Printed: 05/18/2006
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	05/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR STREET CASPER, WY 82601

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F 225 SS=D	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS	F 225		

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 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 and staff interview, it was determined that the facility failed to verify one

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Arlon W Johnson	NHA	6/16/06

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.

2nd amended PoC

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F 225 SS=D	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS 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 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 and staff interview, it was determined that the facility failed to verify one	F 225	225 Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by provision of Federal State law. **IMMEDIATE** CNA #1, #2 & #3 reference checks have been completed. No problems noted. CNA #1 certification has been verified on 5/10/06, no problems noted. **RISK** A complete review of the following items has been completed: • Personnel references • Licensure verifications. Action has been taken immediately on any findings.	6/17/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kathleen Johnson | N/A | 6-13-06

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	F 225		

Certified Nurse Aide's (CNA) status with the Nurse Aide Registry and failed to conduct reference checks for three of nine newly hired employees. At the time of the survey, there was no evidence that this information had been obtained and/or reviewed. The findings included:

1. Review of facility policy titled, "Employee Reference Checks", indicated that the facility completed a minimum of two reference checks from prior employees on each applicant for employment to ensure necessary skills and experience for the position. Review of nine employee files for five dietary staff, two nurses and two Certified Nurse Aides (CNA) revealed the following:

a. Personnel file for CNA #1 (date of hire 1/17/06) showed no evidence that two reference checks had been conducted.

b. Personnel file for CNA #2 (date of re-hire 2/21/06) showed no evidence that two reference checks had been conducted.

c. Personnel file for Nurse #3 (date of hire 3/7/06) showed no evidence that two reference checks had been conducted.

2. Personnel file for CNA #1 (date of hire 1/17/06) showed no evidence that the facility had called the state Board of Nursing to verify certification status of this individual for possible findings of abuse with the State Board of Nursing or Nurse Aide Registry.

SYSTEM

The NHA will monitor and sign off weekly with the SDC new hires to ensure the following items are completed:

- Personnel references
- Licensure verifications.

The SDC will be in-serviced on the policy & procedure regarding

- Personnel references
- Licensure verification

This will be done by the NHA & or Designee completed by June 16, 2006.

Staff will only be hired upon receipt and confirmation of a reference check, and Licensure verification. Monitored by the NHA.

MONITOR

Weekly review of the new hires by the NHA will be reviewed by the QA&A committee for recommendation, and continued compliance monthly X3 months and then re-evaluate for further review.

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F 246 SS=D	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This Requirement is not met as evidenced by: Based on observation, record review, and resident, family, and staff interview, it was determined that the facility failed to accommodate the needs of three of 24 sample residents (#13, #3, and #7) and one supplemental resident (#28) by not ensuring that these residents had access to their call lights. The findings included: 1. On 5/9/06 at 2:12 PM, sample resident #13 was observed to be lying in bed on top of the bedspread. The resident's alarm and call light were observed to be under the bedspread. The resident was awake but did not have a call light accessible for use. 2. On 5/9/06 at 3:02 PM, during a resident interview, resident #3 revealed that on three occasions his/her call light was out of reach. According to the resident, one night the call light was hooked to the cord on the wall. The resident indicated that he/she tried to reach for the call light and felt some pain in his/her chest area. The resident indicated that he/she required treatment in an emergency room for this pain. The second occurrence was on the same night as the one when he/she felt the pain in his/her chest. The third time was after the night when the two incidents happened. 3. On 5/10/06 at 10:47 AM, supplemental resident	F 246	246 **IMMEDIATE** Resident #3, #13 & #7 call lights are presently within reach, no negative effects from the alleged deficient practice. Resident #28 no longer resides at the facility. **RISK** A complete review of the call lights has been completed any issues with action taken immediately. **SYSTEM** Staff has been in-serviced on the necessity of ensuring the call lights are available. Done by the SDC & or Designee. Completed by June 16, 2006. Random daily review by the IDT of the call lights has been completed to ensure that the call lights are with in reach. Resident random weekly interviews will be done to ensure that the call lights are within reach, done by the SSD & or Designee.	6/17/06

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F 246	Continued From page 3 #28 was heard calling for help. When the surveyor entered the resident's room, the resident stated, "I can't find the button." The surveyor was unable to reach the call light as it was under the bed. The surveyor stopped a nurse who was walking past the room and requested assistance for the resident. 4. Review of resident #7's medical record review revealed the resident was admitted to the facility on 6/25/02. The resident's diagnoses included: Parkinson's disease, CHF (congestive heart failure), atrial fibrillation, bladder disorder, anxiety and depression and urinary tract infection. a. Review of the MDS (Minimum Data Set) dated 2/26/06 identified the resident as requiring total dependence on staff for care and as having limitations in range of motion. b. Review of the resident's current plan of care dated 3/7/06 identified a problem which was for potential for injury and included an approach of "Place call light within reach". c. Interview with a family member on 5/11/06 at 8:15 AM revealed a recent concern had been brought to the facility's attention which included the resident not having the call light in reach. The family member expressed that he/she thought the facility had responded and addressed the concerns. The family member also reported that the resident gets very anxious when the call light was not in the resident's reach. d. Observation on 5/11/06 at 2:00 PM revealed the resident was seated in a wheelchair in his/her room. The call light was attached to the resident's recliner and not within the resident's reach. At 2:10 PM the DON (Director of Nursing) was	F 246	The call lights will be reviewed in the monthly resident council to ensure that call lights are within reach. Done by the SSD/Activity Director & or Designee. **MONITOR** The daily random reviews of the call lights within reach will reviewed by the QA&A committee for recommendation and continued compliance monthly x3 months and re-evaluate for continued review.	

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F 246	Continued From page 4 asked to observe the call light out of the resident's reach. The DON reported that the resident does use the call light and instructed staff on placement of call light.	F 246	253 **IMMEDIATE** No residents identified. **SYSTEM** Random weekly environmental rounds will be done to ensure compliance on the following issues: RM 304, 306, 310 & 311 the devices were cleaned labeled and properly stored The rust circles housekeeping will ensure that excess liquids are removed in a timely manner. Incontinent pads were picked up and placed in the closet. Personal items will be marked and stored appropriately. Done by the DON & or Designee. Closets will be checked and organized appropriately, by housekeeping & or Designee. Peeled paint will be fixed by June 17. Corrected by the maintenance supervisor Curtain rod will be repaired by June 17. Corrected by the maintenance supervisor Wallpaper border will be repaired by June 17. Corrected by the maintenance supervisor	6/17/06
F 253 SS=D	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 and staff interview, it was determined that the facility failed to ensure maintenance and/or housekeeping services to provide a safe and sanitary environment for the residents. The findings included: 1. During the initial environmental tour on 5/9/06 from 8:30 AM to 10:30 AM, unlabeled, unbagged bedpans, fracture bed pans, and urinary collection pans were observed on the floors in the resident bathrooms in rooms 304, 306, 310 and 311. 2. On 5/10/06 starting at 10:20 AM, the following observations were made: Room 205 - four three - inch rust circles were noted under the end of the bed; a bag of incontinent pads were on the floor in the bathroom; an unlabelled toothbrush was lying on the back of the sink; a bedside commode was stored in the bathroom. Room 207 - closet was messy with clothing on the floor and thrown on the top shelf; peeled paint	F 253		

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F 253	Continued From page 5 on the bathroom wall next to the light switch; the window curtain was hanging down in the center and the curtain (slide rod) was standing in the window; the wallpaper border was torn off above the "A" bed; the "B" bed had no light fixture above the bed. 3. Observation on an environmental tour of the facility on 5/10/06 from 1:30 PM to 3:05 PM with the Maintenance Director identified the following issues: a. The shower on the 400 wing had an area of floor tile which was chipped, cracked and broken. The Maintenance Director identified the area as a "2 foot by 3 foot area of tile which needs to be replaced". This area of broken tiles was not a smooth cleanable surface and had a potential for harborage of bacteria. b. The whirlpool tub on the 400 wing was chipped. There was a 2 inch by 3 inch chip inside the tub by the drain. There were also multiple chipped areas on the back of the inside edge of the tub, where the chair lift had hit the tub. This chipped surface did not provide a smooth surface for proper cleaning. The Maintenance Director reported that the tub had been resurfaced in the past and was in need of repair again.	F 253	Light fixture will be replaced by June 17. Corrected by the maintenance supervisor. The whirlpool tub on W-4 chipped area will be repaired by June 17. . Corrected by the maintenance supervisor. The tile on W-4 has been repaired. Monitored by the Maintenance supervisor & NHA. The Maintenance supervisor will in-service the staff on reporting damage items through the maintenance log process. Done by June 16, 2006. **MONITOR** Random weekly environmental rounds, will be reviewed by the QA&A committee for recommendation and continued compliance monthly x3 then re-evaluate for further review.	

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F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This Requirement is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to accurately complete the Resident Assessment Instrument (RAI) as specified and required for 14 of 24 sample residents (#13, #15, #3, #19, #14, #7, #16, #4, #18, #8, #17, #9, #2, and #6). The	F 272	272 **IMMEDIATE** No residents were affected by this alleged deficient practice **SYSTEM** IDT was in-serviced by the Regional Care Management Coordinator regarding signatures at AA9 on May 24th.. MDS office will ensure that a draft copy of the MDS is printed after the ARD has ended and that IDT members initial and date draft copy as accurate and complete after review of applicable sections of MDS. Completion dates at AA9 will be transferred to final copy of MDS after it is closed at R2b as complete and printed **MONITOR** The review of the ARD date and the signatures will be reviewed for timeliness of the signatures by the by the QA&A committee monthly x3 months then re-evaluate for further review.	6/17/06

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F 272	Continued From page 7 findings included: 1. Review of the medical record for sample resident #13 revealed the resident had a quarterly Minimum Data Set (MDS) assessment completed on 4/4/06. The assessment reference date (which indicates the last day of the MDS observation period) was 3/31/06. Two individuals who had completed different sections of the assessment had signed off on dates listed as 3/28/06 and 3/30/06 which were before the 3/31/06 assessment reference date. A quarterly MDS assessment completed on 2/17/06 showed an assessment reference date of 2/7/06. Two individuals who had completed different sections of the assessment had signed off on dates prior to the assessment reference date of 1/17/06. A significant change MDS assessment completed on 11/17/05 showed an assessment reference date of 11/13/05. Six individuals who had completed different sections of the assessment had signed off on dates prior to the assessment reference date of 11/13/05. 2. Review of the medical record for sample resident #15 revealed the resident had an annual MDS assessment completed on 11/1/05. The assessment reference date was 10/30/05. All six of the individuals who had completed different sections of the assessment had signed off on dates prior to the assessment reference date of 10/30/05 (dates included 10/24/05, 10/25/05, and 10/27/05). 3. Review of the medical record for sample resident #3 revealed the resident had an admission MDS assessment completed on 2/21/06. The assessment reference date was 2/16/06. Two individuals who had completed different sections of the assessment had signed	F 272		

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off on date 2/15/06 which was before the 2/16/06 assessment reference date.

4. Review of the medical record for sample resident #19 revealed the resident had a quarterly MDS assessment completed on 3/6/06. The assessment reference date was 2/28/06. Five of the six individuals who had completed different sections of the assessment had signed off on dates listed as 2/23/06, 2/24/06, and 2/27/06 which were before the 2/28/06 assessment reference date. A quarterly MDS assessment was completed on 12/15/05. The assessment reference date was 12/13/05. Six of the seven individuals who had completed different sections of the assessment had signed off on dates listed as 12/7/05 and 12/8/05 which were before the 12/13/05 assessment reference date.

5. Review of the medical record for sample resident #14 revealed the resident had an annual MDS assessment completed on 3/6/06. The assessment reference date was 2/28/06. Five of the six individuals who had completed different sections of the assessment had signed off on dates prior to the assessment reference date of 2/28/06 (dates included 2/23/06 and 2/24/06).
6. Review of resident #7's medical record revealed the resident had a significant change MDS assessment dated 02/26/06. The assessment reference date was 02/26/06 which indicated the last day of the MDS observation period. The seven individuals who had completed different sections of the assessment had been signed off on dates listed as 2/20/06, 2/21/06, and 2/23/06, which were before 2/26/06 the last day of the MDS observation period.

7. Review of resident #16's medical record revealed the resident had a quarterly MDS

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3/21/06 and a annual MDS dated 10/16/05. Both assessments noted that the individuals who had completed different sections of the assessment had all signed off before the last day of the MDS observation periods. A quarterly MDS dated 3/21/06 had been signed off on 3/16/06, 3/17/06, and 3/20/06 before the last day of the MDS observation period (3/21/06).
The annual MDS dated 10/16/05 had six staff that had signed as completed 10/10/05, one staff signed off on 10/11/05 and one staff on 10/16/05. This showed that seven staff had signed off as completing the assessment before the last day of the MDS observation period.

8. Review of the medical record for sample resident #18 revealed the resident had a quarterly MDS assessment completed on 4/10/06. The assessment reference date was 4/4/06. Two individuals who had completed different sections of the assessment had signed off on dates listed as 3/31/06 and 3/28/06 which were before the 4/4/06 assessment reference date. An admission MDS assessment completed on 1/23/06 showed an assessment reference date of 1/17/06. All six of the individuals who had completed different sections of the assessment had signed off on dates prior to the assessment reference date of 1/17/06.

9. Review of the medical record for sample resident #4 revealed the resident had a quarterly MDS assessment completed on 1/25/06. The assessment reference date was 1/24/06. All six of the individuals who had completed different sections of the assessment had signed off on dates prior to the 1/24/06 assessment reference date. An annual MDS assessment completed on 3/23/06 showed an assessment reference date of

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3/21/06. Six of the individuals who had completed different sections of the assessment had signed off on dates prior to the assessment reference date of 3/21/06.

10. Review of the medical record for sample resident #8 revealed the resident had an Annual MDS assessment completed on 8/31/05. The assessment reference date was 8/28/05. All of the individuals who had completed different sections of the assessment had signed off between 8/22/05 and 8/25/05. A Quarterly MDS assessment completed on 2/6/06 showed an assessment reference date of 2/5/06. All six of the individuals who had completed different sections of the assessment had signed off on dates prior to the assessment reference date of 2/5/06.

11. Review of the medical record for sample resident #17 revealed the resident had an Annual MDS assessment completed on 11/17/05. The assessment reference date was 11/13/05. All six of the individuals who had completed different sections of the assessment had signed off on dates prior to the assessment reference date of 11/13/05.

12. Review of the medical record for sample resident #9 revealed the resident had an Annual MDS assessment done with an assessment reference date of 1/22/06. All seven of the individuals who had completed different sections of the assessment had signed off on dates prior to the assessment reference date of 1/22/06.

13. Review of resident #6's medical record revealed the resident had a quarterly MDS assessment completed on 2/02/06. The

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assessment reference date was 1/31/06. The six of the seven individuals who had completed different sections of the assessment had signed off on 1/26/06, 1/27/06 and 1/30/06 which was before 1/31/06 the last day of the MDS observation period.

Review of resident's medical record revealed the resident had another quarterly MDS assessment completed on 4/24/06. The assessment reference date was on 4/18/06. The three of the eight individuals who had completed different sections of the assessment had all signed off on 4/12/06 which was before 4/18/06 the last day of the MDS observation period.

14. Review of resident #2's medical record revealed the resident had a quarterly MDS assessment completed on 12/28/05. The assessment reference date was 12/27/05. The two of the six individuals who had completed different sections of the assessment had signed off on 12/23/05 which was before 12/27/05 the last day of the MDS observation period.

Review of resident's medical record revealed the resident had another quarterly MDS assessment completed on 02/07/06. The assessment reference date was 1/29/06. The three of the eight individuals who had completed different sections of the assessment had signed off on 12/27/05 and 12/23/05 which was before 1/29/06 the last day of the MDS observation period.

15. On 5/12/06 at 8:00 AM, in an interview with the MDS Coordinator, she verified that staff do the assessment and sign off prior to the assessment reference date (end day of the observation period). She indicated that if there was a change in the resident after the staff

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F 272	Continued From page 12 completed the assessment, they would make the corrections in their original assessment. Review of numerous MDS assessments for the 14 sample residents cited revealed that no staff corrections were noted after the staff member signed off on the assessment. The requirements of this regulation are that the entire time period in the observation period must be utilized to collect information to make a comprehensive assessment. If the assessment reference date is set so that the information collection partially occurs before the resident enters the facility, each staff member must collect that information on the areas of assessment before the facility stay started and through the entire length of the observation period before doing the assessment.	F 272		

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F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This Requirement is not met as evidenced by: Based on observtion, record review, and staff interview, it was determined that two of 24 sample residents (#5 and #2) experienced one or more significant changes in his/her status without having a comprehensive re-assessment done. A significant change as defined in the Long Term Care Resident Assessment Instrument (RAI) User's Manual, updated by the Centers For Medicare & Medicaid Services (CMS) in December, 2002, is "a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting'; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan."	F 274	274 **IMMEDIATE** Resident #5 is having a significant change assessment completed by June 17. Resident #10 no longer resides in the facility. **RISK** A complete review of the MDS's for accuracy, has been done action has been taken on any issues noted during the review. **SYSTEM** The MDS Coordinator has been in-serviced on the RAI process section on "change of condition", done by the Corporate MDS Coordinator. The facility will be utilizing the MDS accuracy tool weekly to ensure that the information on the draft MDS is accurate, done by the IDT.	6/17/06

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F 274	Continued From page 14 "A significant change assessment is appropriate if there are either two or more areas of decline or two or more areas of improvement." The findings included: 1. Review of the resident #5's 1/27/06 significant change MDS assessment and a quarterly Minimum Data Set (MDS) assessment dated 4/25/06 revealed the following changes in the resident's status. There was no evidence that the facility staff had completed a full, comprehensive re-assessment for this resident to determine if any new care plan approaches were warranted. 1/06 - The resident was assessed as requiring no assistance with eating. 4/06 - The resident was assessed as requiring total assistance from staff with eating. 1/06 - The resident was assessed as being continent of bowel. 4/06 - The resident was assessed as being occasionally incontinent of bowel. 1/06 - The resident was assessed as having no weight loss/gain. 4/06 - The resident was assessed as having a weight loss. 1/06 - The resident was assessed as having no falls in last 180 days. 4/06 - The resident was assessed as having falls in last 180 days. In an interview with the assistant MDS coordinator on 5/9/06 at 8:15 AM, she confirmed that the resident had declined and a significant change MDS should have been completed.	F 274	An in-service on the 24H report will be done with the nursing staff. Done by the SDC & or Designee. Done by June 16, 2006. The 24H report will be reviewed in the AM meeting by the IDT members to identify residents with change of condition. **MONITOR** The weekly review of the MDS's for accuracy and necessary change of condition utilizing the MDS accuracy tool will be reviewed by the QA&A committee for recommendation and continued compliance monthly x3 months and re-evaluate.	

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2. Review of the medical record of sample resident #10 revealed the resident was admitted to the facility on 2/22/06 with diagnoses that included chronic obstructive pulmonary disease, hypothyroidism, electrolyte/fluid disorder, GERD (Gastroesophageal Reflux Disease) and episodic mood disorder. Review of the hospital history dated 2/17/06 indicated the resident had a "past medical history significant for lung cancer diagnosed in 09/2005, which was initially classified as probably terminal".

The resident's admission MDS assessment dated 3/6/06 indicated the following:

a. The resident was assessed to need limited assistance with eating. During the survey the staff was observed to provide total assistance with eating as the resident was bedridden due to his/her decline since admission.

b. The resident's assessment indicated he/she was occasionally incontinent of bowel and incontinent of bladder. The admission assessment did not indicate that the resident had an indwelling urinary catheter. During the survey the resident was observed to have a Foley retention catheter.

c. Although the MDS indicated the resident had a history of ulcers (resolved in last 90 days) the assessment indicated he/she had no pressure ulcers or stasis ulcer during the 14-day assessment period (Section M) and that the resident had no other skin problems or lesions (Section M.4). The resident's admission assessment (Resident Data Set) dated 2/22/06 indicated the resident had a stage 2 open area on his/her sacral area at the time of admission.

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Review of a "Non-Pressure Skin Condition Record" dated 3/22/06 indicated the resident had a Kennedy Terminal Ulcer (KTU) 4 centimeters by 0.5 cm on his/her sacral area.

d. The resident's MDS weight was listed as 74 pounds with no weight gain/loss in last 30 days although the resident's admission weight was 80.5 pounds (on 2/23/06). During the MDS assessment reference time period the resident lost 6.5 pounds.

e. On the resident's admission assessment (Resident Data Set) dated 2/22/06 pain was described as daily, sharp and aching and located in his/her right hip. The admission assessment (Resident Data Set) indicated that the resident had expressed that "laying flat on back (with) little mvmt (movement)" relieved his/her pain. The MDS indicated pain was assessed as less than daily at a moderate intensity (location hip). Cross Reference F307 the facility failed to provide care in a manner to ensure adequate pain relief.

After the surveyor interviewed the MDS coordinator regarding the changes in resident #10 since his/her admission, a notation was made in the Interdisciplinary Progress (IDP) Notes indicating "significant (change) in condition not completed R/T (related to) resident having a terminal illness per RAI manual pg (page) 2-11".

According to the MDS Resident Assessment Instrument (RAI) User's Manual, the determination to complete a significant change MDS for a resident with a terminal condition should be made when a change is reflected in more than one area of decline; the resident's status will not normally resolve itself; and the resident's status requires interdisciplinary review

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F 274	Continued From page 17 and/or revision of the care plan. Because resident #10's status demonstrated changes in several areas, continued through the time of the survey (two months after the initial MDS) and required changes in his/her plan of care, a significant change assessment for this resident would be required.	F 274		

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F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This Requirement is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to accurately assess three of 24 sample residents (#10, #4, and #13). These residents' Minimum Data Set (MDS) assessments did not contain accurate information for the residents at the time the assessments were completed. The findings included:	F 278	278 **IMMEDIATE** Resident #10 no longer resides in the facility. J5c. end-stage disease could not have been marked per RAI instructions. Chapter 3, J5c states "A doctor's certification that the resident has 6 months or less to live must be present in the record before coding the resident as terminal on the MDS". No such physician statement could be found in the closed chart. Resident #4-MDS will be modified to reflect indwelling catheter vs. intermittent catheter. Resident #13 Braden scale was reviewed. **SYSTEM** A complete chart review of active charts will be completed by June 16, 2006 to verify current MDS accuracy against supporting documentation for assessment reference	6/17/06

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F 278	Continued From page 19 1. Review of the medical record of sample resident #10 revealed the resident was admitted to the facility on 2/22/06 with diagnoses that included chronic obstructive pulmonary disease, hypothyroidism, electrolyte/fluid disorder, GERD (Gastroesophageal Reflux Disease) and episodic mood disorder. Review of the hospital history dated 2/17/06 indicated the resident had a "past medical history significant for lung cancer diagnosed in 09/2005, which was initially classified as probably terminal". The resident's admission Minimum Data Set (MDS) assessment dated 3/6/06 indicated the following: a. Although the MDS (Section I.1.pp) did not indicate the resident had cancer, a hospital history dated 2/17/06 and physician notations indicated a history of lung cancer with metastasis to the throat. b. The resident was not assessed as end-stage disease (Section J.5.c) When the resident was initially admitted to the facility he/she received therapy rehabilitation services (physical and occupational therapy) until approximately 3/20/06. Although therapy services were discontinued in mid-March 2006 the resident continued on "skilled" services through April 2006. c. The resident's MDS weight was listed as 74 pounds with no weight gain/loss in last 30 days although the resident's admission weight was 80.5 pounds (on 2/23/06). During the MDS assessment reference time period the resident lost 6.5 pounds. 2. Review of resident #4's record revealed the resident was admitted to the facility on 8/4/05 with	F 278	period. This will include the following items: • End of life care • Catheters Current Braden scales will be audited for accuracy by June 16, 2006. Random weekly review of the MDS's & care plans will be reviewed for the following items end of life care & catheters to ensure that the MDS accurately reflects the residents present plan of care. **MONITOR** Review of random charts for MDS accuracy as so stated above will be reviewed by the QA&A committee for recommendation and continued compliance monthly x3 and re-evaluate for further review.	

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diagnoses of depressive disorder, urinary tract infection, malaise and fatigue. The resident had a Foley retention catheter inserted on 9/6/05 and continued to have this indwelling catheter throughout the survey.

An annual MDS assessment completed on 3/23/06, Section H.3 showed the resident as having an intermittent catheter but not an indwelling Foley catheter. Review of nursing notes for the 14 days of the MDS observation period prior to 3/21/06 did not reveal that the resident's Foley catheter had been changed in an intermittent catheter.

3. Record review for sample resident #13 revealed diagnoses that included anemia, gastrointestinal hemorrhage, diabetes, Parkinson, congestive heart failure, and glaucoma. Review of the resident's 4/26/06 significant change Minimum Data Set (MDS) evidenced that the resident required extensive assistance with bed mobility, transfer, walk in the corridor, and eating and total assistance with locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing. The resident was assessed to frequently be incontinent of bowel and incontinent of bladder and to have a Stage II pressure ulcer. The resident was further assessed to have a mechanical lift in use as a transfer aid.

a. Review of the resident's Weekly Pressure Ulcer Records revealed that the resident had the following pressure ulcers:

2/22/06 - sacral, Stage 2, 3 cm (centimeters) noted to be healed 3/15/06.

4/1/06 - sacrum, Stage 2, 2 cm (newly re-opened), noted to be healed 4/12/06

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5/10/06 - sacrum, Stage 2, shearing, and 4 cm x 2.5 cm and shallow in depth. Review of the documentation evidenced that this "reopened on sacrum."

b. Review of a fax, dated 5/10/06, to the physician revealed that the resident skin breakdown was "noted shearing to sacrum 3 cm x 2.5 cm. "

c. Review of the resident's dietary notes revealed the following:

5/2/06 - "Quarterly dietary assessment shows a nutrition risk score of 15 - related to mental status, self-feeding, weight loss, good intake, food allergies, labs and predisposing conditions. __ (His/her) wt on 5/2/06 was 97.1 lbs. (pounds) down rt (related to) previous low intake....receives Ensure between meals and fort (fortified) foods @ meals (fort milk).....may be offered a supplement after meals if ___ (he/she) doesn't eat well...needs could be met with meal intake and supplement intake. Skin is intact @ the present time."

4/21/06 - "IDT (interdisciplinary team) met on weight loss. ___ (His/her) wt this week 99.9 lbs. Down this month. ... meal intake has been increased lately but was down last week. MD (doctor) is aware of weight loss... Hgb (hemoglobin) and Hct (hematocrit) is decreased & supplementation hasn't helped. ___ (He/she) does receive Ensure between meals... can meet needs with current intake but intake was decreased. We also try fortified milk."

4/17/06 - "...weight loss....down 5.53% @ 1 month, down 8.04% @ 3 months, 7.78% @ 6

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months. ...Altered skin just healed on 4/12/06 but keep needs increased for now."

4/12/06 - "IDT met on wt loss..will ask for supplement at meals, gets ensure & supplements between meals."

4/4/06 - "Follow up due to skin. ...She also receives Ensure or Boost BID (twice a day)..."

3/7/06 - "Wt decrease... Alb (Albumin) decreased to 2.7. ..." No mention was made of skin breakdown.

2/27/06 - "F/u (follow up) due to skin. Resident has a Stage II area per nursing. ...Albumin 3.4..."

d. Review of the resident's most recent Braden Scale, dated 5/3/06, revealed that the resident's score was 14 (moderate risk). Review of this assessment indicated that the resident had adequate nutrition and had a potential problem for friction and shear. Based on record review, there was no documentation to show what the resident's actual supplement/fortified milk intake was to enable an accurate nutritional assessment to be done. The resident's albumin was low. The resident had recently experienced weight loss. Based on staff interviews and record review, the resident had an ongoing history of problems with friction and shearing.

The facility failed to accurately assess the resident using the Braden Scale and its definitions. Refer to F314 for details.

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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. This Requirement is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined that the facility failed to provide care in a manner to ensure adequate pain relief, failed to position a resident to facilitate the resident's ability to eat, and failed to provide appropriate catheter positioning. This failure affected two of 24 sample residents (#10 and #21) abilities to reach their highest practicable level of physical, mental, and/or psychosocial functioning. The findings included: PAIN MANAGEMENT: Review of the medical record of sample resident #10 revealed the resident was admitted to the facility on 2/22/06 with diagnoses that included chronic obstructive pulmonary disease, hypothyroidism, electrolyte/fluid disorder, GERD (Gastroesophageal Reflux Disease) and episodic mood disorder. Review of a hospital history dated 2/17/06 indicated the resident had a "past medical history significant for lung cancer diagnosed in 09/2005, which was initially classified as probably terminal". a. The facility failed to have a comprehensive	F 309	**309** **IMMEDIATE** Resident #10 no longer resides at the facility. Resident #21 PT & OT Therapy continues to work with the resident on positioning, ROM since 3/20/06 and was continuing to work with the resident with a new order on 5/2/06 to improve the residents quality of care. Resident has received also a new cushion to enhance his positioning. **RISK** Residents have been reviewed for the following issues utilizing the Resident Data Set (RDS): • Pain management • Catheters Residents will be reviewed by Therapy and nursing for the following items: • Positioning • Equipment Any issues will be addressed immediately.	6/17/06

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and consistent pain management program for resident #10 which caused the resident to experience pain at an assessed level of 4-5 (scale of 0-5) with no evidence of pain relief interventions.

b. The resident's admission Minimum Data Set (MDS) assessment dated 3/6/06 indicated the resident was assessed to have pain that was less than daily, at a moderate intensity and located in his/her hip.

c. On the resident's admission assessment (Resident Data Set) dated 2/22/06, pain was described as daily, sharp and aching and located in his/her right hip. The admission assessment (Resident Data Set) indicated that the resident had expressed that "laying flat on back (with) little mvmt (movement)" relieved his/her pain.

d. Review of the resident's medical record revealed the resident had increasing pain which was unrelieved with the oral pain medications initially ordered by the physician. The resident's admission physician orders indicated the resident was on Tylenol 325 milligrams 1-2 tablets every four hours for PRN (as needed) pain.

1) A Physician Fax Transmittal Form dated 2/27/06 indicated the resident "c/o (complained of) all over pain that is not relieved by Tyl (Tylenol)". Tylenol is a non-opiate, non-salicylate analgesic. Although the facility was utilizing a pain scale of 0-5, this form used to communicate with the physician indicated the resident's pain scale was 8-10 on a scale of 1-10. This faxed form showed the physician ordered Darvocet N-100 (DCN, a narcotic analgesic) every four hours PRN for pain.

SYSTEM

Staff will be in-serviced on the guideline for pain utilizing the company chosen pain scale 0-5 the MAR's (Medication Administration Record) has been update for the staff to utilize the appropriate pain scale, done by the DON & or Designee. Done by June 16, 2006.

The DON has reviewed with the physicians the company pain scale 0-5 rating to ensure further consistency.
Residents will be reviewed and categorized into three areas of pain management; this will be determined through the Resident data Set (RDS):

- Mild pain
- Moderate pain
- Severe pain

The IDT pain committee will review Resident's on admission & Bi-monthly. This will ensure that residents are being appropriately assessed and treated for pain in a timely manner.

- Residents with mild pain will be reviewed

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F 309	Continued From page 25 2) A Physician Fax Transmittal Form dated 3/2/06 indicated the resident was complaining of a "lump in (his/her) throat and difficulty swallowing." The faxed form did not indicate if what the resident's current pain scale was. 3) A Physician Fax Transmittal Form dated 3/9/06 indicated "Res (resident) c/o (complaining of) right lower quad (quadrant) tenderness". Communication from the physician on this form indicated that the resident had "lung cancer spreading since a mass was found in the L (left) of (his/her) neck on swallow study". Although the form indicated the resident had complaints of pain there was no indication of what the resident's current pain scale was. 4) A Physician Fax Transmittal Form dated 3/13/06 indicated the resident was having coughing and choking when he/she attempted to eat or drink fluids. This faxed form did not notify the physician of any resident complaints regarding pain with swallowing or anxiety. 5) A Physician Fax Transmittal Form dated 3/16/06 indicated "Res (resident) having (symbol for increased) pain (and) anxiety". The form also indicated the resident was getting "poor results" from the Tylenol and Darvocet and liquid Morphine Sulfate (MS) was ordered every 2-3 hours PRN. Although the form indicated the resident had increased pain there was no indication of what the resident's current pain level was. 6) A Physician Fax Transmittal Form dated 3/22/06 indicated the wound care nurse had communicated signs and symptoms of a Kennedy Terminal Ulcer (KTU) to the physician. According to Kennedy Terminal Ulcer.com by	F 309	monthly and PRN. • Residents with moderate pain will be reviewed by the IDT bi-monthly and PRN. • Residents with severe pain will be reviewed weekly and PRN by the IDT members. Staff has been in-serviced on positioning residents and use of the equipment, done by the OT & or Designee. Done by June 16, 2006. Residents on admission will be reviewed by therapy or nursing to ensure that the resident is appropriately positioned and has appropriate equipment to enhance quality of care. Random weekly review of residents will be done by the IDT members, to ensure that the residents are appropriately positioned and that there pain is under control.. A list of residents with catheters will be compiled to ensure that each catheter is in appropriate position and not touching the floor.	

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F 309	Continued From page 26 Karen Lou Kennedy-Evans RN, CS, FNP, a Kennedy Terminal Ulcer is a pressure ulcer that some individuals develop in the end-of-life stages of a terminal illness. This faxed form also indicated the resident was complaining of "severe left side throat pain, palpable mass increased in size" but the form did not indicate the resident's current level of pain per the pain scale. 7) Communication to the physician on 3/31/06 (Report of Consultation) indicated the resident continued to have increasing difficulty swallowing and pain. 8) A Physician Fax Transmittal Form dated 4/12/06 indicated the resident complained of difficulty breathing, "I can't breathe". This faxed form did not indicate the resident current pain level. 9) A Physician Fax Transmittal Form dated 5/1/06 indicated the resident was refusing to be repositioned due to difficulty breathing and increased pain. This faxed form did not indicate the resident's current pain level. CARE PLAN FOR PAIN: e. The resident's care plan dated 3/28/06 indicated "needs to be kept comfortable as resident is comfort care." A care plan for "Pain/Discomfort" indicated the resident had a potential for pain due to his/her wound and a diagnosis of cancer and was on "comfort care". These two care plans did not outline or specify what "comfort care" for this resident entailed. The care plan for pain indicated an approach to "Medicate resident for pain prior to treatments and therapy if indicated". When staff was questioned regarding the meaning of "Comfort	F 309	Random weekly review of the catheters will be done by the DON/& or Designee to ensure that the catheters are in appropriate position. **MONITOR** Random weekly reviews of residents for appropriate positioning, pain control and appropriate catheter placement, will be reviewed by the QA&A committee for recommendation and continued compliance monthly x3 months then re-evaluate for further review.	

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Care" they indicated the resident was his/her own decision-maker and directed what the care should be.

f. Review of the resident's medication sheet and current physician orders dated 5/1/06 did not reveal that the resident was on routine pain management. The resident had orders for PRN (as needed) liquid Morphine, Tylenol and Darvocet N-100 tablets.

g. A wound care notation dated 4/19/06 indicated the resident had increased pain with repositioning yet the CNA (Certified Nurse Aide) worksheet indicated to reposition the resident every two hours. The care plan did not reflect "comfort care" measures related to the resident's verbalized pain with positional changes such as delaying positional changes until after effective pain measures were implemented or achieved.

h. The care plan did not reflect when the resident should be medicated with the liquid Morphine (i.e. at what pain level on the pain assessment scale). The physician's order indicated to give two to four milliliters of Morphine for PRN/severe pain. The care plan did not indicate at what pain level to give the lower or higher dose.

PAIN MANAGEMENT DURING WOUND CARE:

i. Observation of sample resident #10 on 5/11/06 at 4:50 PM revealed the resident was awake. When asked if he/she was uncomfortable the resident nodded "yes". When asked if he/she had had any medication for pain the resident nodded "no". The wound care nurse was observed to gather equipment/supplies to change the resident's wound dressing but did not inquire

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regarding the need for pain medication or evaluate the resident's pain level prior to this procedure until the surveyor asked about pain management during dressing changes.

j. On 5/12/06 at 8:20 AM, in an interview with the wound care nurse, she stated, "(He/she) has pain all of the time. (He/she) has cancer and is dying. She gets routine pain med (medication). (I) don't give pain meds - not my responsibility."

k. Review of a "Non-Pressure Skin Condition Record" dated 3/22/06 indicated the resident had a Kennedy Terminal Ulcer (KTU) 4 cm (centimeters) by 0.5 cm on his/her sacral area. This form indicated the wound care was painful. Additional wound notations on 3/29/06, 4/5/06, 4/12/06, 4/19/06, 4/26/06, 5/1/06, 5/3/06 and 5/8/06 also indicated the wound care was painful and to "see pain management flow sheet". There was no indication on these records that the resident received any pain medication prior to wound care/dressing changes.

l. The Treatment Sheet indicated the resident received wound care on 13 days in April and four times in May. Neither the treatment sheets nor the Non-Pressure Skin Condition Records showed the time this wound care was performed, the resident's pain level at the time of the wound care or if pain medications were given prior to this treatment as per the resident's care plan.

According to "Ethical Wound Management for the Palliative Patient'" by Cynthia A. Fleck, RN, BSN, MBA, ET/WOCN (Extended Care Product News, May 2005), "Pain control remains a mainstay of palliative care. Since wounds often produce pain, minimizing discomfort is paramount. Assume that every wound is painful and every patient who has

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a wound is in pain. Patients frequently experience pain during dressing changes (e.g., from dried dressings, strong adhesives, debridement, and the pressure of exudate), around wound edges, and in infected or inflamed wounds. Wound pain can serve as an important indicator of inadequate wound management, untreated underlying cause, and/or infection. Look to dressings that can remain in place for longer periods of time, minimizing wound bed manipulation and decreasing the leading cause of wound pain...Dressing removal is considered to be the time of most pain. "

PAIN ASSESSMENT/ADMINISTRATION OF MEDICATIONS:

m. Review of medication records in mid-March 2006 through May 2006 showed documentation that the resident starting having daily pain requiring Morphine 1-5 times a day. The resident did not receive a routine pain medication but only had medications ordered for breakthrough pain although he/she was experiencing daily pain.

n. In an interview with the Director of Nursing on 5/12/06 at 8:30 AM she indicated that the facility had changed their pain assessment scale from a scale of 1-10 to a scale of 0-5. She indicated that some nurses continued to use the pain scale of 1 -10 instead of the new scale. She was unable to supply evidence of which scale was being used to assess resident #10's pain. The DON indicated that the facility had implemented the new pain scale in February 2006 (three months prior to the survey).

o. Review of the resident's medical record revealed a Pain Management Flow Sheet which utilized a pain scale of 0-5 for the assessment of

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the resident's pain. The resident's admission assessment (Resident Data Set) dated 2/22/06 indicated a pain scale of 0-5 for the assessment of the resident's pain.

p. Review of the medication sheets (for medications given and documentation of the level of pain), nursing notes, Narcotic Control Logs and Pain Management Flow Sheets from March 2006 through May 2006 revealed assessments of the resident's pain and administration of medication were inconsistently documented. Although the nursing staff assessed the resident's pain and recorded the level for the day/evening shift (7 AM to 7 PM) and the evening/night shift (7 PM to 7 AM), the actual time of the assessment and the action taken for a resident assessed pain level of 4-5 was not clearly evident in the record.

1) In March 2006, the resident's pain was assessed on the medication sheet every shift, except for 7 PM to 7 AM shift on 3/9/06, 3/17/06, 3/29/06, 3/30/06; the day and night shift on 3/25/06 and the day shift on 3/31/06.

a) The resident had his/her pain rated at a "4" (0 -5 pain scale) on the day shift (7 AM to 7 PM) but no evidence on the medication sheet that any medication was given to the resident on the following dates: 3/9/06, 3/10/06, 3/11/06 and 3/12/06.

b) Although the medical record indicated the Tylenol (the non-opiate analgesic) was not relieving the resident's pain the nursing staff administered two tablets of Tylenol on 3/16/06. The pain assessment on the medication sheet for this date indicated the resident's pain level was a "5" on both shifts.

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c) On 3/17/06 although the resident was assessed at a "3" he/she received both a dose of Morphine and a dose of DCN (Darvocet). Neither the medication sheet nor the nursing notes indicated the time these medications were given or the effectiveness of these interventions.

d) On 3/18/06 the medication sheet indicated the resident received Darvocet N-100 for pain (no time recorded). The nursing note for 3/18/06 (7 PM to 7 AM) showed the resident received DCN (Darvocet) but no actual time or pain level was recorded. The medication sheet indicated the resident's pain level was a "4" on both shifts.

e) On 3/19/06 the resident received two doses of MS but the pain assessment only showed a "3" and a "0". The nursing notes for 3/19/06 do not indicate pain, time pain medications were administered or effectiveness of pain medications.

f) Although the medication sheet showed the resident received three doses of MS on 3/21/06 the assessment only reflected two pain levels of "3" and "4". There were no nursing notes dated 3/21/06 evident in the medical record.

g) On 3/22/06 the nursing note at 0200 (2:00 AM) indicated the resident received two does of MS. The pain assessment for the 7PM to 7AM (on 3/21/06) indicated the resident's pain was a level "4". There is no indication for the reason that two doses of MS were given at this time.

h) The resident received two doses of MS on both 3/23/06 and 3/24/06 but nursing notes do not reflect the effectiveness of these pain measures. The resident was assessed with pain at a "4" on day shift on 3/24/06 but no nursing notes were

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documented.

i) On 3/26/06 the resident had four doses of MS according to the medication sheet. The assessment sheet only indicated two pain levels, "3" and "1". The nursing notes for 3/26/06 showed no notation for the 7 AM -7 PM shift. The nursing note for the 7 PM to 7 AM shift on 3/26/06 indicated resident "has cough that is relieved with MS", although the note does not indicate time medication was given or pain level. This notation also indicated the resident was on Morphine on a "regularly scheduled basis" which was not reflected in the resident's medical record.

j) The medication sheet indicated the resident received five doses of Morphine on 3/27/06 and 3/28/06 as well as doses of DCN. There were no nursing notes documented on 3/27/06 or 3/28/06 to show the increase in the resident's pain which required these medications.

k) Nursing notes for 3/29/06 do not reflect the resident's complaints of pain, although the resident was assessed as a "3" pain level on the 7 AM-7PM shift. The medication sheet showed the resident received three doses of MS.

2) In April 2006, the medication sheet did not reflect all of the doses of MS that were administered to the resident.

a) On 4/18/06 the medication sheet indicated two doses had been given but the Narcotic Control Log (NCL) indicated the resident received three doses of MS.

b) On 4/19/06 and 4/25/06 the NCL indicated four doses but the medication sheet only showed two doses were given on those dates.

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c) On 4/20/06 the NCL showed two doses but the medication sheet only recorded one dose.

d) The medication sheet did not show any MS had been given to the resident on 4/21/06, 4/22/06, 4/23/06, or 4/28/06 although the NCL indicated the resident received from 1-3 doses on those days.

e) Although the resident's pain was assessed on 4/24/06 as a "4" there is no evidence that he/she received any pain medication (medication sheets or NCL).

3) In May 2006, medication/pain management interventions were inconsistently documented. Assessments documented in nursing notes showed the resident had little or no chest/flank pain but no evaluation of the locations where the resident had verbalized having pain (wounds/ulcers, back, abdomen, neck/throat or right hip).

a) The May medication sheet for 5/1/06 did not indicate that the resident had received any pain medications and his/her pain was assessed as "0" for both shifts. The NCL indicated the resident received a dose of MS at 1300 (1 PM) and again at 2100 (9:00 PM) on 5/5/06. The nursing notes for 5/1/06 showed no notation for the 7 AM to 7 PM shift and the notation for the 7PM to 7 AM shift did not mentioned that the resident had received MS, pain level or effectiveness of the MS given at 2100.

b) On 5/2/06 the resident was assessed both shifts with a pain level of "3", but there was no indication the resident received medication or refused medication. The NCL indicated the

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resident received a dose of MS at 0300 (3 AM) on 5/3/06 (the 7 PM to 7 AM shift). The nursing notes did not reflect the resident's status at this time (pain level and effectiveness of medication administration).

c) On 5/3/06 the medication sheet did not indicate that the resident had received any pain medications although his/her pain was assessed as a "3" on the 7 AM-7 PM shift. The NCL indicated the resident received two dose of MS, at 0900 (9 AM) and again at 1400 (2:00 PM). The nursing notes did not reflect the resident's status at these times (pain level and effectiveness of medication administration).

d) Although the resident's pain assessment from 5/4/06 through 5/7/06 showed the resident had pain at a level of 3-4 the medication sheets and the NCL did not indicate the resident had received any Morphine for his/her pain. Nursing notes for this time period showed resident "denied discomfort" or "offers no c/o pain", although the pain levels were 3-4. A nursing note dated 5/5/06 indicated the resident complained of "generalized pain, mostly in abd (abdomen) and throat" and received Morphine. Neither the medication sheet nor the NCL showed this dose of MS on 5/5/06.

e) The Pain Management Flow Sheet dated 5/8/06 indicated the resident's pain level was "5", location "decub sites" and Morphine was given. This form indicated pain was assessed using a scale of 0-5. A score of five was labeled as pain that "Hurts Worst". The flow sheet did not indicate how effective the pain medication was or the time the pain was assessed at the level of "5". According to the NCL this medication was given at 2300 (11:00 PM). The medication sheet

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showed the pain level for the 7 PM to 7 AM shift on 5/8/06 was "0".

f) The Pain Management Flow Sheet dated 5/10/06 indicated the resident's pain level was "4", location "back" and Morphine was given. The flow sheet did not indicate how effective the pain medication was or the time the pain was assessed at the level of "4". The medication sheet does not reflect this "4" pain level. The medication sheet does not indicate that any MS was given on 5/9/06 or on 5/10/06, although the NCL indicated the resident received MS at 0400 (4:00 AM).

g) Although the patient's pain was assessed on the medication sheet as "2" and "1" on 5/11/06 the NCL indicated the resident received two doses of MS, at 1700 (5:00 PM) and at 2100 (9:00 PM). Although the nurse noted on the Pain Management Flow Sheet (no time indicated) that the resident complained of "pain all over", the resident's pain was indicated at a "2" and MS was given.

q. After the facility staff was interviewed regarding this resident's pain management, a Report of Consultation dated 5/11/06 indicated the facility staff had requested a pain assessment from the Medical Director (who was not the resident's attending physician). There was no documentation that the Medical Director had ever examined the resident prior to 5/11/06.

1) This physician noted at 9:15 PM that the resident was asked if he/she was in pain and the resident responded "yes". The resident indicated he/she was in pain "all over" and requested something for pain. The Medical Director indicated the resident "whispered" this answer

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and was lying quietly. The review of the medical record showed the resident was having pain in his/her throat due to a large metastatic mass and that one pain relief measures he/she used was lying quietly with little or no movement. Nursing notes reflected that the resident's speech was often very soft (3/19/06 and 3/20/06) and as the resident became weaker his/her voice was "very nearly a whisper" (5/8/06).

2) In assessing this resident's pain the Medial Director indicated that he/she had reviewed nursing notes (which showed inconsistent documentation of pain assessment, administration of medications and effectiveness of interventions). The Medical Director indicated that the resident's pain was assessed with pain scale of 1-10 at "2-4", although the policy and charting forms indicated the staff was using a scale of 0-5 to assess the resident ' s pain.

3) There was no evidence that the Medical Director evaluated or observed the resident's wounds (sacral and on his/her scapula) in relationship to the resident's pain. The resident's prior complaints of pain included pain in these wounds and his/her "back" .

4) The Medical Director indicated the resident was in no distress and manifested no evidence of anxiety. Review of nursing notes from 3/1/06 through 5/11/06 indicated the resident was having increasing pain, shortness of breath and difficulty swallowing due to lung cancer with a metastatic mass in his/her throat which was increasing in size. The notes also reflected repetitive concerns from the resident that he/she was "going to die".

a) The resident's admission assessment (Resident Data Set) dated 2/22/06 indicated the

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resident had a "sad, apathetic, anxious appearance".

b) A Physician Fax Transmittal Form dated 3/13/06 indicated the resident was having coughing and choking when he/she attempted to eat or drink fluids. This Faxed form did not notify the physician of any resident complaints regarding pain with swallowing or anxiety.

c) A Report of Consultation dated 3/14/06 indicated a written note that the resident had expressed concerns that he/she was dying.

d) A nursing note dated 3/22/06 indicated the resident was "anxious about being alone in rm (room)".

e) A Physician Fax Transmittal Form dated 3/25/06 indicated the resident was having difficulty sleeping and "states that (he/she) feels anxious". This form indicated the resident's pain was at a level of "10" (pain scale of 1-10).

5) The Medical Director's recommendations on this report indicated "Pain meds appropriate - but only PRN - recommend to give routine for good pain control and avoid oversedation...no antianxiety meds indicated @ (at) this time".

CATHETER TUBING:

r. Observation of sample resident #10 on 5/9/06 at 1:35 PM, on 5/10/06 at 6:50 AM and on 5/11/06 at 4:50 PM revealed the tubing of the Foley catheter was hanging over the side of the bed with a large loop outside of the privacy bag, touching the floor. During the 5/11/06 observation the wound care nurse was observed to trip over this tubing before the Certified Nurse Aide placed

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the tubing inside the privacy bag. In addition to creating the potential for traumatic removal of the Foley, the looping of the tubing and the placement of the tubing on the floor created a potential for urinary tract infections and backflow of the urine into the bladder.

According to "The Lippincott Manual of Nursing Practice," 7th Edition, (2001), pages 694-696, it states, "Infectious organisms can migrate to the bladder along the outside of any indwelling catheter. The urinary drainage bag should not be in contact with the floor, to prevent possible bacterial contamination. Catheter tubing should be arranged so that accumulation of urine in the bladder does not occur and that loops of stagnant urine do not occur. Placement should always be such that the drainage bag and catheter tubing are below the level of the bladder."

POSITIONING OF RESIDENT DURING MEALS:

During the evening meal on 5/9/06 revealed that sample resident #21 was not positioned to facilitate the resident's ability to eat. Observation of the resident during the evening meal on 5/9/06 revealed a CNA assisted the resident to eat during the entire meal. The resident was observed to lean to the left, over the arm rest of the wheelchair. There were no pillows or cushion supports in the wheelchair to keep the resident in an upright position during the meal to enhance his/her swallowing. The CNA had to reach across the resident to spoon food into the resident's mouth and did not reposition the resident until the meal was almost completed.

Review of the resident's tray card revealed that the resident was assessed to need puree food and nectar thick liquids. The resident's annual

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F 309	Continued From page 39 MDS assessment dated 12/4/05 indicated the resident was assessed to need total staff assistance with eating.	F 309	314 **IMMEDIATELY** Resident #1 Right Malleolus continues to have a stage 3 with signs of healing process. This occurred due to the resident continuously crossing her legs with a cast on the opposite leg even with interventions. Left Buttocks resident has never had a pressure area unable to respond. Right foot resident sustained a scratch caused from the resident placing her feet up against the wall no evidence or documentation of a pressure area, it is noted by the physician 3/24/06 to be a lesion. Resident #13 chronic area to Sacrum healing. Resident #15 no skin problems noted unable to respond. **RISK** A complete review of the charts has been completed utilizing the RDS (Resident Data Set) section on risk for pressure ulcers to determine who is a risk for pressure	6/17/06
F 314 SS=G	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 record review, observation, and staff interview, it was determined that the facility failed to implement appropriate, timely interventions to prevent the development of pressure ulcers and/or to treat the ulcers once they developed for three of 24 sample residents (#13, #15, and #1). These residents were facility-assessed to be at risk for the development of pressure ulcers. The findings included: Reference: According to "Pressure Ulcers in Adults: Prediction and Prevention", U.S. Department of Health and Human Services, Clinical Practice Guideline, Number 3, "Any person at risk for developing a pressure ulcer should avoid uninterrupted sitting in any chair or wheelchair. The individual should be repositioned, shifting the points under pressure at least every hour or be put back to bed if consistent with overall patient management goals."	F 314		

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F 314	Continued From page 40 According to "Pressure Ulcer Treatment", U.S. Department of Health and Human Services, Clinical Practice Guideline, Number 15, the resident should have an individually prescribed seat cushion which will relieve or reduce pressure on bony prominences. Support surface and positioning needs should be assessed and reviewed regularly and determined by results of skin inspection, patient comfort, ability, and general state. Covering these support services with bed linens, towels or incontinent pads decreases their effectiveness for pressure relief. 1. Record review for sample resident #1, admitted on 12/21/05 following a left communicated femur fracture revealed diagnoses that included dementia, anemia secondary to blood loss, osteoporosis, pelvic fracture, cerebral vascular accident, hypertension and urinary tract infection. The resident was identified as having developed a pressure sore on the right malleolus (the bony prominence on either side of the ankle). This resident was facility assessed to be high risk for the development of pressure ulcers. The facility failed to provide care to prevent the development of new pressure ulcers. OBSERVATIONS a. On 5/9/06 during observation from 2:20 PM until 4:05 PM the resident was observed in bed laying on his/her right side creating pressure on the affected foot. The resident remained in this position until two CNAs (certified nurse aides) went into the room at 4:05 PM to do pericare and get the resident out of bed. On 5/11/06 at 3:45 PM the resident was observed again laying on his/her right side from 2:10 PM to	F 314	ulcers and that appropriate action for prevention has been implemented. **SYSTEM** In-service nursing staff on the 10-step skin program. Done by the SDC & or Designee. Done by June 16, 2006 In-service nursing staff on the policy and procedure SSP1401.00 Skin Care. Done by the SDC & or Designee. Done by June 16, 2006 Develop a list of residents that need to be laid down after meals. Done by the Don & or Designee. Develop a turning schedule: ➢ 10-4 face the door ➢ 6-2 face the view ➢ Meals & snacks on your back (8-12). Do random daily review to ensure that the residents that require repositioning are turned timely. Done by the IDT members. A complete review of the residents care plans has been done for the following items to ensure that the care	

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F 314	Continued From page 41 3:45 PM. Review of the nursing notes revealed no documentation of positioning and turning for this resident who had one stage III pressure ulcer. The resident was observed during the survey laying on the right side most of the time. b. On 5/09/06 during the Foley catheter care and pericare observation with two CNAs, the resident's left buttock area near the fold was noted to have a bright red to purplish color area measuring approximately 10 x 7 cms area with a 4-5 mm opened area. She proceeded to apply Calazine protectant paste to the area. c. On 5/10/06 at 6:40 AM during a wound care observation with the wound nurse of the resident's right malleolus pressure sore, she stated that the resident had developed the right malleolus sore by folding his/her cast left leg over the right ankle area. She stated that the pressure sore had been there for months. The nurse stated that it was caused from the rubbing and pressure of the cast over the right ankle. She stated "if the staff doesn't let me know then it could be there for awhile". She stated that the staff was to do skin check when providing a shower. She also stated "the staff is laying the resident on the right side without proper pillow support over the right ankle area. They are applying the pillow directly on the right ankle causing pressure". "The staff needs to keep the resident off the right side". She stated that she had discussed this with the staff many times. The observation of the right malleolus pressure during the dressing change revealed a stage III wound measuring 3 cms with a depth of approximately 3-4 mm (millimeter) with a small	F 314	provided is accurate with the planned individual care: • Equipment required for the resident to be appropriate positioned done by the MDS Coordinator/Designee. Staff has been in-serviced to utilize the communication tool when a resident has a pressure ulcer. The communication slip a copy is given to the DON, Treatment Nurse and NHA for further investigation, done by the DON/Designee. Residents that take supplements the amount in percentage will be recorded on the MAR (Medication Administration Record). This will be in-serviced by the Dietician/Designee. The percentage of supplements consumed by residents, will be reviewed at the weekly skin meeting by the IDT members. to ensure that residents are maintaining adequate amounts or if changes need to occur.	

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F 314	Continued From page 42 amount of scan white exudate. There was an area of black eschar to the lateral aspect of the right foot distal to the fifth toe measuring 2 x 0.5 cms with some redness surrounding the skin breakdown. The wound nurse applied some clear gel to the black area. The wound nurse proceeded to look at the left buttock area after the surveyor mention of it. The red/purplish area showed a decrease in size with minimal skin breakdown. The nurse felt that the area was not opened. The nurse applied a clear film matrix over the area to help with the healing. d. On 5/11/06 at 3:45 PM during a pericare and wound observation with the wound nurse and a CNA of the right malleolus pressure sore, right foot and left buttock opened area; the nurse stated once again that the resident needed to lay off the right side. Again, she stated that the staff did not place the pillows under the resident's legs properly causing increased pressure over the right malleolus sore area. There was no mention of these new pressure sores on the left buttock and right foot. There was also no documentation in the Weekly Pressure Ulcer Record form dated 5/3/06 of the new pressure sore on the right foot. RECORD REVIEW e. Review of the Braden Scale-For Predicting Pressure Sore Risk on admission dated 12/21/05 revealed under risk assessment that the resident had a total score of 9. A score of 9 points or below indicated severe risk for skin breakdown. f. Review of the Weekly Pressure Ulcer Record form dated 12/21/05 revealed that the resident	F 314	**MONITOR** Random daily review of repositioning to include necessary checking of residents with toileting as per care plan and residents timely weekly review of the percentage of supplement consumption will be reviewed by the QA&A committee for recommendation and continued compliance monthly X3 months then re-evaluate for further review.	

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had an unstageable pressure sore upon admission to the facility on the right buttock. On 4/19/06, the pressure sore size was minimal and on 4/26/06, the nurse documented that the pressure sore was healed.

g. Review of the Weekly Pressure Ulcer Record form dated 1/25/06 revealed that the resident had a new facility acquired pressure sore documented to be unstageable on the right lateral aspect of the ankle over the bony area or malleolus measuring 3 cms (centimeter) without a documented depth. The nurse documented the following:

1) 2/01/06, pressure sore measured 2 cms, was unstageable and without a documented depth.

2) 2/08/06, pressure sore was a stage II, measuring 1.5 cms with a shallow depth.

3) 2/15/06, pressure sore was a stage II, measuring 1 cm with 0.5 cm depth.

4) 2/22/06, pressure sore was a stage II, measuring 1 cm with 0.3 cm depth.

5) From 3/01/06 to 3/15/06, the nurse documented that the pressure sore was a stage III measuring 1.5 cms with 0.25 cm to shallow depth with serosanguinous drainage and scant exudate. The nurse documented in the progress notes on 3/01/06 and 3/08/06 that the area was showing improvement, the care plan was reviewed and to continue current plan of care.

6) On 3/22/06, the nurse documented that the pressure sore now measured 2.5 cms with zero depth. Even though there was a size increased of 1 cm in one week, the nurse documented in

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the progress notes the following: "res (resident) c (with) improvement cont (continue) to monitor pt (physical therapy) wkly (weekly) et (and) nursing daily.

7) On 3/28/06, the nurse documented that the pressure sore now measured 3.5 cms with unknown depth. This was again another increase in size from the previous weekly assessment. The nurse documented "area showing improvement....continue current plan of care. IDT (Interdisciplinary Team) to re-eval (evaluate) in one week".

8) From 4/05/06 to 4/12/06, the nurse documented that the pressure sore was a stage II measuring 3.5 cms with unknown depth. On 4/05/06, the nurse documented in the progress notes the following: "[change sign] to treatment c noted improvement".

9) On 4/19/06, the nurse documented that the pressure sore was a stage II, measuring 3 cms without a documented depth.

10) On 4/26/06, the nurse documented that the pressure sore was now a stage III, measuring 4 cms with "shallow boggy" depth. The nurse stated in the progress notes "area slightly bigger in circumference".

11) On 5/03/06, the nurse documented that the pressure sore continued to be a stage III, measuring 4 cms and shallow depth. The nurse stated in the progress notes "area showing small improvement...continue care plan".

h. Review of Report of Consultation form dated 1/21/06 revealed "unstageable pressure ulcer to the R lat (lateral) ankle, wound bed has 70%

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necrotic tissue, 30% slough/non viable tissue, s/sx's (signs and symptoms) of colonization, periwound area. red 3 cm circumference, warm to touch, 0 (zero) drng (drainage) noted, + (positive) peripheral edema, erythema spreading increase lat.calf stops midway, warm to touch also, applied iodeform + foam drsg (dressing). Placed res. (resident) on turn schedule to restrict lying on R side. The physician's notes stated under impression: "1.Cellulitis rt LE (lower extremity) related to decub (decubitus) rt ankle. On 2/28/06 in the physician's progress notes under impression: s/p (status post) distal femur fx (fracture) out of splint."

i. Review of the resident's Interdisciplinary Progress Notes form from 2/18/06 to 5/09/06 revealed an assessment and documentation of a pressure sore on the resident's right malleolus on 2/22/06 which is unstageable and a stage II area on the left buttock. The nurse documented the following:

2/18/06 "cont (continue) c brace to lt (left) leg".

2/19/06 at 1546 (3:46 PM) "Lt leg remains c splint on and intact 0 (zero) edema".

2/25/06 "stage II wounds R (right buttocks and L (left ankle).
(Note: The pressure sore was documented on the Weekly Pressure Ulcer Record form to be on the right ankle over the malleolus instead of the left ankle).

3/11/06 from 7:00 AM to 7:00 PM "wound areas to RT (right) malleolus + (plus) RT buttock resolving via secondary intension, tx (treatment) effective, all other integlumentary unremarkable". The nursing notes indicated that the resident

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required total assist of 1-2 CNAs (certified nurse aid) for all transfers (Hoyer lift) + to complete all ADL's, appetite fair...requires assist to eat".

3/12/06 from 7:00 AM to 7:00 PM the nurse documented that the resident had trace of edema over feet".

3/14/06 at 13:36 (1:36 PM) the resident was complaining of pain in the feet which the resident rated at #6.

3/16/06 at 13:10 (1:13 PM) the dietician documented "she has a stage III and stage II area. She is on a regular mechanical soft diet c nectar thick liquids + receives med pass 60 cc (cubic centiliter) TID (three times a day) between meals which she accepts".

3/14/06 at 13:36 (1:36 PM) the nurse's notes stated "Dressing intact on bilat (bilateral) heels. Edema +2 R foot".

3/24/06 at 1020 (10:20 AM) the nurse stated "L (left) foot 0 (zero) edema, R foot +1 edema.....Dressing intact L knee, R maleurs (sp), R buttock".

4/02/06 at 11:00 AM the nurse stated "Dr...(name of physician) in for routine rounds. Orders for: 1. Tx (treatment) nurse to assess new R ankle wound, to consider use of spenco boots while in bed".

4/13/06 from 7 AM to 7 PM the nurse stated "Pt (patient) noted to have R hip covered c wound gel (?) dressing. Reported pt had red-unopened area".

5/01/06 dietary notes stated "skin continues c a

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stage III area to R malleolus, and had a stage II area to R buttock but deemed healed on 4/26/06". There were no additional notes regarding the pressure ulcers. The surveyor had asked the Director of Nursing for a copy of the Interdisciplinary Progress Notes but was provided with only a copy of the notes starting on 2/18/06 and ending on 5/09/06.

j. Review of the admission MDS (Minimum Data Set) dated 1/13/06 revealed under skin condition, no pressure sore. The Weekly Pressure Ulcer Record form dated 12/21/05 revealed that the resident had an unstageable pressure sore upon admission to the facility on the right buttock. The quarterly MDS dated 2/20/06 revealed under skin condition, a stage 2 and stage 3 pressure sores. Skin treatments were: "pressure relieving device (s) for chair, pressure relieving device (s) for bed, turning /repositioning program, nutrition or hydration intervention to manage skin problems, ulcer care and other preventative or protective skin care and application of dressing (with or without topical medications) other than to feet". The admission and the quarterly MDS revealed that the resident was assessed to be severely impaired for daily decisions making. Both MDS assessments revealed that the resident was total assist with activity of daily living (ADL) for bed mobility, transfer, locomotion on and off unit, extensive to total assist with dressing and total assist with toileting and personal hygiene. The resident was assessed to be incontinent with bowel and had an indwelling Foley catheter.

k. Review of the resident's care plan dated 12/21/05 evidenced the following:

Problem/Need: Potential for decline related to recent L (left) femur fracture

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F 314	Continued From page 48 Approaches: One of the approaches was to follow weight bearing and ROM (range of motion) precautions as ordered by MD (medical doctor). Problem/Need: Res (resident) requires assist c (with) ADLs (Activity of Daily Living) Approach: Dependent on 2 staff for bed mobility and transfers; dependent on 1 staff for dressing, toileting and personal hygiene; extensive assist c (with) meals and dressing; res non ambulatory; w/c (wheelchair) primary means of locomotion c staff propelling Problem/Need: "Pressure Ulcers - Braden Score: 9. Actual: "right buttock healed 04/26/06, right malleolus continues". Related to: sensory perception, moisture/incontinence, decreased activity, impaired mobility, nutritional/hydration risks, friction and shear problem, co-morbid conditions and hx (history) of healed pressure ulcer". Approach: "Apply pressure reduction mattress to bed and pressure reduction cushion or wheelchair. Reposition in chair Q (every) 2o (hour)/PRN (as needed), turn and reposition Q 2o/PRN while in bed, provide incontinence care Q PRN and after each incontinence episode, measure and stage wound weekly using the pressure ulcer healing assessment form, complete a full body check weekly, monitor lab values as ordered, IDT (interdisciplinary team) referrals PRN, pressure ulcer treatment as ordered and other: air mattress (with a hand written note) D/c'd (discontinued) (without a documented date)". Problem/Need: Skin breakdown which may require nutrition interventions Approach: Provide diet per MD orders. Provide oral supplements per RD (registered dietician)	F 314		

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recommendations and MD orders. Monitor food and fluid intake at meals. Monitor weight as ordered by MD. Fortified foods per RD. Wound team to monitor weekly.

This resident was facility assessed to be high risk for the development of pressure ulcers. The facility failed to provide care to prevent the development of new pressure ulcers.

2. Record review for sample resident #13 revealed diagnoses that included anemia, gastrointestinal hemorrhage, diabetes, Parkinson, congestive heart failure, and glaucoma. Review of the resident's 4/26/06 significant change Minimum Data Set (MDS) evidenced that the resident required extensive assistance with bed mobility, transfer, walk in the corridor, and eating and total assistance with locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing. The resident was assessed to frequently be incontinent of bowel and incontinent of bladder and to have a Stage II pressure ulcer. The resident was further assessed to have a mechanical lift in use as a transfer aid.

a. Review of the resident's current C.N.A. (Certified Nurse Aide) Care Cardex revealed the following plan/approaches for providing this resident's care:

Toileting - by staff

Eating - supervise

Mobility - wheelchair - by staff - turn q 2 hr (every two hours) and position - lift - 1 person - sit to stand

Bladder/bowel status - bladder incontinence -

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bowel incontinence - toilet before and after meals @ bedtime @ PRN (as needed) - Depends are worn when up - blue pads placed on bed for containment

Behavioral/Mental Status - depressed - uncooperative - confused - reality orientation - reassurance

Other information - TABS monitor.

b. Review of the resident's care plan evidenced the following:

"Problem - Res (resident) requires assist with ADLs (Activities of Daily Living)
Approaches - Dependent on staff for bed mobility, dressing, and bathing; Extensive assist with transfers; Ambulation in hallways with therapy; w/c (wheelchair) primary means of locomotion with staff propelling."

"Problem - Pressure Ulcers - Res has hx (history) of severe agitation, restlessness, noted to slide self up and down in w/c and in bed causing persistent friction/shearing problems
Approaches - ... Reposition in chair q 2 hr/PRN; Turn and reposition q 2 hr/PRN while in bed; Provide incontinence care q PRN and after each incontinent episode; ..."

"Problem - Potential for decline related to fracture - left hip, right malleolus, 2nd phlange right hand
Approaches - .... Place call light within reach. Remind resident to call for help when needed."

"Problem - Mobility impaired related to: Impaired Mobility
Approaches - Pt to begin Amb (ambulation) with FWW (front wheeled walker), gait belt, pull w/c

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behind with A (assist) of ii (2) cue to go slow with take long steps 3 X 1 wk (week); Pt to perform LE (lower extremity) Ex's 2 1/2 # (pound) wts (weights) on LAqs. (? meaning) 30 reps (repetitions) in 3 sets of 10. 3 X 1 wk; Hamstring stretch - in w/c stretch knee straight slow and gentle hold 1 - 2 min (minutes) 1 X each leg. 3 X wk."

"Problem - Mobility impaired related to decrease in ROM (range of motion) and strength
Approaches - B (bilateral) U/E (upper extremity) and L/E AROM (active range of motion) 10 reps X 1 set 5 X wk as tolerated."

"Problem - Potential for injury. Impaired ability to self-transfer related to: mental status, weakness, ambulation status, gait/balance, history of falls; requires use of: mechanical lift - sit to stand; Sling type - safety vest; to/from portable seat toilet, chair, and bed.
Approaches - Place call light within reach; Encourage resident to obtain assistance for transfers; Provide mechanical lift..."

"Problem - At Risk for Falls
Approaches - Place call light in reach; ...Landing strip at bedside; TABS monitor in bed; w/c (alarm) DC'd (discontinued) 4/26/06..."

c. On 5/10/06, the following observations were made:

At 6:37 AM, 6:55 AM, and 7:12 AM, the resident was observed to be in bed lying on his/her back, apparently sleeping.

At 6:55 AM, the nurse attempted to administer medication to this resident. The nurse was unable to arouse the resident and stated that the

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medication would have to be given later.

At 7:50 AM, two CNAs were observed to provide care to this resident and his/her roommate. The CNAs were not able to awaken this resident, but one of the CNAs provided pericare and verified that the resident's blue underpad was not wet (no brief was in place at this time). This CNA indicated that the resident is provided total care. The resident was observed to have skin breakdown which was on both sides of the sacral area and a small bright red area on a bony area above the coccyx. The open area was heavily coated with a barrier cream. After the pericare was completed, the CNA added more barrier cream to cover the breakdown. The resident's lower body was dressed and he/she was transferred by the two CNAs, using the sit to stand lift (Sabina) with a vest type sling. As the resident continued to sleep during the transfer, he/she was unable to hold the hand grasp areas. The vest slide up under the resident's armpits as the resident was moved to the wheelchair. The two CNAs commented on how stiff the resident was and they had difficulty getting the resident's shirt on. The resident's face was washed and then he/she opened his/her eyes. The resident was taken out of the dining room at 8:38 AM without the TABs alarm attached to the resident's clothing.

At 8:50 AM, an observation revealed that the resident was taken into the dining room.

Observations made every fifteen to thirty minutes evidenced that the resident was not in his/her room.

At 11:05 AM, the resident was observed in the Sunshine Room, leaning far forward in his/her

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wheelchair. No staff were present in this area. The surveyor notified the Unit Manager (UM) of the resident's positioning in the wheelchair. The UM indicated that the chair alarm was in place and verified that the resident would have to come off of the wheelchair before an alarm would sound. She stated that the resident's TAB could not be used as that was a double restraint.

At 12:50 PM, the resident was observed in the Sunshine Room with his/her wheelchair pushed up to a table. The resident was observed to be digging in his/her mouth. When the surveyor approached the resident's table, there was a piece of chicken skin (approximately 2 inches by 3 inches) lying on the table. At 12:55 PM, a nurse verified that the item on the table was chicken skin.

At 1:06 PM, one of the two CNAs observed in the morning getting the resident out of bed brought the resident to his/her room. The CNA left the resident in the wheelchair in the room.

At 1:12 PM, when the two CNAs entered the room, they confirmed that these residents had both been up the entire time from the morning observation. They verified that the residents had not been toileted or placed in bed.

At 1:20 PM, the two CNAs, using the sit to stand lift with a vest sling, transferred the resident to the portable toilet seat riser in the bathroom. Both CNAs verified that the resident's brief was not wet but that it had a red colored substance on it. When the surveyor asked the CNA what the red substance was, the CNA indicated that it was probably blood from the open area. The resident, who sat in the bathroom while the two CNAs used the sit to stand lift for the resident's roommate,

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was observed with his/her head down. The CNAs verified that the resident was sleeping.

At 1:27 PM, the CNAs reattached the vest sling and moved the resident out of the bathroom. The CNA provided pericare to the resident and commented that the open area was bleeding and that the nurse needed to be told. The resident voided a small amount of yellow urine on the floor. The CNA pushed the resident back into the bathroom while she cleaned the floor with periwipes. The resident was then placed in bed and a nurse was notified of the skin breakdown. One of the CNAs verified that the resident had not voided into the toilet and that the nurse would be notified of the resident's lack of output.

At 1:48 PM, a nurse was observed to wipe the open sacral area with dry 4 by 4 gauze pads. Then she applied a foam pad over the area.

d. On 5/11/06 at 2:40 PM, the facility's wound nurse was observed providing wound care to this resident. The nurse revealed that she had measured, staged, and dressed the breakdown yesterday. She commented that this area was caused by "shearing, not pressure." The nurse cleaned the area, applied skin prep, and a clear dressing which wrinkled at the top end when it was applied. The nurse indicated that the wrinkled dressing was no problem.

According to " Prevention of Pressure Ulcers in Older Patients " , by Agostini, Baker, and Bogardus, Yale University Schools of Medicine and Public Health, Chapter 27, pressure ulcers develop due to pressure over a bony prominence. Risk factors include immobility, friction, shear, incontinence, cognitive impairment and poor nutritional status. Accoring to " Treatment of

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Pressure Ulcers, " University of Iowa Gerontological Nursing Interventions Research Center; 1997, individuals at risk for pressure ulcer development include residents with friction and shearing (i.e. unable to pull self up in bed, patient who has involuntary muscle movements that cause rubbing against sheets). The treatment of pressure ulcers should center on management of tissue loads (i.e. pressure, friction, and shearing).

At this time the surveyor described that 5/10/06 observations of the resident not being repositioned and toileted for approximately five hours. The wound nurse stated, "They (this resident and his/her roommate) are to be the last up and the first down. Up for no more than two hours."

e. Review of the resident's Interdisciplinary Progress Notes, dated 1/12/06, evidenced that the resident "has open area to coccyx."

f. Review of the resident's Weekly Pressure Ulcer Records revealed that the resident the following pressure ulcers:

2/22/06 - sacral, Stage 2, 3 cm (centimeters) noted to be healed 3/15/06.

4/1/06 - sacrum, Stage 2, 2 cm (newly re-opened), noted to be healed 4/12/06

5/10/06 - sacrum, Stage 2, shearing, and 4 cm x 2.5 cm and shallow in depth. Review of the documentation evidenced that this "reopened on sacrum."

g. Review of a fax, dated 5/10/06, to the physician revealed that the resident skin breakdown was "noted shearing to sacrum 3 cm x 2.5 cm. "

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h. Review of the resident's dietary notes revealed the following:

5/2/06 - "Quarterly dietary assessment shows a nutrition risk score of 15 - related to mental status, self-feeding, weight loss, good intake, food allergies, labs and predisposing conditions. ___ (His/her) wt on 5/2/06 was 97.1 lbs. (pounds) down rt (related to) previous low intake....receives Ensure between meals and fort (fortified) foods @ meals (fort milk).....may be offered a supplement after meals if ___ (he/she) doesn't eat well...needs could be met with meal intake and supplement intake. Skin is intact @ the present time."

4/21/06 - "IDT (interdisciplinary team) met on weight loss. ___ (His/her) wt this week 99.9 lbs. Down this month. ... meal intake has been increased lately but was down last week. MD (doctor) is aware of weight loss... Hgb (hemoglobin) and Hct (hematocrit) is decreased & supplementation hasn't helped. ___ (He/she) does receive Ensure between meals... can meet needs with current intake but intake was decreased. We also try fortified milk."

4/17/06 - "...weight loss....down 5.53% @ 1 month, down 8.04% @ 3 months, 7.78% @ 6 months. ...Altered skin just healed on 4/12/06 but keep needs increased for now."

4/12/06 - "IDT met on wt loss..will ask for supplement at meals, gets ensure & supplements between meals."

4/4/06 - "Follow up due to skin. ...She also receives Ensure or Boost BID (twice a day)..."

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3/7/06 - "Wt decrease... Alb (Albumin) decreased to 2.7. ..." No mention was made of skin breakdown.

2/27/06 - "F/u (follow up) due to skin. Resident has a Stage II area per nursing. ...Albumin 3.4..."

i. Review of the resident's physician orders evidenced the following:

3/30/06 - NCS (no concentrated sweets) - regular texture.

3/13/06 - Ensure or Boost "BID" nutritional support. (No amount noted in the order).

4/17/06 - May give supplement after meal if does not eat well @ mealtime.

j. Review of the resident's Medication Administration Records revealed the following:

April, 2006 or May, 2006 - no charted supplement for this resident who was not eating well.

April, 2006 - Ensure was documented as refused 18 of 60 times.
Ensure was not documented 3 of 60 times.
Ensure was documented as "60" 33 of 60 times.
Ensure had no amount documented 6 of 60 times.

May, 2006 - Ensure was documented as refused 8 of 20 times.
Ensure was documented as "60" 11 of 20 times.
Ensure had no amount documented 1 of 20 times.

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k. On 5/11/06 at 8:25 AM, in an interview with the Director of Nursing, the surveyor asked how much Ensure the resident was receiving since the order did not specify. She stated that the resident received 240 cc (cubic centimeters) twice a day.

l. On 5/12/06 at 8:53 AM, in an interview with the nurse, who indicated that she was normally assigned to the hallway where this resident resided, stated that she gave the resident 60 cc of Med Pass or 120 cc of Ensure.

m. Review of the Meal Intake Records for this resident revealed that food and fluid were recorded at meals. However, there was no separate charting for the fortified milk. The charting of the bedtime snacks revealed that for the month of April, the resident had "A" (accepted) charted twice. The remainder of the time "S" (sleeping), "R" (refused), or nothing was charted. For the first ten days of May, no "A"s were charted, only "S" or nothing was charted. The majority of the meal intakes for April and May were noted to be 50% or less, with some intakes of 75% and 100%.

n. Review of the resident's most recent Braden Scale, dated 5/3/06, revealed that the resident's score was 14 (moderate risk). Review of this assessment indicated that the resident had adequate nutrition and had a potential problem for friction and shear. Based on record review, there was no evidence documented to show what the resident's actual supplement/fortified milk intake was to enable an accurate nutritional assessment to be done. The resident's albumin was low. The resident had recently experienced weight loss. Based on staff interviews and record review, the resident had an ongoing history of

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F 314	Continued From page 59 problems with friction and shearing. The facility failed to ensure that the resident was repositioned as care planned and failed to ensure that the resident's nutritional interventions were implemented as planned. There was no evidence to show that the CNA reported the pressure ulcer after 5/10/06 morning care was provided to the resident or that the facility implemented interventions that morning to prevent further shearing. 3. Record review for sample resident #15 revealed diagnoses that included hypertension, osteoarthritis, gout, dementia with behaviors, and Vitamin B complex deficiency. Review of the resident's 4/6/06 quarterly MDS assessment evidenced that the resident required total assistance with bed mobility, transfer, locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing. The resident was assessed to be incontinent of bowel and bladder. a. Review of the resident's care plan evidenced the following: "Problem - Res (resident) requires assist with ADLs (Activities of Daily Living) Approaches - Dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing; Nonambulatory; w/c (wheelchair) primary means of locomotion with staff propelling; limited assist with meals." "Problem - Pressure Ulcers - Actual right ischium; 12/28/05 area re-opened; 2/8/06 - area healed. Related to sensory perception, moisture/incontinence, decreased activity, impaired mobility, friction and shear problem, co-morbid conditions, hx of healed pressure	F 314		

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ulcer.
Approaches - ... Reposition in chair q 2 hr/PRN; Turn and reposition q 2 hr/PRN while in bed; Provide incontinence care q PRN and after each incontinent episode; Measure and stage wound weekly using the pressure ulcer healing assessment form..."

"Problem - Potential for injury. Impaired ability to self-transfer related to: mental status, weakness, ambulation status, gait/balance, history of falls; requires use of: mechanical lift - sit to stand; Sling type - safety vest; to/from portable seat toilet, chair, and bed.
Approaches - Place call light within reach; Encourage resident to obtain assistance for transfers; Provide mechanical lift..."

"Problem - At Risk for Falls
Approaches - Place call light in reach; ...Landing strip at bedside; TABS monitor in bed; w/c (alarm) DC'd (discontinued) 4/26/06; do not leave res in room with supervision unless in bed."

b. On 5/10/06, the following observations were made:

At 6:37 AM, 6:55 AM, and 7:12 AM, the resident observed to be in bed.

At 7:50 AM, two CNAs were observed to provide care to this resident and his/her roommate. One of the CNA's commented that the resident had had skin breakdown. This area was observed to be located in the right buttock crease and was dark reddish in color. The area was coated with a barrier cream. After the pericare was completed, the CNA added more barrier cream to cover this area. The resident was dressed and he/she was transferred by the two CNAs, using the sit to

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stand lift (Sabina) with a vest type sling. The resident intermittently held the hand grasp areas during the transfer. The vest slide up under the resident's armpits and he/she was moved to the wheelchair. The resident's face was washed. The resident was taken out of the room at 8:18 AM without the TABs alarm attached to the resident's clothing.

Observations made every fifteen to thirty minutes evidenced that the resident was not in his/her room.

At 11:05 AM, the resident was observed in the Sunshine Room. No staff were present in this area.

At 12:50 PM, the resident was observed in the Sunshine Room, leaning far to the right side of his/her wheelchair. The resident was wiggling about in the wheelchair. A nurse approached the resident and called a staff member to take the resident out of the Sunshine Room. The nurse indicated that the resident had a fecal odor so she got staff to take care of him/her.

At 12:58 PM, the resident was observed seated in his/her wheelchair next to his/her bed with the call light attached (but not turned on). No staff was present. The fecal odor remained. The resident was observed continuously until at 1:06 PM, one of the two CNAs observed in the morning getting the resident #13 out of bed brought that resident to his/her room. The CNA left the resident #13 in the wheelchair in the room.

At 1:12 PM, when the two CNAs entered the room, they confirmed that these residents had both been up the entire time from the morning observation. They verified that the residents had

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F 314	Continued From page 62 not been toileted or placed in bed. At 1:15 PM, one of the CNAs confirmed that the resident had a fecal odor. At 1:25 PM, the two CNAs, using the sit to stand lift with a vest sling, transferred the resident to bed. The resident did not hold onto the hand grips when he/she was transferred. Both CNAs verified that the resident's brief was not wet. The resident was observed to have had a bowel movement. The resident was provided pericare. c. Review of the resident's Weekly Pressure Ulcer Records revealed that the resident the following pressure ulcers: 11/23/05 - right gluteal fold, Stage 2, 2 cm noted to be healed 12/14/05. 12/28/05 - right gluteal fold, Stage 2, 2 cm, re-opened, noted to be healed 4/15/06. The facility failed to ensure that the resident was repositioned as care planned. The resident was left unsupervised in his/her room. This resident who had a history of skin breakdown was left for at least 35 minutes before he/she was provided incontinent care.	F 314		
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 by:	F 323		

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F 323	Continued From page 63 Based on observation and staff interview, it was determined that the facility failed to ensure that the environment was as free of accident hazards as possible. The findings included: 1. During the initial environmental tour on 5/9/06 from 8:30 AM to 10:30 AM, the following observations were made: a. Medications were found in the medicine cabinet and bedside cabinets in room 412 (Phillips Milk of Magnesia tablets) and room 411 (Tums). b. Observation of the resident in room 301 revealed a medication cup sitting next to the resident with a tablet of Tums in the cup. According to "Clinical Nursing Skills & Techniques," by Perry & Potter, 5th Edition, (2004), page 448, it states: "Remain with the client as the client takes the medication. Provide assistance if necessary. Do not leave medications at a client's (resident's) bedside without a prescriber's order to do so." c. Florescent lights in the hallway outside of rooms 403, 406 and 412 did not have protective covers over the bulbs. d. The heater cover was off leaving heater foils/fins exposed in room 207. The wooden sink cabinet in room 207 was also damaged with bare wood exposed and gauges noted. This left the surface rough with sharp edges and had a potential for splinters. The rough edges were a potential hazard for residents and staff. The heater cover remained off along the wall at the head of sample resident #15's bed in room 207 on 5/9/06 at 2:12 PM and on 5/10/06 at 10:37 AM. On 5/10/06 at 10:37 AM, the following	F 323	323 **IMMEDIATE** Resident #15 footboard was replaced. **SYSTEM** Random weekly environmental rounds will be done to ensure compliance on the following issues: RM 412 the medication was removed from the medicine cabinet when identified to the DON. RM 411 the medication was removed from the drawer when identified to the DON. RM 301 medication removed immediately on observation by ADON. Florescent lights on W-4 bulbs were replaced when identified on exit 5/12/06. Heater covers were repaired in 207, 505, & 607 on 5/11/06. RM 207 the sink cabinet will be repaired by June 17. Vinyl panel protectors will be repaired by June 17. Corrected by the maintenance supervisor. Wall heater in the dining room will be repaired by June	6/17/06

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F 323	Continued From page 64 observation were made in Room 207: 1) The heater fins were exposed at the head of bed "B", 2) The sink cabinet was scraped and rough all over the surface of it and 3) The vinyl panel on the outside of the door was torn/splintered at the bottom. 2. On 5/9/06 during the evening meal observation, it was observed that part of the metal top of the wall heater unit was missing. This was located along the wall next to the second table from the dining room entrance door. 3. On 5/10/06 at 10:28 AM, two Certified Nurse Aides (CNA) were observed toileting supplemental resident #28 in the bathroom located in the resident's room. The CNA left the bathroom door open. There was a bedside commode in front of the sink in the bathroom. The CNA brought the resident into the bathroom without removing the commode. The staff member was observed climbing over the commode several times in order to assist the resident. This created a potential hazard for the resident and the staff. 4. On 5/10/06 at 12:58 PM, sample resident #15 was observed to be seated in his/her wheelchair with a foot board in place behind the resident 's legs and under the resident's feet. The surface of the foot board was observed to have a 3/4 inch hole and approximately a 2 1/2 inch tear extending from the hole and both corners were torn open. This created a rough surface which had the potential for injury to the resident. 5. Observation on an environmental tour of the facility on 5/10/06 from 1:30 PM to 3:05 PM with the Maintenance Director the following issues were reviewed:	F 323	17. Corrected by the maintenance supervisor. Bedside commode removed from the bathroom when providing care. Monitored by the Maintenance supervisor & NHA The Maintenance supervisor will in-service the staff on reporting damage items through the maintenance log process. Done by June 16, 2006. **MONITOR** Random weekly reviews of environmental rounds will be reviewed by the QA&A committee for recommendation and continued compliance monthly X3 months then re-evaluate for further review.	

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a. The heater covers in resident rooms 207, 505, and 607 were checked. The Maintenance Director reported that he had not been told about room 505 and 607. The heater cover in room 505 was noted to be partially off leaving the heater foils and electrical wiring exposed. The Maintenance Director stated that he was unaware of the cover being off. He indicated that the staff had not mentioned this to him. He stated that there was no risk for electrical shock since no electricity was passing through the wires. He stated that the heater vent covers were a problem because of the lower beds being at the same level as the heaters and hitting the heaters when the staff moved the beds.

b. There were four fixtures with fluorescent lights on the 400 wing that did not have covers or shatter proof bulbs in place. The Maintenance Director confirmed that the bulbs were not double covered or scatter proof fluorescent tubes.

c. The door to resident room 207 had a plastic cover on the bottom half of the door. The plastic had a 4 to 6 inch splintered piece of plastic sticking out from the door. The Maintenance Director reported they were trying to do rooms as the rooms had become empty. There was not a plan in place to ensure that the rooms with the broken plastic would be done first or how soon they would be repaired.

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F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to provide adequate supervision and/or to use proper technique when transferring two of 24 sample residents (#13 and #15) with mechanical lifts. The findings included: According to the manufacturer's information regarding the Sabina lift, this sit-to-stand lift is intended for residents who are able to actively participate in the standing exercise. The lift has two different slingbar alternatives with a variety of vests/slings. The resident's functional status determines the choice of slingbar and vest to use. Safety instructions included a directive to ensure that each individual lifting situations be evaluated for the correct type, size, material and design of sling and accessories to ensure resident safety. Instructions for "passive lifting" of a resident as well as lifts with active participation of the resident demonstrated the application of vests which did not place undue pressure under the resident's arms and the ability of the resident to grasp the slingbar. According to Occupational Safety & Health Administration (OSHA) guidelines for lifting residents, an analysis of any resident lifting and repositioning task involves an assessment of the needs and abilities of the resident involved...including the level of assistance the resident requires; the size and weight of the resident; the ability and willingness of the resident to understand and cooperate; and any medical	F 324	324 **IMMEDIATE** Resident #13 was reassessed utilizing the Resident Data Set Addendum Resident Transfer Evaluation in which she scored a "5" which indicates that the resident assists 50% of the task and only requires a gait belt transfer. Resident 15 was reassessed utilizing the Resident Data Set Addendum Resident Transfer Evaluation in which she scored a "5" which indicates that the resident assists 50% of the task and only requires a gait belt transfer. **RISK** A complete review of residents will be done utilizing the Resident Data Set Addendum Resident Transfer Evaluation. The care plans will to reflect the present needs for the resident. **SYSTEM** In-service ADON/DON on the Resident Data Set Addendum Resident Transfer Evaluation to be done on admission, quarterly and change of condition. The care	6/17/06

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F 324	Continued From page 67 conditions that may influence the choice of methods for lifting or repositioning...The physical and mental abilities of the resident play an important role in selecting appropriate solutions. For example, a resident who is able and willing to partially support their own weight may be able to move from his or her bed to a chair using a standing assist device, while a mechanical sling lift may be more appropriate for those residents who are unable to support their own weight. 1. Record review for sample resident #13 revealed diagnoses that included anemia, gastrointestinal hemorrhage, diabetes, Parkinson, congestive heart failure, and glaucoma. Review of the resident's 4/26/06 significant change Minimum Data Set (MDS) evidenced that the resident required extensive assistance with bed mobility, transfer, walk in the corridor, and eating and total assistance with locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing. The resident was further assessed to have a mechanical lift in use as a transfer aid. a. Review of the resident's current C.N.A. (Certified Nurse Aide) Care Cardex revealed the following plan/approaches for providing this resident assistance with mobility and safety: Mobility - wheelchair - by staff - turn q 2 hr (every two hours) and position - lift - 1 person - sit to stand Other information - TABS monitor. b. Review of the resident's care plan evidenced the following approaches for mobility and safety: "Problem - Res (resident) requires assist with ADLs (Activities of Daily Living)	F 324	plan will reflect the resident's needs. Done by the SDC & or Designee. Done by June 16, 2006. Random review of the residents that are utilizing the lifts will be done to ensure that the appropriate equipment is being utilized. Done by the DON & or Designee. **MONITOR** Random review of residents utilizing the lifts for appropriateness, will be reviewed by the QA&A committee for recommendation and continued compliance monthly X3 months then re-evaluate for further review.	

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F 324	Continued From page 68 Approaches - Dependent on staff for bed mobility, dressing, and bathing; Extensive assist with transfers; Ambulation in hallways with therapy; w/c (wheelchair) primary means of locomotion with staff propelling." "Problem - Potential for decline related to fracture - left hip, right malleolus, 2nd phlange right hand Approaches - .... Place call light within reach. Remind resident to call for help when needed." "Problem - Mobility impaired related to: Impaired Mobility Approaches - Pt to begin Amb (ambulation) with FWW (front wheeled walker), gait belt, pull w/c behind with A (assist) of ii (2) cue to go slow with take long steps 3 X 1 wk (week); Pt to perform LE (lower extremity) Ex's 2 1/2 # (pound) wts (weights) on LAqs. (? meaning) 30 reps (repetitions) in 3 sets of 10. 3 X 1 wk; Hamstring stretch - in w/c stretch knee straight slow and gentle hold 1 - 2 min (minutes) 1 X each leg. 3 X wk." "Problem - Mobility impaired related to decrease in ROM (range of motion) and strength Approaches - B (bilateral) U/E (upper extremity) and L/E AROM (active range of motion) 10 reps X 1 set 5 X wk as tolerated." "Problem - Potential for injury. Impaired ability to self-transfer related to: mental status, weakness, ambulation status, gait/balance, history of falls; requires use of: mechanical lift - sit to stand; Sling type - safety vest; to/from portable seat toilet, chair, and bed. Approaches - Place call light within reach; Encourage resident to obtain assistance for transfers; Provide mechanical lift..."	F 324		

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"Problem - At Risk for Falls
Approaches - Place call light in reach; ...Landing strip at bedside; TABS monitor in bed; w/c (alarm) DC'd (discontinued) 4/26/06..."

c. On 5/10/06, the following observations were made:

At 6:37 AM, 6:55 AM, and 7:12 AM, the resident was observed to be in bed lying on his/her back, apparently sleeping.

At 7:50 AM, two CNAs were observed to provide care to this resident and his/her roommate. The CNAs were not able to awaken this resident. This CNA indicated that the resident is provided total care. The resident's lower body was dressed and he/she was transferred by the two CNAs, using the sit to stand lift (Sabina) with a vest type sling. As the resident continued to sleep during the transfer, he/she was unable to hold the hand grasp areas. The vest slide up under the resident's armpits as the resident was moved to the wheelchair. The resident was taken out of the room at 8:38 AM without the TABs alarm attached to the resident's clothing.

At 11:05 AM, the resident was observed in the Sunshine Room, leaning far forward in his/her wheelchair. No staff were present in this area. The surveyor notified the Unit Manager (UM) of the resident's positioning in the wheelchair. The UM indicated that the chair alarm was in place and verified that the resident would have to come off of the wheelchair before an alarm would sound. She stated that the resident's TAB could not be used as that was a double restraint.

At 12:50 PM, the resident was observed in the Sunshine Room with his/her wheelchair pushed

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up to a table. The resident was observed to be digging in his/her mouth. When the surveyor approached the resident's table, there was a piece of chicken skin (approximately 2 inches by 3 inches) lying on the table. At 12:55 PM, a nurse verified that the item on the table was chicken skin.

At 1:20 PM, the two CNAs, using the sit to stand lift with a vest sling, transferred the resident to the portable toilet seat riser in the bathroom. The resident, who sat in the bathroom while the two CNAs used the sit to stand lift for the resident's roommate, was observed with his/her head down. The CNAs verified that the resident was sleeping.

At 1:27 PM, the CNAs reattached the vest sling and moved the resident out of the bathroom. The resident voided a small amount of yellow urine on the floor. The CNA pushed the resident back into the bathroom while she cleaned the floor with periwipes. The resident was then placed in bed, using the lift.

The facility failed to ensure that this resident, who was observed to not participate in the transfer, was safely transferred using the Sabina lift/vest sling as specified in the manufacturer's directions. The facility failed to monitor the resident while he/she was in the Sunshine Room and when he/she was left on the toilet with the two CNAs attending to the resident's roommate.

2. Record review for sample resident #15 revealed diagnoses that included hypertension, osteoarthritis, gout, dementia with behaviors, and Vitamin B complex deficiency. Review of the resident's 4/6/06 quarterly MDS assessment evidenced that the resident required total assistance with bed mobility, transfer, locomotion

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on and off the unit, dressing, toilet use, personal hygiene, and bathing.

a. Review of the resident's care plan evidenced the following approaches related to mobility and safety:

"Problem - Res (resident) requires assist with ADLs (Activities of Daily Living)
Approaches - Dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing; Nonambulatory; w/c (wheelchair) primary means of locomotion with staff propelling; limited assist with meals."

"Problem - Potential for injury. Impaired ability to self-transfer related to: mental status, weakness, ambulation status, gait/balance, history of falls; requires use of: mechanical lift - sit to stand; Sling type - safety vest; to/from portable seat toilet, chair, and bed.
Approaches - Place call light within reach; Encourage resident to obtain assistance for transfers; Provide mechanical lift..."

"Problem - At Risk for Falls
Approaches - Place call light in reach; ...Landing strip at bedside; TABS monitor in bed; w/c (alarm) DC'd (discontinued) 4/26/06; do not leave res in room with supervision unless in bed."

b. On 5/10/06, the following observations were made:

At 7:50 AM, two CNAs were observed to provide care to this resident and his/her roommate. The resident was dressed and he/she was transferred by the two CNAs, using the sit to stand lift (Sabina) with a vest type sling. The resident intermittently held the hand grasp areas during

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the transfer. The vest slide up under the resident's armpits and he/she was moved to the wheelchair. The resident was taken out of the room at 8:18 AM without the TABs alarm attached to the resident's clothing.

At 11:05 AM, the resident was observed in the Sunshine Room. No staff were present in this area.

At 12:50 PM, the resident was observed in the Sunshine Room, leaning far to the right side of his/her wheelchair. The resident was wiggling about in the wheelchair.

At 12:58 PM, the resident was observed seated in his/her wheelchair next to his/her bed with the call light attached (but not turned on). No staff was present. The resident was observed continuously until at 1:06 PM, when one of the two CNAs observed in the morning getting the resident out of bed brought this resident's roommate into the room. The CNA left the room.

At 1:12 PM, the two CNAs entered the room.

At 1:25 PM, the two CNAs, using the sit to stand lift with a vest sling, transferred the resident to bed. The resident did not hold onto the hand grips when he/she was transferred. When the resident was lowered to the bed, it was observed that the resident's head was almost hit by the frame of the lift. One of the CNAs loudly said "Watch --- (his/her) head."

The facility failed to ensure that this resident, who was observed to not participate in the transfer, was safely transferred using the Sabina lift/vest sling as specified in the manufacturer's directions. The facility failed to monitor the resident while

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F 324	Continued From page 73 he/she was in the Sunshine Room and when he/she was left alone unsupervised in his/her room.	F 324	365 **IMMEDIATE** Resident #28 was given the correct diet immediately no negative affects from the alleged deficient practice. Resident #29 was not given the pureed coleslaw. Resident #25 & #26 both fluids were replaced immediately no negative affects from the alleged deficient practice. **RISK** A complete review of residents on mechanically altered and thicken liquids has been completed and action taken as needed. **SYSTEM** Staff has been in-serviced on the following items *Dietary staff will review of the dietary cards and provide the correct diet & liquids per the physicians order. Done by the Dietician & or Designee. *The nursing staff have been in-serviced on the process for thicken liquids utilizing the dot system. Done by the DON & or Designee. Done by June 16, 2006.	6/17/06
F 365 SS=D	483.35(d)(3) FOOD Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to provide food and/or liquids in a form which was appropriate and safe for four supplemental residents (#28, #29, #25, and #26). The findings included: On 5/9/06 during the evening meal observation, supplemental resident #28 was served a regular texture meal. The staff discussed this and replaced the meal with a mechanical soft meal. On 5/9/06 during the evening meal observation, the pureed cole slaw appeared to have lumps in it. In an interview with a Certified Nurse Aide (CNA) at this time, the CNA stated that she would not give the cole slaw to supplemental resident #29 because the resident would chew and chew on it. Review of the facility's list of resident diets confirmed that the resident was to receive a puree texture diet. Two surveyors tasted the pureed cole slaw. They found that there were small lumps of cabbage throughout the pureed cole slaw.	F 365		

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F 365	Continued From page 74 During the evening meal on 5/9/06 revealed that two supplemental sample residents (#25 and #26) were served juice, water and milk, which were not thickened. Review of the residents' tray cards revealed that these two residents were assessed to need nector thick liquids.	F 365	*The nursing staff will be in-service on the dietary cards to ensure residents are provided the correct diet. Done by the Dietician & or Designee. The in-service will be continued in the orientation process of new staff. The Dietary Manager will do random daily reviews of the tray line to ensure residents are being provided with the correct diet per physician orders. The diet cards will be reviewed to ensure that they match the physician's orders. Done by the Dietary manager & or Designee. **MONITOR** Random daily review of the tray line for accuracy of the diets per physicians orders will be reviewed by the QA&A committee for recommendation and continued compliance monthly x3 months then re-evaluate for further review.	
F 368 SS=D	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility served the evening meal and the breakfast meal with greater than a fourteen hour time span between these meals for three of 24 sample residents (#7, #13, and #5) and two supplemental residents (#29 and #27). The facility failed to provide nourishing evening snacks to these residents. The findings included:	F 368		

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F 368	Continued From page 75 1. Observation of the evening meal service on 5/9/06 at 4:30 PM to 6:00 PM revealed there were three round tables across the back of the dining room with nine residents. Staff had brought in residents and positioned them at the tables in their wheelchairs. The staff identified these residents as needing assistance or needing to be fed and were served first. Resident #7 and #13 had a CNA sitting between them and were being fed at 4:38 PM. The next table had a CNA sitting between resident #29 and #5 and were served at 4:46 PM. Resident # 15 was also at this table and was served at 4:40 PM. The next assist table had 3 residents which included resident #27 who was being fed by a family member. This table had been served by 4:45 AM. 2. Observations the next morning on 5/10/06 in the dining room revealed the following: a. At 7:15 AM Resident #7 was seated at the table in a wheelchair. The resident had a newspaper on his/her armrest of his/her wheelchair. The resident stated that he/she was hungry and ready for breakfast as the resident watched the other residents being served. This resident had not been served and had 3 glass of fluids on the table out of the resident's reach. The staff was asked about the resident and reported that the resident had to be fed and staff was not available until 8:00 AM to feed and assist residents and the independent resident were currently being served. At 8:05 AM the resident had still not been served and the DON (Director of Nursing) was told of the resident stating he/she was hungry and informed the resident had been in the dining room before 7:15 AM. The resident was then served. The length of time for this	F 368	368 **IMMEDIATE** Resident #7, #13, #5, # 29, & #27 will be offered a nutritious snack each night. **RISK** Residents participating in the open dining process are at risk of this alleged deficient practice. **SYSTEM** Resident council will be educated as to the Federal Regulations in regards to this alleged deficient practice and given the option to discontinue "open dining". Nursing and dietary staff will be in-serviced regarding offering resident's a nutritious snack nightly. The meal intake records will be reviewed weekly by the ADON/Designee for residents accepting or refusing snacks. Residents that are refusing snacks on a continuous basis the Dietician will be notified to do further follow-up	6/17/06

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F 368	Continued From page 76	F 368		

resident between meals was from 4: 40 PM on 5/9/06 to 8:05 AM on 5/10/06 which was over 15.5 hours.

b. At 8:45 AM resident #27 was brought into the dining room and place at an assist table. Staff reported that the resident had to be fed. This resident had been observed the evening before being fed at 4:45 PM. This was over 16 hours between meals.

c. At 8:50 AM resident #13 was brought into the dining room and for breakfast. This resident was observed the evening before being fed at 4:38 PM. This was over 16 hours between

3. Interview with the dietary manager on 5/10/06 confirmed that the residents needing assistants or needing to be fed were served first during the evening meals and sometime after 8:00 AM for the breakfast meal. This serving schedule created more than 14 hours between meals for the dependent residents.

4. There was no evidence provide to show how the facility was ensuring these resident were provided a "Nourishing snack". A "Nourishing Snack" is defined as a verbal offering of items, single or in combination, from the basic food groups.

5. Review of resident #7 medical record review revealed the resident was admitted to the facility on 6/25/02. The resident diagnoses included: Parkinson's disease, CHF (congestive heart failure), atrial fibrillation, bladder disorder, anxiety and depression and urinary tract infection.

a. Review of the MDS (minimum data set) dated 2/26/06 identified the resident as requiring

MONITOR
Weekly review of the meal intake records for constant offering of snacks will be reviewed by the QA&A committee for recommendation and continued compliance monthly X3 then re-evaluate for further review.

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F 368	Continued From page 77 total dependence on staff for care including eating. The assessment included documentation RAP (Resident Assessment Protocol) review for nutritional status. It stated, "Resident is on a Regular/Mechanical soft diet with pureed meats. He/she's assisted at meals but does drink his/her fluids on his/her own at times. He/she has a swallowing problem and receives the modified texture for this..." b. Review of the "Report of Consultation" dated 2/7/06 stated, "Wt (weight) stable at 125 although gradual wt loss (10#) over last year... Main problem with difficulty eating [sign secondary] Parkinson... " The report dated 5/4/06 identified, "Wt 121.5 [down] 5# since last visit... Parkinson's anxiety/depression, wt loss secondary poor feeding secondary above. 1) Offer supplement tid as needed per nutrition..." c. This resident was observed on 5/9/06 and 5/10/06 with a extended time between meal service and the resident reported being hungry on 5/10/06. Review of the "Meal Intake Record" for 5/06 showed that the area for "Snack" HS (bedtime) was blank for 5/8/06 and 5/9/05. There was documentation of three dates as S (sleep), two dates as R (refused) and three dates as A (accepted). There was no indication of what was being offered to this resident as a "Nourishing snack" with extended times between meals and special needs. The resident was identified as having had weight loss and as having swallowing problems. Review of the "Meal Intake Record" for 4/06 showed eleven blanks when there was no indication HS snack was offered. There were five entries as S (sleeping) and 12 as R (refused).	F 368		

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F 371 SS=F	483.35(h)(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 and staff interview, it was determined that the facility failed to store, prepare, and distribute food in a manner that minimized the potential for the spread of food-borne illness. The findings included: During the kitchen tour observations, the following was revealed: 1. On 5/9/06 at 4:45 PM, it was observed that the dishwashing room was located in an area adjacent to the main dining room. The dishwasher equipment was located on the right side of the room. The dishwashing room allowed for the dirty dishes to be brought in through a doorway on the left hand side of the room. This main doorway also served as a passage way through the left side of the dishwashing room to a 2nd door that lead into the rear area of the kitchen. On either side of the 2nd door were racks that were utilized to dry and store the clean items that came out of the dishwasher. Upon entry via the main doorway, a hand sink and cleaning equipment were located to the immediate left. At 8:15 AM on 5/9/06, the Maintenance Director was observed washing out a coffee cup in the handsink. During the dinner meal observation on 5/9/06, staff were walking in and out of the dishwashing room to use the handsink. In the dishwashing	F 371	371 **IMMEDIATE** No residents identified. **SYSTEM** Clean food service items (e.g. dishes, utensils, pots and pans) will be relocated to a different area of the kitchen after they are air-dried so that they do not pass through the dirty-side of the dish room The hand sink will be used for hand washing only. Clean items will not be stored directly adjacent to dirty items Non-dietary staff will not be allowed to cross from the dirty-side of the dish room to the clean-side. Random daily review of the clean dishes appropriately transported to other areas with	6/17/06

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F 371	Continued From page 79 room, a clean cart of dishes was setting next to dirty carts full of utensils. During the Breakfast meal on 5/10/06 at 6:15 AM, the main doorway and 2nd doorway were propped open creating a clear pathway in and out of the kitchen. A CNA (Certified Nursing Assistant) was observed walking into the dishwashing room and obtained a large mug from the clean rack of dishes. She returned in a few minutes to obtain a lid for the mug from the same clean dish rack. Dietary staff were observed carrying loafs of bread through the dishwashing room and placing them on the SCU (Special Care Unit) cart. During an interview with the DM (Dietary Manager) on 5/10/06 at 1:05 AM, she said she is aware of the cross-contamination that existed in the dishwashing room and desired to separate clean side from dirty side. She verified that staff often used the handsink to wash their hands and clean out coffee cups. Observation during this time showed that clean dishes were being air dried on the stainless steel run connected to the end of the dishwasher. The DM stated that this layout of the dishwashing room had been in existence for 7-8 years. She also stated that when the 2nd doorway is propped open, it created a draft and the residents in the dining room had complained about the cold breeze coming from the area. To prevent cross-contamination, cleaned food service items (such as dishes, utensils, pots and pans) should be stored in an area that does not repeatedly expose the items to an unclean environment. 2. On 5/9/06 at 8:05 AM, clean cups stored on	F 371	out cross contamination done by the Dietary Manager/Designee. **MONITOR** The random daily review of the clean dishes transported appropriately will be reviewed by the QA/A Committee for recommendation and continued compliance monthly X 3 months then re-evaluate for further review.	

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F 371	Continued From page 80 racks were observed to have hard water spots inside and out. The DM said this was a problem. She normally contacted her dishwasher maintenance company (Ecolab) for service of this problem. In the kitchen proper, the vents over the cooking range were dirty. 3. On 5/10/06 at 12:50 PM, water was observed dripping from a large pipe located behind the dishwasher. Clean mugs were noted to still have hard water deposits on them. 4. Observation of the SCU kitchenette on 5/9/06 at 4:00 PM showed that the ceiling vent was dirty.	F 371		
			372 **IMMEDIATE** No residents identified	6/17/06
F 372 SS=E	483.35(h)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL The facility must dispose of garbage and refuse properly. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to dispose of garbage in a proper manner. The findings included: Observation on 5/9/06 at 2:00 PM from a resident's room two garbage carts were noted to be over flowing with trash. Further inspection revealed that the garbage containers were located outside the boiler room door and had open lids due to being over filled with trash bags. There was a second area which had a garbage container which was located outside the kitchen. The garbage container in this area was also full and had an open lid.	F 372	**SYSTEM** In-service the dietary and housekeeping staff on proper disposal of trash. Done by the Maintenance supervisor. Done by June 16, 2006. Random daily review of the trash receptacles to prevent any overflow of garbage will be done by the Housekeeping supervisor & or Designee. The environment around the generator will be reviewed daily by the maintenance supervisor, to ensure the area is free from debris.	

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F 372	Continued From page 81 Observation on an environmental tour of the facility on 5/10/06 from 1:30 PM to 3:05 PM with the Maintenance Director revealed the facility was not ensuring that garbage/waste was properly maintained. 1) The garbage receptacle/containers located outside the boiler room were open due to being over filled. The Maintenance Director reported that the two wheeled carts were dumped into a larger dumpster at the back of the facility twice a day. The staff was not to over fill the containers and if the carts were full they were to be empty in the dumpster. The containers had straps to hold the lids down when the containers were not over filled. 2) There was also a build up of trash and debris in an area between the back up generator and the outside of the building. Observation on 5/11/06 at 1:30 PM two blue garbage carts located outside the kitchen had the lids open and were over flowing with garbage bags which contained food waste. The facility failed to ensure garbage and refuse was properly contained. The open lids and over flowing containers/carts had a potential of harborage of pests.	F 372	**MONITOR** The daily reviews of the trash receptacles to ensure there is no overflowing of trash, and the daily rounds to ensure around the generator is not cluttered with garbage will be reviewed by the QA&A committee for recommendation and continued compliance monthly X3 months then re-evaluate for further review.	
F 445 SS=F	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure that	F 445		

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Printed: 05/18/2006
FORM APPROVED
OMB NO. 0938-0391

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F 445	Continued From page 82 staff handled, processed, and stored linens in a manner which minimized the potential for spreading infection. The findings included: During observations on an environmental tour of the facility on 6/10/06 from 1:30 PM to 3:05 PM with the Maintenance Director, a problem with the air flow in the laundry was identified. The soiled linens came through a small room. The small room was where the linens bins were stored and dirty linens were separated. This room opened into the main laundry area which was one room with two washing machines and four dryers. There was also a wash sink located by the washing machines which had soiled linens soaking. The laundry staff identified the sink as being used to wash out soiled linens and as the soaking area. The laundry staff was also observed folding and pressing clean clothes in the area next to the washing machines and dirty linen area. The Maintenance Director was asked how the air flow was checked in this room to ensure proper air pressure to prevent the contamination from the soiled side of the laundry to the clean. He reported that it had not been checked. He then reported and showed that there had been a vent located directly above the washing machines but it had been capped. There had been a problem with condensation and steam over the washing machines and the resolution at that time was to cap the vent. The vent had been capped about six years. He stated, "I know with the size of the room and with four dryers running we need approximately 7.6 cubic feet of air flow per minute to have the right air flow. The unit has to be big enough for that much draw out with this room. It is every difficult to have adequate air flow with	F 445	445 IMMEDIATE No residents identified SYSTEM Air flow requirements for the laundry room as outlined by the "Hospital and Health Care Design and Construction" provided by Milt Werner, Wyoming Department of Health Consultant, was air cone flow tested by Casper Tin and Mechanical Company.The 4378 cubic foot laundry room requires 729.67cubic feet per minute exhaust air flow to meet the 10 air changes per hour for this size room. The cone air flow test found that the current fan was obtaining 795 cfm, which is 65.33 cfm more than required. See attachment #1.	6-17-06

2nd amended PoC

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F 445	Continued From page 82 staff handled, processed, and stored linens in a manner which minimized the potential for spreading infection. The findings included: During observations on an environmental tour of the facility on 5/10/06 from 1:30 PM to 3:05 PM with the Maintenance Director, a problem with the air flow in the laundry was identified. The soiled linens came through a small room. The small room was where the linens bins were stored and dirty linens were separated. This room opened into the main laundry area which was one room with two washing machines and four dryers. There was also a wash sink located by the washing machines which had soiled linens soaking. The laundry staff identified the sink as being used to wash out soiled linens and as the soaking area. The laundry staff was also observed folding and pressing clean clothes in the area next to the washing machines and dirty linen area. The Maintenance Director was asked how the air flow was checked in this room to ensure proper air pressure to prevent the contamination from the soiled side of the laundry to the clean. He reported that it had not been checked. He then reported and showed that there had been a vent located directly above the washing machines but it had been capped. There had been a problem with condensation and steam over the washing machines and the resolution at that time was to cap the vent. The vent had been capped about six years. He stated, "I know with the size of the room and with four dryers running we need approximately 7.6 cubic feet of air flow per minute to have the right air flow. The unit has to be big enough for that much draw out with this room. It is every difficult to have adequate air flow with	F 445	445 **IMMEDIATE** No residents identified **SYSTEM** As per reference material "Hospital and Health Care Design and Construction" provided by Milt Werner, Wyoming Department of Health Consultant, the current exhaust fan located in the dirty holding area provides the 765 CFM as required for this laundry operation. However, to insure the maximum air flow from the clean area, the Maintenance Department will remove the non essential door between the wash processing area and the dirty holding area. No clean linens will be stored in the dirty holding or processing areas. The exhaust fan is being monitored bi-monthly to ensure that it functioning appropriately, done by the Maintenance Director.	6/17/06

Printed: 05/18/2006
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	05/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR STREET CASPER, WY 82601

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F 445	Continued From page 83 this set up and have everything in one room." There was no evidence of proper air flow to eliminate the air crossing from the soiled side of the laundry to the clean side. During observations on 5/12/06 at 9:08 AM, the main laundry room was checked. The windows in front of the clean linen/folding area were open. There was a build up of dirt and debris noted along the window sills, a breeze was blowing into the room over the clean linens. During initial tour on 5/9/06 staff had identified residents with a history of having MRSA (Methicillin Resistant Staphylococcus Aureus) infections that were now colonized. Interview with the laundry staff reported that when there was linen from a resident in isolation it came in a red bag and it was separated in front of the washing machines. This had a potential of contamination of the linens on the clean side of the laundry. The facility failed to ensure the soiled side of the laundry was well ventilated and maintained under a relative negative air pressure to eliminate the potential of contamination from the soiled side of the laundry to the clean side..	F 445	**MONITOR** The exhaust fan is being monitored bi-monthly to ensure that it is functioning appropriately reviewed by the QA&A committee for recommendation and continued compliance monthly x3 months then re-evaluate for further review	6-17-06

2nd amended PoC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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 See 2nd amended PoC NOOO1

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F 464 SS=E	483.70(g) DINING AND RESIDENT ACTIVITIES The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This Requirement is not met as evidenced by: Based on observation and resident and staff interview, it was determined that the dining room did not have sufficient space or was not arranged to allow residents free access to and from their assigned dining seating and/or to allow staff to access residents in emergency situations. The findings included: 1. The facility had an "open dining" policy which allowed residents to come to meals throughout the meal service time. Due to the continual influx of residents, frequent moving of residents sitting in wheelchairs was needed to place incoming residents at tables which became available. 1. Observation of the evening meal service on 5/9/06 at 4:30 PM to 6:00 PM issues concerning lack of sufficient space in the dining room for residents, staff and family was identified. a. There were three round tables across the back of the dining room. Staff had brought in residents and positioned them at the tables in their wheelchairs. The staff identified these residents as needing assistance or needing to be fed. A staff member sat between resident #13 and #7 and began assisting the residents. This staff member then had to ask another staff for drinks and stated, "I can't get out." The residents	F 464	464 **IMMEDIATE** Resident #13, #7, #27 and #19 were not affected by this alleged deficient practice. Tables have been spread out to ensure sufficient space available. **SYSTEM** The floor will be marked to ensure that the tables are in their proper spot to ensure proper dining space. Dining room rounds will be done prior to meal service to ensure that the tables are placed appropriately, done by the dietary department/Designee. **MONITOR** The review of the dining room tables for proper placement will be reviewed by the QA&A committee for recommendation and continued compliance monthly X3 then re-evaluate for further review.	6/17/06

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F 464	Continued From page 85	F 464		

in their wheelchairs at these tables had the staff member blocked in. The staff member could not exit the area unless moving a resident away from the table.

b. Resident #27 was observed seated in a wheelchair, in the back of the dining room, being fed by a family member. At 5:00 PM the resident had a large emesis. The family member had to move another resident at the table and the table to get resident #27 out from behind the table and out of the dining room.

c. There were residents sitting in the hall in wheelchairs who reported they had to wait until space opened up at tables to eat. A resident stated, "It's pretty crowded so I'm just waiting for a spot. It always seems busy at supper." During the evening meal service it was observed that residents while trying to enter and leave the dining area in wheelchairs and walkers met with narrow pathways and obstacles caused by other residents seated at tables in wheelchairs.

2. Observation of the breakfast meal service on 5/10/06 at 7:20 AM there were 27 residents eating in the dining room. Staff identified the meal as "open breakfast" and these residents as eating independently. Staff also reported that staff does not start with the resident's needing assistance or fed until 8 AM. The resident eating breakfast commented that you don't usually have to wait for breakfast because there is room.

3. Observation of the evening meal service on 5/11/06 at 4:30 PM to 5:30 PM noted resident #19 seated at a table in a wheelchair in the back of the dining room. At 4:55 the resident was observed coughing and complained of have

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F 464	Continued From page 86 trouble swallowing. A CNA at the table went to check the resident. The resident continued to cough and the surveyor went to the nurses station to get a nurse. The nurse went to the dining room to check the resident. The nurse had difficulty accessing the resident and had to move another resident in a wheelchair to get to the resident seated in the back of the dining room. The nurse was interview concerning access to the resident and limited space at meal time. The nurse stated, "I would have to move 3 or 4 residents to get him/her out of the dining room if he/she had trouble. I couldn't even get to him/her very easy to even check him/her." 4. During the Group Interview on 5/10/06 residents expressed concerns with space in the dining room which is currently being used. They reported that residents line up outside the dining room and then have to wait until someone leaves in order to be space or room. Residents reported waiting 30 minutes to an hour to get into the dining room. The residents stated, "We asked about running the other room across the hall for meals but we were told not enough staff."	F 464		

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F 516 SS=E	483.75(l)(3), 483.20(f)(5) CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to safeguard medical records from unauthorized access and to protect the residents' privacy. The findings included: Observation on an environmental tour of the facility on 5/10/06 from 1:30 PM to 3:05 PM with the Maintenance Director revealed issues with the storage of residents' medical records being accessible to unauthorized persons. During the tour a storage shed located outside the building that was checked. The Maintenance Director got a key from the maintenance room and opened the storage shed. The shed contained multiple 4 drawer file cabinets as well as boxes of records. An unlocked file cabinet was opened and contained files with names. The Maintenance Director reported that these file cabinets contained medical records and financial	F 516	**516** **SYSTEM** The maintenance Supervisor has changed the complete locking system, and the only key is kept by the Medical records staff member. Monitored by NHA. **MONITOR** The key will be reviewed weekly by the NHA to ensure that the Medical Records personnel has it secured this will be reviewed by the QA/A Committee for recommendation and continued compliance monthly X3 months and re-evaluate for further review.	6/17/06

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F 516	Continued From page 88 records of past residents waiting to be destroyed. The boxes were labeled as purged records. Interview with the Maintenance Director confirmed he and other maintenance staff did have access to the storage shed. He reported the storage shed was locked but the keys hanging in the maintenance room allowed him and his staff access to the residents' files.	F 516		