

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW REHABILITATION &amp; HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 BARROW ROAD</b> <b>LITTLE ROCK, AR 72204</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 157 SS=E	<p>Complaint #13577 was substantiated (all or in part) with a deficiency cited at F314.</p> <p>Complaint #13602 was substantiated (all or in part) with deficiencies cited at F157 and F314.</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>	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>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: Complaint #13602 was substantiated (all or in part) with these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure the physician was immediately consulted after complaints of new pain for 1 (Resident #4) of 19 case mix residents (Residents #1 through #13 and #16 through #21). The failed practice had the potential to affect all 110 residents who could potentially experience new onset pain, as documented on the Resident Census and Conditions of Residents form dated 6/19/08. The findings are:</p> <p>Resident #4 had diagnoses of Cerebrovascular Accident, Left-sided Hemiplegia and Aphasia. The Quarterly Minimum Data Set (MDS) dated 6/6/08 documented the resident was moderately impaired in cognitive skills for daily decision making, rarely was understood and usually understood others and had lost some or all natural teeth.</p> <p>a. Printed Physician Order sheets signed on 6/6/08 documented: "Routine... May have podiatry and dental consults PRN [as needed]."</p> <p>b. On 6/17/08 at 10:03 a.m., Licensed Practical Nurse (LPN) #3 and Certified Nursing Assistants (CNA's) #8 and #12 were in the resident's room. The resident was non-verbal, but appropriately</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>answered yes/no questions by nodding/shaking her head. The resident repeatedly pointed and held her right hand to her lower mouth. The Surveyor asked the resident if she could look at her mouth and the resident nodded, "Yes." The resident had no teeth in her upper gums, 3 teeth in the lower gums and at least one tooth in the lower gums that was broken at the gumline. No bleeding was noted.</p> <p>1.) The Surveyor asked the resident, "Do your teeth hurt?" The resident nodded, "Yes." The surveyor asked the resident, "Have you told others?" The resident nodded, "Yes." CNA #8 stated, "Been pointing at her mouth all morning long."</p> <p>2.) After a transfer to the bed from a wheelchair, the resident continued to hold her right hand to her mouth/lower jaw. CNA #8 stated the nurse was going to call the resident's family and, "wants dentures." There was no discussion about addressing the resident's complaint of mouth/tooth pain.</p> <p>c. On 6/18/08 at 2:08 p.m., the resident's daughter was asked if the facility had notified her about the resident's mouth pain. She stated on Tuesday (6/17/08) the facility called her about the resident's dentures. She denied the facility had told her about the resident's complaint of pain on that day.</p> <p>d. On 6/19/08 at 2:40 p.m., the Director of Nursing (DON) was informed of the resident's complaint of mouth pain that was made on 6/17/08, while LPN #3 and CNA's #8 and #12 were present in the resident's room, a period of 52 hours and 37 minutes prior. The DON was not</p>	F 157			

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F 157	Continued From page 3 aware of the resident's complaint on that day. The DON was asked to provide evidence of an assessment of the resident's pain and consult with a physician since that date.	F 157			
F 221 SS=E	e. On 6/20/08 at 11:00 a.m., the Licensed Social Worker (LSW) was asked if she had knowledge of the resident's complaints of pain on 6/17/08 and whether any dental services were planned for the resident. The LSW stated no one had told her, "anything, except with [resident], they told me this morning and we've got her a dentist appointment."  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: Based on observation, record review and interview, the facility failed to ensure assessments were conducted or less restrictive alternative measures were attempted prior to the initiation of physical restraints, failed to ensure restraint reduction attempts were made and failed to ensure reassessments for the continued appropriateness of restraint use were conducted for 5 (Residents #6, #11, #12, #16 and #17) of 7 case mix residents with restraints in use (Residents #4, #6, #11, #12, #16 and #17). The failed practices had the potential to affect 16 residents with physical restraints in use, as identified by the Administrator on 6/20/08. The findings are:	F 221			

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F 221	<p>Continued From page 4</p> <p>1. Resident #16 had diagnoses of Agitation, Alzheimer's Disease and Weakness. The Quarterly Minimum Data Set (MDS) dated 5/15/08 documented the resident was severely impaired in cognitive skills for daily decision making, independent with locomotion on and off the unit and used a chair that prevented rising daily.</p> <p>a. A Physical Therapy Screen Form dated 1/7/08 documented: "Pt [patient] [with] recent falls... feel R [resident] may require soft belt restraint."</p> <p>b. A physician order dated 1/8/08 documented the resident was to have a lap buddy in the wheelchair due to, "inability to ambulate alone due to poor judgement due to senile dementia."</p> <p>c. Physical Therapy Progress Notes dated 1/8/08 documented, "...Feel R [resident] requires lap buddy now 2 [secondary to] multiple falls. Nursing notified." There was no documentation that less restrictive alternatives were attempted prior to initiating the use of a physical restraint or of an assessment to determine the least restrictive restraint device that would be appropriate for the resident.</p> <p>d. The Care Plan dated 3/24/08 documented: "Restraint use related to cognitive deficit and loss of mobility... Approaches... assure restraint is applied properly, apply restraint(s) as ordered." The Care Plan did not address plans to assess the restraint use routinely or to attempt restraint reductions or time-limitations of the physical restraint.</p> <p>e. On 6/16/08 at 3:37 p.m. and 6/20/08 at 8:20 a.m., the resident was sitting in a wheelchair with</p>	F 221			

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F 221	<p>Continued From page 5 a lap buddy in place.</p> <p>f. On 6/20/08 at 10:05 a.m., Assistant Director of Nursing (ADON) #2 was asked to provide information about the restraint use for this resident. On 6/20/08 at 11:30 a.m., ADON #2 stated the resident, "is in a lap buddy because of falls." ADON #2 was asked about evaluations for the use of the restraint or attempts to reduce restraint use for the resident and she stated, "We don't have it. This is all we have."</p> <p>2. Resident #4 had diagnoses of Hypertension, Cerebrovascular Accident (CVA) and Congestive Heart Failure. The Significant Change MDS dated 5/15/08 documented the resident was severely impaired in cognitive skills for daily decision making, required limited assistance for locomotion on and off the unit and used no physical restraints.</p> <p>a. A Physical Restraint Consent form dated 9/24/07 documented, "Soft belt in w/c [wheelchair]... I understand the reasons for this restraint are: safety." The section of the form designated for documentation of, "less restrictive measures attempted prior to restraint request" was blank.</p> <p>b. A Telephone Order dated 12/20/07 documented, "PT [Physical Therapy] eval [evaluation] for restraint reduction and transfers."</p> <p>c. A Physical Therapy Progress Note dated 1/7/08 documented the resident was discharged from PT after 1/4/08 and, "Pt. [patient] [with] improved transfers from mod [moderate] A [assist] to min [minimal] A. Pt. however continues to require soft belt 2 [secondary to] attempts to</p>	F 221			

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F 221	Continued From page 6 get & pt. pulls on furniture in room." There was no documentation of an actual attempt to reduce physical restraint use for the resident at that time.  d. The Care Plan dated 4/8/08 documented: "...Restraint use with risk of complications... Assure restraint is applied properly, Apply restraints as ordered... release Q [every] 2 hr [hours] for activity..." The Care Plan problem did not document a specific medical symptom, planned reduction attempts or further time-limitations in restraint use for this resident.  e. The Physician Order sheet signed 6/6/08 documented an order dated 12/18/07 for, "Restraint: soft belt seat belt when in w/c due to unsteadiness for safety."  f. On 6/17/08 at 9:12 a.m., 12:57 p.m. and 5:55 p.m., the resident was sitting in a wheelchair at a feeder table in the South Dining Room with a soft belt restraint in place. Nursing staff were in attendance, but the soft belt restraint was not released during this time of direct staff supervision.  g. On 6/18/08 at 4:40 p.m., the Director of Nursing (DON) was asked to provide evidence of an assessment prior to restraint use that determined the least restrictive, appropriate restraint device and attempts at restraint reduction since September 2007. The requested documentation had not been provided as of 6/20/08 at 6:15 p.m.  3. Resident #6 had diagnoses of Arthritis, Depression and Cervical Spine Stenoses. The MDS dated 5/29/08 documented the resident was moderately impaired in cognitive skills for daily	F 221			

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F 221	<p>Continued From page 7</p> <p>decision making, totally dependent on staff for transfers and locomotion and used a chair that prevented rising daily.</p> <p>a. A physician order dated 2/23/08 documented: "Restraint: Soft belt seat belt when in w/c [wheelchair] D/T [due to] inability to ambulate alone due to confusion and disorientation."</p> <p>b. An Occupational Therapy Screen Form dated 3/25/08 documented: "Comments... recommend at this time pt [patient] be placed on bed/w/c [bed/wheelchair] schedule where pt up in chair [for] meals + [and] placed back in bed after meals for his safety."</p> <p>c. An Occupational Therapy Outcome Progress Note dated 3/26/08 documented the resident was also issued a non-releasable belt, "but he removes and falls out of chair. Recommend pt be placed on w/c [wheelchair] to bed schedule where pt is up in w/c for all meals and placed back in bed after meals to avoid him rocking the w/c and falling to increase his safety."</p> <p>d. On 6/16/08 at 3:30 p.m., 6/17/08 at 8:30 a.m. and 12:11 p.m. and 6/19/08 at 9:20 a.m., the resident was sitting in a wheelchair with a soft belt restraint in place.</p> <p>e. As of 6/19/08 at 9:20 a.m., there was no documentation in the clinical record of a pre-restraint assessment, quarterly restraint reduction assessments or reassessments for the continued appropriateness of using a restraint that had been in use when the resident fell.</p> <p>4. Resident #11 had diagnoses of Anxiety and Depression. The Quarterly Minimum Data Set</p>	F 221			

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F 221	Continued From page 8 dated 5/15/08 documented the resident had long and short term memory problems, was severely impaired in cognitive skills for daily decision making, required extensive assistance for transfers and required a trunk restraint daily.  a. A physician order dated 2/22/07 documented: "RESTRAINT: SOFT BELT SEAT BELT when in chair D/T [due to] Inability to ambulate alone D/T POOR JUDGEMENT (impulsive) check Q [every] 30 MINUTES release Q 2 HRS [hours] FOR ACTIVITY continuous use."  b. The Occupational Therapy Plan of Care for Rehabilitation form dated 4/21/08 documented: "Pt [patient] referred to skilled OT [Occupational Therapy] for w/c [wheelchair] positioning & [and] restraint reduction..."  c. A physician order dated 4/22/08 documented: "OT [Occupational Therapy] ORDER: 3 x wk x 3 [3 times per week for 3 weeks] for W/C [wheelchair] management and therapeutic exercise to ^ [increase] W/C position, restraint reductions."  d. The Occupational Therapy Discharge Progress Note dated 5/26/08 documented: "Clinical Impression: Pt [patient] demonstrates improvement [with] w/c positioning. Lowered her 18 [inches in] w/c so pt. could ambulate on own. Attempted pommel wedge cushion, but it elevated pt up in w/c & feet didn't reach floor, so, returned gel cushion [with] Dycem. Issues R [resident's] [right] armrest support to prevent leaning to L [left] & pt demonstrated improvements. Nursing staff educated on w/c equipment & proper positioning & ed [education] carryover noted." There was no documentation of OT recommendations for the	F 221			

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F 221	<p>Continued From page 9</p> <p>lap belt restraint to be continued.</p> <p>e. On 6/16/08 at 2:15 p.m., 6/17/08 at 8:40 a.m., 10:35 a.m., 12:40 p.m., 5:25 p.m. and 5:30 p.m. and 6/18/08 at 8:11 a.m., the resident was sitting in a wheelchair with a soft seat belt around her abdomen.</p> <p>f. On 6/18/08 at 3:45 p.m., the Assistant Director of Nursing was asked why the resident had on a lap belt and she provided a list of 9 falls dated 2006 as documentation of the reason the resident required a restraint. She stated the resident was "confused, combative and demented. That is why she is restrained."</p> <p>g. As of 6/18/08, there was no documentation in the clinical record of a restraint reduction attempt and no documentation of a current clinical rationale for the continued use of the belt restraint.</p> <p>5. Resident #17 had diagnoses of Parkinson's Disease and Cerebral Vascular Disease. The MDS dated 4/14/08 documented the resident was moderately impaired in cognitive skills for daily decision making.</p> <p>a. A Physical Restraint Consent form dated 3/25/07 documented: "Reason for this restraint: Fall Precaution." The section of the form designated for documentation of less restrictive measures attempted documented: "None."</p> <p>b. A physician order dated 8/27/07 documented: "Soft belt seat belt when in w/c to increase mobility D/T poor judgement due to unsteadiness R/T [related to] Parkinsonism."</p>	F 221			

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F 221	Continued From page 10 c. On 6/16/08 at 4:20 p.m. and 6/20/08 at 10:20 a.m., the resident was sitting in a wheelchair with a soft belt restraint in place.  d. As of 6/19/08, there was no documentation in the clinical record of a pre-restraint assessment, quarterly restraint reduction assessments or of less restrictive devices that were used prior to the initiation of the belt restraint.  e. On 6/19/08, the Director of Nursing was asked for a pre-restraint assessment, quarterly restraint reduction assessment or less restrictive devices used prior to the use of the restraint. As of 6/20/08 at 6:00 p.m., the facility had not provided the requested documentation.	F 221			
F 241 SS=B	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.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff provided care/services in a manner to promote resident dignity, as evidenced by failure to knock/wait for permission to enter prior to entering 3 non-case mix resident rooms and failure to provide appropriate, respectful assistance with a transfer to the commode for 1 (Resident #11) of 6 case mix residents who required assistance with transfers (Residents #2, #8, #10, #11, #12 and #21). The failed practice had the potential to affect all 110 residents, including 63 residents who required assistance with transfers, as documented on the Resident	F 241			

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F 241	Continued From page 11 Census and Conditions of Residents form dated 6/19/08. The findings are:  1. On 6/16/08 at 2:45 p.m. during the initial tour of the facility, the Surveyor was accompanied on rounds with Licensed Practical Nurse (LPN) #4. During the tour, Housekeeper #1 entered Rooms 409, 410 and 412 without knocking on the doors. LPN #4 stated the resident in Room 409 was alert but confused and the residents in Rooms 410 and 412 were alert and oriented.  2. Resident #11 had diagnoses of Anxiety and Depression. The Quarterly Minimum Data Set dated 5/15/08 documented the resident had long and short term memory problems, was severely impaired in cognitive skills for daily decision making, required extensive assistance of one person for transfers and required a trunk restraint daily.  On 6/19/08 at 10:03 a.m., Certified Nursing Assistant (CNA) #1 propelled the resident to the restroom, washed her hands, put on gloves and instructed the resident to stand. The resident grabbed the handrail with both hands and started pulling upwards. As the resident pulled upwards, CNA #1 grabbed the waistband of the resident's pants and, in assisting the resident to stand, pulled the waistband of the pants up to the resident's mid-back area, which caused the crotch of the pants to be pulled between the resident's buttocks. Once the resident was in a standing position, she bore her own weight and pivoted to turn to the commode.	F 241			
F 248 SS=E	483.15(f)(1) ACTIVITIES  The facility must provide for an ongoing program of activities designed to meet, in accordance with	F 248			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 248	<p>Continued From page 12</p> <p>the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an ongoing group activity program that was varied and included that were based on the assessed interests and wishes of 7 (Residents #2, #5, #8, #10, #11, #18 and #20) of 11 case mix residents who were capable of attending group activities (Residents #2, #3, #4, #5, #7, #8, #10, #11, #18, #19 and #20). The failed practice had the potential to affect 32 residents who routinely attended group activities, as documented on a list provided by the Administrator on 6/20/08. The findings are:</p> <ol style="list-style-type: none"> <li>1. On 6/17/08 at 10:00 a.m., a Group Interview was conducted with 6 alert and oriented residents. When asked about the facility's activity program, 6 of the 6 residents stated they needed more activities. Those residents also stated no one had asked them their specific interests, they would like more games, different card games (the residents stated the facility offered only one card game, "Bottoms-Up") and would like a manicure day, outdoor activities and the ability to go out to eat.</li> <li>2. Individual interviews were conducted between 6/17/08 and 6/20/08 with 5 alert and oriented residents. Three of five residents made statements as follows: <ol style="list-style-type: none"> <li>a. "Activity Director doesn't come see me." This statement was made by a resident who had not</li> </ol> </li> </ol>	F 248			

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

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F 248	Continued From page 13 been able to attend activities due to limited mobility. (6/20/08 at 9:35 a.m.)  b. "Would like to play more cards, bridge or lift weights." (6/20/08 at 9:30 a.m.)  c. "Nothing outdoors." (6/19/08 at 8:25 a.m.)  3. Activity Calendars dated for April, May and June 2008 were reviewed. Those calendars did not document planned activities for arts, crafts, music, gardening, sports, outdoor activities or different types of card games.  a. Resident #2's Annual Minimum Data Set (MDS) dated 10/25/07 documented interests of arts, crafts, outdoors and cards.  b. Resident #5's Annual MDS dated 3/21/08 documented interests of arts, crafts, music and cards.  c. Resident #8's Medicare 14-day MDS dated 3/7/08 documented an interest of music.  d. Resident #10's Medicare 5-day MDS dated 10/3/07 documented interests of cards, arts, crafts, sports and music.  e. Resident #11's Annual MDS dated 2/15/08 documented interests of crafts, cards, outdoors, music and gardening.  f. Resident #18's Annual MDS dated 4/15/08 documented an interest of music.  g. Resident #20's Initial MDS dated 4/16/08 documented "none of above" for the resident's interests. That resident was interviewed 6/20/08	F 248			

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

PRINTED: 07/08/2008  
FORM APPROVED  
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F 248	Continued From page 14 at 9:30 a.m. and stated he liked card games.  4. The April, May and June 2008 Activity Calendars documented the following activity selections:  a. One-on-one visits were documented as one of two planned activities on April 3rd, 4th, 10th, 11th, 17th, 18th, 24th and 25th; May 1st, 2nd, 6th, 8th, 9th, 15th, 16th, 22nd, 23rd, 29th and 30th and June 5th, 6th, 12th, 13th, 19th, 20th, 26th and 27th.  b. "Social Support Group" meetings were documented as one of two planned activities on June 3rd, 10th, 17th and 24th, 2008.  5. On 6/20/08 at 4:10 p.m., the Activity Director was interviewed and stated he had become a certified Activity Director recently and began employment in the facility 5/5/08. When asked how the activity calendars were developed, he stated the April and May 2008 calendars were already planned when he began his job. He stated he planned the June 2008 group activities and, "went with what they had been doing." When asked what activities were planned for residents at the times he had one-on-one room visits scheduled, he stated, "didn't realize when I had in-room visits, I had to have something else for the others." When asked if he had talked to residents about their interests, or other activities they might want in the facility, he stated he planned to conduct a survey with residents to see what they liked, but had not done so as yet.	F 248			
F 280 SS=B	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS  The resident has the right, unless adjudged	F 280			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 280	<p>Continued From page 15</p> <p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents who were able to participate in the preparation of their comprehensive care plans were invited to care plan meetings with the facility's interdisciplinary team. The failed practice had the potential to affect 15 residents who were able to participate in planning their care and treatment, as documented by the Administrator on 6/20/08. The findings are:</p> <p>1. On 6/17/08 at 10:00 a.m., a Group Interview was conducted with 6 alert and oriented residents. The residents were asked if they were invited to meetings in which the staff planned their nursing care, medical treatment and activities. All</p>	F 280			

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F 280	<p>Continued From page 16</p> <p>6 residents agreed to one resident's statement, ""We've never been, or never [been] asked." All 6 residents denied that they were invited to care plan meetings after the intent of those meetings were explained to them.</p> <p>2. Between 6/17/08 and 6/20/08, 5 alert and oriented residents were individually interviewed. All 5 residents denied they were invited to care plan meetings and made statements as follows:</p> <p>a. Two residents stated they didn't know what the surveyor was talking about. (6/18/08 at 8:06 a.m.)</p> <p>b. "They don't ask me, I don't think I've been." (6/19/08 at 8:25 a.m.)</p> <p>c. "Never been invited to any meeting, no idea what a care plan is." 6/20/08 at 8:18 a.m.)</p> <p>d. "I have never been, or invited. I'm in my right mind, I don't like it when they ignore me. They don't tell me about new meds [medications]." (6/20/08 at 9:35 a.m.)</p> <p>3. On 6/20/08 at 1:00 p.m., the Care Plan Coordinator stated she had held the position since May 2008. When asked, "Who invites residents to care plan meetings?" she stated, "The former MDS [Minimum Data Set] person said they send family members Progress Notes, but they do not have actual care plan meetings, where we set up times and have families come out... If a family requests a meeting, they will schedule a meeting." The Care Plan Coordinator was asked, "Do you have routine meetings with residents who are invited and discuss their care plans with dietary, activities, etc.?" She stated, "No, I'm used to that, but not here." When asked</p>	F 280			

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

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FORM APPROVED  
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F 280	Continued From page 17	F 280			
F 282 SS=E	<p>if she had been told anything about that, she stated, "No, don't do that here."</p> <p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the physician's plan of care was implemented for 1 (Resident #9) of 5 case mix residents with physician orders for Pro-Stat (a liquid protein supplement) (Residents #1 and #6 through #9). The failed practice had the potential to affect 23 residents who had physicians' orders for Prostat protein supplements as documented by the Administrator on 6/20/08. The findings are:</p> <p>Resident #9 had diagnoses of history of healed Pressure Sore, Non-Insulin Dependent Diabetes Mellitus, Gastrostomy Tube, Right-sided Hemiplegia and Heart Failure. The Quarterly Minimum Data Set (MDS) dated 6/2/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required total assistance of two persons for bed mobility and had a swallowing problem.</p> <p>a. A Telephone Order sheet dated 2/15/08 documented, "Start on Prostat 30 mls [milliliters] po [by mouth] bid [twice per day]."</p> <p>b. As of 6/18/08 at 9:24 a.m., the February,</p>	F 282			

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

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F 282	Continued From page 18 March, April, May and June 2008 Physician Order sheets and Medication Administration Records (MAR's) were reviewed and there was no documentation of the Prostat order or its administration.	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 and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure staff provided urinary catheter care after incontinent bowel movements for 1 (Resident #6) of 3 case mix residents with urinary catheters (Residents #1, #6 and #20). The failed practice had the potential to affect 9 residents with urinary catheters, as identified by the Administrator on 6/20/08. The findings are:  Resident #6 had diagnoses of Diabetes Mellitus and Urinary Retention. The Minimum Data Set dated 5/29/08 documented the resident was moderately impaired in cognitive skills for daily decision making was incontinent of bowel and	F 309		

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F 309	Continued From page 19 bladder.  a. A physician order dated 3/28/08 documented the resident was to have an indwelling catheter for urinary retention.  b. On 6/17/08 at 1:30 p.m., Certified Nursing Assistants (CNA's) #6 and #2 provided incontinent care to the resident who had been incontinent of feces. The CNA's did not provide catheter care.  c. On 6/19/08 at 9:50 a.m., the resident was incontinent of feces. CNA #7 performed catheter care then provided incontinent care to the resident. The catheter was not re-cleaned by the CNA after the feces were removed.  d. The facility's Policy and Procedure titled, "Catheter Care, Indwelling Catheter" was received 6/20/08 and documented: "...To prevent infection. To reduce irritation... NOTE: Do not contaminate area with feces. If resident has had an involuntary bowel movement, clean this area first. Wash hands and obtain clean equipment for catheter care."	F 309			
F 314 SS=H	483.25(c) PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314			

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

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F 314	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Complaints #13577 and #13602 were substantiated (all or in part) with these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure interventions were implemented to prevent the development of new pressure ulcers and the deterioration of existing pressure ulcers for 1 (Resident #7) of 7 case mix residents (Residents #1, #2, #3, #4, #7, #9 and #21) who had pressure ulcers or were at risk for development of pressure ulcers. The facility failed to ensure residents at risk for pressure ulcers were repositioned at least every 2 hours in accordance with the plan of care and accepted standards of nursing practice and failed to ensure pressure relieving devices at bony prominences were provided to prevent the development of pressure sores for 2 (Residents #3 and #9) of 7 case mix residents (Resident #1, #2, #3, #4, #7, #9 and #21) who had pressure ulcers or were at risk for development of pressure ulcers. These failed practices resulted in a pattern of actual harm to Resident #7 and had the potential to affect 10 residents with pressure ulcers, as documented on the Resident Census and Conditions of Residents form dated 6/19/08 and 25 residents at risk for pressure ulcer development, as identified by the Director of Nursing on 6/20/08. The findings are:</p> <p>1. Resident #7 had diagnoses of Cerebral Vascular Accident, Arthritis and Arteriosclerotic Heart Disease. The Minimum Data Set dated 3/14/08 documented the resident had modified independence in cognitive skills for daily decision making, was totally dependent on staff for bed mobility and transfers, required extensive</p>	F 314		

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

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F 314	Continued From page 21 assistance of staff for dressing, and had 4 stage II pressure ulcers.  a. A Physician's order dated 2/14/08 documented, "Bridge knees with pillow 7A-7P [7:00 a.m. to 7:00 p.m.] 7P-7A [7:00 p.m. to 7:00 a.m.]."  b. A Care Plan dated 6/5/08 documented: "Impairment of skin integrity and breakdown, manifested by:... Stage III to left knee... Approach... Provide ulcer care treat as ordered.... Minimize pressure on bony prominences..."  c. Nurses' Notes and Wound Documentation sheets documented the following progression of the pressure ulcer on the left inner knee:  2/8/08 - wound 2 centimeters (cm) by (x) 2 cm acquired. 2/18/08 - wound 1.8 X 1.6 X 0.1 cm with bloody drainage, stage II. 3/7/08 - wound 2 X 2.2 X 0.3 cm yellow slough, getting worse, stage II. 3/16/08 - stage III exposed subcutaneous (SubQ) tissues - presents as a deep crater. 3/28/08 - wound 2.3 X 1.8 X 0.3 cm pink with yellow center. 4/4/08 - wound 3.5 X 2.1 X 0.3 cm debrided stage III. 4/11/08 - wound 3.1 X 1.9 X 0.3 cm stage III pink with yellow center. 4/22/08 - wound 2.5 X 2.5 X 0.3 cm. 5/28/08 - wound 2.5 X 2 X 0.3 cm stage III no change. 6/6/08 - wound 3 X 2 X 0.5 cm stage III pink with yellow center. 6/13/08 - wound 2.5 X 2.5 X 0.2 cm. 6/17/08 - Full thickness of skin is lost, exposing	F 314			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 314	<p>Continued From page 22</p> <p>the SubQ tissues-presents as a deep crater (pressure stage III left knee).</p> <p>d. On 6/17/08 at 9:55 a.m., 12:20 p.m., 1:15 p.m., 5:40 p.m. and 6:12 p.m., the resident was sitting in her wheelchair without any pillowing between her knees. The resident was observed to keep her knees together whether in the bed or chair.</p> <p>e. On 6/18/08 at 9:05 a.m., the resident was sitting in her wheelchair with no pillowing/bridging device between the knees.</p> <p>f. On 6/18/08 at 10:25 a.m., Licensed Practical Nurse #2 changed the dressing on the left knee. The wound measured 2.5 cm X 1.7 cm with a depth of 0.2 cm. The wound edge was red and the wound bed was yellow. The LPN stated, "They bridge her knees in bed with a pillow and when she is up in the chair they normally have a pillow between her knees."</p> <p>g. On 6/18/08 at 11:50 a.m., Certified Nursing Assistants (CNA's) #2 and #3 transferred the resident from the bed to her wheelchair with a mechanical lift. The CNA's straightened the resident's clothes, put a lap robe over the resident and propelled her out to the dining room. The CNA's did not put a pillow or other device between the resident's knees to reduce pressure.</p> <p>h. On 6/19/08 at 9:25 a.m., CNA #4 was asked to lift the resident's lap robe to view the dressing on the resident's left knee. The CNA lifted the lap robe. There was no pillow or other device between the resident's knees. The CNA put the lap robe over the resident and left the room and did not place a pillow or other device between the</p>	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 314	<p>Continued From page 23</p> <p>resident's knees.</p> <p>i. On 6/19/08, the June 2008 Treatment Administration Record (TAR) was reviewed and incorrectly documented that the resident's knees were bridged with a pillow from 7:00 a.m. to 7:00 p.m. from 6/1/08 through 6/19/08.</p> <p>2. Resident #3 had diagnoses of Gouty Arthritis, Alzheimer's Disease and Congestive Heart Failure. The Comprehensive MDS dated 7/17/07 documented the resident had 2 stage II pressure ulcers. The Quarterly MDS dated 4/14/08 documented the resident had modified independence in cognitive skills for daily decision making, required extensive assistance in bed mobility, transfers, dressing and toilet use, was incontinent of bowel and bladder, had no pressure ulcers and was on a turning/repositioning program.</p> <p>a. A Care Plan dated 4/8/08 documented: "Potential for impairment skin integrity manifested by history of ulcers skin breakdown."</p> <p>b. Nurses' Notes dated 6/2/08 documented the resident complained about wanting the blue lift pad removed from under her.</p> <p>c. On 6/16/08 at 3:55 p.m., the resident stated she had told the Administrator that the lift pad (pad used with the mechanical lift) hurt her when it was left under her in the wheelchair.</p> <p>d. On 6/18/08 at 3:40 p.m., the resident stated, "They just put me to bed and the pad (lift pad) in the wheelchair tore my bottom up." The resident stated she had been up since 11:00 a.m. Licensed Practical Nurse (LPN) #2 was asked to</p>	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 314	<p>Continued From page 24</p> <p>perform a skin audit on the resident at this time. The resident had a indentation in her skin from her right hip to her left buttock that matched the edging on the lift pad that was in the resident's wheelchair. The resident was asked to show where her bottom hurt, the resident rubbed her hand along the indentation.</p> <p>e. On 6/18/08 at 4:00 p.m., Assistant Director of Nursing (ADON) #2 was informed of when the resident was laid down in bed. She stated, "We got her up before lunch about 11:30 a.m."</p> <p>3. Resident #9 had diagnoses of history of healed Pressure Sore, Non-Insulin Dependent Diabetes Mellitus, Gastrostomy Tube, Right-sided Hemiplegia and Heart Failure. The Quarterly Minimum Data Set (MDS) dated 6/2/08 documented the resident was moderately impaired in cognitive skills for daily decision making, had no pressure ulcers and required total assistance of two persons for bed mobility.</p> <p>a. The Care Plan dated 2/4/08 documented a problem regarding potential for impairment of skin integrity and breakdown related to decreased mobility. That problem did not address the provision of pressure relief and cushioning at bony prominences for this resident.</p> <p>b. On 6/18/08 at 8:24 a.m. and 6/19/08 at 9:04 a.m., the resident was in bed without cushioning or pressure relief at the bony prominences of his knees.</p> <p>c. On 6/19/08 at 9:43 a.m., CNA's #1 and #13 provided incontinent care to the resident, repositioned him and left the room without placing cushioning or pressure relief at the resident's</p>	F 314			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 314	Continued From page 25	F 314			
F 323 SS=E	<p>483.25(h) ACCIDENTS AND SUPERVISION</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure adequate torso and lower extremity support were provided during manual lift transfers for 4 (Residents #2, #11, #12 and #21) of 6 (Residents #2, #8, #10, #11, #12 and #21) case mix residents who required one-person assistance with transfers. The facility failed to ensure staff remained in attendance for 1 (Resident #2) of 8 (Residents #2, #8, #10 through #13, #16 and #20) case mix residents who required assistance and supervision during toileting. The facility failed to ensure physical restraints were applied in accordance with the manufacturer's instructions for 3 (Residents #11, #12 and #17) of 4 (Residents #6, #11, #12 and #17) case mix residents who used soft-belt restraints. The facility also failed to ensure the facility was free of potential accident hazards in resident areas, including sharp, splintered surfaces and multi-plug outlets. The failed practices had the potential to affect 54 residents who were transferred manually, 41 residents who required assistance to the bathroom and 11 independently mobile residents who were confused, as</p>	F 323			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 323	Continued From page 26 documented by the Director of Nursing (DON) on 6/20/08 and 16 residents who used physical restraints, as documented by the Administrator on 6/20/08. The findings are:  1. The manufacturer's instructions for the Adjusta-Loop cushion belt (or soft-belt) restraint documented, "Wheelchair Application: Seat patient as far back in the wheelchair as possible. 2. Place the Belt at the patient's waist... Behind the wheelchair, cross the straps and place the right loop over the left kick-spur and the left loop over the right kick-spur... Use the slider buckles to adjust the straps so that the belt fits snugly."  2. The facility's Transfer Activity policy and procedure documented, "Purpose: To transfer the resident from bed to chair, toilet or tub safely... Procedure: ...Hold the transfer belt from underneath, straighten your hips and legs slightly and lift the client to a standing position on a count of three... Support may be provided by use of a transfer belt. Do not support the resident under the arms as this prevents the resident from using his/her unaffected extremity. Do not allow resident to put arms around your neck."  3. Resident #2 had diagnoses of Closed Fracture of Femur (10/2005), Osteoporosis and Hypotension. A Quarterly Minimum Data Set (MDS) dated 4/14/08 documented the resident had modified independence in cognitive skills for daily decision making, required limited assistance of one person for transfers and toilet use, had functional limitations in range of motion with partial loss of voluntary movement for one leg and had no accidents in the past 180 days.  a. The Care Plan dated 2/4/08 documented a	F 323			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 323	<p>Continued From page 27</p> <p>potential for falls/injury related to unsteady gait with approaches documented as, "Assist with ambulating, transferring, toileting. Do not leave unattended when toileting."</p> <p>b. On 6/17/08 at 9:16 a.m., the resident was sitting on the toilet in her bathroom. There was no staff in attendance. The Care Guide posted on the wall above the resident's bed documented, "transfer - needs assist [assistance]... Toileting - briefs, total care."</p> <p>1.) On 6/17/08 at 9:22 a.m., (the resident was left unattended for a period of 6 minutes) Certified Nursing Assistant (CNA) #9 entered the resident's room after the resident had pulled the emergency call light in her bathroom. CNA #9 then left the resident unattended again while she left the room for supplies. CNA's #9 and #10 returned 1 minute later at 9:23 a.m. CNA #10 stated the resident required assistance for transfers and CNA #9 stated, "Someone had to put her on and then left."</p> <p>2.) During this observation, the resident kept repeating, "Please hurry, I'm hurting on this thing." CNA #10 assisted the resident to stand from the toilet. The resident was holding to the metal bar on the wall, was partially bent from the waist with her buttocks out and both knees bent and then was assisted to sit in a wheelchair. CNA #10 did not use a gait belt during the transfer.</p> <p>4. Resident #21 had diagnoses of Heart Failure, Chronic Organic Brain Syndrome and Rheumatoid Arthritis. The Quarterly MDS dated 6/15/08 documented the resident was severely impaired in cognitive skills for daily decision</p>	F 323			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 323	<p>Continued From page 28</p> <p>making, required total assistance of one person for transfers and had no functional limitations in range of motion.</p> <p>a. The Care Plan problem dated 5/3/08 documented a potential for falls or injury related to forgetfulness, with a history of falls. There were no approaches on that problem or on others in the Care Plan for how much assistance the resident required for transfers or what method of transfer should be used.</p> <p>b. On 6/20/08 at 9:42 a.m., CNA #8 placed the resident's wheelchair next to a shower chair in the South Women's Central Bath and applied the wheelchair brakes. CNA #8 told the resident to hold onto her. The resident held to the CNA's shoulders, then CNA #8 held the resident by placing her arms around the resident's back and lifted the resident out of the wheelchair. The resident's knees were bent and her feet were both off the floor with no weight bearing. CNA #8 did not use a gait-belt or mechanical lift for the transfer.</p> <p>5. Resident #12 had diagnoses of Senile Dementia, Osteoporosis and Rheumatoid Arthritis. A Significant Change MDS dated 5/15/08 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive assistance of one person for transfers and toilet use, had functional limitations in range of motion with partial loss of voluntary movement for one arm and hand and had no restraints in use.</p> <p>a. A physician order dated 12/18/07 documented: "Restraint: Soft belt seat belt when in w/c [wheelchair] due to unsteadiness for safety."</p>	F 323			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 323	Continued From page 29  b. The Care Plan dated 6/5/08 documented a self-care deficit with an approach of, "Assist with toileting, assist with transferring... Transfer - Two+ [plus] persons physical assistance."  c. On 6/17/08 at 9:30 a.m., CNA #11 assisted the resident to stand from a wheelchair in the resident's bathroom. The resident was able to bear weight; however, she did not lift her feet to take steps. The resident scooted her feet and slowly turned for 3 minutes before she was able to sit on the toilet. At 9:41 a.m., CNA #11 assisted the resident to stand from the toilet. The resident took small scooting steps and was assisted to sit in the wheelchair. CNA #11 did not use a gait belt during either of the manual transfers and did not request assistance from a second staff member.  1.) At 9:41 a.m., CNA #11 also placed a soft belt restraint around the resident's lower abdomen and attached the loops over the wheelchair tilt bars. After the CNA left the room, the resident's soft belt was able to be pulled approximately 4-5 inches from the resident's body, not snugly attached.  2.) At 10:16 a.m., the resident remained in a wheelchair with the soft belt restraint while she propelled herself in the hall by her room. The resident was sitting forward in the wheelchair and her lower back/buttocks were approximately 4-6 inches from the back of the wheelchair.  3.) On 6/17/08 at 11:34 a.m., the resident remained in the wheelchair with a soft belt restraint positioned as described above, which allowed the resident to lean forward in the	F 323			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 323	Continued From page 30 wheelchair.  6. Resident #11 had diagnoses of Anxiety and Depression. The Quarterly Minimum Data Set dated 5/15/08 documented the resident had long and short term memory problems, was severely impaired in cognitive skills for daily decision making, required extensive assistance of one person for transfers and required a trunk restraint daily.  a. The plan of care revised 5/2/08 documented: "Problem: Restraint use... Nurses - assure restraint is applied appropriately..."  b. On 6/17/08 at 4:00 p.m., the resident was sitting in a wheelchair with a soft seat belt restraint in use. The restraint belt was positioned around the resident's breasts. The straps of the restraint criss-crossed behind the resident, then went down between the seat and the back of the wheelchair to the opposite kick-spurs.  c. On 6/19/08 at 10:00 a.m., the resident was in the wheelchair with the soft seat belt positioned under her breasts. The straps were criss-crossed behind the resident, then went down between the seat and the back of the wheelchair to opposite kick-spurs.  d. On 6/19/08 at 10:03 a.m., Certified Nursing Assistant (CNA) #1 transported the resident to the restroom in a wheelchair. The CNA washed her hands, put on gloves and instructed the resident to stand. The resident grabbed the handrail with both hands and started pulling upwards. As the resident pulled upwards, CNA #1 took hold of the waistband of the resident's pants and in helping the resident to stand, pulled the waistband of the	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 323	<p>Continued From page 31</p> <p>pants up the resident's back to mid-back, pulling the pants in between the resident's buttocks. Once the resident was in a standing position, she bore her own weight and pivoted to turn to the commode. There was no gait belt used during the transfer.</p> <p>7. Resident #17 had diagnoses of Parkinson's Disease and Cerebral Vascular Accident. An MDS dated 4/14/08 documented the resident had modified independence in cognitive skills for daily decision making.</p> <p>a. A physician order dated 8/27/07 documented: "Soft belt seat belt when in wheelchair to increase mobility due to poor judgement due to unsteadiness related to Parkinson's."</p> <p>b. On 6/16/08 at 4:20 p.m., the resident was sitting in a wheelchair propelling himself from the main dining room down the 100/200 Hall. The resident's soft belt was applied incorrectly - the left tie strap went through the opening between the backrest and seat of the wheelchair, the right tie strap went around the right side of the wheelchair. Both tie straps were then wound around each other and attached to the left tip bar on the wheelchair in a non-quick release tie.</p> <p>8. On 6/17/08 at 4:20 p.m. during the environmental tour with the facility's Maintenance Director and Co-Administrator, the following observations were made:</p> <p>a. The North Dining Room had a cracked electrical outlet cover located on the wall next to the exit door and the mini-blind on the window above the outlet had broken louvers in which part of the louver was missing, exposing sharp plastic</p>	F 323			

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F 323	Continued From page 32 edges.  b. The North Hall Men's Shower Room had two broken tiles located in Shower Stall #1, one broken tile in Shower Stall #2 and a broken corner tile at the sink area, all exposing broken edges and sharp ceramic corners.  c. The Main Dining Room had one window located next to the exit door that had a chunk of wood missing (approximately 2 inches in length) on the edge of the sill, exposing splinters.  d. In the hall next to Room #102, there was an electrical outlet cover that was cracked and broken.  e. The South Dining Room had a multi-plug outlet (6 outlets) in use behind the television with two items plugged into the outlets.  f. The following rooms had gouges in the decorative trim on the entrance doors that exposed wood splinters: Room #212, #216, #217 and #415.  g. The South Hall Men's Central Shower had one broken tile located next to the sink area.  h. The South Hall Women's Shower had one tile missing in Stall #2.	F 323			
F 325 SS=H	483.25(i)(1) NUTRITION  Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 325	Continued From page 33  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure interventions were planned and/or implemented to provide finger-foods, fortified foods at all meals, assess for likes/dislikes, offer snacks, conduct weekly weights and failed to identify inappropriate feeding techniques for 1 (Resident #12) of 5 (Residents #1, #4, #6, #8 and #12) case mix residents with a history of weight loss. The failed practice resulted in a pattern of actual harm for Resident #12, who suffered severe weight loss and had the potential to affect 5 residents with significant weight loss, as documented by the Director of Nursing (DON) on 6/20/08. The findings are:  Resident #12 had diagnoses of Senile Dementia, Depressive Disorder, Iron Deficiency Anemia and Aphasia.  a. Weekly Weight Tracking forms documented weights for the resident as follows: 9/9/07-9/16/07 - 147 pounds (lbs.), 9/30/07-10/7/07 - 145 lbs. The Weight Tracking forms documented the resident had decreased appetite, weight fluctuations and a history of poor intake. The Tracking forms documented planned interventions to record food intake, offer encouragement, provide ordered diet and provide snacks.  1) Nutrition Notes dated 9/19/07 documented an observation during a noon meal, "having some difficulty feeding self" and "will be moved to TDR [Therapeutic Dining Room] for meals." The	F 325			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 325	<p>Continued From page 34</p> <p>Notes also documented planned interventions to include supercereal and milk with meals, addition of weekly weights and "Red Napkin Program."</p> <p>2) Physician Order sheets documented orders dated 9/24/07 for Remeron 15 milligrams (mg) daily, "Appetite Stimulant," 10/3/07 for diet of Regular with ground meat and 10/19/07 for Hi-Cal (a high calorie supplement) 80 cubic centimeters (cc) three times per day.</p> <p>b. Weekly Weight Tracking forms dated between 10/8/07 and 12/3/07 documented the resident's weights continued to decrease, between 143 lbs. and 138 lbs. Weekly Weight Records documented the resident's weight on 12/10/07 as 138 lbs.</p> <p>Telephone physician order sheets dated 12/19/07 documented, "Megace ES (an appetite stimulant) 5 cc q [every] AM [morning] X [times] 7 days." There was no documentation in the resident's Physician Order sheets, Telephone Order sheets, Medication Administration Records (MAR's) or Nurse's Notes the Megace was administered after the 7 day time period.</p> <p>c. Weekly Weight Records dated 1/21/08 documented the resident's weight was 136 lbs. Weight Meeting Summary sheets dated 1/23/08 documented, "fluctuations in weights, nursing to check on appetite stimulant, dietary add two cups hi-pro milk [a high calorie/protein supplement]." There was no documentation in the Nurses Notes or Nutritional Notes that nursing followed up on the plan to check on a new appetite stimulant for the resident.</p> <p>d. Weekly Weight Records dated 2/3/08</p>	F 325			

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F 325	<p>Continued From page 35</p> <p>documented the resident's weight was 134 lbs. Weekly Weight Summary sheets dated 2/6/08 documented, "she's already in T. [therapeutic] dining, and receiving fortified foods. Add milk shake between meals." There was no documentation on the MAR's or Consumption Records, available for review as of 6/20/08, of the resident's consumption of milk shakes between meals.</p> <p>e. Weekly Weight Records dated 3/3/08 documented the resident's weight at 133 lbs. A Weight Meeting Review dated 3/5/08 documented the resident was moved out of the Therapeutic Dining Room, "wt. [weight] stable."</p> <p>1) Nutritional Notes dated 3/3/08 and signed by the Dietary Manager documented the resident's intake met 76-100% of her estimated needs, "receives Megace to stimulate appetite" and red napkin, "will continue plan of care." There was no documentation the resident received Megace at that time.</p> <p>2) A Quarterly Minimum Data Set (MDS) dated 3/7/08 documented the resident had short and long term memory problems, was severely impaired in cognitive skills for daily decision making, required extensive assistance for eating, weighed 133 lbs., had chewing problems, a weight loss of 5% in the past month or 10% in the last 6 months and received an antidepressant medication (Remeron, for appetite stimulant) 7 days per week. As of 6/18/08, there was no Care Plan dated for that period of time for review in the resident's computerized medical record.</p> <p>3) Weekly Weight Sheets documented the resident's weights as follows: 3/9/08 and 3/16/08 -</p>	F 325			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 325	<p>Continued From page 36</p> <p>131 lbs. and 3/23/08 - 129 lbs. The Weight Meeting Summary dated 3/26/08 documented, "Trending down 2# [pounds], Nurse to assess." Nutritional Notes dated 3/30/08 and signed by Licensed Practical Nurse (LPN) #3 documented the resident did not have chewing/swallowing problems, did not appear to have mouth pain, "has good appetite" and "no special nutritional approaches are necessary for the resident."</p> <p>4) Weekly Weight Sheets dated 3/30/08 documented the resident's weight as 127 lbs., a further loss of 2 lbs. in one week.</p> <p>f. The Weight Meeting Summary dated 4/2/08 documented, "Nurse to assess." Nutritional Notes dated 4/8/08 and signed by LPN #3 documented the resident did not have chewing/swallowing problems, did not appear to have mouth pain, "has fair appetite, leaves 25% of his/her food uneaten; receives a diet supplement daily [the Hi-Cal supplement ordered since 10/19/07]." There was no documentation of new interventions planned for this resident at that time. Weekly Weight sheets dated 4/6/08 documented the resident's weight remained at 127 lbs., a weight loss of 6 lbs. in one month, or 4.51%.</p> <p>Weight Meeting Minutes dated 4/9/08 documented the resident's weight was, "stable X 2 wks [weeks], cont [continue] poc [plan of care]." Weight Meeting sheets dated 4/16/08 documented the resident's weights had been "stable" for 4 weeks, "d/c [discontinue]" weekly weights.</p> <p>g. Weight Records dated 5/4/06 documented the resident's weight as 126 lbs. and 6/2/08 as 123</p>	F 325			

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F 325	<p>Continued From page 37</p> <p>lbs. Weight Meeting Minutes dated 6/4/08 documented, " trending, add to wkly [weekly] wts. " There was no documentation of other interventions planned at that time. There was no documentation in the Weight Records of a weekly weight for 6/9/08 as planned.</p> <p>h. The resident's Care Plan dated 6/5/08 documented a problem, "Decreased appetite, weight fluctuation... inadequate intake or hx [history] of poor intake... record food intake, offer encouragement... Alteration in diet: ground meat... record food intake, provide snacks."</p> <p>i. Consumption Records dated 5/1/08 through 5/31/08 documented the resident ate 50% or less of 46 out of 91 meals. Consumption Records dated 6/1/08 through 6/15/08 (no meal consumption was documented for 6/16/08) documented the resident ate 50% or less of 30 out of 45 meals. Thirteen out of those 30 meals had consumptions documented 0 - 25% of each meal.</p> <p>j. Weekly Weight Records dated 6/15/08 documented the resident's weight as 121 lbs. That weight demonstrated significant weight loss 7.63% for 3 months (3/16/08-131 lbs.) and severe weight loss 12.32% for 6 months (12/10/07-138 lbs.)</p> <p>k. On 6/17/08 at 8:38 a.m., the resident was at a feeder table in the South Dining Room. At 9:12 a.m., the resident's tray was served to her. The tray contained supercereal and 10 ounces fortified milk. A red napkin was on the tray. The resident did not attempt to feed herself. She was fed approximately 50% of the meal and no substitutes were offered.</p>	F 325			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 325	Continued From page 38  l. On 6/17/08 at 12:57 p.m., the resident was at the same feeder table and her lunch tray was served. The resident's tray card documented in the "other" section, "Fortified Food." The tray contained ice cream, ground beef, baked beans, potato salad, 16 oz. fortified milk, lemonade and water. The resident fed herself 100% of a small carton of ice cream and approximately 50-75% of the rest of the food. The resident was not agitated and did not refuse feeding by the nursing assistant at the table. The resident was not offered additional ice cream, which would have increased her caloric intake. Other than the milk, no fortified "foods" were observed at that meal.  m. On 6/17/08 at 5:55 p.m., the resident's supper tray card documented, "Fortified Food." The resident's tray contained a ground turkey sandwich, strawberries, chicken noodle soup, steamed vegetables and 10 oz. fortified milk. There were no fortified foods observed on the tray. When the tray was served, the resident immediately began feeding herself the sandwich. She consumed 100% of the sandwich and milk and 0% of the other foods. No other food was offered to the resident.  n. Nutritional Notes dated 6/18/08 and signed by the RD documented, "Resident monitored for wt. loss. Weighed weekly... Often refuses to allow them to feed her. Observed at noon meal, refused to eat, took a few bites of her cake." The RD Consultant report dated 6/19/08 documented recommendations for this resident, "suggest MD [Medical Doctor] consider using Megace ES to stimulate appetite, Also add fort [fortified] foods to trays (she may already be getting fort - [Dietary Manager] check."	F 325			

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 325	Continued From page 39  o. On 6/20/08 at 8:51 a.m., the resident was sitting in the South Dining Room at a feeder table. Certified Nursing Assistant (CNA) #5 attempted to feed the resident. The resident repeatedly raised her hands in front of her face when the CNA held the spoon to her mouth. After the resident lowered her hands, CNA #5 then pushed the spoon with food into the resident's mouth two different times. When the resident was left alone, she picked up a carton of jello and attempted to eat it with her fingers. No finger foods were offered to the resident. The Director of Nursing (DON) was present and shown the inappropriate feeding technique used by CNA #5.  p. On 6/20/08 at 10:30 a.m., an interview was conducted with the Dietary Manager (DM). The DM was asked how the facility's weight management team developed interventions to address weight loss and he stated they based their plans on residents' individual needs, for example, provision of snacks, milkshakes, double portions. He stated the facility encouraged the use of food versus supplements. The DM was read the listing of the resident's lunch and supper meals on 6/17/08 and asked what foods were fortified. The DM stated the resident should have received fortified potatoes at the lunch and supper meals on that day. The resident did not receive the fortified foods at those meals.  q. On 6/19/08 at 2:50 p.m., the DON was asked to provide documentation about the short-term use of the Megace (in 12/2007) and other interventions the facility had attempted to address the resident's significant and severe weight loss. On 6/20/08 at 8:40 a.m., the Administrator provided the Weekly Weight Tracking forms and	F 325			

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 325	Continued From page 40 the Nutritional Notes dated between 6/4/07 and 6/18/08. On 6/20/08 at 1:02 p.m., the Administrator provided the Weight Meeting Summaries dated between 1/6/08 and 6/4/08 and the Registered Dietitian (RD) weight review summaries dated 3/12/08, 5/21/08 and 6/19/08. There was no evidence provided of further planned interventions since the resident's weight loss that began in March 2008.  r. The facility's Weight Management Protocol documented inclusion of a sheet titled, "Weight Monitoring and Loss Check List." The Check List documented multiple procedures to address weight loss and another column titled, "Completed." The Weight Management Protocol documented, "If weight has been trending down for two (2) consecutive periods, Weight Management Checklist will be completed" and "Completed checklist will be brought to Weight Management Meeting."  On 6/20/08 at 10:30 a.m., the Dietary Manager was asked to provide all documentation about Resident #12 from the facility's weekly weight meetings, the most recent documentation of the resident's likes/dislikes, documented attempts to provide the resident fingerfoods during meals and evidence the resident was offered between meal snacks (milkshakes as planned). As of 6/20/08 at 6:15 p.m., the facility had not provided the Weight Management Checklists for Resident #12 or the other information specifically requested earlier that day.	F 325			
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	F 329			

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

PRINTED: 07/08/2008  
FORM APPROVED  
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F 329	<p>Continued From page 41</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: Based on observation, record review and interview, the facility failed to ensure anticoagulant levels were monitored as ordered for 1 (Resident #7) of 1 case mix resident who was on Coumadin, failed to ensure indications for the use of antipsychotic medications were present for 3 (Residents #12, #16 and #21) of 7 case mix residents (#3, #5, #7, #12, #13, #16 and #21) who were on antipsychotic medications, failed to ensure indications for the extended use of Proton Pump Inhibitors were present and documented for 1 (Resident #2) of 1 case mix residents who was on Prilosec and that blood pressures were monitored and documented for 1 of 1 resident</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 329	<p>Continued From page 42</p> <p>(Resident #4) who was on antihypertensives with a physician order to hold the medication if the blood pressure low. The failed practices had the potential to affect 12 residents on Coumadin, 33 residents on antipsychotic medications, 22 residents on Proton Pump Inhibitors and 6 residents on antihypertensives with physician orders to hold the medication if the blood pressure was low, as identified by the facility on 6/20/08. The findings are:</p> <p>1. Resident #7 had diagnoses of Cerebral Vascular Accident, Arteriosclerotic Heart Disease and Rhabdomyolysis.</p> <p>a. A physician order dated 12/18/07 documented the resident was to receive Coumadin 2 milligrams (mg) by mouth every night at bedtime (HS) for, "Clotting Disorder."</p> <p>b. A physician order dated 1/2/08 documented: "LAB: INR [international normalized ratio] every thirty days lab start date 1/31/08."</p> <p>c. A Laboratory Report dated February 2008 documented a protime with INR (PT/INR) level; no other PT/INR results were available for review in the clinical record as of 6/19/08.</p> <p>d. On 6/19/08 at 10:07 a.m., Licensed Practical Nurse (LPN) #2 was asked for PT/INR levels from March, 2008 to the present. The LPN searched for the records and stated, "They're not in the computer. I can't find them. It's not been done. There has been no level since February." The LPN found an order for a PT/INR that had been drawn 6/16/08.</p> <p>e. On 6/20/08 at 11:15 a.m., the Director of</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 329	<p>Continued From page 43</p> <p>Nursing stated, "The PT/INRs were not done between February and June 16th, 2008."</p> <p>2. Resident #2 had a diagnosis of Esophageal Reflux (10/2005).</p> <p>a. A physician order dated 11/1/07 documented the resident was to receive Prilosec (a proton pump inhibitor) 20 milligrams daily for Gastroesophageal Reflux Disease. This order was documented as a current order on the June 2008 Physician Orders sheet. The resident had received the Prilosec for a period of 7 months and 16 days.</p> <p>b. The Care Plan dated 2/4/08 documented a problem of Gastric Discomfort with an approach, "GI [gastrointestinal] Assessment prn [as needed]."</p> <p>c. The Consultant Pharmacist Medication Regimen Review sheet dated 2/14/08 documented a request for a review of the Prilosec use. As of 6/20/08, there was no documented response in the consultant or physician orders section of the resident's medical record.</p> <p>d. Physician's Progress Notes dated 5/13/08 documented the resident was seen "for f/u [follow up] of chronic medical issues." The Notes documented the resident was reviewed for chronic arthritic pain, a healed right heel decubitus, stable weight, Anemia and Neuropathic Pain. There was no documentation of chronic or acute symptoms of gastroesophageal disease for this resident.</p> <p>e. A Pharmacist's Consult to Physician letter dated 5/15/08 documented, "Please review</p>	F 329			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 329	<p>Continued From page 44</p> <p>diagnosis and the resident's current status to determine the continued need for a proton pump inhibitor. PPI's may increase the risk of clostridium difficile colitis and, studies have shown long-term PPI use increases risk of hip fracture significantly. Manufacturers do not recommend for use over 12-16 weeks except for Zollinger-Ellison syndrome. May we discontinue the Prilosec 20 mg." The letter also documented it was "faxed" to the physician on 5/16/08. The Medication Regimen Review (MRR) sheet dated 6/11/08 documented, "response pending" for the previous month's recommendation for Prilosec discontinuation.</p> <p>f. Nurse's Notes, Nutritional Notes and Laboratory/X-rays sections were reviewed and no information was located that documented a continued medical need for the Prilosec medication.</p> <p>g. On 6/19/08 at 11:30 a.m., Assistant Director of Nursing (ADON) #1 was asked to provide evidence of indications for the extended use of the Prilosec. That information had not been provided as of 6/20/08 at 6:15 p.m.</p> <p>3. Resident #12 had diagnoses of Senile Dementia and Depressive Disorder. A Significant Change MDS dated 5/15/08 documented the resident had short and long term memory problems, was severely impaired in cognitive skills for daily decision making, had behavioral symptoms of physical abusiveness, resisted care less than daily and was not easily altered, received an antidepressant medication 7 days per week, did not have delusions or hallucinations and did not receive antipsychotic medications.</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 329	<p>Continued From page 45</p> <p>a. Nurses' Notes dated 5/1/08 through 5/31/08 were reviewed and documented the resident refused medications on 5/2/08 (Fibercon, Accupril, Loratadine and Preservision), 5/4/08 (Fibercon and Preservision), 5/19/08 (Fibercon, Remeron, Travatan, Preservision and a Hi-Cal supplement), 5/25/08 (Hi-Cal supplement) and 5/30/08 (Fibercon, Remeron, Travatan, Preservision and a Hi-Cal supplement).</p> <p>b. Nurses' Notes dated 5/1/08 through 5/31/08 were reviewed and documented behaviors of the resident as follows:</p> <p>1.) 5/6/08 - "is uncooperative resistive, wanders. Difficult to redirect."</p> <p>2.) 5/17/08 at 10:59 a.m. - "is uncooperative, is combative, is agitated, noisy, resistive, yells and shouts, swings hands/fists. Difficult to redirect with cares, at all times, with staff. Screams, yells, shouts, hits, shoves." That Note did not document specifically what was going on around the resident at that time or if staff allowed the resident to calm and then re-attempted to perform care. At 11:05 a.m., "while trying to put restraint on resident, resident was swinging arms and trying to hit staff. This LPN [Licensed Practical Nurse] was hit by resident at this time. With the help of two staff we got the restraint back on, resident now wandering throughout the nursing home." That Note did not document a one on one approach with the resident or allowing the resident to calm and then re-attempting the application of a restraint device.</p> <p>3.) 5/20/08 - "noisy, wanders, resistive, yells and shouts. Difficult to be redirected."</p>	F 329			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 329	<p>Continued From page 46</p> <p>4.) 5/22/08 - "agitated, noisy, resistive with cares, refusing to eat, starts yelling and swinging hands trying to knock the food out of aides hands."</p> <p>There was no quantitative documentation, except for the 5/17/08 Nurses Note, of how often the resident's behaviors occurred. There was no documentation the behaviors were continuous or how they decreased the resident's level of functioning. There was no documentation of what measures the facility staff attempted to limit the resident's reactions during care or investigations into what might have caused the resident's behaviors.</p> <p>c. Nurse's Notes dated 5/23/08 documented the Medical Director was consulted "regarding a small amount of bleeding from vagina. Received orders for stat CBC [complete blood count] and UA [urinalysis]. In and out cath, resident tolerated well. Lab results received at 22:00 [10:00 p.m.]." A laboratory report dated 5/22/08 documented the resident's UA with Culture and Sensitivity cultured greater than 100,000 of the organism Klebsiella Pneumoniae, a white blood cell count (WBC) of 4-8 and Bacteria 1+ (normal=0). Telephone orders were received for Ceftin (an antibiotic medication) 250 milligrams (mg) for 6 days for treatment of a Urinary Tract Infection (UTI).</p> <p>d. A Telephone Order dated 5/30/08 documented the resident was to receive a Psychiatric Consult with "[Advanced Practice Nurse's name]." A Psychiatric Evaluation form dated 5/30/08 documented, "Chief Complaint: Behavior Disturbance... [resident] was referred for a psych consult due to behavior disturbance, screaming, yelling, combative with staff when they try to feed her, noncompliant [with] Rx's [medications]."</p>	F 329			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 329	<p>Continued From page 47</p> <p>Family reported to ns [nurse] that R [resident] was ganged raped in the past. R [resident] has a UTI presently tx [treatment] [with] Cefitin ABT [antibiotic]."</p> <p>e. A Telephone Order dated 5/30/08 documented new diagnoses, "Delirium due to UTI... Alz [Alzheimer's] Dementia, severe [with] Behavior Disturbance... Noncompliant [with] tx [treatment] &amp; [and] Rx's." Another Telephone Order dated 5/30/08 documented the resident was to receive Zyprexa (an antipsychotic medication) 1.25 mg by mouth every morning and at 5:00 p.m. and, "May give IM [intramuscularly] if R refuses." The medication was also ordered, "prn [as needed]" every 8 hours for "severe agitation, psychosis." Another Telephone Order dated 5/30/08 documented orders for Neurontin 100 mg by mouth 30 minutes prior to showers.</p> <p>f. The Care Plan dated 5/30/08 documented a problem, "Altered mood pattern, combativeness, hitting at staff during care... Approaches... allow resident to verbalize, allow resident to ventilate feelings, offer diversional activities." There was no documentation of the resident's new medication orders in that Care Plan.</p> <p>g. Nurses' Notes dated between 6/1/08 and 6/19/08 were reviewed. The Notes documented the resident refused medications on 6/12/08 (Travatan and Medrol 4 mg), 6/17/08 (Medrol 4 mg), 6/18/08 (Fibercon) and 6/19/08 (Hi-Cal "all meds refused").</p> <p>h. A Telephone Order dated 6/4/08 documented an increase in the Zyprexa to 2.5 mg twice per day. There were no Physician's Progress Note or Nurses Notes documented on that date and no</p>	F 329			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 329	<p>Continued From page 48</p> <p>documentation was available for review that indicated why the antipsychotic medication dosage was increased.</p> <p>i. The Care Plan dated 6/5/08 documented a problem, "Forgetfulness, loss of memory... psychiatric consult regarding med use, as ordered... arrange environment to meet resident's needs... remove resident from activity/area if agitated... take resident to a quiet place and provide one on one... May need to go back and try to complete cares again at a later time if resident is agitated."</p> <p>j. A Telephone Order dated 6/9/08 documented the Zyprexa was discontinued, "due to rash on face" and Seroquel (another antipsychotic medication) 25 mg twice per day was ordered for this resident.</p> <p>k. Nurses Notes dated between 6/1/08 and 6/13/08 documented behaviors as follows:</p> <p>1.) 6/6/08 - "is uncooperative, wanders, resistive, yells and shouts, swings hands/fists, difficult to redirected."</p> <p>2.) 6/13/08 - "resident refusing to eat breakfast, will continue to monitor."</p> <p>l. On 6/17/08 at 8:38 a.m., 9:12 a.m., 9:30 a.m., 9:41 a.m., 10:16 a.m., 11:34 a.m. and 12:57 p.m., the resident was observed at meals, during care with staff and while she self-propelled throughout the facility. The resident did not demonstrate agitation, combativeness or resistance of care during those observations. Nurses Notes dated 6/17/08 at 1:44 p.m. documented, "is uncooperative, is combative, noisy, is agitated, is</p>	F 329			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 329	<p>Continued From page 49</p> <p>disruptive, difficult to redirect." The documentation in those Notes was not qualitatively correct.</p> <p>m. On 6/17/08, the resident was observed at breakfast, lunch and supper meals. The resident did not become agitated when she was given finger foods or other foods that she could feed herself.</p> <p>On 6/20/08 at 8:51 a.m., the resident was sitting at the South Dining Room at a feeder table. Certified Nursing Assistant (CNA) #5 attempted to feed the resident. The resident repeatedly raised her hands in front of her face when the CNA held the spoon to her mouth. After the resident lowered her hands, CNA #5 then pushed the spoon with food into the resident's mouth two different times. When the resident was left alone, she picked up a carton of jello and attempted to eat it with her fingers. The DON was present and shown the inappropriate technique used by CNA #5.</p> <p>n. On 6/19/08 at 11:30 a.m., Assistant Director of Nursing (ADON) #1 was asked to provide indications for use of the antipsychotic medication. She stated, "post-traumatic stress syndrome" in reference to the resident's history of rape. The surveyor informed ADON #1 that diagnosis was not documented, the resident had no prior use of antipsychotic medications, was being treated for a UTI at the time the antipsychotic medication was ordered and that no documentation of continuous behaviors or ones that represented a danger to the resident or others could be located. ADON #1 was also asked to provide documentation of facility attempts to lessen possible fear during baths,</p>	F 329			

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F 329	<p>Continued From page 50</p> <p>ADL cares and restraint use for this resident. As of 6/20/08 at 6:15 p.m., that requested information had not been provided.</p> <p>4. Resident #4 had diagnoses of Hypertension, Cerebrovascular Accident and Congestive Heart Failure.</p> <p>a. Medication Administration Records (MAR's) documented physician orders dated 11/15/07 (and reordered 5/20/08) for Norvasc (an antihypertensive medication) 5 mg daily and Normodyne (an antihypertensive medication) 100 mg twice per day. The Normodyne order dated 5/20/08 also documented, "Hold if BP [blood pressure] is less than 130/70."</p> <p>b. The April, May and June 2008 Medication Administration Records (MAR's) did not document blood pressure readings for this resident as of 6/19/08.</p> <p>c. The resident's clinical record was computerized. The section for nurse aide charting contained a subsection titled, "vital signs." The records for the section were printed for the dates of 4/1/08 through 6/19/08. The resident's blood pressure reading was documented on one date, 4/22/08 (136/83).</p> <p>d. On 6/19/08 at 2:40 p.m., the DON was asked to provide evidence of monitoring for the administration of two antihypertensive medications, as ordered. That information had not been provided as of 6/20/08 at 6:15 p.m.</p> <p>5. Resident #21 had a diagnosis of Chronic Organic Brain Syndrome. The Quarterly MDS dated 6/15/08 documented the resident had short</p>	F 329			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 329	Continued From page 51 and long term memory problems, was severely impaired in cognitive skills for daily decision making, had no behavioral symptoms, required limited assistance for locomotion on and off the unit, did not have a UTI in the last 30 days, received an antidepressant medication 7 days a week and did not receive an antipsychotic medication.  a. Nurse's Notes for dated 2/15/08, 2/17/08, 2/25/08, 3/2/08, 3/10/08, 3/15/08, 3/30/08 and 4/8/08 documented the resident was cooperative with cares and/or easily directed. Behavior Notes dated 4/16/08 documented, "Resident talking about needing to call her parents and sisters, when trying to orient, becomes very upset, has history of constipation, was checked with large amount of stool in lower bowels. Physician on call notified, awaiting return call."  b. Behavior Notes dated 4/22/08 documented, "easily redirected, noisy, wanders, resistive."  1) The Geropsych Follow-up sheet dated 4/22/08 documented the resident's formal complaint, "my mother is right over there, I've got to get to her, she is dying, (resident not redirectable)." The Nursing Report section documented, "s/p [status post] hospital tour due to UTI, continues with confusion, Rx: Remeron and Levaquin [an antibiotic]; Behavior: Cooperative, suspicious-Delusional; trying to get OO bed [out of bed]; Speech: Conversant, illogical; Mood: Agitated, Anxious, near tears." The "Assessment/Impression:" section documented, "Dementia, Delirium [a physical medical emergency, that is time-limited after treatment for the physical condition] due to UTI, Hx [history] of Depression... [resident] is actively hallucinating.	F 329			

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F 329	Continued From page 52 She continues in a delirium."  2) The Geropsych Follow-up sheet documented new orders, "Seroquel [an antipsychotic medication] 12.5 mg now X 1, hs [bedtime] & prn for delirium... [increase] Remeron 30 mg hs - usual dose of Rx for depression."  3) The same Geropsych Follow-up sheet had a note dated 4/26/08 that documented, "[resident] presents delusional, still looking for her mother. She is not redirectable. She has no recall of recent hospital tour. Will [increase] Seroquel 12.5 mg a.m. [morning], noon & 12.5 hs."  4) There was no documentation of how the resident's delirium was affecting her level of functioning to require the initial order for an antipsychotic or the second order for an increase in the medication dosage. As of 6/20/08, there was no information available for review that documented what interventions the facility had attempted prior to the administration of antipsychotic medications.  c. A laboratory UA with C&S report collected on 4/25/08 and reported on 4/27/08 documented the resident had signs of a UTI with trace protein (normal=negative), trace blood (normal=negative), positive nitrates (normal=negative), 2+ bacteria (normal=none seen), 5-10 RBC's (normal=none seen) and 0-2 WBC's (normal=none seen).  d. Behavior Nurses Notes documented the following: "5/6/08... wanders, resistive, difficult to redirected... 5/14/08... is cooperative with cares at all times... 5/20/08... uncooperative at times, easily redirected... 6/7/08 difficult to redirected..."	F 329		

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

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F 329	<p>Continued From page 53</p> <p>6/17/08... wanders, resistive, difficult to redirected at times."</p> <p>e. On 6/20/08 at 9:42 a.m., CNA #8 took the resident to a shower room. The resident was not resistive, however, the CNA had to coax and reassure the resident multiple times to persuade her to enter the shower room. The resident voiced concerns about her hair getting wet and not leaving articles of her clothing in the shower room. CNA #8 took her time with the resident and the resident's cares were provided as planned.</p> <p>6. Resident #16 had diagnoses of Agitation, Alzheimer's Disease and Dementia. A Minimum Data Set dated 5/15/08 documented the resident was severely impaired in cognitive skills for daily decision making and had no behaviors.</p> <p>a. Nurses Notes dated 5/9/08 documented the resident had a resident-to-resident altercation where she grabbed another resident's arm. No injury was noted. On 5/29/08, Nurses' Notes documented the resident had a UTI. There was no documentation of the resident having any further behaviors until 5/31/08 in which the resident was agitated and ran into another resident's wheelchair with a skin tear on Resident #16's ankle. Resident #16 was on antibiotics for a UTI. Nurses Notes dated 6/2/08 documented the resident was ordered another antibiotic for 7 days related to a UTI.</p> <p>b. Physician's Telephone Orders dated 6/10/08 documented: "Seroquel 25 mg p.o. BID [twice daily] and Q [every] 6 hours PRN [as needed] for Agitation." The order also requested laboratory blood tests and a Urinalysis with culture and</p>	F 329			

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

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FORM APPROVED  
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F 329	Continued From page 54 sensitivity.  c. A Psychiatric Evaluation dated 6/12/08 documented the resident was referred for the evaluation due to behavior disturbance, argumentative with peers and staff, grabs food off other residents trays, babbling conversation and fear with complaints of wheelchair is going to kill me per nurse's report. The evaluation form also documented that the resident had, "Delirium due to UTI... Needs mood stabilizer. Start VPA [valproic acid] 250 mg p.o. tid with level in 5 days. Resident is manic."  d. Physician Orders dated 6/12/08 documented: "Start Depakote 250 mg tid [3 times a day] with blood level in 5 days. Dx [Diagnosis] for Depakote Mood lability."  e. A physician order dated 6/13/08 documented the resident was to receive Cefitin 250 mg 2 times a day for 5 days for UTI.  f. A Physician Telephone Order dated 6/14/08 documented to reduce the Seroquel to 12.5 mg BID p.o. and Q 6 hours PRN..  g. As of 6/20/08, there was no further documentation of behaviors in the resident's clinical record from 5/31/08 to 6/17/08.  h. On 6/20/08 at 11:30 a.m., Assistant Director of Nursing (ADON) #1 stated, "The resident has the behaviors but the nurses are not documenting them in the resident's record. All I can find is the documentation from the APN [Advanced Practice Nurse]. Our documentation shows 1 incident of agitation and then the resident is put on Seroquel and Depakote."	F 329			

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

PRINTED: 07/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/20/2008</b>
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F 332 SS=E	<p>483.25(m)(1) MEDICATION ERRORS</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation of the 8:00 a.m. medication pass on 6/18/08 and record review, the facility failed to ensure the medication error rate was less than 5%. Physician orders were not followed for 2 (Residents #14 and #15) of 10 residents observed during the medication pass. Medication errors were made by 1 Licensed Practical Nurse (LPN #1) of 4 nurses who administered medications. The failed practice had the potential to affect 12 residents who received medications from this nurse, as identified by the Director of Nursing (DON) on 6/18/08. The medication error rate was 8.89% based on administration of 45 medications and a total of 4 errors detected. The findings are:</p> <ol style="list-style-type: none"> <li>1. Resident #14 had a physician order dated 5/22/08 for Wellbutrin Sustained Release (SR) 150 milligrams (mg) every morning. The order specified, "do not crush medications." <ol style="list-style-type: none"> <li>a. On 6/18/08 at 7:35 a.m., LPN #1 crushed the Wellbutrin SR before administering it to the resident.</li> <li>b. The manufacturer's instructions for Wellbutrin SR documented the medication was a sustained-release medication which should not be crushed.</li> </ol> </li> <li>2. Resident #14 had a physician order dated</li> </ol>	F 332			

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

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F 332	Continued From page 56 5/25/08 for Toprol XL 50 mg every morning. The order specified the resident's medications were not to be crushed.  a. On 6/18/08 at 8:50 a.m., LPN #1 crushed the Toprol XL prior to administering it to the resident.  b. The manufacturer's instructions for Toprol XL documented the medication was an extended-release medication which should not be crushed.  3. Resident #15 had a physician order dated 6/13/08 for Calcium Carbonate 500 mg plus vitamin D three times a day.  On 6/18/08 at 7:58 a.m., LPN #1 administered plain Calcium Carbonate 500 mg to the resident, instead of Calcium Carbonate plus vitamin D as ordered by the physician.  4. Resident #14 had a physician order dated 6/3/08 for sliding scale Novolin R insulin as follows:  For fingerstick blood sugar (FSBS) of less than 150, no insulin. 150-199, 4 units (U). 200-249, 6U. 250-299, 8U. 300-349, 12U. 350-399, 16U.  On 6/18/08 at 7:35 a.m., the resident's FSBS result was 344. This would require 12 units of Novolin R insulin based on the sliding scale, but LPN #1 did not administer Novolin R to the resident.	F 332			
F 333	483.25(m)(2) MEDICATION ERRORS	F 333			

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

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F 333 SS=D	Continued From page 57  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation of the 8:00 a.m. medication pass on 6/18/08 and record review, the facility failed to ensure physician orders were followed to prevent a significant medication error for 1 (Resident #14) of 10 residents observed during the medication pass. A significant medication error was made by 1 Licensed Practical Nurse (LPN #1) of 4 nurses who administered medications. The failed practice had the potential to affect 12 residents who received medications from this nurse, as identified by the Director of Nursing on 6/18/08. The findings are:  Resident #14 had a diagnosis of Insulin-Dependent Diabetes Mellitus and a physician order dated 6/3/08 for 18 units of Novolin N every morning and Novolin R based on the following sliding scale:  For fingerstick blood sugar (FSBS) of less than 150, no insulin. 150-199, 4 units (U). 200-249, 6U. 250-299, 8U. 300-349, 12U. 350-399, 16U.  a. On 6/18/08 at 7:35 a.m., the resident had a FSBS of 344 which would have required 12 units of Novolin R according to the sliding scale. LPN #1 administered the 18 units of Novolin N at 7:35 a.m. then stated that the resident did not receive	F 333			

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

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F 333	Continued From page 58 sliding scale insulin. No Novolin R was administered.	F 333		
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE  The facility must store, prepare, distribute, and serve food under sanitary conditions.  This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure frozen foods were tightly sealed to prevent potential freezer-burn, failed to ensure frozen pork was thawed in the refrigerator or under running water to prevent potential foodborne illness and failed to ensure Dietary Staff did not re-contaminate their hands between handwashing and handling food. The failed practices had the potential to affect 98 residents who were not tube fed, as documented on the Resident Census and Conditions of Residents form dated 6/19/08. The findings are:  1. On 6/16/08 at 1:37 p.m. during the initial tour of the kitchen, 1 box of white rolls, 1 box of wheat rolls, 1 bag of okra, 2 boxes of cookie dough, 1	F 371		

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

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F 371	Continued From page 59 box of blended vegetables and 1 box of potatoes were stored in the walk-in freezer in unsealed containers, which exposed the food to potential freezer-burn.  2. On 6/18/08 at 9:05 a.m., Dietary Aide #1 washed her hands, used her clean hands to open the lid of a large gray garbage next to the handwashing sink, disposed of the paper towel she had used to dry her hands, then returned to the food preparation counter to prepare desserts.  3. On 6/18/08 at 9:23 a.m., Dietary Aide #2 washed her hands, used her clean hands to open the lid of a large gray garbage next to the handwashing sink, disposed of the paper towel she had used to dry her hands, then assisted the cook to prepare the vegetables for the noon meal.  4. On 6/19/08 at 7:30 a.m., frozen pork chops for the noon meal were thawing in a pan of water on the edge of the 2-compartment sink instead of under cold running water.	F 371			
F 502 SS=E	483.75(j)(1) LABORATORY SERVICES  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure laboratory services were provided as ordered by the physician for 3 (Residents #3, #4 and #17) of 19 case mix residents with physician orders for laboratory services (Resident #1 through #13 and #16 through #21). The failed	F 502			

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F 502	<p>Continued From page 60</p> <p>practice had the potential to affect all 110 residents, as documented on the Resident Census and Conditions of Residents form dated 6/19/08. The findings are:</p> <ol style="list-style-type: none"> <li>1. Resident #17 had diagnoses of Parkinson's Disease, Cerebral Vascular Accident and Diabetes Mellitus. <ol style="list-style-type: none"> <li>a. A physician order dated 6/12/08 documented a complete blood count (CBC), basic metabolic panel (BMP), thyroid-stimulating hormone (TSH) level, red blood cell count (RBC), Folate level, B-12 level and Homocysteine level were to be drawn STAT (immediately).</li> <li>b. On 6/20/08 at 3:35 p.m., the Director of Nursing (DON) was asked for the laboratory reports for the STAT laboratory tests ordered by the physician on 6/12/08. She stated, "It was not drawn. The LPN [Licensed Practical Nurse] did not fill out a requisition."</li> </ol> </li> <li>2. Resident #3 had diagnoses of Senile Dementia, Hypertension and Congestive Heart Disease. A physician order dated 6/6/08 documented the resident was to receive Synthroid 0.1 milligrams (mg) by mouth every day. <ol style="list-style-type: none"> <li>a. A physician order dated 6/12/08 documented a TSH level was to be drawn.</li> <li>b. As of 6/20/08 at 3:30 p.m., there was no documentation in the clinical record that the TSH had been drawn.</li> <li>c. On 6/20/08 at 3:35 p.m., the DON stated the ordered TSH was not done.</li> </ol> </li> </ol>	F 502		

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F 502	Continued From page 61	F 502			
F 514 SS=E	<p>3. Resident #4 had a diagnosis of Cerebrovascular Accident.</p> <p>a. A Physician Order sheet signed on 6/6/08 documented a laboratory order dated 5/27/08 for a TSH level.</p> <p>b. As of 6/19/08, there was no documentation in the clinical record that the TSH level had been drawn.</p> <p>c. On 6/19/08 at 2:40 p.m., the DON was asked to locate the TSH results for the labwork ordered on 5/27/08.</p> <p>d. On 6/20/08 at 3:35 p.m., the DON stated the TSH report could not be located.</p> <p>483.75(l)(1) CLINICAL RECORDS</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure clinical records were complete and accurate for 3</p>	F 514			

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F 514	<p>Continued From page 62</p> <p>(Residents #4, #9 and #25) of 20 case mix residents whose clinical records were reviewed (Residents #1 through #13, #16 through #21 and #25), as evidenced by failure to consistently document the administration of routine and as-needed (PRN) medications and failure to document the use of a splint and the resident's tolerance of the splint, progress made or lack thereof. The failed practice had the potential to affect all 110 residents, as documented on the Roster Matrix provided by the facility on 6/16/08. The findings are:</p> <ol style="list-style-type: none"> <li>1. Resident #9 had diagnoses of Heart Failure and Hypertension. Physician Orders dated 11/1/07 documented: "Hytrin [an antihypertensive medication] 5 mg [milligrams] every evening" and "Clonidine [an antihypertensive medication] PRN if systolic blood pressure greater than 150 or diastolic blood pressure greater than 95." <ol style="list-style-type: none"> <li>a. On 6/20/08, computerized vital sign records and Medication Administration Records (MAR's) dated March, April and May 2008 were reviewed. Blood Pressure readings were documented on 3/25/08 (162/56), 4/27/08 (139/101) and 5/8/08 (147/95) that would have required administration of the PRN Clonidine. The MAR's dated March, April and May 2008 did not document administration of the PRN Clonidine on those dates.</li> <li>b. On 6/20/08, the DON provided a list of blood pressures for this resident and a handwritten note which documented, "No evidence found MD [Medical Doctor] notified or medication given."</li> </ol> </li> <li>3. Resident #4 had diagnoses of Left-sided Hemiplegia and Cerebrovascular Accident. The</li> </ol>	F 514			

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F 514	<p>Continued From page 63</p> <p>Quarterly MDS dated 6/6/08 documented the resident was bedfast, required total assistance for activities of daily living (ADL's) and did not receive Restorative Nursing services or use a splint/brace.</p> <p>a. Occupational Therapy (OT) Progress Notes dated 10/26/07 documented the facility nursing staff and the resident, "demonstrate good understanding of splint application." The Notes documented the resident was discharged to Restorative Therapy for further passive range of motion, splint application and long term care.</p> <p>b. An OT Discharge Plan of Care dated 11/16/07 documented: "...to prevent contracture of R [right] hand... Treatment/Recommendations: perform PROM [passive range of motion] to L [left] hand for 10 minutes. Place L resting hand splint at 7 a.m. &amp; [and] remove at 7 p.m."</p> <p>c. As of 6/16/08, the Care Plan dated 4/8/08 did not document approaches for use of a splint for this resident. Computerized Physician Orders dated between 5/31/07 and 6/11/08 were printed on 6/19/08 and there were no physician orders for the use of a splint.</p> <p>d. On 6/16/08 at 4:00 p.m. and 6/17/08 at 8:31 a.m. and 11:55 a.m., the resident wore a Velcro-splint on her left hand/forearm.</p> <p>e. On 6/20/08 at 10:09 a.m., Restorative Certified Nursing Assistant (RCNA) #1 was asked if the resident received Restorative Nursing services. She stated, "No." When asked about the use of the hand splint, RCNA #1 stated the resident, "wears it all day" and she did not know if its use was documented by facility staff. When asked</p>	F 514			

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F 514	<p>Continued From page 64</p> <p>who was responsible for the provision of Restorative Nursing services when it was for maintenance purposes, RCNA #1 stated, "Restorative." RCNA #1 was asked about documentation of the resident's baseline assessment and further assessments of the limitation in range of motion for the resident's left hand and she stated that Restorative Aides documented what services they provided daily, but did not document weekly progress notes of residents' tolerance, improvements or lack thereof.</p> <p>f. Medication Administration Records (MAR's) documented physician orders dated 11/15/07 (and reordered 5/20/08) for Norvasc (anti-hypertensive) 5 mg daily and Normodyne (anti-hypertensive) 100 mg twice per day. The Normodyne order dated 5/20/08 also documented, "hold if BP [blood pressure] is less than 130/70." This order would require a blood pressure reading twice per day prior to the administration of the Normodyne.</p> <p>1.) The MAR's dated April, May and June 1 through 19, 2008 did not document blood pressure readings for this resident.</p> <p>2.) The MAR's dated May 2008 had 30 skips out of 40 opportunities for documentation of administration of the Normodyne (between 5/5/08 and 5/20/08).</p>	F 514			