of 3 (Resident # 9, #12, and #22) case mix residents who had a Physician's Order for compression stockings and failed to ensure a Percutaneous Enterogastrostomy (PEG) Tube was flushed with the ordered amount of fluid for 1 (Resident #8) of 1 case mix resident with a PEG tube. These failed practices had the potential to affect 12 residents with a Physician's Order for supplemental feedings as documented on the diet list dated 12/10/07, 17 residents who had a Physician's Order for compression stockings as documented on a list provided by the Director of Nursing (DON) on 12/14/07 and 7 residents with feeding tubes as documented on the Resident Census and Conditions of Residents form dated 12/11/07. The findings are: 1. Resident #1 had diagnoses of Pneumonia, Alzheimer's disease and Dementia. The Quarterly Minimum Data Set (MDS) dated 10/29/07 documented the resident was severely impaired in cognitive skills for daily decision | F 282 | | | |

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| F 282 | Continued From page 6 making and required one person assist for eating. a. A Physician's Order dated 9/24/07 documented the resident was to receive a regular mechanical soft diet with pureed meat and fortified foods. b. On 12/11/07 at 8:05 a.m., the resident was served corn flakes, scrambled eggs, pancakes, a carton of prune juice and a carton of whole milk. There were no fortified food items served to the resident. 2. Resident #12 had diagnoses of Dementia with Behaviors, Alzheimer's Disease and Non Insulin Dependent Diabetes Mellitus. The MDS dated 8/30/07 documented the resident was moderately impaired in cognitive skills for daily decision making and required set up help only for eating. a. A Physician's Order dated 4/16/07 documented, "Regular, No Concentrated Sweets, sugar free fortified foods." b. On 12/11/07 at 8:10 a.m., the resident was served one biscuit, cheerios, a carton of 2 % reduced fat free milk, bacon and a carton of apple juice. There were no fortified food items served to the resident. 3. Resident #14 had diagnoses of Weight loss and Pernicious Anemia. The Quarterly MDS dated 9/5/07 documented the resident was moderately impaired in cognitive skills for daily decision making and required one person assist for eating. a. A Physician's Order dated 12/24/06 documented, "Mechanical Soft No Added Salt | F 282 | | | |

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| F 282 | Continued From page 7 With Fortified Foods." b. On 12/11/07 at 8:08 a.m., the resident was served scrambled eggs, pan cakes, a carton of apple juice, a carton of whole milk, a bowl of oat meal and ground bacon. There were no fortified foods served to the resident. 4. On 12/11/07 at 11:12 p.m., Dietary employee #1 stated, "We give cottage cheese, yogurt or a boiled egg to the resident who gets extra protein and or on fortified foods." 5. Resident #9 had a diagnosis of Varicose Veins Left Lower Leg. The Significant Change MDS dated 10/2/07 documented the resident was moderately impaired in cognitive skills for daily decision making and required the assistance of 1 for activities of daily living. a. A Physician's Order dated 9/6/07 documented, "Knee high medium compression venous stocks wear at all times." b. A Care Plan dated 9/6/07 documented, "Knee high compression stockings - wear [at] all times." c. On 12/12/07 at 9:31 a.m., the resident was in the hall by the Nurse's Station . He was not wearing compression stockings. Registered Nurse (RN) #1 was asked if the resident had compression stockings. The RN stated she would look and surveyor accompanied her to the resident's room. There were no compression stockings in the resident's room. Certified Nursing Assistant (CNA) #10 and #11 were asked about the compression stockings. CNA #10 stated, "You mean, like TED hose." CNA #10 and #11 stated they have never put those kind of | F 282 | | | |

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| F 282 | Continued From page 8 stockings on him and they had worked there 5 and 6 years respectively. d. On 12/12/07, a review of the clinical record documented the resident had 2 stasis ulcers on the left leg and had been going to the wound clinic since 8/23/07. 6. Resident #8 had diagnoses of Alzheimer's Disease, Cerebrovascular Accident, and Nutritional Deficiency. The Annual Minimum Data Set dated 10/1/07 documented the resident was severely impaired in cognitive skills for daily decision making, had a feeding tube and received 1501 to 2000 cc (cubic centimeters) fluid intake per day by tube. a. A Physician's Order dated 10/31/07 documented, "G-tube feedings Jevity as follows 1 can =0600, 2 cans = 0900, 1 can=1300 & 2 cans = 1900 follow each feeding with 1 can 240ml (milliliters) H2O (water) bolus." b. On 12/12/07 at 8:15 a.m., Licensed Practical Nurse (LPN) #5 administered a bolus tube feeding of Jevity 2 cans followed by a 100cc (cubic centimeter) bolus of water. c. On 12/12/07 at 3:40 p.m. LPN #5 looked at the Physician's Order and stated, "It says follow each bolus with 1 can 240 ml. I didn't give her enough." | F 282 | | | |
| F 309 SS=D | 483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment | F 309 | | | |

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| F 309 | Continued From page 9 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure a back to front motion was not used and tubing was not cleansed in an upward motion towards the urinary meatus during catheter care to prevent the potential for Urinary Tract Infections (UTI's) for 1 (Resident #7) of 1 case mix resident that had a foley catheter. The facility failed to ensure nurses notified the physician and implemented interventions for abnormal glucose levels for 1 (Resident #3) of 2 (Resident #3 and #18) case mix residents with Physician's Orders for accuchecks. These failed practices had the potential to affect 5 residents with indwelling urinary catheters as documented on the Residents Census and Conditions of Residents form dated 12/11/07 and 6 residents with Physician's Orders for accuchecks as documented on a list provided by the Director of Nursing (DON) on 12/14/07. The findings are: 1. Resident #7 had diagnoses of Vascular End Stage Dementia and Acute Urinary Tract Infection. The Quarterly Minimum Data Set dated 11/19/07 documented the resident had moderately impaired cognitive skills for daily decision-making and had an indwelling catheter. a. A Physician's Order dated 11/27/07 documented, "...UA (urinalysis) with C & S (culture and sensitivity) if indicated DX (diagnosis): UTI (urinary tract infection)." b. A Lab Report dated 11/28/07 documented a | F 309 | | | |

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| F 309 | <p>Continued From page 10</p> <p>final report for a urine culture and sensitivity that indicated growth of bacteria of greater than 100,000 CC (colony count) of organisms <i>Providencia stuartii</i> and <i>Morganella morganii</i>.</p> <p>c. A Physician's Telephone Order dated 11/30/07 documented, "1 Rocephin 500 mg. (milligrams) IM (intramuscular) every 24 hours x 7 days. 2. Catheterized UA with C & S if indicated 72 post ABT (antibiotic therapy)."</p> <p>d. On 12/11/07 at 4:25 p.m., Certified Nursing Assistant (CNA) #6 provided catheter care for the resident. The CNA cleansed the rectum and then, with the resident positioned on her back, reached between the resident's legs and wiped back to front. The CNA then wiped the catheter tubing 4 times towards the urinary meatus. Gloves were not changed during the care.</p> <p>2. The policy and procedure entitled "Catheter Care" documented, "...Make sure the genital/perineal area is clean. ...Wash with soap and water around the entire area where catheter enters the urethra. Gently separate labia with your thumb and forefinger on female residents and apply solution. ... Wash four inches of catheter tubing nearest to the resident, starting nearest to the resident. ..."</p> <p>3. Resident #3 had diagnoses of Insulin Dependent Diabetes Mellitus and Parkinson's Disease. The Quarterly MDS dated 10/9/07 documented the resident was moderately impaired in cognitive skills for daily decision making.</p> <p>a. A Physician's Order dated 7/29/2006</p> | F 309 | | | |

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| F 309 | Continued From page 11 documented, "Accuchecks AC (before meals) [and] HS (bedtime) If [less than] 80 give 8 oz (ounces) OJ (orange juice) and recheck in 45 min. (minutes). Call if [less than] 80 or [greater than] 300." b. The Care Plan dated 10/3/07 documented, "...At risk for hyper/hypoglycemia, and other complications, related to diabetes mellitus, ...Report abnormal results promptly. Accuchecks as per order." c. The Medication Administration Record (MAR) dated 9/1/07 thru 9/30/07 documented the following accucheck results: "9/1/07 69 orange juice given, 9/2/07 58 orange juice given, 9/8/07 77 no intervention, 9/14/07 45 no intervention, 9/15/07 64 no intervention, 9/16/07 77 no intervention, 9/20/07 64 no intervention, 9/21/07 36 orange juice given, 9/22/07 74 no intervention, 9/27/07 66 no intervention, 9/28/07 36 orange given, 9/28/07 74 no intervention, 9/30/07 64 orange juice given." All results occurred at 6:00 a.m. and one occurrence on 9/28/07 at 11:00 a.m.. The MAR had no documentation of abnormal glucose levels being rechecked or the physician being consulted. d. The MAR dated 10/1/07 thru 10/31/07 documented the following at 6:00 a.m.: " accucheck 10/5/07 49 orange juice given recheck 133, 10/13/07 36 no intervention, 10/18/07 65 orange juice given recheck 94, 10/21/07 54 orange juice given, 10/21/07 at 11:00 a.m. 79 no intervention, 10/27/07 78 orange given, 10/28/07 77 no intervention, 10/29/07 56 no intervention. One occurrence was documented on 10/12/07 at 8:00 p.m. with a result of 326 and no intervention." The MAR | F 309 | | | |

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| F 309 | Continued From page 12 documented the glucose levels were rechecked on 2 occasions and there was no documentation that the physician was consulted. e. The MAR dated 11/1/07 thru 11/30/07 documented the following results at 6:00 a.m.: "11/1/07 55 no intervention, 11/2/07 68 no intervention, 11/8/07 67 no intervention. The following results were documented at 11:00 a.m. 11/10/07 68 orange juice times 2 given, 11/10/07 75 no intervention, 11/12/07 75 no intervention." The MAR had no documentation of abnormal glucose levels being rechecked or the physician being consulted. f. The MAR dated 12/1/07 thru 12/31/07 documented the following; "12/1/07 77 orange juice given/MD (Medical Doctor) notified, 12/7/07 31 orange juice times 2 given with sandwich, 12/8/07 68 MD notified." There was no documentation that the physician was consulted regarding the glucose result of 31 on 12/7/07 and no documentation of the glucose level being rechecked following the intervention. g. On 12/12/07, the clinical record was reviewed. There was no documentation in the Nurse's Notes dated 9/15/07 through 11/30/07 of interventions implemented (give orange juice 8 ounces, recheck glucose level) and no documentation that the physician was consulted regarding the abnormal glucose levels from the accuchecks. | F 309 | | | |
| F 312 SS=E | 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. | F 312 | | | |

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| F 312 | Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure all areas of the perineum were cleansed of urine during incontinent care for 3 (Resident #1, #8 and #9) of 9 (Resident #1, #4, #5, #8, #9, #10, #11, #12, and #20) case mix residents who were incontinent and dependent on staff for incontinent care and failed to ensure nail care was provided for 2 (Resident #12 and #23) of 23 (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #18, #19, #20, #21, #22 and #23) case mix residents who required assistance with nail care. These failed practices had the potential to affect 48 residents who were dependent on staff for incontinent care as documented on the Resident Census and Conditions of Residents form dated 12/11/07 and 102 residents who required assistance with nail care as documented on a list provided via facsimile by the Director of Nursing (DON) on 12/19/07. The findings are: 1. Resident #9 had a diagnosis of history of Benign Prostatic Hypertrophy. The Significant Change Minimum Data Set (MDS) dated 10/2/07 documented the resident was moderately impaired in cognitive skills for daily decision making, was frequently incontinent of bladder and occasionally incontinent of bowel, required assistance for activities of daily living, used a wheel chair for mobility and had a trunk restraint. On 12/12/07 at 10:00 a.m., Certified Nursing Assistant (CNA) #10 and #11 stood the resident up in the bathroom and had the resident hold on | F 312 | | | |

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| F 312 | <p>Continued From page 14</p> <p>to the safety bar. They pulled down his pants, removed a brief saturated with urine and sat him down on the toilet. The resident was assisted back up and, using disposable wipes, the CNA's cleaned around the rectal area. The buttocks, scrotum, pelvic, groin and penis were not cleansed. The scrotum, and groin was red and the penis had a white ring of smegma around the head of the penis. CNA #11 applied skin protectant to the buttocks without cleansing them first. The resident had an odor of stale urine as did the bathroom.</p> <p>2. Resident #1 had diagnoses of Alzheimer's, Dementia and Chronic Urinary Tract Infections (UTI's). A Quarterly MDS dated 11/5/07 documented the resident was severely impaired for cognitive skills for daily decision making, had urinary tract infection in the last thirty days and was dependent for toileting.</p> <p>a. A Care Plan dated 11/05/07 documented, "...Provide incontinent care following each episode. Keep [Resident #1] clean, dry and odor free ..."</p> <p>b. On 12/11/07 at 10:10 a.m., CNA #9 provided incontinent care after an episode of bladder incontinence. The CNA cleansed the resident's perineal area with one swipe using a moist cloth peri-wipe. The labia was not spread to clean the urinary meatus.</p> <p>3. Resident #8 had diagnoses of Alzheimer's Disease, Cerebrovascular Accident, and Osteoarthritis. The Annual Minimum Data Set (MDS) dated 10/1/07 documented the resident was severely impaired in cognitive skills for daily decision making, had total dependence for</p> | F 312 | | | |

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| F 312 | <p>Continued From page 15</p> <p>activities of daily living and was incontinent of bladder and bowel.</p> <p>On 12/11/07 at 2:45 p.m., Certified Nursing Assistant (CNA) #3 provided care to the resident by removing an incontinent brief that was marked in red ink, "12/11/07 at 9:30 a.m. shower." The CNA was asked what the markings meant and she stated, "It's when the shower aide put the diaper on." The CNA was then asked if the resident was wet with urine and she stated, "Yes, just a little." The incontinent brief was saturated with urine and bowel movement (BM) was present. The CNA took a disposable wipe and wiped from the front to the back one time then with the assistance of CNA #5 turned the resident and applied a clean incontinent brief. The resident's perineal area including the labia, groins, mons pubis, and buttocks were not cleansed of urine or BM.</p> <p>4. The policy and procedure for "Perineal Care" documented, " ... separate labia and wash area downward from front to back. ..."</p> <p>5. Resident #12 had a diagnosis of Alzheimer's Disease. The MDS dated 11/15/07 documented the resident was moderately impaired in cognitive skills for daily decision making and needed the assistance of one person for activities of daily living.</p> <p>On 12/14/07 at 9:00 a.m., the resident was in the hall self propelling her wheel chair. Her fingernails were broken and jagged. The fingernails were long and extended beyond the end of the fingers with an encrusted white and brown substance under the nails.</p> | F 312 | | | |

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| F 312 | Continued From page 16 6. Resident #23 had diagnoses of Major Depressive Severe without Mention Psychotic, Arthritis, and Congestive Heart Failure (CHF). A Quarterly MDS dated 9/6/07 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent for personal hygiene. a. The Care Plan dated 6/20/07 documented, "...assist him with shaving and other personal grooming QD (every day) PRN (as needed) ..." b. On 12/10/07 at 3:23 p.m., the resident had long, dirty fingernails with a black substance under each nail. c. On 12/12/07 at 5:40 p.m., the resident had long fingernails with a blackish brown material under each nail. d. On 12/13/07 at 8:30 a.m., the third toe on the resident's left foot had a thick, long nail curling under to the tip of the toe. e. On 12/13/07 1:55 p.m., the resident's right hand nails were long and dirty. The left hand was not visible. | F 312 | | | |
| F 314 SS=D | 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. | F 314 | | | |

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| F 314 | Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all areas of the perineum were cleansed of urine and bowel movement (BM) to prevent the potential development of pressure sores for 1 (Resident #8) of 7 (Resident #2, #4, #5, #6, #7, #8 and #21) case mix residents who had a pressure ulcer or a history of pressure ulcers and 5 (Resident #9, #11, #19, #20, #23) case mix residents at risk for pressure ulcers. This failed practice had the potential to affect 11 residents with pressure sores as documented by the Resident Census and Conditions of Residents form dated 12/11/07 and 46 residents at risk for pressure ulcers according to the Director of Nursing (DON) on 12/19/07. The findings are: Resident #8 had diagnoses of Alzheimer's Disease, Cerebrovascular Accident, Osteoarthritis and had a history of pressure ulcer. The Annual Minimum Data Set dated 10/1/07 documented the resident was severely impaired in cognitive skills for daily decision making, had total dependence for activities of daily living, incontinent of bowel and bladder and had a history of a pressure ulcer. a. A Care Plan dated 9/26/07 documented, "...Provide incontinent care following each episode ... Check [every] 2 hrs (hours). Pericare with each episode ... Assess tissue for signs of redness, discoloration or swelling. Document and report abnormal findings to charge nurse. Observe closely for skin breakdown ..." | F 314 | | | |

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| F 314 | Continued From page 18 b. On 12/11/07 at 2:45 p.m. Certified Nursing Assistant (CNA) #3 provided care to the resident by removing an incontinent brief that was marked in red, "12/11/07 at 9:30 a.m. Shower." The CNA was asked what the markings meant and she stated, "It's when the shower aide put the diaper on." The CNA was then asked if the resident was wet with urine and she stated, "Yes, just a little." The incontinent brief had an extensive wet area to the crotch and posterior area of the incontinent brief. The resident was then turned to her right side and the incontinent brief was removed from the buttocks. The resident had a small soft BM. The CNA took a disposable wipe and wiped from the front to the back one time and then with the assistance of CNA #5 turned the resident and applied a clean incontinent brief. The perineal area including the labia, groins, mons pubis, and buttocks were not cleansed of urine or BM. The resident had an area of redness approximately 4-5 centimeters in diameter and an area of scarring approximately 1.5 to 2 centimeters in diameter on the coccyx area. CNA #3 stated, "We've told the nurse about that right there." The resident had remained in the same incontinent brief that was marked at 9:30 a.m. for 5 hours and 15 minutes. | F 314 | | | |
| F 315 SS=D | 483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. | F 315 | | | |

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| F 315 | Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure a back to front motion was not used when incontinent care was provided for 1 (Resident #10) of 9 (Resident #1, #4, #5, #8, #9, #10, #11, #12 and #20) case mix residents who were dependent on staff for incontinent care. This failed practice had the potential to affect 48 residents that were occasionally or frequently incontinent of bladder and bowel and required assistance as documented on the Resident Census and Conditions of Residents form dated 12/11/07. The findings are: 1. Resident #10 had diagnoses of Urinary Urgency, Congestive Heart Failure (CHF), and Alzheimer's. The Quarterly Minimum Data Set dated 10/15/07 documented the resident was severely impaired in cognitive skills for daily decision making, had a urinary tract infection within the last thirty days, and was dependent for toileting. a. On 12/12/07 at 9:45 a.m., Certified Nursing Assistant (CNA) #1 provided incontinent care for the resident. The CNA cleansed the vaginal area and then rolled the resident to the right side and cleansed the rectal area using a back to front motion. b. On 12/13/ 07 at 2:00 p.m., CNA #1 stated, "As soon as I left the room, I realized I wiped from back to front ..." 2. The policy and procedure entitled "Perineal Care" documented, "... wash perineal area, wiping | F 315 | | | |

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| F 315 | Continued From page 20 from front to back. ... wash the rectal area thoroughly ... wipe from the base of the labia towards and extending over the buttocks." | F 315 | | | |
| 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 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure accidents/falls were investigated, post fall assessments were completed, interventions were initiated and care plans were updated for 2 (Resident #9 and #12) of 13 (Resident #1, #2, #3, #5, #7, #8, #9, #12, #14, #15, #16, #19, and #20) case mix residents who were assessed as at risk for falls, failed to ensure a physical restraint was applied correctly for 1 (Resident #12) of 7 (Resident #1, #6, #8, #9, #11, #12, and #20) case mix residents who had a Physician's Order for physical restraints and failed to ensure medicated creams and chemical hazards were stored in a manner to prevent accidents. These failed practices had the potential to affect 63 residents who were assessed to be at risk for falls as documented on a Resident List provided via facsimile by the Director of Nursing (DON) on 12/18/07, 17 residents who had a Physician's Order for a physical restraint as documented by a Restraint Audit list provided via facsimile by the Director of Nursing (DON) on 12/18/07 and 20 cognitively | F 323 | | | |

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| F 323 | Continued From page 21 impaired self mobile residents as documented on a Resident List provided by the DON via facsimile on 12/19/07. The findings are: 1. Resident #9 had diagnoses of Alzheimer's Disease and Dementia with Behavior. The Significant Change Minimum Data Set (MDS) dated 10/2/07 documented the resident was moderately impaired in cognitive skills for daily decision making and had mobility per wheel chair. a. A Physician's Order dated 8/14/07 documented, "Lap buddy while up in chair due to inability to stand alone." b. A Care Plan dated 8/31/07 documented, "Lap buddy while in w/c (wheel chair)". c. The Fall Risk Assessment and Post Fall Assessment form revised on 9/22/07 documented, under instructions, "This Fall Risk Assessment is to be completed upon Admission, Re-Admission, Quarterly and after each fall. Add the column numbers to attain the Fall Risk Score. If the total is 12 or greater, the resident is considered to be at high risk for falls and is to be placed on the Fall Prevention Program immediately. In addition, the care plan must be updated to include this intervention." d. On 12/13/07, the clinical record was reviewed. The Nurse's Notes documented the resident sustained falls on 8/12/07/ 8/14/07, 9/21/07, 9/22/07, 9/25/07, 10/22/07, 10/23/07, and 11/21/07. There was no documentation of investigations related to the falls including the fall of 8/12/07 in which there was a small skin tear. No documentation was found in the clinical record of post fall assessments for the falls of 8/12/07, | F 323 | | | |

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| F 323 | Continued From page 22 9/22/07, and 9/25/07. No interventions were found documented on the care plan for the falls of 8/12/07, 8/14/07, 9/21/07, 9/22/07, 9/25/07, 10/22/07, 10/23/07, and 11/20/07. e. The Fall Prevention Program Policy documented, "The interdisciplinary care team is responsible for implementing the Fall Prevention Program. This is accomplished by means of a weekly Fall Risk Team conference". Under Procedure "1. All residents are assessed for fall risk using the Fall Risk and Post Fall Assessment form". 1. (d) "Residents are assessed for fall risk following a fall". 4. (b) "If a resident is determined to be at ongoing risk for falls, extrinsic and intrinsic causes of falls should be reviewed to see which factors might apply. c. After identifying particular potential causes of falls for a resident, the team, which should include information from the resident and/or the surrogate caregiver, will choose interventions likely to prevent falls or serious injury for the resident. d. The team will review and adjust the plan of care following a resident fall. 7. Interventions that are approved for residents on the Fall Prevention Program also include but are not limited to: a. Body alarms; b. Floor mat alarms; c. "U" shaped pillows; e. Perimeter mattresses; f. Low beds; g. Reorientation to call light system; h. Anti-tip bars for W/C's, i. Automatic locking brakes. 9. The members of the team will evaluate the program for each resident on the program at least monthly to determine the need for each resident to remain on the Fall Prevention Program." 2. Resident #12 had diagnoses of Alzheimer's Disease and Dementia with Behaviors. The Quarterly Minimum Data Set dated 11/15/07 | F 323 | | |

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| F 323 | <p>Continued From page 23</p> <p>documented the resident was moderately impaired in cognitive skills for daily decision making and had a trunk restraint.</p> <p>a. A Physician's order dated 8/15/07 documented, "Soft lap belt while up in W/C (wheel chair) due to attempts to transfer without assist and unable to do so without falling."</p> <p>b. A Nurse's Note dated 11/25/07 at 7:30 p.m. documented, "...scouted off the edge of wheel chair & sat in floor, lap belt still in place. Wheelchair had not turned over, but lap belt was caught under (arrow pointing down) abdomen, & groin area causing abrasion to (R with circle around it) groin & (L with circle around it) groin redness that will probably bruise."</p> <p>c. An Incident/Accident Report dated 11/25/07 documented, "Keep resident in hall & in sight at all times." No assessment for the appropriateness of this restraint was found in the clinical record, nor was the care plan updated.</p> <p>d. On 12/13/07 at 2:02 p.m., the resident was observed self propelling her wheel chair down the hall. Certified Nursing Assistant (CNA) #7 and #8 took the resident to her room and placed her on the toilet then transferred her back to the wheel chair and put the soft waist restraint back on the resident. It was loosely applied. The CNA's stated that they tighten the restraint but the resident scoots right out until her hips are on the edge of the wheel chair. The soft waist restraint was applied incorrectly to the wheel chair. The right strap was brought straight down from the seat of the chair and the arm of the chair and was attached to the tip bar behind the wheel chair on the right side. The left strap of the restraint was</p> | F 323 | | | |

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| F 323 | <p>Continued From page 24</p> <p>brought down the left side of the seat and arm of the wheel chair, crossed over underneath the wheel chair and attached to the same tip bar as the right strap. CNA #7 and #8 stated they knew the restraint was not applied correctly but had applied it to accommodate the oxygen "E" tank on the back of the wheel chair.</p> <p>e. On 12/14/07 at 9:00 a.m., the resident was in a wheel chair with the restraint applied incorrectly. The restraint was loose which allowed the resident to scoot forward in the wheel chair. Her buttocks were out on the edge of the wheel chair. The right strap was brought straight down from the seat of the chair and the arm of the chair and was attached to the tip bar behind the wheel chair on the right side. The left strap of the restraint was brought down the left side of the seat and arm of the wheel chair, crossed over underneath the wheel chair and attached to the same tip bar as the right strap.</p> <p>f. On 12/10/07 at 1:46 p.m., Resident #12 had 3 clear medication cups of white cream at the bedside. Licensed Practical Nurse (LPN) #6 stated, "It's skin barrier." The resident was not in the room.</p> <p>g. On 12/14/07 at 10:35 p.m., the skin barrier tube (Baza Antifungal Moisture Barrier Cream) documented, "If swallowed, get medical help or contact a poison control center."</p> <p>3. The manufacturer's recommended guidelines for lap belt application documented, "...Discontinue use immediately if the patient is able to slide forward or down underneath the device." Under Application Instruction it is documented. "...Go around the back post and</p> | F 323 | | | |

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| F 323 | Continued From page 25 cross the straps behind the patient. Secure the loops on the wheelchair tilt levers. The belt should be over the patient's hips at a 45 degree angle holding the hips against the back of the chair." 4. On 12/10/07 at 1:55 p.m., in resident room #882, there was a 4 ounce bottle of Dial brand hand sanitizer gel sitting on the overbed table. The bottle was labeled, "Warning-For external use only. When using this product avoid contact with face, eyes, broken skin, if eye contact occurs, flush thoroughly with water and seek medical advice. If swallowed, get medical help or contact a Poison Control Center right away." 5. On 12/13/07 at 8:12 a.m., there was a 4 ounce bottle of BioSoft Hand Sanitizer with Neu-Thera Moistures on a shelf located outside resident room #684. The label on the container documented, " ... If swallowed, get medical help or contact a Poison Control Center right away. ..." | F 323 | | | |
| F 328 SS=D | 483.25(k) SPECIAL NEEDS 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. This REQUIREMENT is not met as evidenced by: | F 328 | | | |

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| F 328 | <p>Continued From page 26</p> <p>Based on observation, record review, and interview the facility failed to ensure masks for nebulizer updrafts and oropharyngeal suction catheters were changed and suction cannisters were dated for 1 (Resident #21) of 1 case mix resident that required nebulizer updraft treatments and suctioning. This failed practice had the potential to affect 16 residents with nebulizer updraft treatments according to a list provided by the Director of Nursing (DON) on 12/14/07 and 4 residents that received suctioning as documented on the Resident Census and Conditions of Residents form dated 12/11/07. The findings are:</p> <p>Resident #21 had diagnoses of Quadriplegia, Cerebrovascular Accident with Right-sided Hemiparesis and Organism Pneumonia. The Initial Minimum Data Set dated 9/23/07 documented the resident was severely impaired in cognitive skills for daily decision making, had respiratory care and was suctioned.</p> <p>a. A Discharge Summary dated 9/18/07 documented, "Final Diagnosis Right-sided pneumonia..."</p> <p>b. On 12/10/07 at 3:05 p.m., the nebulizer updraft mask and tubing was on the resident's bedside and dated 12/02/07. There was an oral suction catheter in an opened package on the overbed table that was not dated.</p> <p>c. On 12/12/07 at 5:15 p.m., the nebulizer mask set up was dated 12/2/07.</p> <p>d. On 12/13/07 at 8:38 a.m., the updraft nebulizer mask and set up was on the nightstand and dated 12/2/07. An opened, undated Yankeur suction</p> | F 328 | | |

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| F 328 | <p>Continued From page 27</p> <p>catheter was in a package on the overbed table and connected by tubing to a suction machine cannister that contained 550cc (cubic centimeters) of cloudy liquid.</p> <p>e. On 12/13/07 at 8:45 a.m., Licensed Practical Nurse (LPN) #3 administered an updraft treatment to the resident with the nebulizer mask dated 12/2/07. The suction cannister contained 600cc of cloudy liquid.</p> <p>f. On 12/14/07 at 8:30 a.m., the updraft nebulizer mask at the resident's bedside was dated 12/2/07 and there was an package opened with a Yankeur suction catheter connected to tubing to a suction machine cannister that was not dated.</p> <p>g. On 12/14/07 at 10:55 a.m., LPN #3 was asked how often suction catheters were changed and she replied, "Weekly." The LPN was then asked how often the suction cannisters were emptied and she stated, "There's no scheduled time to change it."</p> <p>h. On 12/14/07 at 11:20 a.m., LPN #6 was asked how often the suction cannister were emptied and she stated, "When it gets 3/4's full." She was asked how often the nebulizer set up was changed and stated, "Weekly. I would have to see the policy."</p> <p>i. On 12/14/07 at 11:25 a.m., LPN #6 accompanied the surveyor to the resident's room and was asked what date was on the nebulizer set up. She stated, "I see 12/2. Every Sunday night they are to change things out. On this (LPN pointed to the Yankeur suction cath) I don't see a date." The LPN was asked if infection can occur from not changing equipment that had multiple</p> | F 328 | | | |

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| F 328 | Continued From page 28 use and she stated, "Yes." j. On 12/14/07 at 11:55 a.m., the DON was asked how often nebulizer masks/tubing and suction catheters are changed. She stated, "I'd have to look at the policy. At least daily." k. The procedure entitled "Procedure Suctioning Oropharyngeal and Nasopharyngeal" documented, "...Suction catheters need to be changed at least every 24 hours. Connecting tubing should be changed every 48 hours. ...Rinse and dry the suction bottle after each use." | F 328 | | | |
| F 329 SS=E | 483.25(l) 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 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. 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. | F 329 | | | |

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| F 329 | Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure clinical rationale for the continued need for proton pump inhibiting drugs was documented for 5 (Resident #3, #6, #11, #21 #22,) of 7 (Resident #2, #3, #6, #11, #19, #21 and #22) case mix residents that received proton pump inhibiting drugs and failed to ensure reductions for psychoactive medications were timely and/or had documented behaviors or diagnosis for the administration of psychoactive medications for 2 (Resident #1, #9 and #22) of 13 (Resident #1, #2, #3, #5, #8, #9, #11, #12, #13, #15, #16, #22 and #23) case mix residents that received psychoactive medications. These failed practices had the potential to affect 34 residents with a Physician's Order for proton pump inhibiting drugs and 69 residents who had a Physician's Order for psychoactive medications according to the Resident Census and Conditions of Residents form dated 12/11/07. The findings are: 1. Resident #6 had a diagnosis of Gastroesophageal Reflux Disease (GERD). The Quarterly Minimum Data Set (MDS) dated 10/21/07 documented the resident was moderately impaired in cognitive skills for daily decision making. a. A Physician's Order dated 8/29/07 documented, "Nexium (Esomeprazole Magnesium) 40 mg (milligram) 1 cap (capsule) PO (by mouth) QAM (every morning)." b. The Care Plan updated 10/18/07 documented, | F 329 | | | |

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| F 329 | <p>Continued From page 30</p> <p>"Problem: Risk of GI (Gastro Intestinal) distress related to GERD. ...Approaches: Review medications for therapeutic and nontherapeutic effects."</p> <p>c. On 12/14/07 at 10:30 a.m., the clinical record was reviewed. There were no indications for the use of Nexium.</p> <p>d. The "Drug Information Handbook for Nursing 2007" 8th Edition, Page #449 documented short-term (4-8 weeks) for the treatment of GERD. Under "Symptomatic gastroesophageal reflux: Oral 20 mg once daily for 4 weeks; may consider an additional 4 weeks of treatment if symptoms do not resolve."</p> <p>2. Resident #11 had a diagnosis of GERD. The Significant Change MDS dated 9/18/07 documented the resident was severely impaired in cognitive skills for daily decision making and was totally dependent on staff for all activities of daily living.</p> <p>a. A Physician's Order dated 2/09/07 documented, "Prilosec (Omeprazole) 20 mg 1 tab (tablet) PO Q AM @ (at) 0600 (6:00 a.m.)."</p> <p>b. The Care Plan updated 11/14/07 did not document the resident to be at risk for GERD or gastric distress.</p> <p>c. On 12/12/07, the clinical record was reviewed. There was no documentation found in the Nurse's Notes that the resident experienced epigastric discomfort or clinical rationale for the continued use of Prilosec.</p> <p>d. The Drug Information Handbook for Nursing</p> | F 329 | | | |

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| F 329 | Continued From page 31 2007, 8th edition, page #911 documented Prilosec short term (4-8 weeks) treatment for symptoms associated with GERD. Under dosing for Symptomatic GERD it is documented "Oral: 20 mg/day for up to 4 weeks". 3. Resident #3 had diagnoses of Parkinson's Disease, History of Trans-Ischemic Attack and Insulin Dependent Diabetes Mellitus. The Quarterly MDS dated 10/9/07 documented the resident was moderately impaired in cognitive skills for daily decision making. a. The Physician's Order dated 7/29/06 documented "Omeprazole (Prilosec) 20mg po Q AM." b. The Drug Regimen Review dated from 2/2/07 through 11/27/07 had no documentation from the consultant pharmacist requesting rationale from the physician for the continued use of the of the Prilosec. c. A review of the Medication Record dated 11/1/07 thru 11/30/07 documented that the resident had received omeprazole daily. d. A review of the Medication Record dated 12/1/07 to current date of 12/14/07 documented that the resident had received omeprazole daily. e. The Drug Information Handbook for Nursing 2007, 8th edition, page #911 documented Prilosec short term (4-8 weeks) treatment for symptoms associated with GERD. 4. Resident #21 had diagnoses of Quadriplegia, Cerebrovascular Accident with Right-sided Hemiparesis, and Gastrostomy. The Initial | F 329 | | | |

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| F 329 | <p>Continued From page 32</p> <p>Assessment MDS dated 9/23/07 documented the resident was severely impaired in cognitive skills for daily decision making.</p> <p>a. A Physician's Order dated 9/18/07 documented, "Prevacid (lansoprazole) 30mg sol tab 1 tab via PEG (percutaneous esophagoenterostomy) tube QD at 0600."</p> <p>b. The Drug Regimen Review dated 11/28/07 had no documentation from the consultant pharmacist requesting rationale from the physician for the continued use of the of the Prilosec.</p> <p>c. The Medication Record dated 12/1/07 to current 12/14/07 documented that the resident had received Prevacid daily.</p> <p>d. The Drug Information Handbook for Nursing 2007, 8th edition, page #708 documented under Dosing "Symptomatic GERD: Oral: Short-term treatment 15 mg once daily for up to 8 weeks."</p> <p>5. Resident #22 had a diagnosis of GERD. The Quarterly MDS dated 11/7/07 documented the resident was independent in cognitive skills for daily decision making.</p> <p>a. A Physician's order dated 3/7/07 documented "Prevacid (Lansoprazole) 30 mg 1 cap (capsule) PO QD (every day)."</p> <p>b. The Care Plan updated on 11/7/07 documented, "Epigastric Discomfort, Related to GERD. ... Assess non-verbal signs of pain... Assess verbal complaints of pain... Provide small, frequent meals rather than three large</p> | F 329 | | | |

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| F 329 | <p>Continued From page 33</p> <p>ones. Encourage [Resident #22] not to lie flat for at least 30 minutes to one hour after meals."</p> <p>c. On 12/13/07, the clinical record was reviewed. There was no documentation of epigastric discomfort in the last 4 months in the Nurse's Notes.</p> <p>d. The Drug Information Handbook for Nursing 2007, 8th edition, page #708 documented under Dosing "Symptomatic GERD: Oral: Short-term treatment 15 mg once daily for up to 8 weeks."</p> <p>e. A Physician's Order dated 3/07/07 documented, "Elavil (Amitriptyline HCL) 20 mg 1 cap PO QHS (every hour of sleep) at 2100 (9:00 p.m.) DX (diagnosis) Depression."</p> <p>f. A Nurse's Note dated 8/22/07 at 2:50 p.m. documented, "Orders rec'd (received) from [physician name] to D/C (discontinue) the following Dx's (diagnoses) Hyponatremia, Anxiety & (and) Depression."</p> <p>g. On 12/14/07, the Medication Administration Record (MAR) for December 2007 documented, "Elavil (Amitriptyline HCL) 20 mg 1 cap po HS at 2100 DX: Depression." The dates 1 thru 13 were initialed.</p> <p>6. Resident #9 had diagnosis of Dementia with Behavior. The Significant Change MDS dated 10/2/07 documented the resident was moderately impaired in cognitive skills for daily decision making, had no mood indicators and exhibited no behaviors.</p> <p>a. A Physician's Order dated 7/30/07 documented, "Haldol (Haloperidol) 0.5 mg 1 tab</p> | F 329 | | |

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| F 329 | <p>Continued From page 34 PO BID (twice a day)."</p> <p>b. On 11/2/07, the Consultant Pharmacist sent a note to the attending Physician informing him of the need for a dose reduction of the Haldol 0.5 mg given twice a day.</p> <p>c. On 11/8/07, the Physician faxed a response back to the facility to reduce the Haldol to 0.25 mg AM and 0.5 mg in the PM.</p> <p>d. A Physician's Telephone Order dated 12/11/07 documented, "DC Haldol 0.5 mg 1 tab PO Bid Give Haldol 0.25 mg in AM and 0.5 mg QHS."</p> <p>e. The December 2007 Medication Administration Record documented "Haloperidol 0.5 mg 1 tab (tablet) PO (by mouth) BID (twice a day)". Resident #9 had continued to receive the original dose of Haldol for 33 days after the Physician had ordered a reduction.</p> <p>f. On 12/12/07, the clinical record was reviewed. There were no documented behaviors in the Nurse's Notes to indicate a need for an antipsychotic drug.</p> <p>g. On 12/12/07 at 10:45 a.m., LPN #3 was asked whose responsibility it was to monitor physician and pharmacist recommendations for changes. The LPN stated, "[DON]. They are faxed to her and she is supposed to bring them to us so we can make the changes. I never saw that piece of paper until it was handed to me yesterday. I wrote the new order." The LPN was asked if she gave the 0.5 mg or 0.25 mg of Haldol this morning. The LPN stated, "I broke it in half and gave 0.25 mg."</p> | F 329 | | | |

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| F 329 | <p>Continued From page 35</p> <p>7. Resident #1 had diagnoses of Alzheimer Disease, Dementia, Depression, and Anxiety. The Quarterly MDS dated 11/5/07 documented the resident was severely impaired in cognitive skills for daily decision making and had no mood indicators or behavioral symptoms.</p> <p>a. A Physician's Order dated 6/26/07 documented, "DC Ativan 0.5 mg [at] 0800 (8:00 a.m.) and 1500 (3:00 p.m.). Give Ativan 1 mg 1 PO [at] 0800 and 1500 dx: (diagnoses) anxiety."</p> <p>b. A Physician's Order dated 7/12/07 documented "DC Ativan 1mg [at] 0800 and 1500. Ativan 1 mg 1 PO [at] 0600 (6:00 a.m.) and 1800 (6:00 p.m.)."</p> <p>c. On 10/31/07, the consultant pharmacist sent a request to the attending physician, informing the physician of a needed dosage reduction for Ativan 1 mg BID. The physician sent back the request dated 11/8/07 and the response was disagree and hand wrote "stable."</p> <p>d. The Medication Administration Records from 6/26/07 through 12/12/07 documented the resident received Ativan 1 mg 1 tab po at 6:00 a.m. and 6:00 p.m.</p> <p>e. The August 2007 Physician's Order Sheet documented, "Ativan 1 mg 1 tab po at 0600 and 1800."</p> <p>f. On 12/11/07, the clinical record was reviewed. There was no documentation in the Nurse's Notes regarding resident behaviors.</p> <p>g. On 12/12/07 at 6:00 p.m., the Director of</p> | F 329 | | | |

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| F 329 | Continued From page 36 Nursing (DON) was asked about behavior assessments for residents that received antipsychotic and psychoactive medications. The DON stated, "We don't have any behavioral assessment forms." The DON was asked if any documentation was available that justified the use of Ativan, and the DON stated, "No." | F 329 | | | |
| 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 and record review of the 4:00 p.m. medication pass on 12/10/07 and the 8:00 a.m. medication pass on 12/11/07, the facility failed to ensure the medication error rate was less than 5%. Physician's Orders were not followed on 4 (Resident #14, #15, #16 and #17) of 12 residents observed during the medication passes. Medication errors were made by 3 Licensed Practical Nurses (LPN's #1, #2 and #3) of 6 nurses that administered medications. This failed practice had the potential to affect 79 residents that received medications from those nurses according to the Director of Nursing (DON) on 12/11/07. The medication error rate was 11.36% based on administration of 43 medications plus 1 medication that was ordered but not administered and observation of a total of 5 errors. The findings are: 1. Resident #14 had a Physician's Order dated 4/25/07 for Systane lubricant eye drops to use 2 drops in each eye 4 times per day. | F 332 | | | |

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| F 332 | Continued From page 37 On 12/10/07 at 4:40 p.m., LPN #1 administered 2 drops of Artificial Tears with no time between the drops. 2. Resident #15 had a Physician's Order dated 8/10/07 for Saline nasal spray to administer 2 sprays in each nostril, a Physician's Order dated 6/2/07 for an Advair 250/50 Diskus to use one puff twice a day and an order dated 6/2/07 for a Spiriva inhaler to use one puff every day. a. On 12/11/07 at 7:53 a.m., only 1 spray of the Saline nasal spray was administered in the left nostril by LPN #2. Both inhalers were administered 19 seconds apart. b. Federal guidelines require at least one minute between puffs to ensure maximum benefit from both inhalers. 3. Resident #16 had a Physician's Order dated 7/10/06 for Vitamin E 400 I.U. twice a day. On 12/11/07 at 8:05 a.m., LPN #3 did not administer the Vitamin E. 4. Resident #17 had a Physician's Order dated 4/7/06 for Refresh Liquigel to use 2 drops in each eye 4 times a day. On 12/11/07 at 8:35 a.m., only one drop was administered by LPN #3. | F 332 | | | |
| F 366 SS=E | 483.35(d)(4) FOOD Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. | F 366 | | | |

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| F 366 | <p>Continued From page 38</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure substitutes were offered for items not eaten at meals for 4 (Resident #1, #6, #12 and #18) of 22 (Resident #1, #2, #3, #4, #5, #6, #7, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21 and #22) case mix residents who received their meals from the kitchen. This failed practice had the potential to affect 92 residents who received their meal trays from the kitchen as documented on the diet list dated 12/19/07. The findings are:</p> <p>1. Resident #1 had diagnoses of Pneumonia, Alzheimer's disease and Dementia. The Quarterly Minimum Data Set (MDS) dated 10/29/07 documented the resident was severely impaired in cognitive skills for daily decision making and required one person assist for eating.</p> <p>a. A Physician's Order dated 9/24/07 documented the resident was to receive a regular mechanical soft diet with pureed meat and fortified foods.</p> <p>b. The Care Plan dated 11/5/07 documented the resident was at nutritional risk due to a diagnosis of Alzheimers and the goal was to provide the resident with food preferences to enhance enjoyment and intake.</p> <p>c. On 12/11/07 at 8:05 a.m., the resident was served corn flakes, scrambled eggs, pancakes, a carton of prune juice and a carton of whole milk. The resident did not eat the pancakes or scrambled eggs. There were no substitutes offered to the resident by the staff.</p> | F 366 | | | |

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| F 366 | <p>Continued From page 39</p> <p>d. On 12/11/07 at 12:32 p.m., the resident was served pureed ham, a bowl of northern beans, turnip greens, corn bread, slices of pineapple, cottage cheese, a carton of butter milk, a carton of Shasta cola, tea and water. The resident did not eat the cottage cheese or corn bread, took 3 bites of the pureed ham, drank half of the Shasta cola, took two bites of the turnip greens and drank 1/4 of the butter milk. At 12:47 p.m., Certified Nursing Assistant (CNA) #1, who fed the resident, stated, "The resident does not like greens, eat cottage cheese sometimes, has a hard time swallowing corn bread and she is just getting used to puree food." The CNA did not offer substitutes to the resident in place of food items not eaten.</p> <p>2. Resident #6 had diagnoses of Congestive Heart Failure and Hypertension. The Quarterly MDS dated 10/17/07 documented the resident was moderately impaired in cognitive skills for decision making and required set up help only for eating.</p> <p>a. A Physician's Order dated 9/18/07 documented for the resident to receive a Mechanical Soft diet.</p> <p>b. On 12/10/07 at 5:45 p.m., the resident was served ground ham, mashed potatoes, mixed vegetables, applesauce, cream of chicken soup and 4 oz cranberry juice. The resident only ate 2 bites of the mixed vegetables. There were no substitutes offered to the resident by the staff.</p> <p>c. On 12/11/07 at 12:18 p.m., the resident was served ground ham with brown gravy, mashed potatoes, greens, three packets of crackers, 1/2 ounce of peanut butter, one packet of jelly,</p> | F 366 | | | |

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| F 366 | Continued From page 40 brownie and 4 ounce of cranberry juice. The resident ate the jelly, icing on the brownie, drank all of cranberry juice, took a sip of water and tea and left the dining room. There was no attempt made by the staff to encourage the resident to eat and no substitutes offered to the resident by the staff. 3. Resident #12 had diagnoses of Dementia with Behaviors, Alzheimer's Disease and Non Insulin Dependent Diabetes Mellitus. The MDS dated 8/30/07 documented the resident was moderately impaired in cognitive skills for daily decision making and required set up help only for eating. a. A Physician's Order dated 4/16/07 documented, "Regular, No Concentrated Sweets. Sugar free fortified foods." b. The Care Plan dated 11/14/07 documented the resident was at nutritional risk related to a diagnoses of Alzheimer's and approaches for the problem were provide the resident with food preferences to enhance enjoyment and intake. c. On 12/10/07 at 5:35 p.m., the resident was served spaghetti with meat sauce, Brussels sprouts, mixed fruit, one garlic bread, strawberry yogurt and a carton of 2 % reduced milk. The resident ate 1/2 of the yogurt, took two bites of the mixed fruits and drank the milk. There were no substitutes offered to the resident by the staff and no encouragement was provided by the staff for the resident to eat. d. On 12/11/07 at 12:34 p.m., the resident was served ham, turnip greens, northern beans, corn bread, cottage cheese, five vanilla wafers and 8 ounces of Shasta cola. The resident left the | F 366 | | | |

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| F 366 | Continued From page 41 cottage cheese, turnip greens, corn bread and 1/4 of the ham. She wheeled her self out of the dining room. There was no attempt made by the staff to encourage her to eat or offer her substitutes for the food items not eaten. 4. Resident #18 had diagnoses of Diabetes Mellitus Type II, and Alzheimer,s Dementia. The MDS dated 9/12/07 documented the resident was severely impaired in cognitive skills for daily decision making and required one person assist for eating. a. A Physician's Order dated 4/24/07 documented the resident was to receive a mechanical soft /No Concentrated Sweets diet with fortified foods. b. The Care Plan dated 6/26/07 documented the resident was at risk for inadequate nutrition due to being on therapeutic diet. c. On 12/11/07 at 12:25 p.m., the resident was served northern beans, corn bread, five vanilla wafers cookies, two cartons of apple juice, carton of prune juice, cottage cheese. At 1:35 p.m., the resident left cottage cheese, turnip greens and beans. Certified Nursing Assistant #2 stated, " No body is eating the turnip greens." | F 366 | | | |
| F 406 SS=E | 483.45(a) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the | F 406 | | | |

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| F 406 | <p>Continued From page 42</p> <p>required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that Occupational Therapy was provided as ordered for 1 (Resident #1) of 1 case mix resident who had a Physician's Order for Occupational Therapy. This failed practice had the potential to affect 10 residents who had a Physician's Order for Occupational Therapy as documented on a list provided by the staff coordinator on 12/14/07. The findings are:</p> <p>Resident #1 had diagnoses of Degenerative Joint Disease, Osteoarthritis, Dementia, Syncopy Episodes and Generalized Pain. The quarterly Minimum Data Set dated 11/5/07 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistance for bed mobility and locomotion, had limitations in range of motion with partial loss of voluntary movement of both arms, was unable to attempt the balance test for sitting and standing without physical support, had a chewing problem and did not receive specialized therapies that included Occupational Therapy (OT).</p> <p>a. A Physician's Telephone Order dated 9/24/07 documented, "OT consult for positioning to [increase] swallow safety [and] efficiency." Physician Order sheets dated 10/2007, 11/2007 and 12/2007 documented the same OT consult orders.</p> | F 406 | | | |

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| F 406 | Continued From page 43 b. The Care Plan dated 11/5/07 documented a problem for ADL assistance related to Osteoarthritis with an approach, "supportive devices for good body alignment and comfort." The resident's Care Plan did not document approaches for provision of OT services. c. On 12/11/07 at 8:59 a.m. and 10:34 a.m. the resident was in a wheelchair and leaned to the right side without supportive / positioning devices present in the chair. d. On 12/13/07, the clinical record was reviewed. Physician Progress Notes, Nurse's Notes and Rehabilitative services records did not contain documentation of the ordered OT consult for positioning. e. On 12/13/07 at 2:01 p.m., the Director of Nursing stated she had spoken to a therapist in the rehab unit who had told her, "the order must have fallen through the cracks." A request was made at that time for a written statement from that therapist. f. On 12/13/07 at 2:40 p.m., the Staff Coordinator provided a typed statement that documented Physical Therapist #1 had spoken to OT #1 (who was out of state at that time) and OT #1 stated, "She has no knowledge of an order for [Resident #1]. The rehab department has no record of the Physician's Order for an OT Consult. | F 406 | | | |
| F 428 SS=E | 483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to | F 428 | | | |

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| F 428 | <p>Continued From page 44</p> <p>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: Based on record review, the facility failed to ensure the drug regimen review, performed by a licensed pharmacist, was reported to the physician and Director of nursing (DON), that proton pump inhibitor medications were being administered beyond the manufacturer's recommended time frame and without evidence of therapeutic benefit for 5 (Resident #3, #6, #11, #21 and #22) of 7 (Resident #2, #3, #6, #11, #19, #21, and #23) that received proton pump inhibitor medications. This failed practice had the potential to affect 34 residents who had a Physician's Order for proton pump inhibitor medications according to a list provided by the staff coordinator on 12/14/07. The findings are:</p> <p>1. Resident #6 had a diagnosis of Gastroesophageal Reflux (GERD). The Quarterly Minimum Data Set (MDS) dated 10/21/07 documented the resident was moderately impaired in cognitive skills for daily decision making.</p> <p>a. A Physician's Order dated 8/29/07 documented, "Nexium (Esomeprazole Magnesium) 40 mg (milligram) 1 cap (capsule) PO (by mouth) QAM (every morning)."</p> <p>b. The Drug Regimen Review dated 9/3/07, 10/30/07 and 11/26/07 by a consultant</p> | F 428 | | | |

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| F 428 | Continued From page 45 pharmacist had no documentation that the Physician or Director of Nursing (DON) had received notification that the resident was taking a proton pump inhibitor beyond the manufacturer's recommendation, beyond the length of time advised by current standards of practice and without evidence of therapeutic benefit. 2. Resident #11 had a diagnosis of GERD. The Significant Change MDS dated 9/18/07 documented the resident was severely impaired in cognitive skills for daily decision making and was dependent on staff for all activities of daily living. a. A Physician's order dated 2/9/07 documented "Prilosec (Omeprazole) 20 mg 1 tab (tablet) Q every AM [at] 0600 (6:00 a.m.)." b. The Drug Regimen Review dated 4/26/07, 6/01/07, 7/03/07, 8/29/07, 10/30/07 and 11/26/07 by a consultant pharmacist had no documentation that the Physician or DON had received notification that the resident was taking a proton pump inhibitor beyond the manufacturer's recommendation, beyond the length of time advised by current standards of practice, and without evidence of therapeutic benefit. 3. Resident #22 had a diagnosis of GERD. The Quarterly MDS dated 11/7/07 documented the resident was independent in cognitive skills for daily decision making a. A Physician's order dated 3/7/07 documented "Prevacid (Lansoprazole) 30 mg 1 cap capsule PO by mouth QD (every day)." b. The Drug Regimen Review dated 5/31/07, | F 428 | | | |

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| F 428 | <p>Continued From page 46</p> <p>7/31/07, 8/29/07, 10/30/07 and 11/27/07 by a consultant pharmacist had no documentation that the Physician or DON had received notification that the resident was taking a proton pump inhibitor beyond the manufacturer's recommendation, beyond the length of time advised by current standards of practice, and without evidence of therapeutic benefit.</p> <p>c. The Drug Regimen Review dated 5/01/07, 5/29/07, 7/09/07, 7/31/07, 9/04/04, 10/31/07, and 11/27/07 by a consultant pharmacist had no documentation that the Physician or DON had been notified that the drug Elavil continued to be administered even though the diagnosis had been removed from the diagnosis list on 8/22/07.</p> <p>4. Resident #3 had diagnoses of Parkinson's Disease, History of Trans-Ischemic Attack, Insulin Dependent Diabetes Mellitus. The Quarterly Minimum Data Set (MDS) dated 10/9/07 documented that the resident had moderately impaired cognitive skills for daily decision-making.</p> <p>a. A Physician's Order dated 7/29/2006 documented, "Prilosec 20mg 1 po Q AM morning.</p> <p>b. The Drug Regimen Review dated 3/17/07, 5/01/07, 5/29/07, 7/09/07, 7/31/07, 9/04/07, 10/31/07 and 11/27/07 by a consultant pharmacist had no documentation that the Physician or DON had received notification that the resident was taking a proton pump inhibitor beyond the manufacturer's recommendation, beyond the length of time advised by current standards of practice, and without evidence of</p> | F 428 | | | |

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| F 428 | Continued From page 47 therapeutic benefit. c. A review of the Medication Record dated 12/1/07 to current date of 12/14/07 documented that the resident had received omeprazole daily. 5. Resident #21 had diagnoses of Quadriplegia, Cerebrovascular Accident with Right-sided Hemiparesis, and Gastrostomy. The Initial Assessment Minimum Data Set dated 9/23/07 documented that the resident had severely impaired cognitive skills for daily decision-making. a. A Physician's Order dated 9/18/07 documented, "Prevacid (lansoprazole) 30mg sol tab 1 tab via PEG (Percutaneous Enterogastrostomy) tube QD every day at 0600." b. The Medication Record dated 12/1/07 to current 12/14/07 documented that the resident had received Prevacid daily. c. The Drug Regimen Review dated 10/31/07 and 11/28/07 by a consultant pharmacist had no documentation that the Physician or DON had received notification that the resident was taking a proton pump inhibitor beyond the manufacturer's recommendation, beyond the length of time advised by current standards of practice, and without evidence of therapeutic benefit. 6. The "Drug Information Handbook for Nursing 2007" 8th Edition, Page #449 documented for Nexium short-term (4-8 weeks) for the treatment of GERD. Under "Symptomatic gastroesophageal reflux: Oral 20 mg once daily for 4 weeks; may consider an additional 4 weeks of treatment if symptoms do not resolve." | F 428 | | | |

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| F 428 | Continued From page 48 | F 428 | | |
| F 441 SS=D | <p>7. The Drug Information Handbook for Nursing 2007, 8th edition, page #911 documented for Prilosec short term (4-8 weeks) treatment for symptoms associated with GERD. Under dosing for Symptomatic GERD it is documented "Oral: 20 mg/day for up to 4 weeks".</p> <p>8. The Drug Information Handbook for Nursing 2007, 8th edition, page #708 documented for Prevacid under Dosing "Symptomatic GERD: Oral: Short-term treatment 15 mg once daily for up to 8 weeks."</p> <p>483.65(a) INFECTION CONTROL</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: Based on observation, record review and interview, the facility failed to ensure infection control measures were followed for 2 (Resident #4 and #7) of 2 case mix residents in contact isolation. This failed practice had the potential to affect all 102 residents as documented on the Resident Census and Conditions of Residents form dated 12/11/07. The findings are:</p> | F 441 | | |

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| F 441 | <p>Continued From page 49</p> <p>1. Resident #4 had diagnoses Dementia with Behaviors (end stage), Non-Insulin Diabetes Mellitus, Failure to Thrive, and Urinary Tract Infection (UTI) with Methicillin Resistant Staphylococcus Aureus (MRSA). The Quarterly Minimum Data Set (MDS) dated 9/12/07 documented the resident was severely impaired in cognitive skills for daily decision making and totally dependent for transfers.</p> <p>a. The Care Plan dated 11/2/07 documented, "MRSA in urine- UTI noted ... Contact Isolation ..."</p> <p>b. On 12/11/07 at 11:55 a.m., Certified Nursing Assistant (CNA) # 1 used a Hoyer Lift to transfer the resident to a geri-chair. The CNA rolled the Hoyer Lift to the shower room on the 600 hall and applied alcohol gel (BioSoft Alcohol Hand Sanitizer) to a paper towel and wiped the Hoyer Lift bars.</p> <p>c. On 12/11/07 at 12:15 p.m., the CNA was asked what was used to clean the lift. The CNA stated, "We use alcohol gel."</p> <p>d. On 12/14/07 at 10:00 a.m. the DON was asked what was used to disinfect the Hoyer Lifts after it was used on a resident on Contact Isolation. The DON stated, "We're using the wipes with some kind of germicide."</p> <p>e. On 12/14/07 at 10:30 a.m., the DON produced a container of the Sani-Cloth Germicidal Towelettes and stated, "This is what is used to clean the lift." The DON was informed that a CNA, after using a lift on a resident in contact isolation, cleaned the lift with alcohol gel. The DON was asked if this was adequate for disinfecting the Hoyer Lift. The DON stated. "No."</p> | F 441 | | | |

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| F 441 | Continued From page 50 f. The Material Safety Data Sheet (MSDS) for the Sani-Cloth Germicidal Towelette provided by the DON on 12/14/07 at 10:30 a.m. documented: "... ingredients ... isopropyl alcohol 55% ... quaternary ammonium CMPD [compound] < [less than] 1%. ..." g. A copy of the label on the BioSoft Alcohol Hand Sanitizer provided by the Maintenance Manager on 12/13/07 at 10:00 a.m. documented: "... active ingredient ethyl alcohol 63% ..." h. A policy and procedure for cleaning and sanitizing equipment documented, "... wheelchairs and other moveable equipment ...they are to be taken into the showers, wet down, and scrubbed using DAWN dish detergent ..." i. On 12/12/07 at 10:17 a.m., Licensed Practical Nurse (LPN) # 4 provided incontinent care for the resident. The LPN cleansed stool from the rectal area. Without changing gloves, the LPN reached into the open drawer of the bedside table and picked up a bottle of Aloe Vesta Foam. The LPN sprayed the resident's rectal area and replaced the bottle back in the drawer. j. On 12/13/07 at 5:10 p.m., the LPN was asked if gloves had been changed during the incontinent care provided on 12/12/07. The LPN stated, "No, I guess I messed up." 2. Resident #7 had diagnoses of Vascular End Stage Dementia and Acute Urinary Tract Infection. The Quarterly MDS dated 11/19/07 documented the resident was moderately impaired in cognitive skills for daily decision | F 441 | | | |

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| F 441 | Continued From page 51 making and had an indwelling catheter. a. On 12/10/07 at 1:45 p.m., the resident had a sign posted on the door to the room that documented, "Contact Precautions ...wear gloves when entering room. Change gloves after contact with infective material. Remove gloves before leaving patient's room..." b. On 12/11/07 at 10:20 a.m., Hospice CNA #1 removed gloves after entering the resident's room and then combed the resident's hair, replaced the oxygen tubing into the nares, and applied a handroll. No gloves were worn during the direct care in the resident's room. c. On 12/11/07 at 10:24 a.m., Registered Nurse #1 entered the resident's room without wearing gloves and touched resident before leaving the room. d. On 12/11/07 at 4:25 p.m., CNA #6 cleansed the resident's rectal area then provided catheter care and had not changed gloves between procedures. | F 441 | | | |