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	045146	A. BUILDING ____ B. WING ____	C 01/23/2009

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F 000	INITIAL COMMENTS Complaint #14173, was substantiated (all of in part) with deficiencies at F314 and F318.	F 000		
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: Complaint #14173 was substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure the buttocks and rectal area were cleaned during incontinent care for 1 (Resident #3) and incontinent care was provided after an episode of incontinent for 1 (Resident #2) of 5 case mix residents (Resident #1 -5) who were incontinent. This failed practice had the potential to affect 53 residents who were incontinent as identified on the Resident Census and Conditions of Residents form provided by the Administrator on 1/21/09. The findings are: 1. The facility Incontinence Care Policy and Procedure provided by the Administrator on 1/23/09 at 9:45 a.m. documented, "Purpose: to keep skin clean, dry, free of irritation and odor... to prevent skin breakdown... Equipment: soap and water... washcloth and towel... Procedure:	F 314		

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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Wash all soiled skin areas and dry very well, especially between skin folds."

2. Resident #3 had diagnoses of Psychosis, Dementia with Behaviors and Transient Ischemic Attacks. The Quarterly Minimum Data Set (MDS) dated 12/2/08 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for personal hygiene, incontinent of bowel and bladder, no pressure ulcers and required turning and repositioning program.

a. The Resident's Care Plan updated on 12/5/08 documented, "Risk of skin breakdown r/t (related to) bladder et (and) bowel incontinence... peri care after each episode of incontinence... adult brief changed prn (as needed)... keep skin clean and dry."

b. The Pressure Ulcer Risk Assessment dated 4/7/08 documented a score of 12 for the resident and "total score of 8 or above represents high risk." An undated column after the 4/7/08 documented a score of 11 on the assessment form.

c. On 1/20/09 at 1:54 p.m., the resident was in bed and there was a strong urine odor at the resident's bedside.

d. On 1/21/09 at 4:40 p.m., CNA #2 and CNA #3 transferred the resident from the geri chair to the bed. The fabric incontinent pad left in the geri chair had a light brown circle approximately 12 inches in diameter of drying urine and the resident's sweat pants were wet on the left side of the seat of the pants. The resident's incontinent brief was saturated with urine up to the top of the

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F 314	Continued From page 2 incontinent brief in the back and within 4 inches from the top in the front. CNA #3 left the room and returned with a clean incontinent brief and no cleansing supplies. The CNA #2 asked CNA #3 to obtain the needed supplies for cleansing. CNA #4 returned with the cleansing supplies. The resident's buttocks and thighs were not cleansed by CNA #2 who provided incontinent care. The resident's left buttock, sacrum and coccyx were reddened. e. On 1/21/09 at 6:10 p.m., CNA #5 confirmed that the resident had been up in the geri chair since the surveyor's 9:40 a.m. observation, but that the resident received incontinent care at approximately 12:30 p.m. while in the geri chair and that the resident was to receive incontinent care every 2 hours. 3. Resident #2 had diagnoses of Pyelonephritis, Urosepsis, Urinary Tract Infection, Bladder Spasm and End Stage Dementia. The Annual MDS dated 11/4/08 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for personal hygiene, incontinent of bowel and bladder and did not have any pressure ulcers. a. The Resident's Care Plan updated on 10/6/08 documented, "Risk of skin breakdown r/t b/b (bowel and bladder) incontinence... peri care after each episode of incontinence... keep skin clean and dry... observe for any red or open areas." b. The Pressure Ulcer Risk Assessment dated 10/6/08 documented a score of 14 for the resident and "total score of 8 or above represents high risk."	F 314		

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F 314	Continued From page 3 c. On 1/21/09 at 10:40 a.m., the resident was incontinent of urine. CNA #9 and CNA #3 removed the resident's saturated incontinent brief and the fabric incontinent pad that had a dried area of urine approximately 18 inches in diameter. A clean incontinent brief and gown were provided for the resident who was not cleansed in any areas. There were no cleansing supplies present in the room. The resident's buttocks and coccyx areas were reddened. The CNAs were asked if they were finished with the resident and CNA #9 stated, "Yep."	F 314		
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: Complaint #14173 was Substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure restorative services were provided and positioning devices were utilized to prevent further contractures and decline in range of motion to resident's hands for 2 of 2 case mix residents (Residents #1, and #3) who had contractures. This failed practice had the potential to affect 8 residents who had contractures to their hands as identified on a list provided by the Administrator on 1/23/09 at 9:45 a.m. The findings are:	F 318		

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1. Resident #3 had diagnoses of Trans-ischemic Attack and Dementia with Behavioral Disturbance. The Quarterly Minimum Data Set dated 12/2/08 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent for all ADLs (activities of daily living), had limited range of motion and partial loss of voluntary movement of 1 hand and arm and limited range of motion and full loss of voluntary movement of both legs and feet.

a. A Physician Progress Note dated 10/26/08 documented severe chronic debilitative state.

b. A Physician Progress Note dated 11/25/08 documented, "She continues to be in somewhat of a fetal position with contractures. Multiple contractures."

c. The care plan, not dated, did not address the resident's contractures or any interventions to prevent further decline in range of motion .

d. On 1/20/09 at 1:54 p.m., LPN (Licensed Practical Nurse) #3 stated the resident had contractures of hands, arms, legs and did not receive therapy or restorative. The resident's fingers on both hands were contracted and there were no hand rolls or other positioning device in place.

e. On 1/20/09 at 4:05 p.m. and 1/21/09 at 7:05 a.m. and 1/21/09 at 9:00 a.m., the resident was in bed and there were no hand rolls or other positioning device in place in either hand.

f. A list of residents who received restorative care

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obtained from the Administrator on 1/23/09 did not document the resident received restorative therapy.

g. On 1/21/09 at 9:05 a.m., CNA (Certified Nursing Assistant) # 4 and 5 took the resident to the shower. The 1st, 2nd, and 3rd fingers of the resident's left hand were straight down from the top of her hand with the middle knuckle straight, directly against the palm of her hand. The resident was unable to move these fingers per self. The CNAs moved them out from her palm a bit and the resident yelled out. The CNAs were unable to move the fingers apart to cleanse them. When the CNAs were asked if the fingers could be moved to cleanse between them, CNA #5 said, "not without hurting her. She probably needs one of those carrot things in her hand now." The CNA was asked if she had ever used that or anything else in her hands before. She said she had worked there for 8 years and, "I've never seen anything there before."

h. On 1/21/09 at 12:35 p.m., 2:55 p.m., 3:25 p.m., and at 4:40 p.m., the resident was in a geri chair and there were no hand rolls or other positioning devices in place.

i. On 1/22/09 at 11:15 p.m., LPN #3 stated she had worked at the facility for 8 years, and "We all should be doing range of motion and placing hand rolls."

j. On 1/22/09 at 9:00 a.m., CNA #6 was asked if he provided active or passive range of motion to residents. He said "Yes, as much as can. The rehab CNA does most of them. Move arms up and down, do knees and hips if not already contracted." When he was asked what they

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F 318	Continued From page 6 specifically did he said, "[Rehab CNA] does a lot of that. We look to see if she does someone, and if not, we do." He said, "There is not a list, and there's nothing on the ADL sheets to check it." k. On 1/22/09 at 9:10 a.m. CNA #7 was asked if he provided active or passive range of motion to residents on his shift. He said, "Not really. We pick them up or move them in bed, move arm a little." He was asked what specifically they did for the residents. He said, "Just move an arm to get them dressed or something." He said they have people (RNA) "to do that... we must do aide work. We don't do that." He was asked if anyone had come to them to let them know to do range of motion for residents. He stated, "No." l. On 1/22/09 at 9:27 a.m., CNA #8 was asked if they (CNA's) provided active or passive range of motion to residents. She said, "When asked to we do. The nurse tells us." She was asked if there's anyone doing restorative now. She said, "Not now." m. On 1/22/09 at 11:15 a.m., LPN #3 was asked if he provided active or passive range of motion to residents. The LPN said, "We all do, nurses and CNAs. Whenever we do anything with them, we all should." She said, "The RNA does some and we do." She said they do not document it. The LPN was asked what she would do if a resident had a decline in range of motion. She said, "The CNAs should tell us and I always let ADON (Assistant Director of Nursing)/DON (Director of Nursing) know. They will talk to the restorative or therapy, and I call the doctor." She was asked who's responsible for placing hand rolls or positioning devices. She said, "We all are, we (CNA/nurse) should be." She was asked if they	F 318		

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F 318	Continued From page 7 have a list of residents who need range of motion or hand rolls/devices. She said, "No, we don't have a list." She was asked how they knew who needed range of motion or hand rolls. The LPN said, "We just do it (range of motion) on everyone. We should be putting hand rolls in anybody that might need it." 2. Resident #1 had diagnoses of Dementia with Behavioral Disturbance and Failure to Thrive. The Quarterly MDS dated 11/7/08 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent for all ADLs and had no limitations in range of motion or loss of voluntary movement to the upper or lower extremities. a. A physician order dated 11/24/08 documented, "OT (occupational therapy) eval and treat. Pt (patient) will benefit from moist heat to left hand and gentle ROM (range of motion) to decrease pain and increase AROM (active range of motion) to left hand." b. Plan of Treatment for Rehabilitation dated 11/24/08 documented treatment diagnoses as "Left Hand Pain and Decreased ROM... the resident has increasing pain and decreasing AROM/PROM (passive range of motion) to left hand and 3/4 digits, who will benefit from maintenance program to prevent increased contractures and hygiene." c. The Plan of Treatment for Rehabilitation dated 11/24/08 documented in under goals, "staff will be educated/trained." d. Physician orders dated 1/16/09 documented to discharge from OT.	F 318		

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F 318	Continued From page 8 e. Physician orders dated 1/18/09 documented to discharge from PT (Physical Therapy). f. On 1/20/09 at 1:21 p.m., LPN #1 stated the resident had contractures to her hands. The resident was sitting in a recliner and did not have any hand rolls or positioning devices in either hand. g. On 1/20/09 at 4:13 p.m. the resident was in the wheelchair at the nurses' station holding a doll with her right hand, her left hand was closed. LPN #1 was asked to ask the resident if she could open her left hand. The resident kept repeating, "I can't." There were no hand rolls or positioning devices in place. h. On 1/21/09 at 6:58 a.m. the resident was lying in bed and there were no hand rolls or positioning devices in place. i. On 1/21/09 at 7:15 a.m., CNA #1 was asked to have the resident try to open her left hand. The CNA opened her hand slightly with the last two fingers not opening or extending. j. On 1/21/09 at 7:50 a.m., the resident did not have a hand roll or positioning device in either hand. k. On 1/21/09 at 2:45 p.m., the Restorative CNA was asked for a list of residents she sees in restorative program. She said she didn't have a list and was asked how she knows who to treat. She said she only sees/treats the residents that are discharged from physical/occupational therapy. She said, "I don't see everybody here. There's no way I would have time to do that."	F 318		

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The Restorative CNA was asked what happens with the residents that begin to have or have been assessed with contractures or decline in ROM. She said that's what CNAs do.

l. A list of residents who received restorative care obtained from the Administrator on 1/23/09 did not document the resident received restorative therapy.

m. On 1/21/09 at 2:45 p.m., LPN #1 was asked who monitored to ensure someone provided restorative/ROM services to the residents who need them. LPN #1 said, "I guess it's really all our responsibility to make sure it's done, hand rolls and devices."

n. On 1/22/09 at 9:55 p.m., LPN #2 was asked who provided ROM to residents. LPN #2 said the restorative CNA does when therapy discharges. He was asked what he would do if he saw a decline in a resident's ROM. He said he would phone the physician to get orders for therapy to treat. He was asked what care/services are provided after therapy stops. He said therapy gets with the restorative CNA and sets up what will be done.

o. On 1/22/09 at 1:30 p.m., LPN #2 was asked if the resident could open her left hand. The resident could not open her left hand or extend her fingers. He was asked what intervention was in place to prevent further loss of ROM to her fingers. He said, "She gets therapy for that." He was asked to show where the resident received therapy to the left hand. He showed a physician order dated 1/16/09 and 1/18/09 which documented to discontinue therapy as well as an order dated 11/24/08 to begin treatment to her left

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F 318	Continued From page 10 hand. He was asked to show where the resident was discharged from therapy to the restorative program for continued treatment to the resident's left hand to prevent further decline. He looked at the restorative sheets and said, "You're exactly right, that show's she's not being treated to her left hand, only BLEs (bilateral lower extremities). He said, "I'll take care of that right now, you're right." p. On 1/22/09 at 3:06 p.m., the DON and Administrator were asked how they determined who received restorative services. The DON said, "Therapy recommends, RNA picks them up. We only have one restorative CNA." The DON was asked what do staff do if they notice a resident has decline in ROM. The DON said, "The CNA will tell the nurse, the nurse tells the ADON or me, and we tell therapy." She further said, "All CNAs are trained any time they take care of residents, to do ROM. Suppose to do ROM on residents that are in bed or need it." She was asked how the CNAs would know what to do. She said they would look at the care plan. q. On 1/23/09 at 9:30 a.m., the DON stated the facility did not have any policy and procedures for the restorative program.	F 318		