

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

PRINTED: 10/05/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045375	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/21/2007
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NAME OF PROVIDER OR SUPPLIER PARKVIEW REHABILITATION & HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 BARROW ROAD LITTLE ROCK, AR 72204
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F 000	<p>INITIAL COMMENTS</p> <p>Complaint #12730 was substantiated (all or in part) with a deficiency cited at F157.</p> <p>Complaints #12899 and #12936 were unsubstantiated.</p>	F 000		
F 157 SS=E	<p>483.10(b)(11) NOTIFICATION OF CHANGES</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the physician was consulted regarding abnormal capillary blood glucose (CBG) results for 1 (Resident #3) of 5 case mix residents with physician orders for CBG testing (Residents #3, #5, #8, #13 and #18). The facility also failed to ensure the resident's family representative was notified regarding medication changes and changes in condition for 2 (Residents #7 and #8) of 15 case mix residents who had medication changes or changes in condition (Residents #1 through #15). The failed practices had the potential to affect 110 residents who had or could potentially have changes in condition, as documented on the facility's Resident Census and Conditions of Residents form dated 9/10/07, including 38 residents with physician orders for CBG testing, as documented on a list provided by the Director of Nursing (DON) on 9/14/07 at 12:00 p.m. The findings are: 1. Resident #3 had a diagnosis of Insulin-Dependent Diabetes Mellitus. The Quarterly Minimum Data Set (MDS) dated 6/12/07 documented the resident was severely impaired in cognitive skills for daily decision making. a. A physician order dated 6/22/07 documented: "Accu-checks ac [before meals] and hs [hour of sleep] 7:30 a.m., 11:30 a.m., 4:30 p.m., 9:00 p.m. Notify physician > [greater than] 250 < [less than] 70 Diabetes... Novolog per sliding scale as follows: > 250 4 u [units]. If blood sugar is still > 200 after 30 minutes, call M.D. [Medical Doctor] 7:30 a.m., 11:30 a.m., 4:30 p.m., 9:00 p.m."	F 157			

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F 157	Continued From page 2 b. The Plan of Care documented a problem identified on 5/24/05 as: "Problem: Potential for fluctuating blood sugars... Nurses - ...check blood sugars as ordered. Insulin as ordered. Observe for hypo/hyperglycemia: thirst, urination, hunger, shaking, sweating, blurred vision..." c. Nurses' Notes dated 8/1/07 at 5:29 p.m. documented the resident's blood glucose was 68. There was no documentation the physician was notified of this result. d. Nurses' Notes dated 8/2/07 at 2:32 p.m. documented the resident's blood glucose was 57. There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. e. Nurses' Notes dated 8/2/07 at 5:31 p.m. documented the resident's blood glucose was 56. There was no documentation that the physician was notified or that any interventions were implemented to address the ongoing hypoglycemia. f. Nurses Notes dated 8/3/07 at 7:55 a.m. and signed by Licensed Practical Nurse (LPN) #4 documented the resident's blood glucose was 49. There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. g. Nurses' Notes dated 8/4/07 at 7:47 a.m. and signed by LPN #4 documented the resident's blood glucose was 68. There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia.	F 157			

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F 157	Continued From page 3 h. Nurses' Notes dated 8/6/07 at 8:57 p.m. documented the resident's blood glucose was 68. There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. i. Nurses' Notes dated 8/10/07 at 4:00 p.m. documented: "Chemstrip result: 46." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. j. Nurses' Notes dated 8/12/07 at 8:20 p.m. documented: "Chemstrip result: 59." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. k. Nurses' Notes dated 8/13/07 at 8:29 a.m. and signed by LPN #4 documented: "Chemstrip result: 60." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. l. Nurses' Notes dated 8/13/07 at 10:07 p.m. and signed by LPN #5 documented: "Chemstrip result: 280." There was no documentation that the physician was notified. m. Nurses' Notes dated 8/18/07 at 8:11 a.m. and signed by LPN #4 documented: "Chemstrip result: 45." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. n. Nurses' Notes dated 8/22/07 at 5:32 p.m. documented: "Chemstrip result: 54." There was no documentation that the physician was notified	F 157			

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F 157	Continued From page 4 or that any interventions were implemented to address the hypoglycemia. o. Nurses' Notes dated 8/27/07 at 8:23 a.m. and signed by LPN #4 documented: "Chemstrip result: 62." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. p. Nurses' Notes dated 8/29/07 at 4:20 p.m. documented: "Chemstrip result: 59." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. q. Nurses' Notes dated 8/30/07 at 11:01 a.m. documented: "Chemstrip result: 54." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. r. Nurses' Notes dated 8/31/07 at 5:26 p.m. documented: "Chemstrip result: 60." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. s. Nurses' Notes dated 9/1/07 at 8:12 a.m. and signed by LPN #4 documented: "Chemstrip result: 41." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. t. Nurses' Notes dated 9/2/07 at 7:57 a.m. and signed by LPN #4 documented: "Chemstrip result: 61." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia.	F 157			

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F 157	Continued From page 5 u. Nurses' Notes dated 9/2/07 at 11:05 p.m. documented: "Chemstrip result: 67." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. v. Nurses' Notes dated 9/3/07 at 3:05 p.m. documented: "Chemstrip result: 56." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. w. Nurses' Notes dated 9/4/07 at 1:31 p.m. documented: "Chemstrip result: 57." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. x. Nurses Notes dated 9/5/07 at 8:06 a.m. and signed by LPN #4 documented: "Chemstrip result: 68." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. y. Nurses' Notes dated 9/6/07 at 8:03 a.m. and signed by LPN #4 documented: "Chemstrip result: 42." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. z. Nurses' Notes dated 9/8/07 at 8:16 p.m. documented: "Chemstrip result: 57." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. aa. Nurses' Notes dated 9/10/07 at 7:58 a.m. and signed by LPN #4 documented: "Chemstrip result: 67." There was no documentation that the	F 157			

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F 157	Continued From page 6 physician was notified or that any interventions were implemented to address the hypoglycemia. bb. Nurses' Notes dated 9/10/07 at 9:17 p.m. and signed by LPN #5 documented: "Chemstrip result: 294." There was no documentation that the physician was notified and no documentation a follow-up blood glucose was done after sliding scale Novolog was administered. cc. Nurses' Notes dated 9/11/07 at 7:55 a.m. and signed by LPN #4 documented: "Chemstrip result: 54." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. dd. Nurses' Notes dated 9/11/07 at 10:19 p.m. documented: "Chemstrip result: 293." There was no documentation that the physician was notified or that a follow-up blood glucose was checked after sliding scale Novolog was administered. ee. On 9/14/07 at 6:35 a.m., LPN #5 was asked to explain the physician-ordered parameters for physician notification of blood glucose readings for this resident. LPN #5 stated, "If greater than 250, give 4 units [of Novolog], wait 30 minutes, recheck. If greater than 200, call the MD." LPN #5 was asked to pull up the follow-up blood glucose tests completed when the resident's blood glucose was greater than 250 on 8/13/07 and 9/10/07. LPN #5 pulled up a blood glucose result of 196 on the Endocrine screen, but was unable to locate a follow-up result for the 9/10/07 blood glucose. The LPN was asked if a follow-up blood glucose was done on 9/10/07 when the resident's blood glucose registered 294. The LPN stated, "Yes." The LPN stated the follow-up result was less than 200 on that date. LPN #5	F 157			

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F 157	<p>Continued From page 7</p> <p>was asked if the physician was consulted when the resident's blood glucose was greater than 250, in accordance with the physician order. The LPN stated, "No, I just gave the insulin and the repeat was not greater than 200."</p> <p>ff. On 9/14/07 at 11:30 a.m., LPN #4 was asked to explain the physician-ordered parameters for notifying the physician of blood glucose readings for this resident. LPN #4 reviewed the physician order, then stated, "Greater than 250 or less than 70." LPN # 4 was asked if the physician was consulted on 9/11/07 when the blood glucose was 54 or on 9/6/07 when the blood glucose was 42. The LPN stated, "No." The LPN was asked if there was any reason why the physician was not notified. LPN #4 stated, "I guess I thought it was close to breakfast and I didn't need to do anything." LPN #4 was asked if the resident's blood glucose was rechecked after breakfast. The LPN stated, "No."</p> <p>gg. On 9/14/07 at 12:55 p.m., the Director of Nursing (DON) was asked, "When should your staff notify the physician regarding low blood glucose readings?" The DON stated, "If 60 or below, if symptomatic or asymptomatic... even if interventions are done."</p> <p>2. Resident #8 had diagnoses of Dementia and Diabetes Mellitus. The Quarterly Minimum Data Set (MDS) dated 4/19/07 documented the resident had modified independence in cognitive skills for daily decision-making and had no behavioral symptoms or indicators of delirium or disordered thinking.</p> <p>a. Nurses' Notes dated 5/9/07 at 10:53 a.m. documented: "...Had no mood indication of</p>	F 157		

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F 157	Continued From page 8 depression, being sad or anxious in past 7 days. Is cooperative with cares at all times..." b. A Physician's Telephone Order dated 5/9/07 documented: "...Abilify 2.5 mg [milligrams] po [by mouth] a.m. [morning] and hs [hour of sleep]." There was no documentation in the clinical record that the resident's family was notified of this order. c. Nurses' Notes dated 5/15/07 documented: "Mood Patterns: Complained of or was overly concerned with health problems today, states she hears voices in her head, that sounds like her own voice even when she isn't talking." There was no documentation in the daily care notes or elsewhere in the clinical record that the resident's family was notified of this change in status. d. A Physicians's Telephone Order dated 6/4/07 documented: "DC [discontinue] Abilify a.m. dose... Abilify 5.0 mg po q [every] hs." There was no documentation in the daily care notes or elsewhere in the clinical record that the resident's family was notified of this change. e. A Physicians's Telephone Order dated 6/14/07 documented: "[Decrease] Abilify to 2.5 mg po q hs." Nurses Notes dated 6/15/07 at 1:25 a.m. documented: "...Behavior: is uncooperative with cares ADL [activities of daily living], resistive with staff, res. [resident] has become shaky and has become incont. [incontinent] on self X [times] 3 this shift. res resist CNA's [Certified Nursing Assistants] in giving care but she is to [too] shaky and weak to do for self. Med [medication] Abilify decreased to 2.5 mg will cont [continue] to monitor." There was no documentation in the Nurses' Notes or elsewhere in the clinical record	F 157			

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F 157	Continued From page 9 that the resident's family was notified regarding this change in status. f. A Physicians's Telephone Order dated 6/15/07 documented: "[Decrease] Abilify to 2.5 mg po q hs due to sedation..." There was no documentation in the clinical record that the resident's family was notified. g. Nurses' Notes dated 6/17/07 documented: "...Displays confusion on this day. Was already in bed when I came on shift at 1830 [6:30 p.m.]. This is not the normal. She doesn't know my name on this day and usually calls me by my name. V/S [vital signs] are in the normal range BS [blood sugar] have been low for her but still on the high side will continue to monitor and turn over to day nurse for further observation." There was no documentation the resident's family was notified of these changes in behavior. h. A Physicians's Telephone Order dated 6/18/07 documented: "D/C [discontinue] Abilify." There was no documentation in the clinical record that the resident's family was notified of this medication change. i. Hearing test results dated 7/11/07 documented: "Recommendations... Hearing Aid Candidate, bilaterally... If interested in hearing aids, bring a family member to hearing aid counseling appt [appointment]." There was no documentation in the Nurses' Notes or elsewhere in the clinical record that this information was shared with the resident's family. j. The Quarterly Minimum Data Set dated 7/16/07 documented the resident had modified independence in cognitive skills for daily decision	F 157			

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F 157	<p>Continued From page 10</p> <p>making and had no behavioral symptoms or indicators of delirium or disordered thinking.</p> <p>k. On 9/13/07 at 1:57 p.m., the Director of Nursing (DON) was asked for documentation of family notification when the resident's medication regimen was changed on multiple occasions and when changes in the resident's behavior were documented. The DON was also asked for documentation that the family was informed of the recommendation for hearing aids and request for the family to be present for a counseling appointment. The DON stated, "I will have to research and get back with you." As of 9/14/07 at 4:48 p.m., the requested documentation had not been provided.</p> <p>l. On 9/14/07 at 7:00 a.m., the DON provided a document dated 6/27/07 which documented: "Training Title: Notification of Physicians and Responsible party of a Resident's condition change... Introduction: Once a resident condition change is identified notification of the physician and responsible party in a manner consistent with the Arkansas Practice Act the nurse will complete the following steps... Document in ECS [electronic charting system] your assessment of the resident and that the physician and family member/POA [power of attorney] was notified."</p> <p>m. On 9/14/07 at 4:48 p.m., the DON stated, "I could not find where the family was notified of new medications, medication changes or condition changes.</p> <p>3. Resident #7 had diagnoses of Dementia and Depression. The Quarterly Minimum Data Set (MDS) dated 8/7/07 documented the resident was moderately impaired in cognitive skills for daily</p>	F 157			

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F 157	Continued From page 11 decision making. a. A Physician's Telephone Order dated 4/25/07 documented: "dc [discontinue] Seroquel..." b. On 9/14/07 at 10:59 a.m., the DON was asked for documentation that the resident's family was notified of the Seroquel being discontinued on 4/25/07. The DON stated, "I will have to research and get back with you." c. On 9/14/07 at 4:48 p.m. the DON stated, "I could not find where the family was notified..."	F 157			
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure suprapubic catheter site care was performed in a manner to prevent potential infection for 1 of 1 case mix resident with a suprapubic catheter (Resident #21). The facility failed to ensure the physician was consulted and interventions were implemented for repeated episodes of hypoglycemia for 1 (Resident #3) of 5 case mix residents with physician orders for blood glucose testing (Residents #1, #3, #5, #8 and #13). The facility failed to ensure urinary catheter drainage bags were positioned below the level of the	F 309			

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F 309	<p>Continued From page 12</p> <p>bladder for 1 (Resident #10) of 3 case mix residents with physician orders for urinary catheters (Residents #10, #20 and #21). The failed practices had the potential to affect 1 resident with a suprapubic catheter and 38 residents with physician orders for blood glucose testing, as identified by the Director of Nursing (DON) on 9/14/07 and 5 residents with physician orders for urinary catheters, as documented on the facility's Resident Census and Conditions of Residents form dated 9/10/07. The findings are:</p> <p>1. Resident #3 had a diagnosis of Insulin-Dependent Diabetes Mellitus. The Quarterly Minimum Data Set (MDS) dated 6/12/07 documented the resident was severely impaired in cognitive skills for daily decision making.</p> <p>a. A physician order dated 6/22/07 documented: "Accu-checks ac [before meals] and hs [hour of sleep] 7:30 a.m., 11:30 a.m., 4:30 p.m., 9:00 p.m. Notify physician > [greater than] 250 < [less than] 70 Diabetes... Novolog per sliding scale as follows: > 250 4 u [units]. If blood sugar is still > 200 after 30 minutes, call M.D. [Medical Doctor] 7:30 a.m., 11:30 a.m., 4:30 p.m., 9:00 p.m."</p> <p>b. The Plan of Care documented a problem identified on 5/24/05 as: "Problem: Potential for fluctuating blood sugars... Nurses - ...check blood sugars as ordered. Insulin as ordered. Observe for hypo/hyperglycemia: thirst, urination, hunger, shaking, sweating, blurred vision..."</p> <p>c. Nurses' Notes dated 8/1/07 at 5:29 p.m. documented the resident's blood glucose was 68. There was no documentation the physician was notified of this result.</p>	F 309			

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F 309	Continued From page 13 d. Nurses' Notes dated 8/2/07 at 2:32 p.m. documented the resident's blood glucose was 57. There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. e. Nurses' Notes dated 8/2/07 at 5:31 p.m. documented the resident's blood glucose was 56. There was no documentation that the physician was notified or that any interventions were implemented to address the ongoing hypoglycemia. f. Nurses Notes dated 8/3/07 at 7:55 a.m. and signed by Licensed Practical Nurse (LPN) #4 documented the resident's blood glucose was 49. There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. g. Nurses' Notes dated 8/4/07 at 7:47 a.m. and signed by LPN #4 documented the resident's blood glucose was 68. There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. h. Nurses' Notes dated 8/6/07 at 8:57 p.m. documented the resident's blood glucose was 68. There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. i. Nurses' Notes dated 8/10/07 at 4:00 p.m. documented: "Chemstrip result: 46." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia.	F 309			

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F 309	Continued From page 14 j. Nurses' Notes dated 8/12/07 at 8:20 p.m. documented: "Chemstrip result: 59." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. k. Nurses' Notes dated 8/13/07 at 8:29 a.m. and signed by LPN #4 documented: "Chemstrip result: 60." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. l. Nurses' Notes dated 8/18/07 at 8:11 a.m. and signed by LPN #4 documented: "Chemstrip result: 45." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. m. Nurses' Notes dated 8/22/07 at 5:32 p.m. documented: "Chemstrip result: 54." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. n. Nurses' Notes dated 8/27/07 at 8:23 a.m. and signed by LPN #4 documented: "Chemstrip result: 62." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. o. Nurses' Notes dated 8/29/07 at 4:20 p.m. documented: "Chemstrip result: 59." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. p. Nurses' Notes dated 8/30/07 at 11:01 a.m. documented: "Chemstrip result: 54." There was	F 309			

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F 309	Continued From page 15 no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. q. Nurses' Notes dated 8/31/07 at 5:26 p.m. documented: "Chemstrip result: 60." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. r. Nurses' Notes dated 9/1/07 at 8:12 a.m. and signed by LPN #4 documented: "Chemstrip result: 41." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. There was no documentation regarding any other symptoms the resident had at this time. s. Nurses' Notes dated 9/2/07 at 7:57 a.m. and signed by LPN #4 documented: "Chemstrip result: 61." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. t. Nurses' Notes dated 9/2/07 at 11:05 p.m. documented: "Chemstrip result: 67." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. u. Nurses' Notes dated 9/3/07 at 3:05 p.m. documented: "Chemstrip result: 56." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. u. Nurses' Notes dated 9/4/07 at 1:31 p.m. documented: "Chemstrip result: 57." There was no documentation that the physician was notified	F 309			

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F 309	Continued From page 16 or that any interventions were implemented to address the hypoglycemia. v. Nurses Notes dated 9/5/07 at 8:06 a.m. and signed by LPN #4 documented: "Chemstrip result: 68." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. w. Nurses' Notes dated 9/6/07 at 8:03 a.m. and signed by LPN #4 documented: "Chemstrip result: 42." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. There was no documentation regarding any other symptoms that the resident had at this time. x. Nurses' Notes dated 9/8/07 at 8:16 p.m. documented: "Chemstrip result: 57." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. y. Nurses' Notes dated 9/10/07 at 7:58 a.m. and signed by LPN #4 documented: "Chemstrip result: 67." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. z. Nurses' Notes dated 9/11/07 at 7:55 a.m. and signed by LPN #4 documented: "Chemstrip result: 54." There was no documentation that the physician was notified or that any interventions were implemented to address the hypoglycemia. There was no documentation regarding any other symptoms that the resident had at this time. aa. On 9/14/07 at 11:30 a.m., LPN #4 was asked to explain the physician-ordered parameters for	F 309			

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F 309	<p>Continued From page 17</p> <p>notifying the physician of blood glucose readings for this resident. LPN #4 reviewed the physician order, then stated, "Greater than 250 or less than 70." LPN # 4 was asked if the physician was consulted on 9/11/07 when the blood glucose was 54 or on 9/6/07 when the blood glucose was 42. The LPN stated, "No." The LPN was asked if there was any reason why the physician was not notified. LPN #4 stated, "I guess I thought it was close to breakfast and I didn't need to do anything." LPN #4 was asked if the resident's blood glucose was rechecked after breakfast. The LPN stated, "No."</p> <p>bb. On 9/14/07 at 12:55 p.m., the Director of Nursing (DON) was asked, "When should your staff notify the physician regarding low blood glucose readings?" The DON stated, "If 60 or below, if symptomatic or asymptomatic... even if interventions are done."</p> <p>2. Resident #21 had diagnoses of Neurogenic Bladder and Multiple Sclerosis. The Minimum Data Set dated 6/12/07 documented the resident had modified independence in cognitive skills for daily decision making, was totally dependent on staff for personal hygiene and had an indwelling catheter.</p> <p>a. A physician order dated 9/10/07 documented: "Change Supra Pubic Catheter Q [every] month..."</p> <p>b. The Plan of Care dated 9/6/07 documented: "Problem: Urinary Catheter... Foley care and monitoring as ordered/per policy ..."</p> <p>c. On 9/14/07 at 10:45 a.m., Licensed Practical Nurse (LPN) #1 cleansed the resident's</p>	F 309			

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F 309	<p>Continued From page 18</p> <p>suprapubic catheter site using a 4x4 gauze pad moistened with normal saline. She cleansed the upper portion of the insertion site, then with a second 4x4, cleansed across the bottom in a circular motion followed by multiple back and forth swipes. The LPN held the soiled 4x4's in her gloved hand, carried them into the bathroom and placed them into the biohazard container. Without changing gloves, the LPN opened and placed a clean 4x4 gauze pad onto the suprapubic site.</p> <p>d. On 9/14/07 at 5:40 p.m., the Director of Nursing (DON) was asked the proper procedure for cleansing a suprapubic catheter site. The DON stated, "Clean around it inner to outer." She was asked if staff should be wiping back and forth across the site. She stated, "No." The DON described the suprapubic catheter care process as, "Take the dressing off, bag it, gloves off, wash hands, open equipment, gel or wash hands, reglove and clean around wound, reglove again if needed and apply a clean dressing. Clean tubing at the same time cleaning site..."</p> <p>3. Resident #10 had diagnoses of Non-Insulin Dependent Diabetes Mellitus and Urinary Tract Infection. The Quarterly Minimum Data Set (MDS) dated 7/19/07 documented the resident had had modified independence in cognitive skills for daily decision making, no short or long-term memory problems, was incontinent of bowel and bladder and did not have an indwelling catheter.</p> <p>a. A physician order dated 9/7/07 documented: "Place Foley [catheter] 9/9/07 for [resident] comfort for office visit 9/10/07. Remove Foley 9/10/07 p.m. [evening]."</p>	F 309			

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F 309	Continued From page 19 b. On 9/10/07 at 3:02 p.m. during the initial tour, the resident's catheter drainage bag was hanging on the left side of the wheelchair at the level of the resident's thigh. The catheter tubing was looped down toward the floor, then back up into the drainage bag.	F 309			
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure incontinent care was provided in a manner to maintain good personal hygiene for 2 (Residents #3 and #9) of 8 case mix residents who were incontinent (Residents #1, #2, #4, #8 through #10, #12 and #14), as evidenced by failure to cleanse urine from all areas of the resident's skin. The failed practice had the potential to affect 52 residents who were incontinent of bladder and 53 residents who were incontinent of bowel, as documented on the facility's Resident Census and Conditions of Residents form dated 9/10/07. The findings are: 1. Resident #9 had the diagnoses of Senile Dementia and Urinary Tract Infection. The Minimum Data Sets (MDS) dated 8/3/07 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and totally dependent on staff for bathing and	F 312			

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F 312	<p>Continued From page 20</p> <p>personal hygiene.</p> <p>a. The Plan of Care dated 7/31/07 documented: "Potential for Incontinence, Total - Potential for UTI [Urinary Tract Infection]... Peri Care when incontinent. Cleanse peri-area... after incontinent episodes and PRN [as needed] Incontinence."</p> <p>b. On 9/11/07 at 10:40 a.m., Certified Nursing Assistants (CNA's) #5 and #6 provided incontinent care to the resident. The wet incontinent brief was removed. The incontinent pad and sheet were also wet with urine. CNA #6 wiped from the anus to the vaginal area multiple times with the same cloth, then a clean incontinent brief was placed on the resident. The CNA did not cleanse the buttocks, thighs, groin, pubic area, inner labia or urinary meatus.</p> <p>c. On 9/14/07 at 11:20 a.m., CNA #6 was asked how incontinent care should be performed. The CNA stated, "Wash front to back." When asked which body parts were included in the incontinent care procedure, "thighs, buttocks, etc?" The CNA stated, "No, you start in the back and work your way to the front." The CNA did not answer the question regarding which body parts should be cleansed.</p> <p>2. Resident #3 had diagnoses of Insulin-Dependent Diabetes Mellitus and Renal Failure. The Quarterly Minimum Data Set (MDS) dated 6/12/07 documented the resident was severely impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and dependent on staff for toilet use and personal hygiene.</p> <p>a. The Plan of Care documented a problem</p>	F 312			

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F 312	Continued From page 21 identified on 6/3/06 as: "Problem: Potential for impairment of skin integrity, and breakdown related to: Incontinence... Nurses - Assess skin condition weekly... Keep clean and dry... Nurses Aides - Assist with hygiene... Keep skin clean and dry..."	F 312		
F 314 SS=H	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure pressure sores were promptly identified and correctly staged, interventions were developed and implemented to prevent further pressure sores and the pressure ulcer risk assessment tool utilized by the facility was properly completed to enable the facility to identify the level of risk for pressure ulcer development for 4 (Residents #2,	F 314		

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F 314	<p>Continued From page 22</p> <p>#3, #9 and #10) of 8 case mix residents with pressure sores (Residents #1, #2, #3, #5, #8, #9, #10 and #15). The facility also failed to ensure a resident with physical restraints in use was repositioned to alleviate pressure and prevent potential pressure ulcer development for 1 (Resident #14) of 3 case mix residents with physical restraints in use (Residents #7, #12 and #14). The failed practices resulted in actual harm to Residents #3 and #9 and had the potential to affect 12 residents with pressure sores, as documented on the facility's Resident Census and Conditions of Residents form dated 9/10/07, 14 residents with soft belt or table top restraints in use, as documented on a list provided by the Director of Nursing (DON) on 9/14/07 and 23 residents who were at risk for pressure ulcer development, as identified by the DON on 9/21/07. The findings are:</p> <p>1. The facility's training documentation dated 7/19/07 and titled, "Basics of Wound Care: Staging and Types of Wounds" was presented to the survey team by the Director of Nursing on 9/14/07 at 7:00 a.m. as the facility policy on assessments and staging of pressure sores. The training documented, "...Target audience: RN [Registered Nurse] and LPN [Licensed Practical Nurse]... The certified nurse aide should let the nurse know as soon as a red spot is noted on the resident. The nurse is to assess the resident's skin weekly. Early detection and prevention is the key ... Common sites of pressure ulcers: ...Sacrum & [and] coccyx... Heel... Wound staging is the basis for developing treatment protocols, selecting reduction support surface... Rules of staging: only used for pressure ulcers, stage all pressure ulcers at the deepest level of damage, once a pressure ulcer is staged, it remains at that</p>	F 314			

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F 314	<p>Continued From page 23</p> <p>stage, and reverse staging/back staging should never be used to describe the healing of a pressure ulcer. Call it a healing stage I, II, III, IV, or unstageable wound..."</p> <p>2. The Braden Scale for Predicting Pressure Sore Risk form utilized by the facility documented the following recommended interventions based on the risk score:</p> <p>For a score of 13 to 14: "Moderate Risk: ...Turning schedule, Use foam wedges for 30 [degree] lateral positioning, Pressure reduction support surface, Maximal remobilization, Protect heels, Manage moisture, nutrition, and friction and shear. If other major risk factors present, advance to next level of risk.</p> <p>For a score of 10 to 12: "High risk: Increase frequency of turning, supplement with small shifts, Pressure reduction support surface, Use foam wedges for 30 [degree] lateral positioning, Maximal remobilization, Protect heels, Manage moisture, nutrition and friction and shear... low air loss beds do not substitute for turning schedules..."</p> <p>3. Resident #9 had diagnoses of Senile Dementia, Congestive Heart Failure, Urinary Tract Infection and Fracture of Left Distal Femur. The Minimum Data Set (MDS) dated 8/3/07 documented the resident was moderately impaired in cognitive skills for daily decision making, left 25% or more of meal uneaten at most meals, was on a mechanically altered diet with supplements, was incontinent of bowel and bladder, had no pressure ulcers, was totally dependent on staff for transfers via a mechanical lift and required extensive assistance with bed</p>	F 314			

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F 314	Continued From page 24 mobility. a. The Plan of Care dated 7/31/07 documented, "...Potential for skin breakdown due to Urinary Incontinence... Nurse Aide - Peri Care when incontinent. Cleanse peri-area and apply barrier cream to after incontinent episodes and PRN [as needed]... Problem: Stage 2 - Partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater [left] coccyx... Problem: Potential for Impairment of skin integrity, and breakdown... Nurse - Assess skin condition weekly... Apply pressure relieving device(s) for chair. Pressure relieving device(s) for bed. Monitor Turning and Repositioning Program... Nurse Aide - Reposition every two hours in bed. Keep skin clean and dry. Keep linen clean, dry and wrinkle free. Change wet linen. Use incontinence pads. Barrier cream to peri-area..." b. The Braden Scale Assessment dated 8/21/07 documented the resident had very limited mobility, required moderate to maximum assistance to move, was chairfast, was occasionally exposed to moisture which necessitated linen changes approximately once a day, rarely ate a complete meal and probably had inadequate nutrition. No numerical values were assigned to the assessment findings on the Braden Scale and the scale was not totaled. When completed as instructed, the total pressure ulcer risk score, based on the assessment findings, was 14. The score legend on the Braden Scale Assessment form documented a score of 13-14 indicated the resident was at moderate risk of developing pressure ulcers. On 9/12/07 at 3:05 p.m., the Director of Nursing (DON) was asked, "Can you tell me the Braden	F 314			

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F 314	<p>Continued From page 25</p> <p>score for this resident?" The DON reviewed the Braden Scale Assessment dated 8/21/07 and stated, "No scores. She's at high risk."</p> <p>c. Nurses Notes dated 9/1/07 at 7:45 p.m. documented the resident was sent to the hospital for knee pain.</p> <p>d. A Nurses Admission Note dated 9/6/07 at 5:07 p.m. documented, "Resident readmitted from [hospital]... redness to periarea and buttocks, rash to back..."</p> <p>e. On 9/10/07 at 6:30 p.m., the resident was sitting in a wheelchair in the dining room. No pressure relieving device was in the wheelchair.</p> <p>f. On 9/11/07 at 8:06 a.m., the resident was lying in bed on a hard plastic non-circulating air waffle mattress covered with a sheet. No pressure relieving devices were on the resident's feet.</p> <p>g. On 9/11/07 at 10:40 a.m., the resident was lying in bed on a hard plastic non-circulating air waffle mattress covered with a sheet. The resident's heels were not offloaded and were in direct contact with the sheet-covered mattress. Certified Nursing Assistants (CNA's) #5 and #6 provided incontinent care to the resident at this time and the following observations were made:</p> <p>1.) The wet incontinent brief was removed. The incontinent pad and sheet were also wet with urine. CNA #6 wiped from the anus to the vaginal area multiple times, then a clean incontinent brief was placed on the resident. The CNA did not cleanse the buttocks, thighs, groin, pubic area, inner labia or urinary meatus and no barrier cream was applied to the resident's skin.</p>	F 314			

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F 314	Continued From page 26 2.) A skin audit was performed at this time and there was a dark-red, open area on the resident's coccyx and a discolored (red/purple/blue) area on the left heel that extended around the entire heel. 3.) After the skin audit was completed, the CNA's used a mechanical lift to transfer the resident to a wheelchair. Once the resident's weight was lifted off of the mattress, a 12 by 12 inch area of the mattress remained flattened, in the area where the resident's coccyx had been resting. The wheelchair had no pressure relieving device in the seat and the CNA's left the mechanical lift sling under the resident. h. On 9/11/07 at 11:50 a.m., the resident was sitting in a wheelchair in the dining room. There was no pressure relief device in the seat of the wheelchair and the mechanical lift sling remained under the resident's buttocks. i. On 9/11/07 at 12:40 p.m., the resident was sitting in a wheelchair at the assisted feeding table. There was no pressure relief device in the wheelchair and the mechanical lift sling remained beneath the resident's buttocks. j. On 9/11/07 at 1:10 p.m., a CNA rolled the resident's wheelchair into the 200 Hall. The mechanical lift sling was still positioned under the resident's buttocks at this time. k. On 9/11/07 at 2:30 p.m., the resident was in bed. The mechanical lift sling remained under the resident and there were no pressure relief devices on the resident's heels. l. On 9/11/07 at 2:36 p.m., Licensed Practical	F 314			

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F 314	<p>Continued From page 27</p> <p>Nurse (LPN) #7 provided colostomy care to the resident. The resident was in bed and the mechanical lift sling remained under the resident. There were no pressure relief devices on the resident's heels, which were in direct contact with the mattress.</p> <p>m. On 9/11/07 at 4:55 p.m., the resident was sitting in a wheelchair in the dining room. The wheelchair had no pressure relief device in the seat and the mechanical lift sling had again been left under the resident.</p> <p>n. On 9/12/07 at 7:15 a.m., CNA's # 11, #13 and #14, who were assigned to the hall where the resident resided, were asked if any special positioning was required for this resident. The CNA's all stated, "No, we put a pillow under her hip and thigh area to keep off the stitches." The CNA's were asked if they did anything special to keep pressure off of the resident's left heel. All 3 CNAs stated, "No."</p> <p>o. On 9/12/07 at 8:12 a.m., the resident was lying in bed on the hard plastic non-circulating air waffle mattress. Thera-boot heel protectors were on both feet.</p> <p>p. On 9/12/07 at 9:35 a.m. and 10:14 a.m., the resident was sitting in a wheelchair in her room with no pressure relieving devices in the wheelchair seat or on her feet.</p> <p>q. On 9/12/07 at 11:45 a.m. and 1:00 p.m., the resident was sitting in a wheelchair in the dining room with no pressure relieving devices in the wheelchair seat or on her feet.</p> <p>r. On 9/12/07 at 2:30 p.m., the resident was lying</p>	F 314			

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F 314	<p>Continued From page 28</p> <p>in bed on the hard plastic non-circulating air waffle mattress. No pressure relieving devices were on the resident's heels, which were in direct contact with the mattress. Licensed Practical Nurse (LPN) #2 performed colostomy care at this time.</p> <p>s. On 9/12/07 at 2:55 p.m., LPN #2 was asked, "How often do you do skin audits?" The LPN stated, "I don't know." LPN #2 was asked if any of the CNA's had reported any skin issues for this resident. LPN #2 stated, "No." LPN #2 was asked if any of the CNA's had mentioned the areas on the resident's coccyx and left heel. The LPN stated, "No."</p> <p>t. On 9/12/07 at 2:58 p.m., the following interview was conducted:</p> <p>The DON was asked, "How often are body audits done?" The DON stated, "On admission, a head-to-toe assessment is done and documented into ECS [Electronic Charting System]. Then it's done on bath day every week."</p> <p>The DON was asked, "How are wound measurements documented?" The DON stated, "If there is a wound treatment ordered, a screen prompts the nurse to enter the measurements."</p> <p>The DON was asked, "When was the last body audit done on [Resident #9]?" Registered Nurse (RN) #1, who was also present during the interview, stated, "I just did it last Thursday." RN #1 was asked, "Did you find any problems with the coccyx or heels?" RN #1 stated, "No."</p> <p>The DON and RN #1 accompanied the surveyors to the resident's room for a skin audit at this time.</p>	F 314			

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F 314	<p>Continued From page 29</p> <p>The resident was lying on her back in bed, on the non-circulating air waffle mattress with no pressure relieving devices on her feet and no offloading of the heels.</p> <p>During the skin audit, the DON measured two areas on the resident's coccyx and stated, "Two areas: One centimeter (cm) by 3 millimeters, Stage II, with surrounding redness." The DON assessed the resident's left heel which had a large, dark-red, purple and black area. The DON measured the area and stated, "6.5 cm by 3 cm."</p> <p>The DON was asked to stage the area on the resident's left heel. RN #1 stated, "It's a deep tissue, but the skin isn't broken, so it's a Stage I." The DON stated, "It's deep tissue, unstageable, so its a Stage IV."</p> <p>The DON was asked, "What kind of mattress is on the bed?" The DON pointed to the mattress and stated, "This is a pressure relieving mattress." The DON was asked, "What kind of mattress is this on top of it?" The DON stated, "It's something that the family brought in to use on the bed. It's an air mattress. I'll get rid of it."</p> <p>The DON was asked, "In the wheelchair, what is in the seat?" RN #1 stated, "It's a cushion." The RN then picked it up, inspected it and stated, "Oh, its a bed pillow." The DON was asked, "Is that a pressure relieving device?" The DON stated, "No. I guess we didn't have a pressure relieving device in the wheelchair."</p> <p>The DON was asked, "Were any heel protectors on the resident when you started your assessment?" RN #1 and the DON both stated "No, there were no heel protectors on the</p>	F 314			

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F 314	<p>Continued From page 30 resident."</p> <p>u. On 9/12/07 at 3:05 p.m., the DON was asked, "How often does [Resident #9] get a bath?" The DON called the nursing unit, received information, then stated, "Tuesday, Thursday and Saturday." The DON was asked, "Can you show me where this is documented?" The DON reviewed the record in the computer, which documented, "9/11/07 - no foot problem." The DON was asked, "What is the process for reporting skin problems in this facility?" The DON stated, "CNA's fill out a slip of paper and turn it in to the nurse. The nurse assesses the resident and the slip then goes to the Assistant Director of Nurses [ADON]. Then the resident is assessed again. If the wound is a Stage II or greater, we send the resident to the Wound Care Center." The DON was informed that during incontinent care on the previous day, the areas on the resident's coccyx and heel were visible and that the CNA's providing care were asked about the area on the resident's coccyx at that time. The DON was asked if this had been reported by the CNA's. The DON called the nursing unit, received information then stated, "No slip or report of the skin problems was ever reported to the nurses."</p> <p>v. On 9/13/07 at 1:05 p.m., the Medical Director was asked if there were any concerns with the resident's skin. The Medical Director stated, "We [myself and the Advanced Practice Nurse (APN)] assessed the resident when she returned to the facility. We didn't notice any skin problems. Her left heel was a little boggy, but not red or anything."</p> <p>w. On 9/13/07 at 1:30 p.m., the DON stated, "There are no measurements [of the wounds]</p>	F 314			

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F 314	<p>Continued From page 31 other than the ones we done together."</p> <p>x. On 9/13/07 at 3:30 p.m., the facility Administration provided product information on the Waffle static air mattress. The product information documented: "...Indications for Use: Treatment: Use for healing therapy to patients with pressure ulcers up to Stage III... Hand check and inflation adjustments: The key to safe patient support is creating the perfect balance between pliability and stiffness of the mattress. If the product is too stiff, the advantages of the surface area are defeated. One inch of air is adequate support for a patient. If you can slide your hand in and out easily under the overlay, pressure is being relieved... [Manufacturer] recommends daily hand checks and then adding or removing air according to the patient's position and body type." The tag on the resident's mattress documented: "...The highest clinical benefits are achieved with a properly inflated mattress. Include skin inspections, daily inflation checks, proper nutrition, and turning schedules as part of a balanced wound care management program..."</p> <p>y. On 9/14/07 at 6:30 a.m., LPN #9, who worked the 7:00 p.m. to 7:00 a.m. shift and was assigned to the resident's hall, was asked when she was first made aware of the breakdown to the resident's coccyx and heel. LPN #9 stated, "Last night [Thursday] for the bottom, the heel the night before [Wednesday]." LPN #9 was asked, "Did the CNA's tell you there were any problems with the skin?" LPN #9 stated, "No."</p> <p>z. On 9/14/07 at 10:45 a.m., CNA #5, who provided incontinent care on 9/11/07, was asked if she saw anything on the resident's heel when the sock was removed. CNA #5 stated, "Yes, a</p>	F 314			

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F 314	<p>Continued From page 32</p> <p>red spot." CNA #5 was asked if she reported the reddened area to anyone. CNA #5 stated, "No." CNA #5 denied seeing any skin problems on the resident's coccyx during incontinent care since she was holding the resident while the other CNA provided incontinent care. CNA #5 was asked, "What are you supposed to do if you find something wrong with a resident's skin?" The CNA stated, "Tell the nurse."</p> <p>aa. On 9/14/07 at 11:20 a.m., CNA #6, who provided incontinent care on 9/11/07, was asked if she saw anything unusual about the resident's skin on that date. CNA #6 denied seeing any skin problems on the resident's coccyx or heels.</p> <p>bb. On 9/17/07 at 11:00 a.m., the DON was asked if the nurses performed hand checks to assess inflation of the waffle static air mattress. The DON stated, "I doubt it." When asked if any inflation apparatus was located in the facility to re-inflate the mattress, the DON stated, "No."</p> <p>4. Resident #3 had diagnoses of Insulin-Dependent Diabetes Mellitus, Dementia and Renal Failure.</p> <p>a. The Plan of Care documented a problem identified on 5/14/07 as: "...Problem: Supportive device use with risk of complications manifested by: Increased incontinence, skin breakdown... Goal: No complications R/T [related to] supportive device use ... Nurses - Watch resident for s/s [signs and symptoms] complications R/T supportive device. Nurse aide - Check q [every] 30 min. [minutes], release q 2 hr [hours] for activity... Assist with toileting and ADLs [activities of daily living] as needed daily. NOTIFY NURSE OF ANY S/S SKIN BREAKDOWN OR OTHER</p>	F 314			

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F 314	<p>Continued From page 33</p> <p>COMPLICATIONS R/T SUPPORTIVE DEVICE USE... 1/22/07 - Problem: Impairment of skin integrity... Manifested by: Pressure ulcer present Stage 4 - a full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone... Nurses - Assess skin condition weekly... Nurse Aide - Reposition every two hours in bed... pressure relieving mattress... 4/11/07 - Problem: Impairment of skin integrity... Manifested by: Pressure ulcer present Stage 2 - a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. To sacrum, coccyx, right heel, left heel, right lateral leg ... Nurses - Assess skin condition weekly... Nurse Aide - Reposition every two hours in bed... pressure relieving mattress..."</p> <p>b. A Pressure Sore Report dated 5/25/07 documented the resident had a Stage II pressure ulcer to the sacral/coccyx area which measured 1.5 centimeters (cm) long, by 1 cm wide, by 0.1 cm deep and was facility-acquired. The ordered treatment for this wound was Zinc oxide twice daily. The report also documented a Stage II pressure ulcer to the right heel which measured 3 cm long by 3 cm wide with eschar present. The ordered treatment for this wound was to cleanse with normal saline (NS), pat dry, apply Accuzyme and cover with Chlorpactin gauze wrap. The report documented a Thera boot was to be used for pressure relief.</p> <p>c. The Braden Scale Assessment form dated 6/11/07 at 8:40 a.m. documented the resident was completely immobile, exposed to constant [skin] friction, chairfast, rarely exposed to moisture, usually ate only half of meals and had slightly limited sensory perception and could not always communicate pain or need to reposition.</p>	F 314			

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F 314	<p>Continued From page 34</p> <p>The Braden Scale was not totaled. When completed as instructed, the total pressure ulcer risk score, based on the above assessment findings, was 13. The score legend on the Braden Scale Assessment form documented a score of 13-14 indicated the resident was at moderate risk of developing pressure ulcers.</p> <p>d. The Quarterly Minimum Data Set (MDS) dated 6/12/07 documented the resident had short and long term memory problems, was severely impaired in cognitive skills for daily decision making, dependent on staff for transfers, bed mobility, toilet use, and personal hygiene, incontinent of bowel and bladder and had one Stage I and four Stage II pressure ulcers.</p> <p>e. The most recent Braden Scale Assessment in the clinical record was dated 6/22/07 at 9:49 p.m. and did not include documentation of the resident's moisture, nutrition or sensory perception status.</p> <p>f. The Pressure Sore Report dated 6/29/07 documented the Stage II pressure ulcer to the resident's coccyx had increased in size, to 2 cm long by 1.5 cm wide and was to be treated with zinc oxide. A new Stage II pressure ulcer to the right ankle was also documented and measured 3.5 by 1.8 cm and was to be treated by cleansing with NS, packed with Silvasorb and covered with gauze and Alleny. The report also documented the Stage II pressure ulcer to the resident's right heel had increased in size to 9 cm long by 8 cm wide by 0.1 cm deep and was to be treated by cleansing with NS, applying Silvadene cream, covering with 4x4's and wrapping with Kerlix.</p>	F 314			

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F 314	Continued From page 35 g. The Pressure Sore Report dated 7/5/07 documented the Stage II pressure ulcer to the coccyx had increased in size to 2.2 cm long by 1.5 cm wide by 0.1 cm deep and was still being treated with zinc oxide. The Stage II pressure ulcer to the right ankle had decreased in size but increased in depth, to 3 cm long by 1 cm wide by 0.2 cm deep and was still being treated with NS, Silvasorb, gauze and Alleny. The pressure ulcer to the right heel had decreased in size but increased in depth, to 8.5 cm long by 6 cm wide by 0.2 cm deep and had eschar present, but was still documented as a Stage II. This wound was still being treated with NS, Silvadene cream, 4x4's and Kerlix. h. The Pressure Sore Report dated 7/13/07 documented the Stage II pressure ulcer to the coccyx was healed. The Stage II pressure ulcer to the right ankle had decreased is size to 2 cm long, by 0.7 cm wide by 0.1 cm deep. The pressure ulcer to the right heel measured 9 cm long by 5.5 cm wide by 0.2 cm deep and had eschar present, but was still documented as a Stage II and there had been no change in the ordered treatment. i. The Pressure Sore Report dated 7/30/07 documented a Stage II pressure ulcer to the coccyx, but no measurements were documented. The ordered treatment for this wound was documented as, "Cleanse with NS apply Zinc Oxide." The wound to the right ankle measured 1 cm long by 0.5 cm wide by 0.1 cm deep and was now documented as a "vascular Stage II wound." The wound to the right heel measured 9 cm long by 5.5 cm wide with unmeasureable depth due to eschar and was now coded as a Stage II vascular wound, but was still receiving the same treatment.	F 314			

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F 314	<p>Continued From page 36</p> <p>j. Nurses' Notes dated 8/1/07 at 11:32 a.m. documented: "...Skin Problems: decubitus ulcer. Location: on right heel, redness to sacral and coccyx area. Skin treatment: Has pressure relieving device for bed. Receives turning/repositioning program. Receives ulcer care. Receives application of ointments/medications... Foot Problems/Care: decubitus on right heel... Pressure ulcer: Full thickness of skin lost, exposing SubQ [subcutaneous] tissue - presents as a deep crater (Pressure Stg. 3). Ulcer location: on right heel. Color: reddened. Drainage: purulent..."</p> <p>k. A physician order dated 8/1/07 documented: "Cleanse coccyx area with normal saline. Apply zinc oxide oint [ointment] bid [twice a day]..."</p> <p>l. A physician order dated 8/2/07 documented: "Cleanse right posterior ankle with normal saline. Rinse with normal saline. Pat dry with 4x4's. Pack with Fibracol 2x2. Cover with foam, wrap with gauze qd [every day]... Cleanse right heel pressure ulcer with normal saline. Pack with Calcium Alginate, cover with 4x4's, foam drsg [dressing]. Wrap with Kerlix qd..."</p> <p>n. The Pressure Sore Report dated 8/3/07 documented the wound to the right ankle was a Stage II vascular wound measuring 2 cm long by 0.7 cm wide by 0.1 cm deep and continued to be treated with NS, 4x4's, Silvasorb, gauze and Alleny. The wound to the resident's right heel was documented as a Stage II vascular wound measuring 9 cm long by 5.5 cm wide by 0.2 cm deep, with eschar present. The treatment for this wound remained unchanged.</p>	F 314		
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F 314	<p>Continued From page 37</p> <p>o. Nurses' Notes dated 8/8/07 at 8:14 p.m. documented: "...Skin Problems: Ulcers... Location: on right heel, coccyx area. Skin Treatment: Has pressure relieving device for bed..."</p> <p>p. The Pressure Sore Report dated 8/10/07 documented the wound to the right ankle was a Stage II and remained the same size and depth as on the 8/3/07 assessment and was being treated with NS, 4x4's, Fibracol, 2x2's, foam wrap and gauze daily. The wound to the right heel remained the same size and continued to have eschar present, but was still documented as a Stage II. The treatment for this wound was documented as: "Cleanse heel with NS then pack with Calcium Alginate, cover with 4x4's, foam drsg."</p> <p>q. The Pressure Sore Report dated 8/17/07 documented the wound to the right ankle was a Stage II and measured 1.5 cm long by 1 cm wide and had increased to 0.2 cm in depth, with drainage present. The treatment for this wound was unchanged. The wound to the right heel was documented as a Stage II measuring 4.5 cm by 7 cm (no depth was documented). The treatment for this wound was unchanged.</p> <p>r. The Pressure Sore Report dated 8/27/07 documented: "...Rt [right] ankle. Stage: II ... Correction last week - 9.5 x 6.5 x 0.2. This week 7.5 x 5.5 x 0.2..." The right heel wound was documented as healed.</p> <p>s. The Pressure Sore Report dated 9/7/07 documented the wound to the right ankle was a Stage II measuring 7.5 cm long by 5.4 cm wide by 0.2 cm deep. The treatment for this wound was</p>	F 314			

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F 314	<p>Continued From page 38</p> <p>unchanged and the Pressure Relief intervention was documented as: "Thera boots." The report also documented an area to the left great toe as a skin tear and a second area to the left great toe as a Stage IV measuring 1 by 2 cm.</p> <p>t. On 9/11/07 at 8:13 a.m., the resident was sitting in a wheelchair with a table top restraint. A mechanical lift sling was under the resident. The resident was not wearing shoes and his left foot was positioned under the foot pedal of the wheelchair. The restraint was marked at this time by sliding a small slip of paper under the right strap of the table top.</p> <p>u. On 9/11/07 at 11:02 a.m., the resident was sitting in the wheelchair with the table top restraint in place. The slip of paper remained unmoved under the right strap of the restraint. The mechanical lift sling remained under the resident. The resident was still not wearing shoes and his left foot remained under the foot pedal of the wheelchair.</p> <p>v. On 9/11/07 at 12:30 p.m., the resident was being fed lunch by a Certified Nursing Assistant (CNA), while sitting in the wheelchair with the table top restraint in place. The slip of paper remained unmoved under the right strap of the restraint. His bare left foot remained under the wheelchair foot pedal.</p> <p>w. On 9/11/07 at 2:35 p.m., the resident was sitting in the wheelchair with the table top restraint in place. The slip of paper remained unmoved under the right strap of the restraint, the mechanical lift pad remained under the resident and the resident's left bare foot remained under the wheelchair foot pedal.</p>	F 314			

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F 314	Continued From page 39 x. On 9/11/07 at 4:30 p.m., the resident was sitting in the wheelchair in the dining room with the table top restraint in place. The slip of paper was no longer under the restraint strap and the resident was wearing different clothing; however, he was still wearing no shoes and his left foot was under the foot pedal of the wheelchair. y. On 9/12/07 at 7:40 a.m., the resident was sitting in a wheelchair with a table top restraint in the dining room. The resident was not wearing shoes and his left foot was under the foot pedal of the wheelchair. The restraint was marked at this time by placing a small slip of paper under the right strap. z. On 9/12/07 at 9:22 a.m., CNA #1 was making the resident's bed. A hard, green, vinyl-covered mattress was leaning against the wall. CNA #1 stated, "The resident just got a new mattress." The new mattress was a low-air-loss, pressure-relieving mattress. aa. On 9/12/07 at 9:50 a.m., CNA's #1 and #2 provided incontinent care to the resident, following an episode of bowel and bladder incontinence. CNA #2 rolled the resident to his left side. There was an open area on the resident's lower, right buttock. CNA #1 sprayed a washcloth with periwash and cleansed the perianal and buttock areas. The CNA then used the washcloth, which was soiled with feces, to wipe across the open area on the resident's buttock and stated, "He has a sore." CNA #1 dried the resident's perianal and buttock areas with a towel, which became soiled with stool as the CNA wiped the resident's skin. The CNA's removed the soiled incontinent brief from the	F 314			

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F 314	<p>Continued From page 40</p> <p>resident, but left the incontinent pad, which was soiled with a 7 by 1-inch streak of stool. The CNA's rolled the resident back onto the soiled incontinent pad after the procedure was completed.</p> <p>bb. On 9/12/07 at 10:15 a.m., CNA #2, who was assigned to provide care to this resident on 9/11/07, was asked when she had repositioned him on 9/11/07. CNA # 2 stated, "Not till after dinner. I did check on him." CNA # 2 was asked how she had checked on the resident. CNA #2 stated, "Took the top off the wheelchair and looked inside his pants." (The slip of paper placed under the right strap of the table top at 8:13 a.m. on 9/11/07 was still present at 2:35 p.m. and would have been dislodged had the top been removed.) CNA #2 was asked how she positioned the resident in bed. The CNA stated, "Pillow between the knees. Don't put the foot up because of drainage. Try and keep him off his bottom." CNA #2 was asked if she did anything about the resident's feet when he was in the wheelchair. CNA #2 stated, "Nothing that I know of."</p> <p>cc. Nurses' Notes dated 9/12/07 at 11:18 p.m. documented: "Skin problem: Has tear/cut(s) present in past 7 days. Location: on left top foot... Size: 0.5 x 0.4. Location: on left top foot. Size: 0.5 x 0.5. On left 3rd toe... Size: 1 x 0.8. Location: on right great toe... Size: 1.5 x 1.8... On right 2nd toe... Size: 0.5 x 0.5... On right buttock... Size: 1.6 x 1..."</p> <p>dd. On 9/13/07 at 10:20 a.m., the Director of Nursing (DON) was asked, "What were the results of the body audit you did last night?" The DON stated, "...Stage II's to the third toe and</p>	F 314			

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F 314	<p>Continued From page 41</p> <p>great toe [on the left foot], a scabbed second toe [on the right foot], Stage II to the coccyx." The DON was asked if she was aware, prior to the body audit, that the resident had skin breakdown on his feet and buttocks. The DON stated, "No, the CNA's did not go to the nurse." The DON was asked when the low-air-loss, pressure-relieving mattress was initiated. The DON stated, "First day was yesterday." The DON was asked if any interventions were implemented to relieve pressure on the resident's toes. The DON stated she planned to order a foot cradle for the resident, "today." The DON was asked to review the Nurses' Notes dated 9/12/07 at 11:18 p.m. which documented the wounds to the resident's toes as "tears/cuts." The DON was asked if this documentation was correct. The DON stated, "No, they were pressure sores. I measured and staged them myself. I asked someone else to document it, and they did it wrong. The DON was asked to correct the documentation. The DON lined through the, "Has tear/cut" area and wrote in, "Stage II PU [pressure ulcer]."</p> <p>ee. On 9/14/07 at 6:50 a.m., CNA #17, who worked the night shift on the hall where the resident resided, was asked, "When did you notice the sore on the resident's buttocks?" CNA #17 stated, "A couple of weeks now." CNA #17 was asked, "Did you tell someone?" The CNA stated, "Charge Nurse [LPN #5]." I've been asking for a air mattress and foot rest on the wheelchair. We've been asking for something to keep his feet up. [LPN # 5] has been e-mailing someone. Now he's got that air mattress, I don't have to turn him."</p> <p>ff. On 9/14/07 at 6:35 a.m., LPN #5, who worked</p>	F 314			

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F 314	Continued From page 42 the evening/night shift on this resident's hall, was asked when she became aware that the resident had an open area on his right buttock. LPN #5 stated, "Wednesday evening [9/12/07]." LPN #5 was asked if she worked on Tuesday night (9/11/07). The LPN stated, "Yes, I work Monday through Thursday." LPN #5 was asked if the CNA's told her that the resident had an open area on his buttock. LPN #5 stated, "No." 5. Resident #10 had diagnoses of Non-Insulin Dependent Diabetes Mellitus, Breast Cancer and Pleural Effusion. a. The Plan of Care dated 12/27/06 and updated 3/18/07 documented: "Problem: Potential for Impairment of skin integrity... Nurses: Assess skin condition weekly. Nurse Aide: ...Reposition every two hours in bed... pressure relieving mattress..." b. A physician order dated 4/21/07 documented: "Thera boots for heel protection (full thickness wounds) 7A-7P [7:00 a.m. to 7:00 p.m.] 7P-7A [7:00 p.m. to 7:00 a.m.]." c. The Braden Scale Assessment form dated 5/15/07 at 9:00 a.m. documented the resident had very limited mobility, no apparent problems with shear/friction, was chairfast, occasionally exposed to moisture, probably had inadequate nutrition, had slightly limited sensory perception and could not always communicate pain or need to reposition. The Braden Scale was not totaled. When the numerical values for each of the assessment areas were added, the total pressure ulcer risk score for this resident was 15, which indicated the resident was at a low risk for pressure ulcer development.	F 314			

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F 314	Continued From page 43 d. The Braden Scale Assessment form dated 5/18/07 at 8:47 a.m. documented the resident's friction/shear score had worsened due to the resident requiring moderate to maximum assistance to move, "...Slides in bed/chair. Constant friction." The assessment was not totaled in order to determine the level of pressure ulcer risk. When the numerical values of the assessment findings were added, the pressure ulcer risk score was 14, which indicated the resident was at moderate risk for pressure ulcer development. e. The Pressure Sore Report dated 5/25/07 documented: "Area: [right] and [left] heels; Stage: IV, Eschar; Size cm [centimeters] healed, 1.9 x 1 x 0.2; ... Treatment: Apply Kerlix, keep dry, qd [every day]... Pressure relief device(s): Y [yes] Thera boots... Area: Sacrum; Stage: II; Size... 2 x 1.5... Treatment: Cleanse with NS [normal saline]. Apply DuoDerm q [every] 3 days..." f. Nurses' Notes dated 6/3/07 at 1:46 a.m. documented: "Skin status: Pressure ulcer: Has persistent area of skin redness that does not disappear when pressure relieved (Pressure Stg [stage] 1). Location: Coccyx buttock, Observation: Dressing intact...Actions: Continue to treat as ordered, protective devices in place..." g. The Pressure Sore Report dated 6/22/07 documented: "Area: Right heel; Stage: IV; Size... 2 x 1 [cm] with eschar ... Treatment: Apply Kerlix to right heel. Do not get wet ... Pressure relief device(s): Y... Area: Sacrum; Stage: II; Size: 1.7 x 1... Treatment: Cleanse with NS. Apply Duoderm q 3 days ..."	F 314		

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F 314	Continued From page 44 h. The Pressure Sore Report dated 7/5/07 documented: "Area: Right heel; Stage: IV; Size... 2 x 1 x 0.2...Treatment: Apply Kerlix to right heel... Area: Sacrum; Stage: II healed..." i. The Pressure Sore Report dated 7/13/07 documented: "Area: Right heel; Stage: IV; Size...1.5 x 1 x 0.2... Treatment: Apply Kerlix to right heel..." j. The Quarterly Minimum Data Set (MDS) dated 7/19/07 documented the resident had modified independence in cognitive skills for daily decision making, had multiple daily episodes of bladder incontinence, was incontinent of bowel all (or most all of the time), dependent on staff for personal hygiene and toilet use and had no stasis or pressure ulcers. k. The Pressure Sore Report dated 7/30/07 documented: "Area: Right heel; Stage: IV; Size... 1.5 x 1 x 0.2 healing... Treatment: Apply Kerlix to right heel... and barrier cream to [right] and [left] heels..." l. The Pressure Sore Report dated 8/10/07 documented: "Area: Right heel; Stage: IV; Size... 1.7 x 0.8 x 2... Treatment: Apply Kerlix to right heel..." m. The Pressure Sore Report dated 8/17/07 documented: "Area: Right heel; Stage: IV; Size... 1.2 x 0.5 x 0.2... Treatment: Apply Kerlix to right heel..." n. Nurses' Notes dated 8/24/07 at 9:52 a.m. documented: "Skin problems: sore mushy area, Location: on left heel (not open), Skin treatment: E-mailed [Advanced Practice Nurse]..."	F 314			

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F 314	Continued From page 45 o. The Pressure Sore Report dated 8/27/07 documented: "Area: Right heel; Stage: IV; Size... 1 x 0.3 x 0.2... Treatment: Apply Kerlix to right heel QD [every day] 7p - 7a [7:00 p.m. to 7:00 a.m.] ..." There was no documentation on this report regarding the "sore, mushy area" to the left heel. p. The Pressure Sore Report dated 9/7/07 documented: "Area: Right heel; Stage: IV; Size... 1 x 0.2 x 0.1...Treatment: Apply Kerlix to right heel QD 7p - 7a..." q. Nurses' Notes dated 9/7/07 at 8:10 p.m. documented: "Skin assessment: 2+ edema, Location: on right/on left lower leg(s)... Skin problems: ulcers ... Location: on right/on left heels... Skin treatment: ...Has pressure relieving device for bed..." r. On 9/10/07 at 6:39 p.m., the resident was in bed. There was no pressure relief mattress on the resident's bed. s. On 9/11/07 at 8:12 a.m., the resident was sitting in a wheelchair in the dining room with her legs elevated. The resident did not have Thera boots on. t. On 9/11/07 at 11:15 a.m., the resident was in her room sleeping in the wheelchair with her legs elevated. The resident did not have Thera boots on. u. On 9/11/07 at 12:30 p.m., the resident was sitting in the wheelchair in the dining room with her legs elevated. The resident stated she had been up in the wheelchair since before breakfast	F 314			

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F 314	<p>Continued From page 46 and had, "not moved." The resident did not have Thera boots on.</p> <p>v. On 9/11/07 at 2:50 p.m., the resident was in bed on her back with the head of the bed elevated. The resident stated she was put back to bed, "Five minutes ago." The resident was asked what time she had originally gotten in the wheelchair that day. The resident stated, "About 8:00 a.m." There was no pressure-relieving device on the resident's bed.</p> <p>w. On 9/12/07 at 8:12 a.m., after the resident was dressed and transferred to her wheelchair, the bed was stripped. The resident had been on a hard, blue, vinyl-covered mattress that had areas of cracks and tears in the mattress cover. The areas were too numerous to count or measure.</p> <p>x. On 9/12/07 at 8:13 a.m., the Director of Nursing (DON) was asked to come to the resident's room to observe the mattress. The DON was then asked if the mattress would be considered a pressure-reduction mattress. The DON stated, "No, I'll get it changed. I agree, she should be on another mattress." The DON was asked to provide the manufacturer's recommendations for this mattress. The manufacturer's recommendations were not provided to the survey team as requested.</p> <p>y. On 9/12/07 at 9:10 a.m., the DON stated she had ordered a new air mattress for the resident.</p> <p>z. The Wound Care Progress Note dated 9/13/07 from the wound clinic documented: "...continuing evaluation and care of a small ulceration on her right heel. This is probably pressure related. The</p>	F 314			

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F 314	<p>Continued From page 47</p> <p>patient is essentially nonambulatory and spends almost her entire time either in a wheelchair or lying in bed... Physical exam is limited to the right lower extremity. She is found to have a very small ulceration on the posterolateral aspect of the heel... Periwound: Normal; Wound bed: Pink gran [granulation]..." The Discharge/Wound Care Instructions documented: "...Note: Patient is not to [be] up longer than 1.5 hours at a time..."</p> <p>6. Resident #14 had diagnoses of Senile Dementia, Abnormality of Gait and Closed Fracture of Intertrochanteric Section of the Femur.</p> <p>a. The Braden Scale Assessment form dated 2/16/07 documented the resident had very limited mobility, a potential shear/friction problem, was bedfast, rarely exposed to moisture, had adequate nutrition and no sensory perception impairment. The assessment was not totaled to determine the resident's total pressure ulcer risk. When the numeric values from the assessment findings were added, the resident's total pressure ulcer risk score was 16, which indicated the resident was at low risk for pressure ulcer development.</p> <p>b. The MDS dated 7/10/07 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent of bowel and bladder, totally dependent on staff for bathing and dressing, had no pressure ulcers, had a pressure relief device in bed and chair and was on a turning/repositioning program.</p> <p>c. The Plan of Care dated 7/13/07 documented: "Problem: Restraint use with risk of complications. Related to: Soft Seat Belt..."</p>	F 314			

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F 314	<p>Continued From page 48</p> <p>Nurses - Assure restraint is applied properly... Nurse Aide - Apply restraint(s) as ordered. Check q [every] 30 min [minutes], release q 2 hr [hours] for activity ... Problem: Potential for impairment of skin integrity related to decreased mobility, manifested by hx [history] of ulcers/breakdown... Nurses - Assess skin condition weekly. Nurse Aide - Assist with hygiene and general skin care. Reposition every two hours in bed. Keep skin clean and dry. Pressure relieving mattress, pressure relieving cushion in wheelchair..."</p> <p>d. A Physician Order dated 8/27/07 documented, "Restraint: Soft belt seat belt when in w/c [wheelchair] due to unsteadiness D/T [due to] poor judgement due to Senile Dementia."</p> <p>e. On 9/10/07 at 6:30 p.m., the resident was sitting in a wheelchair with no pressure relieving device in the seat. A soft belt was in use around the resident's waist.</p> <p>f. On 9/11/07 from 8:10 a.m. to 2:30 p.m., the resident was sitting in or near the dining room on the 200 Hall, in a wheelchair with no pressure relief device in the seat, wearing a soft belt restraint.</p> <p>g. On 9/11/07 at 5:40 p.m., the resident was sitting in a wheelchair near the dining room on the 200 Hall wearing a soft belt restraint. There was no pressure relief device in the seat of the wheelchair and a strong urine smell was emanating from the incontinent brief.</p> <p>h. On 9/12/07 from 8:00 a.m. to 10:30 a.m., the resident sat in or near the dining room on the 200 Hall in a wheelchair with no pressure relief device in the seat. The resident was wearing a soft belt</p>	F 314			

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F 314	Continued From page 49 restraint. No release or repositioning of the resident was observed by this Surveyor, who kept the resident under observation during this entire 2.5 hour time period. 7. Resident #2 had diagnoses of Cerebrovascular Accident and Rhabdomyolysis. a. A Braden Scale Risk Assessment form dated 8/16/07 did not document the total risk score and did not specify whether the resident was at high, moderate or low risk for pressure ulcer development. The Sensory Perception section of the assessment was not completed. On 9/13/07 at 12:50 p.m., the Director of Nursing (DON) stated, "I would put her at medium risk." b. A Physician's Progress Report dated 8/23/07 documented: "...Wound care by Nursing for sheer on her buttocks from scooting across the floor as she attempted to get up. (Fell at home prior to admission)." c. A Physician's Progress Note dated 8/30/07 documented: "...Heels are intact but left heel is soft, boggy and dark... Treatment Plan: DuoDerm to left heel q [every] 72 hours until healed. Bridge heels while in bed... Encourage resident to get up out of bed." A Physician's Order dated 8/30/07 documented: "Apply DuoDerm to Left Heel and Sacrum Q 72 hours..." d. The Minimum Data Set dated 9/5/07 documented the resident had modified independence in cognitive skills for daily decision making and had one Stage 2 pressure ulcer. e. The Pressure Ulcer Report dated 9/7/07 documented: "Onset date: 8/27/07... Area - left	F 314			

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F 314	<p>Continued From page 50 heel, Stage 1... Acquired."</p> <p>On 9/13/07 at 1:55 p.m., Licensed Practical Nurse (LPN) #8 was shown the 9/7/07 Pressure Ulcer Report which documented the resident's heel wound as a Stage I. The LPN was asked what the wound looked like when it was first identified. She stated, "I found it because I was assessing her. She had swelling in her feet. It was purplish in color, closed, no breakage. It was unstageable. The wound report is an error because it is unstageable." She was asked what kind of positioning was being done to relieve pressure on the resident's heels. The LPN stated, "Thera boots now for when she is in the bed. She has foot rests on the wheelchair." She was asked if the foot rests had any type of pressure relief. She stated, "The Thera boots are the only thing that we have for pressure relief of the feet... I think anyone that has a wound on the heel should have some type of pressure relief."</p> <p>f. On 9/10/07 at 6:10 p.m., 9/11/07 at 8:08 a.m., 12:22 p.m., 2:35 p.m. and 4:50 p.m. and 9/12/07 at 8:13 a.m. and 1:00 p.m., the resident was sitting in a wheelchair. The resident was wearing booty socks and had her feet positioned on the wheelchair foot rests. There was no pressure relief on the foot rests.</p> <p>g. On 9/12/07 at 4:00 p.m., the resident was sitting in a wheelchair in her room with booty socks on. Her feet were on the foot rest of the wheelchair. There was no pressure relief on the foot rests. Licensed Practical Nurse (LPN) #1 removed the DuoDerm from the left heel. The wound was on the left lateral and bottom part of the heel and was approximately 5 to 6 centimeters round and dark bluish/purple in color.</p>	F 314			

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F 314	Continued From page 51 h. On 9/13/07 at 11:50 a.m., Certified Nursing Assistant (CNA) #10 was asked what positioning was done to relieve pressure on the resident's heels while up in the wheelchair. She stated, "I haven't done anything different. I haven't been instructed to. We bridge them when she is in the bed so her heels aren't touching the bed." i. On 9/13/07 at 11:55 a.m., LPN #1 was asked if any interventions had been implemented to relieve pressure on the resident's heels when she was sitting in the wheelchair. The LPN stated, "As far as the feet, we haven't done anything special." j. On 9/13/07 at 12:50 p.m., the Director of Nursing (DON) stated, "...I got an order for Thera boots last night. She has the pressure relief mattress." When asked about the wound to the resident's heel, the DON stated, "It's unstageable. It's dark. We staged it at a IV last night." 8. On 9/13/07 at 3:55 p.m., LPN #8 was asked who completed the weekly skin assessments. LPN #8 stated, "There's no who. A sheet is printed from ECS [Electronic Charting System]. It's a list of who should get audits. On monthly, we do a head to toe and if weekly, we do a general skin check. Then chart in ECS." LPN # 8 was asked where the wound measurements and stages were charted. LPN # 8 stated, "Only the ADON [Assistant Director of Nursing] does measurements. LPN's, CNA's whoever finds it fills out a green slip, then we go down and check the resident regarding what the CNA identified. LPN calls the doctor, family and gets orders and informs QMT/DON that a wound was found on the resident. Once the DON is informed, she	F 314			

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F 314	Continued From page 52 gives it to the ADON for measurements." 9. On 9/14/07 at 11:30 a.m., LPN #4, who worked the day/evening shift on the hall where Residents #3 and #10 resided, was asked if the CNA's had reported that Resident #3 had a wound on his buttock or feet on 9/11/07. LPN #4 stated, "No." LPN #4 was asked when she became aware that the resident had additional skin breakdown. The LPN stated, "This morning." LPN # 4 was asked who was responsible for completing body audits on Resident #3. The LPN stated, "Depends on ECS calendar and what it falls on. We pull up reports every shift and it [ECS report] prints out what's due, like weekly or monthly skin audit." LPN #4 was shown skin audits that she had completed on Residents #3 and #10, which documented the presence of pressure-relief devices on the residents' beds. The LPN was then asked what pressure relieving devices were on the residents' beds at the time she documented the assessments. LPN #4 stated, "I thought they had an air mattress on the bed. They do now." LPN #4 was asked if she remembered what type of mattresses were on the 2 residents' beds on 9/11/07. The LPN stated, "I thought it was an air mattress. I guess I was wrong." LPN #4 was asked if residents like Residents #3 and #10, who had existing pressure ulcers, should be left up in a wheelchair from breakfast until after lunch. LPN #4 stated, "[Resident #3's] CNA should lay him down after lunch." LPN #4 was asked when Residents #3 and #10 or any other resident with pressure ulcers should be transferred back to bed. LPN #4 stated, "After meals." LPN #4 was asked how she monitored to ensure the CNA's transferred these residents back to bed after meals. LPN #4 stated, "I look." LPN #4 was asked if she verified	F 314			

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F 314	<p>Continued From page 53</p> <p>that these residents were transferred back to bed after meals. The LPN stated, "No, I guess I didn't think they needed to go back to bed." LPN #4 was asked if she was aware that Resident #3 sat in the wheelchair from 8:00 a.m. until after lunch and was not transferred back to bed until 2:45 p.m. on 9/11/07. LPN #4 stated, "The resident said the wound clinic said for her to only stay up for one and a half hours. I told her I'd have to see that order." LPN #4 was asked, "In your nursing judgement, should residents with pressure sores stay up for long periods of time?" LPN #4 stated, "No." LPN #4 was again asked if she was aware that Resident #3 was up in the wheelchair for an extended period of time on 9/11/07. The LPN stated, "No."</p> <p>10. On 9/14/07 at 12:55 p.m., the Director of Nursing (DON) was asked, "How do you interpret the Braden Risk Assessment Scale that was done for [Resident #10]?" The DON stated, "High risk." The DON was asked if she had found the recommendations for the vinyl covered mattresses that had been on the beds of Residents #3 and #10. The DON stated, "No, they were not a pressure relieving mattress."</p> <p>11. On 9/14/07 at 5:40 p.m., the DON was asked when pressure relieving devices should be placed on residents' beds. The DON stated, "Pressure relieving devices should be used if a resident is high risk." (The Braden Risk Assessment Scale documented that residents at moderate risk should be placed on a pressure reduction support surface.) The DON was asked how the CNA's were trained on assessment/reporting of skin problems. The DON stated, "Its part of orientation; it's on the checklist." The CNA's Orientation Checklist was reviewed at this time</p>	F 314			

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F 314	Continued From page 54 and did not contain training on reporting skin problems. 12. On 9/14/07 at 5:20 p.m., the DON was asked if any monitoring or audits of the LPN's documentation on pressure sores had been done. The DON stated, "My ADON was monitoring that, but now I'm going to have to do it." The DON was asked if the ADON's documentation had been inaccurate. The DON stated, "Yes." The DON was asked what the ADON had been monitoring. The DON stated, "Documentation, the presence of pressure relieving devices." The DON was asked if she had routinely monitored to ensure pressure relieving devices, staging, measurements, risk scales were correct and interventions were implemented. The DON stated, "I was focused on other things, but I will be doing it now."	F 314			
F 315 SS=E	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure incontinent care was provided in a manner to prevent potential Urinary Tract Infections (UTI's) for 3	F 315			

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F 315	<p>Continued From page 55</p> <p>(Residents #3, #9 and #14) of 9 case mix residents who were incontinent of bowel or bladder (Residents #1 through #4, #8 through #10, #12 and #14). The facility also failed to ensure a resident's medical condition warranted the insertion of a urinary catheter before catheterizing 1 (Resident #10) of 3 case mix residents with physician orders for urinary catheters (Residents #10, #20 and #21). The failed practices had the potential to affect 52 residents who were incontinent of bladder, 53 residents who were incontinent of bowel and 5 residents with physician orders for urinary catheters, as documented on the facility's Resident Census and Conditions of Residents form dated 9/10/07. The findings are:</p> <p>1. The facility's Certified Nursing Assistant (CNA) Pericare Check Off Skills Checklist was provided by Administration on 9/14/07 and documented: "...Expose Perineal Area: Female: Separate labia and gently wash wiping from front to back in downward motion, changing to a clean area of washcloth with each wipe. Male: Gently pull back foreskin and gently wash in a circular motion changing to a clean area of washcloth with each swipe. When done, replace foreskin. Dry perineal area with clean towel. Remove glove and wash hands... Incontinent care always includes periarea and rectal area to be cleansed each time. Even if resident is only incontinent [of] stool or urine."</p> <p>2. Resident #10 had diagnoses of Non-Insulin Dependent Diabetes Mellitus and Urinary Tract Infection. The Quarterly Minimum Data Set (MDS) dated 7/19/07 documented the resident had had modified independence in cognitive skills for daily decision making, no short or long-term</p>	F 315			

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F 315	<p>Continued From page 56</p> <p>memory problems, was incontinent of bowel and bladder and did not have an indwelling catheter.</p> <p>a. A physician order dated 9/7/07 documented: "Place Foley [catheter] 9/9/07 for [resident] comfort for office visit 9/10/07. Remove Foley 9/10/07 p.m. [evening]."</p> <p>b. On 9/10/07 at 3:02 p.m. during the initial tour, Licensed Practical Nurse (LPN) #4 stated, "We put a Foley catheter in her temporarily, so she could go to her appointments today." The resident was asked if she was routinely catheterized before each physician appointment. The resident stated, "This is the first time I've been to the doctor since I've been here. I guess I'll get one each time I go to the doctor."</p> <p>c. On 9/14/07 at 12:55 p.m., the Director of Nursing (DON) was asked to review the physician order dated 9/7/07 for the temporary catheterization. The DON was asked if the physician order included a medical diagnosis that necessitated the insertion of a urinary catheter. The DON stated, "No." The DON was asked if insertion of a urinary catheter for the resident's comfort would be considered a medical diagnosis that would warrant the catheterization. The DON stated, "No, I didn't know they had done that. Anyone who's had a catheter knows they are not comfortable."</p> <p>3. Resident #14 had diagnoses of Senile Dementia and Closed Fracture of Intertrochanteric Section of the Femur. The MDS dated 7/10/07 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and totally dependent on staff for bathing,</p>	F 315			

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F 315	<p>Continued From page 57</p> <p>personal hygiene and dressing.</p> <p>a. The Plan of Care dated 7/13/07 documented: "Problem: Incontinence... Nurse Aide - Use protective pads. Wear incontinent briefs, change PRN [as needed]. Cleanse peri-area and apply barrier cream to after incontinent episodes and PRN. Peri care when incontinent."</p> <p>b. On 9/12/07 at 2:00 p.m., Certified Nursing Assistant (CNA) #7 provided incontinent care to the resident. CNA #7 wiped the vaginal area with a cloth, then cleansed the perianal area, which soiled the cloth with feces. The CNA then wiped over the vaginal area again, including the urinary meatus, without changing to a clean cloth. CNA #7's hair fell onto the cloth and also came into direct contact with the resident's perineal area as the CNA bent over to provide care.</p> <p>4. Resident #3 had diagnoses of Insulin-Dependent Diabetes Mellitus and Renal Failure. The Quarterly Minimum Data Set (MDS) dated 6/12/07 documented the resident was severely impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and dependent on staff for toilet use and personal hygiene.</p> <p>a. The Plan of Care documented a problem identified on 6/3/06 as: "Problem: Potential for impairment of skin integrity, and breakdown related to: Incontinence... Nurses - Assess skin condition weekly... Keep clean and dry... Nurses Aides - Assist with hygiene... Keep skin clean and dry..."</p> <p>b. On 9/12/07 at 9:50 a.m., CNA's #1 and #2 provided incontinent care to the resident,</p>	F 315			

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F 315	<p>Continued From page 58</p> <p>following an episode of bowel and bladder incontinence. CNA #2 rolled the resident to his left side. CNA #1 wiped the perianal and buttock areas with a washcloth, then dried the areas with a towel, which became soiled with stool. CNA's #1 and #2 rolled the resident onto his back, then CNA #1 used the same soiled towel to wipe the groin area. Without changing gloves, CNA #1 sprayed a clean washcloth with peri-wash, retracted the resident's foreskin and cleansed the urinary meatus.</p> <p>5. Resident #9 had the diagnoses of Senile Dementia and Urinary Tract Infection. The Minimum Data Sets (MDS) dated 8/3/07 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and totally dependent on staff for bathing and activities of daily living.</p> <p>a. The Plan of Care dated 7/31/07 documented: "Potential for Incontinence, Total - Potential for UTI [Urinary Tract Infection]. Potential for skin breakdown due to Urinary Incontinence... Peri Care when incontinent. Cleanse peri-area and apply barrier cream to after incontinent episodes and PRN [as needed] Incontinence."</p> <p>b. On 9/11/07 at 10:40 a.m., Certified Nursing Assistants (CNA's) #5 and #6 provided incontinent care to the resident. The wet incontinent brief was removed. The incontinent pad and sheet were also wet with urine. CNA #6 wiped from the anus to the vaginal area multiple times, then a clean incontinent brief was placed on the resident.</p> <p>c. On 9/14/07 at 11:20 a.m., CNA #6 was asked</p>	F 315			

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F 315	Continued From page 59 how incontinent care should be performed. The CNA stated, "Wash front to back." 6. On 9/14/07 at 5:40 p.m., the Director of Nursing stated incontinent care should be, "...started in the middle. The labia is cleansed, each side and then to the outer labia, then to the thighs, always cleansing front to back."	F 315			
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure hazardous chemicals were stored in a secure area to prevent potential access by cognitively impaired residents and failed to ensure doors and furniture were free of sharp or splintered areas to prevent potential skin tears. The failed practices had the potential to affect all 110 residents, as documented on the facility's Resident Census and Conditions of Residents form dated 9/10/07. The facility also failed to ensure soft belt restraints were applied in accordance with the manufacturer's instructions to prevent potential injury for 2 of 2 case mix residents with soft belt restraints in use (Residents #12 and #14). The failed practice had the potential to affect 9 residents with soft belt restraints in use, as documented on a list provided by the Director of	F 323			

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F 323	Continued From page 60 Nursing (DON) on 9/14/07. The findings are: 1. On 9/10/07 from 2:18 p.m. to 2:42 p.m., during the initial tour, the following observations were made: a. Room 309: A 6-ounce bottle of nail polish remover, approximately 1/3 full was sitting on the bedside table next to Bed B. The resident was not present in the room at this time. The label on the bottle of nail polish remover documented: "Caution: Flammable... In case of ingestion, give fluids liberally and consult with your local Poison Control Center..." b. Room 302: 1.) A 10-ounce bottle of nail polish remover, approximately 1/2 full was sitting on the bedside table next to Bed A. The resident was not present in the room at this time. The label on the bottle of nail polish remover documented: "Danger: Extremely flammable... Harmful if taken internally. In case of accidental ingestion, give fluids liberally and consult a physician or local poison control center..." 2.) A 13-ounce bottle of Renuzit Super Odor Neutralizer was on the bedside table by Bed B. The resident was not present in the room at this time. The Material Safety Data Sheet for Aerosol Home Fragrance Spray documented: "...Acute Health Effects: Inhalation: Vapors may cause irritation of the nose, throat, and respiratory tract ... Intentional misuse of product (i.e. huffing) may produce death. Skin contact: Repeated or prolonged excessive exposure may cause irritation or dermatitis. Eye Contact: May cause moderate to severe irritation. Ingestion: Not an	F 323			

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F 323	Continued From page 61 anticipated route of exposure... Medical conditions generally recognized as being aggravated by exposure: Pre-existing respiratory conditions such as asthma. Emergency and First Aid Procedures: Inhalation: ...If breathing has stopped, give artificial respiration, and get medical attention immediately ...Ingestion: Treat symptomatically and supportively. Maintain airway and respiration. DO NOT induce vomiting ..." 2. On 9/13/07 at 8:17 a.m. during the environmental tour, conducted with the Maintenance Manager and the Housekeeping Supervisor, the following observations were made: a. A box of 0.5 ounce packets of Lantiseptic Skin Protectant, approximately 1/3 full, was stored on a tray table outside Room 120 on the 100 Hall. The Material Safety Data Sheet for Lantiseptic Skin Protectant documented: "Emergency and First Aid Procedures - If ingested, seek medical assistance or contact local poison control center." b. The door to Room 107 had a 1 ¼-inch gouged area with rough, sharp edges approximately 28 ½ inches up from the floor. c. In Room 204, two 0.5 ounce packets of Lantiseptic Skin Protectant were on the television table. d. The door facing at the entrance to Room 207 had a ¾ inch splintered area approximately 25 inches up from the floor. e. The curved table in the South Dining Room had a piece of laminate missing, which caused an	F 323			

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F 323	<p>Continued From page 62</p> <p>approximately 2-inch sharp and jagged edge to be exposed.</p> <p>f. One dining table in the North Dining Room had an approximately 2.5 by ¾ inch piece of wood missing which exposed a sharp, jagged edge. Another dining table had an approximately ¾ by ½ inch piece of broken wood, which caused a sharp, splintered area to be exposed.</p> <p>g. The door to Room 307 had an approximately 1 by ½ inch piece of wood missing, which left a rough and splintered edge.</p> <p>h. A vinyl chair in the sitting area at the end of the 300 Hall had 3 spots of missing or cracked vinyl ranging from 1 inch to 2 by ¾ inches on the right chair arm and one cracked area measuring approximately 1 by 2 inches on the left chair arm which left rough, jagged areas exposed.</p> <p>i. On 9/11/07 at 10:30 a.m., the door to the Central bath on the South Station was unlocked and unattended. There were 2 packages of Lantiseptic Skin Protectant and two 4-ounce bottles of antiseptic gel hand wash stored in this room. The label on the bottle of hand wash documented: "In case of ingestion, seek medical attention or consult a poison control center."</p> <p>3. The manufacturer's recommendations for the Adjusta-Loop Cushion Belt (Soft Belt Restraint) in use in the facility were provided by the Administrator on 9/13/07 at 3:30 p.m. and documented: "...Contraindications for Use - Do not use this device for a patient who: Slides down in the wheelchair... Wheelchair Application: ...Place the belt at the patient's waist ... Place both the straps behind the patient and pass the</p>	F 323			

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F 323	Continued From page 63 ends through the space between the wheelchair seat and backrest..." 4. Resident #12 had diagnoses of Alzheimer's Disease and Depression. The Admission Minimum Data Set (MDS) dated 9/5/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance from staff for transfers and locomotion and had no falls in the last 180 days. a. A physician order dated 8/23/07 documented: "...Restraint: Soft Belt seat belt when in a chair due to unsteadiness D/T [due to] poor judgement due to Alzheimer's Disease - Do not D/C [discontinue] without notification to MD [Medical Doctor] or APN [Advanced Practice Nurse]... Restraint: Seatbelt when in w/c [wheelchair] due to unsteadiness D/T poor judgement due to Alzheimer's Disease." b. On 9/11/07 at 8:18 a.m., the resident was sitting in a wheelchair in the dining room. A soft belt restraint was wrapped around the resident on at chest level in the front. Both restraint straps were wrapped around the outside of the arm rest bars, crisscrossed in the back and fastened to the lower bars of the wheelchair. The straps were not positioned between the wheelchair seat and backrest. c. On 9/11/07 at 9:40 a.m., the resident was sitting in a wheelchair in her room with the soft belt restraint positioned across her chest. d. On 9/11/07 at 11:55 a.m., the resident was sitting in a wheelchair in her room with the soft belt slightly above waist level. The strap on the	F 323			

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F 323	<p>Continued From page 64</p> <p>right was under the armrest bar and the strap on the left was over the outside of the armrest bar, instead of between the seat and backrest, as per the manufacturer's instructions.</p> <p>e. On 9/11/07 at 5:00 p.m., the resident was sitting in a wheelchair in the dining room with the left strap of her soft belt restraint positioned under the arm rest bar, and the right strap positioned over the outside of the armrest bar.</p> <p>f. On 9/12/07 at 8:20 a.m., the resident was sitting in a wheel chair in the dining room with the soft belt restraint's right strap under the armrest bar and the left strap over the armrest bar.</p> <p>g. On 9/12/07 at 9:49 a.m., the resident was sitting in a wheelchair in the Beauty Shop with the soft belt restraint positioned above waist level.</p> <p>h. On 9/12/07 at 11:00 a.m., the resident was sitting in a wheelchair in the dining room with the soft belt restraint positioned at chest level. The right restraint strap was positioned under the armrest bar and the left strap was positioned over the arm rest bar.</p> <p>i. On 9/12/07 at 11:35 a.m. and 12:57 p.m., the resident was sitting in a wheelchair in the dining room with the right restraint strap under the armrest bar and the left strap over the armrest bar.</p> <p>j. On 9/14/07 at 11:35 a.m., the resident was sitting in a wheelchair in the corridor with a soft belt restraint in place. The straps were threaded through the space between the wheelchair seat and back rest (per the manufacturer's recommendations). The Assistant Director of</p>	F 323			

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F 323	Continued From page 65 Nursing (ADON) was asked how the restraint should be applied. The ADON stated, "It is not tied right now. The straps should not be under her seat area. They should go on the outside of the seat back bars, under the arm rest bars and crisscrossed in back." 5. Resident #14 had diagnoses of Senile Dementia and Closed Fracture of Intertrochanteric Section of the Femur. The MDS dated 7/10/07 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent of bowel and bladder, totally dependent on staff for bathing and dressing, required extensive assistance for transfers and had no restraints in use. a. The Plan of Care dated 7/13/07 documented: "...Problem: Restraint use with risk of complications. Related to: Soft Seat Belt... Nurses - Assure restraint is applied properly... Nurse Aide - Apply restraint(s) as ordered. Check q [every] 30 min [minutes], release q 2 hr [hours] for activity..." b. A physician order dated 8/27/07 documented: "Restraint: Soft belt seat belt when in w/c [wheelchair] due to unsteadiness D/T [due to] poor judgement due to Senile Dementia." c. On 9/10/07 at 6:30 p.m., the resident was sitting in a wheelchair and wearing a soft belt restraint around the waist. The left strap of the restraint was threaded between the seat and the backrest, but; the right strap was positioned over the metal bar below the right armrest, then around the right frame of the wheelchair.	F 323			
F 328 SS=E	483.25(k) SPECIAL NEEDS	F 328			

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F 328	<p>Continued From page 66</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility also failed to ensure colostomy care was provided in a manner to prevent potential infection or other complications for 1 of 1 case mix resident with a colostomy (Resident #9). The facility also failed to ensure oxygen was administered at the prescribed rate for 2 (Residents #22 and #23) of 6 case mix residents with physician orders for oxygen therapy (Residents #6, #13, #19, #20, #22 and #23) and oxygen tubing, updraft masks and Continuous Positive Airway Pressure (CPAP) masks were stored properly when not in use, to prevent potential contamination for 5 (Residents #13, #18, #19, #22 or #23) of 8 case mix residents who received respiratory services (Residents #6, #7, #13, #18, #19, #20, #22 and #23). The failed practices had the potential to affect 1 resident with a colostomy, 7 residents with physician orders for updraft treatments, 21 residents with physician orders for oxygen therapy and 1 resident with physician orders for CPAP, as identified by the Director of Nursing (DON) on 9/14/07. The findings are:</p>	F 328			

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F 328	Continued From page 67 1. Resident #9 had diagnoses of Senile Dementia, Urinary Tract Infection and Fracture of Left Distal Femur. The Minimum Data Set (MDS) dated 8/3/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance for toilet use and had a colostomy. a. A physician order dated 4/24/07 documented, "Change Colostomy Bag PRN [as needed]... Administer Colostomy Care PRN..." b. A physician order dated 5/04/07 documented, "Clean ulcer area ABOVE AND below stoma with normal saline pat dry with 4 x 4's, Apply CELLERATE COVER with 4 x 4's secure with paper tape QD [daily] until healed..." c. The Plan of Care dated 7/31/07 documented: "Problem: Colostomy... Nurses - ...Colostomy monitoring and care as ordered. ...Monitor skin and report changes to MD [Medical Doctor]..." d. On 9/11/07 at 2:30 p.m., the resident was in bed with a blue lift pad/sling positioned under her. The resident had no gown on and her left breast was exposed. The colostomy clamp was laying on the left breast. No staff were present in the room. e. On 9/11/07 at 2:36 p.m., Licensed Practical Nurse (LPN) #7 entered the resident's room. The LPN stated, "I was in the middle of things and had to get a different bag." LPN #7 wiped around the stoma with an alcohol skin prep pad. There was a 6-inch wide reddened area on the resident's abdomen, approximately 3 inches below the stoma. LPN #7 applied the ostomy wafer with the	F 328			

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F 328	Continued From page 68 colostomy bag attached onto the stoma site. LPN #7 then fastened the clamp on the end of the bag. LPN #7 was asked what care had been provided prior to leaving the room to obtain a different bag. The LPN stated, "I removed the old bag and I washed around the stoma with soap and water. I rinsed the stoma and I patted it dry." No Cellerate or 4x4 gauze pads were applied to the stoma ulcer, as ordered by the physician. f. On 9/12/07 at 2:30 p.m., LPN #2 provided colostomy care to the resident. The LPN removed the stoma appliance and bag and discarded them in the trash can, touching the trash can liner with her gloved hand in the process. Without changing gloves, LPN #2 then reached into the package of clean 4 x 4's and pulled out several of the clean gauze pads. The LPN then wet the gauze with normal saline and wiped around the stoma. LPN #2 then discarded the gauze into the trash can. LPN #2 used her gloved hand to reach inside the rim of the trash can in order to pull it closer to the bed. Without changing gloves, LPN #2 reached back into the package of clean 4 x 4's, wet them with normal saline, and wiped the stoma site. After the third wipe, blood was noted on the stoma at the left lower section at approximately the 5 o'clock position. A Hollister #3704 appliance with a 1 centimeter (cm) center hole was placed over the stoma and the adhesive edge was secured over the stoma. The LPN did not cut the colostomy wafer appliance to fit the stoma. The opening of the Hollister #3704 appliance covered all but approximately 25% of the center of the stoma. The tape adhesive around the wafer partially covered the red ulcer area below the stoma. LPN #2 fastened the colostomy clamp onto the bag and stated, "I've only done this one time and it	F 328			

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F 328	Continued From page 69 was in school." The bag was then secured to the appliance ring. LPN #2 removed her gloves and discarded them in the trash can. g. On 9/12/07 at 2:55 p.m., LPN #2 was asked, "Is this the first time you've done a colostomy bag change?" LPN #2 stated, "Yes, since I've been here... I started here 3 weeks ago." LPN #2 was asked, "How often are you supposed to change it?" LPN #2 stated, "I can't tell you. It's not on the MAR [Medication Administration Record]." LPN #2 was asked, "What is Cellerate Cover? When is that done?" LPN #2 stated, "I do that when I do my treatments." LPN #2 was asked, "Do you remove the appliance to use Cellerate?" LPN #2 stated, "No." LPN #2 was asked, "If there is any procedure you feel uncomfortable about doing, what do you do?" LPN #2 stated, "I ask the RN [Registered Nurse]." LPN #2 was asked, "Is there anything different about the colostomy wafer you removed and the wafer you placed on? Was the hole smaller?" LPN # 2 stated, "I put the colostomy appliance on the resident the way it came from the package." LPN #2 was asked, "How were you taught to do colostomy care?" LPN #2 stated, "I was taught to put it on the way it came out of the package." LPN #2 was asked, "Have there been any inservices on colostomy care since you've worked here?" LPN #2 stated, "No." h. On 9/12/07 at 3:05 p.m., the Director of Nursing (DON) was asked how the nursing staff were trained on colostomy care. The DON stated, "We have an inservice and then observe the nurse perform and check off the skills check." The DON was asked, "When was the last inservice on ostomy care?" The DON stated, "I haven't had one since I've been here. I came in	F 328			

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F 328	<p>Continued From page 70</p> <p>July. We do a skills check to make sure new employees know how." The skills check list for LPN #2 was requested from the Director of Nursing (DON) at this time, but was never provided.</p> <p>i. On 9/14/07 at 5:40 p.m., the DON was asked to describe the steps in providing proper colostomy care. The DON stated, "Glove, remove thing - wafer, etc., bag it, tie up, change gloves, wash hands. Clean colostomy site per order - cut out to fit stoma site, apply paste, etc., whatever is ordered, place bag over site, hold it to ensure sealed, put on bag and clip, pick up and wash hands."</p> <p>2. Resident #22 had diagnoses of Anxiety and Atrial Fibrillation. The Quarterly Minimum Data Set (MDS) dated 9/6/07 documented the resident was independent in cognitive skills for daily decision making, required limited assistance from staff for transfers and bed mobility and did not receive oxygen therapy or respiratory therapy.</p> <p>a. A physician order dated 4/24/07 documented: "Apply oxygen 2.0 - 3.0 liter/minute [liters per minute] per nasal cannula prn [as needed]."</p> <p>b. On 9/10/07 at 2:07 p.m. and 9/12/07 at 5:45 p.m., the resident was receiving oxygen via e-cylinder. The flow meter on the e-cylinder was set to deliver oxygen at 1.5 liters per minute, instead of 2 to 3 liters per minute as ordered by the physician.</p> <p>c. On 9/13/07 at 7:51 a.m., 9:30 a.m., 11:30 a.m., 1:50 p.m. and 3:50 p.m. and 9/14/07 at 7:30 a.m., a nasal cannula dated 9/12/07 was on the resident's oxygen concentrator and was not</p>	F 328			

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F 328	<p>Continued From page 71</p> <p>bagged or covered to prevent potential contamination. The oxygen tubing was rolled up on top of the concentrator with the nasal prongs touching the top of the concentrator.</p> <p>d. On 9/14/07 at 7:30 a.m., Licensed Practical Nurse (LPN) # 6, the 7:00 p.m. to 7:00 a.m. nurse on the resident's hall, was asked if the resident had used the oxygen concentrator last night. LPN # 6 stated, "Yes. She uses it for a short while most nights, then she gets back up and I put her back on the tank."</p> <p>3. Resident #23 had diagnoses of Acute Upper Respiratory Infections and Pneumonia. The Quarterly Minimum Data Set (MDS) dated 9/6/07 documented the resident had modified independence in cognitive skills for daily decision making and no oxygen therapy.</p> <p>a. A physician order dated 4/24/07 documented: "Administer oxygen 2.0 - 3.0 liter/min [minute] per nasal cannula continuous."</p> <p>b. On 9/13/07 at 9:30 a.m., the resident was receiving oxygen via e-cylinder. The flow meter on the e-cylinder was set to deliver oxygen at 1 liter per minute via nasal cannula.</p> <p>c. On 9/10/07 at 2:31 p.m., the oxygen tubing attached to the resident's concentrator was dated 9/5/07. The nasal cannula was not bagged and the nasal prongs were touching the wheelchair handle.</p> <p>d. On 9/12/07 at 5:50 p.m., the resident was in the restorative dining room receiving oxygen via e-cylinder. The oxygen tubing was dated 9/5/07.</p>	F 328			

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F 328	<p>Continued From page 72</p> <p>e. On 9/12/07 at 5:42 p.m., the oxygen tubing dated 9/5/07, with nasal cannula was rolled up on top of the concentrator with the nasal prongs pointing downward and touching the top of the concentrator.</p> <p>4. Resident #13 had diagnoses of Congestive Heart Failure, Pneumonia and Chronic Airway Obstruction. The Minimum Data Set dated 8/27/07 documented the resident had modified independence in cognitive skills for daily decision making, was dependent on staff for activities of daily living and received oxygen therapy.</p> <p>a. A physician order dated 5/8/07 documented: "Administer oxygen 2.0 - 3.0 liter/min [minute] per nasal cannula PRN [as needed] for shortness of breath."</p> <p>b. A physician order dated 8/14/07 documented: "Proventil 0.083% inh sol [inhalation solution]... q 6 H [every 6 hours] 0600 [6:00 a.m.], 1200 [12:00 p.m.], 1800 [6:00 p.m.], 2400 [12:00 a.m.]."</p> <p>c. On 9/10/07 at 2:26 p.m., the nasal cannula was uncovered and draped over the top of the oxygen concentrator. The updraft machine was sitting on a bedside commode with the face mask uncovered and the end of the updraft tubing that connects to the updraft machine was hanging in the trash can next to the bedside commode.</p> <p>d. The September 2007 Medication Administration Record (MAR) was reviewed on 9/12/07 at 4:40 p.m. and documented a Proventil updraft was administered to the resident at 6:00 p.m. on 9/10/07.</p> <p>e. On 9/10/07 at 6:25 p.m., the resident was</p>	F 328			

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F 328	<p>Continued From page 73</p> <p>receiving oxygen via nasal cannula at 2 liters per minute. The updraft machine was sitting on the bedside commode with the updraft tubing attached and the mask uncovered. The portable oxygen tank was standing near the closet with the tubing laid in coils on top of the cylinder and the nasal cannula uncovered.</p> <p>5. Resident #18 had a diagnosis of Insomnia with Sleep Apnea. The Quarterly Minimum Data Set (MDS) dated 8/6/07 documented the resident had modified independence in cognitive skills for daily decision making, required limited assistance from staff for bed mobility and transfers and received oxygen therapy.</p> <p>a. The Physician Orders sheet dated 9/13/07 documented the resident had a current order which was originally initiated on 4/7/04 to: "Apply C-PAP [Continuous Positive Airway Pressure] machine while asleep... sleep apnea."</p> <p>b. On 9/10/07 at 2:27 p.m., 9/13/07 at 7:54 a.m. and 9/14/07 at 7:10 a.m., the CPAP tubing was on the resident's bedside table with the inner surface of the mask against the table-top. The tubing was not dated. On 9/10/07 at 2:27 p.m., the surveyor marked a small dot on the external tubing by the mask and this dot remained as of 9/14/07 at 7:10 a.m.</p> <p>c. On 9/14/07 at 7:10 a.m., the Director of Nursing (DON) observed the CPAP face mask with no bag or covering to prevent potential contamination. The DON was asked who was responsible for placing the mask in a bag when not in use. The DON stated, "The CNA who gets the resident up in the morning."</p>	F 328			

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F 328	<p>Continued From page 74</p> <p>6. Resident #19 had diagnoses of Chronic Airway Obstruction and Congestive Heart Failure. The Admission Minimum Data Set (MDS) dated 7/25/07 documented the resident was severely impaired in cognitive skills for daily decision making and received oxygen therapy.</p> <p>a. A physician order dated 8/21/07 documented: "Per nasal cannula administer oxygen 2.0 - 3.0 liter/min continuous first date: 8/21/07."</p> <p>b. On 9/13/07 at 3:30 p.m., the resident was not in her room. Oxygen tubing dated 9/12/07 was draped across the concentrator and the cannula was on the floor.</p> <p>c. On 9/14/07 at 8:20 a.m., the same oxygen tubing, dated 9/12/07 was draped over the concentrator in the resident's room and was not bagged or covered.</p> <p>d. On 9/14/07 at 8:45 a.m., CNA # 9 was asked if she got the resident up out of bed that morning. She stated, "Yes." When asked if the resident was wearing the nasal cannula at that time, the CNA stated, "Well, it was draped over the side rail. She takes it off sometimes. I got her up on the side of the bed and put it back on her."</p> <p>7. On 9/14/07 at 5:40 p.m., the Director of Nursing (DON) stated there was no facility policy on storage of CPAP, oxygen tubing or updraft masks when not in use. The DON was asked how CPAP masks should be stored when not in use. The DON stated, "Should be bagged when not in use." The DON was asked how oxygen tubing should be stored when not in use. The DON stated, "Tubing should be bagged on the side of the machine." The DON was asked what</p>	F 328			

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F 328	Continued From page 75 staff should do if they found a resident's oxygen tubing stored without a bag or other covering. The DON stated, "It should be replaced. It's contaminated."	F 328			
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the 8:00 a.m. medication pass on 9/12/07 and record review, the facility failed to ensure the medication error rate was less than 5%. Physician orders were not followed for 3 (Residents # 16, #17 and #18) of 7 residents observed during the medication pass, which resulted in medication errors. Medication errors were made by 3 Licensed Practical Nurses (LPN's #1, #2 and #3) of 4 nurses who administered medications. The failed practice had the potential to affect 87 residents who received medication from these nurses, as identified by the Director of Nursing (DON) on 9/12/07. The medication error rate was 8.89%, based on observation of 43 medications administered plus 2 medications ordered but not administered and a total of 4 errors detected. The findings are: 1. Resident #16 had a physician order dated 9/11/07 for Toprol XL 200 milligrams (mg) every day. a. On 9/12/07 at 8:40 a.m., LPN #1 administered Lopressor 100 mg, 2 tablets instead of Toprol XL 200 mg as ordered by the physician.	F 332			

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F 332	Continued From page 76 b. The Toprol XL website at astrazeneca.com documented Toprol XL is an extended release medication and, "...has been formulated to provide a controlled and predictable release of metoprolol for once daily administration..." The 2003 Lippincott's Nursing Drug Guide documented Lopressor is a non-extended release formulation of metoprolol. 2. Resident #17 had a physician order dated 7/31/07 for a Spiriva inhaler, one puff every day at 8:00 a.m. On 9/12/07 at 8:55 a.m. during the 8:00 a.m. medication pass, LPN #2 administered the resident's 8:00 a.m. medications, but did not administer the Spiriva inhaler. 3. Resident #18 had a physician order dated 11/2/06 for a Flonase inhaler, 2 sprays in each nostril every day at 8:00 a.m. On 9/12/07 at 9:25 a.m., LPN #3 administered the resident's 8:00 a.m. medications but did not administer the Flonase inhaler. 4. Resident #18 had a physician order dated 11/2/06 for Artificial Tears, one drop in each eye at 6:00 a.m., 1:00 p.m., 6:00 p.m. and 10:00 p.m. daily. On 9/12/07 at 9:25 a.m., LPN # 3 administered a dose of the Artificial Tears without a physician order to do so. The 6:00 a.m. dose had already been administered by the night shift.	F 332		
F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides	F 364		

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F 364	<p>Continued From page 77</p> <p>food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure food was served at a temperature that was palatable to the residents. The failed practice had the potential to affect 105 residents who received meal trays from the kitchen, as documented on the Diet List dated 9/10/07. The findings are:</p> <p>1. On 9/11/07 at 9:00 a.m., 3 of 6 alert and oriented residents who participated in the group interview complained that their food was served cold, especially at the breakfast meal.</p> <p>a. On 9/12/07, the facility's menu for the supper meal documented scrambled eggs, sausage links and hash browns. At 4:40 p.m., the temperature of the food on the serving line in the kitchen registered as follows:</p> <p>Scrambled Eggs - 180 degrees Fahrenheit (F.). Hash Browns - 160 degrees F. White Gravy - 180 degrees F. Sausage Links - 190 degrees F.</p> <p>b. On 9/12/07 at 5:23 p.m., a cart with 12 meal trays was sent to the South Hall. A test tray was also placed on the cart at this time.</p> <p>c. On 9/12/07 at 5:32 p.m., a Certified Nursing Assistant began passing trays down the hall.</p>	F 364			

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F 364	Continued From page 78 d. On 9/12/07 between 5:32 and 5:51 p.m., the CNA Supervisor, the Hall Monitor and another CNA passed by the tray cart on 3 different occasions without assisting the CNA to finish passing the meal trays. At 5:51 p.m., the temperatures of the food on the test tray were tested with the facility's thermometer and registered as follows: Scrambled Eggs - 98 degrees F. Hashbrowns - 105 degrees F. Link Sausage - 90 degrees F.	F 364			
F 371 SS=B	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 observation, the facility failed to ensure the rear kitchen door was repaired to prevent insects or other pests from potentially entering the kitchen. The failed practice had the potential to affect 105 residents who received meals from the kitchen, as documented on the Diet List dated 9/10/07. The findings are On 9/14/07 at 10:00 a.m., the rear kitchen door hit against the frame, which impeded complete closure of the door. There was an approximately three eights inch gap at the top of the door and on the latch side, which could potentially allow pests to enter the kitchen.	F 371			
F 445 SS=E	483.65(c) INFECTION CONTROL - LINENS	F 445			

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F 445	<p>Continued From page 79</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure linens were handled in a manner to prevent potential cross contamination for 2 (Residents #4 and #12) of 13 case mix residents who resided on the 100 and 300 Halls and required assistance with personal hygiene (Residents #1 through #5, #7 through #12, #14 and #15). The failed practice had the potential to affect 55 residents who resided on the 100 and 300 Halls and required assistance with personal hygiene, as identified by the Director of Nursing (DON) on 9/14/07 at 5:40 p.m. The findings are:</p> <p>1. Resident #4 had diagnoses of Cerebrovascular Accident and Flaccid Hemiplegia. The Minimum Data Set dated 6/12/07 documented the resident had modified independence in cognitive skills for daily decision making, was totally dependent on staff for bathing and had a Clostridium difficile infection.</p> <p>a. A physician order dated 7/4/07 documented: "Contact Isolation..."</p> <p>b. On 9/11/07 at 9:30 a.m., Certified Nursing Assistant (CNA) #8 was in the resident's room preparing for a bed bath. She was holding the bedspread that had been removed from the resident's bed against her uniform top. After the bed bath was completed, the CNA held clean bed linens against her uniform top, then used them to make the resident's bed. CNA #8 stated, "It [the</p>	F 445			

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F 445	Continued From page 80 bedspread] was on her bed. We're going to get a clean one." 2. Resident #12 had diagnoses of Alzheimer's Disease and Dementia. The Quarterly Minimum Data Set (MDS) dated 6/4/07 documented the resident was moderately impaired in cognitive skills for daily decision making, totally dependent on staff for personal hygiene and bathing and incontinent of bowel and bladder. On 9/12/07 at 1:16 p.m., Certified Nursing Assistant (CNA) #4 provided incontinent care to the resident. The CNA cleansed the perineal area then used a towel to dry the perineal area. The CNA then placed the soiled towel on the overbed table. The CNA then washed the perianal area and used the soiled towel to dry the perianal area and buttocks. After incontinent care was completed, the CNA did not clean the overbed table. 3. On 9/14/07 at 11:30 a.m., the Director of Nursing (DON) was asked how soiled linen should be handled. The DON stated, "It should be carried away from the uniform and it should be put in a bag for soiled linens after used."	F 445			
F 490 SS=H	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 490			

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F 490	Continued From page 81 interview, the facility's Nursing Administration failed to monitor the implementation of interventions to ensure pressure sores were promptly identified and correctly staged, failed to ensure interventions were developed and implemented to prevent further pressure sores and the pressure ulcer risk assessment tool utilized by the facility was properly completed to enable the facility to identify the level of risk for pressure ulcer development for 4 (Residents #2, #3, #9 and #10) of 8 case mix residents with pressure sores (Residents #1, #2, #3, #5, #8, #9, #10 and #15) and failure to ensure a resident with physical restraints in use was repositioned to alleviate pressure and prevent pressure ulcer development for 1 (Resident #14) of 3 case mix residents with physical restraints in use (Residents #7, #12 and #14). The failed practices resulted in actual harm to Residents #3 and #9 and had the potential to affect 12 residents with pressure sores, as documented on the facility's Resident Census and Conditions of Residents form dated 9/10/07, 14 residents with soft belt or table top restraints in use, as documented on a list provided by the Director of Nursing (DON) on 9/14/07 and 23 residents who were at risk for pressure ulcer development, as identified by the DON on 9/21/07. The findings are: 1. The facility's training documentation dated 7/19/07 and titled, "Basics of Wound Care: Staging and Types of Wounds" was presented to the survey team by the Director of Nursing on 9/14/07 at 7:00 a.m. as the facility policy on assessments and staging of pressure sores. The training documented, "...Target audience: RN [Registered Nurse] and LPN [Licensed Practical Nurse]... The certified nurse aide should let the	F 490			

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F 490	<p>Continued From page 82</p> <p>nurse know as soon as a red spot is noted on the resident. The nurse is to assess the resident's skin weekly. Early detection and prevention is the key ... Common sites of pressure ulcers: ...Sacrum & [and] coccyx... Heel... Wound staging is the basis for developing treatment protocols, selecting reduction support surface... Rules of staging: only used for pressure ulcers, stage all pressure ulcers at the deepest level of damage, once a pressure ulcer is staged, it remains at that stage, and reverse staging/back staging should never be used to describe the healing of a pressure ulcer. Call it a healing stage I, II, III, IV, or unstageable wound..."</p> <p>2. The Braden Scale for Predicting Pressure Sore Risk form utilized by the facility documented the following recommended interventions based on the risk score:</p> <p>For a score of 13 to 14: "Moderate Risk: ...Turning schedule, Use foam wedges for 30 [degree] lateral positioning, Pressure reduction support surface, Maximal remobilization, Protect heels, Manage moisture, nutrition, and friction and shear. If other major risk factors present, advance to next level of risk.</p> <p>For a score of 10 to 12: "High risk: Increase frequency of turning, supplement with small shifts, Pressure reduction support surface, Use foam wedges for 30 [degree] lateral positioning, Maximal remobilization, Protect heels, Manage moisture, nutrition and friction and shear... low air loss beds do not substitute for turning schedules..."</p> <p>3. Resident #9 had diagnoses of Senile Dementia, Congestive Heart Failure, Urinary</p>	F 490			

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F 490	<p>Continued From page 83</p> <p>Tract Infection and Fracture of Left Distal Femur. The Minimum Data Set (MDS) dated 8/3/07 documented the resident was moderately impaired in cognitive skills for daily decision making, left 25% or more of meal uneaten at most meals, was on a mechanically altered diet with supplements, was incontinent of bowel and bladder, had no pressure ulcers, was totally dependent on staff for transfers via a mechanical lift and required extensive assistance with bed mobility.</p> <p>a. The Plan of Care dated 7/31/07 documented, "...Potential for skin breakdown due to Urinary Incontinence... Nurse Aide - Peri Care when incontinent. Cleanse peri-area and apply barrier cream to after incontinent episodes and PRN [as needed]... Problem: Stage 2 - Partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater [left] coccyx... Problem: Potential for Impairment of skin integrity, and breakdown... Nurse - Assess skin condition weekly... Apply pressure relieving device(s) for chair. Pressure relieving device(s) for bed. Monitor Turning and Repositioning Program... Nurse Aide - Reposition every two hours in bed. Keep skin clean and dry. Keep linen clean, dry and wrinkle free. Change wet linen. Use incontinence pads. Barrier cream to peri-area..."</p> <p>b. The Braden Scale Assessment dated 8/21/07 documented the resident had very limited mobility, required moderate to maximum assistance to move, was chairfast, was occasionally exposed to moisture which necessitated linen changes approximately once a day, rarely ate a complete meal and probably had inadequate nutrition. No numerical values were</p>	F 490			

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F 490	<p>Continued From page 84</p> <p>assigned to the assessment findings on the Braden Scale and the scale was not totaled. When completed as instructed, the total pressure ulcer risk score, based on the assessment findings, was 14. The score legend on the Braden Scale Assessment form documented a score of 13-14 indicated the resident was at moderate risk of developing pressure ulcers. On 9/12/07 at 3:05 p.m., the Director of Nursing (DON) was asked, "Can you tell me the Braden score for this resident?" The DON reviewed the Braden Scale Assessment dated 8/21/07 and stated, "No scores. She's at high risk."</p> <p>c. Nurses Notes dated 9/1/07 at 7:45 p.m. documented the resident was sent to the hospital for knee pain.</p> <p>d. A Nurses Admission Note dated 9/6/07 at 5:07 p.m. documented, "Resident readmitted from [hospital]... redness to periarea and buttocks, rash to back..."</p> <p>e. On 9/10/07 at 6:30 p.m., the resident was sitting in a wheelchair in the dining room. No pressure relieving device was in the wheelchair.</p> <p>f. On 9/11/07 at 8:06 a.m., the resident was lying in bed on a hard plastic non-circulating air waffle mattress covered with a sheet. No pressure relieving devices were on the resident's feet.</p> <p>g. On 9/11/07 at 10:40 a.m., the resident was lying in bed on a hard plastic non-circulating air waffle mattress covered with a sheet. The resident's heels were not offloaded and were in direct contact with the sheet-covered mattress. Certified Nursing Assistants (CNA's) #5 and #6 provided incontinent care to the resident at this</p>	F 490			

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F 490	Continued From page 85 time and the following observations were made: 1.) The wet incontinent brief was removed. The incontinent pad and sheet were also wet with urine. CNA #6 wiped from the anus to the vaginal area multiple times, then a clean incontinent brief was placed on the resident. The CNA did not cleanse the buttocks, thighs, groin, pubic area, inner labia or urinary meatus and no barrier cream was applied to the resident's skin. 2.) A skin audit was performed at this time and there was a dark-red, open area on the resident's coccyx and a discolored (red/purple/blue) area on the left heel that extended around the entire heel. 3.) After the skin audit was completed, the CNA's used a mechanical lift to transfer the resident to a wheelchair. Once the resident's weight was lifted off of the mattress, a 12 by 12 inch area of the mattress remained flattened, in the area where the resident's coccyx had been resting. The wheelchair had no pressure relieving device in the seat and the CNA's left the mechanical lift sling under the resident. h. On 9/11/07 at 11:50 a.m., the resident was sitting in a wheelchair in the dining room. There was no pressure relief device in the seat of the wheelchair and the mechanical lift sling remained under the resident's buttocks. i. On 9/11/07 at 12:40 p.m., the resident was sitting in a wheelchair at the assisted feeding table. There was no pressure relief device in the wheelchair and the mechanical lift sling remained beneath the resident's buttocks. j. On 9/11/07 at 1:10 p.m., a CNA rolled the	F 490			

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F 490	Continued From page 86 resident's wheelchair into the 200 Hall. The mechanical lift sling was still positioned under the resident's buttocks at this time. k. On 9/11/07 at 2:30 p.m., the resident was in bed. The mechanical lift sling remained under the resident and there were no pressure relief devices on the resident's heels. l. On 9/11/07 at 2:36 p.m., Licensed Practical Nurse (LPN) #7 provided colostomy care to the resident. The resident was in bed and the mechanical lift sling remained under the resident. There were no pressure relief devices on the resident's heels, which were in direct contact with the mattress. m. On 9/11/07 at 4:55 p.m., the resident was sitting in a wheelchair in the dining room. The wheelchair had no pressure relief device in the seat and the mechanical lift sling had again been left under the resident. n. On 9/12/07 at 7:15 a.m., CNA's # 11, #13 and #14, who were assigned to the hall where the resident resided, were asked if any special positioning was required for this resident. The CNA's all stated, "No, we put a pillow under her hip and thigh area to keep off the stitches." The CNA's were asked if they did anything special to keep pressure off of the resident's left heel. All 3 CNAs stated, "No." o. On 9/12/07 at 8:12 a.m., the resident was lying in bed on the hard plastic non-circulating air waffle mattress. Thera-boot heel protectors were on both feet. p. On 9/12/07 at 9:35 a.m. and 10:14 a.m., the	F 490			

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F 490	<p>Continued From page 87</p> <p>resident was sitting in a wheelchair in her room with no pressure relieving devices in the wheelchair seat or on her feet.</p> <p>q. On 9/12/07 at 11:45 a.m. and 1:00 p.m., the resident was sitting in a wheelchair in the dining room with no pressure relieving devices in the wheelchair seat or on her feet.</p> <p>r. On 9/12/07 at 2:30 p.m., the resident was lying in bed on the hard plastic non-circulating air waffle mattress. No pressure relieving devices were on the resident's heels, which were in direct contact with the mattress. Licensed Practical Nurse (LPN) #2 performed colostomy care at this time.</p> <p>s. On 9/12/07 at 2:55 p.m., LPN #2 was asked, "How often do you do skin audits?" The LPN stated, "I don't know." LPN #2 was asked if any of the CNA's had reported any skin issues for this resident. LPN #2 stated, "No." LPN #2 was asked if any of the CNA's had mentioned the areas on the resident's coccyx and left heel. The LPN stated, "No."</p> <p>t. On 9/12/07 at 2:58 p.m., the following interview was conducted:</p> <p>The DON was asked, "How often are body audits done?" The DON stated, "On admission, a head-to-toe assessment is done and documented into ECS [Electronic Charting System]. Then it's done on bath day every week."</p> <p>The DON was asked, "How are wound measurements documented?" The DON stated, "If there is a wound treatment ordered, a screen prompts the nurse to enter the measurements."</p>	F 490			

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F 490	Continued From page 88 The DON was asked, "When was the last body audit done on [Resident #9]?" Registered Nurse (RN) #1, who was also present during the interview, stated, "I just did it last Thursday." RN #1 was asked, "Did you find any problems with the coccyx or heels?" RN #1 stated, "No." The DON and RN #1 accompanied the surveyors to the resident's room for a skin audit at this time. The resident was lying on her back in bed, on the non-circulating air waffle mattress with no pressure relieving devices on her feet and no offloading of the heels. During the skin audit, the DON measured two areas on the resident's coccyx and stated, "Two areas: One centimeter (cm) by 3 millimeters, Stage II, with surrounding redness." The DON assessed the resident's left heel which had a large, dark-red, purple and black area. The DON measured the area and stated, "6.5 cm by 3 cm." The DON was asked to stage the area on the resident's left heel. RN #1 stated, "It's a deep tissue, but the skin isn't broken, so it's a Stage I." The DON stated, "It's deep tissue, unstageable, so its a Stage IV." The DON was asked, "What kind of mattress is on the bed?" The DON pointed to the mattress and stated, "This is a pressure relieving mattress." The DON was asked, "What kind of mattress is this on top of it?" The DON stated, "It's something that the family brought in to use on the bed. It's an air mattress. I'll get rid of it." The DON was asked, "In the wheelchair, what is in the seat?" RN #1 stated, "It's a cushion." The	F 490			

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F 490	<p>Continued From page 89</p> <p>RN then picked it up, inspected it and stated, "Oh, its a bed pillow." The DON was asked, "Is that a pressure relieving device?" The DON stated, "No. I guess we didn't have a pressure relieving device in the wheelchair."</p> <p>The DON was asked, "Were any heel protectors on the resident when you started your assessment?" RN #1 and the DON both stated "No, there were no heel protectors on the resident."</p> <p>u. On 9/12/07 at 3:05 p.m., the DON was asked, "How often does [Resident #9] get a bath?" The DON called the nursing unit, received information, then stated, "Tuesday, Thursday and Saturday." The DON was asked, "Can you show me where this is documented?" The DON reviewed the record in the computer, which documented, "9/11/07 - no foot problem." The DON was asked, "What is the process for reporting skin problems in this facility?" The DON stated, "CNA's fill out a slip of paper and turn it in to the nurse. The nurse assesses the resident and the slip then goes to the Assistant Director of Nurses [ADON]. Then the resident is assessed again. If the wound is a Stage II or greater, we send the resident to the Wound Care Center." The DON was informed that during incontinent care on the previous day, the areas on the resident's coccyx and heel were visible and that the CNA's providing care were asked about the area on the resident's coccyx at that time. The DON was asked if this had been reported by the CNA's. The DON called the nursing unit, received information then stated, "No slip or report of the skin problems was ever reported to the nurses."</p> <p>v. On 9/13/07 at 1:05 p.m., the Medical Director</p>	F 490			

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F 490	<p>Continued From page 90</p> <p>was asked if there were any concerns with the resident's skin. The Medical Director stated, "We [myself and the Advanced Practice Nurse (APN)] assessed the resident when she returned to the facility. We didn't notice any skin problems. Her left heel was a little boggy, but not red or anything."</p> <p>w. On 9/13/07 at 1:30 p.m., the DON stated, "There are no measurements [of the wounds] other than the ones we done together."</p> <p>x. On 9/13/07 at 3:30 p.m., the facility Administration provided product information on the Waffle static air mattress. The product information documented: "...Indications for Use: Treatment: Use for healing therapy to patients with pressure ulcers up to Stage III... Hand check and inflation adjustments: The key to safe patient support is creating the perfect balance between pliability and stiffness of the mattress. If the product is too stiff, the advantages of the surface area are defeated. One inch of air is adequate support for a patient. If you can slide your hand in and out easily under the overlay, pressure is being relieved... [Manufacturer] recommends daily hand checks and then adding or removing air according to the patient's position and body type." The tag on the resident's mattress documented: "...The highest clinical benefits are achieved with a properly inflated mattress. Include skin inspections, daily inflation checks, proper nutrition, and turning schedules as part of a balanced wound care management program..."</p> <p>y. On 9/14/07 at 6:30 a.m., LPN #9, who worked the 7:00 p.m. to 7:00 a.m. shift and was assigned to the resident's hall, was asked when she was first made aware of the breakdown to the</p>	F 490			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045375	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/21/2007
NAME OF PROVIDER OR SUPPLIER PARKVIEW REHABILITATION & HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 BARROW ROAD LITTLE ROCK, AR 72204		
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F 490	<p>Continued From page 91</p> <p>resident's coccyx and heel. LPN #9 stated, "Last night [Thursday] for the bottom, the heel the night before [Wednesday]." LPN #9 was asked, "Did the CNA's tell you there were any problems with the skin?" LPN #9 stated, "No."</p> <p>z. On 9/14/07 at 10:45 a.m., CNA #5, who provided incontinent care on 9/11/07, was asked if she saw anything on the resident's heel when the sock was removed. CNA #5 stated, "Yes, a red spot." CNA #5 was asked if she reported the reddened area to anyone. CNA #5 stated, "No." CNA #5 denied seeing any skin problems on the resident's coccyx during incontinent care since she was holding the resident while the other CNA provided incontinent care. CNA #5 was asked, "What are you supposed to do if you find something wrong with a resident's skin?" The CNA stated, "Tell the nurse."</p> <p>aa. On 9/14/07 at 11:20 a.m., CNA #6, who provided incontinent care on 9/11/07, was asked if she saw anything unusual about the resident's skin on that date. CNA #6 denied seeing any skin problems on the resident's coccyx or heels.</p> <p>bb. On 9/17/07 at 11:00 a.m., the DON was asked if the nurses performed hand checks to assess inflation of the waffle static air mattress. The DON stated, "I doubt it." When asked if any inflation apparatus was located in the facility to re-inflate the mattress, the DON stated, "No."</p> <p>4. Resident #3 had diagnoses of Insulin-Dependent Diabetes Mellitus, Dementia and Renal Failure.</p> <p>a. The Plan of Care documented a problem identified on 5/14/07 as: "...Problem: Supportive</p>	F 490			

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F 490	<p>Continued From page 92</p> <p>device use with risk of complications manifested by: Increased incontinence, skin breakdown... Goal: No complications R/T [related to] supportive device use ... Nurses - Watch resident for s/s [signs and symptoms] complications R/T supportive device. Nurse aide - Check q [every] 30 min. [minutes], release q 2 hr [hours] for activity... Assist with toileting and ADLs [activities of daily living] as needed daily. NOTIFY NURSE OF ANY S/S SKIN BREAKDOWN OR OTHER COMPLICATIONS R/T SUPPORTIVE DEVICE USE... 1/22/07 - Problem: Impairment of skin integrity... Manifested by: Pressure ulcer present Stage 4 - a full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone... Nurses - Assess skin condition weekly... Nurse Aide - Reposition every two hours in bed... pressure relieving mattress... 4/11/07 - Problem: Impairment of skin integrity... Manifested by: Pressure ulcer present Stage 2 - a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. To sacrum, coccyx, right heel, left heel, right lateral leg ... Nurses - Assess skin condition weekly... Nurse Aide - Reposition every two hours in bed... pressure relieving mattress..."</p> <p>b. A Pressure Sore Report dated 5/25/07 documented the resident had a Stage II pressure ulcer to the sacral/coccyx area which measured 1.5 centimeters (cm) long, by 1 cm wide, by 0.1 cm deep and was facility-acquired. The ordered treatment for this wound was Zinc oxide twice daily. The report also documented a Stage II pressure ulcer to the right heel which measured 3 cm long by 3 cm wide with eschar present. The ordered treatment for this wound was to cleanse with normal saline (NS), pat dry, apply Accuzyme and cover with Chlorpactin gauze wrap. The</p>	F 490			

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F 490	<p>Continued From page 93</p> <p>report documented a Thera boot was to be used for pressure relief.</p> <p>c. The Braden Scale Assessment form dated 6/11/07 at 8:40 a.m. documented the resident was completely immobile, exposed to constant [skin] friction, chairfast, rarely exposed to moisture, usually ate only half of meals and had slightly limited sensory perception and could not always communicate pain or need to reposition. The Braden Scale was not totaled. When completed as instructed, the total pressure ulcer risk score, based on the above assessment findings, was 13. The score legend on the Braden Scale Assessment form documented a score of 13-14 indicated the resident was at moderate risk of developing pressure ulcers.</p> <p>d. The Quarterly Minimum Data Set (MDS) dated 6/12/07 documented the resident had short and long term memory problems, was severely impaired in cognitive skills for daily decision making, dependent on staff for transfers, bed mobility, toilet use, and personal hygiene, incontinent of bowel and bladder and had one Stage I and four Stage II pressure ulcers.</p> <p>e. The most recent Braden Scale Assessment in the clinical record was dated 6/22/07 at 9:49 p.m. and did not include documentation of the resident's moisture, nutrition or sensory perception status.</p> <p>f. The Pressure Sore Report dated 6/29/07 documented the Stage II pressure ulcer to the resident's coccyx had increased in size, to 2 cm long by 1.5 cm wide and was to be treated with zinc oxide. A new Stage II pressure ulcer to the right ankle was also documented and measured</p>	F 490			

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F 490	<p>Continued From page 94</p> <p>3.5 by 1.8 cm and was to be treated by cleansing with NS, packed with Silvasorb and covered with gauze and Alleny. The report also documented the Stage II pressure ulcer to the resident's right heel had increased in size to 9 cm long by 8 cm wide by 0.1 cm deep and was to be treated by cleansing with NS, applying Silvadene cream, covering with 4x4's and wrapping with Kerlix.</p> <p>g. The Pressure Sore Report dated 7/5/07 documented the Stage II pressure ulcer to the coccyx had increased in size to 2.2 cm long by 1.5 cm wide by 0.1 cm deep and was still being treated with zinc oxide. The Stage II pressure ulcer to the right ankle had decreased in size but increased in depth, to 3 cm long by 1 cm wide by 0.2 cm deep and was still being treated with NS, Silvasorb, gauze and Alleny. The pressure ulcer to the right heel had decreased in size but increased in depth, to 8.5 cm long by 6 cm wide by 0.2 cm deep and had eschar present, but was still documented as a Stage II. This wound was still being treated with NS, Silvadene cream, 4x4's and Kerlix.</p> <p>h. The Pressure Sore Report dated 7/13/07 documented the Stage II pressure ulcer to the coccyx was healed. The Stage II pressure ulcer to the right ankle had decreased is size to 2 cm long, by 0.7 cm wide by 0.1 cm deep. The pressure ulcer to the right heel measured 9 cm long by 5.5 cm wide by 0.2 cm deep and had eschar present, but was still documented as a Stage II and there had been no change in the ordered treatment.</p> <p>i. The Pressure Sore Report dated 7/30/07 documented a Stage II pressure ulcer to the coccyx, but no measurements were documented.</p>	F 490			

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F 490	<p>Continued From page 95</p> <p>The ordered treatment for this wound was documented as, "Cleanse with NS apply Zinc Oxide." The wound to the right ankle measured 1 cm long by 0.5 cm wide by 0.1 cm deep and was now documented as a "vascular Stage II wound." The wound to the right heel measured 9 cm long by 5.5 cm wide with unmeasureable depth due to eschar and was now coded as a Stage II vascular wound, but was still receiving the same treatment.</p> <p>j. Nurses' Notes dated 8/1/07 at 11:32 a.m. documented: "...Skin Problems: decubitus ulcer. Location: on right heel, redness to sacral and coccyx area. Skin treatment: Has pressure relieving device for bed. Receives turning/repositioning program. Receives ulcer care. Receives application of ointments/medications... Foot Problems/Care: decubitus on right heel... Pressure ulcer: Full thickness of skin lost, exposing SubQ [subcutaneous] tissue - presents as a deep crater (Pressure Stg. 3). Ulcer location: on right heel. Color: reddened. Drainage: purulent..."</p> <p>k. A physician order dated 8/1/07 documented: "Cleanse coccyx area with normal saline. Apply zinc oxide oint [ointment] bid [twice a day]..."</p> <p>l. A physician order dated 8/2/07 documented: "Cleanse right posterior ankle with normal saline. Rinse with normal saline. Pat dry with 4x4's. Pack with Fibracol 2x2. Cover with foam, wrap with gauze qd [every day]... Cleanse right heel pressure ulcer with normal saline. Pack with Calcium Alginate, cover with 4x4's, foam drsg [dressing]. Wrap with Kerlix qd..."</p> <p>n. The Pressure Sore Report dated 8/3/07 documented the wound to the right ankle was a</p>	F 490			

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F 490	<p>Continued From page 96</p> <p>Stage II vascular wound measuring 2 cm long by 0.7 cm wide by 0.1 cm deep and continued to be treated with NS, 4x4's, Silvasorb, gauze and Alleny. The wound to the resident's right heel was documented as a Stage II vascular wound measuring 9 cm long by 5.5 cm wide by 0.2 cm deep, with eschar present. The treatment for this wound remained unchanged.</p> <p>o. Nurses' Notes dated 8/8/07 at 8:14 p.m. documented: "...Skin Problems: Ulcers... Location: on right heel, coccyx area. Skin Treatment: Has pressure relieving device for bed..."</p> <p>p. The Pressure Sore Report dated 8/10/07 documented the wound to the right ankle was a Stage II and remained the same size and depth as on the 8/3/07 assessment and was being treated with NS, 4x4's, Fibracol, 2x2's, foam wrap and gauze daily. The wound to the right heel remained the same size and continued to have eschar present, but was still documented as a Stage II. The treatment for this wound was documented as: "Cleanse heel with NS then pack with Calcium Alginate, cover with 4x4's, foam drsg."</p> <p>q. The Pressure Sore Report dated 8/17/07 documented the wound to the right ankle was a Stage II and measured 1.5 cm long by 1 cm wide and had increased to 0.2 cm in depth, with drainage present. The treatment for this wound was unchanged. The wound to the right heel was documented as a Stage II measuring 4.5 cm by 7 cm (no depth was documented). The treatment for this wound was unchanged.</p> <p>r. The Pressure Sore Report dated 8/27/07</p>	F 490			

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F 490	<p>Continued From page 97</p> <p>documented: "...Rt [right] ankle. Stage: II ... Correction last week - 9.5 x 6.5 x 0.2. This week 7.5 x 5.5 x 0.2..." The right heel wound was documented as healed.</p> <p>s. The Pressure Sore Report dated 9/7/07 documented the wound to the right ankle was a Stage II measuring 7.5 cm long by 5.4 cm wide by 0.2 cm deep. The treatment for this wound was unchanged and the Pressure Relief intervention was documented as: "Thera boots." The report also documented an area to the left great toe as a skin tear and a second area to the left great toe as a Stage IV measuring 1 by 2 cm.</p> <p>t. On 9/11/07 at 8:13 a.m., the resident was sitting in a wheelchair with a table top restraint. A mechanical lift sling was under the resident. The resident was not wearing shoes and his left foot was positioned under the foot pedal of the wheelchair. The restraint was marked at this time by sliding a small slip of paper under the right strap of the table top.</p> <p>u. On 9/11/07 at 11:02 a.m., the resident was sitting in the wheelchair with the table top restraint in place. The slip of paper remained unmoved under the right strap of the restraint. The mechanical lift sling remained under the resident. The resident was still not wearing shoes and his left foot remained under the foot pedal of the wheelchair.</p> <p>v. On 9/11/07 at 12:30 p.m., the resident was being fed lunch by a Certified Nursing Assistant (CNA), while sitting in the wheelchair with the table top restraint in place. The slip of paper remained unmoved under the right strap of the restraint. His bare left foot remained under the</p>	F 490			

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F 490	<p>Continued From page 98 wheelchair foot pedal.</p> <p>w. On 9/11/07 at 2:35 p.m., the resident was sitting in the wheelchair with the table top restraint in place. The slip of paper remained unmoved under the right strap of the restraint, the mechanical lift pad remained under the resident and the resident's left bare foot remained under the wheelchair foot pedal.</p> <p>x. On 9/11/07 at 4:30 p.m., the resident was sitting in the wheelchair in the dining room with the table top restraint in place. The slip of paper was no longer under the restraint strap and the resident was wearing different clothing; however, he was still wearing no shoes and his left foot was under the foot pedal of the wheelchair.</p> <p>y. On 9/12/07 at 7:40 a.m., the resident was sitting in a wheelchair with a table top restraint in the dining room. The resident was not wearing shoes and his left foot was under the foot pedal of the wheelchair. The restraint was marked at this time by placing a small slip of paper under the right strap.</p> <p>z. On 9/12/07 at 9:22 a.m., CNA #1 was making the resident's bed. A hard, green, vinyl-covered mattress was leaning against the wall. CNA #1 stated, "The resident just got a new mattress." The new mattress was a low-air-loss, pressure-relieving mattress.</p> <p>aa. On 9/12/07 at 9:50 a.m., CNA's #1 and #2 provided incontinent care to the resident, following an episode of bowel and bladder incontinence. CNA #2 rolled the resident to his left side. There was an open area on the resident's lower, right buttock. CNA #1 sprayed a</p>	F 490			

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F 490	<p>Continued From page 99</p> <p>washcloth with periwash and cleansed the perianal and buttock areas. The CNA then used the washcloth, which was soiled with feces, to wipe across the open area on the resident's buttock and stated, "He has a sore." CNA #1 dried the resident's perianal and buttock areas with a towel, which became soiled with stool as the CNA wiped the resident's skin. The CNA's removed the soiled incontinent brief from the resident, but left the incontinent pad, which was soiled with a 7 by 1-inch streak of stool. The CNA's rolled the resident back onto the soiled incontinent pad after the procedure was completed.</p> <p>bb. On 9/12/07 at 10:15 a.m., CNA #2, who was assigned to provide care to this resident on 9/11/07, was asked when she had repositioned him on 9/11/07. CNA # 2 stated, "Not till after dinner. I did check on him." CNA # 2 was asked how she had checked on the resident. CNA #2 stated, "Took the top off the wheelchair and looked inside his pants." (The slip of paper placed under the right strap of the table top at 8:13 a.m. on 9/11/07 was still present at 2:35 p.m. and would have been dislodged had the top been removed.) CNA #2 was asked how she positioned the resident in bed. The CNA stated, "Pillow between the knees. Don't put the foot up because of drainage. Try and keep him off his bottom." CNA #2 was asked if she did anything about the resident's feet when he was in the wheelchair. CNA #2 stated, "Nothing that I know of."</p> <p>cc. Nurses' Notes dated 9/12/07 at 11:18 p.m. documented: "Skin problem: Has tear/cut(s) present in past 7 days. Location: on left top foot... Size: 0.5 x 0.4. Location: on left top foot. Size:</p>	F 490			

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F 490	<p>Continued From page 100</p> <p>0.5 x 0.5. On left 3rd toe... Size: 1 x 0.8. Location: on right great toe... Size: 1.5 x 1.8... On right 2nd toe... Size: 0.5 x 0.5... On right buttock... Size: 1.6 x 1..."</p> <p>dd. On 9/13/07 at 10:20 a.m., the Director of Nursing (DON) was asked, "What were the results of the body audit you did last night?" The DON stated, "...Stage II's to the third toe and great toe [on the left foot], a scabbed second toe [on the right foot], Stage II to the coccyx." The DON was asked if she was aware, prior to the body audit, that the resident had skin breakdown on his feet and buttocks. The DON stated, "No, the CNA's did not go to the nurse." The DON was asked when the low-air-loss, pressure-relieving mattress was initiated. The DON stated, "First day was yesterday." The DON was asked if any interventions were implemented to relieve pressure on the resident's toes. The DON stated she planned to order a foot cradle for the resident, "today." The DON was asked to review the Nurses' Notes dated 9/12/07 at 11:18 p.m. which documented the wounds to the resident's toes as "tears/cuts." The DON was asked if this documentation was correct. The DON stated, "No, they were pressure sores. I measured and staged them myself. I asked someone else to document it, and they did it wrong. The DON was asked to correct the documentation. The DON lined through the, "Has tear/cut" area and wrote in, "Stage II PU [pressure ulcer]."</p> <p>ee. On 9/14/07 at 6:50 a.m., CNA #17, who worked the night shift on the hall where the resident resided, was asked, "When did you notice the sore on the resident's buttocks?" CNA #17 stated, "A couple of weeks now." CNA #17</p>	F 490			

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F 490	<p>Continued From page 101</p> <p>was asked, "Did you tell someone?" The CNA stated, "Charge Nurse [LPN #5]." I've been asking for a air mattress and foot rest on the wheelchair. We've been asking for something to keep his feet up. [LPN # 5] has been e-mailing someone. Now he's got that air mattress, I don't have to turn him."</p> <p>ff. On 9/14/07 at 6:35 a.m., LPN #5, who worked the evening/night shift on this resident's hall, was asked when she became aware that the resident had an open area on his right buttock. LPN #5 stated, "Wednesday evening [9/12/07]." LPN #5 was asked if she worked on Tuesday night (9/11/07). The LPN stated, "Yes, I work Monday through Thursday." LPN #5 was asked if the CNA's told her that the resident had an open area on his buttock. LPN #5 stated, "No."</p> <p>5. Resident #10 had diagnoses of Non-Insulin Dependent Diabetes Mellitus, Breast Cancer and Pleural Effusion.</p> <p>a. The Plan of Care dated 12/27/06 and updated 3/18/07 documented: "Problem: Potential for Impairment of skin integrity... Nurses: Assess skin condition weekly. Nurse Aide: ...Reposition every two hours in bed... pressure relieving mattress..."</p> <p>b. A physician order dated 4/21/07 documented: "Thera boots for heel protection (full thickness wounds) 7A-7P [7:00 a.m. to 7:00 p.m.] 7P-7A [7:00 p.m. to 7:00 a.m]."</p> <p>c. The Braden Scale Assessment form dated 5/15/07 at 9:00 a.m. documented the resident had very limited mobility, no apparent problems with shear/friction, was chairfast, occasionally</p>	F 490		

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F 490	<p>Continued From page 102</p> <p>exposed to moisture, probably had inadequate nutrition, had slightly limited sensory perception and could not always communicate pain or need to reposition. The Braden Scale was not totaled. When the numerical values for each of the assessment areas were added, the total pressure ulcer risk score for this resident was 15, which indicated the resident was at a low risk for pressure ulcer development.</p> <p>d. The Braden Scale Assessment form dated 5/18/07 at 8:47 a.m. documented the resident's friction/shear score had worsened due to the resident requiring moderate to maximum assistance to move, "...Slides in bed/chair. Constant friction." The assessment was not totaled in order to determine the level of pressure ulcer risk. When the numerical values of the assessment findings were added, the pressure ulcer risk score was 14, which indicated the resident was at moderate risk for pressure ulcer development.</p> <p>e. The Pressure Sore Report dated 5/25/07 documented: "Area: [right] and [left] heels; Stage: IV, Eschar; Size cm [centimeters] healed, 1.9 x 1 x 0.2; ... Treatment: Apply Kerlix, keep dry, qd [every day]... Pressure relief device(s): Y [yes] Thera boots... Area: Sacrum; Stage: II; Size... 2 x 1.5... Treatment: Cleanse with NS [normal saline]. Apply DuoDerm q [every] 3 days..."</p> <p>f. Nurses' Notes dated 6/3/07 at 1:46 a.m. documented: "Skin status: Pressure ulcer: Has persistent area of skin redness that does not disappear when pressure relieved (Pressure Stg [stage] 1). Location: Coccyx buttock, Observation: Dressing intact...Actions: Continue to treat as ordered, protective devices in place..."</p>	F 490			

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F 490	Continued From page 103 g. The Pressure Sore Report dated 6/22/07 documented: "Area: Right heel; Stage: IV; Size... 2 x 1 [cm] with eschar ... Treatment: Apply Kerlix to right heel. Do not get wet ... Pressure relief device(s): Y... Area: Sacrum; Stage: II; Size: 1.7 x 1... Treatment: Cleanse with NS. Apply Duoderm q 3 days ..." h. The Pressure Sore Report dated 7/5/07 documented: "Area: Right heel; Stage: IV; Size... 2 x 1 x 0.2...Treatment: Apply Kerlix to right heel... Area: Sacrum; Stage: II healed..." i. The Pressure Sore Report dated 7/13/07 documented: "Area: Right heel; Stage: IV; Size...1.5 x 1 x 0.2... Treatment: Apply Kerlix to right heel..." j. The Quarterly Minimum Data Set (MDS) dated 7/19/07 documented the resident had modified independence in cognitive skills for daily decision making, had multiple daily episodes of bladder incontinence, was incontinent of bowel all (or most all of the time), dependent on staff for personal hygiene and toilet use and had no stasis or pressure ulcers. k. The Pressure Sore Report dated 7/30/07 documented: "Area: Right heel; Stage: IV; Size... 1.5 x 1 x 0.2 healing... Treatment: Apply Kerlix to right heel... and barrier cream to [right] and [left] heels..." l. The Pressure Sore Report dated 8/10/07 documented: "Area: Right heel; Stage: IV; Size... 1.7 x 0.8 x 2... Treatment: Apply Kerlix to right heel..."	F 490		

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F 490	Continued From page 104 m. The Pressure Sore Report dated 8/17/07 documented: "Area: Right heel; Stage: IV; Size... 1.2 x 0.5 x 0.2... Treatment: Apply Kerlix to right heel..." n. Nurses' Notes dated 8/24/07 at 9:52 a.m. documented: "Skin problems: sore mushy area, Location: on left heel (not open), Skin treatment: E-mailed [Advanced Practice Nurse]..." o. The Pressure Sore Report dated 8/27/07 documented: "Area: Right heel; Stage: IV; Size... 1 x 0.3 x 0.2... Treatment: Apply Kerlix to right heel QD [every day] 7p - 7a [7:00 p.m. to 7:00 a.m.] ..." There was no documentation on this report regarding the "sore, mushy area" to the left heel. p. The Pressure Sore Report dated 9/7/07 documented: "Area: Right heel; Stage: IV; Size... 1 x 0.2 x 0.1...Treatment: Apply Kerlix to right heel QD 7p - 7a..." q. Nurses' Notes dated 9/7/07 at 8:10 p.m. documented: "Skin assessment: 2+ edema, Location: on right/on left lower leg(s)... Skin problems: ulcers ... Location: on right/on left heels... Skin treatment: ...Has pressure relieving device for bed..." r. On 9/10/07 at 6:39 p.m., the resident was in bed. There was no pressure relief mattress on the resident's bed. s. On 9/11/07 at 8:12 a.m., the resident was sitting in a wheelchair in the dining room with her legs elevated. The resident did not have Thera boots on.	F 490			

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F 490	Continued From page 105 t. On 9/11/07 at 11:15 a.m., the resident was in her room sleeping in the wheelchair with her legs elevated. The resident did not have Thera boots on. u. On 9/11/07 at 12:30 p.m., the resident was sitting in the wheelchair in the dining room with her legs elevated. The resident stated she had been up in the wheelchair since before breakfast and had, "not moved." The resident did not have Thera boots on. v. On 9/11/07 at 2:50 p.m., the resident was in bed on her back with the head of the bed elevated. The resident stated she was put back to bed, "Five minutes ago." The resident was asked what time she had originally gotten in the wheelchair that day. The resident stated, "About 8:00 a.m." There was no pressure-relieving device on the resident's bed. w. On 9/12/07 at 8:12 a.m., after the resident was dressed and transferred to her wheelchair, the bed was stripped. The resident had been on a hard, blue, vinyl-covered mattress that had areas of cracks and tears in the mattress cover. The areas were too numerous to count or measure. x. On 9/12/07 at 8:13 a.m., the Director of Nursing (DON) was asked to come to the resident's room to observe the mattress. The DON was then asked if the mattress would be considered a pressure-reduction mattress. The DON stated, "No, I'll get it changed. I agree, she should be on another mattress." The DON was asked to provide the manufacturer's recommendations for this mattress. The manufacturer's recommendations were not	F 490			

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F 490	<p>Continued From page 106 provided to the survey team as requested.</p> <p>y. On 9/12/07 at 9:10 a.m., the DON stated she had ordered a new air mattress for the resident.</p> <p>z. The Wound Care Progress Note dated 9/13/07 from the wound clinic documented: "...continuing evaluation and care of a small ulceration on her right heel. This is probably pressure related. The patient is essentially nonambulatory and spends almost her entire time either in a wheelchair or lying in bed... Physical exam is limited to the right lower extremity. She is found to have a very small ulceration on the posterolateral aspect of the heel... Periwound: Normal; Wound bed: Pink gran [granulation]..." The Discharge/Wound Care Instructions documented: "...Note: Patient is not to [be] up longer than 1.5 hours at a time..."</p> <p>6. Resident #14 had diagnoses of Senile Dementia, Abnormality of Gait and Closed Fracture of Intertrochanteric Section of the Femur.</p> <p>a. The Braden Scale Assessment form dated 2/16/07 documented the resident had very limited mobility, a potential shear/friction problem, was bedfast, rarely exposed to moisture, had adequate nutrition and no sensory perception impairment. The assessment was not totaled to determine the resident's total pressure ulcer risk. When the numeric values from the assessment findings were added, the resident's total pressure ulcer risk score was 16, which indicated the resident was at low risk for pressure ulcer development.</p> <p>b. The MDS dated 7/10/07 documented the resident was moderately impaired in cognitive</p>	F 490			

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F 490	<p>Continued From page 107</p> <p>skills for daily decision making, incontinent of bowel and bladder, totally dependent on staff for bathing and dressing, had no pressure ulcers, had a pressure relief device in bed and chair and was on a turning/repositioning program.</p> <p>c. The Plan of Care dated 7/13/07 documented: "Problem: Restraint use with risk of complications. Related to: Soft Seat Belt... Nurses - Assure restraint is applied properly... Nurse Aide - Apply restraint(s) as ordered. Check q [every] 30 min [minutes], release q 2 hr [hours] for activity ... Problem: Potential for impairment of skin integrity related to decreased mobility, manifested by hx [history] of ulcers/breakdown... Nurses - Assess skin condition weekly. Nurse Aide - Assist with hygiene and general skin care. Reposition every two hours in bed. Keep skin clean and dry. Pressure relieving mattress, pressure relieving cushion in wheelchair..."</p> <p>d. A Physician Order dated 8/27/07 documented, "Restraint: Soft belt seat belt when in w/c [wheelchair] due to unsteadiness D/T [due to] poor judgement due to Senile Dementia."</p> <p>e. On 9/10/07 at 6:30 p.m., the resident was sitting in a wheelchair with no pressure relieving device in the seat. A soft belt was in use around the resident's waist.</p> <p>f. On 9/11/07 from 8:10 a.m. to 2:30 p.m., the resident was sitting in or near the dining room on the 200 Hall, in a wheelchair with no pressure relief device in the seat, wearing a soft belt restraint.</p> <p>g. On 9/11/07 at 5:40 p.m., the resident was sitting in a wheelchair near the dining room on the</p>	F 490			

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F 490	<p>Continued From page 108</p> <p>200 Hall wearing a soft belt restraint. There was no pressure relief device in the seat of the wheelchair and a strong urine smell was emanating from the incontinent brief.</p> <p>h. On 9/12/07 from 8:00 a.m. to 10:30 a.m., the resident sat in or near the dining room on the 200 Hall in a wheelchair with no pressure relief device in the seat. The resident was wearing a soft belt restraint. No release or repositioning of the resident was observed by this Surveyor, who kept the resident under observation during this entire 2.5 hour time period.</p> <p>7. Resident #2 had diagnoses of Cerebrovascular Accident and Rhabdomyolysis.</p> <p>a. A Braden Scale Risk Assessment form dated 8/16/07 did not document the total risk score and did not specify whether the resident was at high, moderate or low risk for pressure ulcer development. The Sensory Perception section of the assessment was not completed. On 9/13/07 at 12:50 p.m., the Director of Nursing (DON) stated, "I would put her at medium risk."</p> <p>b. A Physician's Progress Report dated 8/23/07 documented: "...Wound care by Nursing for sheer on her buttocks from scooting across the floor as she attempted to get up. (Fell at home prior to admission)."</p> <p>c. A Physician's Progress Note dated 8/30/07 documented: "...Heels are intact but left heel is soft, boggy and dark... Treatment Plan: DuoDerm to left heel q [every] 72 hours until healed. Bridge heels while in bed... Encourage resident to get up out of bed." A Physician's Order dated 8/30/07 documented: "Apply DuoDerm to Left Heel and</p>	F 490			

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F 490	Continued From page 109 Sacrum Q 72 hours..." d. The Minimum Data Set dated 9/5/07 documented the resident had modified independence in cognitive skills for daily decision making and had one Stage 2 pressure ulcer. e. The Pressure Ulcer Report dated 9/7/07 documented: "Onset date: 8/27/07... Area - left heel, Stage 1... Acquired." On 9/13/07 at 1:55 p.m., Licensed Practical Nurse (LPN) #8 was shown the 9/7/07 Pressure Ulcer Report which documented the resident's heel wound as a Stage I. The LPN was asked what the wound looked like when it was first identified. She stated, "I found it because I was assessing her. She had swelling in her feet. It was purplish in color, closed, no breakage. It was unstageable. The wound report is an error because it is unstageable." She was asked what kind of positioning was being done to relieve pressure on the resident's heels. The LPN stated, "Thera boots now for when she is in the bed. She has foot rests on the wheelchair." She was asked if the foot rests had any type of pressure relief. She stated, "The Thera boots are the only thing that we have for pressure relief of the feet... I think anyone that has a wound on the heel should have some type of pressure relief." f. On 9/10/07 at 6:10 p.m., 9/11/07 at 8:08 a.m., 12:22 p.m., 2:35 p.m. and 4:50 p.m. and 9/12/07 at 8:13 a.m. and 1:00 p.m., the resident was sitting in a wheelchair. The resident was wearing booty socks and had her feet positioned on the wheelchair foot rests. There was no pressure relief on the foot rests.	F 490			

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F 490	<p>Continued From page 110</p> <p>g. On 9/12/07 at 4:00 p.m., the resident was sitting in a wheelchair in her room with booty socks on. Her feet were on the foot rest of the wheelchair. There was no pressure relief on the foot rests. Licensed Practical Nurse (LPN) #1 removed the DuoDerm from the left heel. The wound was on the left lateral and bottom part of the heel and was approximately 5 to 6 centimeters round and dark bluish/purple in color.</p> <p>h. On 9/13/07 at 11:50 a.m., Certified Nursing Assistant (CNA) #10 was asked what positioning was done to relieve pressure on the resident's heels while up in the wheelchair. She stated, "I haven't done anything different. I haven't been instructed to. We bridge them when she is in the bed so her heels aren't touching the bed."</p> <p>i. On 9/13/07 at 11:55 a.m., LPN #1 was asked if any interventions had been implemented to relieve pressure on the resident's heels when she was sitting in the wheelchair. The LPN stated, "As far as the feet, we haven't done anything special."</p> <p>j. On 9/13/07 at 12:50 p.m., the Director of Nursing (DON) stated, "...I got an order for Thera boots last night. She has the pressure relief mattress." When asked about the wound to the resident's heel, the DON stated, "It's unstageable. It's dark. We staged it at a IV last night."</p> <p>8. On 9/13/07 at 3:55 p.m., LPN #8 was asked who completed the weekly skin assessments. LPN #8 stated, "There's no who. A sheet is printed from ECS [Electronic Charting System]. It's a list of who should get audits. On monthly, we do a head to toe and if weekly, we do a general skin check. Then chart in ECS." LPN # 8</p>	F 490			

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F 490	<p>Continued From page 111</p> <p>was asked where the wound measurements and stages were charted. LPN # 8 stated, "Only the ADON [Assistant Director of Nursing] does measurements. LPN's, CNA's whoever finds it fills out a green slip, then we go down and check the resident regarding what the CNA identified. LPN calls the doctor, family and gets orders and informs QMT/DON that a wound was found on the resident. Once the DON is informed, she gives it to the ADON for measurements."</p> <p>9. On 9/14/07 at 11:30 a.m., LPN #4, who worked the day/evening shift on the hall where Residents #3 and #10 resided, was asked if the CNA's had reported that Resident #3 had a wound on his buttock or feet on 9/11/07. LPN #4 stated, "No." LPN #4 was asked when she became aware that the resident had additional skin breakdown. The LPN stated, "This morning." LPN # 4 was asked who was responsible for completing body audits on Resident #3. The LPN stated, "Depends on ECS calendar and what it falls on. We pull up reports every shift and it [ECS report] prints out what's due, like weekly or monthly skin audit." LPN #4 was shown skin audits that she had completed on Residents #3 and #10, which documented the presence of pressure-relief devices on the residents' beds. The LPN was then asked what pressure relieving devices were on the residents' beds at the time she documented the assessments. LPN #4 stated, "I thought they had an air mattress on the bed. They do now." LPN #4 was asked if she remembered what type of mattresses were on the 2 residents' beds on 9/11/07. The LPN stated, "I thought it was an air mattress. I guess I was wrong." LPN #4 was asked if residents like Residents #3 and #10, who had existing pressure ulcers, should be left up in a wheelchair from</p>	F 490			

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F 490	<p>Continued From page 112</p> <p>breakfast until after lunch. LPN #4 stated, "[Resident #3's] CNA should lay him down after lunch." LPN #4 was asked when Residents #3 and #10 or any other resident with pressure ulcers should be transferred back to bed. LPN #4 stated, "After meals." LPN #4 was asked how she monitored to ensure the CNA's transferred these residents back to bed after meals. LPN #4 stated, "I look." LPN #4 was asked if she verified that these residents were transferred back to bed after meals. The LPN stated, "No, I guess I didn't think they needed to go back to bed." LPN #4 was asked if she was aware that Resident #3 sat in the wheelchair from 8:00 a.m. until after lunch and was not transferred back to bed until 2:45 p.m. on 9/11/07. LPN #4 stated, "The resident said the wound clinic said for her to only stay up for one and a half hours. I told her I'd have to see that order." LPN #4 was asked, "In your nursing judgement, should residents with pressure sores stay up for long periods of time?" LPN #4 stated, "No." LPN #4 was again asked if she was aware that Resident #3 was up in the wheelchair for an extended period of time on 9/11/07. The LPN stated, "No."</p> <p>10. On 9/14/07 at 12:55 p.m., the Director of Nursing (DON) was asked, "How do you interpret the Braden Risk Assessment Scale that was done for [Resident #10]?" The DON stated, "High risk." The DON was asked if she had found the recommendations for the vinyl covered mattresses that had been on the beds of Residents #3 and #10. The DON stated, "No, they were not a pressure relieving mattress."</p> <p>11. On 9/14/07 at 5:40 p.m., the DON was asked when pressure relieving devices should be placed on residents' beds. The DON stated, "Pressure</p>	F 490		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045375	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/21/2007
NAME OF PROVIDER OR SUPPLIER PARKVIEW REHABILITATION & HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 BARROW ROAD LITTLE ROCK, AR 72204		
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F 490	Continued From page 113 relieving devices should be used if a resident is high risk." (The Braden Risk Assessment Scale documented that residents at moderate risk should be placed on a pressure reduction support surface.) The DON was asked how the CNA's were trained on assessment/reporting of skin problems. The DON stated, "Its part of orientation; it's on the checklist." The CNA's Orientation Checklist was reviewed at this time and did not contain training on reporting skin problems. 12. On 9/14/07 at 5:20 p.m., the DON was asked if any monitoring or audits of the LPN's documentation on pressure sores had been done. The DON stated, "My ADON was monitoring that, but now I'm going to have to do it." The DON was asked if the ADON's documentation had been inaccurate. The DON stated, "Yes." The DON was asked what the ADON had been monitoring. The DON stated, "Documentation, the presence of pressure relieving devices." The DON was asked if she had routinely monitored to ensure pressure relieving devices, staging, measurements, risk scales were correct and interventions were implemented. The DON stated, "I was focused on other things, but I will be doing it now."	F 490			
F 502 SS=D	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	F 502			

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F 502	<p>Continued From page 114</p> <p>failed to ensure laboratory tests were completed as ordered by the physician for 2 (Residents #10 and #11) of 14 case mix residents with physician orders for laboratory services (Residents #1 through #14). The failed practice had the potential to affect all 110 residents, as documented on the Resident Census and Conditions of Residents form dated 9/10/07. The findings are:</p> <p>1. Resident #11 had diagnoses of Insulin-Dependent Diabetes Mellitus and Renal Failure.</p> <p>a. A physician order dated 8/10/07 documented: "Lab 8/13/07: Lipids, LFT [liver function test], A1C [Glycosylated hemoglobin], Urine micro-albumin, BMP [Basic Metabolic Panel]... CBC [Complete Blood Count]... PSA [Prostate Specific Antigen]... TSH [Thyroid Stimulating Hormone], B12, folate level, Vitamin D..."</p> <p>b. On 9/12/07 at 9:17 a.m., the Director of Nursing (DON) was asked if the labs ordered on 8/13/07 had been completed. The DON stated, "I can't find them; let me check."</p> <p>c. On 9/12/07 at 11:00 a.m., the DON stated all of the laboratory test results had been located, with the exception of the urine micro-albumin. The DON stated, "That was collected and sent to the lab - contaminated specimen. The lab says they called and notified a nurse, but couldn't tell us who they talked to."</p> <p>2. Resident #10 had diagnoses of Non-Insulin Dependent Diabetes Mellitus, Breast Cancer and Pleural Effusion.</p>	F 502			

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F 502	Continued From page 115 a. A physician order dated 8/22/07 documented: "...CBC [with] diff [differential], BMP, Vitamin D - 25 Hydroxy, TSH, Mag [Magnesium], Phos [Phosphorous], B12..." b. On 9/11/07 at 11:00 a.m., all of the above ordered laboratory results were located in the clinical record, with the exception of the BMP. c. On 9/12/07 at 9:17 a.m., the DON was asked if the BMP ordered on 8/22/07 had been completed. The DON stated, "I can't find them; let me check." d. On 9/12/07 at 11:00 a.m., the DON stated, "BMP was not done - it was not marked on the lab request." 3. On 9/12/07 at 11:00 a.m., the DON was asked to describe the facility's process to verify that physician-ordered laboratory services were provided. The DON stated, "When we get an order, the MDS [Minimum Data Set] Coordinator gets the pink copy and then pulls the labs off the computer against the requisition. I don't know what happened that we didn't catch it wasn't done." The MDS Coordinator was not present in the facility from 9/12/07 through 9/14/07, so was unavailable for interview.	F 502			