TNto LB 7-22-04

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

PRINTED: 7/13/2004
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465152	A. BUILDING _____ B. WING _____	6/16/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOLOB CARE & REHABILITATION	178 SOUTH 1200 EAST ST GEORGE, UT 84790

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F 274 SS=B	483.20(b)(2)(ii) RESIDENT ASSESSMENT Within 14 days after the facility determines, or should have determined, that there has been a significant change in the residents physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the residents 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 residents health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not complete a significant change Minimum Data Set (MDS) assessment for 5 of 21 sample residents (residents 4, 8, 29, 30 and 60) who had been documented by the facility as having a significant change in status. Findings include: 1. Resident 8 was admitted on 9/16/03, with diagnoses which included malignant neoplasm of the breast, hypothyroidism, anemia, senile dementia, hypertension, constipation and osteoporosis. On 9/29/03, an admission comprehensive MDS was completed for resident 8. On 12/29/03, a quarterly MDS was completed for resident 8. A comparison of the two assessments documented a significant change in the resident's condition. These significant changes triggered the need for a comprehensive MDS assessment to be done.	F 274	F 274 ***The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:*** **Resident 8, 29, 30, 60, 4**: The facility has completed a significant change MDS for each of these residents. ***How the facility will identify other residents having the potential to be affected by the same deficient practice:*** The facility will complete a full resident audit to determine any resident that may need a significant change MDS. Any resident found to need a significant change MDS will have one completed. This audit will be completed by the MDS Coordinator or designee to ensure compliance. The RAI manual was reviewed by facility MDS staff to ensure proper identification and determination of a significant change in resident status. Utah Department of Health JUL 22 2004 Bureau of Medicare/Medicaid Program Certification and Resident Assessment	8-6-04

8/4/04 POC acceptable completion date 8/16/04 Rosenbaum RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		(X6) DATE
[signature]	Administrator	7-20-04

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 274	Continued From page 1 The areas that documented significant change included: Resident 8 had a documented improvement in Bed Mobility: a. MDS (9/29/03) Section G1-a (3= Extensive Assistance) b. MDS (12/29/03) Section G1-a (2= Limited Assistance) Resident 8 had a documented improvement Walk in Room: a. MDS (9/29/03) Section G1-c (3= Extensive Assistance) b. MDS (12/29/03) Section G1-c (2= Limited Assistance) Resident 8 had a documented improvement Walk in Corridor: a. MDS (9/29/03) Section G1-d (3= Extensive Assistance) b. MDS (12/29/03) Section G1-d (2= Limited Assistance) Resident 8 had a documented improvement Locomotion on Unit: a. MDS (9/29/03) Section G1-e (3= Extensive Assistance) b. MDS (12/29/03) Section G1-e (2= Limited Assistance) Resident 8 had a documented improvement Locomotion off Unit: a. MDS (9/29/03) Section G1-f (3= Extensive Assistance)	F 274	***The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:*** The facility will complete a bi-monthly full resident audit to determine any resident that may need a significant change MDS. This audit will be completed every 2 weeks by the MDS Coordinator or designee to ensure continued compliance. ***How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.*** The facility's Quality Assurance Team, which meets monthly, will review the bi-monthly significant change MDS audits to ensure compliance. The QA Team will review these logs for 3 months or until the team feels certain that the practice continues to be in compliance.	

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F 274	Continued From page 2 b. MDS (12/29/03) Section G1-f (2= Limited Assistance) Resident 8 had a documented decline in Eating: a. MDS (9/29/03) Section G1-h (2= Limited Assistance) b. MDS (12/29/03) Section G1-h (3= Extensive Assistance) Resident 8 had a documented decline in Bladder Continence: a. MDS (9/29/03) Section H1-b (1= Usually Continent) b. MDS (12/29/03) Section H1-b (4= Incontinent) 2. Resident 29 was admitted on 12/16/03 with diagnoses which included, senile dementia, Alzheimers, congestive heart failure, benign hypertrophy prostate, femur fracture, depression, anxiety and Parkinson's disease. On 3/6/04, a significant change comprehensive MDS was completed for resident 29. On 6/2/04, a quarterly MDS was completed for resident 29. A comparison of the two assessments documented a significant change in the resident's condition. These significant changes triggered the need for a comprehensive MDS assessment to be done. The areas that documented significant change included: Resident 29 had a documented decline in Cognitive Skills for Daily Decision Making: a. MDS (3/6/04) Section B4 (1 = Modified Independence) b. MDS (6/02/04)	F 274		

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F 274	Continued From page 3 Section B4 (3= Severely Impaired) Resident 29 had a documented decline in Behavioral symptoms (Wandering): a. MDS (3/6/04) Section E4-a-B (0= Behavior not present or behavior was easily altered) b. MDS (6/2/04) Section E4-a-B (1= Behavior was not easily altered) Resident 29 had a documented decline in Behavioral symptoms (Physically Abusive Behavioral Symptoms): a. MDS (3/6/04) Section E4-c-B (0= Behavior not present or behavior was easily altered) b. MDS (6/2/04) Section E4-c-B (1= Behavior was not easily altered) Resident 29 had a documented decline in Bowel Continence: a. MDS (3/6/04) Section H1-a (1= Usually Incontinent) b. MDS (6/2/04) Section H1-a (3= Frequently Incontinent) 3. Resident 30 was admitted to the facility on 5/24/02 with the diagnoses which included, renal failure, congestive heart failure, hypertension, esophagitis, hypothyroidism, insulin dependent diabetes mellitus, arthritis, gout and anemia. On 9/29/03, a quarterly MDS was completed for resident 30. On 12/21/03, a quarterly MDS was completed for resident 30. A comparison of the	F 274		

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F 274	Continued From page 4 two assessments documented a significant change in the resident's condition. These significant changes triggered the need for a comprehensive MDS assessment to be done. The areas that documented significant change included: Resident 30 had a documented improvement in Transfers: a. MDS (9/29/03) Section G1-b (3= Extensive Assistance) b. MDS (12/21/03) Section G1-b (2= Limited Assistance) Resident 30 had a documented improvement in Dressing: a. MDS (9/29/03) Section G1-g (3= Extensive Assistance) b. MDS (12/21/03) Section G1-g (2= Limited Assistance) Resident 30 had a documented improvement in Hygiene: a. MDS (9/29/03) Section G1-j (3= Extensive Assistance) b. MDS (12/21/03) Section G1-j (2= Limited Dependence) On 12/21/03, a quarterly MDS was completed for resident 30. On 3/30/04, an annual MDS was completed for resident 30. A comparison of the two assessments documented a significant change in the resident's condition. These significant changes triggered the need for a comprehensive MDS assessment to be done. The areas that documented significant change included:	F 274		

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F 274	Continued From page 5 Resident 30 had a documented decline in Transfers: a. MDS (12/21/03) Section G1-b (2= Limited Assistance) b. MDS (3/30/04) Section G1-b (3= Extensive Assistance) Resident 30 had a documented decline in Dressing: a. MDS (12/21/03) Section G1-g (2= Limited Assistance) b. MDS (3/30/04) Section G1-g (3= Extensive Assistance) Resident 30 had a documented decline in Hygiene: a. MDS (12/21/03) Section G1-j (2= Limited Assistance) b. MDS (3/30/04) Section G1-j (3= Extensive Dependence) 4. Resident 60 was admitted on 11/13/02 with diagnoses which included, hypothyroidism, senile psychotic with mixed emotional features as adjustment reaction, hypertension, congestive heart failure, atrial fibrillation, osteoarthritis and urinary incontinence. On 2/18/04, a quarterly MDS was completed for resident 60. On 5/17/04, a quarterly MDS was completed for resident 60. A comparison of the two assessments documented a significant change in the resident's condition. These significant changes triggered the need for a comprehensive MDS assessment to be done. The areas that documented significant change	F 274		

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F 274	Continued From page 6 included: Resident 60 had a documented decline in Behavioral Symptoms (Resists Care): a. MDS (2/18/04) Section E4 (0 = Behavior not exhibited in last 7 days) b. MDS (5/17/04) Section E4 (2= Behavior of this type occurred 4 to 6 days, but less than daily) Resident 60 had a documented decline in Transfers: a. MDS (2/18/04) Section G1-b (2= Limited Assistance) b. MDS (5/17/04) Section G1-b (3= Extensive Assistance) Resident 60 had a documented decline in Dressing: a. MDS (2/18/04) Section G1-g (2= Limited Assistance) b. MDS (5/17/04) Section G1-g (4= Total Dependence) Resident 60 had a documented decline in Hygiene: a. MDS (2/18/04) Section G1-j (2= Limited Assistance) b. MDS (5/17/04) Section G1-j (4= Total Dependence) Resident 60 had a documented decline in Bowel Incontinence: a. MDS (2/18/04)	F 274		

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F 274	Continued From page 7 Section H1-a (0= Continent) b. MDS (5/17/04) Section H1-a (2= Occasionally Incontinent) Resident 60 had a documented decline in Bladder Incontinence: a. MDS (2/18/04) Section H1-b (0= Continent) b. MDS (5/17/04) Section H1-b (4= Incontinent) 5. Resident 4 was admitted to the facility on 10/20/01 with the diagnoses which included senile dementia, hypertension, cerebrovascular disease, constipation and incontinence. On 06/14/04, a complete review of resident 4's chart was completed. On 10/13/03, an annual MDS assessment was completed for resident 4. On 04/09/04, a quarterly MDS assessment was completed for resident 4. A comparison of the two assessments documented a significant change in resident 4's condition. These significant changes triggered a need for a comprehensive MDS assessment to be done. The areas that documented significant changes included: Resident 4 had a documented improvement in Mood and Behavior Patterns: a. MDS (10/13/03) Section E2 was coded as 1, meaning indicators present, easily altered. b. MDS (04/09/04) Section E2 was coded as 0, meaning no mood indicators.	F 274		

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F 274	Continued From page 8 Resident 4 had an improvement in Ambulation: a. MDS (10/13/03) Section G1-d, was coded as 3, meaning extensive assistance. b. MDS (04/09/04) Section G1-d, was coded as 2, meaning limited assistance Resident 4 had an improvement in dressing: a. MDS (10/13/03) Section G1-g, was coded as 4, meaning extensive assistance. b. MDS (04/09/04) Section G1-g, was coded as 2, meaning limited assistance. Resident 4 had an improvement in Hygiene and bathing: a. MDS (10/13/03) Section G1-j, was coded as 4, meaning extensive assistance. b. MDS (04/09/04) Section G1-j, was coded as 2, meaning limited assistance.	F 274	**F 278** ***The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:*** **Residents 2, 8, 9, 10, 18, 23, 27, 29, 30, 46, 47, 60, 63, 64, 104** : A registered nurse has manually signed over the digital signature on the resident's MDS to certify its accuracy and completion. **Residents CL-1, CL-2**: A list of closed charts that were reviewed during the survey process was not provided on the confidential resident list in the Statement of Deficiencies or in the corrected Statement of Deficiencies. The facility cannot identify the resident cited as this information was not provided.	
F 278 SS=C	483.20(g) - (h) 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	F 278	**Resident CL-3**: A list of closed charts that were reviewed during the survey process was not provided on the confidential resident list in the Statement of Deficiencies or in the corrected Statement of Deficiencies. Although the Statement of	8-6-04

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F 278	Continued From page 9 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 Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or 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 the facility did not ensure that a registered nurse signed and certified that the MDS (Minimum Data Set) assessment was completed for 18 of 21 sampled resident (Residents 2, 8, 9, 10, 18, 23, 27, 29, 30, 46, 47, 60, 63, 64, 104, CL1, CL2 and CL3). Findings include: 1. Resident 8 was admitted to the facility on 9/16/03, with diagnoses of malignant neoplasm of the breast, hypothyroidism, anemia, senile dementia, hypertension, constipation and osteoporosis. Resident 8's active medical record contained two quarterly MDS assessments dated 12/29/03 and 3/25/04.	F 278	Deficiencies does not identify resident CL-3, the facility is aware of the identity of this resident. The resident's MDS will be signed and certified by the registered nurse who completed the MDS. This will be completed by our date of alleged compliance. ***How the facility will identify other residents having the potential to be affected by the same deficient practice:*** The MDS Coordinator and/or designee will complete an audit of all current residents' charts. Each MDS found to be missing a manual signature will be signed by the appropriate RN and dated on the date of signature. ***The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:*** The MDS staff has been inserviced as to needing a manual signature in addition to the electronic signature. The DON and/or designee will complete a random audit of 10 residents MDS's per month to confirm that a manual signature is in place as well as the electronic	

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F 278	Continued From page 10 A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 2. Resident 29 was admitted to the facility on 12/16/03, with diagnoses of senile dementia, Alzheimers, congestive heart failure, benign hypertrophy prostate, femur fracture, depression, anxiety and Parkinson. Resident 29's active medical record contained an admission MDS assessment dated 12/29/03, significant change MDS assessment dated 3/6/04 and quarterly MDS assessment dated 6/2/04. A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 3. Resident 47 was admitted to the facility on 1/21/03 and re-admitted to the facility on 2/28/04 with diagnoses which included b-complex deficiency, senile dementia with delusions, hypertension, atrial fibrillation, backache, urinary incontinence and syncope. Resident 47's active medical record contained an annual MDS assessment dated 1/28/04, significant change MDS assessment dated 5/27/04, and 2 quarterly MDS assessments dated 10/31/03 and 4/26/04. A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 4. Resident CL1 was admitted to the facility on 3/19/03 with diagnoses of senile dementia and macular degeneration.	F 278	signature. If signatures are found to be missing, the random audit will be expanded to include more residents to ensure continued compliance. ***How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.*** The findings from the random MDS audit noted above will be reviewed at each QA meeting X 3 months, or until the QA Team feels the alleged deficiency is effectively addressed to ensure continued compliance.	

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F 278	Continued From page 11 Resident CL1's active medical record contained a quarterly MDS assessment dated 12/27/03. A review of the MDS revealed that Section R2 had a computer signature and was not signed by a registered nurse. 5. Resident CL2 was admitted to the facility on 4/1/04 with diagnoses of senile dementia, atrial fibrillation, backache and a spinal cord injury. Resident CL2's active medical record contained a medicare 5 day MDS assessment dated 4/13/04. A review of the MDS revealed that Section R2 had a computer signature and was not signed by a registered nurse. 6. Resident CL3 was admitted to the facility on 12/1/03 with diagnoses of senile dementia, anxiety, osteoarthritis and nausea and vomiting. Resident CL3's active medical record contained an admission MDS assessment dated 12/13/03, a significant change MDS assessment dated 2/16/04 and a quarterly MDS assessment dated 5/15/04. A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 7. Resident 30 was admitted to the facility on 5/24/02 with the diagnoses which included, renal failure, congestive heart failure, hypertension, esophagitis, hypothyroidism, insulin dependent diabetes mellitus, arthritis, gout and anemia. Resident 30's active medical record contained an annual MDS assessment dated 3/30/04.	F 278		

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F 278	Continued From page 12 A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 8. Resident 60 was admitted on 11/13/02 with diagnoses which included, hypothyroidism, senile psychotic with mixed emotional features as adjustment reaction, hypertension, congestive heart failure, atrial fibrillation, osteoarthritis and urinary incontinence. Resident 60's active medical record contained an annual MDS assessment dated 11/20/03, a quarterly MDS assessment dated 2/18/04 and 5/17/04. A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 9. Resident 63 was admitted to the facility on 7/9/01 with diagnoses which included, dementia, senile dementia with delusional features, Alzheimers, chronic airway obstruction and unspecified esophagitis. Resident 63's active medical record contained two quarterly MDS assessments dated 12/31/03, and 3/23/04. A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 10 .Resident 2 was admitted to the facility in March 2002 with diagnoses of Alzheimers, paralysis and hypertension. Resident 2's active medical record contained one	F 278		

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F 278	Continued From page 13 quarterly MDS assessment dated 1/13/04 and an annual MDS assessment dated 4/11/04. A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 11. Resident 9 was admitted to the facility in October 2003 with diagnoses of dementia with depressive features, bladder disorder and convulsions. Resident 9's active medical record contained two quarterly MDS assessments dated 1/10/04 and 4/7/04. A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 12. Resident 10 was admitted to the facility in July 2003 with diagnoses of Alzheimers and hypertension. Resident 10's active medical record contained three quarterly MDS assessments dated 11/1/03, 1/29/04 and 4/27/04. A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 13. Resident 46 was admitted to the facility in July 2002 with diagnoses of constipation, bladder disorder and spinal stenosis. Residents 46's active medical record contained one annual MDS dated 10/25/03, and two quarterly MDS's dated 1/22/04 and 4/24/04.	F 278		

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F 278	Continued From page 14 A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 14. Resident 104 was admitted to the facility in January 2002 with the diagnosis of Alzheimers. Resident 104's active medical record contained three quarterly MDS's dated 11/4/03, 2/1/04 and 4/29/04. A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 15. Resident 27 was admitted to the facility on 11/8/03 and readmitted on 4/2/04 with the diagnoses of cellulitis and abscess of foot, closed fracture of the ankle, renal failure, diverticulitis, asthma, hypotension, atrial fibrillation and visual loss. Resident 27's medical record contained an admission MDS assessment dated 1/23/04, a 14 day Medicare MDS assessment dated 2/5/04, a 30 day Medicare MDS assessment dated 2/12/04, a significant change MDS assessment dated 3/2/04 and a readmission MDS assessment dated 4/15/04. A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 16. Resident 64 was admitted to the facility on 5/21/01 with the diagnoses of senile dementia with delusional features, cataract, hypertension, atrial fibrillation, sinoatrial node dysfunction, congestive heart failure and osteoarthritis.	F 278		

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F 278	Continued From page 15 Resident 64's medical record contained a quarterly MDS assessment dated 11/11/03 and 2/9/04 and an annual MDS assessment dated 5/7/04. A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 17. Resident 23 was admitted to the facility on 12/19/02 and readmitted on 3/4/04 with the diagnoses of closed fracture of the femur, functional disorder of the stomach, myocardial infarction, hypertension, depression disorder, senile psychotic condition, hypercholesterolemia and hyponatremia. Resident 23's medical record contained a Quartey MDS assessment dated 12/16/03, a significant change MDS assessment dated on 3/17/04, a 14 day Medicare MDS assessment dated 3/28/04, a 30 day Medicare MDS assessment dated 4/8/04 and a 60 day Medicare MDS assessment dated 5/6/04. A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse. 18. Resident 26 was admitted to the facility on 7/25/03, with diagnoses of pulmonary congestion and hypostasis, osteoarthritis, osteoporosis, s/p (status post) fractured pelvis, and adult fail to thrive. Resident 26's medical record was reviewed on 6/15/04. Resident 26's active medical record contained one quarterly MDS assessment dated 4/26/04.	F 278		

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F 278	Continued From page 16 A review of the MDS's revealed that Section R2 had a computer signature and was not signed by a registered nurse.	F 278	**F 309** Ok ***The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:***	
F 309 SS=E	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. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility was not providing the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Specifically, the facility was not repositioning 3 of 21 sample residents at least every 2 hours according to the facility's assessment and care plans for the residents. (Residents 2, 36, and 104) Findings include: 1. Resident 2 was admitted to the facility in March 2002, with diagnosis of Alzheimers, paralysis, and hypertension.	F 309	**Resident 2**: Resident has been placed on a turning and repositioning program and has been added to the facility skin at risk log. **Resident 36:** Resident has been placed on a turning and repositioning program and has been added to the facility skin at risk log. **Resident 104** Resident has been placed on a turning and repositioning program and has been added to the facility skin at risk log. ***How the facility will identify other residents having the potential to be affected by the same deficient practice:*** Although, according to the residents identified in the Statement of Deficiencies, the facility is not deficient in this practice; all residents who have been assessed and found to be dependant for	8-6-04

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F 309	Continued From page 17 A review of resident 2's medical record was completed on 6/14/04. An annual Minimum Data Set (MDS) assessment was completed by facility staff for resident 2 on 4/11/04. Facility staff documented on the assessment that resident 2's cognitive skills for daily decision making were severely impaired. Facility staff also documented that resident 2 required total assistance of two people for all activities of daily living, including bed mobility, transfers, dressing, eating, and locomotion. Facility staff documented that resident 2 had range of motion limitations on all extremities with partial loss of voluntary movement. Facility staff also documented that resident 2 required a turning and repositioning program. On a care plan dated 4/1/04, facility staff documented that resident 2 had a potential for impairment of skin integrity, related to incontinence, sensory perception and immobility; manifested by loss of positioning ability. One of the approaches to the problem facility staff had identified was to reposition resident 2 every two hours. A continuous observation was made of resident 2 on 6/14/04, from 12:00 PM to 5:00 PM. From 12:00 PM to 12:48 PM, resident 2 was in a wheel chair in the dining room being assisted with lunch. At 12:48 PM resident 2 was taken to an activity in living room two. Resident 2 remained in living room two until 5:00 PM when resident 2's family member took him out of the room and was wheeling him about the facility. The family member made the comment to the surveyor, "Well, they didn't lay him down again."	F 309	repositioning needs will be reviewed. ***The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:*** Although, according to the residents identified in the Statement of Deficiencies, the facility is not deficient in this practice; all residents who have been assessed and found to be dependant for repositioning needs will be placed on a repositioning program. This repositioning program consists of a turning schedule. This turning schedule is every 2 hours. All nursing staff has been inserviced and will continue to be inserviced upon hire and at least monthly at nurse staff meetings. Monitoring of the effectiveness of this program will be done by DON or designee. Monitoring will consist of 10 random checks per week of all residents who have been assessed and found to be dependant for repositioning needs to ensure they are being turned as care planned. The 10 random weekly checks may be increased depending on effectiveness of the staff to	

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F 309	Continued From page 18 At 4:00 PM, an interview was held with the facility nursing assistant that had been providing care to resident 2 on 4/14/04. The nursing assistant stated that she had not had time to lay resident 2 down that day and had not repositioned him. Resident 2 was observed to be up in the wheel chair for a period of 5 hours without being repositioned. On 6/15/04 at 10:00 AM, an observation of resident 2's skin was done by a facility nurse with a nurse surveyor present. Resident 2 was lying in bed on his back. Resident 2 was wearing a brief that was saturated with urine that had soaked through to his pants. Resident 2 did not have any red or open areas on his skin. 2. Resident 36 was admitted to the facility on 7/9/02 with diagnosis of constipation, bladder disorder, and spinal stenosis. A review of resident 36's medical record was completed on 6/14/04. A quarterly MDS assessment was completed by facility staff for resident 36 on 4/24/04. Facility staff documented on the assessment that resident 36 was independent in daily decision making. Facility staff also documented that resident 36 required extensive assistance of one person for all activities of daily living, including bed mobility, transfers, dressing, eating, and locomotion. Faculty staff documented that resident 36 had range of motion limitations on both lower extremities with partial loss of voluntary movement. Facility staff also documented that resident 36 had a stage 1 pressure ulcer and required a turning and repositioning program.	F 309	implement the repositioning program. Staff will receive counseling and in servicing as needed based on the results of the random checks. ***How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.*** The findings from the 10 random weekly checks noted above will be reviewed at each QA meeting X 3 months, or until the QA Team feels the practice is effectively addressed to ensure continued compliance.	

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F 309	Continued From page 19 On a care plan dated 10/31/03, and updated 4/22/04, facility staff documented that resident 36 had an impairment of skin integrity, related to incontinence, altered nutrition state and immobility; manifested by pressure ulcer present. The goal was to regain skin integrity with no skin breakdown. One of the approaches to the problem facility staff had identified was to reposition resident 36 every two hours. Resident 36 was observed at various times during the day on 6/14/04. At 7:30 AM, resident 36 was lying in bed. At 7:55 AM, resident 36 was assisted up into a wheelchair and served breakfast. At 9:00 AM, resident 36 was assisted to the bathroom and then assisted to dress. From 9:30 AM to 11:00 AM, resident 36 was observed to be sitting in a wheelchair, in his room watching television. At 12:10 PM, resident 36 was observed to be sitting in a wheelchair in his room, eating lunch. From 12:58 PM to 5:00 PM, resident 36 was observed to be sitting in a wheelchair in his room. An interview was held with resident 36 on 4/14/05 at 5:00 PM. Resident 36 stated that he had been up in the wheel chair since breakfast and no one had offered to lay him down and no one had repositioned him in the wheelchair. Resident 36 had been up in the wheelchair for 9 hours without being repositioned. On 6/15/04 at 10:10 AM, an observation of resident 36's skin was done by a facility nurse with a nurse surveyor present. Resident 36 had a dressing in place on the coccyx area. The	F 309		

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F 309	Continued From page 20 facility nurse removed the dressing. There were no open areas. There was a reddened area 4 centimeters by 3 centimeters on the coccyx area. 3. Resident 104 was admitted to the facility in January of 2002, with diagnoses of Alzheimers. A review of resident 104's medical record was completed on 6/15/04. An annual MDS assessment was completed by facility staff for resident 104 on 4/29/04. Facility staff documented on the assessment that resident 104's cognitive skills for daily decision making were severely impaired. Facility staff also documented that resident 104 required total assistance of one person for all activities of daily living, including bed mobility, transfers, dressing, eating, and locomotion. Facility staff also documented that resident 104 had a history of resolved ulcers and required a turning and repositioning program. On a care plan dated 5/7/04, facility staff documented that resident 104 had a potential for impairment of skin integrity, has a stage 1 pressure ulcer; related to incontinence, and limited mobility; manifested by reddened area present, loss of positioning ability and history of pressure ulcers. The goal was no skin breakdown. One of the approaches to the problem facility staff had identified was to reposition resident 104 every two hours. Random observations were made of resident 104 on 6/15/04, from 12:05 PM to 5:00 PM. At 12:05 PM, resident 104 was in a wheelchair, in the dining room being assisted with lunch. At 12:45, resident 104 was taken to living room two for an activity. At 1:30 PM, resident 104 was in living	F 309		

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F 309	Continued From page 21 room two, in an activity. Resident 104 had her head down and eyes closed. From 2:00 PM to 4:00 PM, resident 104 remained living room two with her head down and eyes closed, through two different activities. At 4:00 PM, resident 104 was moved from living room two and placed in front of the south nurses station, where she remained until 5:00 PM. Resident 104 had been up in the wheelchair for 5 hours without being repositioned.	F 309		
F 314 S=G	483.25(c) QUALITY OF CARE 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 interview, review of resident medical record and review of the facility's policy and procedures, it was determined that for one of twenty one sampled residents (Resident CL3), the facility did not ensure that a resident who entered the facility without pressure sores did not develop pressure sores. The facility did not ensure that a resident who developed pressure sores received the necessary treatment and services to promote wound healing. In addition, at the time this resident was admitted, the facility did not have a policy and procedure in place	F 314	**F 314** ***The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:*** A list of closed charts that were reviewed during the survey process was not provided on the confidential resident list in the Statement of Deficiencies. Although neither the Statement of Deficiencies nor the corrected Statement of Deficiencies identifies resident CL-3, the facility is aware of the identity of this resident. Resident CL3 was discharged on 5-25-04. Resident CL3 was admitted with "…2nd toe [right] foot-bruised-dark purple [and] along posterior foot. Stated 'she had fallen'. Abrasion to [right] interior knee. Feet dry [and] flaky…" This indicates that the resident's feet condition was compromised on admission and how easy it is for rapid skin decline. Due to this, the facility provided an air mattress overlay to resident's bed upon admission. In	8-6-04

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F 314	Continued From page 22 concerning pressure sores. Findings include: 1. Resident CL3 was admitted to the facility from an assisted living facility on 12/1/03, with diagnoses of senile dementia, anxiety, osteoarthritis, post herpatic neuralgia (pain associated with shingle lesions after they have healed) and nausea and vomiting. An admission MDS (minimum data set), a mandatory comprehensive assessment of the resident, completed by the facility staff, dated 12/13/03, documented that the cognitive skills for resident CL3 were moderately impaired and that she needed extensive assistance when moving to and from a lying position, turning side to side and positioning herself while in bed and she needed extensive assistance when moving to or from a bed or wheelchair. The MDS also documented that resident CL3 was continent of bowel and bladder and did not have any pressure ulcers. Facility nursing staff completed two admission notes, dated 12/1/03. Neither nurse's note identified any skin breakdown on or near resident CL3's heels or coccyx. The "Resident Admission Assessment" dated 12/1/03 at 4:45 PM, documented the following under "Skin Condition Assessment, " "...2nd toe [right] foot- bruised-dark purple [and] along posterior foot. Stated 'she had fallen'. Abrasion to [right] interior knee. Feet dry [and] flaky..." The admission "Pressure Sore Risk Assessment" completed by a facility nurse on 12/5/04, documented that resident CL3 had no sensory perception impairment, was occasionally moist, was chairfast, had very limited mobility, had	F 314	signed witness statements provided to the surveyor during survey, two RN's in charge of this resident's care confirmed that the air mattress overlay was placed on the bed and stayed on the bed until it was replaced by an alternating pressure low air loss mattress replacement system. The facility was fully aware of resident's compromised condition as evidenced on initial care plan and Braden scale as noted in statement of deficiencies and the facility put into place necessary pressure sore prevention interventions including air mattress overlay on bed. The resident care plan, dated 12-12-03 also confirms that an air mattress overlay was part of her care from admission to prevent pressure sores. The initial care plan states, "air mattress on bed". Another care plan was written on 12-26-03 that stated, "air mattress on bed while patient in bed and gel pad on chair when up." The air mattress overlay was documented in the resident's plan	

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F 314	Continued From page 23 probably inadequate nutrition and had potential problems for friction and shearing. The facility nurse documented a score of 15. The "Pressure Sore Risk Assessment" form stated "...At risk for pressure ulcer if score is < (less than) 17..." The facilities's policy and procedure for "Skin Assessment and Documentation" stated that "...A licensed nurse will complete a head to toe skin assessment within 24 hours of admit to identify skin integrity problems that occurred prior to admission...All new admissions will receive an assessment to predict pressure sore risk...The Director of Nursing/designee will be responsible to complete and maintain the Monthly At Risk For Impaired Skin Integrity Log..." On 6/21/04 at 1:30 PM, the DON (director of nurses) was interviewed by phone. The DON stated that she did not keep an "At Risk Log" that she only kept a log of stage I and greater pressure sores. She further stated that the "facility determines all of their residents are at risk for pressure sores so a log is not kept." The care plan for resident CL3, dated 12/12/03, included the problem "Potential for impairment of skin integrity related to dementia, limited mobility, altered nutritional status." The documented goal was "No skin breakdown." Approaches documented included, "Assess skin [every] shower days; ensure adequate hydration, Monitor Turning/Reposition Program; Treat as ordered, Nurse Aide---Assist with hygiene and general skin care; Reposition every two hours; Keep skin clean and dry; Keep linen clean, dry, and wrinkle free; Air mattress on bed; Lotion/massage as needed." On 12/2/03 at 2:00 PM, a facility nurse	F 314	of care and documentation in each nurse's note is unnecessary. Further indication that the facility was fully aware of resident's compromised condition and put into place necessary pressure sore prevention interventions are found in the plan of care from 12-12-03 which also states, "reposition every two hours; keep skin clean and dry; keep linen clean, dry, and wrinkle free; air mattress on bed; lotion and massage as needed." The facility continued to provide necessary pressure sore prevention interventions as evidenced by following the initial and ongoing care plans. In an interview with the Doctor of Podiatry Medicine on July 19, 2004, he disagreed with the RN surveyor's interpretation of his and the facility's care for this wound. He confirmed that the facility provided the appropriate care by stating, "Everything was appropriate and within the normal standard of care for that kind of wound."	

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F 314	Continued From page 24 documented, "...[up] in w/c (wheelchair) most of the day and tried to get up [without] assist several times. Applied alarm on pt (patient)..." At 10:00 PM a facility nurse documented, "...Pt (patient) has been refusing to go to bed..." On 12/9/03, a facility nurse completed a "Weekly Nursing Summary." The facility nurse documented under the section "Skin Condition" that resident CL3's skin was dry. On 12/9/03, resident CL3 was assessed by the facility's RD (registered dietitian) as having no pressure sores. She assessed that the resident's protein needs were normal. On 12/16/03, a facility nurse completed a "Weekly Nursing Summary." The section labeled "Skin Condition" was not marked as being assessed. On 12/21/03 at 11:10 AM, a facility nurse documented, "c/o (complain of) feet hurting. Dry flaky skin. Lotion applied [with] LE's (lower extremities) [and] feet..." On 12/22/03 at 11:30 AM, a facility nurse documented, "...Pt (patient) cooperating this AM...Pleasant affect today..." At 12:00 PM, a facility nurse documented, "Podiatrist ordered cream to feet QD (every day)..." On 12/23/03, a facility nurse completed a "Weekly Nursing Summary." The facility nurse documented under the section "Skin Condition" that resident CL3's skin was fair and dry. On 12/26/03, a facility nurse documented, "...DPM (doctor of podiatry medicine) in house [and] NO (nursing order) for near Stage III on [right] heel obtained lanced, drained	F 314	On 12-21-03 at 11:10 AM, a facility nurse documented, "c/o (complain of) feet hurting. Dry flaky skin. Lotion applied [with] LE's (lower extremeties) [and] feet..." This complaint from the resident generated an immediate response on the part of the facility as evidenced by this nurse's note. Due to the facility's recognition of the resident's compromised condition, a call was also placed to the Podiatrist for further evaluation and treatment of this skin condition. On 12-22-03 the Podiatrist ordered cream to feet every day and came in to the facility to personally assess condition of resident's feet. According to the statement of deficiencies, on 12-23-03 a facility nurse documented, "resident skin was fair and dry." Thus indicating that skin was intact at this point with no signs or symptoms of break down. On 12-26-03, just four days of the Podiatrist coming in and doing a	

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F 314	Continued From page 25 wound...Heels floated." There was no documentation of the use of any pressure relieving devices on resident CL3's bed. On 12/26/03, a podiatrist documented, "Eval (evaluation) [right] heel requested by nsg (nursing). Large bullous lesion posterior/plantar aspect [right] heel [with] purulent drainage...post (posterior) [right] heel ulcer. Presently stage II..." On 12/28/03 at 1:30 PM, a facility nurse documented, "...Pt (patient) c/o (complain of) tenderness [and] feet on pillows is difficult because they like to slide off the pillows..." There was no documentation of the use of any pressure relieving devices on resident CL3's bed. On 12/29/03 at 3:00 PM, a facility nurse documented, "...Resd (resident) not keeping legs up on pillows. Resistant to turn off back, pillows placed to attempt to keep her turned." There was no documentation of the use of any pressure relieving devices on resident CL3's bed. On 12/30/03, a facility nurse completed a "Weekly Nursing Summary." The facility nurse documented under the section "Skin Condition" that resident CL3's skin was dry and she had a pressure ulcer on her right heel. On 12/30/04, a podiatrist documented, " F/U (follow up) [right] heel ulcer...Stage III involvement..." On 12/31/04 at 11:00 AM, a facility nurse documented, "Moderate serosangious [sic] fluid from [right] heel [with] black eschar in the middle...Pt (patient) moves feet a lot when in bed [and] constantly have to reposition feet on pillows to float..." There was no documentation of the	F 314	complete evaluation of resident's feet, the nurse noticed a blister on resident's heel. The nurse immediately requested an evaluation by the Podiatrist. On the same day, the Podiatrist came to facility and documented, "Eval (evaluation) [right] heel requested by nsg (nursing). Large bullous lesion posterior/plantar aspect [right] heel [with] purulent drainage. [negative] deep tracking on inspection. Sight debrided/dressed. Erythema surround wound margins. Imp (impression)/post (posterior) right heel ulcer. Presently stage II. Cellulitis present. Plan- antibiotics, wound care, and float heels." This indicates that due to an acute infection, a large blister formed on her right heel, filling with purulent drainage, and was treated as such. Nowhere in the Physician's evaluation is it indicated that this wound was caused from pressure, however, the air mattress overlay remained on bed, according to plan of care, and heels were floated per Physician's order.	

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F 314	Continued From page 26 use of any pressure relieving devices on resident CL3's bed. On 1/4/04, a facility nurse documented, "Resd (resident) would not keep legs in bed putting her at a high risk for falling. heels were [elevated] when they were in bed..." There was no documentation of the use of any pressure relieving devices on resident CL3's bed. On 1/6/04, a facility nurse completed a "Weekly Nursing Summary." The facility nurse documented under the section "Skin Condition" that resident CL3's skin was dry and fragile and she had a pressure ulcer on her "[right] heel [with] opening [and] dry feet." On 1/6/04 at 1:00 PM, a facility nurse documented, "Dr...in to see pt (patient)...order written for multipodis boot for pt (patient) [right] foot..." The order for the multipodis boots was written 9 days after a facility nurse documented that resident CL3 was having difficulty keeping her feet elevated on pillows because her feet slide off of the pillows. There was no documentation of the use of any pressure relieving devices on resident CL3's bed. On 1/12/04 at 6:15 PM, a facility nurse documented, "...Open sores to coccyx area discovered [at] 1700 (5:00 PM)...Sores appear to be result of sheering [sic]..." There was no documentation of the use of any pressure relieving devices. On 1/12/04 at 6:15 PM, the following physician order was obtained, "Change tegasorb to open sores on coccyx area [every 3rd] day until healed."	F 314	It was left out of the statement of deficiencies that the Podiatrist also noted on 12-30-03 the wound was "slightly dryer – cellulitis (decreased)...Cont (continue) off loading, Abx (antibiotics), wound care..." This clearly indicates that with the decrease in cellulites, the interventions put in place by the Physician and followed by the facility were working. The Physician chose to continue with the same plan of care. Please note that in a statement written by the Podiatrist on June 22, 2004, and given to the surveyor, the Podiatrist states, "She had peripheral vascular problems which would have allowed the ulceration to progress rapidly to the resultant depth." As noted through various nurses notes quoted in the statement of deficiencies (i.e. 12-26-03, 12-28-03, 12-29-03, 12-31-03, 1-04-04), resident's heels were constantly being elevated, floated and repositioned. These notes are also prevalent throughout the nurse notes in the resident's chart.	

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F 314	Continued From page 27 On 1/13/04, a facility nurse completed a "Weekly Nursing Summary." The facility nurse documented under the section "Skin Condition" that resident CL3's skin had a pressure ulcer and other skin problems "sear [sic] on coccyx [and] [right] heel [with] wound." On 1/13/04 at 2:00 PM, a facility nurse documented, "[changed] coccyx dressing [and] blister is open [and] raw. Wound team assessed. [right] heel dressing [changed] and not working or debriding. Black eschar apparent..." There was no documentation of the use of any pressure relieving devices. On 1/13/04, the wound team documented, "coccyx 14.5 x 15.3 cm (centimeter) beefy red center [with] purple edges, Shearing not pressure. Tegasorb applied to coccyx...Pt (patient) stated tenderness to site...1st layer of skin peeled back. gel mat in w/c (wheelchair) now..." There was no documentation of the use of any pressure relieving devices on resident CL3's bed. On 1/20/04, a facility nurse completed a "Weekly Nursing Summary." The facility nurse documented under the section "Skin Condition" that resident CL3's skin was dry and fragile, had pressure ulcers and other skin problems "[right] heel [and] coccyx." On 1/21/04 at 3:15 AM, a facility nurse documented, "Called to pt (patient) room by CNA (certified nursing assistant) to look at pt (patient) coccyx. Pt (patient) has large area of necrotic tissue [with] a foul odor to the wound..." There was no documentation of the use of any pressure relieving devices on resident CL3's bed.	F 314	The resident's foot care was under the direct supervision of a Doctor of Podiatry Medicine. The Podiatrist chose to continue the plan of care and did not choose to order a multipodis boot until 1-6-04, at 8:00 PM. The multipodis boot was placed on the resident by 10:00 AM the following morning. The Podiatrist placed the multipodis boot order when he felt it was appropriate and the facility followed the Physician's order immediately and appropriately. In an interview with the Doctor of Podiatry Medicine on July 19, 2004, he disagreed with the RN surveyor's interpretation of his and the facility's care for this wound. He stated, "It was a calculated decision on my part to order the multipodis boot when I did." In summary, in regards to the wound on the resident's heel, the facility believes that all appropriate preventative measures were care planned and put into place from admission. The resident was under the direct care and supervision of	

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F 314	Continued From page 28 On 1/22/04, the RD re-assessed resident CL3's nutritional needs. The registered dietitian documented the following, "Notified by DON (director of nurses) of coccyx breakdown [and] black heel. Intake assessed to be inadeg (inadequate) for needs which are adj (adjusted) [with] breakdown...Will provide [increased] pro (protein) [increased] kcal (calorie) suppl (supplement) TID (three times a day), vit C jc (vitamin C juice) TID (three times a day)..." The RD did not re-assess resident CL3's nutritional needs until 27 days after the near stage III heel ulcer was identified and 10 days after the wound on resident CL3's coccyx was identified. On 1/24/04, a facility nurse documented, "...Coccyx is very red and breaking down Stage IV decub present. Wound open in places [with] some mild seraguanous [sic] drainage...Could not find supplies for her drsg (dressing) [change]..." There was no documentation of the use of any pressure relieving devices on resident CL3's bed. On 1/25/04 at 8:00 PM, the following physician order was obtained, "1. Wound clinic eval (evaluation) stage IV buttocks. 2. Cleanse [with] NS (normal saline), use NS (normal Saline) soaked gauze [with] 4x4 to cover and secure [with] Tegaderm QD (every day) until seen by wound clinic." This physician's order for change in treatment was not obtained until 4 days after resident CL3's coccyx was identified as having necrotic tissue and a foul odor. The facilities's policy and procedure for "Pressure Sores Staging Protocol" stated the following, "...Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures (for example, tendon or joint capsule)...When eschar	F 314	the Podiatrist until her right heel was resolved. We believe the wound to her heel was unavoidable due to her medical condition. We also believe that this resident received the appropriate and necessary treatment to promote healing. The facility was fully aware of resident's compromised condition as evidenced on initial care plan and Braden scale as noted in statement of deficiencies and the facility put into place necessary the pressure relieving device (air mattress overlay on bed). The resident care plan, dated 12-12-03 also confirms that an air mattress overlay was part of her care from admission to prevent pressure sores. The initial care plan states, "air mattress on bed". Another care plan was written on 12-26-03 that also stated, "air mattress on bed while patient in bed and gel pad on chair when up." A pressure relieving device, the air mattress overlay, was documented in the resident's plan of care and	

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F 314	Continued From page 29 is present, accurate staging of the pressure ulcer is not possible until the eschar has sloughed or the wound has been debrided..." On 1/27/04, a facility nurse completed a "Weekly Nursing Summary." The facility nurse documented under the section "Skin Condition" that resident CL3 had other skin problems "shear on coccyx." On 1/27/04 at 4:00 PM, a facility nurse documented, "[changed] coccyx at 1130 (11:30 AM) and wound bed is yellowish/green slough [with] superior bed dark necrosis [with] odor [with] hole. [right] heel [changed] and looks smaller [with] necrotic tissue [and] pink round wound bed...Opening/hole noticed by coccyx/rectum." There was no documentation of the use of any pressure relieving devices on resident CL3's bed. On 1/28/04 at 12:30 PM, a facility nurse documented, "Large opening by rectum. Odor is strong. Noticed tunnelling [sic] in hole by rectum..." There was no documentation of the use of any pressure relieving devices on resident CL3's bed. On 1/28/04, the wound team documented, "12.5 x 10 cm (centimeter) [with] 5.5 cm depth. Greenish yellow foul odor [with] red edges. referred to wound clinic. coccyx wound open tunneling deep..." There was no documentation of the use of any pressure relieving devices on resident CL3's bed. On 1/29/04, resident CL3 was sent to the wound clinic (4 days after the physician's order was written to send resident CL3 to the wound clinic for evaluation). On the referral the wound clinic documented the following, "...Intact blister left	F 314	further documentation of this in each nurse's note is unnecessary. The facility continued to provide necessary pressure sore prevention interventions as evidenced by following the initial and ongoing care plans. On 1-12-04 nurses note states, "open sores to coccyx area...sores appear to be result of shearing." This is evidenced by large irregular shaped wound that occurred after lifting resident up in bed. On 1-25-04 an appointment was made for the resident to go to the wound clinic at the wound clinics earliest available time. The wound clinic's earliest available time was on 1-29-04. The four day space was due to the inability to fit her in to the wound clinics schedule. The statement of deficiencies states, "A review of the nursing progress notes prior to the wound clinic visit on 1-29-04, did not provide any documentation concerning the blister the wound clinic found on resident CL3's left	

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F 314	Continued From page 30 heel- stage I. Unstaged pressure wound [with] eschar rt (right) heel coccyx wound unstageable..." The following were the measurements of the wound on the coccyx by the wound clinic, "...Length 12.6 cm Width 11.1 cm, no depth was documented..." The wound clinic measured the left heel blister as 1.0 centimeter by 1.6 centimeter and the right heel as 3.7 centimeters by 3.7 centimeters. A review of the nursing progress notes prior to the wound clinic visit on 1/29/04, did not provide any documentation concerning the blister the wound clinic found on resident CL3's left heel. The facilities's policy and procedure for "Pressure Sores Staging Protocol" stated the following "...Stage II: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater..." Based on this protocol, the nursing progress notes and the wound clinic referral resident CL3 had a stage II pressure ulcer on her left heel which was not identified by the facility's nursing staff. On 2/1/04, resident CL3 was seen by her attending physician. The physician documented the following in a progress note, "...She has a recently discovered stage 4 coccyx ulcer that needs to be debrided...Coccyx [with] large ulcer that seems to go right to the bone [approximately] 10 cm (centimeters) diameter..." On 2/2/04 at 3:00 PM, a facility nurse documented the following, "...Over-lay air mattress on bed..." The over lay air mattress was not documented as being applied to resident CL3's bed until 38 days after the pressure ulcer on her right heel was identified and 21 days after	F 314	heel." This is incorrect as evidenced by: On 1-13-04 a Physician's order for skin prep to left heel BID related to redness and softness was implemented. On 1-18-04 the nurses notes states, "Skin prep to left heel with redness and tenderness on left heel." On 1-28-04 the C.N.A. body assessment indicated redness to left heel. Also on 1-21-04 the nurses note state, "left heel, no open sore." In addition, concerning the left heel, the statement of deficiencies states that the wound clinic staged the wound on the left heel as a stage II. This is inaccurate as noted on the referral the wound clinic documented the following"... "intact blister left heel – stage I." Although the Physician documented on 2-1-04 that"...She has a recently discovered stage 4 coccyx ulcer that needs to be debrided...", the resident had gone to the wound clinic 2 days prior to be debrided and the coccyx wound	

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F 314	Continued From page 31 the pressure ulcer on her coccyx was identified. On 2/5/04, resident CL3 was sent to the wound clinic. On the referral the wound clinic documented the following, "...Unstaged p/u (pressure ulcer) sacrum at least stage III possible IV unable to stage due to necrotic tissue..." The following were the measurements of the wound on the coccyx by the wound clinic, "...Length 13.5 cm Width 10.1 cm, depth 4 cm..." On 2/12/04, the facility DON documented the following on a wound team progress note, "...We discussed this wound's origin: from a shearing wound to ulcer. I told her that this wound was identified on 1/12 [and] our wound team identified her [and] implemented interventions...I told [wound clinic nurse practitioner] that pt (patient) refuses to lay on side, would often lay on her back [and] refuses to turn, despite many attempts..." A review of the nursing progress notes revealed only one documented incident (on 12/29/03) of resident CL3 being resistant to being repositioned prior to the wound being found on resident CL3 coccyx. There was no documentation in resident CL3's medical record to evidence that she refused to be turned and repositioned. On 2/12/04, resident CL3 was seen by her attending physician. The physician documented the following in a progress note, "...The pressure sore on coccyx looks about the same only cleaner..." On 2/17/04, resident CL3 was sent to the wound clinic. On the referral the wound clinic documented the following, "...Stage IV pressure ulcer coccyx- bone visible..." The following were	F 314	was unstageable at that time and not staged at a stage IV. On 2-2-04 the overlay air mattress is actually an alternating pressure low air loss mattress replacement system. This was actually ordered and implemented four days prior (1-30-04). The invoice for this specialty bed was given to surveyor with the date to confirm placement and to verify that it was not the air overlay mattress used since admission. In the statement of deficiencies it is stated that "There is no documentation in resident CL3's medical record to evidence that she refused to be turned and repositioned." It is documented throughout the resident's chart that she was resistant to care, which would include turning and repositioning. Examples of the resident being resistive to care can be found in the following: **December Nurses Notes:** 12-3-03 "...refusing all care and meds..."	

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F 314	Continued From page 32 the measurements of the wound on the coccyx by the wound clinic, "...Length 10.4 cm Width 13.1 cm, depth 3.2 cm..." On 6/14/04 and 6/15/04, the facility was observed not to reposition three residents, at least every 2 hours according to the facility's assessment and care plans for the residents. These three residents were assessed and care planned by the facility, for being at risk for pressure sores. (Refer to F Tag 309) On 6/16/04 at approximately 9:30 AM, an interview was held with two nurse surveyors, the administrator, the DON and the RD. The DON stated that it is the facility's policy to have air overlays on all of their non-electric beds. She further stated that the facility goes beyond the industry's standard to prevent pressure ulcers on their residents. She stated that all new admissions have an air overlay applied to their beds. The DON stated that after the pressure sores were discovered on resident CL3, they provided treatment. She stated that resident CL3 was a very ill lady and was admitted to the facility due to her decline. When the DON was asked for policy and procedures regarding pressure ulcers, she handed the nurse surveyors a book. She stated that this book went into effect at the end of February 2004. When the DON was asked what policy and procedures were used prior to the new book she stated she would get a copy to the survey team prior to exit. On 6/16/04 at 10:30 AM, the DON, administrator and nurse surveyor viewed a new admission's bed in room 212. The new admission in room 212 had a light blue mattress (which was not a pressure relieving mattress) with no air overlay. The DON stated that this resident did not have an	F 314	12-4-03 "...physically aggressive with routine cares. Unable to redirect." 12-6-03 "Pt refused all meds and stayed in bed during breakfast" 12-21-03 "Uncooperative with cares, occ (occasionally) slapping at C.N.A.'s" **Weekly Summary:** The weekly summary form has a box indicating "interferes with care". This box is checked for this resident on the following dates: 12-16-03, 12-23-03, 12-30-03, 1-13-04, 1-20-04, 1-27-04, 2-10-04, 2-24-04, 3-9-04, 3-16-04 **Medication Administration Records:** On the MAR (Medication Administration Record) it is documented the resident resists care. For the month of December alone it was documented on the following dates: 12-3, 12-4, 12-5, 12-6, 12-7, 12-8, 12-9, 12-10, 12-11, 12-12, 12-13, 12-14, 12-15, 12-16, 12-21, 12-23, 12-24, 12-25, 12-28, 12-31	

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F 314	Continued From page 33 air overlay on his mattress because he might have asked for it to be removed. On 6/16/04 at 10:40 AM, the new admission in room 212 was interviewed. He stated that he did have an air mattress on his bed but it was removed when he soiled the bed. He further stated that facility staff took the air mattress off and they never replaced it. On 6/16/04 from approximately 10:00 AM until 10:40 AM, all the beds in the facility were checked by the survey team. Twenty-five of the beds being used in the facility had light blue mattresses (which were not pressure relieving) with no air overlays and one bed had a light blue mattress with a deflated air overlay. While the survey team was assessing the beds, a resident in room 213 stated that she had asked everyone in the building for an air mattress. She stated that the bed was too hard. This resident's bed was observed to have a light blue mattress with no air overlay. Another resident in room 320 stated that her bed was "bumpy and hard." She further stated that she has had the facility staff turn her mattress a few times. This resident was observed to be laying on a light blue mattress with no air overlay. On 6/16/04 at approximately 11:00 AM, the DON provided the nurse surveyor with a copy of the policy and procedures concerning pressure sores used prior to February 2004. The policy and procedures addressed "Skin Assessment and Documentation" and "Pressure Sore Staging Protocol." On 6/21/04 at 1:30 PM, the DON was interviewed by phone. The DON stated that the new policies	F 314	With this documentation it is clear that the resident was resistant to all areas of her care. To assume that she was resistant to all of the above, but not resistant to turning and repositioning, seems inconsistent. In regards to "...the facility was observed not to reposition three residents..." please refer to F 309. The following statements on the statement of deficiencies need to be clarified: Page 33, paragraph 3: "...The DON stated that it is the facility's policy to have air overlays on all of their non-electric beds..." The DON actually stated that it is the facility's policy to have air overlays placed on all of their non-electric beds UPON ADMISSION. It is not the policy of the facility to have air overlays on every non-electric bed. The facility does not require air overlays on residents that request to have them removed after admission.	

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	465152	A. BUILDING _____ B. WING _____	6/16/2004

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F 314	Continued From page 34 and procedures on pressure sores went into effect at the end of February 2004, beginning of March 2004. She further stated that in February 2004, she went out of town and signed a contract to begin the new program. The DON stated that they care planned for all at risk pressure sores, but she had "nothing concrete in writing" concerning pressure sores prior to February 2004. She further stated that they had no policy and procedures in place because they used the air overlays on all of their beds. The DON stated that resident CL3 did not have a terminal illness diagnoses, but was admitted to the facility due to "failure to thrive." When the DON was asked if a physician gave that diagnoses she stated "No, I did, this second." On 6/23/04, the DON faxed a letter from resident CL3's podiatrist to the nurse surveyor. The podiatrist documented the following in his letter regarding her right heel ulceration, "...She had peripheral vascular problems which would have allowed the ulceration to progress rapidly to the resultant depth..." On 6/23/04 at 11:00 AM, resident CL3's attending medical physician was interviewed by phone. When the physician was asked about the pressure sores he stated "someone dropped the ball." He further stated that resident CL3 was admitted to the facility due to immobility and her family could not care for her any longer. He stated that the immobility put her at risk for pressure sores but she did not have any prior to her admission into the facility. Resident CL3's physician stated that he was concerned that the pressure sores went so long before they were identified and by the time they were identified they were "huge" and made him wonder if her skin was being checked. Resident CL3's physician	F 314	Page 33, paragraph 3: "...When the DON was asked for policy and procedures regarding pressure ulcers, she handed the nurse surveyors a book. She stated that this book went into effect at the end of February 2004." The book that was given to the surveyors was the facility's new policy and procedure manual on wound care and documentation. The facility is constantly working on improvement. A new policy had been identified that could improve this aspect of the facility's practice and the facility took steps to adopt it. Page 33, paragraph 3: "The DON stated that after the pressure sores were discovered on resident CL3, they provided treatment." The facility believes it is evident from the above plan of correction response that appropriate preventative care was also given since admission. Page 34, Paragraph 2: "On 6/16/04 at 10:40 AM, the new admission in room 212 was interviewed. He stated that he did have an air	

mattress on his bed but it was removed when he soiled the bed. He further stated that facility staff took the air mattress off and they never replaced it." It is evident by this example that new admissions with non-electric beds receive an air mattress overlay.

The facility was cited for not having "a policy and procedure in place concerning pressure sores." It is evident that the facility did have a policy and procedure in place for pressure sores as the policy was given to the surveyor prior to surveyor leaving the building as noted in the statement of deficiencies. This same pressure sores policy and procedure is quoted from throughout the statement of deficiencies. Below are a few examples from the statement of deficiencies to which our pressure sores policy and procedure is referred:

Page 24, Paragraph 2, "The facility's policy and procedure..."

Page 29, Paragraph 4, "The facilities's policy and procedure for Pressure Sores..."

Page 31, Paragraph 3, "The facilities's policy and procedure for Pressure Sores..."

Page 34, Paragraph 5, "...the DON provided the nurse surveyor with a copy of the policy and procedures concerning pressure sores used prior to February 2004."

How the facility will identify other residents having the potential to be affected by the same deficient practice:
The facility identified the benefits of initiating an improved system, as evidenced by the following actions which were implemented February 2004 and continue to be in place. The current policies and procedures will be continuously reassessed and improved as deemed necessary by the wound team:

On admission, a Braden scale assessment is done on each resident to identify at risk residents. New intervention guidelines (see attached F 314 A) will be initiated

and assessed for adequacy as part of the plan of care.

The C.N.A.'s will complete weekly skin checks (see attached F 314 D) on every resident to enable the facility to identify potential for skin breakdown and actual skin breakdown. A wound contest will be implemented to identify new wounds, reddened areas, and the potential for skin breakdown. Any staff who reports a new skin integrity issue will be rewarded. A contest was also organized by unit to identify the least amount of skin integrity breakdown issues acquired over the course of the month and the winning unit rewarded with a pizza party (see attached F 314 B).

The wound team was reorganized with an interdisciplinary team consisting of the DON, RD, Unit Managers, OT, Lead C.N.A., QA nurse, Night Shift Charge nurse, and Restorative C.N.A.
The wound team meets weekly as part of the Nutrition/Skin at Risk Meeting to review all residents with potential and actual skin break

down. New interventions are implemented at this meeting and reassessed weekly to insure compliance.

The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:

All residents found to be at risk, with a Braden scale score of 18 or less will be placed on the newly implemented turning and repositioning program (see attached F 314 E), placed on and monitored with the "At Risk for Pressure Sores" log, assessed with the "Skin Integrity Action Sheet" (see attached F 314 C), and will be reviewed at each Nutrition/Skin at Risk Meeting. The facility dietitian will implement nutritional interventions as deemed appropriate for each resident based on stage of pressure sore (see attached F 314 G), lab values, intake, and current nutritional status. This process will ensure that each resident at risk is identified and treated appropriately

to ensure continued compliance in accordance with facility policy and procedure.

As noted in survey, a new pressure sore prevention and treatment policy and procedure manual was implemented February 2004. Appropriate interventions are and will continue to be implemented according to facility policy and procedures. (see attached F 314 A).

A minimum of 5 to 10 random rounds will be completed each week to ensure residents at risk are being turned as per facility guidelines. Corrective action and in servicing will be given to staff found to be out of compliance with the turning guidelines.

Facility will provide continued and ongoing pressure prevention and treatment with nursing staff and interdisciplinary team. C.N.A.'s will use C.N.A.Skin Saver Program forms (see attached F 314 F) daily to document newly identified areas of concern. The forms are completed in triplicate with one

copy given to DON, one copy given to Wound Care team leader, and the third remaining in the book for tracking purposes.

The DON and/or designee and wound team will monitor the above corrective action to ensure continued compliance.

How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.

Results of the monitoring by the DON and/or designee will be reviewed at each monthly QA Meeting x 3 months or until the QA Team feels the alleged deficiency is consistently and effectively addressed to ensure continued compliance.

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F 314	Continued From page 35 stated that she did not have any peripheral compromise or neuropathy. He stated that she had spinal stenosis which contributed to her immobility and along with resident CL3's age put her at risk for pressure sores.	F 314	**F 323** ***The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:***	
F 323 SS=C	483.25(h)(1) QUALITY OF CARE 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: Based on observation, it was determined that the facility did not ensure that the resident environment was as free of accident hazards as possible. Specifically, the facility had not installed anti siphon valves in resident shower rooms. Findings include: During the annual survey conducted 6/13/04 through 6/16/04, each resident shower room was inspected. In 56 out of the 62 resident shower rooms, the shower hose could be placed into an adjacent hand sink. If the sinks were to become plugged up, and the shower hose placed in the sink with the standing water, there was a potential for the water to siphon up the shower hose and contaminate the culinary water. The rooms were this condition existed were as follows: 100 Hall 101, 102, 103, 104, 105, 107, 108, 109, 110, 111,	F 323	Anti-siphon valves have been installed in each resident shower room identified. ***How the facility will identify other residents having the potential to be affected by the same deficient practice:*** All resident shower rooms that had this problem were identified and have been corrected. ***The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:*** All resident shower rooms have had anti-siphon valves installed and this alleged deficiency has been corrected. Prior to replacement of any anti-siphon valves in the resident showers, the Director of Plant Operations and/or designee will approve the new part to ensure it is compliant with this regulation.	8-6-04

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F 323	Continued From page 36 112, 113, 114, 115, and 117. 200 Hall 201, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, and 213. 300 Hall 303, 305, 307, 309, 311, 313, 315, 317, 318, 319, 320, 321, 322, 323, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, and 308.	F 323	Monitoring of this change will be done by the Director of Plant Operations. ***How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.*** The installation of the new anti-siphon valves will be reviewed at the next monthly QA meeting. Prior to replacement of any anti-siphon valves in the resident showers, the Director of Plant Operations and/or designee will approve the new part to ensure it is compliant with this regulation and report to QA meeting of the change.	
F 502 SS=D	483.75(j) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on review of the resident's medical record and facility staff interviews, it was determined that the facility did not provide laboratory services as ordered by the physician. Specifically, laboratory tests were not completed timely and or laboratory (lab) results were missing for 2 out of 21 sampled residents. Resident identifiers 27 and 64. Findings include: 1. Resident 27 was admitted to the facility on 11/8/03 with the diagnoses of cellulites and abscess of the foot, closed fracture of the ankle, renal failure, diverticulitis asthma, hypotension, atrial fibrillation, and visual loss. A review of resident's 27 medical record was completed on 6/14/04.	F 502		

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F 502	Continued From page 37 A physician order, dated 2/4/04, documented an order for a "Prothrombin time (PT) and an INR (International Normalized Ratio) weekly, Wednesday's lab start date: 2/11/04". This lab monitors bleeding times in residents who take the blood thinner warfarin (Coumadin). Resident 27 had at PT and INR on the medical record dated 2/12/04. The next PT and INR was not completed untill 2/23/04. Eleven days after the first one was obtained. Resident 27 had a PT and INR on the medical record dated 3/14/04. Twenty days after the PT and INR on 2/23/04. Resident 27 had a PT and INR drawn on 3/15/04 and 3/16/04. On 3/25/04 resident 27 was admitted to the hospital and returned to the facility on 4/2/04. Resident 27's monthly physician orders continued weekly PT and INRs. Resident 27 had a PT and INR on the medical record dated 4/13/04. Eleven days after readmission. The next PT and INR was completed 4/28/04, fifteen days after the previous draw. Resident 27 had a PT and INR on the medical record dated 5/23/04, twenty five days from the previous lab on 4/28/04. The next PT and INR was completed on 6/2/04, ten days from the previous lab on 5/23/04. An interview with the unit's nursing manager was completed on 6/14/04 regarding missing labs. The facility did not provide documented evidence	F 502	**F 502** ***The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:*** **Resident 27**: Resident 27 has a PT/INR ordered every week. He has current results in the chart, which have been faxed to the MD. **Resident 64**: Resident 64 has current labs in the chart, which have been faxed to the MD. We have implemented a lab exception report which will identify labs that have been missed, as well as a new lab file in the electronic charting system, which will allow us to obtain all labs in a timely basis. ***How the facility will identify other residents having the potential to be affected by the same deficient practice:*** A list of labs will be run weekly (at a minimum) in order for the QA nurse and/or designee to check to ensure they are completed, with the results faxed to the physician in a timely manner.	8-6-04

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F 502	Continued From page 38 that the PT and INR had been done weekly as ordered. 2. Resident 64 was admitted to the facility on 5/21/01 with the diagnoses of senile dementia with delusional features, cataract, hypertension, atrial fibrillation, sinoatrial node dysfunction, congestive heart failure, esophagitis and osteoarthritis. A review of resident's 64 medical record was completed on 6/15/04. An order was noted for a "Basic Metabolic Panel (BMP), PT and INR on the fourth Monday starting 1/19/04." There was no documented evidence that a PT and INR was completed for the month of April. There was no documented evidence that a BMP was completed in the month of May. An interview with the unit's nursing manager was completed on 6/15/04. She stated that the May BMP was late and was completed on 6/4/04 and that an additional one would be completed later in the month. She also stated "with the new computer system we have missed some labs and are correcting them as we go."	F 502	***The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:*** A list of labs will be run weekly (at a minimum) in order for the QA nurse and/or designee to check to ensure they are completed, with the results faxed to the physician in a timely manner. Monitoring of this procedure will be done by the DON or designee to ensure continued compliance. ***How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.*** The findings from the monitoring noted above will be reviewed at each QA meeting X 3 months, or until the QA Team feels the alleged deficiency is effectively addressed to ensure continued compliance.	
F 510 SS=D	483.75(k)(2)(i) ADMINISTRATION The facility must provide or obtain radiology and other diagnostic services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced	F 510		

F 510 8-6-09

The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:

Resident 47: Resident 47 has had a chest X-Ray obtained and results are in the chart. Results have been faxed to MD.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

A list of labs/procedures will be run weekly (at a minimum) in order for the QA nurse and/or designee to check to ensure they are completed, with the results faxed to the physician in a timely manner.

The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:

A list of labs/procedures will be run weekly (at a minimum) in order for the QA nurse and/or designee to check to ensure they are completed, with the results faxed to the physician in a timely manner. Monitoring of this procedure will

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F 510	Continued From page 39 by: Based on medical record review and interview, it was determined that the facility did not obtain radiology services to meet the needs for 1 of 21 residents (resident 47). Findings include: Resident 47 was admitted to the facility on 1/21/03 and re-admitted to the facility on 2/28/04, with diagnoses which included B-complex deficiency, senile dementia with delusions, hypertension, atrial fibrillation, backache, urinary incontinence and syncope. On 3/27/04, resident 47's physician ordered the following, "...CXR (chest x-ray) repeat in 1 week (April 2nd)..." On 5/6/04, resident 47's physician ordered the following, "...CXR (chest x-ray)..." There was no documentation in resident 47's medical record to evidence that these chest x-rays were performed as ordered. On 6/14/04 at 2:25 PM, the special needs unit manager was interviewed. She stated she called the hospital radiology department and the chest x-rays on 4/2/04 and 5/6/04 were not completed. On 6/14/04 at 3:40 PM, the special needs unit manager stated that she called resident 47's physician and he still wanted the facility to obtain a chest x-ray on resident 47.	F 510	be done by the DON or designee to ensure continued compliance. ***How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.*** The findings from the monitoring noted above will be reviewed at each QA meeting X 3 months, or until the QA Team feels the alleged deficiency continues to be in compliance.	

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F 511	Continued From page 40	F 511		
F 511 SS=D	483.75(k)(2)(ii) ADMINISTRATION The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that the facility did not promptly notify the attending physician of a Holter monitor finding for 1 of 21 sampled residents (resident 47). Findings include: Resident 47 was admitted to the facility on 1/21/03 and re-admitted to the facility on 2/28/04, with diagnoses which included B-complex deficiency, senile dementia with delusions, hypertension, atrial fibrillation, backache, urinary incontinence and syncope. Resident 47 was re-admitted to the facility with a physician's order to obtain a Holter monitor on Monday 3/1/04. On 3/6/04, resident 47's physician documented the following in a progress note, "...Holter pending..." On 3/27/04, resident 47's physician documented the following in a progress note, "...Awaiting Holter..." On 3/27/04, resident 47's physician ordered the following, "...Holter monitor approx (approximately) 1 month ago ? please get results faxed..."	F 511	**F 511** ***The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:*** **Resident 47**: Resident 47 has had holter monitor results faxed to the physician. ***How the facility will identify other residents having the potential to be affected by the same deficient practice:*** A list of labs/procedures will be run weekly (at a minimum) in order for the QA nurse and/or designee to check to ensure they are completed, with the results faxed to the physician in a timely manner. ***The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:*** A list of labs/procedures will be run weekly (at a minimum) in order for the QA nurse and/or designee to check to ensure they are completed, with the results faxed to the physician in a timely manner. Monitoring of this procedure will	8-6-04

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F 511	Continued From page 41 On 4/4/04, resident 47's physician documented the following in a progress note, "...Holter not back..." On 4/4/04, resident 47's physician ordered the following, "...Need Holter report done over a month ago. Need results faxed...Do it if not done..." On 5/6/04, resident 47's physician ordered the following, "...Holter monitor..." A review of the medical record revealed that the Holter monitor for resident 47 was completed on 3/7/04, faxed to the facility on 5/6/04 and the facility faxed the results to resident 47's physician on 5/7/04 (2 months after the Holter monitor was completed). On 6/14/04 at 2:25 PM, the special needs unit manager was interviewed. She stated that the Holter monitor which was ordered on 5/6/04 was not completed because her understanding was that resident 47's physician just wanted the results of the Holter monitor which was done in March of 2004. On 6/14/04 at 3:40 PM, the special needs unit manager stated that she contacted resident 47's physician and he just wanted the results of the first Holter monitor and did not want another Holter monitor to be completed.	F 511	be done by the DON or designee to ensure continued compliance. ***How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.*** The findings from the monitoring noted above will be reviewed at each QA meeting X 3 months, or until the QA Team feels the alleged deficiency is effectively addressed to ensure continued compliance.	

Risk Assessment Procedure

Pressure Ulcer Risk Assessment

Purpose

To assess the need to implement preventive/supportive measures.

Rationale

Use of a validated risk assessment tool (Braden Scale) will help identify individuals who are at risk for skin breakdown. It is important to remember that a risk assessment score complements, but does not substitute for, the professional's assessment of risk. When using the Braden Scale, the following guidelines for determining risk can be used:

Score 15–18	=	At Risk
Score 12–14	=	Moderate Risk
Score ≤ 11	=	High Risk
Score < 9	=	Severe Risk

Background

Measures and strategies designed to prevent the development of chronic wounds and facilitate healing of existing ulcers may include, but are not limited to:

- optimizing the resident's nutritional status
- frequent repositioning of the resident
- providing pressure redistribution, **pressure-relieving**, or repositioning devices
- protecting the skin against **shear/friction**
- keeping skin clean, dry, and well-hydrated

Pressure redistribution/**pressure-relieving devices** (**support surfaces**) may include:

- foam mattress overlays (3" to 4" thick and density of 1.3 lbs/cubic foot)
- static flotation (air or water) devices
- dynamic **support surfaces** (alternates amount of pressure/shape in a cyclical fashion, eg, alternating air-mattress or overlay)
- low-air-loss beds (interconnected fabric air pillows)
- air-fluidized beds (bed contains fine particulate matter which is fluidized by high rate of air flow)

Repositioning devices include:

- pillows (to prevent contact between knees or elevate the heels)
- foam wedges

Date effective:

Approved by:

Date:

Approved by:

Date:

Approved by:

Date:

Revised by:

Date:

Revised by:

Date:

Revised by:

Date:

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Shear/friction can be reduced by:

- maintaining the head of the bed at the lowest degree of elevation consistent with medical conditions and other restrictions
- lifting instead of sliding the resident
- protecting/lubricating the skin with creams or protective (transparent film or thin hydrocolloid) dressings

Supplies/Equipment

- Risk assessment tool, eg, Braden Scale [Abruzzese Scale, Gosnell Scale, Hemphill Scale, Norton Scale, Waterlow Scale]
- Gloves
- **Skilled nursing** visit report or resident care plan

Steps	Key points
1. Wash hands.	
2. Complete risk assessment tool.	Alterations in mobility, activity, nutrition, sensory perception, increased or decreased moisture (skin), as well as shear and **friction**, are risk factors for the development of **pressure ulcers**.
3. Apply gloves.	
4. Inspect the skin for areas of hyperemia.	Skin in areas over bony prominences is particularly prone to pressure-induced ulceration
5. Assess knowledge of the resident/caregiver related to risk of pressure ulcer development and methods of prevention.	
6. Remove gloves, wash hands.	
7. Complete risk assessment tool. Calculate total score. Complete long-term-care plan.	Possible nursing diagnoses include: Impaired Skin Integrity: high risk for; Nutrition Altered: less than body requirements or Nutrition Altered: more than body requirements; Knowledge Deficit: Noncompliance.

Date effective:

Approved by:
Date:
Approved by:
Date:
Approved by:
Date:

Revised by:
Date:
Revised by:
Date:
Revised by:
Date:

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Braden Pressure Ulcer Risk Assessment

Patient Name ____________________

Age ________ Address ____________________

Date ____________________

(Indicate appropriate numbers below)

NOTE: Bed- and chairbound individuals with impaired ability to reposition themselves should be assessed for risk of developing pressure ulcers.
Patients with established pressure ulcers should be reassessed periodically.

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited:** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	**2. Very Limited:** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	**3. Slightly Limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment:** Responds to verbal commands, has no sensory deficit which would limit ability to feel or voice pain or discomfort.	
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist:** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist:** Skin is often, but not always, moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist:** Skin is usually dry, linen only requires changing at routine intervals.	
ACTIVITY degree of physical activity	**1. Bedfast:** Confined to bed.	**2. Chairfast:** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	
MOBILITY ability to change and control body position	**1. Completely Immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited:** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited:** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitations:** Makes major and frequent changes in position without assistance.	
NUTRITION usual food intake pattern	**1. Very Poor:** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate:** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate:** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent:** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	
FRICTION AND SHEAR	**1. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction.	**2. Potential Problem:** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem:** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		

NOTE: Patients with a score of 15 - 18 are considered to be at risk of developing pressure ulcers.
(15 - 18 = at risk, 12 - 14 = moderate risk, ≤ 11 = high risk, < 9 = severe risk)

1 Braden BJ, Bergstrom N. Clinical utility of the Braden Scale for Predicting Pressure Sore Risk. *Decubitus*, 1989;2:44-51.

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Intervention Guidelines

At Risk (15-16)*

- If bedbound, reposition every 2 hours; if chairbound, reposition every hour
- Increase mobility and activity for immobile residents
- Elevate heels off bed surface and avoid skin-to-skin contact
- Keep the head of the bed at a 30-degree angle or lower unless otherwise indicated by physician or nurse
- Manage Moisture, Nutrition, and **Friction** and **Shear**
- Use pressure reduction device if bed- or chairbound

* If other major factors present, advance to next level of risk

Moderate Risk (12-14)*

- If bedbound, reposition every 2 hours; if chairbound, reposition every hour
- Increase mobility and activity as tolerated
- Elevate heels off bed surface and avoid skin-to-skin contact
- Keep the head of the bed at a 30-degree angle or lower unless otherwise indicated by physician or nurse
- Keep individual off trochanter (hip) or the wound with positioning of 30 degrees or below
- Manage Moisture, Nutrition, and **Friction** and **Shear**
- Use pressure reduction device if bed- or chairbound
- DO NOT massage bony prominences

* If other major factors present, advance to next level of risk

High Risk (≤ 11)

- Reposition in bed every 1-2 hours (supplement with small shifts in position as indicated); if chairbound, reposition every hour
- Increase mobility and activity as tolerated
- Elevate heels off bed surface and avoid skin-to-skin contact
- Use pillows and foam wedges to keep the individual in place. Do not use donut-shaped pads.
- Keep individual off trochanter (hip) or the wound with positioning of 30 degrees or below
- Keep the head of the bed at a 30-degree angle or lower unless otherwise indicated by physician or nurse
- Manage Moisture, Nutrition, and **Friction** and **Shear**
- Use pressure reduction device if bed- or chairbound
- DO NOT massage bony prominences

Severe Risk (< 9)

- Low-Air-Loss Beds and Prevention*
- Reposition in bed every 1-2 hours (supplement with small shifts in position as indicated); if chairbound, reposition every hour
- Increase mobility and activity as tolerated
- Elevate heels off bed surface and avoid skin-to-skin contact
- Use pillows and foam wedges to keep the individual in place. Do not use donut-shaped pads.
- Keep individual off trochanter (hip) or the wound with positioning of 30 degrees or below
- Keep the head of the bed at a 30-degree angle or lower unless otherwise indicated by physician or nurse
- Manage Moisture, Nutrition, and **Friction** and **Shear**
- Use pressure reduction device if bed- or chairbound
- DO NOT massage bony prominences

* Low-Air-Loss Beds do not substitute for turning schedules

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Kolob Care and Rehabilitation of St. George

Braden Scale Intervention Guidelines

At Risk (Braden scale score of 15-18):

_____ If bed bound, reposition every 2 hours; if chair bound, reposition every hour.

_____ If bed bound, place an air mattress overlay or a pressure relieving mattress on bed.

_____ If chair bound, place a gel pad in the wheel chair.

_____ Increase mobility and activity for immobile residents.

_____ Elevate heels off bed surface and avoid skin to skin contact.

_____ Keep head of bed at a 30 degree angle or lower unless otherwise indicated by physician or nurse.

_____ Manage moisture, Nutrition, and friction and shear.

_____ Refer to Restorative Nursing Program for evaluation.

_____ Educate resident regarding interventions and benefits of compliance.

_____ Use skin barrier for incontinent residents.

_____ Do Not Massage Bony Prominences.

_____ Use pillows, foam wedges, etc to keep resident in place.

Resident Name: _____ Admit Date: _____ Braden Scale Score: _____

Current pressure ulcer: _____yes _____no Referred to the wound team _____yes _____no Referred to R.D. _____yes _____no

Comments:

Nursing Signature: _____ Date: _____

Kolob Care and Rehabilitation of St. George

Braden Scale Interventions Guidelines

Moderate Risk (Braden Scale Score of 12-14)

_____ If bed bound, reposition every two hours, if chair bound, reposition every one hour.

_____ If bed bound, place an air mattress overlay, or a pressure relieving mattress on the bed.

_____ If chair bound, place a gel pad in the wheel chair.

_____ Increase mobility and activity as tolerated.

_____ Elevate heels off bed surface and avoid skin to skin contact.

_____ Keep the head of the bed at a 30 degree angle or less, unless otherwise indicated by the physician or nurse.

_____ Keep individual off trochanter (hip) or the wound with positioning of 30 degrees or below.

_____ Manage moisture, nutrition, and friction and shear.

_____ DO NOT massage bony prominences.

_____ Refer to Restorative Nursing Program for evaluation.

_____ Skin barrier for incontinent residents.

_____ Pillows, Foam wedges to keep resident in place.

_____ Keep resident off affected area.

Residents Name: _____ Admit Date: _____ Braden Scale Score: _____

Current Pressure Ulcer: ____ Yes No: ____ Referred to the wound team____yes____no Referred To R.D ____ yes ____ no

Nursing Signature: _____ Date: _____

8 of 9 pages

Kolob Care and Rehabilitation of St. George

Braden Scale Intervention Guidelines

High Risk (Braden scale score of <11):

_____ If bed bound, reposition every 2 hours; if chair bound, reposition every hour.

_____ If bed bound, place an air mattress overlay or a pressure relieving mattress on bed.

_____ If chair bound, place a gel pad in the wheel chair.

_____ Increase mobility and activity for immobile residents.

_____ Elevate heels off bed surface and avoid skin to skin contact.

_____ Keep head of bed at a 30 degree angle or lower unless otherwise indicated by physician or nurse.

_____ Manage moisture, Nutrition, and friction and shear.

_____ Refer to Restorative Nursing Program for evaluation.

_____ Educate resident regarding interventions and benefits of compliance.

_____ Use skin barrier for incontinent residents.

_____ Do Not Massage Bony Prominences.

_____ Use pillows, foam wedges, etc to keep resident in place.

_____ Low Air loss mattress overlay and prevention.

_____ Keep resident off of affected area.

Resident Name: _____ Admit Date: _____ Braden Scale Score: ____

Current pressure ulcer:____yes____no Referred to the wound team____yes____no Referred to R.D.____yes____no

Nursing Signature: _____ Date: _____

8 of 8 314 A

Kolob Care and Rehabilitation of St. George

Braden Scale Intervention Guidelines

Severe Risk (Braden scale score of <9):

_____ If bed bound, reposition every 2 hours; if chair bound, reposition every hour.

_____ If bed bound, place an air mattress overlay or a pressure relieving mattress on bed.

_____ If chair bound, place a gel pad in the wheel chair.

_____ Increase mobility and activity for immobile residents.

_____ Elevate heels off bed surface and avoid skin to skin contact.

_____ Keep head of bed at a 30 degree angle or lower unless otherwise indicated by physician or nurse.

_____ Manage moisture, Nutrition, and friction and shear.

_____ Refer to Restorative Nursing Program for evaluation.

_____ Educate resident regarding interventions and benefits of compliance.

_____ Use skin barrier for incontinent residents.

_____ Do Not Massage Bony Prominences.

_____ Use pillows, foam wedges, etc to keep resident in place.

_____ Low Air loss mattress replacement system and prevention.

_____ Keep resident off of affected area.

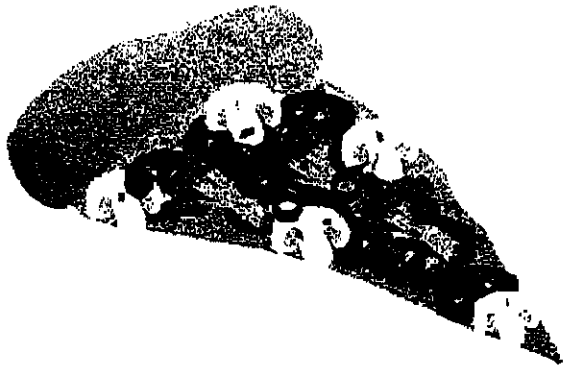
Resident Name: _____ Admit Date: _____ Braden Scale Score: _____

Current pressure ulcer:_____yes_____no Referred to the wound team_____yes_____no Referred to R.D._____yes_____no

Nursing Signature: _____ Date: _____

8+08 d 4/12

CONTEST



What: Pizza and Soda party

When: Thursday, June 3rd.

Where: Living room A

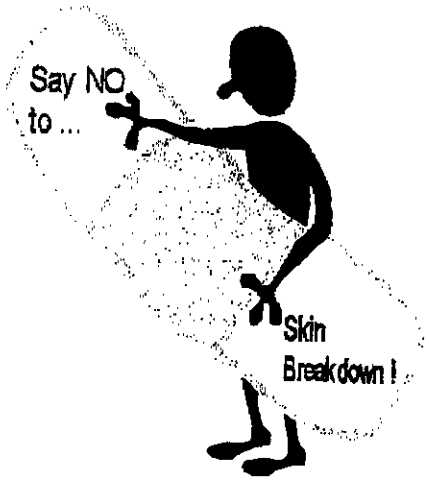
Why: To prevent skin breakdown

Who: The team who has the least number of NEW skin ulcers for the entire month of May.

In an effort to prevent further skin breakdown, and keep our patients safe and hydrated we are having a skin breakdown reducing party.

Remember...

Early intervention and reporting of Stage I wounds prevent Stage II ulcers !



There will be three teams.

Team 1: Station A

Team 2: Station B

Team 3: Legacy

Kolob Care and Rehabilitation of St. George

Be Part of the FUN

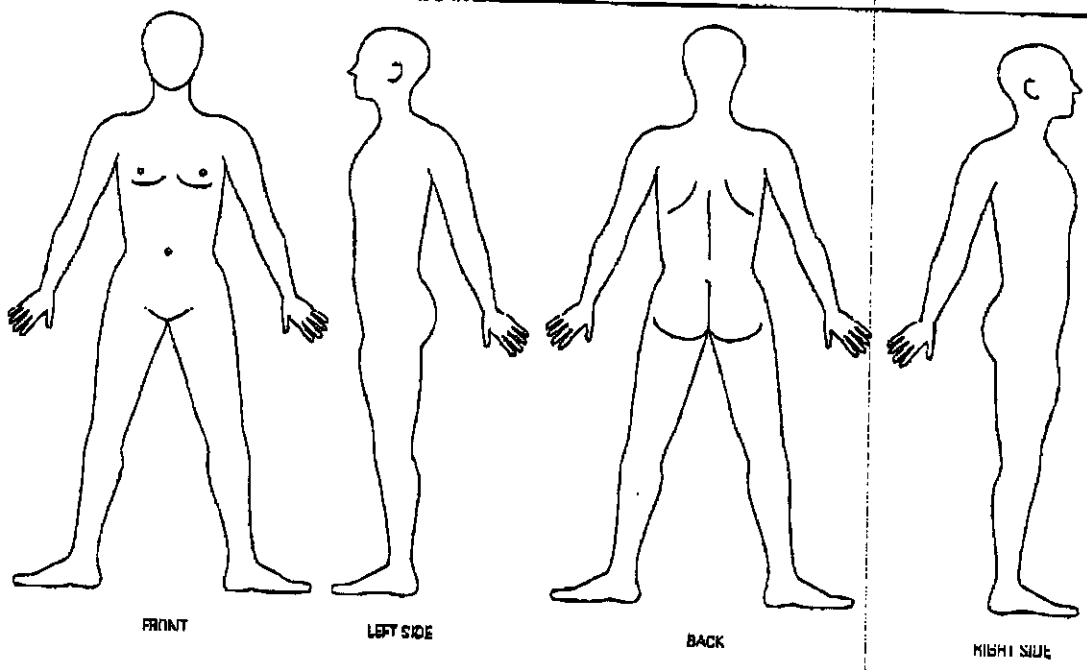
314 B

Skin Integrity Action Sheet

Resident's Name: Date:

Is there a skin integrity problem? Yes ☐ No ☐

Description:



Pressure reduction/relief mattress? Yes ☐ No ☐

CNA Signature: Date:

Dietary consult generated?	Yes ☐	No ☐	N/A ☐
Wound measurement?	Yes ☐	No ☐	N/A ☐
Wound and Skin Progress Report initiated?	Yes ☐	No ☐	N/A ☐
Turning/positioning schedule?	Yes ☐	No ☐	N/A ☐
Incontinence protocol?	Yes ☐	No ☐	N/A ☐
(ET) Nurse consult (if indicated)?	Yes ☐	No ☐	N/A ☐
Treatment order obtained via physician?	Yes ☐	No ☐	N/A ☐
PT/OT consult generated?	Yes ☐	No ☐	N/A ☐

Nurse Signature: Date:

Solutions™ Wound and Skin Management System

Issued: December 1997 Printed in USA

ConvaTec
A Bristol-Myers Squibb Company
Wound and Skin Care

314 P

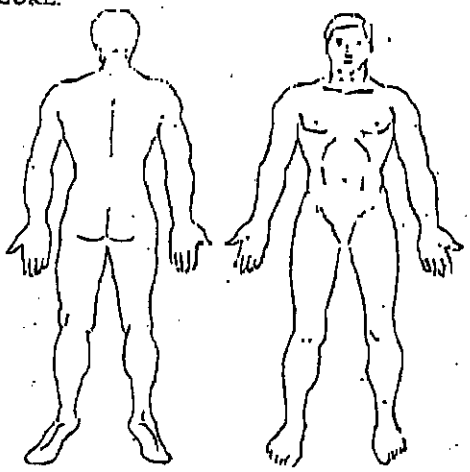
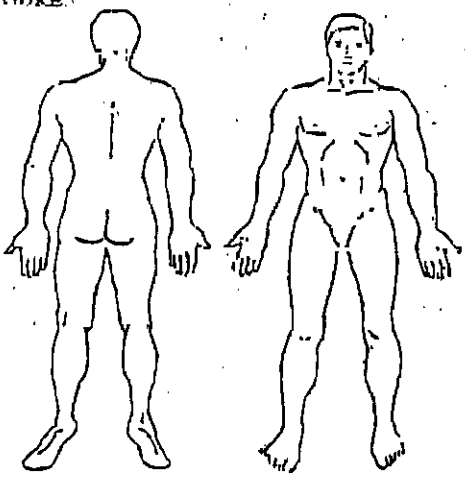
Kolob Care and Rehabilitation of St. George

C.N.A. WEEKLY BODY ASSESSMENT

MONTH: _____

PATIENT NAME: _____ **ROOM #:** _____

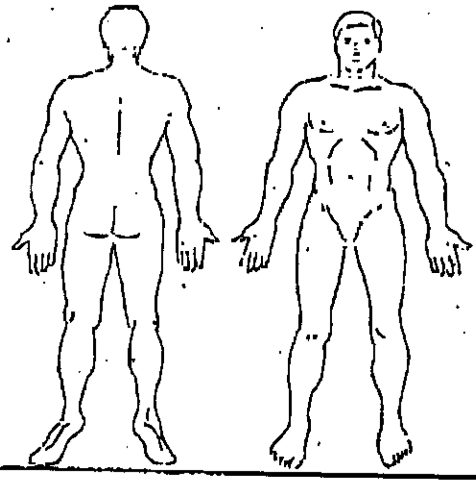
Please assess each resident weekly. Note any problems such as: Bruising, skin tears, reddened areas, painful spots/areas, scalp sores/flakes, swelling, etc. If any problems exist, the C.N.A. is responsible to report this to the nurse on duty and have them sign this assessment.

• CHECK ALL PRESSURE POINTS CAREFULLY. MARK SITE, TYPE AND APPROX. SIZE OF ANY SKIN PROBLEM ON FIGURE. 	1. **Head:** _____ 2. **Face:** _____ 3. **Neck:** _____ 4. **Arms:** _____ 5. **Chest/Abdomen:** _____ 6. **Back/Buttock:** _____ 7. **Legs:** _____ 8. **Feet:** _____ 9. **Other:** _____ _____ **C.N.A. Signature:** _____ **Nurse Signature:** _____ Date:
• CHECK ALL PRESSURE POINTS CAREFULLY. MARK SITE, TYPE AND APPROX. SIZE OF ANY SKIN PROBLEM ON FIGURE. 	1. **Head:** _____ 2. **Face:** _____ 3. **Neck:** _____ 4. **Arms:** _____ 5. **Chest/Abdomen:** _____ 6. **Back/Buttock:** _____ 7. **Legs:** _____ 8. **Feet:** _____ 9. **Other:** _____ _____ **C.N.A. Signature:** _____ **Nurse Signature:** _____ Date:

Assessments for Week 3, 4, and 5 are on reverse side.

314 D

- CHECK ALL PRESSURE POINTS CAREFULLY. MARK SITE, TYPE AND APPROX. SIZE OF ANY SKIN PROBLEM ON FIGURE.



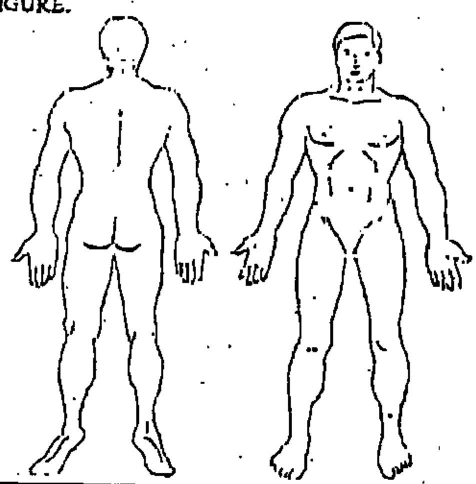
1. Head: __________
2. Face: __________
3. Neck: __________
4. Arms: __________
5. Chest/Abdomen: __________
6. Back/Buttock: __________
7. Legs: __________
8. Feet: __________
9. Other: __________

C.N.A. Signature: __________

Nurse Signature: __________

Date:

- CHECK ALL PRESSURE POINTS CAREFULLY. MARK SITE, TYPE AND APPROX. SIZE OF ANY SKIN PROBLEM ON FIGURE.



1. Head: __________
2. Face: __________
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6. Back/Buttock: __________
7. Legs: __________
8. Feet: __________
9. Other: __________

C.N.A. Signature: __________

Nurse Signature: __________

Date:

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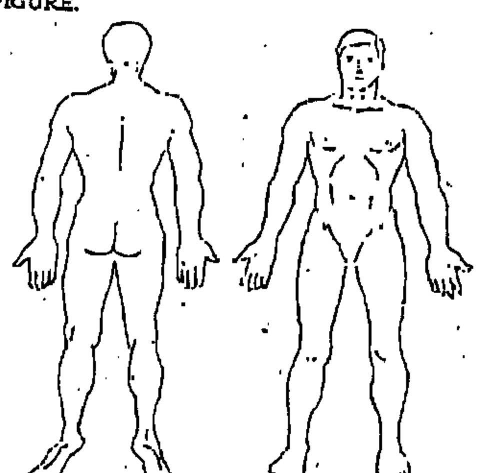

1. Head: __________
2. Face: __________
3. Neck: __________
4. Arms: __________
5. Chest/Abdomen: __________
6. Back/Buttock: __________
7. Legs: __________
8. Feet: __________
9. Other: __________

C.N.A. Signature: __________

Nurse Signature: __________

Date:

SKIN SAVER PROGRAM

TURN AND REPOSITION
EVERY TWO HOURS
10 AND 4 – FACE THE DOOR
2 AND 8 – LAY ME STRAIGHT
6 AND NOON – FACE THE MOON

SKIN SAVER PROGRAM

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EVERY TWO HOURS
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6 AND NOON – FACE THE MOON

314 E p1 of;

WAYS TO PREVENT WOUNDS

OFFER FLUIDS EVERY TIME YOU
ANSWER A CALL LIGHT.
REPORT WOUNDS IMMEDIATELY
PROP FEET ON PILLOWS, BETWEEN LEGS
AND BEHIND BACK.
ENCOURAGE MEALS AND SUPPLEMENTS.

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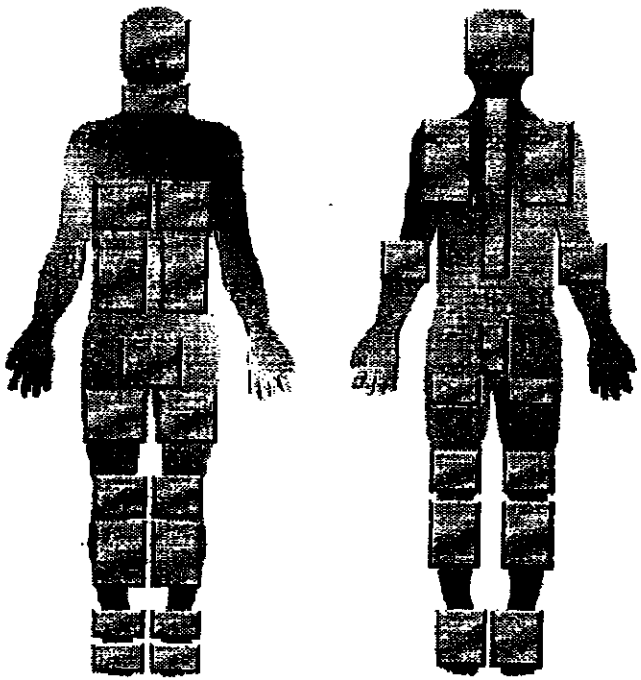
314E p2of2



R Front L L Rear R

Patient Name: _____ Location _____

Reported by: _____ Date: _____

Received by: _____ RN/LVN Date: _____

KCI USA, Inc. 1-888-275-4524 • Skin Saver Program
White: Tx Nurse • Yellow: DON/CG Nurse • Pink: CNA

KCI
The Clinical Advantage®

CNA Skin Saver Program

3 Steps to Early Intervention

1. Full Body Check
2. Record Findings and note areas on diagram
3. Report Findings to Charge Nurse or DON

KCI USA, Inc.1-888-275-4524 • Skin Saver Program

3/4 F

Nutrition Assessment for Pressure Ulcers

Nutrient Needs for Pressure Ulcers

Nutrient Needs: Based on individual assessment	Prevention	Stage I	Stage II	Stage III	Stage IV (or Unstageable***)
Calories/kg body weight*	28-30 30-35 if additional calories needed	30-35	30-35	35-40	35-40
Protein, grams/kg body weight to promote a positive nitrogen balance	1.0 1.0-1.2 if additional protein needed	1.0-1.2 Up to 1.5 if additional protein needed	1.0-1.5	1.0-1.5 Up to 2.0 (Monitor renal function/hydration)	1.0-1.5 Up to 2.0 (Monitor renal function/hydration)
Fluids, cc/kg body weight**	30	30-33	30-33	30-33	30-33
Vitamins/Minerals *if* deficiencies are confirmed or suspected: • Multivitamin & mineral supplement (up to 100% USRDI)	• Daily	• Daily	• Daily	• Daily • Reevaluate in 2-6 weeks.	• Daily • Reevaluate in 2-6 weeks.
• Zinc sulfate 220mg bid	• NA	• NA	• NA		

* **Note:** Alternate method of calculation: BEE X Activity Factor X Injury Factor of 1.2-1.6

****Note:** 1 mL/calorie or 1500 mL minimum per day. Additional 10-15 cc/kg body weight fluids needed for draining wounds, air fluidized beds, fever

***Unstageable may be defined as pressure ulcers with eschar and/or necrotic tissue covering wound; deep tissue injury (may appear as a stage I, but has underlying damage or necrotic underlying tissue, such as boggy or mushy heels, etc.)

Sources: AHCPR, NPUAP, CMS