OK

POC is acceptable [signature] 11/07/01

10/31/01 HT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 10/11/
FORM APPROVE
2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465116	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 9/27/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN NURSING & REHAB CENTER	1480 N 400 E LOGAN, UT 84321

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F 221 SS=E	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the medical record, it was determined that the facility did not assess or reassess the use of physical restraints, identify a medical symptom that would warrant the use of physical restraints, or engage in a systematic and gradual process towards reducing restraints for 7 of 19 sample residents. (Residents 28, 68, 69, 92, 93, 95, 105) Findings include: 1. Resident 93 was admitted to the facility on 2/25/00 with diagnoses of fractured femur, coronary artery disease, atrial fibrillation, dementia, anemia, urinary incontinence and degenerative joint disease. The resident's medical record was reviewed on 9/24/01. A physician's order, dated 4/24/00, documented the resident was to have 2 siderails (bedrails) up while in bed. A physician's order, dated 11/21/00, documented the resident was to use a lap buddy (a trunk restraint) for postural support. The physician's orders did not document a medical symptom that would warrant the use of physical restraints for resident 93. Review of resident 93's annual MDS (minimum data set) assessment, dated 3/7/01, indicated the following: Section G, 1a., Bed mobility: The resident was totally dependent on 2 staff to be able to move to and from a	F 221	**Note:** On October 22, 2001 the Quality Assurance Committee met, under the direction of the A.D.O.N. (committee chair), and participated in the following plan of correction. The Q.A. committee will meet on a regular basis to insure positive outcome and progress of the plan. This will be accomplished by committee members reviewing documentation, quality indicators, resident charts and direct resident observation. Direct care staff will quickly receive feed back and recommendation from the committee members, including the D.O.N., A.D.O.N., D.S.D and R.A.C. **F. 221** **Specific Resident Resolve:** **Resident 93;** The resident has been assessed. The assessment indicated that lap buddies are utilized as positional devices. The use of side rails have been discontinued. The M.D.S. has been updated. The resident consent form has been signed. **Resident 92;** Assessment has been completed for the use of side rails and lap buddies. Side rails will not be utilized. The lap buddys has been assessed as a positioning device. The M.D.S. has been updated and the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: Oct. 31, 2001

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is 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 221	Continued From Page 1 lying position, turn side to side, and to position her body while in bed. Section G, 1b, Transfer: The resident was totally dependent on 2 staff to move to and from the bed, chair, wheelchair, and standing position. Section G, 6., Modes of transfer: The resident transferred by being lifted manually. The resident was not assessed as requiring bed rails for bed mobility or transfer. Section P, 4a., Devices and Restraints: Full bedrails on all open sides of the bed, used daily. There was no documentation that the resident had been assessed for the use of a trunk restraint (lap buddy) per the physician's order, dated 11/21/00. The Resident Assessment Protocol Summary (RAPS) for this comprehensive assessment did not document the problem of physical restraints for resident 93. Review of resident 93's quarterly MDS, dated 6/6/01, indicated Section G, 1a. and b., and Section P4a., were assessed and documented the same as on the 3/7/01 MDS. Review of the resident's current quarterly MDS, dated 9/5/01, indicated the following: Section G, 1a., Bed mobility: The resident was now assessed as being totally dependent on only 1 staff to be able to move to and from a lying position, turn side to side, and to position her body while in bed. Section G, 6., Modes of transfer: The resident was now assessed as using bedrails for mobility and transfer. Section P4, Devices and Restraints: Documentation of the assessment indicated the resident did not use any bedrails or a trunk restraint. On 9/26/01 at 11:00 AM, the resident was observed to require total assist by 2 staff to transfer her from the bed to the wheelchair, then to the toilet, back to the	F 221	consent form signed. **Resident 68;** The assessment has been completed. Although restraints are not necessary, the resident has requested side rails be utilized for bed mobility. The M.D.S. has been corrected and consent forms signed. **Resident 69;** The assessment has been completed. The resident has requested that side rails be utilized. The M.D.S. has been updated and the consent form signed. **Resident 28;** The resident has been assessed and determined that no restraints are necessary. Bed rails are used for resident bed mobility. The M.D.S. has been corrected and the consent form signed. **Resident 105;** The resident has been discharged to a facility closer to family in Wyoming. **Resident 95;** Assessment has been completed for the resident. Due to the fact that the resident is able to remove the lap buddies independently, it is used as a positioning device, not a restraint device. The M.D.S. has been updated and the resident consent form signed.	

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F 221	Continued From Page 2 wheelchair, and back to bed. The resident was not observed to have the ability to use the siderails for transfers or for mobility. The resident's care plan was reviewed. The care plan problem for physical restraints, including goals and interventions were not care planned. The facility documented the resident's use of the side rails and lap buddy under interventions on the resident's Fall Risk Care Plan, dated 9/5/01. The interventions were: "...Resident has the following: (Must have MD order) Side rails to prevent falling out of bed...Lap buddy in wheelchair to prevent pitching forward out of w/c (wheelchair). Family agrees to it's use. NSG (nursing)/family aware of possible neg. (negative) outcomes r/t (related to) sr (siderail) & lap buddy use. Staff monitor for safety & positioning. Release q (every) 2 hrs (hours) for toileting & repositioning." These interventions were documented as being updated on 9/25/01. The resident's Care Plan Conference Summaries for the dates of 3/7/01, 6/6/01, and 9/5/01 were reviewed. The interdisciplinary team did not document that they assessed or reassessed the use of physical restraints, identified a medical symptom that would warrant the use of physical restraints, or engaged in a systematic and gradual process towards reducing restraints for resident 93. Resident 93 was observed to be in a wheelchair with a lap buddy in place on the following dates: 9/25/01 at 7:40 AM while being transported to the dining room. 9/25/01 at 8:15 AM sitting at the nurse's station. 9/26/01 at 7:45 AM in the resident's room. 9/26/01 at 9:15 AM sitting at the nurse's station Resident 93 was observed to be in bed with 1 siderail	F 221	The physical restraint/device program has been revised to include; the assessment tool, risk vs. benefit, restraint education, I.D.T. review, and consent form. See Exhibit A. The assessment will be completed by the attending nurse prior to placement of restraint or device. The assessment will be reviewed by the A.D.O.N. for accuracy and completeness. The inter disciplinary team (I.D.T.) will review each resident on the program on a quarterly basis. It will be the responsibility of the A.D.O.N. to insure implementation of this plan of correction. The A.D.O.N. will also coordinate reporting and outcome review on a regular basis with the Q.A. committee. The administrator will insure over all compliance with this plan of correction through review of residents on the program and regular attendance at the Q.A.C. meetings. Date of completion is November 20, 2001.	

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F 221	Continued From Page 3 up and the other side of the bed positioned against the wall for the dates: 9/24/01 at 8:45 AM and 3:10 PM. 9/25/01 at 9:00 AM and 2:30 PM. 9/26/01 at 10:15 AM and 2:30 PM. The surveyor did not observe both siderails to be in the upright position while the resident was in bed during the survey. A facility consent form, dated 6/2/01,was reviewed. The following was documented: "I consent to the use of siderail as a physical restraint. I understand that a restraint is being used for the following reasons: to prevent independent movement out of bed. I understand that the restraint will be used when (the) resident is in bed..." The form listed the negative aspects of restraint use. The facility staff had signed the form, however, the area for the resident's signature or the family member's signature and date were left blank. There was no consent form for the resident's lap buddy found in the resident's medical record. The DON (director of nurses) and the ADON (assistant director of nurses) were interviewed on 9/26/01. The ADON stated they did not consider resident 93's siderails and lap buddy as restraints and that she was unaware that they still needed to be assessed. 2. Resident 92 was admitted to the facility on 3/23/00 with diagnoses of dementia, vitamin B12 deficiency, urinary retention, left inguinal hernia, and edema. The resident's medical record was reviewed on 9/24/01. A physician's order, dated 4/24/00, documented the resident was to have 2 siderails up while in bed. A physician's order, dates 2/14/01, documented the resident was to use a lap buddy for	F 221		

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F 221	Continued From Page 4 postural support. The physician's orders did not document a medical symptom that would warrant the use of physical restraints for resident 92. Review of resident 92's annual MDS assessment, dated 4/3/01, indicated the following: Section G, 1a., Bed mobility: The resident required extensive assistance of 1 staff person to move to and from a lying position, to turn side to side, and position his body while in bed. Section G, 1b., Transfer: The resident required extensive assistance of 2 staff to move to/from bed, chair, wheelchair, and standing position. Section G, 6, Modes of transfer: The resident was assessed as being able to use the bedrails for mobility and transfer and that he required a manual lift for transfer. Section P,4a., Devices and Restraints: Full bedrails on all open sides of bed, used daily. There was no documentation that the resident had been assessed for the use of a trunk restraint (lap buddy). Review of resident 92's quarterly MDS, dated 7/3/01, indicated the following: Section G, 1a., Bed Mobility: The resident now required extensive assistance of 2 staff to move to and from a lying lying position, to turn side to side, and position his body while in bed. Section P,4a., Devices and Restraints: Full bedrails on all open sides of bed, used daily. There was no documentation that the resident had been assessed for the use of a trunk restraint (lap buddy) per the physician's order, dated 2/14/01. The resident's care plan was reviewed. The care plan problem for physical restraints, including goals and interventions were not care planned. The facility documented the resident's use of the side rails and lap buddy under interventions on the resident's Fall Risk	F 221		

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F 221	Continued From Page 5 Care Plan, updated 7/3/01. The interventions were: "...8. S/R (siderail) (up) while in bed to prevent falling OOB (out of bed). NSG (nursing) staff to monitor for safe positioning while in bed Q 30 minutes. 9. Lap buddy in w/c to prevent pitching forward out of wheelchair. Family agrees to the use of lap buddy and is aware of possible negative outcomes r/t use of lap buddy." Review of the facility's Fall Risk Checklist form for the dates 4/3/00, 4/18/01, and 7/8/01, indicated documentation of "0" for a history of falls. The resident's Care Plan Conference Summaries for the dates of 1/3/01, and 7/3/01, were reviewed. The interdisciplinary team did not document that they assessed or reassessed the use of physical restraints, identified a medical symptom that would warrant the use of physical restraints, or engaged in a systematic and gradual process towards reducing restraints for resident 92. Resident 92 was observed to be in a wheelchair with a lap buddy in place on the following dates: 9/25 at 7:45 AM and 12:00 PM, while being transported to the dining room. 9/26/01at 8/00 AM, while being transported to the dinning room. Resident 92 was observed to be in bed with 1 siderail up and the other side of the bed positioned against the wall for the dates: 9/24/01at 8:45 AM and 3:10 PM. 9/25/01at 9:00 AM and 2:30 PM. 9/26/01 at 10:15 AM and 2:30 PM. The surveyor did not observe both siderails to be in the upright position while the resident was in bed during the survey. 3. Resident 68 was a 57 year old male admitted to this	F 221		

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F 221	Continued From Page 6 facility with diagnoses of quadriplegia, seizure disorder, hypertension, depression, diabetes, asthma, a stage IV pressure sore and a history of pressure sores. Review of resident 68's MDS, dated 7/16/01, revealed that this was an initial assessment after a readmission from the hospital. Section G1-a&b, identified resident 68 as being totally dependent requiring a two or more person physical assist for bed mobility and transfer. Section G3, identified resident 68 as not able to attempt balance while standing, sitting, and was unable to maintain trunk control. Section G4, identified resident 68 as having partial functional loss in his neck, arms, hands, legs, and feet. Section G5, identified resident 68 as requiring a manual or mechanical lift for transfers. Section G6, does not identify resident 68 as having a need for bed rails for mobility or transfer. Section P4, identified resident 68 as using full bed rails on all open sides of the bed. Every observation of resident 68 in bed, between the dates of 9/24/01 to 9/27/01, revealed that resident 68's bed rails were up at all times while he was in bed. The bed was positioned against the wall. On 9/26/01, observation of the transfer of resident 68 from his bed to his wheelchair, revealed that a Hoyer lift, a mechanical lifting device, was used to transfer resident 68 into his wheel chair. Observation of resident 68, during the dressing change on 9/26/01, revealed that resident 68 was not able to use the bed rails when turning. Review of resident 68's medical record revealed that there was no assessment done by the facility for the use of bed rails as a restraint or as an aid to bed mobility. There was no documentation in resident 68's medical record that the risks and benefits of the bed	F 221		

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F 221	Continued From Page 7 rails had been discussed with the resident. There was no consent, signed by the resident, that allowed the facility to use bed rails on his bed. There was no care plan problem addressing the need for bed rails or the risks involved in using rails. 4. Resident 69 was a 32 year old female admitted to this facility with diagnoses of quadriplegia, seizure disorder, degenerative joint disease, depression, anxiety, a stage IV pressure sore and a history of pressure sores. Review of resident 69's MDS, dated 11/7/00, revealed that it was an admission review assessment. Section G1-a&b, identified resident 69 as being totally dependent requiring a two or more person physical assist for bed mobility and transfer. Section G3, identified resident 69 as not able to attempt balance while standing, sitting, and an inability to maintain trunk control. Section G4, identified resident 69 as having partial or full functional loss in her arms, hands, legs, and feet. Section G5, identified resident 69 as requiring a manual or mechanical lift for transfers. Section G6, does not identify resident 69 as having a need for bed rails to assist with mobility or transfer. Section P4, identified resident 69 as using full bed rails on all open sides of the bed. Review of resident 69's medical record revealed that there was no assessment done by the facility for the use of bed rails as a restraint or as an aid to bed mobility. There was no documentation in resident 69's medical record that the risks and benefits of the bed rails had been discussed with the resident. There was no consent, signed by the resident, that allowed the facility to use bed rails on resident 69's bed. There was no care plan problem addressing the need for bed rails or the risks of using them.	F 221		

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F 221	Continued From Page 8 Every observation of resident 69 in her bed between the dates of 9/24/01 to 9/27/01, revealed that while resident 69 was in bed, both bed rails were up continuously and the bed was positioned against the wall. On 9/25/01, an observation of resident 69 being transferred, revealed that a Hoyer lift, a mechanical lifting device, was used to transfer resident 69 from her bed to her wheel chair. Observation of resident 69 during a dressing change on 9/26/01, revealed that resident 69 was not able to use the bed rails to assist her in turning and positioning for the dressing change. 5. Resident 28 was admitted to the facility on 6/14/96, with diagnoses of spinal stenosis, constipation, status post femur fracture, severe osteoporosis, and chronic adjustment disorder with depressed mood. A review of the resident's medical record was done. The physician's re-certification orders, dated September, 2001 and signed by the physician, did not document an order for side rails to be used while the resident was in bed. Review of resident 28's annual MDS assessment, dated 5/9/01, indicated the following: Section G, 1b., Transfer: The resident was identified as requiring limited assistance to move from the bed to the wheelchair. Section G, 6., Modes of Transfer: The resident was identified as being bedfast all or most of the time. It was also documented the resident was transferred by being lifted manually or by using a transfer aide (e.g. slide board, trapeze, cane walker or brace). The resident was observed to have a trapeze above her bed. The resident was not assessed as requiring bed rails for bed mobility or transfer.	F 221		

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F 221	Continued From Page 9 Section P, 4a., Devices and Restraints: There was no documentation that full rails on all open sides of the bed were being used daily. Review of resident 28's quarterly MDS, dated 8/15/01, indicated the following: Section G, 1b., Transfer: The resident was identified as requiring extensive assistance to move from the bed to the wheelchair. Section G, 6., Modes of Transfer: The resident was identified as being bedfast all or most of the time. The resident was not assessed as requiring bed rails for bed mobility or transfer. Section P, 4a., Devices and Restraints: The resident was identified as using full bed rails on all open sides of the bed daily. The resident's care plans were reviewed. There was no documented care plan, including goals and interventions, addressing physical restraints. The facility documented the use of resident 28's side rails on the Fall Risk Care Plan, dated 8/13/01. The interventions were: "... Resident has the following: (Must have MD order) side rails". On 9/24/01 resident 28 was observed in bed with both side rails up at 3:18 PM and 4:21 PM. On 9/25/01 resident 28 was observed in bed with both side rails up at 7:38 AM, 8:05 AM, 8:47 AM, 10:07 AM, 10:32 AM, 12:25 PM, 1:13 PM, 1:44 PM, 2:08 PM, 2:32 PM, 3:01 PM and 3:36 PM. On 9/26/01 resident 28 was observed in bed with both side rails up at 7:48 AM, 8:31 AM, 9:11 AM, 10:18 AM, 10:57 AM and 3:03 PM. On 9/27/01 resident 28 was observed in bed with both side rails up at 7:55 AM, 9:21 AM, 10:45 AM, and	F 221		

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F 221	Continued From Page 10 1:52 PM. Review of resident 28's medical record revealed that there was no assessment done by the facility for the use of bed rails as a restraint or as an aid to bed mobility. There was no documentation in resident 28's medical record that the risks and benefits of the bed rails had been discussed with the resident. There was no documentation that the resident had given consent for the facility to use bed rails on resident 28's bed. 6. Resident 105 was admitted to the facility on 6/14/96 with diagnoses of urinary tract infection, dementia, cerebrovascular accident, and degenerative joint disease right knee. A review of the resident's medical record was done. A physician's order, dated 9/11/01, documented the resident was to use a lap buddy to prevent falls. A physician's order, dated 9/18/01, documented resident 105, "may have lap buddy for postural support". A review of resident 105's initial 5 day Medicare assessment MDS, dated 9/14/01, indicated the following: Section G 1b., Transfer: The resident was identified as requiring limited assistance to move from the bed to the wheelchair. Section G 3., Test for Balance: The resident was identified as being unsteady, but able to rebalance self without physical support while in a sitting position and with trunk control. Section P, 4a., Devices and Restraints: The resident was identified as using a chair that prevents rising. Resident 105's care plans were reviewed. There was no documented care plan, including goals and interventions, addressing physical restraints. The	F 221		

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F 221	Continued From Page 11 facility documented the use of resident 105's lap buddy on the Fall Risk Care Plan, dated 9/14/01. The interventions were, "... Resident has the following: (Must have MD order) Bed Alarm, Lap Buddy... use of lap buddy discussed [with] family, family aware of possible complications/risks associated [with] use of lap buddy". On 9/24/01, at 4:21 PM and 4:38 PM resident 105 was observed in her wheelchair without the physician ordered lap buddy in place. The lap buddy was observed in the resident's room. On 9/25/01, at 7:40 AM, 8:08 AM, 10:09 AM, 12:27 PM, 12:45 PM, 1:11 PM, 1:44 PM, 2:30 PM, 3:00 PM and 3:36 PM resident 105 was observed in her wheelchair without the physician ordered lap buddy in place. The lap buddy was observed in the resident's room. On 9/26/01, at 7:45 AM, 8:30 AM, 8:54 AM, 9:31 AM, 10:27 AM and 3:13 PM resident 105 was observed in her wheelchair without the physician ordered lap buddy in place. The lap buddy was observed in the resident's room. On 9/27/01, at 7:57 AM and 10:45 AM resident 105 was observed in her wheelchair without the physician ordered lap buddy in place. The lap buddy was observed in the resident's room. An interview with the DON (director of nursing) on 9/25/01 at 4:45 PM during the daily exit conference with the facility was done. He stated that resident 105's lap buddy was to be used whenever she was not under direct care staff supervision. A review of resident 105's medical record revealed that there was no assessment done by the facility for	F 221		

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F 221	Continued From Page 12 the use of a lap buddy as a restraint or as an aid to prevent falls or for postural support. There was no documented evidence that the interdisciplinary team assessed the use of physical restraints or identified a medical symptom that would warrant the use of physical restraints for resident 105. 7. Resident 95 was admitted to the facility on 3/8/01 with diagnoses of cholecystitis, senile dementia of the Alzheimer's type, atherosclerotic heart disease and hypertension. A review of the medical record was done. A physician's order, dated 9/17/01, documented resident 95, "may use lap buddy in w/c [wheelchair] for postural support". The physician re-certification orders, dated September, 2001 and signed by the physician, did not document an order for side rails to be used while the resident was in bed. Review of resident 95's initial 30 day Medicare MDS assessment, dated 4/6/01, indicated the following: Section G, 1a., Bed Mobility: The resident was identified as requiring two persons to physically assist him with positioning while in bed. Section G, 1b., Transfer: The resident was identified as requiring two persons to physically assist him from the bed to the wheelchair. Section G, 6., Modes of Transfer: The resident was identified as being lifted manually. It was also documented the resident was transferred by being lifted manually or by using a transfer aide (e.g. slide board, trapeze, cane walker or brace). The resident was not assessed as requiring bed rails for bed mobility or transfer. Section P, 4a., Devices and Restraints: The resident was identified as using full bed rails on all open sides of the bed.	F 221		

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F 221	Continued From Page 13 A review of resident 95's quarterly MDS, dated 6/20/01, indicated Section G, 1a. and b., and Section P 4a., were assessed and documented the same as on the 4/6/01 MDS. Section G6, documented the resident used bed rails for bed mobility or transfer. Resident 95's care plans were reviewed. There was no documented care plan, including goals and interventions, addressing physical restraints. The facility documented the use of resident 95's lap buddy on the Fall Risk Care Plan, dated 9/17/01. The approaches were, " lap buddy in w/c [wheelchair] for postural support... remove lap buddy for toileting [and repositioning and for periods of supervised activities...possible negative outcomes have been discussed [with] family [and] family agrees to use of lap buddy". Resident 95's use of two full side rails was not care planned. On 9/26/01 at 3:33 PM, resident 95 was observed in his room with his lap buddy in place on his wheelchair. On 9/27/01 at 8:22 AM, resident 95 was observed lying in bed with both side rails up and one side of the bed against the wall. On 9/27/01, at 10:40 AM and 1:10 PM, resident 95 was observed in the hallway with his lap buddy in place on his wheelchair. A review of resident 95's medical record revealed that there was no assessment done by the facility for the use of a lap buddy as a restraint or for postural support. There was no assessment done by the facility for the use of bed rails as a restraint or as an aid to bed mobility. There was no documentation in resident 95's medical record that the risks and benefits of the bed rails had been discussed with the resident or the resident's family. There was no documentation that the	F 221		

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F 221	Continued From Page 14 resident or the resident's family gave consent for the facility to use bed rails on resident 95's bed or for the use of a lap buddy. There was no documented evidence that the interdisciplinary team assessed the use of physical restraints or identified a medical symptom that would warrant the use of physical restraints for resident 95.	F 221		
F 241 SS=E	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: 2. On 9/25/01, at 12:55 PM, observation revealed the call light signaling above the door of room 203. Six staff members were observed to walk down the hall toward the light signal, but turned just prior to the room, down another hall. At 1:04 PM, a nurse aid entered room 203 to assist the residents. There was a nine minute wait, for the residents in room 203, before they received assistance from facility staff. 3. On 9/25/01, at 1:18 PM, observation revealed the call light signaling above the door of room 109. Two staff members were conversing outside the residents' room. At 1:21 PM, one of the staff who worked in the laundry, went into room 109 and turned off the call light. The staff member was not observed to assist the residents. The staff member exited the room, and crossed the hall to another resident's room. She was not observed to contact nursing staff concerning the residents' need for assistance. At 1:25 PM, the resident in room 109, again turned on her call light for assistance. At 1:34 PM, a staff member entered room	F 241	**F. 241** On October 10th and 25th, mandatory staff inservices were held. The staff were reminded of the importance of call light response. Constant announcements and staff reminders are given by management personnel on a daily basis. Nursing Administration and selected department heads will randomly check call light response times. Disciplinary action will be taken for staff members who fail to answer call lights adequately. This topic will continue to receive emphasis at monthly staff meetings and during staff orientation. The Director of Staff Development (D.S.D.) is responsible to implement this plan of correction. The D.S.D. will also report to the Q.A.C. on a monthly basis on effectiveness of the plan. The administrator is responsible to insure completeness to this plan through regular reports through the D.S.D. and direct observation of call	

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F241	Continued From Page 15 109 to assist the resident. There was a total of sixteen minutes from the time the resident in room 109 first turned her call light on until she received assistance with her needs. Based on observations and comments made in the confidential group meeting it was determined that the facility did not provide care for the residents in a manner that maintained each resident's dignity and respect in full recognition of his or her individuality as evidenced by staff failing to answer call lights in a timely manner. Room identifiers 109, 203, 209, 239 Findings include: 1. On 9/26/01 at 8:34 AM, observation revealed a call light signaling above the doorway to room 239 and at the nursing station. At that time, a licensed staff member was observed to be passing medications in the hallway two doors down from room 239. At 9:53 AM, a nurse aide was observed to enter room 239 and respond to the call light. This was 19 minutes after the surveyor observed the call light on in the hallway. 4. On 9/26/01 at 10:42 AM, room 209's call light was observed to light up at the nurse's station and beep. There was also a light above the door of Room 209, signaling a request for assistance had been made. The call light was on for nine minutes when a nursing assistant was observed to walk into room 209 at 10:51 AM and turned the light off. 5. A confidential interview was held with a group of residents on 9/26/01 at 9:37 AM. Thirteen residents participated in the interview. Six (6) of the 13 residents stated that they have had to wait too long for their call light to be answered. One resident stated she has had to wait up to 40 minutes for her call light to be answered. One resident stated she has had to wait over a half hour before her call light was answered.	F 241	light response. Date of completion is November 20, 2001	

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F 246 SS=E	483.15(e)(1) QUALITY OF LIFE A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, 3 residents (Resident identifiers 28, 39 and 72) did not receive services in the facility with reasonable accommodations for their individual needs and preferences in regards to their ability to physically access their room call lights. Findings include: 1. On 9/25/01 at 8:05 AM, observation of resident 28, in room 30, revealed the resident was in bed. The resident's call light was observed to be on the floor beside the bed and unaccessible to her. On 9/25/01 at 10:07 AM, 10:32 AM, 12:25 PM, 1:44 PM, 2:08 PM, 2:32 PM, 3:01 PM and 3:36 PM, observation of resident 28, in room 30, revealed the resident was in bed. The call light was observed to be sitting in a chair beside the bed five feet away from the resident and out of reach. On 9/27/01 at 7:55 AM, observation of resident 28, in room 30, revealed the resident was in bed. The resident's call light was observed to be on the floor beside the bed and unaccessible to her. A review of resident 28's quarterly MDS (minimum data set), dated 8/15/01, identified her as requiring a	F 246	**F. 246** **Specific Resident Resolve:** **Resident 28, 39, and 72;** The residents call cords have been positioned correctly from bed, chair and wheelchair. The call cords will be monitored closely by the direct resident care staff. The staff were inserviced on October 10th and 25th on the importance of call cord placement. Reminders will be given to staff on a regular basis by the D.S.D. The D.S.D. will make random room checks on a regular basis to check for proper placement. The staff will be regularly reminded by the D.S.D. to anticipate the needs of those residents who are physically or mentally unable to utilize the call light system. The D.S.D. is responsible to implement this plan of correction as well as reporting to the Q.A.C. on progress and compliance. The administrator is responsible for compliance to this plan of correction. Date of completion is November 20, 2001.	

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F 246	Continued From Page 17 two person physical assist with transfers. The resident was able to verbalize appropriate use of the call light when interviewed 9/27/01 at 7:55 AM. A review of resident 28's Fall Risk Care Plan, dated 8/13/01, documented problems including, history of falls with injury, history of multiple falls without serious injury, generalized weakness due to age and decreased visual acuity. Goals listed for this problem included, " Staff/resident to practice injury prevention measures for Resident TNR [through next review]." A documented intervention to address the problem of falls was listed as, "Call light in reach respond promptly". 2. On 9/24/01 at 3:25 PM, observation of resident 39, in room 114, revealed the resident in bed with side rails up. The resident's call light was observed to be on the floor and unaccessible to her. On 9/25/01 at 1:35 PM, 2:32 PM and 4:10 PM, observation of resident 39, in room 114, revealed the resident in bed with side rails up. The resident's call light was observed to be on the chair and unaccessible to her. On 9/26/01 at 9:24 AM, 10:55 AM, 11:15 AM, 2:15 AM and 4:00 PM, observation of resident 39, in room 114, revealed the resident was in bed with the side rails up. The resident's call light was observed to be on the chair and unaccessible to her. A review of resident 39's quarterly MDS (minimum data set), dated 9/19/01, identified her as requiring a one person physical assist with transfers. On 9/21/01, resident 38 had a score of 18 on her fall risk checklist which reflects a risk for falls and need for an appropriate plan of care to be developed. Resident 38's fall risk care plan was dated 9/19/01 and identified the following problems: history of multiple	F 246		

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F 246	Continued From Page 18 falls, unsteady gait, cognitive loss, generalized weakness, decreased visual acuity and ambulation with assistance only. Two of the interventions listed on the fall risk care plan for resident 38 were to assist with transfers and to have "call light in reach respond promptly". 3. Observations revealed the following: On 9/25/01 at 12:20 PM, observation of resident 72, in room 222, revealed the resident was in her gerichair. The resident's call light was observed to be on the floor and unaccessible to her. On 9/25/01 at 2:00 PM, observation of resident 72, in room 222, revealed the resident was in bed with the side rails up. The resident's call light was observed to be on the floor and unaccessible to her. On 9/26/01 at 9:30 AM and 11:05 AM, observation of resident 72, in room 222, revealed the resident was in bed with side rails up. The resident's call light was observed to be on the vacant bed in the room and unaccessible to her. A review of resident 72's 30 day admission MDS, dated 8/17/01, identified her as requiring a two person physical assist with transfers. On 7/19/01, resident 72 had a score of 14 on her fall risk checklist which reflects a risk for falls and for an appropriate plan of care to be developed. Resident 72's fall risk care plan was dated 8/7/01 and identified the following problems: generalized weakness, non-ambulatory and the medical condition of a CVA (cerebral vascular accident). Two of the interventions listed on the fall risk care plan for resident 72 were to assist with transfers and to have "call light in reach respond promptly".	F 246		

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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 the facility did not ensure that comprehensive assessments (including the RAI or resident assessment instrument) of the residents' needs were completed within 14 days after the facility determined, or should have determined, that there had been a significant change in the resident's physical or mental condition. Significant change assessments were not completed for 2 residents (who had experienced declines according to he quarterly assessments) of 19 sampled residents reviewed. Residents identifiers 28 and 9.

Finding include:

RESIDENT 28:

A review of resident 28's medical record completed on 9/25/01, revealed the following:

1. Resident 28 was admitted on 6/14/96 with diagnoses including spinal stenosis, severe

F 274

F. 274
Specific Resident Resolve:
Resident 28 and 9; Assessments have been completed for the residents. The M.D.S. has been corrected, negating the need for a "significant change".

The M.D.S. coordinator is responsible to ensure that comprehensive assessments are completed within 14 days after determination of a significant change. Staff assigned to complete certain sections of the M.D.S. have been formalized to eliminate subjective and differing assessment of residents. Nursing Administration (D.O.N., A.D.O.N., D.S.D. and R.A.C.) have been assigned one of four specific halls to serve as case manager. They will provide information to the R.A.C. to assist in resident assessment for the M.D.S. The R.A.C. is responsible to implement this plan of correction. The D.O.N. and Administrator is responsible to ensure compliance to the plan by reviewing the M.D.S. with the R.A.C. on a regular basis. Date of completion is November 20, 2001

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F 274	Continued From Page 20 osteoporosis, and chronic adjustment disorder with depressed mood. 2. On 5/9/01, an annual comprehensive MDS (minimum data set) assessment was completed for resident 28. On 8/15/01, a quarterly MDS assessment was completed for the resident. 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 changes included: The resident had a documented decline in Transfer: a. MDS (5/9/01) Section G1 Transfer (2 = Limited assistance needed). b. MDS (8/15/01) Section G1 Transfer (3 = Extensive assistance needed). The resident had a documented decline in Dressing: a. MDS (5/9/01) Section G1 Dressing (2 = Limited assistance needed). b. MDS (8/15/01) Section G1 Dressing (3 = Extensive assistance needed). The resident had a documented decline in Toilet Use: a. MDS (5/9/01) Section G1 Toilet Use (2 = Limited assistance needed). b. MDS (8/15/01) Section G1 Toilet Use (3 = Extensive assistance needed). The resident had a documented decline in Personal	F 274		

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Hygiene:

a. MDS (5/9/01)
Section G1 Personal Hygiene (2 = Limited assistance needed).
b. MDS (8/15/01)
Section G1 Personal Hygiene (3 = Extensive assistance needed).

RESIDENT 9

A review of resident 9's medical record was completed on 9/26/01and revealed the following:

1. Resident 9 was an eighty four year old female admitted on 05/27/01, with the following diagnoses: fever, osteopenia, altered mental status, chronic dementia and aggressive features.

2. On 11/15/00 and 2/14/01, quarterly MDS (minimum data set) assessments were completed on resident 9. A comparison of the two assessments documented a significant change in the resident's condition. These significant changes triggered the need for a full comprehensive MDS assessment to be done. The areas that documented significant changes included:

The resident had a documented decline in locomotion off the unit:

a. MDS (11/15/00)
Section G1f. Locomotion off the unit (1=supervision needed).
b. MDS (2/14/01)
Section G1f. Locomotion off the unit (4=total dependence on staff).

The resident had a documented decline in bowel

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F 274	Continued From Page 22 Continence: a. MDS (11/15/01) Section H1b. Bowel Continence (0=Continent with complete control) b. MDS (2/14/01) Bowel Continence (3=Frequently incontinent but some control still present) The resident had a documented decline in that she now needed to use devices and restraints: a. MDS (11/15/01) Section P4e. Chair prevents rising (0=Not used) b. MDS (2/14/01) Section P4e. Chair prevents rising (2=Used daily) The resident had a documented decrease in the frequency of behaviors: a. MDS (11/15/00) Section E4a. Wandering (3=behavior of this type occurred daily) b. MDS (2/14/01) Section E4a. Wandering (0=behavior not exhibited in the last 7 days) a. MDS (11/15/00) Section E4d. Socially inappropriate/disruptive behaviors (1=behavior occurred 1 to 3 days in the last 7 days) b. MDS (2/14/01) Section E4d. Socially inappropriate/disruptive behaviors (0=behavior not exhibited in last 7 days) a. MDS (11/15/00) Section E4e. Resists Care (1=behavior of this type occurred 1 to 3 days in last 7 days) b. MDS (2/14/00) Section E4e. Resists Care (0=Behavior not exhibited	F 274		

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F 274	Continued From Page 23 in last 7 days) Comprehensive MDS assessment were not done to reflect resident 28 an 9's significant changes.	F 274		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 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, medical record review, and interview, the facility did not provide the necessary care and services to attain or maintain the highest practicable physical well-being for three of nineteen sampled residents, as evidenced by: Observation, on 9/26/01, of two dressing changes on two residents (68) (69) with stage IV pressure sores revealed potential cross contamination of the wounds and the potential for destruction of viable tissue. Review and observation of one resident (72), with a history of pressure sores, revealed that the resident was not turned and repositioned routinely in accordance with physician orders and facility policy. Client 72 did not maintain adequate hydration after admission to the facility and was admitted with hypoalbumenia for which dietary interventions were not implemented in a timely manner. Resident identifiers 68, 69, 72 Findings include:	F 309	**F. 309** **Specific Resident Resolve:** **Resident 68:** The nurse observed during wound rounds has been re-educated on proper dressing change technique. The resident is continually educated about the risks of non-compliance and their significant impact on wound healing including but not limited to: poor diet, refusal of turning and positioning, sitting in wheelchair for prolonged periods of time, refusing showers or whirlpools and refusing Foley catheter changes. **Resident 69:** The nurse observed during wound rounds has been re-educated on proper dressing change technique.The resident is continually educated about the risks of non-compliance and their significant impact on wound healing including but not limited to: poor diet, refusal of turning and positioning, sitting in wheelchair for prolonged periods of	

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1. Resident 68 was a 57 year old male admitted to this facility with diagnoses of quadriplegia, seizure disorder, hypertension, depression, diabetes, asthma, chronic obstructive pulmonary disease, stage IV pressure sore and a history of decubitus ulcers.

Review of resident 68's recertification orders revealed that there was a physician's order written on 7/30/01, for a dressing change to the resident's stage IV pressure sore. The physician's orders said to pack kaltostat, (an alginate product to keep the wound bed moist), to the perineal wound bed and cover with one half abdominal pad, secure with hypafix tape and change twice a day.

During observation on 09/26/01, of the dressing change to resident 68's stage IV pressure sore, on his perineum, the nurse was observed to press the kaltostat material into the wound with enough force to cause resident 68's body to move from the side lying position to a partially prone position (stomach lying).

Review of the facility's skin care and pressure ulcer record for resident 68, on 9/23/01, identified his wound measurements as 4 centimeters wide by 2 centimeters long by 6 centimeters deep. The measurements obtained during the dressing change observation on 9/26/01, were 4.5 centimeters wide by 4 centimeters long by 7 centimeters deep. The stage IV pressure sore had increased in size and depth within one week.

2. Resident 69 was a 32 year old female admitted to this facility with diagnoses of quadriplegia, seizure disorder, degenerative joint disease, depression, anxiety, and a history of decubitus sores with a stage IV pressure sore present.

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time and refusing showers and/or peri-care.

Resident 72;
Nursing administration reviews charting daily for documentation of turning and positioning, meal percentages, intake and output, bowel status, signs of adequate hydration and proper pressure relief intervention. Weekly checks are done for weights and wound team rounds. Resident discharged to home 10/28/01.

At inservices held on October 10th and 25th, direct care staff received in-depth training on the facility's "Prevention of Skin Breakdown Program". The importance of adhering to the program and proper documentation was stressed. The nursing staff were alsoeducated on the proper use of terminology related to bowel care.

The D.S.D. will give training to all newly hired employees regarding wound care, prevention and documentation. Reminders will be given to staff at each monthly inservice on the importance of following the program and documentation. The A.D.O.N. will

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F 309	Continued From Page 25 Review of resident 69's recertification orders revealed a physician's order for a dressing change to resident 69's stage IV pressure sore on her coccyx. The physician's order said to pack the wound with Nugauze and cover with an abdominal pad, and tape with hypafix tape. Nugauze is an absorbent wound packing that measures one fourth to one half inch in width, and is packaged in a sterile bottle. The Nugauze is packed into the wound with a small amount left outside the wound opening. This allows better contact with the drainage in a wound for absorption, and less traumatic removal with dressing changes. During observation on 09/26/01,of the dressing change to resident 69's stage IV pressure sore, on her coccyx, the nurse was observed to remove the packing from the wound. It was noted at this time that the packing had greenish, yellow drainage on it which was malodorous. The nurse cleansed the wound with normal saline from a syringe. Observation revealed that the nurse used a 4x4 gauze to dry the saline. She wiped over the vaginal area, over the rectum, and used the same 4x4 to dry around and in the wound bed. The nurse gloved with clean gloves. She placed the Nugauze packing into the wound with her gloved hand by gathering it in a bunch. The nurse used a six inch Q-tip to press the Nugauze packing into the wound. The nurse was observed to use enough force to cause resident 69's body to move from the side lying position to a partially prone position. Review of resident 69's facility skin care and pressure ulcer record, on 9/20/01, identified her wound as measuring 1 centimeter wide by 3 centimeters long by 5 centimeters deep. The director of nursing stated that the review of the 9/26/01 skin care and pressure ulcer record, identified resident 69's wound with measurements of 3 centimeter wide by 1 centimeter long by 4.5 centimeters deep. The stage IV pressure	F 309	continue to perform weekly wound checks on all residents on the program, checking for healing progress, documentation, etc. As Q.A.C. chairperson, the A.D.O.N. will report findings to the Q.A.C. on a monthly basis and implement suggestions given by committee members. The A.D.O.N. and D.O.N. are responsible for implementation of this plan of correction. The Administrator is responsible for compliance of this plan of correction. This will be accomplished by receiving weekly verbal reports from the A.D.O.N. and D.O.N., attendance at monthly Q.A.C. meetings and periodic review of resident specific documentation. Date of completion is November 20, 2001	

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F309	Continued From Page 26 sore had more than doubled in width within one week. Review of the facility, wound prevention and resolution policy, revealed that the objectives of all wound assessments and treatments specified: granulation, contraction and epithelialization as the main objectives of wound treatment. Contamination of the packing material and aggressive packing of the wound could prevent the wound from healing. 3. Resident 72 was a 68 year old female, who was admitted to the facility on 7/19/01 with the diagnoses of CVA (cerebral vascular accident) with right hemiparesis, old CVA with dense left hemiplegia, dysarthria, aphasia, dysphagia, hypertension, agitation, Foley catheter for urinary retention, early decubitus ulcer and UTI (urinary tract infection). a. Turning and positioning of Resident 72: The medical record for resident 72 was reviewed on 9/25/01. The admission orders on 7/19/01, instructed the facility to implement decubitus precautions for this resident due to the prior decubitus ulcer, history of decubitus ulcers and history of hypoalbuminemia. The physicians history and physical examination, dated 7/15/01, stated that resident 72 "had some problems with bedsores and apparently does not use a bedside commode." There was the diagnosis of hypoalbuminemia (level of 3.0 gram per deciliter) and there were early decubitus ulcers on her buttocks. The physician included in his report that resident 72 had a history of decubitus ulcers and low albumin. The nursing history and admission assessment, dated 7/19/01, stated that resident 72 had been bedridden for 17 years and had a "h/o [history of] breakdown needs, DQ [decubitus] precautions", "abrasion." On that	F 309		

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F 309	Continued From Page 27 assessment an arrow was pointing to the left buttock of a body diagram. On the nursing admission assessment, under special skin routines, it read, "turn and reposition q (every) 2 hours." The Braden Scale, initiated by the facility on admit, scored resident 72 as a 12, which placed her at high risk for developing pressure ulcers. The MAR's (medication administration records) for July, August and September had decubitus precautions written as a FYI (for your information). The facility's wound prevention and resolution policy indicated that residents scoring less than 17 (hers was 12) on the Braden scale would be placed on the preventative skin program. The residents on the preventative program should have had the following: "a. turn schedule b. pressure reducing devices (air mattresses, gel pads, heel boot's, hand rolls, etc.) c. dietary consult (increase fluid intake, supplements, nutritional needs) d. MD consult (for serum albumin level and protective creams, possible multivitamin) e. podiatry consult (for foot deformities, decreased pedal pulses, and diabetes) f. PT [physical therapy] consult for special equipment or mobility training g. proper footwear evaluation h. toileting routine i. family notification and consult" In addition to the facility wound prevention and resolution policy, the 5 day admission MDS (minimum data set), dated 7/26/01, the 14 day MDS for 8/01/01 and the 30 day MDS for 8/17/01 documented under M5c for skin treatments, that resident 72 was on a turning and repositioning program. The care plan for skin integrity, dated 8/07/01 had "reposition resident q 2 hr. [hours] in bed / chair" as one of the interventions.	F 309		

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F 309	Continued From Page 28 The facility had a nursing form for documenting turning and positioning for residents on a turn schedule. The CNA's (certified nursing assistant) would initial the form every time the resident was turned. Resident 72 did not have this form in her medical record or the current month's CNA documentation book. On 9/27/01 at 8:30 AM, during an interview with the DON (director of nursing), he stated that there was a documentation problem but that the resident had been turned every two hours by staff members. The D.O.N. also stated that sometimes the nurses documented that resident 72 was turned in their nurse's notes. The nurse's notes documented turning resident 72 every 2 hours on the following dates: 7/24/01 day shift 7/25/01 night shift 7/26/01 day shift 7/30/01 night shift 7/31/01 day shift 8/04/01 night shift 8/14/01 night shift 8/18/01 night shift 8/19/01 night shift 8/29/01 day shift 8/31/01 day shift 9/05/01 night shift 9/06/01 night shift 9/08/01 night shift 9/10/01 night shift 9/12/01 day shift 9/12/01 night shift 9/15/01 night shift 9/18/01 night shift 9/19/01 day shift 9/20/01 day shift 9/24/01 night During further medical record review, on 9/27/01, a	F 309		

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F 309	Continued From Page 29 nursing turn sheet was found in the CNA's documentation book that was not there on 9/25/01 or 9/26/01. The turn sheet had initials on it for 9/25/01 at 2:00 AM, 4:00 AM and 6:00 AM; the rest of the month of September was blank. From the time of admission on 7/19/01 to 9/25/01 the facility documented that they followed their preventative skin breakdown protocol by turning resident 72 for, 8 of 69 day shifts and 14 of 69 night shifts. Resident 72 was observed on 9/25/01 at the following times in the same position: 2:00 PM positioned on her back, in bed, in semi-fowlers position. 2:30 PM positioned on her back, in bed, in semi-fowlers position. 4:10 PM positioned on her back, in bed, in semi-fowlers position. On 9/26/01, resident 72 was observed the following times in the same position: 8:10 AM, positioned on her back, in bed, in semi-fowlers position. 9:30 AM, resident was on her back, in bed, in semi-fowlers position. At this time the nurse surveyor was with the assistant DON and another staff member to observe pressure ulcers and dressing changes. Resident 72 had a pillow under each arm and a pillow under her knees. The staff member rolled the head of the bed down flat and turned resident 72 onto her right side, to change her coccyx dressing. The surveyor observed resident 72's pressure ulcer on the coccyx that was a stage II and measured 1.5 x 1 cm (centimeter) with a pink wound base. The stage II pressure ulcer on resident 72's left elbow measured 1 x 1 cm and had a yellow wound base. After the dressing change the resident was turned onto her back and the head of the bed was left flat. The surveyor left the	F 309		

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F 309	Continued From Page 30 room and continued to make skin rounds with the staff. At 11:05 AM, resident 72 remained on her back, in bed with the head of the bed flat. On 9/25/01, review of the 14 day RAPS (resident assessment protocol summary), dated 8/01/01, documented that resident 72 had problems in the area's of cognitive loss, communication, ADL (activities of daily living) function, urinary incontinence and indwelling catheter, mood state, activities, nutritional status, dehydration/fluid maintenance, pressure ulcers and psychotropic drug use. b. Dietary Concerns on Resident 72: The facility's wound prevention and resolution policy indicated that dietary consultation and recommendations be completed. Resident 72 was admitted with a dysphagia diet or puree diet. The nutritional assessment by the dietitian, dated 7/30/01, recommended a supplement TID (three times per day) due to "Skin is intact but does have a history of skin breakdowns. Labs appears significant for inadequate fluid intake. Meal intakes are fair. She is at nutritional risk related to: requires assistance at meals, unable to make needs known and dysphagia related to stroke." The care plan dated 8/07/01, for skin integrity had an intervention listed of "maintain adequate nutrition and hydration". Dietary consult on 9/17/01, recommended that resident 72 get 1.4 grams of protein per day or 82 grams of protein per day, high protein milk, supplement, multivitamin, vitamin C 500 mg (milligrams), 220 mg of Zinc Sulfate due to her "stage II & III skin breakdown on elbows & coccyx". A doctor's order was dated 9/17/01, as "dietitian consult: recommend 120 cc supp [supplement] TID, MVI [multivitamin] q day, 500 mg Vit [vitamin] C, 220 mg Zinc Sulfate". The September MAR reflected that the dietitian's initial recommendation for supplement was	F 309		

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F 309	Continued From Page 31 implemented on 9/24/01 at 5:00 PM; this was 56 days after the recommendation. On 9/25/01, according to the September MAR, the multivitamin and the Zinc Sulfate was given 8 days after the dietitian had recommended these supplements. The dietary needs of resident 72 for pressure ulcers were not followed in a timely manner. According to the Clinical Practice Guideline, Number 15 Treatment of Pressure Ulcers, "When the nutritional assessment confirms that the individual is malnourished, the first intervention consists of assisted oral feeding and oral supplements. A second assessment should be done within 3 working days to determine whether intake goals have been achieved (U.S. Department of Health and Human Services, Agency for Health Care Policy and Research, 1994; pp. 29-30). Hydration and Constipation Concerns on Resident 72: The nutritional assessment dated 7/30/01, completed by the dietitian, stated: "labs significant for inadequate fluid intake"; the recommended fluid intake for resident 72 was 1700 to 1800 milliliters per day. Resident 72's bowel and bladder assessment dated for 9/17/01 revealed no history of constipation, use of enemas or laxatives prior to admission. The documentation for July's bowel movement tracking was on the nursing history and admission assessment, which stated that resident 72 had a bowel movement on 7/19/01 prior to admission. No other documents of bowel movement tracking could be found in the facility for the month of July. The MAR for July had orders for tracking intake and output, and Colace (stool softner)100 mg PO [by mouth] BID [twice per day]. The 5 day MDS, dated 7/26/01 and the 14 day MDS, dated 8/01/01, triggered RAP [resident assessment protocol] problem areas as followed: cognitive loss, communication, ADL [activities of daily living] function, indwelling catheter, mood state,	F 309		

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F 309	Continued From Page 32 activities, nutritional status, dehydration/fluid maintenance, pressure ulcers and psychotropic drug use. The care plan for bladder elimination dated, 8/07/01, listed the following interventions: monitor I & O [intake and output], encourage fluids, monitor for signs and symptoms of dehydration. The care plan for bowel elimination dated for 8/07/01, identified a problem of constipation and had interventions listed as follows: identify factors that contribute to constipation, record color, odor, amount, and frequency of stool and monitor patterns of bowel incontinence. The care plan for bowel elimination was the first medical record documentation to identify a problem with constipation for resident 72. On 8/09/01, in the nursing notes and doctors orders, it was documented that an order for Dulcolax suppository PR PRN [per rectum as needed] for constipation was obtained by the nursing staff from the physician. The August MAR had an FYI [for your information] to "Push fluids", dated 8/31/01. The MARs for July, August and September reflect that resident 72 did not get the recommended fluid intake per day of 1700 ml for 58 days. The MARs also reflect that client 72 had an inadequate urine output for 43 days of the 58 days since her admission. Inadequate urinary output is defined as less than 30 ml per hour or less than 720 ml per day which could be an indicator of dehydration. According to Smeltzer and Bare's 7th edition of Medical Surgical Nursing, 1992; "after fluid volume deficit has fully developed, the kidneys attempt to conserve needed body fluids, leading to a urinary output less than 30 ml per hour in an adult" pg. 312. The nursing notes for day shift, dated 9/04/01 stated, "Mouth dry with slight bleeding at gums. Mouth care with lemon glycerin swabs done". The total fluid intake for 9/03/01 was 420 ml and the total fluid intake for 9/04/01 was 120 ml which was an insufficient amount of intake for resident 72, who weighed 128 pounds. In the nursing notes on 9/05/01 for day shift, the nurse noted, "Lethargic. Pt	F 309		

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[patient] also has a dry mouth, which petroleum jelly was applied et water intake increased today. We are to give pt more fluids." The total fluid intake for 9/05/01 was 60 ml and total urine output was 400 ml. Resident 72 was given a Dulcolax suppository on 9/05/01 according to the MAR and midnight nursing notes. The last bowel movement documented was on the CNA flow sheet, dated 8/31/01, for diarrhea prior to the lethargic episode on 9/05/01. On the monthly summary nursing notes, dated for 8/19/01, "B.M. [bowel movement] q 3 days receives dulcolax supp PR PRN. - effective" was documented for nursing care plan number six. The following are dates of constipation that were extrapolated from the CNA flow sheets and the nurse's notes:

Dates of constipation	total number of days
8/01/01 to 8/07/01	7
8/17/01 to 8/23/01	7
8/24/01 to 8/31/01	8
9/01/01 to 9/05/01	5
9/06/01 to 9/10/01	5
9/14/01 to 9/21/01	8

According to the nurse's notes and the MARs, the following were dates that the dulcolax suppositories were administered:

8/14/01	9/05/01
8/15/01	9/09/01
8/23/01	9/21/01
8/30/01	

The following were documented incidents of fecal impaction in the nursing notes:

8/15/01 "Constipation continues - rectal check - medium semi-soft B.M. manually removed another dulcolax supp PR for remaining stool higher up in

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F 309	Continued From Page 34 colon that can not be disimpacted." 8/23/01 Stool: "formed round, brown some digitally removed by nurse" "Pt digitally checked for impaction. Small impaction noted with hard brown for med [medium] stool. PRN Dulcolax suppository given. Pt hasn't had any results yet from suppository being given. Pt had not had a BM for 6 days prior to digital removal. Will continue to monitor." 9/20/01 "Dulcolax supp. PR for constipation - pending results. Rectum checked colon full of formed BM - manually removed mod. [moderate] soft formed BM unable to reach more BM higher up." The following were observations of resident 72 with dry lips, dry tongue, poor skin turgor and dark yellow urine with residue in foley catheter: 9/25/01 at 8:00 AM, 2:00 PM, 2:30 PM and 4:10 PM 9/26/01 at 8:10 AM, 9:30 AM and 11:05 AM On 9/27/01 at 8:30 AM, during an interview with the DON, he stated that the fluid intake of client 72 was actually better than what was documented. The DON stated that resident 72 had clear, yellow urine and appeared to be hydrated. On 9/27/01 at 9:00 AM, the surveyor observed resident 72 to have clear yellow urine in foley catheter and she appeared to have red moist lips. On 9/10/01, there was a physician's order to change colace to sorbitol 30 ml PO qd but the colace was not discontinued on the September MAR and was continued to be initialed as given to resident 72 by the facility nursing staff.	F 309		

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	465116	A. BUILDING ______ B. WING ______	9/27/01

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F 323 SS=E	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 of resident rooms and interview with staff it was determined that the facility did not ensure that the resident environment remained as free of accident hazards as is possible. Fifty two of 84 resident over bed light fixtures observed during survey had been modified by the facility. Extenders had been attached which allowed bare standard light bulbs or halogen bulbs to extend out of the metal light fixture cover. The light bulbs were positioned so they rested close to the wallpaper posing a fire hazard or hazard from the bare bulb shattering over the residents bed. Three resident rooms had blackened areas on the wall where the wall covering was scorched. Resident rooms: 106B, 110B, 112A, 102A, 102B, 112B, 110A, 114B, 113B, 116A, 116B, 117A, 117B, 119A, 119B, 118A, 118B, 121A, 122A, 124A, 124B, 126A, 128B, 134B, 136A, 136B, 131B, 127A, 127B, 125A, 125B, 205A, 205B, 207B, 209A, 212B, 214A, 214B, 213A, 213B, 216A, 216B, 217A, 217B, 218A, 218B, 222A, 223A, 223B, 226B, 227A, 227B. Findings include: 1. Observations of the resident rooms on 9/26/01, between 11:15 AM and 12:00 PM revealed the following: Several rooms had rectangular metal light fixtures attached to the wall above the head of the residents' bed. The fixtures were designed to hold two standard light bulbs positioned inside the metal frame cover. Extenders were in place which allowed the bare light	F 323	**F. 323** The light fixtures in the resident rooms are listed not to exceed 75 watts. Five 100 watt bulbs were located in the building and replaced with 40 watt halogen bulbs. The scorched areas in rooms 106B, 110B, and 112B have been repaired. The extended halogen light is needed to produce the code required lumens. The halogen bulb does not produce sufficient heat to pose as a safety hazard. The Maintenance Engineer will not purchase or allow to be purchased, bulbs exceeding 75 watts. The administrator is responsible to ensure completion to this plan of correction by reviewing light bulb inventory and light bulbs in rooms on a periodic basis. Date of completion is November 20, 2001	

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F 323	Continued From Page 36 bulbs or halogen type light bulbs to extend out of the fixture. The bulbs were resting close to the surface of the wall paper. a. North Wing Three resident rooms 106B, 110B and 112B had round dark brown scorch marks on the wall paper near the light fixtures. Other rooms observed with either a standard light bulb or halogen light bulb which extended outside the fixture were: 102A, 102B, 112B, 110A, 114B, 113B, 116A, 116B, 117A, 117B, 119A, 119B, 118A, 118B, 121A, 122A, 124A, 124B, 126A, 128B, 134B, 136A, 136B, 131B, 127A, 127B, 125A, 125B. b. South Wing Rooms observed with bulbs extending outside of the light fixture were: 205A, 205B, 207B, 209A, 212B, 214A, 214B, 213A, 213B, 216A, 216B, 217A, 217B, 218A, 218B, 222A, 223A, 223B, 226B, 227A, 227B. 2. Interviews were conducted with the maintenance man and the administrator on 09/26/01. a. An interview was conducted with the maintenance man when scorch marks were observed in room 106B. He stated that the facility was in the process of changing the standard light bulbs in the fixtures to halogen light bulbs which did not radiate as much heat. He indicated that the standard light bulbs used should be no higher wattage than 60. The two light bulbs extending out of the metal light fixture cover in Room 106B were observed to be 100 watt bulbs. b. An interview was conducted with the facility administrator during which he indicated that the	F 323		

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F 323	Continued From Page 37 facility had placed extenders in the existing light fixtures to provide more light at the residents' bed side for reading or other activities. They were in the process of switching to halogen bulbs to reduce heat production. He was unaware of what wattage bulb should be used in the fixtures.	F 323		
F 431 SS=E	483.60(d) PHARMACY SERVICES Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This REQUIREMENT is not met as evidenced by: Based on observation of the 100 and 200 hall medication refrigerators, and staff interview, it was determined that 2 of 2 medication refrigerators contained expired medications. Findings include: 1. On 9/25/01, the 100 hall medication refrigerator was checked and found to have the following expired medications: 1 box of Compazine suppositories 25 mg. (milligram) with an expiration date of 4/01. 1 box of Compazine suppositories 25 mg with an expiration date of 6/01. 1 box of Acetaminophen suppositories 650 mg with an expiration date of 6/01. 2. On 9/25/01, the 200 hall medication refrigerator was checked and found to have the following expired medications: 1 box containing 4 pneumococcal vaccines with	F 431	**F. 431** All expired medications have been removed from the medication refrigerators and Medication rooms. The nursing staff were reminded of the disposing of outdated medication policy in staff inservice meeting on October 10, 2001. The D.O.N. will be responsible to check for and remove any outdated medications on a monthly basis. The Administrator will be responsible to ensure compliance to this plan by spot checking medication errors and reviewing correction plan with D.O.N. on a monthly basis. Date of completion is November 20, 2001	

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F 431	Continued From Page 38 the expiration date of 6/01. 1 vial of Influenza A&B vaccine with the expiration date of 6/01. There were also 2 containers of unopened normal saline on the shelf in the 200 hall medication room with the expiration date of 8/01. 3. In an interview on 9/25/01 with a nurse on the 100 hall, the nurse stated she was unaware that there were expired medications in the 100 hall medication refrigerator. The nurse stated the night shift nurses routinely checked for expired medications in the medication refrigerators. 4. The Nursing 99 Drug Handbook, Springhouse Corporation, Springhouse, Pennsylvania copyright 1999, page 12 states, "When using a drug prescribed for occasional or prolonged use, check the container for an expiration date. Discard any drugs that are outdated or no longer needed."	F 431		
F 514 SS=D	483.75(l)(1) ADMINISTRATION The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This REQUIREMENT is not met as evidenced by: Based on medical record review, the facility did not maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete, accurately documented, readily accessible; and systematically organized; as evidenced by: Three of nineteen sampled residents	F 514	**F. 514** **Inservice meetings were held on October 10th and 25th enforcing with the staff the importance of documentation. Nursing Administration check on a frequent basis the documentation of clinical record including but not limited to, I and O's, turn schedules, frequency of B.M.'s, etc. on "at risk" residents. The D.S.D. will emphasize documentation in each orientation and training sessions held**	

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E514	Continued From Page 39 had medical records that were incomplete in the documentation of turning and repositioning, monitoring of pressure sore size and stage, and frequency of bowel movements. Resident identifiers 68, 69, 72 Findings include: 1. Resident 68 was a 57 year old male admitted to this facility with diagnoses of quadriplegia, seizure disorder, hypertension, depression, diabetes, asthma chronic obstructive pulmonary disease, and a stage IV pressure sore. Review of resident 68's care plan revealed a care plan problem #6 stating that the resident had a pressure sore on his perineum. The goals was to prevent worsening of that wound and prevention of a new pressure sore. One of the interventions was to turn and reposition at least every two hours and as needed. Review of resident 68's nursing turn sheet, initiated by the facility, for the month of July, 2001, revealed the following lack of documentation that resident 68 was turned every two hours: 1. July 3 - from 1:00 PM until 4:00 PM 2. July 4 -from 11:00 AM until 9:00 PM 3. July 5- from 7:00 AM until 5:00 PM 4. July 7- from 7:00 AM until 1:00 PM 5. July 8- from 7:00 AM until 11:00 AM 6. July 9- from 3:00 PM until 6:00 AM 7. July 10- from 3:00 PM until 8:00 PM 8. July 11- from 7:00 AM until 10:00 AM 9. July 12- from 3:00 PM until Midnight 10. July 13- from 6:00 AM until 9:00 AM and from 3:00 PM until 7:00 PM 11. July 14- from 7:00 AM until 9:00 AM 12. July 15- from 5:00 PM until 6:00 AM	F 514	with staff. Inservice reminders will be given frequently throughout the year. The D.O.N. will be responsible for follow-up and ensuring implementation to this plan for correction. The D.O.N. will also report progress to the Q.A.C.. The Administrator is responsible for compliance to this plan of correction by reviewing progress with Nursing Administration and checking resident documents on a regular basis. Date of completion is November 20, 2001	

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F 514	Continued From Page 40 13. July 16- from 12:00 AM until 6:00 AM 14. From July 17 until July 31 there was no documentation available Review of resident 68's nursing turn sheet, initiated by the facility, for the month of August, 2001, revealed the following lack of documentation that resident 68 was turned every two hours: 1. August 4- from 12:00 AM until 6:00 AM 2. August 8- from 4:00 PM until 10:00 PM 3. August 14- from 4:00 PM until 10:00 PM 4. August 16- from 12:00 AM until 6:00 AM 5. August 26- from 12:00 AM until 6:00 AM 6. August 27- from 8:00 AM until 2:00 PM 7. August 31- from 8:00 AM until 2:00 PM 2. Resident 69 was a 32 year old female admitted to this facility with diagnoses of quadriplegia, seizure disorder, degenerative joint disease, depression, anxiety, gastroesophageal reflux disorder, and a stage IV pressure sore. Review of resident 69's care plan revealed care plan problem #2 to address a stage IV pressure sore on her coccyx. The problem identified its goal as prevention of further skin breakdown and that the present pressure sore would heal. One intervention for the care plan problem was to do weekly skin assessments. to evaluate the pressure sore by the wound team. Review of the facility policy for wound prevention and resolution, revealed that for each pressure sore the licensed nurse would be responsible to measure the wound at regular intervals and chart the progression of wound closure. Review of resident 69's weekly skin assessment sheets, initiated by the facility, revealed the following	F 514		

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F 514	Continued From Page 41 information regarding the lack of documentation of the size of the pressure sore to the coccyx. 1. On 7/3/01 and on 7/11/01, there were no measurements of the pressure sore documented on the weekly skin care and pressure ulcer record. 2. On 9/1/01, there were no measurements of the pressure sore documented on the weekly skin care and pressure ulcer record. 3. Resident 72 was a 68 year old female, who was admitted to the facility on 7/19/01 with the diagnoses of CVA (cerebral vascular accident) with right hemiparesis, old CVA with dense left hemiplegia, dysarthria, aphasia, dysphagia, HT (hypertension), agitation, chronic Foley for urinary retention, early decubitus ulcer and UTI (urinary tract infection). a. Resident 72's medical record documented the need for turning and positioning. The nursing admission assessment, dated 7/19/01, under special skin routines, read: "turn and reposition q (every) 2 hours." The 5 day admission MDS (minimum data set), dated 7/26/01, the 14 day MDS for 8/01/01 and the 30 day MDS for 8/17/01 documented under M5c for skin treatments that they had resident 72 on a turning and repositioning program. The care plan for skin integrity, dated 8/07/01 had "reposition resident q 2 hr. [hours] in bed / chair" as one of the interventions. b. Review of the facility's wound prevention and resolution policy also indicated the resident was to be turned every 2 hours.	F 514		

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F 514	Continued From Page 42	F 514		

c. The facility had a form for documenting the turning and positioning for those residents on a turning schedule. The CNA's (certified nursing assistant) would initial every time the resident was assisted with turning. Resident 72 did not have the form documenting turning and positioning in her medical record or the current month's CNA documentation book.

d. On 9/27/01 at 8:30 AM, during an interview with the D.O.N. (director of nursing), he stated that this was a lack of documentation problem. But the resident had been turned every two hours by staff members. The D.O.N. also stated that sometimes the licensed nurses would document that resident 72 was turned in their nurse's notes.

e. The nurse's notes documented turning resident 72 every 2 hours at the following times:

7/24/01 day shift — 8/18/01 night shift — 9/10/01 night shift
7/25/01 night shift — 8/19/01 night shift — 9/12/01 day shift
7/26/01 day shift — 8/29/01 day shift — 9/12/01 night shift
7/30/01 night shift — 8/31/01 day shift — 9/15/01 night shift
7/31/01 day shift — 9/05/01 night shift — 9/18/01 night shift
8/04/01 night shift — 9/06/01 night shift — 9/19/01 day shift
8/14/01 night shift — 9/08/01 night shift — 9/20/01 day shift
9/24/01 night shift

f. During further medical record review, on 9/27/01, a nursing turn sheet was found in the CNA's

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F 514	Continued From Page 43 documentation book that was not there on 9/25/01 or 9/26/01. The turn sheet was initialed on 9/25/01 at 2:00 AM, 4:00 AM and 6:00 AM. The rest of the form was blank. From the time of admission on 7/19/01 up to 9/25/01 the facility documented that they followed their preventative skin breakdown protocol for turning resident 72 eight of 69 day shifts and 14 of 69 night shifts. 4. On 9/26/01, resident 72's dressing change to the left elbow was observed by the nurse surveyor, the assistant DON and another staff member. There was a stage II pressure ulcer on resident 72's left elbow which measured 1 x 1 cm and had a yellow wound base. Review of Resident 72's medical record revealed a nurse's note for night shift, dated 8/09/01, documented as followed: "Dr's office called facility and left orders for......dsg [dressing] change rt [right] elbow per protocol". This was the only documentation of a right elbow ulcer or injury in the medical record. 5. Review of resident 72's intake and output record revealed that the resident's intake and output were recorded in amounts below adequate hydration recommendations. The intake and output amounts were not totaled for each 24 hour period on the MAR for resident 72. Refer to F-309. On 9/27/01 at 8:30 AM, during an interview with the DON, he stated that the fluid intake of client 72 was actually better than what was documented. The DON stated that resident 72 had clear, yellow urine and appeared to be hydrated. 6. During the review of the medical record a nurse's note, dated 9/03/01, with another resident's name on it was found in resident 72's nursing notes. Resident 72 had no nurse's note for 9/03/01.	F 514		

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