

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

PRINTED: 06/08/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/24/2007
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS HEALTHCARE AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 8701 RILEY DRIVE LITTLE ROCK, AR 72205	
(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 164 SS=E	<p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure personal privacy was provided for 2 (Residents #6 and 7) of 8 (Residents #1, 3, 5, 6, 7, 9, 10, and 13) case mix residents who were incontinent of bowel/bladder. This failed practice had the potential to affect 547</p>	F 164		

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 164	Continued From page 1 residents who were incontinent of bowel/bladder according to according to a list provided by the Director of Nursing on 5/24/07 at 12:15 p.m.. The findings are: 1. Resident #7 had diagnoses of Bilateral Above The Knee Amputation, and Cerebral Vascular Accident. The MDS (Minimum Data Set), dated 4/6/07 documented the resident had modified independent cognitive skills for daily decision making, was incontinent of bowel and bladder, and required total staff performance for hygiene, toileting, and mobility. a. On 5/22/07 at 1:48 p.m., CNA (Certified Nursing Assistant) #2 performed incontinent care for the resident with the window blinds open. The resident's bed was beside the window, and the resident's room was located on the front side of the facility. 2. Resident #6 had diagnoses of Depression and Anxiety. The MDS dated 4/18/07 documented the resident had moderately impaired cognitive skills for daily decision making, was frequently incontinent of bowel and bladder, and required extensive assistance with hygiene and toileting. a. On 5/23/07 at 2:23 p.m., CNA #1 pulled the resident's brief and pants half way down her thighs, then left the resident's room to obtain supplies. The hallway door was left open approximately 24 inches, allowing anyone passing the resident's doorway to view the resident who was uncovered and visible from the hallway. After the CNA left the room, the resident shouted "Shut the door, Shut the door."	F 164			
F 241 SS=D	483.15(a) DIGNITY	F 241			

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F 241	<p>Continued From page 2</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure dignity was maintained by providing repositioning/incontinent care prior to the noon meal for 1 (Resident #8) of 7 (#3, #5, #6, #7, #9, #10 and #13) case mix residents who required incontinent care/positioning by staff. This failed practice had the potential to affect 7 residents on Hall A who required incontinent care/positioning by staff as documented on a list provided by the Administrator on 5/24/07. The findings are:</p> <p>1. Resident #8 had diagnoses of Cerebral Vascular Accident (CVA) with right Hemiparesis. The significant change MDS dated 3/2/07 documented the resident had a modified independence in cognitive skills for daily decision making and had long term memory problems. The resident required total care by staff. The resident was occasionally incontinent of bowel and had an indwelling Foley catheter.</p> <p>a. The Plan of Care dated 2/26/07 documented the following:</p> <p>Problem: Extensive assistance with bed mobility, transfers, dressing, eating, toileting, personal hygiene, related to old CVA.</p> <p>Approach: Provide incontinent care following each episode. Keep resident clean, dry and odor</p>	F 241		

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F 241	<p>Continued From page 3 free. Maintain dignity.</p> <p>b. On 5/22/07 ay 9:15 a.m, 2 CNA's (#4 and #5) were observed during incontinent care. The resident did not have an indwelling Foley catheter. The resident was incontinent of bowel and bladder.</p> <p>c. On 5/23/07 at 10:00 a.m, the resident was observed in her wheel chair by the bed. The resident was marked on paper for positioning/incontinent care with the date and the time under the left thigh.</p> <p>d. On 5/23/07 at 1:10 p.m, the resident was observed eating her noon meal in her wheel chair by the bed. The resident was still marked with paper under the left thigh. The residents sweat pants were wet to touch. The resident was marked for positioning/incontinent care for a total of 3 hours and 10 minutes without a change in position or incontinent care.</p> <p>e. On 5/24/07 at 10:00 a.m. during an interview, CNA #7 was asked what they are taught about incontinent care/repositioning. CNA #7 stated, "I am team leader and I make sure floor work is done. I try to keep up with repositioning too".</p> <p>f. On 5/24/07 at 11:30 a.m, during an interview, LPN #3 was asked who is responsible to monitor ADL care. LPN #3 stated, "charge nurses. Try to get down there as often as you can to see what they are doing".</p> <p>g. On 5/24/07 at 11:10 a.m, during an interview, LPN #6 was asked who was responsible to monitor ADL care. LPN #6 stated, "charge nurses. I can miss something. Can't see</p>	F 241			

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F 241	Continued From page 4 everything".	F 241		
F 253 SS=C	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure wall paper was in good repair, furniture was free of breaks, linoleum was free of holes, halls were free of buildup along the baseboards and showers were free of buildup in the grout lines. This failed practice had the potential to affect 105 residents in the facility as identified by the Administrator on 5/21/07. The findings are: On 5/22/07 at 1:35 p.m. the following observations were made: a. The corner located next to the coffee machine in the Main Dining Room had an gouged area approximately 2X2 inches that left a hole in the drywall of the corner. b. The Manor Lodge Dining Room had the wall paper peeling away from the wall below the window that faced G Hall. There was a straight backed chair in the room that had the right arm broken and hanging down the side of the chair. c. On F Hall, resident room # PR12 had an area of linoleum in the entry doorway approximately 3 inches wide and 3 feet in length in which the edges were curling up along the length of the linoleum.	F 253		

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F 253	Continued From page 5 d. The Central Supply alcove, located up the hall from the Main Dining Room had an area of wall paper torn away from the wall leaving a hole in the paper approximately 2 inches by 6 inches. The border at the top of the wall was not secured to the wall in an area measuring approximately 4 feet. e. The Dining Room located next to A Hall, had a feeder table with the leg broken away from the table and hanging down from the table approximately 1 foot. There were two straight backed chairs in the room that had the bottom cross section supports broken and hanging down from the chairs. f. A Hall had a dirt buildup along the entire length of the hall along the baseboard. g. The Therapeutic Dining Room located between A and B Hall had the handwashing sink shifted to the right allowing the right side to dip down approximately 1 inch away from the caulking. h. At the entry to B Hall, to the right of the door, the wall paper was torn away from the wall along the bottom of the handrail to the floor, approximately 8 inches in width. i. Resident rooms # B5, B9 and B10 had linoleum flooring that contained holes in the center of the room. Room B9 had holes in an area measuring approximately 4 feet by 6 inches, room B5 had 3 holes measuring approximately 1 inch to 2 inches in diameter and B10 had 4 holes in the flooring. j. Beside the Nursing Center ice machine the wall paper was peeling away from the wall from the	F 253			

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F 253	Continued From page 6 ice scoop holder to the floor.	F 253		
F 282 SS=E	<p>k. At the entrance to D Hall on the left side of the hall, the bottom 1/2 of the wall was marked with orange marks on the wall paper.</p> <p>l. B Hall shower room had an area of black mildew in the grout lines of the stall wall measuring approximately 3 feet by 2 feet.</p> <p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure physician's orders were implemented correctly for 1 (Resident #3) of one case mix residents with physician orders for anti anxiety medication, and for 2 (Residents #8 and 11) of 2 case mix resident with physician orders for TED hose. These failed practices had the potential to affect 1 resident with physician orders for antianxiety medication according to a list provided by the DON on 5/24/07 and 2 residents with physician orders for TED hose according to a list provided by the Administrator on 5/24/07. The findings are:</p> <p>1. Resident # 3 had a diagnosis of End Stage Renal Disease. The Quarterly Minimum Data set dated 4/10/07 documented the resident had severely impaired cognitive skills for daily</p>	F 282		

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F 282	<p>Continued From page 7</p> <p>decision making, was dependent on staff for all activities of daily living and had received a Antianxiety medication 3 of the past 7 days and had dialysis treatments.</p> <p>a. The plan of care updated 4/11/07 documented, " Problem: At risk for complicating factors, related to Renal Dialysis ... Interventions: ... Medication as ordered per M.D (Medical Doctor)."</p> <p>b. A Physician's order dated 3/10/06 documented, "Xanax 0.25 mg po (by mouth) 30-60 minutes prior to transport."</p> <p>c. On 5/23/07 at 10:00 a.m., the clinical record was reviewed. The January 2007 Medication Administration record (MAR) was blank in the space provided by documenting the Xanax was given. The February and March 2007 MAR's documented the resident received the medication as ordered. The April 2007 MAR was blank in the spaces provided by documenting the Xanax was given. The May 2007 MAR documented that the medication was administered on May 2, 4, 7, 9, 14, 16, 18 21 and 23, 2007.</p> <p>d. On 5/23/07 at 4:00 p.m., the order for the medication to be administered as needed was requested from the Director of Nursing.</p> <p>e. On 5/24/07 at 7:55 a.m., the Director of Nursing stated there was no order for the medication to be given PRN and the resident should have received it routinely since the initial order on 3/10/06.</p> <p>2. Resident #8 had diagnoses of Peripheral Vascular Disease (PVD). The significant change</p>	F 282			

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F 282	<p>Continued From page 8</p> <p>MDS dated 3/2/07 documented the resident had modified independent cognitive skills for daily decision making and required total care by staff.</p> <p>a. Physicians orders dated 4/2/07 documented: "Apply TED stockings daily and remove at night."</p> <p>b. On 5/22/07 at 9:15 a.m., 2 CNA's (Certified Nursing Assistant) #4 and #5 were providing morning care. The resident was dressed and transferred to her wheel chair. CNA's #4 or #5 did not apply TED hose to the residents lower extremities.</p> <p>c. On 5/22/07 at 10:30 a.m., and 2:50 p.m., the resident was in a wheel chair. The resident did not have TED hose applied to the lower extremities.</p> <p>d. On 5/23/07 at 9:35 a.m., 2 CNA's (#4 and #5) were providing morning care. The resident was dressed and transferred to her wheel chair. CNA #4 nor #5 apply TED hose to the residents lower extremities.</p> <p>e. On 5/23/07 at 12:40 p.m., the surveyor asked CNA #4 about the TED hose for this resident. CNA #4 stated, "She is supposed to have them but she refused them yesterday morning and again this morning." The surveyor had observed morning care for the resident on 5/22 and 5/23/07 by CNA #4 and #5. TED hose were not offered to the resident.</p> <p>3. Resident #11 had diagnoses of Peripheral Vascular Disease (PVD). The quarterly MDS dated 3/29/07 documented the resident had independent cognitive skills for daily decision making and required extensive assistance of staff</p>	F 282			

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F 282	Continued From page 9 for dressing and personal hygiene. a. Physician orders dated 5/16/06 documented, "TED hose to Bilateral lower extremities. On in AM (morning). Off at HS (hour of sleep)". b. On 5/23/07 at 10:50 a.m., the resident was asked if he wore Ted hose during the day when he was up in the wheel chair. The resident stated, "Sometimes I do." The surveyor asked the resident when were the TED hose worn. The resident stated, "When my feet go to swelling." The resident was also asked if the TED hose were in place now, the resident stated, "No." c. On 5/23/07 at 11:15 a.m., CNA #7 was asked about the TED hose for this resident. CNA #7 stated, "He wears them most of the time and then he rests his legs because they are so tight." CNA #7 was then asked if the resident could apply the TED hose himself. CNA #7 stated, "It's pretty difficult to get them on. He needs help." d. On 5/23/07 at 11:20 a.m., the surveyor asked LPN #3 about the TED hose for this resident. LPN #3 stated. "He don't refuse to wear them. He usually has them on." LPN #3 was asked if the resident had been educated on the reason for the TED hose. LPN #3 asked the resident, "Don't you know to wear them every day?" The resident stated, "No, I didn't know I was supposed to."	F 282			
F 309 SS=G	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.	F 309			

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F 309	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure pain medication was administered prior to the treatment for 1 (Resident #1) of 1 case mix resident with Stage III and Stage IV pressure sores. This failed practice caused actual harm to Resident #1 as evidenced by the resident moaning during the care and treatment of the decubitus ulcers and the resident confirmation of the presence of pain. The facility also failed to ensure that a foley catheter tubing was secured and catheter care was provided for 1 (Resident #1) of 2 (Residents #1 and 8) case mix residents with a Foley catheter. These failed practices had the potential to affect 4 residents residing in the facility with Stage III and/or Stage IV pressure sores that required treatment according to the Weekly Wound Report dated 5/24/07 and 6 residents with a foley as according to the Roster/Sample Matrix dated 5/21/07. The findings are: 1. Resident #1 had diagnoses of Decubitus Ulcer, Multiple, Cerebrovascular Accident and Dementia. The Quarterly Minimum Data Set dated 2/14/07 documented the resident had modified independent cognitive skills for daily decision making, was dependent on staff for all activities of daily living, had a catheter, was incontinent of bowel and had a Stage III pressure sore. a. The plan of care dated 4/3/07 and updated 5/23/07 did not address pain management with dressing changes.	F 309			

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F 309	<p>Continued From page 11</p> <p>b. A physician orders dated 5/3/07 documented: " Hydrocodone/Acetaminophen tablets 2.5 mg P/T (per tube) Q (every) 4 hours as needed for pain."</p> <p>c. On 5/22/07 at 11:15 a.m., LPN (Licensed Practical Nurse) #1 and #2 entered the room to do dressing changes. LPN #2 removed the dressing from the right scapula and measured the wound as 2.2 cm (centimeter) x 2.9 cm with 0.5 cm tunneling at 9 o'clock. LPN #2 cleansed the wound with Normal Saline and the resident moaned with pain. LPN #1 asked the resident, "Are you hurting?" The resident stated, "Yes." LPN #1 left the room to get the resident some pain medication. LPN #2 continued to clean and dress the wound with the resident moaning.</p> <p>The sacrum dressing which was saturated with serosanguinous/light green exudate, was removed and three wounds were identified on the sacral and buttocks. The actual sacral wound was a Stage IV measuring 5.2 cm x 3.4 cm x 1.4 cm with 3.0 cm of tunneling at 4 o'clock. There was a Stage III pressure sore to the left of the Stage IV that measured 7.3 cm x 4.6 cm with necrosis in the center measuring 2.4 cm x 2.5 cm. There was a Stage II to the right of the Stage IV measuring 5.0 x 3.8 cm. The wound to the left lower buttocks was measured at 1.9 cm x 1 cm. There was a Stage II identified on the right heel measuring 0.5 cm x 1.0 cm.</p> <p>At 11:27 a.m., after completing the dressing to the right scapula, CNA (Certified Nursing Assistant) #7 asked LPN #2 if she wanted her to turn the resident over to do the sacrum. LPN #2 stated, " No, let ' s give her a minute." At 11:27</p>	F 309			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2007
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS HEALTHCARE AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 8701 RILEY DRIVE LITTLE ROCK, AR 72205		
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F 309	Continued From page 12 a.m., LPN #2 told CNA #7 " Go ahead & turn her and then when she gets her pain medication she can rest." LPN #1 came back to the room with the resident's pain medication but could not get to the peg tube to administer the medication until the treatment to the sacrum was completed. LPN #2 cleansed with wounds to the sacrum with Normal Saline and 4 x 4's. The resident moaned in pain during the entire treatment of the sacrum. 2. The plans of care dated 4/03/07 and 5/23/07 documented, " Problem: At risk for complications, related to Indwelling catheter ... Interventions ... Ensure that catheter tubing is secured and reposition resident carefully to prevent trauma of urinary meatus and dislodging." a. On 5/21/07 at 2:26 p.m., the resident was in bed. The Foley catheter tubing had straw colored urine in it and the tubing was pulled tautly. There was no leg strap or mechanism to secure the Foley catheter tubing. b. On 5/22/07 at 7:45 a.m. and 8:52 a.m., the resident was in bed. The resident had no leg strap or mechanism to secure the Foley catheter tubing. c. On 5.22/07 at 9:10 a.m., the resident was in bed turned to the right side and the Foley catheter tubing was pulled tautly over the left leg. The resident had feces on the brief. There was no catheter care performed after this bowel movement.	F 309			
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312			

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F 312	Continued From page 13 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, and record review the facility failed to ensure that the perineum , groin, and buttocks was cleansed, and/or the foreskin was retracted from the head of the penis and cleansed when providing incontinent care for 2 (Residents #3, and 7), and the labia was separated and the mons pubis was cleansed when providing incontinent care for 1 (Resident #5) of 8 (Residents #1, 3, 5, 6, 7, 8, 9, and 13) and case mix residents who required incontinent care. This failed practice had the potential to affect 57 residents currently residing in the facility that required assistance for incontinent care as per a list provided by the Director of Nursing on 5/24/07. The findings are. 1. Resident # 3 had diagnosis of End Stage Renal Disease. The Quarterly Minimum Data Set (MDS) dated 4/10/07 documented the resident had severely impaired cognitive skills for daily decision making, was dependent on staff for transfers and was incontinent of bowel/bladder. a. The plan of care dated 10/18/06 and updated 1/17/07 and 4/17/07 documented, " Problem: Incont (incontinent) of B/B (Bowel and Bladder) - unable to retrain due to mental status secondary to dementia ... Interventions ... Provided incontinent care following each episode. Keep resident clean, dry and odor free." b. On 5/22/07 at 1:20 p.m., the resident was taken to his room for body audit. The brief was	F 312			

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F 312	<p>Continued From page 14</p> <p>soiled with urine and feces. CNA's (Certified Nursing Assistants) #8 and #9 performed incontinent care . The resident was washed on the inner folds of the buttocks. There was no incontinent care performed to the front perineum, groins or penis.</p> <p>2. Resident #5 had diagnoses of Depression, and Anxiety. The MDS dated 3/21/07, documented the resident had moderately impaired cognitive skills for daily decision making, was incontinent of bowel and bladder, and required limited assistance with toileting and hygiene.</p> <p>a. On 5/22/07 at 1:48 p.m., during incontinent care, CNA, #1 wiped from the Vagina across the rectum x 2 without changing to a clean area of the cloth, did not cleanse the Mons Pubis, separate the Labia, or dry the resident before placing a clean brief on her. The resident had been incontinent of urine and stool.</p> <p>3. Resident #7 had diagnoses of Bilateral Above The Knee Amputation, and Cerebral Vascular Accident. The MDS dated 4/6/07 documented the resident had modified independent cognitive skills for daily decision making, was incontinent of bowel and bladder and required total staff performance for hygiene, toileting, and mobility.</p> <p>a. On 5/22/07 at 1:23 p.m., during incontinent care, CNA #2 using only a wet washcloth without cleanser or soap, wiped up the Scrotum and the Left Groin without changing to a clean area of the cloth, did not cleanse the Right Groin or Left Buttock, did not pull back the Foreskin to cleanse the head of the Penis, and did not dry the resident before placing a clean brief on him. The resident</p>	F 312			

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F 312	Continued From page 15	F 312		
F 314	had been incontinent of urine.			
SS=H	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure accurate assessments of pressure sores were conducted and documented at least weekly for 1 (Resident #1) of 2 (Residents #1 and #14) case mix residents with pressure sores; interventions were developed, implemented, monitored, & revised to ensure the prevention or healing of pressure sores for 1 (Resident #1) of 2 (Residents #1 and #14) case mix residents with pressure sores and 3 (Resident #3, #6, and #8) of 7 (Residents #3, #5, #6, #7, #9, #10 and #13) case mix residents who were at risk for developing pressure; and failed to ensure deterioration of the pressure sores or the development of additional pressure sores were promptly identified and the physician consulted for 1 (Resident #1) of 2 (Residents #1 and #14) case mix residents with pressure sores; failed to ensure wounds were covered with the appropriate absorbive dressing to manage wound exudate for 1 (Resident #1) of 2 (Residents #1 and #14) case mix residents with pressure sores; failed to ensure the Dietary	F 314		

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F 314	<p>Continued From page 16</p> <p>Assessment was accurate and the nutritional needs for wound healing were being met for 1 (Resident #1) of 2 (Residents #1 and #14) case mix residents with pressure sores. These failed practices resulted in a pattern of actual harm for Resident #1 who experienced a deterioration in pressure sores and had the potential to affect 8 residents residing in the facility with pressure sores and 15 residents in the facility who were at risk for developing pressure sores as documented on a list provided by the Administrator on 5/24/07. The findings are:</p> <p>1. The facility policy/procedure for " Pressure ulcers & Body Audits, obtained from the Director of Nursing on 5/22/07, documented the following:</p> <p>a. Pressure ulcer skin condition assessment to be completed every week.</p> <p>b. Required documentation includes measurements (length, width and depth)</p> <p>c Pressure ulcer to be documented on weekly on a nurses note in the body audit book with a description of a wound.</p> <p>2. Resident #1 had diagnoses of Decubitus Ulcer, Multiple, Cerebrovascular Accident and Dementia. The Quarterly Minimum Data Set dated 2/14/07 documented the resident had short/long term memory problems, had modified independence in cognitive skills for daily decision making, was dependent on staff for all activities of daily living, had an indwelling urinary catheter, was incontinent of bowel and had a Stage III pressure sore.</p> <p>a. An Admission nursing assessment dated 2/1/07 documented the resident had pressure sores to the right shoulder and the sacrum area.</p>	F 314			

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F 314	<p>Continued From page 17</p> <p>There was no documented description of the pressure sores and no measurements to ensure that lack of progress in healing was quickly identified.</p> <p>b. A physician's order dated 2/2/07 documented, "Measure wounds."</p> <p>c. A Non-pressure skin condition report dated 2/8/07 (Six days after the physician ordered the wounds to be measured) documented the resident had a wound to the right shoulder that measured 1.8 cm (centimeter) x 1.7 cm x 0.3, had a large amount serosanguineous exudate and the surrounding tissue wound edges were macerated.</p> <p>There was another non pressure skin condition report dated 2/8/07 that documented the resident had a wound to the sacrum that measured 3.0 cm x 2.0 cm x 0.5 cm, had a large amount of serosanguineous exudate and the surrounding tissue wound edges were macerated."</p> <p>d. Nurses notes dated 2/14/07 (3-11) documented, "Odor detected strongly from decubs." There was no documentation in the nurses notes, physician's orders or physician progress notes that the physician was notified of the strong odor.</p> <p>e. A Non-pressure skin condition report dated 2/15/07 documented the right shoulder wound had deteriorated to measure 2.7 cm x 1.5 cm x 0.6 cm with 0.6 cm of tunneling at 9 0'clock. The form further documented the wound had a copious amount of blood tinged drainage with slight odor noted. The space provided for the date the physician was notified was left blank.</p>	F 314			

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F 314	<p>Continued From page 18</p> <p>There was no documentation in the nurses notes, physician's orders or physician progress notes that the physician was notified of the tunneling, copious drainage or odor.</p> <p>A Non-pressure skin condition report dated 2/15/07 documented the Sacrum wound measured 3.0 cm x 2.3 cm x 0.3 cm with a large amount of Serosanguineous drainage and the surrounding tissue was macerated.</p> <p>f. Nurses notes dated 2/16/07 (7-3) documented the physician called with an order for Tobramycin 120 mg (milligram) IM (intramuscular) daily for 3 days for Urinary Tract Infection.</p> <p>g. A Non-pressure skin condition report dated 2/22/07 documented the measurements of the right shoulder wound as 2.8 cm x 1.8 cm x 0.8 cm with 1.0 cm of tunneling at 9 o'clock. The report further documented the wound had copious blood tinged drainage and an increase in odor. Nurses notes dated 2/22/07 documented " R (resident) noted with deterioration to wound (R) shoulder area with [increased] tunneling, copious blood tinged drainage with odor. Treatment changed."</p> <p>A Non-pressure skin condition report dated 2/22/07 documented the sacrum wound measured 3.0 cm x 2.3 cm x 0.3 cm with a large amount of serosanguineous drainage and the surrounding tissue was macerated. This form also documented the physician was notified and the treatment changed.</p> <p>h. Nurses notes dated 2/27/07 (3-11) documented " T.O. (telephone order) send to (name of hospital) ER (emergency room) for Eval [evaluation] of elevated temp."</p>	F 314		

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F 314	Continued From page 19 i. The hospital History and Physical dated 2/27/07 documented the resident had a sharply elevated temperature of 101 and was admitted, "Fever, uncertain etiology. Possibly early sepsis. Her sacral wounds are frequently the cause of this." j. A wound consultant report dated 3/1/07 (while resident in the hospital) documented, "Scars noted from previous pressure wounds. Rt. Shoulder - clean area 2.5 cm x 2.5 cm x .6 cm with 4 cm tunnel medially, clean well granulated. Sacrum 1.5 cm x 1.5 cm x 0.4 cm - red, clean well granulated. Rec: (recommendation) Shoulder: pack lightly with NS [Normal Saline] in tunnel - cover with covaderm - no paper or adhesive tape. Sacrum: Hydrogel & cover with Covaderm. Frequent turning." k. An admission nursing assessment dated 3/15/07 documented the resident was re-admitted to the facility with a pressure sore to the right shoulder and coccyx (sacrum,). There were no measurements or descriptions of the wounds. l. The Weekly Ulcer (cumulative report) report dated 3/5/07 through 3/11/07 documented wound A (RT. Shoulder) as 1.8 cm x 1.7 cm x 0.3 cm and wound B (sacrum) as 3.0 cm x 2.0 cm x 0.5 cm. The resident was in the hospital during these measurement. There were no individual records for these wounds for this resident. m. The Weekly Ulcer report from 3/12/07 through 3/25/07 documented the measurements as the same as the measurements documented on 2/22/07 for both wounds. There was no weekly report obtained for 3/26 through 4/2/07.	F 314		

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F 314	<p>Continued From page 20</p> <p>n. The plan of care developed 4/3/07 documented the resident had pressure sores to the sacrum, the left hip and the right hip.</p> <p>o. The Weekly Ulcer report from 4/2/07 through 4/29/07 the wounds were exactly the same as the measurements documented on 2/22/07. The report dated 4/30/07 through 5/6/07 documented the resident was in the hospital.</p> <p>p. Nurses notes dated 4/14/07 at 4:30 p.m., documented the resident was sent to a local hospital and was admitted.</p> <p>q. The physician progress notes from the local hospital dated 4/17/07 documented the wounds as chronic wound beds - clean, pink tissue with necrosis. Wound measurements: (R) shoulder 2 cm x 2 cm x 1 cm with sinus tract 13.5 cm noted at 9 o'clock. Sacral wound 4 cm x 2 cm x 2 cm with undermining 1 cm noted 9-3 o'clock.</p> <p>r. There was a Admission nursing assessment dated 5/3/07 that documented the resident was re-admitted with wounds to the right shoulder and coccyx (sacrum,). There was no documentation of any description of the wound. The Admission Physician orders documented the resident was to receive Osmolite 1.5 @ 47 cc/hr.</p> <p>s. An individual wound/skin healing record dated 5/6/07 documented the wound to the Right Shoulder (Wound A) was a Stage II, measured 1.8 cm x 1.7 cm x 0.3 cm., had a small amount of serous drainage and the surrounding tissue was macerated.</p> <p>An individual wound/skin healing record dated 5/6/07 documented the wound to the Sacrum</p>	F 314			

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F 314	<p>Continued From page 21</p> <p>(Wound B) was a Stage III, measured 3.0 cm x 2.0 cm x 0.5 cm with 4 cm of tunneling (no description of where on the wound) (This was the first documentation of tunneling by the facility.) This report documented the wound had moderate serous drainage and the surrounding tissue was macerated. The response to the treatment was checked as improved.</p> <p>t. The Dietary Progress notes dated 5/8/07 documented the resident was receiving 2 Cal HN at 31 cc/hr x 23 hours. (The resident was receiving Osmolite) The Dietary progress note dated 5/18/07 documented the resident had tube feeding changed to Osmolite on 5/3/07 that supplied on 1621 Kcal, 63 gm Pro and 1858 ml of free water. This note also documented the resident was being treated for 2 Stage II pressure sores. New interventions documented " Current TF (Osmolite) may not be meeting needs for wound healing. Suggest increase to 65 ML/hr."</p> <p>u. An individual wound/skin healing record dated 5/13/07 documented the wound to the Right Shoulder (Wound A) measured 1.8 cm x 1.5 cm x 0.3 cm with a small amount of serous drainage and the surrounding tissue was macerated.</p> <p>v. An individual wound/skin healing record dated 5/13/07 documented the wound to the Sacrum (Wound B) measured 2.75 cm x 2. cm x 0.5 cm with 4 cm of tunneling (no description of where on the wound), had moderate serous drainage and the surrounding tissue was macerated.</p> <p>w. An individual wound/skin healing record dated 5/20/07 documented the wound to the Right Shoulder (Wound A) measured at 1.75 cm x 1.5 cm x 0.3 cm with a small amount of serous</p>	F 314		

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F 314	<p>Continued From page 22</p> <p>drainage and the surrounding tissue was macerated.</p> <p>An individual wound/skin healing record dated 5/20/07 documented the wound to the Sacrum (Wound B) measured 3.0 cm x 2.0 cm x 0.5 cm with 4 cm tunneling (no description of where on the wound), had serous drainage and the surrounding tissue was macerated.</p> <p>x. On 5/22/07 at 9:10 a.m., CNA #6 performed a bed bath. CNA #6 stated the resident never gets out of bed and only received bed baths. There was a dressing to the right scapula and a saturated dressing to the sacrum. The resident had a bowel movement and the lower 1/3 of the dressing on the sacrum had feces on it. The resident had a cratered Stage II pressure sore to the left lower buttocks approximately 12 cm circular. The resident also had a superficial Stage II pressure sore to the right heel approximately 0.5 cm. At 9:35 a.m., CNA #6 stated that she informed LPN #1 of the feces soiled dressing to the sacrum.</p> <p>1) At 11:15 a.m., LPN #1 and #2 entered the room to do the dressing changes. LPN #2 removed the dressing from the right scapula and measured the wound as 2.2 cm x 2.9 cm with 0.5 cm tunneling at 9 o'clock.</p> <p>2) The sacrum dressing which was saturated with serosanguinous/light green exudate, was removed and three wounds were identified. The actual sacral wound was a Stage IV measuring 5.2 cm x 3.4 cm x 1.4 cm with 3.0 cm of tunneling at 4 o'clock. There was a Stage III pressure sore to the left of the Stage IV that measured 7.3 cm x 4.6 cm with necrosis in the center measuring 2.4</p>	F 314			

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F 314	<p>Continued From page 23</p> <p>cm x 2.5 cm. There was a Stage II to the right of the Stage IV measuring 5.0 x 3.8 cm . The wound to the left lower buttocks was measured at 1.9 cm x 1 cm. The right heel measured 0.5 cm x 1.0 cm. Both LPN's stated they did not know about the deterioration of the wounds.</p> <p>3) At 11:45 a.m., the clinical record was reviewed. There was a physician's telephone order dated 5/22/07 for "NS wet-dry dressing to shoulder and sacrum, wound clinic appointment."</p> <p>y. On 5/22/07 at 12:05 p.m., the Director of Nurses was interviewed. When asked who was responsible for assessing the wounds, measuring and notifying the physician of any changes, she stated: "The Charge Nurse is responsible." When asked if anyone reported any new wounds or changes in the wounds for this resident, she replied: "No, I saw them Sunday and measured them." When asked if the wound looked better or worse, she replied: "Well, I didn't see the wounds, I just wrote down the measurements from the past weeks measurements." She was asked if she knew of any changes that were called to the physician and she replied: "Not that I know of." "When asked if that would that be reported to her, she stated: " Yes." She was asked why the physician referred the resident to the wound clinic this morning and she replied: " I told [LPN #1] to get an order for the wound clinic because she has had no changes in the wound."</p> <p>z. On 5/23/07 at 8:00 a.m., the nurses notes documented the changes in the wound and new treatments obtained for the 3 on the sacrum and the right heel. There was no treatment obtained for the cratered Stage II to the left lower buttocks.</p>	F 314			

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F 314	<p>Continued From page 24</p> <p>1) At 9:35 a.m., the dressing to the sacral area was saturated with a serosanguinous green drainage. There was no dressing/treatment to the left lower buttocks. The right heel had a Kerlix dressing.</p> <p>2) At 10:20 a.m., LPN #3 was asked: " Did you perform the treatment to the sacrum and right shoulder on Monday [5/21/07]?" She replied, "Yes." She was then asked, "When did you notice a change in the wound and how had the wound changed?" She replied, "The only difference I saw was some shearing."</p> <p>3) At 10:55 a.m., LPN #3 was asked: "When was the last time you measured the wounds?" She replied: "Done one some time back when she came back from the hospital, I thought someone else was doing them."</p> <p>4) At 11:05 a.m., the right scapula dressing was removed. LPN #3 stated that there was no change in the wound from Monday. The sacral area dressing was removed. LPN #3 stated "I saw the gray area around the left of the wound on Monday."</p> <p>5) At 3:45 p.m., DON was asked to explain how the measurements of the wounds could remain the same from February until May when the hospital reports documented different findings. The DON stated " I either have to measure or get from body audits, I have not been trained to measure a wound so, the numbers could be different.</p> <p>An inservice training report dated 2/7/07 documented the Licensed Nurses were inserviced regarding Pressure ulcer assessment</p>	F 314		

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F 314	<p>Continued From page 25</p> <p>and documentation. The training handout documented the following regarding exudate: Wound exudate contains dead cells and liquified necrotic debris. The goal of wound healing is to treat and maintain an optimal moist wound healing environment. Too little exudate can desiccate the wound, too much can saturate dressing leading to peri wound maceration. This handout further documented how to measure, stage, size a wound as well as assessment of the wound bed and surrounding tissue. The Director of Nursing documented she attended this inservice.</p> <p>a. The resident plan of care for 7/3/06 through 5/23/07 was reviewed. Each quarter the interventions remained the same. The plan of care dated 5/23/07 did not include the additional wounds that were identified on 5/22/07 and there was no new interventions attempted.</p> <p>3. Resident # 14 had diagnoses of Congestive Heart Failure and Blindness. The Quarterly Minimum Data Set dated 2/15/07 documented the resident had short term memory problems, modified independence in cognitive skills for daily decision making, was frequently incontinent of bowel/bladder and had 3 Stage II pressure sores.</p> <p>a. The plan of care updated 3/14/07 documented a problem of "Pressure sores" with interventions that included " Encourage to turn and reposition q (every) 2 hrs." The Nursing Assistant Assessment (CNA care plan) documented the resident was to be turned and repositioned every 2 hours.</p> <p>b. On 5/23/07 at 9:20 a.m., the resident was observed up in the wheelchair at the nursing</p>	F 314			

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F 314	<p>Continued From page 26</p> <p>station. The resident's position was marked with a pink piece of paper under the left lower thigh. At 9:30 a.m., 9:45 a.m., 10:15 a.m., the resident was observed in activities in the same marked position. At 11:00 a.m., the resident was observed up in the wheelchair at the nurses station and in the same marked position.. At 12:00 p.m., and 1:25 p.m., the resident was observed in the therapeutic dining room in the same marked position.. At 1:25 p.m., the Director of Nursing was asked to locate the pink piece of paper. She felt under the left lower thigh and retrieved the pink piece of paper. The resident was up 3 hours and 55 minutes.</p> <p>4. Resident # 3 had diagnosis of End Stage Renal Disease. The Quarterly Minimum Data set dated 4/10/07 documented the resident had short/long term memory problems, was severely impaired in cognitive skills for daily decision making , was dependent on staff for transfers and was incontinent of bowel/bladder. The Braden Scale form dated 4/11/07 documented the resident's score as14, a score of 13-14 indicated the resident was at a moderate risk for pressure sores.</p> <p>a. The plan of care developed 10/18/06 and updated 1/17/07 and 4/17/07 did not identify the resident to be at risk for pressure sores and there were no documented interventions to prevent the development of pressure sores.</p> <p>b. On 5/22/07 at 10:00 a.m., the resident was up in the wheelchair with a lap buddy, sitting at the nurse ' s station. This writer was in view of the resident until 10:25 a.m., at which time his position was marked by placing a piece of pink paper under the left lower thigh. At 10:45 a.m.</p>	F 314			

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F 314	<p>Continued From page 27</p> <p>and 1:20 p.m., the resident was observed in the same marked position. At 1:20 p.m., LPN #1 was asked to look for the pink piece of paper and she retrieved it from under the resident's left lower thigh. The resident was up in the chair for 3 hours and 20 minutes.</p> <p>5. Resident #6 had diagnoses of Depression and Anxiety. The MDS dated 4/18/07 documented the resident had moderately impaired cognitive skills for daily decision making, was frequently incontinent of bowel and bladder, required extensive assistance with hygiene and toileting, and had a history of a Sacral Pressure Ulcer that was documented healed 4/23/07.</p> <p>a. On 5/23/07 at 9:50 a.m., the resident was observed sitting in wheelchair visiting with family in lobby by nurse's station. This surveyor placed a small 1 inch square paper, marked, dated, and timed, into the waist band of the resident's pants.</p> <p>b. On 5/23/07 at 2:16 p.m., the resident was observed sitting in the dining room in her wheelchair. This surveyor requested a body audit, and the resident was taken to her room by CNA #1 and LPN (Licensed Practical Nurse), #4. As the resident was assisted to stand the paper fell to the floor, and the CNA asked "What is that?" This surveyor showed the dated and timed paper to the CNA and asked him if he had checked and/or changed the resident since 9:50 a.m., and he stated, "No, I haven't." The resident's brief was soaked with urine, and dried feces was on rectal area and her inner buttocks.</p> <p>6. Resident #8 had diagnoses of Cerebral Vascular Accident (CVA) with right Hemiparesis. The significant change MDS dated 3/2/07</p>	F 314			

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F 314	<p>Continued From page 28</p> <p>documented the resident had modified independence in cognitive skills for daily decision making, had long term memory problems, required total care by staff, was occasionally incontinent of bowel, had an indwelling Foley catheter and had no pressure sores.</p> <p>a. The Plan of Care dated 2/26/07 documented: "Problem: Extensive assistance with bed mobility, transfers, dressing, eating, toileting, personal hygiene, related to old CVA....Approach: Encourage to turn and reposition Q (every) 2 hrs. (hours), in bed- staying off back and buttocks." The care plan did not address the residents risk for pressure sore.</p> <p>On 5/23/07 at 2:00 p.m., during an interview, the surveyor asked the DON, was the resident at risk for pressure sores. The DON stated, "Yes, she had pressure sores on her last admission to the facility and should have been care planned on this admission."</p> <p>b. The Pressure Ulcer Risk Assessment form dated 3/7/07 documented a score of 13 (Total score of 8 or above represents High Risk).</p> <p>c. On 5/22/07 at 9:15 a.m., 2 CNA's (#4 and #5) were observed during incontinent care. The resident did not have an indwelling Foley catheter. The resident was incontinent of bowel and bladder.</p> <p>d. On 5/23/07 at 10:00 a.m., the resident was observed in her wheel chair by the bed. The resident was marked on paper for positioning/incontinent care with the date and the time under the left thigh. On 5/23/07 at 1:10 p.m, the resident was observed in her wheel chair by</p>	F 314		

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F 314	Continued From page 29 the bed. The resident was still marked with paper under the left thigh. The resident's sweat pants were wet to touch. The resident was marked for positioning/incontinent care for a total of 3 hours and 10 minutes without a change in position/incontinent care. e. On 5/24/07 at 10:00 a.m. during an interview, CNA #7 was asked what they were taught about incontinent care/repositioning. CNA #7 stated, "I am team leader and I make sure floor work is done. I try to keep up with repositioning too." 1) On 5/24/07 at 11:30 a.m., during an interview, LPN #3 was asked who was responsible to monitor ADL care. LPN #3 stated, "Charge nurses. Try to get down there as often as you can to see what they are doing." 2) On 5/24/07 at 11:10 a.m., during an interview, LPN #6 was asked who was responsible to monitor ADL care. LPN #6 stated, "Charge nurses. I can miss something. Can't see everything."	F 314			
F 318 SS=D	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 observations, record review the facility failed to ensure positioning devices to prevent	F 318			

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F 318	Continued From page 30 contractures were in place for 1 (Resident #1) of 1 case mix resident who had hand contractures on the D hall. This failed practice had the potential to affect 1 resident with hand contractures on the D hall as per a list provided by the Director of Nursing on 5/24/07. The findings are: Resident #1 had diagnoses of Multiple Decubitus Ulcer, Cerebrovascular Accident and Dementia. The Quarterly Minimum Data Set dated 2/14/07 documented the resident had modified independence cognitively for daily decision making skills and was dependent on staff for all activities of daily living. a. The plan of care updated 5/23/07 did not identify a problem with contractures. b. On 5/21/07 at 2:26 p.m., the resident was observed in bed. Both hands were in a fist. There were no positioning devices in place to prevent contractures. c. On 5/22/07 at 7:45 a.m., the resident was again observed in bed. Both hands were in a fist. There were no positioning devices in place to prevent contractures. d. On 5/22/07 at 8:42 a.m., the DON placed sheepskin hand rolls in the resident's hands.	F 318			
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced	F 323			

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F 323	Continued From page 31 by: Based on observation the facility failed to ensure the entry doors were free of splinters and staples protruding from the doors, dryers were free of lint buildup, furniture was free of breaks, shower rooms were free of sharp edging on the tiles and the Biohazard room doors were securely locked. This failed practice had the potential to affect all 105 residents in the facility as identified by the Administrator on 5/21/07. The findings are: 1. On 5/22/07 at 2:37 p.m. a. The following door had gouges on the hinged side of the entry door approximately 4 1/2 feet up from the floor exposing splinters: B Hall: B12 b. The following doors had gouges on the hinged side of the entry door approximately 4 feet up from the floor exposing splinters: B Hall: B2 and B6. c. The following door had gouges on the hinged side of the entry door approximately 3 1/2 feet up from the floor exposing splinters: D Hall: D7 d. The following doors had gouges on the hinged side of the entry door approximately 3 feet up from the floor exposing splinters: 1. A Hall: A1, A7, A8 and A9 2. B Hall: B3 and B11	F 323		

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F 323	Continued From page 32 3. C Hall: PR4, C1, C7 and C11 4. D Hall: D5, D7 and D9 5. E Hall: E1, E11 and E13 6. F Hall: F1, F2, F4 and F5 7. G Hall: PR14, G2 and G8 8. H Hall: H4 and H13 e. The following doors had gouges on the hinged side of the entry door approximately 2 1/2 feet up from the floor exposing splinters: 1. A Hall: PR1, 2. C Hall: C6 3. E Hall: E6. f. The following doors had gouges on the hinged side of the entry door approximately 2 feet up from the floor exposing splinters: 1. A Hall: A14, 2. C Hall: C10, 3. H Hall: H2. g. The following doors had gouges on the hinged side of the entry door approximately 1 1/2 feet up from the floor exposing splinters: D Hall: PR5. h. The left entry door to the Manor Lodge Dining	F 323			

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F 323	<p>Continued From page 33</p> <p>Room had gouges with splinters along the hinged side of the door approximately 1 1/2 feet up from the floor.</p> <p>i. The Nursing Center shower room located next to D Hall, had an entry door to the commode room. The door had gouges on the hinged side of the door approximately 3 feet up from the floor exposing splinters.</p> <p>j. Room B4 and B7 entry doors had 3 staples in the door with one end of the staple protruding out from the door along the bottom 1/2 of the door.</p> <p>k. In the Laundry, 2 of 3 dryers had a lint buildup of approximately 1/8 inch around the top compartment where the flames of the dryers was located. The same two dryers had an area of lint ball buildup in the back corners of the bottom lint compartments.</p> <p>l. The Nursing Center shower room had three 2 inch tiles missing along the divider wall along the narrow shower stall exposing sharp grout edges and there were two 2 inch tiles missing along the corner next to the commode room exposing sharp grout edges.</p> <p>m. On D Hall between room PR7 and the fire door. There was an approximate 2 inch gouged indentation in the handrail to the right of Room D2 exposing splinters.</p> <p>n. On 5/22/07 at 8:50 a.m., the Biohazard room on Manor Lodge was unlocked. The door was not closing completely allowing the staff to push the door open with their shoulder, without unlocking the push button lock on the door. The door was unlocked from 8:50 a.m. to 9:16 a.m.</p>	F 323			

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F 323	Continued From page 34 The room contained a bucket of mop water, Pizzaz Burnishing Cream and the label documented "may cause eye irritation", a box of #18 florescent lights, a box of Neutral Floor cleaner, 1 bucket of Finished Low Odor Floor Stripper and the label documented "corrosive", a spray bottle of Spray Buff shine maintenance and 3 barrels containing plastic bags of soiled linen and briefs. At 9:20 a.m., the Administrator stated the room was supposed to be locked. The Administrator was asked "When was it to be locked?" The Administrator stated, " At all times. " The Administrator was asked if the door should be locked even when there was staff in the area at the nurses station, etc?" She stated, "Yes." 2. On 5/22/07 at 1:35 p.m. the following observations were made: a. The Dining Room located next to A Hall, had a feeder table with the leg broken away from the table and hanging down from the table approximately 1 foot. There were two straight backed chairs in the room that had the bottom cross section supports broken and hanging down from the chairs. 3. On 5/22/07 at 2:37 p.m., the Nursing Center Biohazard room door was unlocked and contained 4 full sharps containers, 1 barrel that had no lid and was overflowing with trash and 3 barrels that had lids that had plastic bags piled on top of the lids. The door was pulled to and had to be slammed two times in order for the lock to catch on the entry door.	F 323			
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance	F 324			

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F 324	Continued From page 35 devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the axilla was not used to support the residents weight for 1 (Resident #7) of 1 case mix resident who was dependent on staff for transfers. This failed practice had the potential to affect 14 residents that are dependent on transfers according to the list provided by the Director of Nursing on 5/24/07. The findings are: Resident #7 had diagnoses of Bilateral Above The Knee Amputation, and Cerebral Vascular Accident. The MDS (Minimum Data Set), dated 4/6/07 documented the resident had modified independent cognitive skills for daily decision making, was incontinent of bowel and bladder, and required total staff performance for hygiene, toileting, and mobility. a. On 5/22/07 at 1:23 p.m., CNAs (Certified Nursing Assistants) #2 and #3 lifted the resident under his arms, placing all of the resident's weight on his shoulders, and swung him from the wheelchair to the bed. This technique placed the weight of the resident onto his armpits.	F 324		
F 328 SS=E	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;	F 328		

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F 328	Continued From page 36 Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure oxygen was administered as per physician orders for 1 (Residents #12 and 16 of 5 (Residents #3, 6, 9, 12 and 16) case mix residents with physician orders for oxygen therapy. This failed practice had the potential to affect 6 residents with physician orders with oxygen according to a list provided by the Director of Nursing on 5/24/07. The findings are: 1. Resident #12 had diagnoses of Coronary Obstructive Pulmonary Disease, Congestive Heart Failure, Respiratory Failure and Tracheostomy. The Quarterly Minimum Data Set dated 2/23/07 documented the resident was independent in cognitive skills for daily decision making, was independent in activities of daily living and required oxygen therapy. a. The physician order dated 5/23/06 documented: "O2 (oxygen) @ (at) 3L (liters) via Trach collar continuous." b. The plan of care revised on 2/27/07 documented: "Problem: At risk for complications ... related to O2 therapy." c. On 5/21/07 at 2:30 p.m. the oxygen concentrator was set at 2.5 L/M (liters per minute).	F 328			

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F 328	<p>Continued From page 37</p> <p>d. On 5/22/07 at 8:05 a.m., 10:28 a.m., 11:55 a.m., 2:26 p.m. and 3:45 p.m. the oxygen concentrator was set at 2.5 L/M.</p> <p>e. On 5/23/07 at 8:40 a.m., 10:29 a.m. and 1:14 p.m. the oxygen concentrator was set at 2.5 L/M.</p> <p>f. On 5/24/07 at 9:30 a.m. the oxygen concentrator was set at 2.5 L/M.</p> <p>2. On 5/24/07 at 9:38 a.m. the Director of Nurses (DON) was asked to accompany the surveyor to the residents room. The DON was asked to verify the oxygen concentrators setting, she stated; "It is set on 2.5 L/M." The DON stated, "The nurse was supposed to be at eye level with the meter, when setting the concentrator. "</p> <p>3. Resident #16 had diagnoses of Acute Respiratory Failure, Bronchitis and Coronary Obstructive Pulmonary Disorder. The Quarterly Minimum Data Set dated 2/18/07 documented the resident had modified independent cognitive skills for daily decision making, required extensive assistance for activities of daily living, required oxygen therapy and tracheostomy care.</p> <p>a. The physician's order dated 6/2/06 documented: "O2 @ 2L via trach collar QHS (every night at bedtime) PRN (per request)."</p> <p>b. The plan of care revised on 5/23/07 documented: "Problem: At risk for alteration upper airway, related to tracheostomy. Approaches: O2 @ 2 LPM ..."</p> <p>c. On 5/21/07 at 2:55 p.m. the oxygen concentrator was set at 1.5 L/M.</p>	F 328			

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F 328	Continued From page 38 d. On 5/23/07 at 2:53 p.m. the oxygen concentrator was set at 1.5 L/M. e. On 5/24/07 at 8:45 a.m. the oxygen concentrator was set at 1.5 L/M. 4. On 5/24/07 at 9:34 a.m. Licensed Practical Nurse #1 stated; "You set it (concentrator) with the turn knob, get down on eye level with the meter and the ball is supposed to be on the line."	F 328		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to follow their own policy for proper handwashing when handling food and utensils during meal preparation, to ensure that trays used to serve residents meals were allowed to air dry and that foods should be at 140 degrees or above prior to being served. This failed practice had the potential to affect all 105 residents who took meals from the kitchen according to the Diet List dated 5/22/07. The findings are: 1. On 5/23/07 at 10:35 a.m., Dietary Employee #1 lifted the trash can lid with her hands to discard trash while preparing beverages for the noon meal. a. On 5/23/07 at 10:35 a.m., Dietary Employee #1 took a carton of juice to the walk-in	F 371		

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F 371	<p>Continued From page 39</p> <p>refrigerator, labeled lids on cups of beverages, took a tray of empty cups and stacked them on top of another tray of empty cups without washing her hands.</p> <p>b. On 5/23/07 at 10:40 a.m., Dietary Employee #1 donned gloves, took a large measuring cup, filled with sugar twice and poured the sugar into a large bin of unsweetened tea after touching the trash can lid a second time, then with the same gloves touched the ice scoop and put ice and sweet tea in the cups on trays. The employee then picked up the contaminated ice scoop and filled 2 pitchers with ice for tea and 1 pitcher with ice for red punch.</p> <p>c. On 5/23/07 at 11:00 a.m. Dietary Employee #1 threw trash away by touching the trash can lid a third time, then put 2 pitchers of tea and 1 pitcher of punch on a cart and pushed it into the walk-in freezer without washing her hands.</p> <p>2. The Facility's Policy on Handwashing documented, "... wash...hands Before you begin a task ... After you take out the garbage ... After you touch anything that might contaminate your hands ..."</p> <p>3. On 5/23/07 at 11:35 a.m. Dietary Employee #1 dried 31 wet trays with 3 red paper napkins before placing them on the serving line for lunch. These trays were not allowed to air dry.</p> <p>4. On 5/23/07 at 4:35 p.m. Dietary Employee #2 dried 28 wet trays with a white cloth in preparation for meal service at supper. They were not allowed to air dry.</p> <p>5. On 5/23/07 at 4:52 p.m. steam table</p>	F 371			

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F 371	Continued From page 40 temperatures registered as follows : a. Pureed turkey, 130 degrees Fahrenheit b. Turkey with no gravy, 120 degrees Fahrenheit. 6. On 5/24/07 at 6:40 a.m. the sausage patties registered 120 degrees Fahrenheit on the steam table.	F 371		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observations and interview the facility failed to ensure linen was not used after being dropped on the floor and failed to ensure a soiled brief was bagged before sitting it on the floor. These failed practice had the potential to affect 14 residents currently residing on the F hall as per the resident roster/matrix. The findings are: 1. On 5/22/07 at 1:41 p.m., CNA (Certified Nursing Assistant) #1 dropped a washcloth on the hallway floor, picked it up, shook it, and put it back in the clean linen cart on top of clean linens.	F 441		

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F 441	Continued From page 41 a. On 5/22/07 at 1:45 p.m., CNA #1 was asked, "Did I see you pick up a washcloth off of the floor, and then place it back onto the linen cart that was used to store clean linens," the CNA stated, "Yes." 2. On 5/22/07 at 1:51 p.m., CNA #1 took a soiled (soiled with feces and urine), brief off of a resident and placed it on the floor of the resident's room during incontinent care.	F 441		
F 468 SS=E	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure the handrails were secured to the walls and free of splintered areas. This failed practice had the potential to affect 6 independently mobile residents on F Hall, D Hall and B Hall according to a list provided by the Director of Nursing on 5/24/07 at 12:15 p.m. The findings are: 1. On 5/22/07 at 1:35 p.m. the following observations were made: a. There was 5 feet of hand rail not secured to the wall on G Hall between rooms G10 and G12. b. There was 2 1/2 feet of hand rail not secured to the wall on F Hall next to the Dining Room. 2. On 5/22/07 at 2:35 p.m. there was 5 feet of hand rail not secured to the wall on D Hall between room PR7 and the fire door. The corner	F 468		

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F 468	Continued From page 42 handrail located under the activity calendar had rough, sharp edges on the corner. 4. On 5/23/07 at 9:45 a.m. there was 6 feet of hand rail not secured to the wall on B Hall between room PR2 and the Janitor's Closet.	F 468		