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	355080	A. BUILDING _____ B. WING _____	C 12/19/2013

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DUNSEITH COM NURSING HOME	15 1ST ST NE DUNSEITH, ND 58329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification and complaint survey started on December 17, 2013 and completed on December 19, 2013, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	F 225 #1. Resident #1 has been discharged to another nursing home. #2. All residents have the potential to be affected by this deficient practice. #3. A. The Policy for Abuse, Neglect, and Misappropriation of Resident's Property has been revised for Lost or Missing Items (See Attached) to assure allegations of Misappropriation of Resident Property are reported to the ND State Survey Agency. B. All staff will be inserviced on the Policy for Abuse, Neglect, and Misappropriation of Resident Property. #4. Administrator/designee will monitor 1 time a week for 3weeks and then 1 time a month for 3 months : A. Was the report of Abuse, Neglect, and Misappropriation of Resident Property reported to the ND State Survey Agency within 24 hours. B. Did DCNH investigate the report and were the results of the investigation forwarded to the ND State Survey Agency within 5 working days. The results of the monitoring will be reviewed at the DCNH regularly scheduled Quality Assurance Meetings. #5. This deficiency will be corrected by January 22, 2014.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jerrold J. Brems	Nursing Home Administrator	1/14/14

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 225	Continued From page 1 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to ensure that all alleged violations involving mistreatment or abuse, including misappropriation of resident property, are investigated and reported to officials in accordance with the State law for 2 of 2 allegations reviewed during the survey. Failure to identify, report, and investigate allegations of abuse and misappropriation of property (controlled medications) placed all residents at risk for abuse or mistreatment. Findings include: Review of the facility policy titled, "Abuse, Neglect, and Misappropriation of Resident Property-Investigation and Reporting" occurred on 12/19/13. This policy, dated 2010, stated, " . . . Policy: . . . Abuse, neglect, and misappropriation of property are prohibited within our facility . . . There are seven key components to our program: . . . 6. Investigation of reported negative events. 7. Reporting to local, state, and federal agencies . . . Abuse can be: Physical (hitting, slapping . . .), . . . Misappropriation of Resident Property- means the deliberate misplacement, exploitation or wrongful, temporary or permanent use of	F 225		

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F 225	Continued From page 2	F 225		

resident's belongings . . . Reporting: 2. The Administrator, Director of Nursing, or Director of Social Services will make a telephone report to the State Health Department immediately. . . . "

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia and osteoarthrosis.

Resident #1's nurses notes identified the following:
* 09/27/13 at 4:30 p.m., "[MD name] notified that duragesic patches[an opiod analgesic patch] have been taken off her back on 3 occasions today and yesterday. Unable to find them-maybe [at] laundry in clothes/linen. [MD name] [discontinued] the patches and ordered Percocet [by mouth]. [Family member name] notified and is satisfied [with] this change. Did have family members visiting today. No one observed taking the patches off."

During an interview on the morning of 12/19/13, an administrative nurse (#1) identified the facility knew about the missing duragesic patches, but failed to complete an investigation.

The facility failed to conduct a thorough investigation to determine if misappropriation of resident property occurred and failed to report an allegation of misappropriation of resident property to the State survey and certification agency.

- Review of a resident grievance/abuse concern form, dated 12/13/13, identified an alleged abuse incident involving a resident. The facility conducted an investigation on 12/15/13.

During an interview on the morning of 12/19/13,

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

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F 225	Continued From page 3 an administrative nurse.(#1) confirmed the facility failed to report the alleged allegation of abuse to the State survey and certification agency.	F 225		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, resident interview and staff interview, the facility failed to provide the necessary care and services to promote optimal well-being for 1 of 1 sampled resident (Resident #7) observed with complaints of pain. Failure to recognize, evaluate, provide comfort measures, and consider alternative interventions for pain relief limits staffs' ability to provide appropriate interventions. Findings include: Review of the facility policy "Pain Management" occurred on 12/19/13. The policy, dated January 2007, stated: "Policy: Each resident who experiences pain is entitled to an assessment of the pain and an individualized plan of care. Purpose: To identify pain and individualize the pain management program to manage/treat pain.		F-Tag 309 #1 a)Pain assessed by MD for possible re-institution of Resident #7's narcotic pain pill or appropriate alternative pain med. b)Assessed for proper use of lift. c)Resident #7 has appointment to see orthopedic MD for consult regarding her shoulder on Jan.16,2014. d)Staff will assess her pain before and after administration of her pain pill. e)Resident #7 will be care planned for non-pharmacologic pain interventions. f)P.T. has evaluated Resident #7 for correct and safe method of transferring with a lift. #2 Any resident who complains of pain when asked or on the quarterly pain assessment have the potential to be affected by this deficient practice. #3 a)Inservice Nursing staff on pain managaement and assessment of pain. b)If pain is acknowledged on the quarterly pain assessment, nurses will address this immediately to know what causes the pain and what can alleviate the pain. If the pain cannot be alleviated, the nurse must notify the MD. c)All residents with the potential for pain will be care-planned for this.	

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F 309	Continued From page 4 . . . - Observation of Resident #7 at 8:10 a.m. on 12/19/13 showed her seated in a wheelchair with an arm rest supporting her right arm. Resident #7 stated she had a stroke and her right shoulder hurt. On 12/19/13 at 8:50 a.m. and 10:10 a.m., two certified nurse assistants (CNAs) (#5 and #6) performed two stand lift transfers to toilet Resident #7. Resident #7's right arm dangled at her side during both transfers. A CNA (#6) stated Resident #7 complains of right shoulder pain all of the time, not just when the lift is used. Review of Resident #7's medical record occurred on 12/19/13. The record identified diagnoses including hemiplegia (paralysis) with right sided weakness, and intellectual difficulties. Resident #7's current care plan identified the problem of "Resident has potential for actual pain" (problem initially dated 05/02/13) with the following interventions: "Nursing will assess complaints of pain and administer medications as ordered. Keep MD informed as to effectiveness of pain control. Staff will assist her to be comfortable and positioned correctly. . . ." The care plan also stated: "Due to paralysis, resident is unable to use her left [sic] hand. . . ." Review of physical therapy notes identified the following: * 05/07/13: ". . . Sit to stand lift is appropriate for transfers. Other recommendations: . . . Shoulder brace to prevent subluxation." * 10/09/13: ". . . Her [right] shoulder is limited in ROM [range of motion] due to pain. X-ray in June was not very conclusive other than showing degenerative changes and possible rotator cuff	F 309	#4a)An initital QA study will be done by the DON or designee on all residents most recent pain assessment to be sure that complaints of pain are properly assessed and appropriate interventions for pain control are in place and included on their care plan. b)The DON/designee will then check(as they come due) all quarterly pain assessments for: 1. Adequate pain control 2. Pain interventions listed on the care plan of each resident. This will be monitored for 1 year and will be Reported on at each of our scheduled QA Mtgs. #5 Jan. 22, 2014	

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F 309	Continued From page 5	F 309		

injury. Resident has not had AROM [active range of motion - i.e. self initiated] in her [right] shoulder since her stroke. She will be seeing an orthopedic doctor regarding this."

The record showed a physician saw Resident #7 on 10/17/13 for shoulder pain and "abnormal x-rays." The physician progress note stated "stroke with osteoarthritis [right] shoulder & shoulder weakness with pain." Orders included a steroid (anti-inflammatory) injection to the right shoulder and follow-up in three months.

Review of "Comprehensive Pain Assessment Forms" identified the following:
* 05/02/13: admission assessment: staff identified Resident #7 experienced moderate, almost constant pain or hurting in her right shoulder in the last 5 days; pain rated as a 5 (on a pain scale of 1-10). The assessment did not identify pain relieving measures at that time. The Medication Administration record (MAR) identified an orders, dated 05/29/13, for Tylenol three times a day (tid) while awake and Hydrocodone with Tylenol every six hours as needed (prn) for severe pain
* 08/02/13: assessment identified the resident experienced moderate, almost constant, throbbing pain in the right shoulder in the last 5 days; pain rated as a 7. This assessment occurred while the resident received scheduled Tylenol tid; and Hydrocodone with Tylenol for severe pain every six hours prn. Non-medication interventions included repositioning, and "Refuses topical anesthetics."
* 11/13/13: assessment identified the resident experienced frequent, throbbing, moderate pain or hurting in the in the last 5 days; rated as a 8. The assessment identified the resident on scheduled Tylenol three times a day, and on prn

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F 309	Continued From page 6 Hydrocodone every 6 hours prn; non-medication interventions included repositioning. The MAR identified the Hydrocodone discontinued on 11/05/13. Review of the MAR showed nursing staff administered Hydrocodone at least once daily for 16 of 30 days in September and 11 of 31 days in October. The October MAR identified the pain rated between 8 and 9 and the Hydrocodone as effective. Physician orders showed the Hydrocodone discontinued on 11/05/13. The November and December MARs showed Resident #7 received no Hydrocodone, or other pain relieving measures besides the scheduled Tylenol, for severe pain in the month of November through December 19. Resident #7's record identified a hospitalization from 10/31/13 through 11/03/13. A physician discharge summary, obtained upon request by fax on 12/19/13, identified the hospitalization occurred due to complaints of nausea and vomiting. The summary identified a discharge diagnoses of acute gastroenteritis. During interview on the morning of 12/19/13, an administrative staff member (#1) stated the Hydrocodone was discontinued after the hospitalization, and did not identify other continued measures utilized to relieve Resident #7's pain. Observation, record review, and staff interview confirmed Resident #7 experienced on-going pain in her right shoulder after hospitalization. The facility failed to contact the resident's physician or attempt other non-pharmacological interventions to relieve her pain.	F 309		

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES		F-Tag 314	

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, review of facility policy, and staff interview, the facility failed to provide the necessary services, including alternative pressure reducing devices, to promote the healing of pressure ulcers for 1 of 1 sampled resident (Resident #2). Failure to provide appropriate interventions including ensuring staff consistently implemented existing approaches, contributed to the deterioration of existing pressure areas.

Findings include:

Review of the "Policy: Skin Care Program" occurred on 12/18/13. The policy, dated 06/10/09, stated:
"Purpose: 1. To maintain skin integrity . . . 3. To implement appropriate preventative measures. 4. To promote healing of pressure sores or other impairment of skin integrity and prevent further breakdown. . . . Preventative Skin Measures . . . b. For Moisture Management consider: . . . Minimize skin exposure to moisture due to incontinence, perspiration, or wound drainage.

#1 a) Resident #2 will be assessed for the following:
1. P.T. will assess that Resident #2 is using the correct lift, sling, type and size of w/c and w/c cushion, necessary for trmt of his pressure sores. P.T. and the DON have consulted with this residents wound specialist for additional suggestions for healing this wound.
b) A new pressure relieving mattress and w/c cushion have been ordered for resident #2.
c) P.T. has educated resident #2 on the seriousness of his condition and importance of following the recommended plan of care.
d) Resident #2's care plan will be changed to include non-medication interventions for pain.
e) Nursing staff was educated at the mandatory meeting on Jan. 8th on the changes added to resident #2's care plan.
#2 Any resident with a pressure sore has the potential to be affected by the same deficient practice.
#3 a) Any resident with the potential for pressure ulcers will continue to be care planned to prevent pressure ulcers.
b) Any resident with a pressure ulcer will continue to be entered in the Skin Care Book and their progress charted on weekly.
c) Nursing staff was re-educated on the trmt and prevention of pressure sores on Jan.8th,2014

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F 314	Continued From page 8 Clean resident immediately upon recognition of incontinence/moisture. . . . Encourage mobility/activity as condition permits iv. Frequent turning (at least every 2-3 hours) . . . For Friction, Shearing, and Pressure Management consider: . . . Apply proper lifting and positioning techniques . . . 7. Reposition at least every 2 hours, or more frequently if indicated. 8. Avoid uninterrupted sitting in a chair or wheelchair; residents bound to a chair or wheelchair should be repositioned at least every hour or be put back to bed for intervals; have resident shift weight at frequent intervals as able. 9. Pressure relieving devices for chair bound residents. 10. Residents using a wheelchair as a primary mode of transport will have a cushion in place . . . . Reposition at least every 2 hours . . . Pressure relieving cushions in chairs or wheelchairs. . . . Pressure relieving mattresses on bed . . . PT/OT [physical therapy/occupational therapy] referral . . . Specific Risk Factor Interventions . . . Manage Moisture Concerns . . . Manage Friction, Shearing, and Pressure Concerns . . . Manage Sensory Perception Concerns . . . Manage Activity or Mobility Concerns . . . Nurse Responsibility . . . Implement additional preventative interventions in order to prevent future occurrences . . . For any pressure ulcer . . . Evaluate current preventative measures and make changes as indicated . . ." Review of Resident #2's medical record occurred on all days of survey and identified admission in 2008. Diagnoses included decubitus ulcer and an impairment in motor or sensory function of the lower extremities. Review of Resident #2's quarterly Minimum Data Set (MDS), dated 11/30/13, and an annual MDS,	F 314	#4 DON/designee will monitor the pressure sores in the Skin Care Book weekly for 6 months and if a pressure sore is not improving after 2 weeks of care/trmt, will consult with charge nurses and Physician if necessary to determine why they are not healing. A new Care Plan will then be implemented for the healing of this wound. #5 Jan. 22, 2014	

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F 314	Continued From page 9 dated 09/02/13, identified Resident #2 as cognitively intact, required extensive assistance of one person for bed mobility, personal hygiene and bathing, extensive assistance of two or more persons for transfers, functional limitation in range of motion of the lower extremities on both sides, a pressure reducing device for the bed and wheelchair, and seven stage II pressure ulcers, with four present upon admission. Resident #2's current care plan identified the following problems and interventions: * Original date 12/03/12: "Skin Integrity. Resident has a Lt. [left] thigh decubitus (on admission). Has ulcer on right side also." Approaches included: ". . . Dressing changes as ordered . . . monitor condition . . . Encourage repositioning self when in bed [extensive assist of 1 in bed] and W/C [wheelchair] every 1 1/2 - 2 1/2 hours and PRN [as needed]. . . . Pressure relieving cushion in W/C. . . . stand-up lift to promote healing of thigh area [see F 323] . . . Follow wound care instructions as recommended . . ." * "Resident is at risk for development of new pressure ulcers" with approaches of ". . . Moisture Management . . . Turn/reposition every 2-3 hours (at least) . . . Avoid uninterrupted sitting in his w/c. Remind him to shift his weight and assist him to reposition . . . No wire clothes hangers in his room as he will you [sic] them to mutilate/dig at his ulcers causing them to get worse . . . Sensory Perception Risk Management: 1.) Reposition every 1 1/2 - 2 1/2 hours. . . . Activity Management: . . . and pressure relieving mattress on bed. . . ." Review of an annual physical therapy evaluation, dated 12/18/12, lacked evidence therapy evaluated Resident #2's wheelchair or bed for	F 314		

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F 314	Continued From page 10 pressure reduction. Review of physician progress notes included: * 04/09/13: "Subjective . . . [Nursing] report the patient has had decubitus ulcer associated wound over the posterior upper thighs for the past year. They report there have not been any fluctuant lesions . . . the patient reports almost constant serosanguineous drainage from the wounds. They attribute the ulcers to friction with position changes as he has little ability to help with the use of his lower legs. . . . SKIN: Small decubitus ulcer over coccyx. Much larger, stage 2 ulcers over posterior upper thighs, beefy, red base. Serosanguineous drainage. . . . ASSESSMENT AND PLAN . . . Decubitus ulcers as well as large ulcerations bilateral posterior upper thigh. Likely due to pressure and friction as the patient is partial paraplegic. Ordered to provide padded toilet chair, wheelchair seat, and air mattress overly if available. Also trapeze setup for bed if available. . . . wound care with wet-to-dry dressings as wounds appear to be on a healing course but concern over length of time required for healing. . . ." * 05/02/13: ". . . decubitus ulcer for greater than 1 year, which nursing reports he completed Bactrim [antibiotic] regimen . . . and they are concerned as the decubitus ulcer is described as worsening . . . ASSESSMENT: . . . placed referral to Wound Care Center . . . Again, reinforced importance of avoiding any friction or pressure to the area and recommended air mattress as well as padded wheelchair seat. He is sitting on foam cushion at the time of exam. . . ." * 06/18/13, a wound care specialist ordered cleansing the right and left thigh wounds with mineral oil; "Apply ostomy powder to wound bed then apply calmo [calmoseptine] et [and] cover	F 314		

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[with] telfa (unable to tape) - Cleanse sacral wound [with] saline - Keep open to air"
* 10/07/13, the same wound care specialist ordered, "Continue Calmoseptine ointment and ostomy powder on posterior thigh BID [twice a day] and cleansing [with] mineral oil [every] 2-3 days. DC [discontinue] medi honey. Daily dressing to coccyx [with] foam dressing or bordered foam dressing of choice every 3 days. Use your judgement for which works best. . . ."

Review of a "Decubitus/Pressure Ulcer Report" (monitoring form), dated from October 19 to December 15, 2013 included weekly (except between 11/23/13 to 12/07/13) measurements of the wounds on each thigh. All measurements identified between six to seven open areas over the posterior thighs. On 12/07/13, the largest of three open areas on the right thigh measured 4 x 3 centimeters (cm), and the largest of four open areas on the left thigh measured 6 cm by 3 cm. Comments, dated 12/15/13, stated, "Wounds remain gouged out - have depth to them where you can see straited muscle;" and "continues to have shearing [with] toilet use."

Observation on the morning of 12/18/13 showed a nurse (#7) provided a dressing change to several open areas on both posterior thighs. A large portion of both posterior thighs showed bright red, open areas. Observation showed the nurse removed the previously applied calmoseptine ointment with gauze moistened with saline, application of a ostomy powder over the open areas, application of calmoseptine ointment over the surface of wound covered with the ostomy powder, and the placement of a large (approximately 8 x 8) non-adherent telfa dressing over the wounds. The nurse stated mineral oil

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would be used to cleanse the wound the next day.

Nurse's notes identified the following:
* 02/15/13: "[Resident] needed a clean chucks under him so I went down to see him and noticed his wounds are all gouged up again. Are actively bleeding again., something they haven't done in quite some time. I am appalled @ [at] the deterioration I see from 2 days ago. . . ."
* 03/02/13: ". . . This pattern of healing & gouging has been going on as long as I can remember. . . ."
* 03/29/13: ". . . While doing wound care today I noticed that [resident's] coccyx wound is purple & bruised looking & I asked [resident] what happened. He said 'why?' 'what's wrong?' I told him its bruised & purplish. He said maybe he brushed it against the back of the toilet. This explanation has no validity as the wound is inner as opposed to outer. I think [resident] takes wipes & rubs his wounds to either clean them or to inhibit the healing process for what ever reason. He really thinks that he is the only one who has healed the wound & he just obsesses over his health. The wound is again building collagen trying to strengthen the tissue, but it'll be gouged open again as it has been time & time again. I have told [resident] to leave hands off wounds as his hands have bacteria but he probably uses gloves to get around that because he really is afraid of bacteria & the chance of getting gangrene."
* 04/03/13: "Took some photos of thigh wounds & coccyx wounds for skin assessment & was talking to [resident] about the wounds being so gouged up and why that may be so. He told me sometimes when he's on the toilet his pants aren't pulled down low enough and he tugs & pulls them

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out of the way & this may be why the wounds aren't healing. I will recommend that staff must pull pants all the way down to avoid the shearing force [the resident] is causing by tugging pants out of the way. This makes sense when I think about it, because I've often wondered how the wounds could degrade so rapidly in the healing process."
* 04/09/13: Notified maintenance to place trapeze in [resident's] room. Plan to order padded toilet seat. W/C cushion. [Resident] was hospitalized . . . States mattress was air mattress & did not like as unable to use urinal."
* 06/16/13: "Noticed the chucks [absorbent thin cloth like sheet] [resident] lays on at night are full of serosanguineous drainage and urine. [Resident] seems to be losing the ability to use urinal without slopping all over the place. [Resident's] dexterity is poor & sitting on edge of bed attempting to use urinal would be very difficult as he would need one hand to keep himself upright without tipping over, and the other hand to use urinal. No wonder why there's urine all over the bed. . . . Don't know what the answers are."
* 06/19/13: "11:45 p.m. . . . noticed the chucks were bloody & wet [with] urine. Wounds were bleeding although they were clotting up. [Resident] hadn't been in bed that long & to see the mess he was laying in makes me wonder what we're going to do for him. I cleaned him up & put clean chucks under him but it'll be the same tomorrow morning."
* 06/21/13: "Maintenance notified us that Resident's wheelchair is broke and is ready to collapse. Resident was immediately put into another wc [wheelchair] and DON [director of nurses] ordered a new wc for him."
* 07/04/13: "[Resident] wanted additional

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F 314	Continued From page 14 calmoseptine put on wounds as there was none on related to his constant motion, whether it be using urinal or just turning to sit @ edge of bed. His wounds are gouged up and meaty looking again. Top layers have been sheared away . . ." * 09/02/13: ". . . Wounds are slowly healing. . . . requires assistance with dressing and bathing. Has issues [with] incontinence as bedding is frequently wet whether from true incontinence or from spilling urinal. . . ." * 10/24/13 at 4:50 a.m.: ". . . awake & wants urinal dumped. . . . Noticed chucks had drainage & urine on them so fresh chucks replaced." * 10/24/13 at 11:45 p.m..: ". . . noticed chucks had bright red blood on them. [Resident] said the nurse had put telfa dressing on [with] nappy [sic] side down on the wound & this had caused the wounds to break down. Granted the wounds are all gouged up again but it possitively [sic] is not from the telfa. [Resident] is angry that the wound wasn't dressed to his exact specifications and I believe he deliberately messed [with] the healing process to cause another set back. The wound is very chewed up as opposed to the way it looked last night and I can't figure out any other explanation." * 11/29/13: ". . . Nothing has changed. Wound continues its cycle of healing then decomposing [sic]. Wire hanger was found in room bent into a configuration which may imply he was scratching at wound but there is no certainty of that. . . ." * 12/10/13: "[Wound specialist] called & was puzzled about why the wound wasn't healing. I told her I felt that [resident] fiddles [with] the wound and is always touching it & what not. . . ." * 12/13/13: "Noted [Residents] top thigh wounds to be gouged open. Meaty texture signifies some very careless movements on his part. Bloody drainage all over soaker pads. . . . [Resident]	F 314		

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F 314	Continued From page 15 touched his wound as he does frequently. Was reminded again to leave his hands off his wounds." During observation on the morning of 12/18/13, two certified nursing assistants (CNAs) (#3 and #4) transferred Resident #2 with a stand-lift to and from the bathroom. During the observation, the bed sheets contained a moderate amount of serosanguineous drainage on the bottom chucks and sheet, and a dry saturated serosanguineous area on one corner of the top sheet. The CNAs returned Resident #2 from the bathroom and laid the resident back onto this unclean bedding. After the nurse provided a dressing change to the wound on the posterior thighs, the CNAs dressed the resident while in bed, over the same soiled bed sheets. During interview on 12/18/13 at 2:45 p.m., Resident #2 stated he could not use a trapeze on his bed due to his arm (shoulder) pain (Refer to F 323); said no other mattress had been tried for him other than the pressure relieving mattress currently on his bed; when asked about using a padded toilet seat he stated he did not have one on his toilet; regarding his wheelchair pad, he stated it had a gel cushion in it which he removed as it made the cushion too uncomfortable and hard, and he replaced it with foam. During interview on 12/18/13 at 3:45 p.m., an administrative staff member (#1) stated she did not know if physical or occupational therapy had evaluated Resident #2's wheelchair or bed for proper pressure reducing measures, and stated an air mattress was attempted but Resident #2 did not like it because he couldn't roll over.	F 314		

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F 314	Continued From page 16 Record review and observations identified: * Cleansing of the thigh wounds with saline verses mineral oil * Incorrect placement of a telfa dressing to the absorbent side verses non-adherent side * Concern with friction or pressure during toileting due to not padding the toilet seat and the bar behind the toilet causing pressure * Friction during toileting from staff not fully assisting Resident #2 to remove his pants. The care plan lacked approaches to avoid this shearing on the toilet. * Resident #2's difficulty using a urinal resulted in spillage, shearing * Failure to have a wheelchair assessment completed * Failure to assist Resident #2 to off-load with bed and wheelchair positioning due to his medical limitations	F 314	F-tag 323 #1 P.T. has assessed residents #2, #7 checking: a) That these residents are being transferred with the correct equipment and if properly done. P.T. has assessed that resident #5 is being transferred correctly with a gait belt. #2 All other residents needing assist to transfer have the potential to be affected by this deficient practice. #3 a) P.T. will assess if lifts are being used correctly on all residents who currently use a lift. b) P.T. has inserviced our Nursing staff at our mandatory meeting on the correct method of using the lifts and the gait belt. c) A new policy has been written on the correct use of gait belts and transferring with lifts. #4 a) DON/designee will observe 4 transfers/week for 8 weeks, then 4/month for 6 months until 100% compliance is obtained both for checking correct gait belt use, as well as using the lifts correctly. b) Every 6 months the DON/designee will assess each resident who uses a lift checking that this lift continues to meet their needs and if transfer was done correctly. Checks will include different CNA's using the lifts. #5 Jan. 23, 2014	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, record review, resident interview and staff interview, the facility failed to re-evaluate the appropriateness of the assistive devices when 2 of 3 sampled residents (Resident #2 and #7)			

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F 323	Continued From page 17 voiced pain with the use of stand lift during transfers, and 1 of 2 residents (Resident #5) transferred with the assistance of a gait belt. Failure to provide for safe transfers resulted in injury and/or increased pain, and may affect patient safety through falls. Findings include: Review of the facility "Pro Assist Lift Operator Instructions" occurred on 12/19/13. The policy, updated April 2001, stated, "The Pro-Assist lift is designed for semi-ambulatory residents/patients (Patients/Residents that have adequate upper body strength) . . . 1. First choose the proper size sling . . . The sling fits across the back just above the waist line with the safety restraint strap buckled very snugly (without pinching) across the chest. . . . To adjust for snugness easily, grasp the sling under the resident's right arm and pull strap to the right until snug. To adjust bottom strap slings, grasp the sling at the waist on the left side, and pull strap to left until snug. . . . 5. Attach both sling couplings and adjust evenly. Encourage patient/resident to grasp handgrips (any of three positions) and use as much arm strength and leg strength as possible during transfer. . . ." Review of the facility policy titled, "Mandatory use of GAIT BELT" occurred on 12/19/13. This policy, dated 2005, stated, " . . . Procedure: . . . 5. To use a gait belt: . . . b. Grasp gait belt with an underhand grasp to provide support for the resident. c. Assist resident to transfer or ambulate. . . ."	F 323		

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F 323	Continued From page 18 - During interview on the afternoon of 12/17/13, Resident #2 (identified as interviewable by the facility) stated he reported to an administrative staff member that the stand lift "messed up" his left shoulder and was told "that's the only thing [stand lift device] they can use." Resident #2 stated he heard "popping noises" in his shoulder when staff first started using the lift for transfers. Resident #2 demonstrated he could not raise his left arm above shoulder level while able to lift his right arm above his head. Resident #2 stated he uses a topical pain reliever medication and pain medications due to his shoulder pain. Resident #2 stated he sleeps two to three hours per night as the pain medications are not strong enough. Review of Resident #2's medical record identified an impairment in motor or sensory function of the lower extremities. Review of Resident #2's Minimum Data Set (MDS), dated 11/30/13, and annual MDS, dated 09/02/13 both identified the resident: cognitively intact; required extensive assistance of two or more persons for transfers, and with a functional limitation in range of motion of the lower extremities on both sides. Both MDSs identified Resident #2 received a scheduled and as needed (prn) pain medications, frequent pain, pain affecting sleep and activities, and an intensity of severe (11/30/13) and horrible (09/02/13). Resident #2's current care plan identified the following problems: * "Risk for falls. Uses w/c [wheelchair]. Is using the stand up lift to transfer." Approaches included: ". . . Staff make sure . . . that resident has good footwear for using the lift. Use stand-up lift when transferring. Educate him to the benefits	F 323		

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of using the lift for transfers."
* "Resident has complaints of back, left shoulder and right wrist pain" with approaches including "Monitor pain . . . Administer . . . pain medications as ordered. . . . Notify GNP/MD [nurse practitioner or medical doctor] if adequate pain control is not achieved. Encourage rest periods and comfortable positioning. Observe care when transferring/repositioning. . . ."

Review of an annual physical therapy evaluation, dated 12/18/12, identified Resident #2 "states his legs are very weak now and his shoulders are painful. . . . Uses bedrail, but no longer able to stand to transfer . . . Would benefit from LE [lower extremity] strengthening/ROM [range of motion] exercises to try to get back to standing transfers, however, resident states he is not interested in RA [restorative therapy] program at this time."

Review of a physician progress note, dated 03/07/13 stated, ". . . He says that his shoulders hurt all the time because of the nurses using the lift and that when the hoist goes under his arms, his shoulders start hurting, especially at night. He says that the tramadol [mild pain reliever] does not work for him. Lidoderm patch [topical pain patch] does not work. He says that he cannot take oxycodone [pain medication used for moderate to severe pain] but he has not tried hydrocodone [pain medication used for moderate to severe pain; similar to oxycodone]. He says that it would be helpful, especially at night. . . . We will increase the dose of Tylenol and put him on hydrocodone as needed and at night. . . ."

Review of nurse's notes identified the following:
* 06/28/13: ". . . [Resident] remarked that the standing lift caused his neck pain, as he was left

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to hang there. He always has an excuse."

Review of a nursing assessment form, dated 11/29/13, stated ". . . complaints of back & shoulder pain. Legs very weak as are hands & arms."

On 12/17/13 at 2:10 p.m., two certified nursing assistants (CNAs) (#3 and #4) transferred Resident #2 from the bed to the toilet using a stand lift. Observation showed the harness moved into the resident's right and left axilla (armpit) during the transfer. When the CNAs began to raise Resident #2 to the standing position, Resident #2 removed his left hand from the handgrip and rested the arm across the top edge of the harness. He stated he does this because the transfer hurts his shoulder. The two CNAs (#3 and #4) voiced awareness and stated Resident #2 does this quite often, and they have made the nurses aware.

Facility staff continued to transfer even after the resident complained of increased pain to his shoulders. A physician progress note, dated 03/07/13, identified the resident said his shoulders hurt all the time because of using the lift. The last PT evaluation, approximately one year ago identified the resident's legs as "very weak now and his shoulders are painful . . . no longer able to stand to transfer." Continued use of the sit-to-stand lift in consideration of these factors placed the resident at risk of falls, further strain on his shoulders and resulted in increased pain.

- Review of Resident #7's medical record occurred on 12/19/13. Resident #7's diagnoses included hemiplegia (paralysis) with right-sided

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F 323	Continued From page 21 weakness, and intellectual difficulties. Observation of Resident #7 at 8:10 a.m. on 12/19/13 showed her seated in a wheelchair with an arm rest supporting her right arm. Resident #7 stated her right shoulder hurt. On 12/19/13 at 8:50 a.m. and 10:10 a.m., two CNAs (#5 and #6) transferred Resident #7 with a stand lift from her wheelchair, positioned just outside of her bathroom, to a toilet in the resident's bathroom. During both observations, Resident #7's right arm dangled at her side unsupported. During both transfers the harness of the lift sling slid up into the resident's right and left axillary region. Resident #7's current care plan identified the problem of "Resident needs assistance with all her ADL [activities of daily living] needs" with interventions of: "Staff will assist her with all her ADL needs. . . ." The care plan did not address the manner in which staff should transfer Resident #7. Review of physical therapy notes identified the following: * 05/07/13: ". . . Sit to stand lift is appropriate for transfers. Other recommendations: . . . Shoulder brace to prevent subluxation." * 10/09/13: ". . . Her [right] shoulder is limited in ROM [range of motion] due to pain. X-ray in June was not very conclusive other than showing degenerative changes and possible rotator cuff injury. Resident has not had AROM [active range of motion - i.e. self initiated] in her [right] shoulder since her stroke. . . ." Record review identified through physical therapy (PT) notes to transfer Resident #7 with a sit to stand lift and shoulder brace. The PT notes also	F 323		

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identified xray report results. Nursing staff failed to ensure proper transfer with the sit to stand lift and utilize a shoulder brace in recognition of Resident #7's impairment in motor or sensory function of the right arm due to her hemiplegia; functional limitation in ROM of the right arm; and with regard of the PT evaluation. Sit-to-stand lift transfers for Resident #7 in consideration of these factors placed the resident at risk of falls, further strain and increased pain in her right shoulder.

Resident #2's and Resident #7's records lacked current transfer assessments.

The facility failed to ensure the completion of a transfer assessment which included an evaluation for safe transfers while pain issues were identified. This resulted in the residents continuing to have pain during transfers and the potential for an accident from the stand lift due to the residents limited assistance with the transfers considering their medical condition and pain.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia and chronic right shoulder pain. Resident #5's current quarterly MDS identified the resident required limited assistance with transfers. Resident #5's care plan identified the resident had chronic right shoulder pain.

Observation on 12/17/13 at 10:15 a.m. showed a CNA (#2) assisted Resident #5 to stand after using the toilet. The CNA lifted the resident under his right arm. The CNA (#2) failed to use the gait belt that was around the resident's waist.

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F9999	Continued From page 23	F9999		
F9999	FINAL OBSERVATIONS Based on observation, record review, review of policies and procedures, and staff interview, the complainant concerns regarding transfers and the facility reporting and investigation of allegations of abuse and misappropriations of resident property could be substantiated.	F9999		