

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

PRINTED: 02/26/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045181</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/13/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRESCOTT MANOR NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 MANOR DRIVE</b> <b>PRESCOTT, AR 71857</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 221 SS=E	<p>Complaint #14245 was unsubstantiated.</p> <p>483.13(a) PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure alternative measures were attempted prior to the use of physical restraints, restraint-reduction attempts were made and assessments for appropriateness of restraints applied were conducted for 7 (Residents #3, #5, #6, #7, #9, #12 and #14) of 10 (Residents #3, #4, #5, #6, #7, #9, #12, #13, #14, and #15) case mix residents with orders for restraints. This failed practice had the potential to affect 24 residents in the facility with physical restraints, according to the Administrator on 2/12/09. The findings are:</p> <p>1. A Policy and Procedure provided by the Administrator on 2/12/09 documented: "Restraints, use and reduction. Purpose: Restraints may be used to prevent injury to resident related to falls, behavior, and medical symptoms that require restraints at the lowest level possible.</p> <p>Procedure: Documentation of assessment should reflect the following based on resident condition, cognition, mobility, history of falls, possible harm to self and others, medical symptoms that require use of restraint, risk of decline in</p>	F 221		

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 221	<p>Continued From page 1</p> <p>function/measures to minimize decline, least restrictive restraint, restraint reduction efforts/status. Pre restraining assessment will be completed prior to application. Restraint reduction assessment will be done quarterly and prn [as needed] to ensure least and most effective restraint is in use and status of resident. Care plan will be initiated."</p> <p>2. A manufacturer's instructions for a Pelvic Holder documented "Indications. The Skil-Care Holder is recommended for use with a patient who: slides down in the wheelchair. Requires restraint while in the wheelchair. Contraindications for use - Do not use this device with a patient who: Has a history of easily removing restraints, requires posture support while seated in the wheelchair, is in bed, geri-chair, or lounge chair. This device is intended for wheelchair use only..."</p> <p>3. Resident #12 had a diagnosis of Alzheimer's Dementia with Behaviors. The Minimum Data Set (MDS) dated 12/19/08 documented the resident was severely impaired in cognitive skills for daily decision making, required supervision with walking and locomotion, balance while standing was unsteady, but able to re-balance self without physical help and devices and had no restraints.</p> <p>a. A Nurse's Note dated 1/18/09 at 1:00 p.m. documented: "Amb. [ambulatory] ad lib [as desired] more balanced [with] walking. w/c [wheelchair] used when res [resident] becomes more into going into other res rms. [rooms]."</p> <p>b. A Physician telephone order dated 1/23/09 documented: "Pelvic restraint on while in w/c</p>	F 221			

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F 221	<p>Continued From page 2</p> <p>[wheelchair]. Release q [every] 2 [hours] x [times] 10 min [minutes] for ROM [Range of Motion], Incont. [incontinence] care &amp; [and] repos. [repositioning]."</p> <p>c. A "Physical Restraint/Alarm Consent" dated 1/23/09 documented: "...Order: Pelvic Restraint while up in w/c ...I understand the reason(s) for this restraint/alarm are: 1) safety..." There was no pre-restraint assessment in the clinical record for the pelvic restraint. There was no documentation on the resident's care plan dated 12/19/08 for the use of the restraint.</p> <p>d. The Nurses' Notes dated 1/25/09, 1/28/09, 1/29/09, 2/5/09, 2/8/09, 2/9/09, 2/10/09 and 2/11/09 documented that the resident would stand up in the wheelchair with the restraint on and that it was used for safety. A Nurse's Note dated 2/5/09 documented: "amb. ad lib [at] times..."</p> <p>e. On 2/11/09 at 2:53 p.m. and on 2/12/09 at 8:45 a.m. and 11:15 a.m., the resident was up in a wheelchair with a pelvic restraint on.</p> <p>4. Resident #6 had a diagnosis of Alzheimer's Dementia. The MDS dated 1/5/09 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive assistance with walking and a chair that prevented rising was used on a daily.</p> <p>a. A Physician order dated 12/22/08 documented: "...May be up in geri-recliner."</p> <p>b. The Physician's Orders for the month of February 2009 documented: "...Restraint. Geri chair when OOB [out of bed] check q [every] 30</p>	F 221			

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F 221	<p>Continued From page 3</p> <p>min [minute] release q 2 hrs. [hour]; to enhance socialization, maintain skeletal alignment and to promote comfort..."</p> <p>c. The Pre-Restraint Assessment dated 1/5/09 documented: "Medical Symptom(s) warranting use of restraint: [decreased] mobility, unsteady gait - cognition. Probable causes for Medical Symptoms: Psychoactive medications, Cognitive Loss/Dementia ...How will the restraint device improve the resident's ability to function? Will assist [with] mobility [and] socialization ...What alternatives to physical restraints have been tried? [Nothing was documented] ...Recommendation: Date 010509 [1/5/09] ...Reason; New admit - geri chair used [at] hosp [hospital] and previous NH [nursing home]..."</p> <p>d. The Physical Restraint Reduction Assessment dated 1/5/09 documented: "...Interdisciplinary Team Assessment Indicates: Candidate for restraint reduction or elimination: [no]. If "No", indicate specific reason: [no] personal safety values..."</p> <p>e. The resident's Plan of Care dated 1/5/09 did not document the use of a Geri-chair.</p> <p>f. On 2/9/09 at 1:02 p.m. and 5:35 p.m., the resident was in a Geri-chair with a tray.</p> <p>g. On 2/10/09 at 8:45 a.m., 11:55 a.m., 12:25 p.m. and 2:40 p.m., the resident was sitting in a Geri-chair with a tray.</p> <p>h. On 2/10/09 at 12:30 p.m., Licensed Practical Nurse (LPN) #3 stated that the resident would attempt to walk without assistance when in a wheelchair, so he was placed in a Geri-chair with</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>tray. She stated that she thought it was safer for him to be in the Geri-chair.</p> <p>i. A Nurse's Note dated 2/10/09 7A/7P (7:00 a.m. to 7:00 p.m.) documented: "...In geri chair and supported by CNA [Certified Nursing Assistant] to bear weight. Transfer per CNA from Geri-chair to bed and from bed to Geri-chair per safety- have been noted to get out of chair to attempt ambulation unsupported[,] this type behavior is redirected..."</p> <p>5. Resident #9 had diagnoses of Schizophrenia, Epilepsy, Psychosis, and Agitation Behavior. The Significant Change MDS dated 1/14/09 documented the resident was severely impaired in cognitive skills for daily decision making, did not walk in the room or hall in the last 7 days, was dependent on staff for locomotion and used bed rails and a trunk restraint daily.</p> <p>a. A Physical Restraint/Alarm Consent dated 1/16/07 documented: "...Order; Pelvic Restraint, I understand the reason(s) for this restraint/alarm are: To prevent falling while up in w/c."</p> <p>b. The Physical Restraint Reduction Assessment dated 10/14/08 documented: "Team assessment for restraint reduction or elimination, [No], If "No," Indicate Specific reason: [no] personal safety values."</p> <p>c. The Pre-restraining Assessment dated 1/14/09 documented: "Medical Symptoms warranting the use of restraint: Cognition, Safety Awareness. Probable causes for Medical Symptoms: Psychoactive Medications and Cognitive Loss/Dementia..."</p>	F 221			

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F 221	<p>Continued From page 5</p> <p>d. A Overall Plan of Care dated 1/14/09 documented, "Problem: At risk for falls secondary to unsteady gait and lower limb weakness, has had recent falls by bending over and/or attempting to transfer self while in un-locked wheel chair. Goal; will apply pelvic restraint to reduce the risk of falls the next 90 days."</p> <p>e. On 2/9/09 at 1:05 p.m. and 4:55 p.m., the resident was in her room in a wheelchair with a pelvic restraint in place.</p> <p>f. On 2/10/09 at 11:50 a.m., the resident was in a wheelchair with a pelvic restraint in place, being pushed to the dining room.</p> <p>6. Resident #14 had diagnoses of Senile Dementia and Alzheimer's Disease. The Annual MDS dated 1/4/09 documented the resident was severely impaired in cognitive skills for daily decision-making, required extensive assistance with ambulation and supervision with locomotion and used a trunk restraint daily.</p> <p>a. The Physical Restraint/Alarm Consent dated 1/11/07 documented: "...Order Pelvic Restraint; Date 1/11/07 I understand the reason(s) for this restraint/alarm are: 1) while up to wheelchair to prevent injury..."</p> <p>b. The Physician Order Sheet for February 2009 documented: "...Restraint: Pelvic Restraint - May use while up in w/c due to unsteady gait and to prevent injury; Check q 30 min and release q 2 hr for ROM [range of motion]..."</p> <p>c. The Pre-Restraint Assessment dated 1/4/09 documented: "Medical Symptoms warranting use of restraint: Dementia, Psychosis, Paranoid</p>	F 221			

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F 221	Continued From page 6 Delusion, Alzheimer's. Probable causes for Medical Symptoms: Psychoactive Medications, Cognitive Loss/Dementia ...Recommendation: Date 1/04/09 ...Reason Mobility/Safety..."  d. The Physical Restraint Reduction Assessment dated 1/4/09 documented: "Interdisciplinary Team Assessment Indicates: Candidate for Restraint reduction or elimination: [no]. If "No", Indicate Specific reason: [no] personal safety values..."  e. The Plan of Care dated 1/04/09 documented: "Need for Restraints, Resident will be restrained in a fashion that will provide him/her physical safety with Dr. [Doctor] order over the next 90 days ...Pelvic Restraint while up in w/c. "  f. On 2/9/09 at 11:00 a.m., on 2/11/09 at 3:00 p.m. and on 2/12/09 at 7:45 a.m., the resident was observed in a wheelchair with a pelvic restraint on.  g. On 2/12/09 at 10:15 a.m., CNA #3 stated that the resident had a pelvic restraint because she would try to get up and walk by herself.  7. Resident #3 had diagnoses of Alzheimer's Disease and Cerebrovascular Accident. The MDS dated 9/15/08 documented the resident had a short/long-term memory problems, was severely impaired in cognitive skills for daily decision making, required total assistance for activities of daily living with total assistance of two staff persons for bed mobility and had full bed rails on all open sides of bed.  a. The Physical Restraint/Alarm Consent dated 4/25/07 documented: "...Date 4/25/07 I	F 221		

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F 221	Continued From page 7 understand the reason (s) for this restraint/alarm are : ...1) for safety 2) Less restrictive measures attempted prior to restraint request: [blank]..."  b. The Plan of Care dated 3/17/08 and updated 12/17/08 documented: "Potential for falls related to poor physical health and unaware of safety related to cognitive status ...Goal #4 Side rails up for safety..."  c. On 2/9/09 at 5:30 p.m., the resident's side rails were in the up position.  d. On 2/10/09 at 8:10 a.m., the resident was in bed with the siderails in the up position.  8. Resident #5 had diagnoses of Alzheimer's with Behaviors and Presenile Dementia. The MDS dated 11/22/08 documented the resident had short/long-term memory problems, was severely impaired in cognitive skills for daily decision making, had repetitive physical movements as indicators of depression, anxiety and mood, was totally dependant on staff for activities of daily living, was not able to attempt a test for balance while standing without physical help, had functional limitations in range of motion of a hand, a wrist and the fingers and had a trunk restraint daily.  a. The Physical Restraint/Alarm Consent dated 4/30/08 documented: "...Order: Geri-Chair [with] tray for eating only. I understand the reason(s) for this restraint/alarm are: 1. to enable proper swallowing..." There was no documentation in the resident's clinical record where a pre-restraining assessment was done prior to placing the resident in the Geri-Chair.	F 221			

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F 221	Continued From page 8 b. On 2/9/09 at 10:44 a.m., 1:05 p.m., 4:20 p.m. and 5:35 p.m., the resident was up in a Geri-chair with a tray. c. On 2/10/09 at 8:30 a.m. and 11:25 a.m., the resident was up in a Geri-chair with a tray. 9. Resident #7 had diagnoses of Cerebrovascular Accident, Osteoarthritis, Extrapramidal Disorder, Glaucoma and Paranoid Schizophrenia. The MDS dated 1/9/09 documented the resident had a short/long-term memory problems, was moderately impaired in cognitive skills for daily decision making, was dependent on staff for bed mobility and had full bed rails on all open sides of the bed daily. a. Physical Restraint/Alarm Consent form dated 4/22/05 documented: "...Less restrictive measures attempted prior to restraint request: [blank]." b. The Nurse's Notes dated 1/22/09, 1/23/09 and 1/27/09 documented the resident had side rails up for safety. c. On 2/9/09 at 4:15 p.m. and 5:40 p.m., the resident was in bed with the side rails up. d. On 2/10/09 at 8:15 a.m., 2:05 p.m. and 3:55 p.m., the resident was in bed with the side rails up.	F 221		
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282	Continued From page 9  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure physical restraint orders for eating and therapy recommendations were followed for 1 of 1 (Resident #5) case mix resident who had an order for a Geri-chair when eating and physician orders for thickened liquids were followed for 2 of 2 (Residents #5 and #9) case mix residents with orders for thickened liquids. This failed practice had the potential to affect 1 resident in the facility with a physical restraint order of a Geri-chair and 3 residents in the facility on thickened liquids, according to the Administrator on 2/12/09. The findings are:  1. Resident #5 had diagnoses of Aphasia, Presenile Dementia and Aspiration Pneumonia. The Quarterly Minimum Data Set (MDS) dated 11/22/08 documented the resident had short/long-term memory problems, was severely impaired in cognitive skills for daily decision making, was totally dependant on staff for activities of daily living, had a swallowing problem, had a trunk restraint daily and did not utilize a chair that prevented rising.  a. A physician's order dated 11/26/07 documented the resident was to receive a pureed diet with nectar liquids.  1) A Physical Restraint/Alarm Consent form dated 10/2/08 documented an order for "Geri-chair with tray for eating only ...to enable proper swallowing."	F 282			

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F 282	<p>Continued From page 10</p> <p>2) On 2/11/09 at 2:15 p.m., Certified Nurse Assistant (CNA) #1 and CNA #2 passed out 2:00 p.m. snacks. The resident was served thickened health shake from a cup. With the resident was lying on a low bed, the CNAs got on their knees, raised the resident's head and gave approximately 1/2 of the thickened health shake to the resident while she continued lying flat on the low bed. The resident's head was laid back on the low bed, with no elevated support. The resident then started to cough.</p> <p>When asked how they usually fed liquids to the resident, CNA #1 stated "She's supposed to be up in the Geri-chair." The CNA then repositioned a pillow underneath the resident's head and left her lying on the low bed.</p> <p>3) On 2/11/09 at 2:43 p.m., the resident remained flat in bed with the pillow underneath her head. The resident was still coughing, with the remaining health shake left on her night stand.</p> <p>b. The Plan of treatment for rehabilitation dated 10/24/08 documented: "...reason for referral/need for skilled therapy services: Pt. [patient] is referred for positioning. Pt. currently in Geri-Chair. Rehab [rehabilitation] screening of pt. reflects need for positioning... Functional goals: Pt. will tolerate upright posture in w/c [wheelchair] through appropriate w/c accessories 100 % of the time. Start status: Pt. up in Geri-chair leaning to left side, and forward and trying to scoot forward at times."</p> <p>1) The Daily record of Treatment Progress dated 10/27/08 documented: "...Progress toward goals R [resident] sliding in gerichair repositioned,</p>	F 282			

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F 282	<p>Continued From page 11</p> <p>discuss with maintenance and staff need for tilt back wheel chair... 10/28/08... Progress toward goals: R seen for wheelchair management, discussed with maintenance need to order wheelchair and lateral support... 10/29/08... Progress toward goals: ...discussed with [name] LPN wheelchair... order submitted to administrator for wheelchair..."</p> <p>2) On 2/11/09 at 3:30 p.m., the Director of Nursing stated she did not know if the wheelchair tilt back with lateral supports was ordered. The Administrator stated she did not remember anything about a wheelchair.</p> <p>2. Resident #9 had diagnoses of Schizophrenia, Agitation Behavior and Dysphagia. The Significant Change Minimum Data Set dated 1/14/09 documented the resident was severely impaired in cognitive skills for daily decision making, was totally dependent on the physical assistance of one person for eating, had chewing problems and</p> <p>a. A Nutritional Screening and Assessment dated 6/6/07 documented, Swallowing Difficulty: Food: yes, Fluid: yes. Diet Order: Pureed Nectar Thickened Liquids.</p> <p>b. The Overall Plan of Care updated 1/14/09 documented: "Problem: at risk for falls secondary to unsteady gait. Approaches: Keep fresh water in reach to prevent reaching long distances. Problem; Nutritional Status; chewing problem/mechanical altered diet. Approaches: Serve diet as ordered, monitor for chewing/swallowing problems."</p> <p>c. A February 2009 Physician Order Sheet</p>	F 282			

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

PRINTED: 02/26/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045181</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/13/2009</b>
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F 282	Continued From page 12 documented: "Diet: Pureed diet with Nectar Thickened liquids."  d. On 2/9/09 at 11:02 a.m., a sign above the resident's bed documented: "Nectar Thickened Liquids only." A mug of regular, water with the resident's name on it, was on the bedside table.  3. A Policy and Procedure on Thicken Liquids, received from the Administrator on 2/12/09 at 2:40 p.m., documented: "Purpose; To provide thickened liquids to aid in the prevention of aspiration and provide hydration safely. Procedure; ...5. The appropriate consistency will be determined by the speech therapist and the physician. ...8. The resident receiving thickened liquids will be identified by a picture of honey bee place at the head of the bed..."	F 282		
F 314 SS=D	483.25(c) PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure a wound treatment was performed using aseptic technique and a pressure relieving device was in use in a wheelchair to promote healing for 1 (Resident #4) of 3 (Residents #2, #3 and #4) case mix residents	F 314		

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F 314	Continued From page 13 with pressure sores. This failed practice had the potential to affect 3 residents in the facility with pressure sores, according to the Administrator on 2/12/09. The findings are:  1. A Policy and Procedure documented: "Dressing Change (Clean)... Purpose: The purpose of changing a clean dressing is to: Protect wound, Prevent irritation, Prevent infection and spread of infection, Promote healing... Infection control: Associates will observe universal precautions at all times... Procedure: ...2. Create clean field with paper towels or towelette drape... 5. Put on first pair of disposable gloves. 6. Remove soiled dressing and discard in plastic bag. 7. Dispose of gloves in plastic bag. 8. Put on second pair of disposable gloves. ...10. Cleanse wound with prescribed solution. 11. Apply prescribed medication if ordered. 12. Apply dressings and secure with tape. 13. Remove gloves and discard with all unused supplies in plastic bag..."  2. Resident #4 had diagnoses of Huntington's with Dementia and Anorexia. The Minimum Data Set dated 11/6/08 documented the resident had modified independence in cognitive skills for daily decision making and had pressure relieving devices for the chair and the bed.  a. A Physician telephone order dated 1/8/09 documented: "Apply wound gel and dry drsg [dressing] to buttocks Q [every] day until healed."  b. The Plan of Care dated 1/8/09 documented: "Potential for pressure sores related to decline Physical health, decreased mobility, use of restraint and incontinence. Actual Stage II to coccyx..."	F 314			

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

PRINTED: 02/26/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045181</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/13/2009</b>
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F 314	Continued From page 14  c. On 2/9/09 at 2:40 p.m. and 5:10 p.m. and on 2/10/09 at 8:37 a.m. and 12:05 p.m., the resident was up in a wheelchair with a pelvic restraint on. There was not a pressure relieving device in the wheelchair.  d. On 2/10/09 at 9:20 a.m., Registered Nurse (RN) #2 performed a treatment to the resident's coccyx. She had supplies in a Styrofoam container. She put on gloves, removed the soiled dressing, picked up the wound cleanser and sprayed four by fours with it. She then laid the wound cleanser on the resident's bed. The RN cleansed the resident's wound, picked up the Hydrogel and applied it to a four by four and laid the Hydrogel on the resident's bed. She then placed the four by four with the Hydrogel onto the resident's wound. The RN taped the dressing in place and then removed her gloves. She did not change her gloves between handling the soiled dressing and the clean dressing.	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	F 315			

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F 315	Continued From page 15 interview, the facility failed to ensure Foley catheters had clinical justification for use for 2 of 2 (Residents #2 and #3) case mix residents with an indwelling catheter. This failed practice had the potential to affect 2 residents in the facility with an indwelling catheter, according to the Resident Census and Conditions of Residents form dated 2/9/09. The findings are:  1. The Catheterization-Urinary policy and procedure documented: "...Medical Indicators for Indwelling Catheters According to CDC [Centers for Disease Control] and AHCP Short term treatment for people who are terminally ill. Short term treatment for those with pressure ulcers. Long term treatment for those who are severely impaired, if other interventions are not an option. The management of urological disease..."  2. Resident #3 had diagnoses of Alzheimer's Disease, Cerebrovascular Accident and Pressure Ulcers. The Minimum Data Set (MDS) dated 9/15/08 documented the resident had short/long-term memory problems, was severely impaired in cognitive skills for daily decision making, required total assist with activities of daily living, was incontinent of bowel and had an indwelling catheter.  a. The Physician order dated 7/12/08 documented: "...indwelling Foley catheter 16 French /10 cc [cubic centimeter] bulb change every 30 days and PRN [as needed] (due 7-16-08)."  b. The weekly Pressure Skin Report dated 2/3/09 documented the resident had 3 small Stage II decubitus ulcers.	F 315			

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

PRINTED: 02/26/2009  
FORM APPROVED  
OMB NO. 0938-0391

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F 315	<p>Continued From page 16</p> <p>c. On 2/9/09 at 11:00 a.m. and 1:30 p.m., the resident had an indwelling catheter.</p> <p>d. On 2/9/09 at 3:20 p.m., the resident's catheter was replaced because it was leaking.</p> <p>e. On 2/9/09 at 5:30 p.m., the resident had an indwelling urinary catheter.</p> <p>f. On 2/10/09 at 8:10 a.m., 11:20 a.m. and 2:00 p.m., the resident had an indwelling urinary catheter.</p> <p>g. On 2/11/09 at 9:10 a.m., the Director of Nursing (DON) was asked what the resident's diagnosis was for the catheter; she stated she did not know, but would find out.</p> <p>h. On 2/11/09 at 9:30 a.m., the DON provided a telephone order dated 2/11/09 with a diagnosis of Foley catheter related to sacral decub to assist with healing.</p> <p>3. Resident #2 had diagnoses of Cerebrovascular Accident and Urinary Tract Infection. The MDS dated 11/11/08 documented the resident was severely impaired in cognitive skills for daily decision making, was incontinent of bowel, had a indwelling catheter and had a urinary tract infection in the last 30 days.</p> <p>a. The Plan of Care dated 11/11/08 documented Altered Urinary elimination- Foley catheter.</p> <p>b. A Physician's Order Sheet for February 2009 documented: "...Catheter: Change Foley every month with 24 FR [french] cath [catheter]. Foley catheter care q [every] shift."</p>	F 315			

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

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F 315	Continued From page 17 c. On 2/9/09 at 10:42 a.m., 1:00 p.m., 2:45 p.m. and 4:05 p.m. and on 2/10/09 at 8:20 a.m. and 10:25 a.m., 11:50 a.m. and 1:50 p.m., the resident was observed with a Foley catheter in place.  d. On 2/10/09 at 2:30 p.m., Licensed Practical Nurse (LPN) #2 stated that the resident had the Foley catheter since she had been hired in 2007.  e. As of 2/10/09, there was no medical justification for the Foley catheter in the resident's clinical record.	F 315		
F 318 SS=E	483.25(e)(2) RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure positioning devices were in place and range of motion exercises were consistently provided for 4 (Residents #2, #3, #5 and #7) of 5 (Residents #1, #2, #3, #5 and #7) case mix residents who required assistance with range of motion exercises. This failed practice had the potential to affect 12 residents in the facility with contractures, according to the Resident Census and Conditions of Residents form dated 2/9/09. The findings are:	F 318		

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F 318	<p>Continued From page 18</p> <p>1. The facility's Policy and Procedure documented: "Contracted Hand Care ...Policy: Residents with contracted hands will receive needed care in order to: ...Prevent further contractions ...Procedure: ...13. Place a hand roll in the palm of the resident's hand. Note: A special hand roll or splint-type device may be used as indicated on the care plan..."</p> <p>2. Resident #2 had diagnoses of Cerebrovascular Accident and Urinary Tract Infection. The Minimum Data Set (MDS) dated 11/11/08 documented the resident was severely impaired in cognitive skills for daily decision making and had functional limitation in range of motion of the arm and the hand on one side.</p> <p>a. The Plan of Care dated 11/11/08 documented: "At risk for skin breakdown. ...7. Provide good body alignment at all times..."</p> <p>b. On 2/9/09 at 10:42 a.m. and 1:00 p.m., the resident did not have a positioning device in her contracted right hand.</p> <p>3. Resident #3 had diagnoses of Alzheimer's Disease and Cerebrovascular Accident. The MDS dated 9/15/08 documented the resident had was severely impaired in cognitive skills for daily decision making, required total assistance for activities of daily living and had no contractures.</p> <p>a. An untitled PT (Physical Therapy) Sheet dated 1/1/09 - 1/31/09 documented: "...ROM Passive 5x [times] week hand roll to right hand..."</p> <p>'W' or 'F' had been used on the sheet to document that in January 2009, on the 9th, 12th, 13th, 14th, 15th, 16th, 26th, 27th, 28th, 29th and</p>	F 318			

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

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FORM APPROVED  
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F 318	<p>Continued From page 19</p> <p>30th the range of motion was not performed by the Restorative Aide, documenting she was working the floor:</p> <p>a. On 2/9/09 at 11:00 a.m., the resident was observed without a positioning device to her contracted left hand or in her right hand.</p> <p>b. On 2/10/09 at 12:20 p.m., the resident was observed with no positioning device in the contracted left hand or in her right hand.</p> <p>c. An untitled PT Sheet dated 2/1/09 - 2/28/09 documented: "...ROM Passive 5x week hand roll to right hand..."</p> <p>'W' or 'F' had been used on the sheet to document that in February 2009 on the 2nd, 3rd, 5th, 6th and 9th the ROM was not performed by the Restorative Aide, documenting she was working the floor.</p> <p>4. Resident #5 had diagnoses of Alzheimer's Disease with Behaviors and Pre-Dementia. The MDS dated 11/22/08 documented the resident was severely impaired in cognitive skills for daily decision making, had repetitive physical movements as indicators of depression, anxiety, sad mood, was totally dependent on staff for activities of daily living, was not able to attempt a test for balance without physical help, had functional limitations in range of motion and had a trunk restraint.</p> <p>a. A Rehab Instruction Record dated 11/14/08 documented: "...Positioning/Splints Hand roll to R [right] hand daily. Do not discontinue ...other Recommendations: needs splint for R hand. Special Programs: Clean hand R massage and</p>	F 318			

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F 318	Continued From page 20 PROM [passive range of motion] to all joints, apply hand roll. daily to [decrease] contracture..."  b. A Rehab Daily record of treatment Progress documented: "...11/4/08 ...carrot for R hand discussed [with] nursing... 11/10/08 ...Requested carrot to be ordered... 11/11/08 ...discussed ordering "carrot" or soft cone for R hand... 11/12/08 ...R [resident] needs carrot for R [right] hand..."  c. The overall Plan of Care dated 1/26/08 did not document anything regarding positioning devices.  d. The Physician Orders dated 2/1/09 to 2/28/09 documented: "ROM Passive 5x week hand roll to right hand."  d. On 2/9/09 at 1:05 p.m., 4:20 p.m. and 5:35 p.m., the resident was observed with no positioning device to the right hand.  e. On 2/10/09 at 8:20 a.m., the resident was observed with no positioning device to her right hand.  f. The Treatment Sheet dated 2/1/09 to 2/28/09 documented: "ROM Passive 5 x week hand roll to right hand."  g. On 2/12/09 at 10:15 a.m., CNA #3 (RNA) was asked what she did for the resident. She stated "I'm just doing her right hand-Passive ROM, wash hand and lotion her hand then place a wash cloth in her hand." How often? "5 times a week." When asked, "What if you are working the floor?" The CNA stated, "The girls [CNAs] do it."  5. Resident #7 had diagnoses of	F 318		

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

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F 318	Continued From page 21 Cerebrovascular Accident and Osteoarthritis. The MDS dated 1/9/09 documented the resident was moderately impaired in cognitive skills for daily decision making, was totally dependant on staff for activities of daily living and had functional limitation in range of motion in a hand, including the wrist and fingers.  a. The Overall Plan of Care dated 1/9/09 had no documentation regarding positioning devices or range of motion.  b. Physician Orders dated 2/1/09 to 2/28/09 documented: "Restorative - PROM [Passive Range of Motion] 5x week hand roll to left hand."  c. On 2/9/09 at 10:45 a.m., the resident was observed without a positioning device to the left hand.  d. On 12/12/09 at 10:15 a.m., the Restorative Aide (RNA) was ask what she did for the resident. She stated "I'm just doing her left hand- PROM, wash hand and lotion her hand then place a wash cloth in her hand." When asked how often, the RNA stated "Five times a week." When asked, "What if you are working the floor?" The RNA stated, "The girls [CNAs] do it."	F 318			
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.	F 323			

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

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F 323	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure water temperatures on 100 Hall were less than 110 degrees, Hall 100 was free of extension cords in the day room and in Room 100, smoke alarms were in working order and transfers were not conducted using the axillae and waist band for 1 (Resident #9) of 3 (Residents #4, #5, and #9) case mix residents who were manually transferred. This failed practice had the potential to affect 9 cognitively impaired self mobile residents, as identified by a list from the Administrator on 2/11/09 at 10:15 a.m. and 11 residents who were transferred manually, as documented on a list from the Administrator on 2/12/09 at 3:00 p.m. The findings are:</p> <p>1. On 2/10/09 at 12:15 p.m., there was an extension cord to the television in the 100-Hall Dayroom.</p> <p>2. On 2/11/09, the following items were noted during Environmental Rounds with the Maintenance Supervisor:</p> <p>a. At 9:00 a.m., on Hall 100, the resident bathroom between Room 116 and Room 118 had a water temperature that was 136.5 degrees Fahrenheit (F). Steam came up from the water in the sink from the hot water. There was urine and toilet paper in the commode which had been in use.</p> <p>1) At 9:05 a.m., the resident bathroom between Room 115 and Room 117 had a hot water temperature of 130 degrees F.</p>	F 323			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045181</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/13/2009</b>
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F 323	<p>Continued From page 23</p> <p>2) At 9:07 a.m., the hot water temperature in Room 110 was 126.5 degrees F. The Maintenance Supervisor stated, "A circulator pump had been put in 1 week ago and a modulator was ordered to circulate the water." When asked at what temperature of water would residents be burned, he stated, "115." He was then asked how long the water temperatures had been running hot and he stated, "Two weeks."</p> <p>3) On 2/11/09 at 10:25 a.m., water temperatures were taken and ranged from 114.3 degrees to 74.8 degrees.</p> <p>On Hall 300 the water temperature was 81 degrees where the locked unit was. The water was running in Room 303 and 305. The Housekeeping Supervisor stated that the Maintenance Supervisor told her to turn the water on to check it. At 10:40 a.m. the Maintenance Supervisor was asked when he told Housekeeping to turn the water on and he stated, "Ten minutes ago." When asked if he could get an adequate temperature now he stated, "No." He was then asked if anyone had said the 300 lock unit temperature was hot. "The Certified Nursing Assistant (CNA) said that it was too hot so I turned the hot water heater. It was 120 degrees."</p> <p>When asked, How long has 100 Hall had hot temps? The Maintenance Supervisor stated, "I say for the last 1 month to 6 weeks." What did you do to fix it? "If hot, adjusted temperature on hot water heater." When asked, Did you document temperatures? The Maintenance Supervisor stated, "No."</p> <p>4) On 2/11/09 at 10:30 a.m., three CNAs on the</p>	F 323			

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F 323	<p>Continued From page 24</p> <p>100 Hall were asked if the water got hot at times and they stated, "Yes." What do you do? "The water will usually cool off if you keep it running." When asked how long this had been going on they stated, "I do not know."</p> <p>On the 200 Hall three CNAs stated that their water has not been too hot in the resident rooms. One CNA stated, "I heard about them talking about the water being too hot on the 300 Hall.</p> <p>5) On 2/11/09 at 1:20 p.m., 5 alert and orientated residents were asked if their water was too hot and they stated, "It has been plenty hot, but not too hot."</p> <p>6) On 2/11/09 at 2:55 p.m., the Administrator provided documentation of the plumbing company work order dated 1/29/09 for installation of a circulatory pump.</p> <p>7) On 2/11/09 at 3:00 p.m., the Water Temperature Log was reviewed for December 2008, January 2009 and up to the 9th of February 2009. All water temperatures ranged from 104 to 120. The documentation did not provide information for if the number in the block was the temperature range or the room number.</p> <p>2. On 2/12/009 at 7:55 a.m., Environmental Rounds were resumed and the following was noted:</p> <p>a. In Resident Room 100 at 8:45 a.m., there was a power strip cord with a refrigerator and microwave plugged in.</p> <p>3. The Smoke Alarm in Room 210 and Room 111 beeped/chirped from 2/10/09 to 2/12/09.</p>	F 323			

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F 323	Continued From page 25  4. Resident #9 had diagnoses of Schizophrenia, Epilepsy, Psychosis and Agitation Behavior. The Significant Change Minimum Data Set (MDS) dated 1/14/09 documented the resident was severely impaired in cognitive skills for daily decision making, was dependent on one person for transfer and used a trunk restraint.  a. On 2/9/09 at 4:55 p.m., CNA #4 and CNA #5 were in the resident's room, in the process of transferring the resident to a wheelchair for dinner. They locked the wheelchair, placed their arms under the residents axillae with their arms and, with their other hand, placed their hand at the back of the pants waist of the resident. There was no gait belt used. The resident did not bear any weight and her toes dragged across the floor. CNA #4 stated, "She used to stand but since she came back from the hospital she can't."  b. On 2/10/09 at 11:15 a.m., CNA #6 was transferring the resident from the bed to a locked wheelchair. While facing the resident, the CNA placed her arms around the resident in a bear hug and transferred her to the wheelchair. A gait belt was not used. The resident did not bear weight.  c. A Policy and Procedure on Transfer Activities received from the Administrator on 2/12/09 at 2:40 p.m. documented: "Purpose: To transfer the resident from bed to chair, toilet or tub safely... Assessment; ...Ability to stand and bear weight, loss of balance, loss of voluntary control of lower extremities... Equipment; Gait Belt. It is recommended that the resident wear a gait belt when you are transferring... The gait belt provides a firm grasping surface for the associate and	F 323			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 26 protects the resident from accidental trauma to the skin.	F 323			
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 4:00 p.m. medication pass on 2/9/09 and the 8:00 a.m. medication pass on 2/10/09 and record review, the facility failed to follow physician orders to ensure that the medication error rate was less than 5%. Physician orders were not followed for 4 (Residents #3, #7, #10 and #11) of 8 residents observed during the medication passes. Medication errors were made by 4 Licensed Practical Nurses (LPN) (LPN #1, LPN #2, LPN #3 and LPN #4) of 5 nurses that administered medication. This failed practice had the potential to affect 53 residents receiving medication from these nurses according to Registered Nurse #1 on 2/10/09. The medication error rate was 10.42% based on the administration of 45 medications plus 3 medications ordered but not administered, resulting in observation of a total of 5 errors. The findings are:  1. Resident #7 had a physician order dated 8/21/08 for Dipyridamole 50 mg (milligram) to administer 2 tablets via percutaneous endogastrostomy (PEG) tube 4 times a day and flush with 100 cubic centimeters (cc) of water before and after medications.  a. On 2/9/09 at 4:31 p.m., LPN #1 did not provide	F 332			

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F 332	Continued From page 27 a water flush after administration of the resident's medication .  b. Federal regulations require a minimum flush of 30 cc of water before and after medication administration.  2. Resident #10 had a physician order dated 5/15/08 for an Albuterol Inhaler to administer 2 puffs four times a day.  a. On 2/10/09 at 7:39 a.m., LPN #2 did not shake the Albuterol container prior to administration of the medication to the resident.  b. Federal regulations require aerosol inhalers to be shaken before administration.  3. Resident #11 had a physician order dated 3/25/08 for a Multivitamin with minerals daily.  On 2/10/09 at 8:15 a.m., LPN #3 did not administer the Multivitamin with minerals to the resident.  4. Resident #3 had a physician order dated 11/24/08 for Vitamin C 500 mg twice a day.  On 2/10/09 at 8:15 a.m., LPN #4 did not administer Vitamin C 500 mg to the resident.  5. Resident #3 had a physician order dated 11/24/08 for Claritin 10 mg every day.  On 2/10/09 at 8:15 a.m., LPN #4 did not administer Claritin 10 mg to the resident.	F 332			
F 372 SS=C	483.35(i)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL	F 372			

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F 372	Continued From page 28 The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the trash dumpster was covered to reduce the potential for pest infestation. This failed practice had the potential to affect all 53 residents in the facility, as documented on the Resident Census and Condition of Residents form dated on 2/9/09. The findings are:  On 2/12/09 at 9:00 a.m., a trash can outside of the facility laundry was full of dirty briefs and gloves; it had no lid on it.	F 372			