

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

PRINTED: 04/01/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/19/2008</b>
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NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>
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F 000	INITIAL COMMENTS	F 000		
F 314 SS=H	<p>Complaint #13379 was substantiated (all or in part) with a deficiency cited at F314.</p> <p>483.25(c) PRESSURE SORES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13379 was substantiated (all or in part) in these findings</p> <p>Based on observation, record review and interview, the facility failed to ensure pressure ulcers were identified and treatments obtained for 1 (Resident #1), pressure relief (off loading of left heel) was provided for 2 (Residents #2 and #3), padding for bony prominences and turning/repositioning was provided for 1 (Resident #3) and the physician was notified and treatments obtained when new pressure ulcers were identified for 2 (Residents #2 and #6) and pressure relieving devices were provided in chairs for 3 (Residents #3, #5 and #7) 6 (Residents #1, #2, #3, #5, #6 and #7) case-mix residents with pressure ulcers or at risk for pressure ulcers. The failed practices resulted in a pattern of actual harm for 2 ( Residents #1 and #2) case mix residents who developed multiple pressure sores that were not promptly responded to and had the</p>	F 314		

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

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F 314	<p>Continued From page 1</p> <p>potential to cause more than minimal harm to 5 residents with pressure sores and 17 residents at risk for pressure sores, as per a list provided by the Assistant Director of Nursing (ADON) on 3/19/08 at 1:45 p.m. The findings are:</p> <p>1. Resident #1 was admitted to the facility on 2/26/08 with diagnoses of Fracture of C (cervical) -Spine and Cerebrovascular Accident. The Admission Minimum Data Set (MDS) dated 3/4/08 documented the resident was independent in cognitive skills for daily decision making, required limited assistance of one person for transfers, toileting and personal hygiene, was continent of bowel, had an indwelling catheter, had a pressure relief device for the bed, was on a turning and repositioning program and received nutritional or hydration intervention to manage skin problems.</p> <p>a. The admission nursing assessment dated 2/26/08 at 2:00 p.m. documented: "Sm (small sores to [lower] ext. (extremity)." There was no documentation of measurements, which extremity was affected, treatment to the areas or description of the wounds to allow for monitoring of healing or non-healing.</p> <p>b. Nurses Notes dated 3/3/08 at 1415 hours (2:15 p.m.) documented the resident was sent to the Emergency room for syncope. The hospital emergency record documented the resident was admitted to Hospital #1 and transferred to Hospital #2 on 3/4/08.</p> <p>The resident was re-admitted to the facility on 3/6/08 based on the readmission orders. The re-admission orders dated 3/6/08 did not contain any orders for treatment of any skin problems.</p>	F 314			

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F 314	<p>Continued From page 2</p> <p>There was no documentation in the nurse's notes of any re-admission assessment</p> <p>c. The plan of care, dated 3/7/08, did not document the resident was at risk for pressure ulcers or contain interventions to prevent the formation of pressure ulcers.</p> <p>d. The resident was sent to [Hospital #1] Emergency Room on 3/9/08 at 9:44 a.m., after becoming non-responsive while in the dining room. The Patient Transfer Form documented: "Section 18. Dressing and Bandages... Bilat [bilateral] feet." [Hospital #1] Emergency record documented the resident was transferred to an acute care hospital [Hospital #3] at 1:40 p.m.</p> <p>e. On 3/9/08 at 4:50 p.m., the resident was admitted to [Hospital #3] with a diagnosis of Sepsis. The hospital admission records (pictures) documented the resident had the following skin ulcers.</p> <p>1) Right heel intact purple wound measures 9 cm (centimeters) x (by) 5.5 cm with 1.5 cm x 2 cm open area. Open area wound bed pink and moist with dry edges surrounding dry and flaky. No foul odor, small amount of edema like blisters to purple areas. Moderate amount of SS (serosanguinous) drainage.</p> <p>2) Left heel wound open area measures 1 cm x 1 cm red base &amp; (and) moist with dry edges purple raised area 1.5 cm x 2 cm all skin dry &amp; flaky, No foul odor with moderate amount SS drainage.</p> <p>3) Coccyx wounds measures 5 cm x 3 cm with 2 cm x 2 cm open area. Open wound base red with dry edges surrounding skin dark purple &amp; fragile,</p>	F 314			

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F 314	<p>Continued From page 3</p> <p>no foul odor, edema with large amount SS drainage.</p> <p>4) Scrotal wounds (numerous) areas red with moderate amount yellow exudate &amp; edema. Moderate amount light yellow drainage. No foul odor.</p> <p>f. On 3/17/08 at 8:55 a.m., the resident was observed in Hospital #3 and both of the resident's heels had hard eschar. The coccyx wound contained brown, yellow whitish slough and the scrotum had numerous open areas with yellow, whitish slough.</p> <p>g. Facility staff interviews regarding the resident's skin condition prior to the hospitalization were conducted:</p> <p>1) On 3/18/08 at 1:00 p.m., the ADON stated that she measured resident's wounds when staff let her know, that she had no knowledge of the resident ever having any open areas and she had assisted in transferring the resident to the hospital on 3/9/08.</p> <p>2) On 3/18/08 at 1:20 p.m., Certified Nursing Assistant (CNA) #3 stated that she worked with the resident on 3/8/08. She stated she put the resident's socks on him and he had a bandage on both feet.</p> <p>3) On 3/18/08 at 1:40 p.m., CNA #4 stated she worked with the resident when he returned to the facility on 3/6/08. She stated that she had no knowledge of any open areas. The CNA further stated that she did not know if the nurse did a body audit when the resident returned.</p>	F 314			

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F 314	<p>Continued From page 4</p> <p>4) On 3/18/08 at 1:45 p.m., Licensed Practical Nurse (LPN) #1 [charge nurse on 3/6/08] stated that he did not perform a body audit, but thought another nurse did.</p> <p>5) On 3/18/08 at 1:50 p.m., LPN #2 stated that she did not see the resident [on 3/6/08], but had to assist with finishing the orders the next day because there were 2 admissions at the same time on 3/6/08 and she was not sure who did the assessment.</p> <p>h. As of 3/19/08 at 1:00 p.m., the facility could not furnish any documentation of the resident's wounds described above.</p> <p>2. Resident #2 had diagnoses of Hemiplegia, Brain Neoplasm, Hypertension, Hypothyroidism, Non Insulin Dependent Diabetes Mellitus, and Congestive Heart Failure. The Quarterly MDS dated 12/19/07 documented the resident was severely impaired in cognitive skills for daily decision making, was dependent on staff for all activities of daily living, was incontinent of bowel and bladder, had a pressure relief device in the bed, was on a turning and repositioning program and received other preventative or protective skin care.</p> <p>a. The Nurses Notes documented the resident was hospitalized on 2/22/08 and was re-admitted to the facility on 3/1/08. The Nurses Notes dated 3/1/08 documented the resident had diagnosis of Congestive Heart Failure, had 2 plus pitting edema to feet and had a pressure area open on coccyx. No other areas of breakdown were noted in the Nurses Notes. No treatment order for the coccyx was documented in the Nurses Notes or the Physician Orders. The March 2008</p>	F 314			

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F 314	<p>Continued From page 5</p> <p>Treatments/Procedures record documented: "Apply Calmoseptine to right buttocks area q (every) shift and PRN (as needed) ...Start Date: 2/19/08." Nurses documented the treatment as administered from 3/4/08 thru the 11-7 shift on 3/18/08.</p> <p>b. The Pressure Sore Forms, obtained from the ADON on 3/17/08 at 2:00 p.m., documented the following pressure ulcers on 3/4/08:</p> <ol style="list-style-type: none"> <li>1) Stage II pressure ulcer to the right lower buttocks that measured 1 cm x .7 cm with Serosanguinous drainage.</li> <li>2) Stage II pressure ulcer to the right buttocks (no specific site documented) that measured 3.5 cm x 2.8 cm with Serosanguinous Drainage.</li> <li>3) Stage I on right heel measured 2 cm x 2 cm</li> <li>4) Stage I on left heel measured 1 cm x 1 cm edges of redness 3 cm x 3 cm. Color was documented as, "Dark purple red."</li> <li>5) There was no documentation in the Physician Orders, the 3/4/08 Nurses Notes or on the Pressure Sore Form that the physician was contacted for treatment orders. The Weekly Skin Audit dated 3/5/08 documented, "R (resident) has stage II pressure sore to R (right) buttock also noted stage I to inner area of buttocks will ask ADON (Assistant Director of Nursing) to call for tx (treatment)."</li> </ol> <p>c. The Pressure Sore Forms documented the following areas on 3/11/08:</p> <ol style="list-style-type: none"> <li>1) Stage II to the right lower buttocks that</li> </ol>	F 314			

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F 314	<p>Continued From page 6</p> <p>measured 2 cm x 2 cm with the color as red/pink and bleeding.</p> <p>2) Stage II to right upper (documented on same page as #2 above) as 1 cm x 1 cm.</p> <p>3) Stage I right heel 2 cm x 1 cm and the color as slight brown.</p> <p>4) Stage I to left heel 0.3 cm x 0.3 cm dark scab.</p> <p>5) Stage II left upper buttocks measuring 0.3 cm x 0.3 cm red.</p> <p>6) Stage II left lower buttocks measuring 0.6 cm 0.3 cm red.</p> <p>d. The physician telephone order dated 3/11/08 documented, "Apply Calmoseptine to open areas on [right] buttocks &amp; [left] BID and PRN (as needed)." There was no documentation of any treatment or preventative measures for the heels.</p> <p>e. On 3/17/08 at 11:43 a.m., the resident was in bed on her back. There was no bridging of the heels. The room smelled of stale urine. CNA #4 and CNA #5 turned the resident to the right side, using the thick incontinent pad. The resident had 4 open areas to the buttocks. The left heel was dark purple, with a small scabbed area. Measurements were requested.</p> <p>On 3/17/08 at 11:53 p.m., LPN #3 measured the right lateral buttocks open area as 2.4 cm x 1.4 cm x 0.2 cm. The medial right buttocks open area measured 0.6 cm x 0.4 cm x 0.1 cm. The left buttocks had two pinpoint areas open. The wounds were covered with a white cream. When the cream was removed, the wounds beds were</p>	F 314			

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F 314	<p>Continued From page 7</p> <p>pink/red. The lateral buttock wound was cratered.</p> <p>f. The plan of care did not address the pressure sores until 3/17/08 when handwritten notes documented: "Stage II pressure areas x (times) 4 sites to r (right) l (left) buttocks" with interventions of, "Apply Calmoseptine to stage II areas to (r) (l) buttocks BID (twice a day) and PRN." There was no documentation of any treatment or preventative measures for the heels.</p> <p>g. On 3/18/08 at 8:30 a.m., the resident was in the bed on her left side. There was no padding between the resident's knees and the resident's Spenco boots were up around her lower calf and the heels were directly on the bed. The resident's bed was a floatation mattress. However, the resident had a bottom sheet and a thick incontinent pad.</p> <p>h. Nurse's notes, written by the ADON on 3/18/08 [no time documented], documented: "Stage II left upper buttocks 1.3 cm x 0.3 dm red with 1 cm redness around. Right heel dark purple area 2 cm x 1 cm no open areas. Right buttocks (upper) 0.3 cm x 0.5 cm red. Right lower buttocks 2.3 cm x 1.3 cm. Left heel 0.3 cm x 0.2 cm scab with 3 cm x 3 cm reddened. Heel floatation booties placed on both feet. MD (Medical Doctor) notified and order received for Floatation heel booties."</p> <p>On 3/18/08 at 2:10 p.m., the ADON was asked if she measured any depth on the right lower buttocks. She stated that there was no depth [to the wound]. She was then asked to re-measure the wound for depth. This writer accompanied the ADON and LPN #3 to the resident's room and the ADON measured the depth to the lateral side</p>	F 314			

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F 314	<p>Continued From page 8</p> <p>of the wound as 0.2 cm and the lower part of the wound as 0.4 cm.</p> <p>i. On 3/19/08 at 8:45 a.m., the ADON was asked for any measurement, physician notification or treatment obtained for the resident's coccyx wound documented on 3/1/08. She stated that she could not locate any documentation and she was not here when the resident was re-admitted and the coccyx wound was not there on 3/11/08, when she first saw the pressure ulcers. When asked for any documentation of the physician being notified of the pressure ulcers documented on 3/4/08, the ADON stated that she could not find any documentation.</p> <p>When asked about the use of Calmoseptine, the ADON provided a tube. The label on the tube of Calmoseptine documented this product was to be used as "A moisture barrier that prevents &amp; help heal skin irritations, Skin irritation from urine, diarrhea, perspiration, fistula drainage, minor burns, cuts, feeding tube site leakage, wound drainage (peri wound skin), scrapes and itching."</p> <p>The active ingredients were documented as, Menthol for External analgesic, first aide antiseptic and Zinc Oxide as skin protectant/moisture barrier. The directions documented, "Cleanse skin gently with mild skin cleanser. Pat dry or allow to air dry. Apply a thin layer of Calmoseptine Ointment to reddened or irritated skin 2-4 times daily, or after each incontinent episode or diaper change to promote comfort and long lasting protection."</p> <p>3. Resident #3 had a diagnosis of Hemiplegia. The Medicare 5-day MDS dated 2/15/08 documented the resident was moderately</p>	F 314			

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F 314	<p>Continued From page 9</p> <p>impaired in cognitive skills for daily decision making, was dependent for bed mobility and transfers, was incontinent of bowel and bladder, had 3 Stage I pressure ulcers, had 2 Stage II pressure ulcers, had a pressure relieving device in the chair/bed, was on a turning/repositioning program and had nutrition/hydration interventions to manage skin problems.</p> <p>a. The plan of care developed 2/15/08 documented a problem of, "The resident has the potential for or a history of break in skin integrity as evidenced by impaired physical status" with interventions "Pressure relieving device (if applicable), turn every 2 hours and PRN with pillows to protect bony prominences."</p> <p>b. On 3/17/07 at 12:10 p.m., the resident was in bed on her back. CNA #6 and CNA #7 came into the resident's room. The top linens were removed and the resident's heels were directly on the bed. The right and left inner heels were a dark red. CNA #6 stated they felt soft. No off-loading of pressure was provided for the heels.</p> <p>c. On 3/18/08 at 8:10 a.m., the resident was in bed on her back. The resident's heels were not off loaded and were lying directly on the mattress.</p> <p>d. On 3/18/08 at 10:16 a.m., the resident was up in a Geri-chair with the feet elevated; she was being pushed to therapy. Her heels were directly on the footrest.</p> <p>e. On 3/18/08 at 11:45 a.m., the resident remained up in the Geri-chair in therapy. The physical therapy aide (PTA) was asked, "What time did the resident arrive this morning?" She</p>	F 314			

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F 314	<p>Continued From page 10</p> <p>replied "Around 10:25 [a.m.]" When asked, "What kind of therapy does this resident receive?" She stated, "We only do range of motion." At 12:00 p.m., the resident was pushed to her room and her heels remained on the footrest of the Geri-chair.</p> <p>f. On 3/18/08 at 12:50 p.m., CNA #7 stated they had just put the resident to bed. The resident remained up in the Geri-chair for approximately 2 and 1/2 hours, with her heels directly on the footrest. There was also no pressure-relieving device in the Geri-chair.</p> <p>4. Resident #5 had a diagnosis of Congestive Heart Failure. The Quarterly MDS dated 1/20/08 documented the resident had severely impaired cognitive skills for daily decision-making, required extensive assistance of two persons for bed mobility and transfers, was incontinent of bowel and bladder and had a pressure relieving device for the chair.</p> <p>a. The plan of care updated 1/21/08 documented a problem: "The resident has the potential for or a history of break in skin integrity as evidenced by incontinence of bowel/bladder &amp; impaired physical status" with interventions, "Chair, if applicable. (pressure relief device)"</p> <p>b. On 3/18/08 at 8:20 a.m., the resident was up in a wheelchair at the nurses' station, without a pressure-relieving device in place. At 9:30 a.m. and 9:55 a.m., the resident remained in the wheelchair, in the day room, without a pressure-relieving device in the wheelchair.</p> <p>c. On 3/18/08 at 11:15 a.m., the resident was pushed to her room and transferred to the toilet.</p>	F 314			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/19/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
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F 314	<p>Continued From page 11</p> <p>Both of the resident's lower buttocks were a dark red. CNA #7 was asked, "Is there a PRD [pressure relief device] in the wheelchair?" She replied, "No, I don't think she has one ordered, but I can check."</p> <p>d. On 3/18/08 at 12:10 p.m., the resident was up in the wheelchair in the dining room and there was no pressure-relieving device in the chair.</p> <p>e. On 3/19/08 at 8:45 a.m., the ADON stated, the resident now has a pressure-relieving device in the chair.</p> <p>5. Resident #6 had a diagnosis of Dementia. The Quarterly MDS dated 1/23/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, was occasionally incontinent of bowel and frequently incontinent of urine.</p> <p>a. The Plan of care updated 1/29/08 documented a problem of, "The resident has the potential for or a history of break in skin integrity as evidenced by impaired mobility" with interventions that included, "Incontinent care after each episode and turn every 2 hours."</p> <p>b. The body audit report dated 3/4/08 documented: "Peri area red, Calmoseptine applied."</p> <p>c. The body audit report dated 3/11/08 documented, "Open area to testicle, lantiseptic applied." There was no documentation in the clinical record the physician was notified of the open area and no documentation a treatment order was obtained. The March 2008 Treatment record documented an order dated 8/28/07:</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
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F 314	<p>Continued From page 12</p> <p>"Apply Calmoseptine to groin, scrotum &amp; penis areas BID till cleared;" this was documented as applied every shift from 3/1/08 through 3/18/08.</p> <p>d. The body audit report dated 3/17/08 documented, "Small sore 0.8 cm x 0.7 cm, SM (small) sore to scrotum 0.4 cm x 0.2 cm, redness noted to peri area."</p> <p>e. On 3/19/08 at 9:15 a.m., when asked, "Were you aware of any open areas for this resident?" The ADON stated, "No, no one has reported anything to me." A body audit was requested.</p> <p>At 9:30 a.m., the resident was lying in the bed and the ADON measured the following areas: 1.2 cm x 1 cm Stage II to dorsal scrotum. She stated that she was not aware of this [wound] and would call the physician for a treatment.</p> <p>6. Resident #7 had diagnoses of Dementia and Failure to Thrive. The Medicare 14-Day MDS dated 12/31/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance of one person for transfers and was incontinent of bowel and bladder.</p> <p>a. The plan of care dated 12/19/07 documented a problem of, "Potential for altered skin integrity related to decrease mobility and incontinence." There were no interventions documented for a pressure-relieving device for the resident's chair.</p> <p>b. On 3/17/08 at 12:15 p.m., the resident was up in a wheelchair at the nurses' station with a lap buddy in place. There was no pressure-relieving device in the chair.</p>	F 314			

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F 314	<p>Continued From page 13</p> <p>c. On 3/19/08 at 9:00 a.m. and 11:00 a.m., the resident was up in a wheelchair in the day room with a lap buddy in place. There was no pressure-relieving device in the chair. A body audit was requested.</p> <p>The resident was pushed to her room and LPN #4 and CNA #7 assisted the resident to stand. The resident's Ischial areas were a dark maroon color. The LPN stated, "I think she has an order for a cushion, I will have to check and see."</p> <p>d. On 3/19/08 at 11:15 a.m., LPN #4 stated there was no order for a cushion.</p>	F 314			