

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

PRINTED: 01/08/2009
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 12/19/2008
NAME OF PROVIDER OR SUPPLIER PARKVIEW REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 BARROW ROAD LITTLE ROCK, AR 72204	
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F 157 SS=D	<p>483.10(b)(11) NOTIFICATION OF CHANGES</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the physician was consulted immediately after a change in condition for 1 (Resident #12) of 6 case mix residents who had</p>	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 157	Continued From page 1 or were at risk for pressure ulcers (Residents #3, #4, #5, #10, #13 and #14). The failed practice had the potential to affect 18 residents who had pressure sores and 13 residents at risk for skin breakdown, as documented by the Administrator on 12/22/08. The findings are: Resident #12 had diagnoses of Diabetes Mellitus, Cerebrovascular Disease and Cerebrovascular Accident. The 30-day Medicare Minimum Data Set dated 10/28/08 documented the resident had short and long term memory problems, was moderately impaired in cognitive skills for daily decision making, required total assistance with activities of daily living and had history of a pressure ulcer that was resolved in the last 90 days. a. Skin/Feet Assessment Notes dated 7/9/08 documented the resident had a water blister on the left hip which required treatment and measured 1 by 1 centimeter. b. Nurse's Notes dated 12/2/08 at 7:00 a.m. documented: "Water Blisters on right, on left upper thighs ... 7:15 a.m. Left message on Voice Mail with physician, awaiting return call ... " Nurse's Notes dated 12/2/08 at 10:31 a.m., 2:15 p.m. and 4:57 p.m. and 12/3/08 at 5:50 a.m. did not document any further attempts to contact the resident's physician regarding the new skin breakdown. c. Nurse's Notes dated 12/3/08 at 9:26 a.m. documented the resident had an increased temperature and orders were received to transfer the resident to a local hospital for evaluation.	F 157			
F 273 SS=E	483.20(b)(2)(i) RESIDENT ASSESSMENT-WHEN REQUIRED	F 273			

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F 273	<p>Continued From page 2</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a comprehensive assessment was completed within 14 days after admission for 3 (Residents #14, #16 and #15) of 6 case mix residents (Residents #6, #10, #13, #14, #15 and #16) who were admitted to the facility in the last 3 months. The failed practice had the potential to affect 30 residents who were admitted to the facility in the last 3 months, as documented on a list provided by the Administrator on 12/18/08. The findings are:</p> <ol style="list-style-type: none"> 1. Resident #14 was admitted to the facility on 10/1/08 and had diagnoses of End Stage Renal Disease, History of Dehydration, Generalized Weakness, Sacral Decubitus and Diabetes Mellitus. <ol style="list-style-type: none"> a. Nurse's Notes documented the resident was admitted to a hospital between 10/15/08 and 11/12/08. b. On 12/15/08 at 1:38 p.m., Licensed Practical Nurse (LPN) #2 stated the resident received dialysis treatments 3 times per week on Mondays, Wednesdays and Fridays. A "Contact 	F 273			

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F 273	<p>Continued From page 3</p> <p>Precautions" sign was on the resident's room door and LPN #2 stated the resident had Vancomycin Resistant Enterococcus (VRE) in the urine. LPN #2 also stated the resident required total assistance with activities of daily living (ADL's), was incontinent of bowel, had an indwelling urinary catheter and a healing pressure sore on the coccyx.</p> <p>c. On 12/18/08 at 2:55 p.m., the initial Minimum Data Set (MDS) with an assessment reference date of 10/6/08 was reviewed. The following sections had not yet been completed:</p> <ol style="list-style-type: none"> 1) Section C. - Communication and Hearing 2) Section G. - Physical Functioning / Structural Problems 3) Section H. - Continence last 14 days 4) Section K. - Oral / Nutritional Status 5) Section L. - Oral / Dental Status 6) Section M. - Skin Condition 7) Section O. - Medications 8) Section P.2. - Interventions for mood, 3. - Nursing Rehabilitation, 4. - Devices and Physical Restraints and 5.-9. 9) Section Q. - Discharge Potential and Overall Status 10) Section R. - Assessment Information <p>d. On 12/18/08 at 3:03 p.m., Licensed Practical Nurse (LPN) #1, the facility's MDS Coordinator, was asked about the resident's incomplete MDS. She stated, "I got behind." LPN #1 also stated no Resident Assessment Protocol (RAP) Summary or RAP further assessments had been completed as yet.</p> <p>2. Resident #16 was admitted to the facility on 11/20/08 and had diagnoses of Cerebrovascular</p>	F 273			

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F 273	<p>Continued From page 4</p> <p>Accident, Hypertension, Diabetes Mellitus and Glaucoma.</p> <p>a. The Plan of Care dated 12/15/08 did not address the resident's diagnosis of Diabetes Mellitus, management of potential Diabetes Mellitus-related emergencies or routine Diabetic foot assessments and care.</p> <p>b. Nurse's Notes dated 12/5/08 documented: "Foot problem/care: Has 1 + [plus] foot problem - eg. [for example] corn, callous, bunion, hammer toe, overlapping toe, pain, structural problem. Called to resident room this a.m. [morning] to assess resident feet. She has long toenails that's thick and dark yellowish and curvy. Resident complain of that they doesn't bother her until she put on her shoes and they hurt. I informed resident I will called the podiatrist to see can she could come today and cut them. She voiced okay."</p> <p>c. The Admission MDS documented an assessment reference date of 12/18/08. No completion date was documented. The following sections of the MDS had not been completed as of 12/18/08:</p> <p>1) Section AA. - Identification Information: Birthdate, race/ethnicity, Social Security and Medicare information, reason for assessment and codes for assessments required for Medicare or the State.</p> <p>2) Section AB - Demographic Information (including the resident's date of entry, residential history, lifetime occupations, education, language and mental health history).</p> <p>3) Section AD - Face Sheet Signatures.</p> <p>4) Section D - Vision Patterns.</p>	F 273		

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F 273	<p>Continued From page 5</p> <p>5) Section G - Physical Functioning and Structural Problems. 6) Section H - Continence in last 14 days. 7) Section I - Disease Diagnosis. 8) Section J - Health Conditions. 9) Section K - Oral/nutrition status. 10) Section L - Oral/dental status. 11) Section M - Skin Condition. 12) Section N - Activity pursuit patterns. 13) Section O - Medications. 14) Section P - Special Treatments and Procedures. 15) Section R - Assessment information. 16) Section T - Therapy Supplement. 17) Section W - Supplemental MDS Items.</p> <p>3. Resident #15 was admitted to the facility on 11/25/08 and had diagnoses of Ogilvie Syndrome, Blindness, Benign Prostatic Hypertrophy, Glaucoma, Post Transurethral Resection, Renal Cyst Disease and Prostatectomy (11/18/08).</p> <p>The Admission MDS had an assessment reference date of 12/18/08, a period of 23 days after the resident was admitted to the facility. The following sections of the MDS had not yet been completed as of 12/18/08:</p> <p>1) Section AB - Demographic Information. 2) Section AD - Face Sheet Signatures. 3) Section A - Identification and Background Information. 4) Section C - Communication/hearing patterns. 5) Section D - Vision patterns. 6) Section G - Physical Functioning and Structural Problems. 7) Section H - Continence in last 14 days. 8) Section I - Disease Diagnosis.</p>	F 273			

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F 273	Continued From page 6 9) Section J - Health Conditions. 10) Section M - Skin Condition. 11) Section N - Activity Pursuit Patterns. 12) Section O - Medications. 13) Section P - Special Treatments and Procedures. 14) Section R - Assessment Information. 15) Section T - Therapy Supplement for Medicare. 16) Section W - Supplemental MDS Items (including influenza and pneumococcal vaccine information).	F 273			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280			

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F 280	<p>Continued From page 7</p> <p>Based on observation, record review and interview, the facility failed to ensure the Plan of Care addressed the following:</p> <p>a. Assessment and necessary care of subclavian Quinton dialysis catheters and emergency procedures for 2 of 2 (Residents #13 and #14) case mix residents who received dialysis treatments.</p> <p>b. Assessments and care of the lower extremities and feet for 6 (Residents #7, #8, #9, #11, #13 and #16) of 7 (Residents #7, #8, #9, #11, #12, #13 and #16) case mix residents who had a diagnosis of Diabetes Mellitus.</p> <p>c. Foot care for 3 (Residents #5, #10 and #14) of 8 (Residents #1, #5, #6, #7, #8, #9, #10 and #14) case mix residents who were dependent on staff for foot care.</p> <p>d. Isolation procedures for 1 (Resident #14) of 2 (Residents #12 and #14) case mix residents who had isolation precautions in effect.</p> <p>The failed practice had the potential to affect 6 residents who received dialysis treatments, 3 residents with subclavian Quinton Dialysis catheters and 31 residents diagnosed with Diabetes Mellitus, as documented by the Administrator on 12/19/08 and 30 residents who were dependent on staff for bathing, as documented on the Resident Census and Conditions of Residents form dated 12/17/08. The findings are:</p> <p>1. Resident #13 had diagnoses of Diabetes Mellitus, Deep Vein Thrombosis and Cerebrovascular Disease. The Admission</p>	F 280			

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F 280	<p>Continued From page 8</p> <p>Minimum Data Set (MDS) dated 6/18/08 documented the resident had modified independence in cognitive skills for daily decision making and had Diabetes Mellitus. Dialysis was not checked as a service the resident received.</p> <p>a. Nurses' Notes dated 11/14/08 at 7:59 p.m. documented: "Bleeding from central line. Applied pressure to site and another nurse called 911. Vital signs: B/P [blood pressure] 117/50, P [pulse] - 80, T [temperature] - 98.2, R [respirations] - 22. Physician notified, family notified..."</p> <p>b. As of 12/15/08, the Plan of Care dated 9/28/08 did not address dialysis or post-dialysis care and assessments and did not document the presence of a subclavian Dialysis catheter or any emergency care for potential complications related to the catheter. The Plan of Care also did not address the resident's Diabetic status or Diabetic foot care.</p> <p>c. As of 12/15/08, there was no documentation in the clinical record of routine lower extremity or foot assessments that included circulation, pedal hair growth, pigmentary changes, pedal skin texture, pedal skin color, temperature changes, edema, paresthesias, corns and calluses and nail changes.</p> <p>d. On 12/15/08 at 2:52 p.m., Licensed Practical Nurse (LPN) #1 stated the resident received dialysis treatments three times per week on Mondays, Wednesdays and Fridays.</p> <p>e. On 12/18/08 at 9:35 a.m., the resident had a subclavian catheter with a clear occlusive dressing on the left upper chest.</p>	F 280			

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F 280	<p>Continued From page 9</p> <p>f. On 12/18/08 at 4:26 p.m., there were no hemostats over the head of the resident's bed or in any visible area of the resident's room for use in the event of bleeding from the subclavian catheter.</p> <p>2. Resident #14 was admitted to the facility on 10/1/08 and had diagnoses of End Stage Renal Disease, History of Dehydration, Generalized Weakness, Sacral Decubitus and Diabetes Mellitus.</p> <p>a. On 12/15/08 at 1:38 p.m., Licensed Practical Nurse (LPN) #2 stated the resident received dialysis treatments 3 times per week on Mondays, Wednesdays and Fridays. A "Contact Precautions" sign was on the resident's room door and LPN #2 stated the resident had Vancomycin-Resistant Enterococcus (VRE) in the urine. LPN #2 also stated the resident required total assistance with activities of daily living (ADL's), was incontinent of bowel, had an indwelling urinary catheter and a healing pressure sore on the coccyx.</p> <p>b. On 12/18/08 at 9:28 a.m., the resident's left foot was observed. The great toe had approximately 1/16 inch of yellow build up under the nail, the second toenail on the left foot extended approximately 1/4 inch over the pad of the toe and the fifth toenail also had yellow buildup.</p> <p>c. On 12/18/08 at 4:39 p.m., the resident had a large-bore, Quinton subclavian Dialysis catheter in the right upper chest. The insertion site was covered with two, non-occlusive bandaids. There was not a sterile dressing over the insertion site. There was no hemostat visible on the wall above</p>	F 280			

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F 280	<p>Continued From page 10</p> <p>the resident's bed or on the nightstand by the resident's bed to clamp the catheter tubing if bleeding should occur. Certified Nursing Assistant (CNA) #5 was in the room and could not find a hemostat upon request.</p> <p>d. As of 12/18/08, the resident's Plan of Care dated 10/5/08 and updated 12/15/08 did not address isolation precautions, dialysis treatments, assessment and treatment of the right subclavian catheter, emergency procedures if bleeding from the subclavian catheter should occur or routine licensed nurse assessments of the lower extremities and Diabetic foot care.</p> <p>3. Resident #8 had a diagnosis of Diabetes Mellitus. The Annual Minimum Data Set (MDS) dated 11/11/08 documented the resident was severely impaired in cognitive skills for daily decision making and required total assistance with all ADL's. The section of the MDS designated for documentation of "nails/calluses trimmed during last 90 days" was not marked to indicate this was done.</p> <p>a. The Plan of Care dated 2/4/08 and 7/17/08 did not document problems or approaches for Diabetic foot care.</p> <p>b. Computerized clinical records documented by Nursing Assistants documented, "Nails cleaned." There was no documentation after 8/30/08 of the resident's fingernails or toenails being trimmed.</p> <p>c. On 12/18/08 at 9:24 a.m., Certified Nursing Assistant (CNA) #3 assisted in an audit of the resident's feet. All toes and skin of both upper feet were dried and cracked in appearance. The resident's toenails were long and had grown over</p>	F 280			

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F 280	Continued From page 11 the ends of the toes. 4. Resident #10 was admitted on 10/3/08 and had a diagnosis of Status Post-Total Hip Replacement. The Initial MDS dated 10/10/08 documented the resident was independent in cognitive skills for daily decision making, required limited assistance of one person for bathing and had no pressure sores. The section of the MDS designated for documentation of "nails/calluses trimmed during last 90 days" was not marked to indicate this was done. a. The Plan of Care dated 10/5/08 did not document problems or approaches to address lower extremity care other than treatment orders to a pressure sore on the right heel. b. Computerized "skin/feet assessments" dated 10/4/08 and 10/7/08 documented: "dry skin," in the section for, "skin problems." There was no further documentation of the skin integrity on the resident's lower extremities through 12/16/08 other than the status of the right heel pressure sore. c. On 12/17/08 at 11:17 a.m., Licensed Practical Nurse (LPN) #4 (the facility's Treatment Nurse) and LPN #2 were observed during the resident's pressure sore treatment. The skin of the resident's left foot was extremely dry and cracked. The toenails of the left foot were yellowed and thickened. LPN #4 completed the pressure sore treatment and stated, "I'm going to look at the other one [foot], make sure there's nothing. Just dry skin, I'll get you an order for some lotion." 5. Resident #5 had a diagnosis of Senile	F 280		

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F 280	<p>Continued From page 12</p> <p>Dementia. The Quarterly MDS dated 10/8/08 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistance for bathing and had nails trimmed in the last 90 days.</p> <p>a. The Plan of Care dated 2/4/08 and updated 6/6/08 did not document approaches to care for the resident's lower extremities/nails.</p> <p>b. On 12/17/08 at 11:30 a.m., Certified Nursing Assistants (CNA's) #1 and #2 completed incontinent care and positioned the resident on the left side. LPN #2 came into the room and stated the CNA's were to take the resident's boots off and look for any skin problems. A request was made to observe the resident's feet. The resident's left great toe was thickened with yellow buildup.</p> <p>6. Resident #16 had a diagnosis of Diabetes Mellitus. The Admission MDS dated 12/18/08 was incomplete and did not indicate the resident was Diabetic. Section M - Skin Condition was also not completed.</p> <p>a. The Plan of Care dated 12/15/08 did not address the resident's Diabetic status, management of potential Diabetic emergencies or routine assessments and care of the lower extremities.</p> <p>b. Nurse's Notes dated 12/5/08 documented: "Foot problem/care: Has 1 + [plus] foot problem - eg. [for example] corn, callous, bunion, hammer toe, overlapping toe, pain, structural problem. Called to resident room this a.m. [morning] to assess resident feet. She has long toenails that's thick and dark yellowish and curvy. Resident</p>	F 280			

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F 280	<p>Continued From page 13</p> <p>complain of that they doesn't bother her until she put on her shoes and they hurt. I informed resident I will called the podiatrist to see can she could come today and cut them. She voiced okay."</p> <p>c. A Podiatry Note dated 12/10/08 documented: "Hypertrophied toenails 1-5 both feet... Nail changes: thickened, discolored... assessment: nail disease (hypertrophy, etc.)... Plan: Debride nails in thickness & [and] length x [by] 6-10. No other assessment of the resident's lower extremities was documented.</p> <p>d. Nurse's Notes dated 12/16/08 documented: "Nails/calluses were trimmed during the last 90 days."</p> <p>e. A list of Diabetic residents received from the Administrator on 12/19/08 did not include Resident #16.</p> <p>7. Resident #11 had a diagnosis of Diabetes Mellitus. The Significant Change MDS dated 9/10/08 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent on staff for personal hygiene. Diabetes Mellitus was not checked as an active diagnosis.</p> <p>a. Skin and Feet Condition Nurse Notes dated 10/2/08, 10/9/08, 10/16/08, 10/23/09, 10/30/08, 12/04/08, 12/11/08 and 12/18/08 documented: "Foot problem/care: Received preventative or protective foot care ..." Circulation Nurse Notes dated 10/17/08 and 11/13/08 documented: "Foot problem/care: Has had no foot problems or care in past 7 days."</p>	F 280			

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F 280	<p>Continued From page 14</p> <p>b. On 12/16/08 at 12:20 p.m. and 12/17/08 at 10:05 a.m., the resident had ankle/foot/orthotic (AFO) boots on both feet.</p> <p>c. As of 12/16/08, the Plan of Care dated 8/19/08 did not address the resident's Diabetic status, care for potential Diabetic emergencies or routine Diabetic foot assessments and care.</p> <p>8. Resident #7 had diagnoses of Phlebitis and Thrombophlebitis of the Lower Extremities and Diabetes Mellitus. The Quarterly MDS dated 11/10/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance from staff for personal hygiene and had Diabetes Mellitus.</p> <p>a. Nurse's Notes dated 10/2/08, 10/9/08, 10/16/08, 10/23/08, 10/30/08, 11/13/08, 11/27/08 and 12/11/08 documented: "Has had no foot problems or care in past 7 days." There was no other documentation elsewhere in the clinical record to indicate that Diabetic foot assessments and care had been provided.</p> <p>b. On 12/18/08 at 8:35 a.m., the resident stated her son trimmed her nails.</p> <p>c. As of 12/18/08, the Plan of Care dated 7/28/08 documented: "Problem: potential for impairment of skin integrity related to diabetes... Goal: no new skin breakdown... assess skin condition weekly... keep clean and dry, assist with hygiene and general skin care..." The Plan of Care did not address care for potential Diabetic emergencies or routine Diabetic foot assessments and care.</p> <p>9. Resident #9 had a diagnosis of Diabetes</p>	F 280		

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F 280	<p>Continued From page 15</p> <p>Mellitus. The Annual MDS dated 9/23/08 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for personal hygiene and had Diabetes Mellitus.</p> <p>a. The Plan of Care dated 7/3/08 did not address Diabetic foot assessments or care.</p> <p>b. Nurse's Notes dated 10/20/08, 11/3/08, 11/10/08, 11/18/08, 12/1/08, 12/6/08 and 12/15/08 documented: "Has had no foot problems or care in past 7 days."</p> <p>10. On 12/18/08 at 4:30 p.m., Licensed Practical Nurse (LPN) #7, who was working on the 400 Hall, was asked about emergency care of a subclavian catheter. The LPN stated, "If the port was bleeding, apply pressure and call 911." When asked what she would do if the catheter clip or cap was open and she was unable to close it, the LPN stated, "Close with hemostats." When asked where she could find a hemostat for this purpose, the LPN stated she did not have one. She then checked the medication cart and did not locate a hemostat.</p> <p>11. On 12/18/08 at 4:41 p.m., LPN #3 was asked if there were hemostats in the medication room. LPN #3 stated, "No, I don't think so." LPN #3 opened the medication room door and searched the room. There were no hemostats in the medication room.</p> <p>12. On 12/18/08 at 4:40 p.m., LPN #6 was asked if there was a hemostat in her (South Hall) medication cart. She looked in the cart and stated, "No, usually have them over their beds."</p>	F 280			

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F 280	Continued From page 16 13. The facility's policy and procedure for, "Dialysis, Emergency Care Protocols," documented multiple possible complications of dialysis access shunts/subclavians as follows: "Bleeding at site ... if catheter pulled out ... cap is off but clamp is on ... cap is off and clamp is off: Turn resident to left side, Apply hemostat (Hemostat taped to head of bed and one kept in each med cart on each unit) ... Signs and symptoms of infection ... Dressing comes off ... sutures pulled loose ... edema in extremity of catheter." 14. The facility's policy and procedure for, "Foot Care," documented, "NOTE: The podiatrist or licensed nurse clip toe nails for all diabetic residents and residents with peripheral vascular disease per facility procedure."	F 280		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure routine assessments were documented and a sterile dressing was kept intact on a Subclavian Quinton dialysis catheter for 1 (Resident #14) of 2 (Residents #13 and #14) case mix residents with Subclavian dialysis catheters. The failed practice had the potential to affect 3 residents who	F 309		

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F 309	<p>Continued From page 17</p> <p>received dialysis through Subclavian Quinton catheters, as documented by the Administrator on 12/19/08. The findings are:</p> <p>Resident #14 was admitted to the facility on 10/1/08 and had diagnoses of End Stage Renal Disease, History of Dehydration, Generalized Weakness, Sacral Decubitus and Diabetes Mellitus. The Minimum Data Set (MDS) dated 12/18/08 documented the resident received dialysis, intravenous medications and transfusions in the past 14 days.</p> <p>a. The Care Plan dated 10/5/08 and updated 12/15/08 did not address dialysis treatments, assessment and treatment of a subclavian catheter or emergency procedures if bleeding from the subclavian catheter should occur.</p> <p>b. On 12/15/08 at 1:38 p.m., Licensed Practical Nurse (LPN) #2 stated the resident received dialysis treatments 3 times per week on Mondays, Wednesdays and Fridays.</p> <p>c. On Thursday, 12/18/08 at 4:39 p.m., the resident had a large-bore, Quinton Subclavian dialysis catheter in the right upper chest. The insertion site was covered with two, non-occlusive, non-sterile bandaids. There was not a sterile dressing over the subclavian insertion site. The insertion site was clean without redness or signs of infection. The resident stated, "The dialysis people" had placed the non-sterile bandaids over the insertion site. At 4:41 p.m., the Director of Nursing (DON) was informed of the non-sterile dressing over the subclavian insertion site.</p> <p>d. On 12/19/08 at 9:54 a.m., a review was made</p>	F 309			

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F 309	<p>Continued From page 18</p> <p>of the resident's computerized physician orders and Nurse's Notes and of the hard-copy clinical record. There was no documentation of licensed nursing assessments of the subclavian insertion site or dressing application to the subclavian catheter insertion site.</p> <p>e. On 12/19/08 at 10:03 a.m., the resident was out of the building for dialysis. LPN #9 stated she had placed a sterile dressing over the subclavian insertion site the previous evening. LPN #9 was asked if subclavian catheters required sterile dressings and she stated the facility's policy and procedure required sterile dressings, but the dialysis facility, "always sends the resident back with bandaids."</p> <p>f. On 12/18/08 at 5:45 p.m., the Administrator was asked to provide the policy and procedure for subclavian catheter dressings from the dialysis provider the resident attended each Monday, Wednesday and Friday. On 12/19/08 at 12:45 p.m., the Administrator provided a policy that documented it had been faxed from the dialysis unit earlier that day. The policy, "Catheter Care," documented: Purpose: To routinely observe the catheter site for signs and symptoms of infection ... Goal: To prevent bacterial infection of the catheter site ... Procedure: 1. Wash hands ... 2. Don PPE [personal protective equipment]. Face mask is required ... 4. Observe for swollen or reddened area, along with any drainage from point of entry. Document ... 5. Swab area with antiseptic skin cleanser, from the inside toward outer area in a circular motion. Change gloves after cleansing the site ... Apply sterile 2x2 [gauze] and secure with tape ... Change dressing at each treatment ... Document dressing change on patient's flowsheet. Document condition of the</p>	F 309			

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F 309	Continued From page 19 site."	F 309			
F 312 SS=D	<p>g. The facility's policy and procedure for, "Dialysis," documented: "The dressing is not to be removed unless wet or missing. Each dressing is changed at the end of each dialysis treatment by the dialysis center. If the dressing is missing or wet, it must be changed. The following procedure is to be followed - Clean with Betadine. (If patient is allergic to Betadine, use sterile normal Saline) - Redress with sterile 4x4 [gauze] and secure with tape."</p> <p>483.25(a)(3) ACTIVITIES OF DAILY LIVING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure fingernail care was provided to 1 (Resident #11) of 5 case mix residents (Residents #3, #7, #11, #15 and #16) who resided on the 300 Hall and were dependent on staff for nail care. The failed practice had the potential to affect 32 residents who resided on the 300 Hall and were dependent on staff for nail care, as documented on a list provided by the Administrator on 12/19/08. The findings are:</p> <p>Resident #11 had a diagnoses of Cerebrovascular Accident, Diabetes Mellitus and Aphasia. The Significant Change Minimum Data Set dated 9/10/08 documented the resident was</p>	F 312			

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F 312	Continued From page 20 moderately impaired in cognitive skills for daily decision making and totally dependent on staff for personal hygiene. a. The Plan of Care dated 8/28/08 documented: "Problem: self care deficit related to: muscular-skeletal impairment, perceptual/cognitive impairment, manifested by: decreased ADL [activities of daily living] participation... assist with grooming, assist with bathing..." b. On 12/17/08 at 10:05 a.m., the resident's fingernails were long and jagged and had a dark substance under them. c. On 12/18/08 at 8:12 a.m., the resident's fingernails remained long and jagged.	F 312			
F 314 SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure heels/ankles were off-loaded to prevent potential pressure ulcer development for 1 (Resident #5) of 6 case mix residents who had or were at risk for pressure ulcers (Residents #3, #4, #5, #10, #13	F 314			

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F 314	Continued From page 21 and #14). The facility also failed to ensure an air mattress and wedge were provided in accordance with the physician's plan of care to facilitate healing and prevent potential deterioration of an existing pressure ulcer for 1 (Resident #3) of 4 case mix residents with existing pressure ulcers (Residents #3, #5, #10 and #14). The failed practice had the potential to affect 13 residents who were at high risk of developing pressure ulcers, as documented on a list provided by the Administrator on 12/22/08 and 18 residents who had existing pressure ulcers, as documented on a list provided by the Administrator on 12/19/08. The findings are: 1. Resident #3 had diagnoses of Congestive Heart Failure and Stasis Ulcers to Lower Extremities. The Quarterly Minimum Data Set (MDS) dated 11/7/08 documented the resident was moderately impaired in cognitive skills for daily decision making, totally dependent on staff for bed mobility, had one Stage II pressure sore, had pressure relief devices for the bed and chair and was on a turning/repositioning program. a. A Wound Clinic physician order dated 12/8/08 documented: "...Sacrum new wound... Air mattress to bed... Frequent turning... Obtain wedge to keep turned..." b. On 12/16/08 at 1:30 p.m., 12/17/08 at 10:37 a.m. and 3:36 p.m. and 12/18/08 at 10:35 a.m., the resident was sitting in her room in a wheelchair. No air mattress or wedge was present on the bed as ordered. c. On 12/18/08 at 10:50 a.m., the resident had 3 areas in the coccyx/sacral area. Two were open areas and one area was closed with a scab. The	F 314			

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F 314	Continued From page 22 top area measured 1 centimeter (cm) by 0.3 cm. d. Nurse's Notes dated 12/18/08 documented: "New area to upper sacral area... Pressure Stg. [Stage] 2). 1 cm x [by] 0.3 cm x 0.1 cm..." e. On 12/17/08 at 4:55 p.m., Licensed Practical Nurse (LPN) #3 was asked why the air mattress and wedge were not provided as ordered. LPN #3 stated, "It was an oversight. The Treatment Nurse is the one who takes off the orders from the wound clinic." 2. Resident #5 had a diagnosis of Senile Dementia. The Quarterly MDS dated 10/8/08 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistance for bed mobility, toilet use and bathing, had one Stage IV pressure sore, had pressure relief devices for the chair and bed and was on a turning/repositioning program. a. The Care Plan dated 7/10/08 documented: " Impaired physical mobility ... Approaches ... use pillows for positioning, pad bony prominences ... Theraboots to leg/feet. There was no approach documented to address how pressure to the feet was to be relieved when the resident was positioned on her side in bed. b. On 12/15/08 at 2:19 p.m., 12/16/08 at 1:21 p.m. and 12/17/08 at 9:43 a.m. and 11:30 a.m., the resident was in bed on her left side with Theraboots on both feet. The resident's left foot was directly against the mattress without pressure relief provided.	F 314			
F 328 SS=E	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive	F 328			

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F 328	<p>Continued From page 23</p> <p>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 failed to ensure routine assessments of the lower extremities were conducted and diabetic foot care was provided for 4 (Residents #8, #5, #11, #13 and #16) of 7 (Residents #7, #8, #9, #11, #12, #13 and #16) case mix residents who had a diagnosis of Diabetes Mellitus and failed to ensure Podiatry consults or foot care by licensed nursing staff were provided for 3 (Residents #5, #10 and #14) of 8 (Residents #1, #5, #6, #7, #8, #9, #10 and #14) case mix residents who were dependent for foot care. The failed practice had the potential to affect 31 residents who had a diagnosis of Diabetes Mellitus, as documented by the Administrator on 12/19/08 and 30 residents who were dependent for bathing, as documented on the Resident Census and Conditions of Residents form dated 12/17/08. The findings are:</p> <p>1. Resident #8 had a diagnosis of Diabetes Mellitus. The Annual Minimum Data Set (MDS) dated 11/11/08 documented the resident was severely impaired in cognitive skills for daily decision making and required total assistance for</p>	F 328			

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F 328	<p>Continued From page 24</p> <p>all activities of daily living (ADL's). Section M.6. - "Foot problems and care" was not marked for "nails/calluses trimmed during last 90 days."</p> <p>a. The Care Plan dated 2/4/08 and updated 7/17/08 did not address Diabetic foot care.</p> <p>b. The December 2008 Physician's Order sheets documented an order for podiatry consults, "PRN [as needed]."</p> <p>c. Computerized clinical records dated 7/1/08 to 12/1/08 by Nursing Assistants for this resident documented: "nails cleaned" with baths. There was no documentation after 8/30/08 of the resident's fingernails or toenails being trimmed.</p> <p>d. On 12/18/08 at 9:24 a.m., Certified Nursing Assistant (CNA) #3 assisted in an audit of the resident's feet. All toes and skin of both upper feet were dried and cracked in appearance. The resident's toenails were long and had grown over the pads of the toes.</p> <p>e. On 12/18/08 at 10:53 a.m., Licensed Practical Nurse (LPN) #2 was asked for this resident's Treatment Administration Record (TAR). The LPN stated the resident did not have one.</p> <p>f. As of 12/18/08, there was no documentation in the resident's clinical record of podiatry visits.</p> <p>g. On 12/18/08 at 9:45 a.m., LPN #2 was asked to provide evidence the resident had been seen by a podiatrist. As of 12/19/08 at 1:10 p.m., the facility had not provided that information.</p> <p>2. Resident #10 was admitted on 10/3/08 and had a diagnosis of Status Post-Total Hip</p>	F 328			

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F 328	<p>Continued From page 25</p> <p>Replacement. The Initial MDS dated 10/10/08 documented the resident was independent in cognitive skills for daily decision making, required limited assistance of one person for bathing and had no pressure sores. Section M.6. - "Foot problems and care" was not marked for "nails/calluses trimmed during last 90 days."</p> <p>a. The Care Plan dated 10/5/08 did not address lower extremity care, other than treatment orders to a pressure sore on the right heel.</p> <p>b. Computerized records for "skin/feet assessments" dated 10/4/08 and 10/7/08 by licensed nursing staff documented, "dry skin," in the section for, "skin problems." There was no further documentation of the skin integrity of the resident's lower extremities through 12/16/08, other than references to the status of the right heel pressure sore.</p> <p>c. The October, November and December 2008 Treatment Administration Records did not document physician orders for treatment of dry skin for this resident. The December 2008 TAR did document daily treatment orders for the right heel pressure sore.</p> <p>d. On 12/17/08 at 11:17 a.m., LPN #4 (the facility's Treatment Nurse) and LPN #2 were observed during the resident's pressure sore treatment. The skin of the resident's left foot was extremely dry and cracked. The toenails of the left foot were yellowed and thickened. LPN #4 completed the pressure sore treatment and stated, "I'm going to look at the other one [foot], make sure there's nothing. Just dry skin, I'll get you an order for some lotion."</p>	F 328			

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F 328	<p>Continued From page 26</p> <p>3. Resident #5 had a diagnosis of Senile Dementia. The Quarterly MDS dated 10/8/08 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistance for bathing and had nails trimmed in the last 90 days.</p> <p>a. The Care Plan dated 2/4/08 and updated 6/6/08 did not address care of the resident's lower extremities.</p> <p>b. The December 2008 Physician's Order sheets documented an order for podiatry consults, "PRN."</p> <p>c. On 12/17/08 at 11:30 a.m., Certified Nursing Assistants (CNA's) #1 and #2 completed incontinent care and positioned the resident on the left side. LPN #2 came into the room at that time. The resident wore Theraboots on both lower extremities and the CNA's were asked if the boots were ever taken off. LPN #2 stated the CNA's were to take the boots off and look for any skin problems. A request was made to observe the resident's feet. The resident's left great toe was thickened with yellow buildup.</p> <p>d. As of 12/18/08, there was no documentation in the resident's clinical record of podiatry visits.</p> <p>e. On 12/18/08 at 9:45 a.m., LPN #2 was asked to provide evidence the resident had been seen by a podiatrist. As of 12/19/08 at 1:10 p.m., the facility had not provided that information.</p> <p>4. Resident #14 was admitted on 10/1/08 and had diagnoses of End Stage Renal Disease, History of Dehydration, Generalized Weakness, Sacral Decubitus and Diabetes Mellitus. The</p>	F 328			

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F 328	<p>Continued From page 27</p> <p>Initial MDS with an assessment reference date of 10/6/08 had not been completed as of 12/18/08. The sections for assessments of skin condition and foot care were blank.</p> <p>a. The Care Plan dated 10/5/08 and updated 12/15/08 did not address assessments of the lower extremities or Diabetic foot care.</p> <p>b. The November and December 2008 TAR's did not include routine nursing assessments of the lower extremities or Diabetic foot care for this resident.</p> <p>c. On 12/15/08 at 1:38 p.m., LPN #2 stated the resident received dialysis treatments 3 times per week on Mondays, Wednesdays and Fridays and required total assistance with ADL's.</p> <p>d. On 12/18/08 at 9:28 a.m., the resident's left foot was observed. The great toe had approximately 1/16 inch yellow build up under the nail, the 2nd toenail on the left foot extended approximately 1/4 inch over the pad of the toe and the 5th toenail also had yellow buildup.</p> <p>e. On 12/18/08 at 9:45 a.m., LPN #2 was asked to provide evidence the resident had been seen by a podiatrist. As of 12/19/08 at 1:10 p.m., the facility had not provided that information.</p> <p>5. Resident #11 had a diagnosis of Diabetes Mellitus. The Significant Change MDS dated 9/10/08 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent on staff for personal hygiene and bathing. Diabetes Mellitus was not checked as an active diagnosis.</p>	F 328			

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F 328	<p>Continued From page 28</p> <p>a. The Care Plan dated 8/19/08 did not address routine Diabetic foot assessments or care.</p> <p>b. Nurse's Notes dated 10/2/08, 10/9/08, 10/16/08, 10/23/09, 10/30/08, 12/04/08, 12/11/08 and 12/18/08 documented: "Foot problem/care: Received preventative or protective foot care ..."</p> <p>c. Nurse's Notes dated 10/17/08 and 11/13/08 documented: "Foot problem/care: Has had no foot problems or care in past 7 days."</p> <p>d. As of 12/18/08, there was no documentation in the clinical record of routine foot assessments that included circulation, pedal hair growth, pigmentary changes, pedal skin texture, pedal skin color, temperature changes, edema, paresthesias, corns and calluses and nail changes. There was no documentation that the resident had been seen by a podiatrist.</p> <p>6. Resident #13 had a diagnosis of Diabetes Mellitus. The Admission Minimum Data Set (MDS) dated 6/18/08 documented the resident had modified independence in cognitive skills for daily decision making, had Diabetes Mellitus and required extensive assistance with personal hygiene and bathing.</p> <p>a. The Plan of Care dated 9/29/08 did not address assessments and care for a Diabetic resident.</p> <p>b. As of 12/18/08, there was no documentation in the clinical record of routine lower extremity/foot assessments to include circulation, pedal hair growth, pigmentary changes, pedal skin texture, pedal skin color, temperature changes, edema, paresthesias, corns and calluses and nail</p>	F 328			

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F 328	<p>Continued From page 29</p> <p>changes. There was no documentation that the resident had been seen by a podiatrist.</p> <p>7. On 12/18/08 at 8:15 a.m., LPN #3 stated, "The Podiatrist comes out once a month. We don't cut the Diabetics' nails. The CNA's let us know who needs their toenails cut and we put them on the list."</p> <p>8. On 12/18/08 at 9:45 a.m., LPN #2 stated the Podiatrist came to the facility monthly, but did not come in November 2008 because, "She [Podiatrist] was on vacation."</p> <p>9. On 12/19/08 at 10:58 a.m., LPN #3 provided a list of residents that had been faxed to the Podiatrist to inform her of which residents needed a Podiatry visit that month. Residents #11 and #12 were the only case mix residents included on the list.</p> <p>10. On 12/18/08 at 9:45 a.m., LPN #2 was asked to provide evidence of Podiatry consults for Residents #5, #8, #10 and #14. As of 12/19/08 at 1:10 p.m., the facility had not provided the requested information.</p> <p>11. On 12/22/08 at 2:59 p.m., the Administrator provided a faxed letter from the Podiatrist's office which documented, "This is in reference to the following patient: [Resident #5], [Resident #10], [Resident #8] and [Resident #14]. These patients were not seen by [Podiatrist] at your facility. There is no record of services rendered."</p> <p>12. The facility's policy and procedure for, "Foot Care" was provided by the Administrator on 12/18/08 at 3:50 p.m. and documented: "NOTE: The podiatrist or licensed nurse clip toe nails for</p>	F 328			

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F 328	Continued From page 30 all diabetic residents and residents with peripheral vascular disease per facility procedure." 13. The facility's "Bath, Bed" policy and procedure documented: "...Care of fingernails and toenails is part of the bath. Be certain nails are clean. If toenails are difficult to cut, inform the charge nurse ... Fingernails and toenails of diabetic residents are cut by the licensed nurse or podiatrist."	F 328		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431		

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F 431	Continued From page 31 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure medications were stored in accordance with the manufacturer ' s recommendations. The failed practice had the potential to affect 13 residents who resided on the South Hall who required Novolin N, Novolin R or Novolin 70/30 and 1 resident who resided on the 400 Hall and required Albuterol Sulfate Inhalation Solution, as identified by the Administrator on 12/19/08. The findings are: 1. On 12/18/08 at 2:00 p.m., the South Station Medication Room was inspected. Five vials of Novolin N, five vials of Novolin R and a vial of Novolin 70/30 were all stored at room temperature. The package inserts documented: "Insulin should be stored in a cold place (36 - 46 F [Fahrenheit]) ... preferably in a refrigerator, but not in the freezing compartment." 2. On 12/18/08 at 2:30 p.m., the 400 Hall medication cart contained 18 vials of Albuterol Sulfate Inhalation Solution 0.083% which were not stored in their foil pouch. The package insert documented: "Protect from light. Return in foil pouch until time of use. "	F 431			
F 514 SS=B	483.75(I)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional	F 514			

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F 514	<p>Continued From page 32</p> <p>standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure clinical records were complete for 2 of 2 (Residents #13 and #14) case mix residents who received dialysis 3 times per week, 2 of 2 (Residents #12 and #14) case mix residents who had isolation precautions in place and 1 of 1 (Resident #18) case mix resident who expired in the facility. The failed practice had the potential to affect 5 residents who had isolation precautions in place and 6 residents who received dialysis treatments outside the facility, as documented by the Administrator on 12/19/08 and 13 residents who expired in the facility in the last 3 months, as documented by the Administrator on 12/15/08. The findings are:</p> <p>1. Resident #14 was admitted to the facility on 10/1/08 and had diagnoses of End Stage Renal Disease and Diabetes Mellitus. The Initial Minimum Data Set (MDS) dated 10/6/08 documented the resident had modified independence in cognitive skills for daily decision making and received dialysis services.</p>	F 514		

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F 514	<p>Continued From page 33</p> <p>a. On 12/15/08 at 1:38 p.m., Licensed Practical Nurse (LPN) #2 stated the resident received dialysis treatments 3 times per week on Mondays, Wednesdays and Fridays. A "Contact Precautions" sign was on the resident's room door and LPN #2 stated the resident had Vancomycin Resistant Enterococcus (VRE) in the urine.</p> <p>b. As of 12/19/08 at 9:54 a.m., there were no physician orders for the resident to receive dialysis treatments or to maintain contact isolation precautions.</p> <p>2. Resident #12 had diagnoses of Diabetes Mellitus and Hypertension. The Minimum Data Set dated 10/28/08 documented the resident was moderately impaired in cognitive skills for daily decision making and had a Urinary Tract Infection in the last 30 days.</p> <p>a. On 12/15/08 at 2:46 p.m., LPN #2 stated Resident #12 had recently been admitted to the hospital after an increased temperature and had not yet returned to the facility.</p> <p>b. A hospital Transfer form dated 12/17/08 documented: "MRSA + [positive] in nares."</p> <p>c. On 12/18/08 at 9:36 a.m., the resident was in bed. A "Contact Precautions" sign was on the door to the resident's room. LPN #2 was asked why the isolation precautions were in place and she stated she thought, "MRSA [Methicillin Resistant Staphylococcus Aureus] in blood."</p> <p>d. As of 12/18/08, the Readmission Physician Order sheets dated 12/17/08 did not document physician orders for Contact Isolation</p>	F 514		

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F 514	<p>Continued From page 34 precautions.</p> <p>3. Resident #18 had diagnoses of Spastic Hemiplegia and Coagulation Defect.</p> <p>Nurses Notes dated 10/10/08 documented the resident expired in the facility and that the resident's body was released to the funeral home. There was no documentation of a physician order to release the body from the facility.</p> <p>4. Resident #13 had diagnoses of Diabetes Mellitus, Deep Vein Thrombosis and Cerebrovascular Disease. The Admission Minimum Data Set dated 6/18/08 documented the resident had Diabetes Mellitus. Dialysis was not checked as a service the resident was receiving.</p> <p>a. On 12/15/08 at 2:52 p.m., Licensed Practical Nurse (LPN) #1 stated, the resident received dialysis three times a week on Mondays, Wednesdays and Fridays.</p> <p>b. As of 12/15/08, there was no physician order or plan of care for renal dialysis.</p>	F 514			