TN to S 2 12-31-01 acceptable POC & addendum dated 1/7/02 Stylowski RN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 12/6/20
FORM APPROVE
2567

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 46A047 | A. BUILDING _____ B. WING _____ | 11/28/2001 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PINE RIDGE CARE CENTER | 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115 |

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| F 221 SS=D | 483.13(a) PHYSICAL RESTRAINTS<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that the facility was using siderails as a restraint on a resident to prevent the resident from voluntarily getting out of bed. The resident did not have a physician order for the siderails and had not been assessed for the use of the siderails. (Resident 18)<br><br>Findings include:<br><br>Resident 18 was admitted to the facility on 8/17/01, with diagnoses of Alzheimers, diabetes, hypothyroid, degenerative joint disease, peptic ulcer disease, coronary artery disease and hiatal hernia.<br><br>Review of resident 18's clinical record revealed a quarterly Minimum Data Set (MDS) dated 11/13/01 that documented the following:<br><br>Under section B2., Memory, it was documented that resident 18 had problems with long and short term memory. Under section B4., Cognitive Skills For Daily Decision Making, it was documented that resident 18 was severely impaired. Under section G1.,a., Bed mobility it was documented that resident 18 required supervision. Under section P4., Devices and Restraints, it was documented that side rails were not being used.<br><br>Review of resident 18's plan of care revealed that the use of or the need for side rails was not on the care | F 221 | no postmark<br>WB | |

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

Lynn K Dee | Admin | 12-26-01

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<br>plan.<br><br>Review of resident 18's Monthly Nursing Summaries that were done by facility nurses on 9/16/01, 10/9/01 and 11/12/01 documented that the side rails were up while resident 18 was in bed for safety.<br><br>No physician order could be found for resident 18 to use siderails.<br><br>No assessment for the need for resident 18 to use siderails could be found.<br><br>The following observations of resident 18 were done on 11/26/01:<br><br>At 1:30 PM, resident 18 was lying in bed on her left side. The bed was pushed up against the wall to the residents left and the siderail was in the down position. A full length side rail was up on the residents right side of the bed. The wall and the siderail would not allow the resident to get out of bed.<br><br>At 2:05 PM, resident 18 was lying in bed on her right side. The bed was still against the wall and the right side rail was in the up position.<br><br>At 2:45 PM, resident 18 was sitting on the right edge of of the bed with both legs under the side rail to her hips.<br><br>An interview with a facility nursing assistant was done on 11/26/01 at 3:05 PM. The nursing assistant stated that the siderails were used to keep resident 18 from walking by herself. She stated that resident 18 was forgetful and would try to walk without help and had fallen several times.<br><br>An interview with the facility administrator was done | F 221 | | |

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| F 221 | Continued From Page 2<br>on 11/26/01 at 3:30 PM. The administrator stated," I didn't know they were using side rails on her. They can't do that without an order." | F 221 | | |
| F 314 SS=H | 483.25(c) QUALITY OF CARE<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that the facility did not ensure that residents without pressure sores did not develop pressure sores when the individual's clinical condition demonstrated that they were avoidable and that residents who had pressure sores received the necessary treatments and services to promote healing. Subsequently, residents at risk or with actual skin breakdown were not provided with preventative, protective care and pressure sore treatments were not administered as ordered, or treated without physician orders. The facility did not have policies or procedures in place for prevention and treatment of pressure sores including the areas of assessment and care planning. Facility nursing staff were not aware that 4 of the 6 residents had pressure sores. Resident identifiers:(3 sample residents, 15,18, 22, and 3 additional residents 6,12, 20.)<br><br>Findings included: | F 314 | | |

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| F 314 | Continued From Page 3<br><br>Interviews:<br><br>On 11/26/01 at 12:30 PM, during tour with the facility Director of Nursing (DON), the DON stated that she knew of only two residents with pressure sores in the building. She stated that residents' 15 and 22 were the two residents who had pressure sores.<br><br>On 11/28/01 at 10:50 AM, the DON was interviewed regarding the facility's skin protocol. The DON handed the surveyor a "Skin Condition Report for non-pressure sore skin conditions" and stated that the form was what the facility used to track pressure ulcers. The surveyor inquired where the form could be found, the form could not be found in the treatment record, medication administration record (MAR) or the medical record of residents 15 & 22. The DON stated that the "skin condition report" forms should be in the treatment record. When the DON was asked what the facility's practice was to prevent the occurrence of pressure sores, she replied that she had only been at the facility for a week and a half and "I don't know what to tell you".<br><br>On 11/28/01 at 10:55 AM, the facility's License Practical Nurse (LPN) stated that she was not aware of a skin break down prevention program or a skin breakdown treatment protocol. The LPN stated that she did not know what other nurses do, to monitor and track for skin breakdown. She stated that she checked the skin of each resident that had showers scheduled during her shift. The facility LPN was not aware of any residents with skin breakdown in the facility.<br><br>U.S. Department of Health and Human Services, Number 15, Treatment of Pressure Ulcers, December 1994, p. 21; states, "The initial assessment of patients with pressure ulcers has several dimensions: (a) | F 314 | | |

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| F 314 | Continued From Page 4<br>Assessment of the pressure ulcer, (b) complete history and physical examination, (c) assessment for complications and comorbidities, (d) nutritional status assessment, (e) pain assessment, (f) psychosocial evaluation, and (g) assessment of risk for developing additional pressure ulcers."<br><br>U.S. Department of Health and Human Services, Number 15, Treatment of Pressure Ulcers, December 1994, p.45; states, "If the ulcer is not healing, the treatment plan should be reassessed and the level of adherence to the plan evaluated. The plan and implementation strategy should be modified as necessary."<br><br>On 11/28/01 at 2:00 PM, the registered nurse surveyor asked the facility LPN what, "N/A" represented in the facility's "Weekly Nurses Note & Skin Assessment", after the question, "Referral made to skin care team?". The facility's LPN stated, "Not applicable". The facility's LPN, who indicated that she had been employed with this facility for 4 weeks to 3 months, stated, "I don't know if we have a skin team, you will have to ask the administrator".<br><br>On 11/28/01 at 2:30 PM, after skin checks had been completed on the residents, the LPN stated to the administrator that she really did not know much about skin breakdown.<br><br>On 11/28/01 at 3:00 PM, the facility LPN asked one of the registered nurse surveyors, "So, how many residents do we [the facility] have with pressure sores?" The registered nurse surveyor informed the facility LPN that there were 6 of the 11 residents (6, 12, 15, 18, 20 & 22) checked that had evidence of skin breakdown.<br><br>In an interview with the administrator on 11/28/01 at | F 314 | | |

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| F 314 | Continued From Page 5<br>10:35 AM, she stated that they had no policies and procedures on pressure ulcers. She stated that they were in need of a policy because they had no written proof that skin checks were being done.<br><br>On 11/28/01 at 4:50 PM, during the exit conference, the facility administrator stated that she knew for a fact the facility's LPN, that was on duty for day shift on 11/28/01, did not perform skin checks for residents that were scheduled for showers on any given day.<br><br>Residents<br><br>1. Resident 22 was an 80 year old female who was admitted to the facility on 12/19/96 with the diagnoses of end stage Parkinson's, status post fractured hip, constipation and sleeplessness.<br><br>A review of resident 22's medical record on 11/26/01, revealed an annual MDS (minimum data set), a mandatory comprehensive assessment of the resident completed by the facility staff, dated 2/25/01, that documented the need of total assistance with ambulation and transfers for resident 22. The annual MDS, dated 2/25/01, reflected that resident 22 was frequently incontinent of bowel and bladder without the use of pads, briefs or a toileting plan; no skin ulcers and no history of resolved skin ulcers within the last 90 days of review. The skin treatments that were in place for resident 22 on her 2/25/01 annual MDS were: a pressure relieving device to her chair and other preventative or protective skin care. Resident 22's redness without break in the skin, that does not disappear when pressure is relieved) & stage II (a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater) pressure ulcer with the skin treatments of ulcer care and application of dressings. No preventative skin treatment measures were marked on the quarterly | F 314 | | |

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| F 314 | Continued From Page 6<br>MDS, dated 11/14/01, for resident 22.<br><br>Upon record review, from 11/26/01 to 11/28/01, it was noted that the care plan for resident 22 did not address skin integrity.<br><br>On 11/26/01, the November 2001, treatment record for resident 22 documented the following: "Hydrogel [crossed out and replaced by the word] DuoDerm to pressure ulcer L [left] buttocks q [every] 3 D [days] until healed, [dated ] 10/08/01". In the November 2001, treatment record there was one measurement of the pressure ulcer for resident 22 that was documented as follows: "Stage III (a full thickness of skin is lost, exposing the subcutaneous tissues- presents as a deep crater with or without undermining adjacent tissue) pressure area is 3 cm [centimeters] round into sub q [subcutaneous] tissue in depth". Resident 22's medical record had a physician's telephone order, dated 10/08/01, for "Hydrogel Drsg [dressing] to stage II pressure sore on coccyx change q [every] 3 days until healed". The medical record for resident 22 did not have evidence that the physician was called to change the order from hydrogel to Duoderm, nor was there a new physician's order for the pressure ulcer treatment.<br><br>On 11/26/01, during record review, there was a physician's telephone order, dated 11/13/01 that documented, "Request MVI [multivitamin] w/ [with] Zinc or Zinc Sulfate 100mg [milligrams] for DQ [decubitus] healing" that was signed by the facility's dietitian. The MVI and Zinc order was not documented in resident 22's November 2001, medication administration record (MAR).<br><br>On 11/27/01 at 8:10 AM, a registered nurse surveyor observed the facility DON administer medications to resident 22. Resident 22 received her medications that were listed in the November 2001, MAR and the DON | F 314 | | |

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| F 314 | Continued From Page 7<br>initialed them as given. The MVI and Zinc Sulfate were not listed in the MAR nor administered to resident 22 as ordered on 11/13/01.<br><br>On 11/28/01 at 3:30 PM, resident 22 still did not have the order for MVI and Zinc sulfate added to the MAR.<br><br>Observations:<br><br>On 11/26/01, resident 22 was observed in her bed lying on her right side with her left hip uncovered which revealed a Duoderm dressing to her left hip and a saturated DuoDerm dressing to her left buttocks that was oozing of light brown drainage. There were pressure relieving devices to resident 22's low bed and wheelchair. Resident 22 appeared to have a wet cloth brief between her legs and her room had an odor of urine. Resident 22 was observed in this position at 1:45 PM, 2:00 PM, 2:15 PM, 2:30 PM, 2:45 PM, 3:00 PM, and 4:00 PM.<br><br>On 11/27/01 at 12:50 PM, two registered nurse surveyors observed the facility's DON perform a skin treatment for resident 22's pressure sore. Resident 22 was positioned on her left side and had her right hip exposed. The survey nurses observed a 1 cm brown scab to resident 22's right hip that was surrounded with a 3cm X (by) 3cm, stage I pressure ulcer. The surveyors observed the facility DON cleanse the scab with a clear solution that created bubbles on the scab. The facility DON stated that she cleansed resident 22's right hip with a half strength hydrogen peroxide solution. The nurse surveyor inquired if this was a doctor's order or the facility's protocol to use hydrogen peroxide solution for the treatment of pressure sores. The DON stated, "I don't know, this is what I used at the last facility I had worked at". The DON, then applied a 4"(inch) X 4" Duoderm to resident 22's right hip. The DON, proceeded to leave the room and go to | F 314 | | |

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| F 314 | Continued From Page 8<br>the nurse's station. The nurse surveyor asked the DON if she was finished with resident 22's treatment? The DON stated that she had just finished the treatment. The nurse surveyor informed the DON that the treatment record documented an ordered treatment to the "left buttocks" and that the ordered treatment was "Hydrogel". At 1:00 PM the two nurse surveyors observed a skin check of resident 22 that was performed by the facility's DON. The survey nurses observed a 1cm X 1cm, stage II pressure ulcer to resident 22's right gluteal fold, above her right thigh. The DON stated, "I wasn't aware of the one's (pressure sores) on her right buttocks and right hip". The DON removed the old dressing from resident 22's left buttocks that had brown drainage on the dressing. The survey nurses observed the DON cleanse the pressure sore with a hydrogen peroxide solution. Resident 22 had a stage II pressure sore to her left buttocks that measured 2.5cm X 2cm with a yellow base. The DON applied Duoderm to the left buttocks pressure sore. Resident 22 had a Duoderm to her left hip but there was not a sore to her left hip. The DON applied a new Duoderm to resident 22's left hip and stated, "Maybe it's there for protection". The DON stated that she was not aware of the Hydrogel dressing order for resident 22's treatment of pressure sores. Resident 22 was then repositioned onto her left side by the DON.<br><br>On 11/27/01, resident 22 was observed sitting in her wheelchair with a lap buddy across her waist and her husband sitting next to her during the following times: 2:30 PM, 2:50 PM, 3:10 PM, 3:20 PM, 3:40 PM, 4:00 PM, 4:15 PM, 4:30 PM, 4:45 PM & 5:00 PM. The facility staff were not observed to remove the lap buddy and reposition resident 22.<br><br>On 11/27/01 at 2:50 PM, during an interview with resident 22's husband, it was revealed that he was not aware of resident 22's skin breakdown. Resident 22's | F 314 | | |

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| F 314 | Continued From Page 9<br>husband stated that he visits his wife five days a week and the facility staff never remove the lap buddy and reposition resident 22 while he visits.<br><br>On 11/28/01, resident 22 was observed in bed lying on her left side with a wet cloth brief between her legs from 1:10 PM to 2:10 PM. At 2:10 PM a facility certified nurse's assistant (CNA) removed the wet brief and applied a dry cloth brief but resident 22 remained positioned on her left side. Resident 22 remained on her left side from 1:10 PM to 4:00 PM.<br><br>U.S. Department of Health and Human Services, Number 15, Treatment of Pressure Ulcers, December 1994, p. 42; "Reposition the sitting individual so the points under pressure are shifted at least every hour. If this schedule cannot be kept or is inconsistent with overall treatment goals, return the patient to bed. Individuals who are able should be taught to shift their weight every 15 minutes."<br><br>Perry & Potter's 3rd edition, Clinical Nursing Skills & Techniques, 1994; p. 122; "Frequently turn and position client to relieve pressure around superficial capillaries and allow tissues to compensate for temporary ischemia. Classic research (Kosiak, 1961) found that tissue ischemia begins within 1 to 2 hours after onset of pressure in paraplegic animals. Turning clients every 1 to 2 hours will help minimize formation of pressure sores."<br><br>On 11/28/01 at 2:00 PM, the nurse surveyor observed resident 22 positioned on her left side with her right hip exposed. The Duoderm to resident 22's right hip had a yellow bubble. At 3:55 PM, the nurse surveyor observed the facility DON remove the Duoderm dressing to resident 22's right hip. Resident 22's right hip was observed to have a stage II pressure sore that measured 1cm X 2.5cm with yellow drainage and a | F 314 | | |

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| F 314 | Continued From Page 10<br>yellow base. The stage II pressure sore to resident 22's right hip was surrounded with a 3cm X 3cm stage I pressure sore. The DON cleansed the pressure sore with a hydrogen peroxide solution and applied a new Duoderm dressing to resident 22's right hip pressure sore. The DON stated, "That Duoderm causes moisture and it (pressure sore) will heal".<br><br>U.S. Department of Health and Human Services, Number 15, Quick Reference Guide for Clinicians Pressure Ulcer Treatment, December 1994 page 15 and 20. "Do not clean ulcer wounds with skin cleansers or antiseptic agents (e.g.., povidone, iodine, iodophor, sodium hypochlorite [Dakin's solution], hydrogen peroxide, acetic acid) because they are cytotoxic....Do not use topical antiseptics (e.g.., povidone, iodine, iodophor, sodium hypochlorite [Dakin's solution], hydrogen peroxide, acetic acid) to reduce bacteria in wound tissue."<br><br>On 11/27/01, the CNA's turning schedule for resident 22 was reviewed by the nurse surveyor for the Month of November 2001, up untill the 26th day. It was not documented that resident 22 was turned every 2 hours, 31 out of 78 possible shifts during the month of November.<br><br>Upon review of resident 22's medical record, the following documentation entries reflect the progression of resident 22's pressure sores from a stage I to 3 stage II pressure sores:<br><br>Doctors Progress Notes:<br>"8/15/01-- Has several red areas on buttocks being tx [treated] w/ [with] Duoderm; stage I decub [decubitus] buttocks healing continue Duoderm per orders until healed".<br><br>Weekly Nurses Note & Skin Assessment: | F 314 | | |

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| F 314 | Continued From Page 11<br>"8/22/01-- Stage I to bottom Tx [treat] with Duoderm".<br><br>Quarterly MDS:<br>"8/24/01"-- Section M1 & 2 document "1" stage II pressure ulcer.<br><br>Weekly nurses Note & Skin Assessment:<br>"8/28/01-- Stage I to bottom Tx [treat] with Duoderm".<br><br>Nurses Note:<br>"8/28/01-- Continues to have small dime size decubitus in crease of upper leg (buttock) Duoderm applied".<br><br>Nurses Note:<br>"9/06/01-- DQ [decubitus] II to L [left] buttock 2cm [centimeters] X 1 cm. Duoderm to area".<br><br>Monthly Nursing Summary Note:<br>"9/08/01-- Pressure sore to R [right] buttock 2cm X 1 cm, tx [treat] with Duoderm; Problem #3 DQ [decubitus] to L [left] buttock".<br><br>Nurses Note:<br>"9/20/01-- Buttocks much improved but still needs to be monitored & treatment to areas".<br><br>Nurses Note:<br>"9/29/01-- Has a skin abrasion 2cm round on L [left] side pink beneath gluteal fold- cleansed & covered w/ [with] sterile 2 X 2 & taped".<br><br>Nurses Note:<br>"10/08/01-- T/O [telephone order] received from Dr. Johnson tx to pressure ulcers change to hydrogel change q 3 days until resolved". | F 314 | | |

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| F 314 | Continued From Page 12<br>Monthly Nursing Summary Note:<br>"10/08/01-- Stage III DQ on coccyx tx by doctor qd [everyday]".<br><br>Doctors Progress Note:<br>"10/10/01-- Has developed decubitus on hip not improving; using Hydrogel on DQ L [left] hip".<br><br>Nurses Note:<br>"10/11/01-- Ulcer to L hip".<br><br>Weekly Nurses Note & Skin Assessment:<br>"10/12/01-- Duoderm to L buttock stage II".<br><br>Nurses Note:<br>"10/16/01-- She has a DQ on coccyx being tx by doctor".<br><br>Nurses Note:<br>"10/19/01-- Tx to gluteal fold dequb area seems to be getting larger. Also some infection noted will monitor".<br><br>Nurses Note:<br>"10/28/01--Pt [patient] has a skin break- through, skin & involving sub q [subcutaneous] tissue on L buttock @ gluteal fold on underneath side. It measures 3cm round & is red colored w/ some bleeding. Area was cleansed & Hydrogel was applied".<br><br>Nurses Note:<br>"11/01/01-- Duoderm placed on open dq [decubitus] on R hip. DQ larger this week".<br><br>Nurses Note:<br>"11/03/01-- Pt has a stage III pressure sore on R inside gluteal fold area cleansed & covered w/ sterile sponge & left open to air". | F 314 | | |

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| F 314 | Continued From Page 13<br>Nurses Note:<br>"11/04/01-- Pt has a stage III pressure area on L inside gluteal fold area was cleansed & Duoderm applied w/ out Hydrogel which didn't seem to help the past week".<br><br>Nurses Note:<br>"11/07/01-- Res [resident] skin breaking down rapidly. Has 2 stage III dq's around buttocks gluteal fold. Dressings applied must keep dry".<br><br>Monthly Nursing Summary Note:<br>"11/07/01-- 0 Dqs".<br><br>November's Treatment Record:<br>"11/10/01-- Hydrogel had been tried & was not effective-Duoderm seems to work best-- q [every] 3 days if pt were to leave on".<br><br>Nurses Note:<br>"11/19/01-- Stage II covered w/ Duoderm area getting smaller in diameter will continue to monitor".<br><br>On 11/28/01 at 3:30 PM, the November 2001, treatment record for resident 22 had "right" buttocks added to her Duoderm treatment with her "left buttocks" treatment. The date of November 28th was initialed for changing resident 22's dressings but there were no notes of resident 22's pressure sores in the treatment record. At 3:30 PM, there was a new "Weekly Nurses Note & Skin Assessment", dated 11/27/01, in resident 22's medical record that documented the following: "She has fragile skin - gets bruises easily", 2 dots on right and left buttocks of a body diagram that were labeled, "DQ [decubitus]"; "Tx [treatment] q [every] day as per order of doctor with DuoDerm"; "Date of Last M.D. notification regarding skin problem: 10-8-01"; "Referral made to skin care team? n/a [not applicable]". There was no evidence in resident 22's medical record that her | F 314 | | |

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| F 314 | Continued From Page 14<br>physician was contacted concerning her skin breakdown.<br><br>2. Resident 20 was a 86 year old female who was admitted to the facility on 3/02/01 with the diagnoses of peripheral vascular disease (PVD), Parkinson's, arthritis, osteoporosis, dementia and failure to thrive.<br><br>Record Review:<br><br>The admission MDS of resident 20 that was completed by the facility staff, dated 3/10/01, documented that resident 20 had a stage II pressure sore and her skin treatments were listed as: application of dressings and ointments. The admission MDS documented that resident 20 did not have a history of resolved pressure sores in the past 90 days. Resident 20's quarterly MDS, dated 6/09/01, reflected 0 pressure ulcers. The 9/08/01, quarterly MDS, documented that resident 20 was on a turning/ repositioning program and was receiving nutritional intervention to manage skin problems but had no pressure relieving devices for her bed or chair. On the 9/08/01, MDS, facility staff documented that resident 20 had 0 pressure ulcers.<br><br>The facility did not have a care plan that addressed resident 20's skin integrity.T<br><br>The admission "Nursing Assessment" for resident 20, dated 3/02/01, documented the following: "Stage I decubitus 1cm X 1cm, depth superficial" and "skin fragile- Stage I ducub [decubitus] R cheek. Wears brief".<br><br>Resident 20's admission Nutritional Assessment, dated 3/06/01, listed "Decubitus" under "Patient Status" and was signed by the facility's dietitian.<br><br>The physician's note for "History" and "Systems | F 314 | | |

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| F 314 | Continued From Page 15<br>Evaluation", dated 3/28/01, documented that resident 20's decubitus on her right hip was healed.<br><br>The following documents were reviewed for resident 20 that pertain to a pressure sore on her right hip:<br><br>Nurses Notes:<br>"7/21/01-- turned & position changed. She has a lg. [large] area on R hip looks like a lg. boil come to a head, cleansed & dressing applied. Temp 101".<br><br>Nurses Notes:<br>"7/26/01-- ...drsg [dressing] change to R hip 2cm open area..."<br><br>The Treatment Record for July 2001, did not have documentation of a dressing for resident 20's right hip.<br><br>Physician's Telephone Orders:<br>"8/02/01-- Wet to Dry drsg to R hip BID [twice a day] until healed".<br><br>Nurses Notes:<br>"8/05/01-- ...W-D [wet to dry] dressing to R hip. Skin is intact on hip, but area is red..."<br><br>Nurses Notes:<br>"8/19/01-- ...Drsg on R hip removed, hip is healing, but a protective drsg was applied to avoid friction rubs as pt. is turned in bed..."<br><br>Monthly Nursing Summary:<br>"11/15/01-- Skin condition: fair, intact".<br><br>Observation:<br><br>On 11/28/01 at 1:35 PM, two registered nurse surveyors observed the facility's LPN perform a skin check on resident 20. Resident 20 was transferred | F 314 | | |

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| F 314 | Continued From Page 16<br>from her wheelchair to her bed with the assistance of the facility's LPN and CNA. The survey nurses observed that resident 20 had a pressure relieving device to her chair but not to her bed. Resident 20 was observed to have wet pants on and carried an odor of urine. The nurse surveyors observed 4 stage II sores that each measured 0.5cm X 0.5cm to the following areas of resident 20: left buttocks, right buttocks, right gluteal fold and right thigh (by the crease of the gluteal fold). Resident 20 was observed to have a stage II pressure ulcer to her right hip that measured 1cm X 1cm. The facility's LPN and CNA stated that they were not aware of resident 20's skin breakdown.<br><br>Perry & Potter's 3rd edition, Clinical Nursing Skills & Techniques, 1994; p. 122; "Specialized beds and matresses distribute pressure on dependent body parts more evenly. Clients at high risk for pressure ulcer formation should be placed on these devices as soon as possible."<br><br>Perry & Potter's 3rd edition, Clinical Nursing Skills & Techniques, 1994; p. 123; "1. Identify client's risk for pressure ulcer formation: Rationale; determines need to administer preventative care in addition to use of topical agents for existing ulcers."<br>3. Resident 15 was a 72 year old male who was admitted to the facility on 8/16/01 with the diagnoses of diabetes mellitus, arthritis, bilateral knee replacement, hypothyroidism, coronary artery disease, and Alzheimer's dementia.<br><br>The MDS dated 8/28/01, documented that resident 15 was severely cognitively impaired. The MDS dated 11/13/01 documented that resident 15 was moderately cognitively impaired. The MDS dated on 8/28/01 and 11/13/01 documented that he needed supervision when moving to and from a lying position, turning side to side, positioning his body in bed and walking between | F 314 | | |

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| F 314 | Continued From Page 17<br>locations in his room. The MDS dated on 8/28/01 and 11/13/01 documented that he was incontinent of bowel and bladder and did not have any pressure or stasis ulcers. Both MDS's documented that resident 15 had received seven days of an anti-anxiety medication, an anti-psychotic medication and anti-depressant medication. The MDS dated 11/13/01 further documented that resident 15 did not have a recent weight loss of 5% or more in last 30 days or 10% or more in the last 180 days.<br><br>A review of resident 15's care plan documented on 11/14/01 and prior to 11/14/01, did not include a care plan problem for a potential or actual skin breakdown.<br><br>The "Weekly Nurses Note and Skin Assessment" documented that resident 15 had no skin breakdown on 8/22/01, 9/4/01 and 9/11/01. Three "Weekly Nurses Notes and Skin Assessments" were completed for resident 15 since his admit date of 8/16/01. The form documented resident 15 was at risk for skin breakdown because he was incontinent and had diabetes. The form documented the preventative measures that were being used, and the only preventive measure documented was that resident 15 was able to turn self and repositioned frequently.<br><br>The "Monthly Nursing Summary" documented on 8/19/01 and 10/19/01 that resident 15's skin condition was dry, warm, and intact. On 9/19/01 the monthly summary report documented that resident 15 had a pressure sore on his gluteal fold.<br><br>The administrator was interviewed on 11/28/01 at 10:00 AM. She stated that she did not have any more weekly nurse notes and skin assessments for resident 15. The facility's "Weekly Nurse Note and Skin Assessment" form dated 9/11/01, was the last documented assessment for his risk for skin | F 314 | | |

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| F 314 | Continued From Page 18<br>breakdown.<br><br>The nurse's note on 11/11/01 documented that resident 15 had a small pressure sore on gluteal area between the buttocks and that a DuoDerm dressing was applied. The nurse's notes on 11/14/01 documented that a DuoDerm was applied to two small pressure sores on the gluteal area and between the buttocks.<br><br>A review of the physician orders, dated 11/18/01, stated that the nurses "May do dressing change on buttocks as needed on back area" for resident 15.<br><br>A review of resident 15's treatment record for November 2001 documented that "DuoDerm (dressing) to both sides of buttocks every three days ?." In resident 15's treatment record, it was documented on the body diagram that resident 15 had stage II pressure sores on his coccyx and gluteal fold on 11/17/01.<br><br>On 11/27/01 at 7:05 AM through 7:30 AM, resident 15 was observed lying on his back on a light blue mattress without any additional pressure relief device added to his bed.<br><br>On 11/27/01 at 7:50 AM through 8:20 AM, resident 15 was observed to be sitting at the table in a dining room chair without any additional pressure relieving device on his chair.<br><br>On 11/27/01 at 9:30 AM through 10:30 AM, resident 15 was observed to be sitting at the table in a dining room chair without any additional pressure relieving device on his chair.<br><br>On 11/27/01 at 1:20 PM, two registered nurse surveyors observed the DON perform a skin check on resident 15. Resident 15 was wearing an incontinent | F 314 | | |

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brief and did not have a dressing on his pressure sore. The DON mixed one half strength of hydrogen peroxide and tap water and cleaned with 2x2 guaze pad over resident 15's pressure sore. The pressure sore on resident 15's right buttock measured 1.5cm X1cm. On resident 15's left coccyx was a pinkish white scab that measured 1.5cm X1.5 cm.

On 11/27/01 at 2:00 PM, the C.N.A. that was assigned to take care of resident 15 was interviewed. She stated she had showered resident 15 that morning and that he did not have any type of dressing on his buttocks prior to being showered.

An aide was interviewed on 11/27/01 at 2:30 PM. The aide stated that resident 15 was "sedated and sits on the couch all day and that he does not walk around the building much."

On 11/28/01 at 1:15 PM, the dietary manager was interviewed. The dietary manager stated that she was concerned about resident 15 because he appeared to be oversedated and was sleeping all day.

A review of the nurses' notes on 11/16/01 documented that resident 15 was napping during meals, that he needed assistance with feeding and they had to arouse resident 15.

A review of resident 15's MDS dated on 8/28/01 and 11/13/01 documented that resident 15 was independent with eating with set up help only

A review of resident 15's physician orders dated 11/16/01 documented to decrease the following medications for resident 15.

Decrease amitriptyline to 50 milligrams an hour before bedtime.

Decrease risperdal, to one milligram every morning

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| F 314 | Continued From Page 20<br>and to decrease his evening dose to two milligrams every night.<br><br>Judith Deglin, Pharm D and April Vallerand, PhD. Sixth Edition. Davis's Drug Guide for Nurses page 41 and 892. documents one of the most frequent adverse side effects of taking amitriptyline is lethergy and sedation...One of the most frequent adverse side effects of taking risperadal is increase sleep duration and sedation...<br><br>A review of the facilities weight log revealed that resident 15 weighed 202 pounds on 8/16/01. On 9/01 resident 15 weighed 185.9 pounds. This represents a 7.9% weight loss which was significant.<br><br>A review of a dietary note dated 10/30/01 documented that resident 15 had a weight loss of 17 pounds since admit. The dietary note further documented that resident 15 was quite active and walks a lot. The dietitian recommended larger portions with his non-concentrated sweet diet. There were no current notes addressing resident 15's pressure sores.<br><br>A LPN was interviewed on 11/28/01 at 10:50 AM. The nurse stated that she notifies the physician, the director of nursing and the administrator when a resident has skin breakdown.<br><br>U.S. Department of Health and Human Services, Number 15, Quick Reference Guide for Clinicians Pressure Ulcer Treatment, December 1994 page 6-7. "The goal of nutritional assessment and management is to ensure that the diet of the individual with a pressure ulcer contains nutrients adequate to support healing.... Nutritional support: Encourage dietary support intake or supplementation if an individual with a pressure ulcer is malnourished. If the dietary intake continues to be inadequate, impracticable, or impossible, | F 314 | | |

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nutritional support should be used to place the patient into positive nitrogen balance (approximately 30 to 35 calories/kg/day/ and 1.25 to 1.50 grams of protein/kg/day) according to the goals of care. As much as 2.00 grams of protein/kg may be needed. "

4. Resident 6 was a 95 year old female who was admitted to the facility on 10/21/97 with the diagnoses of hypertension, hypothyroidism, osteoporosis, and arthritis. Resident 6's also had documented history of stasis ulcers with stasis dermatitis on her legs.

The MDS, dated 10/16/01, documented that resident 6 required limited assistance with transfers and supervision with her bed mobility. The MDS also documented that resident had a stasis ulcer and was incontinent of urine and feces.

On 11/28/01 at 11:15 AM, two registered nurse surveyors observed an LPN perform a skin check on resident 6. While the aide transferred resident 6 from her wheelchair to her bed, resident 6 was observed to not bear weight on her feet and the aide performed full assistance to transfer the resident into her bed. Resident 6's wheelchair was observed to have a folded up blanket in her wheelchair and an eggcrate mattress to her bed. Resident 6 was wearing a soiled incontinent brief with feces and urine without any dressings on her open sores. On resident 6's left buttock near her coccyx, there was a .2 cm x .2 cm and .5 cm x .5 cm partial thickness loss of the epidermis that was reddened, nonblanchable and was round in appearance. Also on resident 6's left buttock near her coccyx, there was a 3 cm x 3 cm of intact skin that was reddened and non blanchable. On resident 6's right buttock there was 4 cm x 4 cm area of intact skin that was reddened, nonblanchable and round in appearance.

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U.S. Department of Health and Human Services, Number 15, Quick Reference Guide for Clinicians Pressure Ulcer Treatment, December 1994 page 1. "A pressure ulcer is defined as any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Pressure ulcers are usually located over bony prominences and are graded or staged to classify the degree of tissue damage observed...Stage I: Nonblanchable erthema of intact skin, the heralding lesion of skin ulceration. Stage II: partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinical as an abrasion, blister or shallow crater."

The care plan for resident 6, dated 8/15/01, included "Skin integrity Impairment of Potential for alteration in skin integrity, skin breakdown" as evidence by "worsening infection on legs" and resident "pulls off dressing." The goal stated to keep dressing intact. The care plan interventions included the following:
1. "Sterile dressings with bacitracin ointment q (every) d (day).
2 "Elevate legs."
3. "Continue Keflex (antibiotic)."
4. "Document behaviors of taking off bandages, scratching ect"
5. "Resident does not complain of significant amount of pain."

Resident 6 also had a care plan for "Stasis dermatitis" with the intervention "see physician progress notes." The care plans did not address resident 6 at risk for pressure sores or interventions to prevent pressure sores.

Resident 6's physician recertification orders documented the following to be applied on resident 6's skin: On 1/30/99 the physician ordered hydrocortisone cream to be applied to affected areas as

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|---|---|---|---|
| | 46A047 | A. BUILDING _____ B. WING _____ | 11/28/2001 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PINE RIDGE CARE CENTER | 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115 |

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| F 314 | Continued From Page 23 | F 314 | | |

need for itching. On 3/16/01 the physician ordered diaper rash ointment to be applied to buttocks as needed. On 8/15/01 bacitracin ointment to be applied to ulcers on legs every day until healed. On 10/10/01 the physician ordered lac hydrin 12% to be applied twice a day to legs for stasis ulcers.

The "Weekly Nurses Note and Skin Assessment" documented that resident 6 had six weekly assessments done since 8/19/01. On 11/8/01 the weekly nurses note and skin assessment documented the following: Resident 6 had fair skin turgor, she was incontinent, she requires much assistance with her daily living skills. Her risk factors for skin breakdown was being incontinent of urine and feces. The preventive measures that were used was an eggcrate and cushion to wheelchair and staff and self to turn and reposition frequently. Resident 6 had occasional skin tears.

A review of resident 6's nurse's notes documented the following: On 11/6/01, resident was up in chair and complains of pain to buttocks and abdomen. On 11/8/01 the resident up to toilet and complains of a general pain to buttocks.

A review of resident 6's dietary notes, dated 4/24/01, documented a weight loss of 6.7% in one month which was significant. There were no notes addressing resident 6's increase needs for wound healing of her stasis ulcers and pressure sores.

On 11/28/01 at 11:15 AM, during a skin check on resident 6 with the LPN, the LPN stated that she observed three broken areas in the skin and was not aware that resident 6 had open areas. She further stated that resident 6 scratches herself. On 11/28/01 at 11:15 AM, resident 6's skin was observed by two registered nurse surveyors from the waist down and there were no scratch marks observed.

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| F 314 | Continued From Page 24 | F 314 | | |

A review of November 2001 treatment record documented that resident 6 could have hydrocortisone cream as needed for itching. There was no nursing initials that documented that the nurse had applied hydrocortisone cream.

A review of the nurse's notes for the month of November 2001 had no documentation of resident 6 scratching at her buttocks. Resident 6 was care planned for skin breakdown and as one of the interventions to skin impairment, the nurses were to document behaviors of taking off bandages and scratching.

On 11/28/01 at 2:30 PM, after skin checks had been completed on the residents, the LPN stated to the administrator that she really did not know much about skin breakdown.

On 11/28/01 at 4:50 PM, during the exit conference, the facility administrator stated that she knew for a fact the facility's LPN, that was on duty for day shift on 11/28/01, did not perform skin checks for residents that were scheduled for showers on any given day.
5. Resident 12 was admitted to the facility on 3/13/01 with diagnoses of hypertension, arthritis, hip fracture, and dementia.

Review of resident 12's clinical record revealed a quarterly MDS dated 10/05/01 that documented the following:

Under section G1., a through j.,physical functioning and structural problems, it was documented that resident 18 was totally dependent on the physical assistance of one person for bed mobility, transfers, dressing, eating, toilet use and personal hygiene. Under section G4., functional limitation in range of

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| F 314 | Continued From Page 25<br>motion, it was documented that resident 18 had limitation in both arms, hands, legs and feet with partial loss of voluntary movement in both arms, hands legs and feet. Under section H1., a. and b. continence, it documented that resident 12 was incontinent of bowel and bladder. Under section M., 2., skin condition, it documented that resident 12 had no pressure ulcers.<br><br>Observation of resident 12's skin was done on 11/28/01, with a facility nurse. Resident 12 had been incontinent of bowel and bladder. Observation of the residents skin revealed an open red area in the right gluteal fold that was approximately 1 cm x .5 cm in size. The residents hips were in a flexed position and his knees were tightly together. The inside of resident 12's knees were observed to be red. There was nothing between resident 12's knees to relieve pressure. The facility nurse stated she had not been aware that resident 12 had any skin problems.<br><br>6. Resident 18 was admitted to the facility on 8/17/01, with diagnoses of Alzheimers, diabetes, hypothyroid, degenerative joint disease, peptic ulcer disease, coronary artery disease and hiatal hernia.<br><br>Observation of resident 18 during the survey from 11/26/01 through 11/28/01, revealed that when resident 18 was not lying on her bed, resident 18 was in a wheelchair that did not have any type of pressure relieving device in the seat.<br><br>An interview with the facility DON was done on 11/27/01. She stated that resident 18 was in a wheelchair due to her being unsteady on her feet and trying to ambulate without her walker. The DON stated that resident 18 had been using the wheelchair for about two weeks. | F 314 | | |

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| F 314 | Continued From Page 26<br><br>An interview was held with a facility nursing assistant on 11/27/01. She stated that resident 18 was incontinent of bowel and bladder. She also stated that resident 18 had been using the wheel chair for about two weeks due to her falling so much.<br><br>An observation of resident 18's skin condition was done on 11/28/01 at 11:00 AM, with a facility nurse. Resident 18's pants were observed to be wet and had a strong urine odor. Resident 18 was observed to have .4 cm yellow base scab area on the right buttocks. The facility nurse stated,"This is the beginning of a pressure sore." Resident 18 complained of pain in the right buttocks area.<br><br>The facility had no assessment to indicate that resident 18 was at risk for pressure sores had not identified that resident 18 was beginning to acquire pressure sores. | F 314 | | |
| F 323 SS=F | 483.25(h)(1) QUALITY OF CARE<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review it was determined that the facility did not ensure that the resident environment was as free of accident hazards as was possible. The facility had not assessed resident beds for entrapment risks. (Resident 18) The facility had not repaired ripped floor coverings that could cause falls. The facility did not have covers over florescent tube lights that if the tube lights shattered, broken glass would fall on residents bed areas and bathroom areas. These have the potential to affect all | F 323 | | |

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| F 323 | Continued From Page 27<br>residents in the facility.<br><br>Findings include:<br><br>Entrapment risks.<br><br>Resident 18 was admitted to the facility on 8/17/01, with diagnoses of Alzheimers, diabetes, hypothyroid, degenerative joint disease, peptic ulcer disease, coronary artery disease and hiatal hernia.<br><br>Review of resident 18's clinical record revealed a quarterly Minimum Data Set (MDS) dated 11/13/01 that documented the following:<br><br>Under section B2., Memory, it was documented that resident 18 had problems with long and short term memory. Under section B4., Cognitive Skills For Daily Decision Making, it was documented that resident 18 was severely impaired. Under section G1.,a., Bed mobility it was documented that resident 18 required supervision. Under section P4., Devices and Restraints, it was documented that side rails were not being used.<br><br>Review of resident 18's plan of care revealed that the use of or the need for side rails was not on the care plan.<br><br>Review of resident 18's Monthly Nursing Summaries, that had been done by facility nurses on 9/16/01, 10/9/01 and 11/12/01 documented that the side rails were up while resident 18 was in bed for safety.<br><br>No physician order could be found for resident 18 to use siderails.<br><br>No assessment for the need for resident 18 to use siderails could be found. | F 323 | | |

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| F 323 | Continued From Page 28 | F 323 | | |

The following observations of resident 18 were done on 11/26/01:

At 1:00 PM, resident 18 was sitting in a wheelchair in the dining room.
At 1:30 PM, resident 18 was lying in bed on her left side. The bed was pushed up against the wall to the residents left. The siderail was down on the left side so the mattress was against the wall. A full length side rail was up on the residents right side of the bed. The bed was observed to have a gap at the foot of the bed between the mattress and the footboard of approximately 6 inches. There was also a gap of approximately 5 inches between the mattress and the side rail on the right side.
At 2:05 PM, resident 18 was lying on her right side.
At 2:45 PM, resident 18 was sitting on the right edge of the bed with both legs under the side rail to her hips. The mattress was depressed where resident 18 was sitting. Resident 18 was observed to keep sliding her hips forward sliding her legs closer to the floor under the rails. The surveyor called to a facility nursing assistant to come and assist resident 18. Resident 18 had the potential to slide down farther and become entrapped or injured fatally.

During an interview with the administrator on 11/28/01, she stated that the facility had never done any kind of assessment on the facility beds or siderails to see if any of them were a potential risk for entrapment.

In August of 1995, the FDA (Food and Drug Administration) issued a safety alert regarding entrapment hazards with hospital side rails. The safety alert documented that there had been several reports of head and body entrapment incidents associated with the use of hospital side rails causing fractures, cuts,

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| F 323 | Continued From Page 29 | F 323 | | |

and abrasions and even death. The report recommended the following:

"Inspect all hospital bed frames, bed side rails, and mattresses as part of a regular maintenance program to identify areas of possible entrapment. Regardless of mattress width, length, and/or depth, alignment of the bed frame, side rail, and mattress should leave no gap wide enough to entrap a patient's head or body. Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement, or bed position...Additional safety measures should be considered for patients identified as high risk for entrapment. Such patients include those with altered mental status (organic or medication related or general restlessness...Bed side rails should not be used as a substitute for patient protective restraints..."

Broken Glass Risk

Observation of the facility during the recertification survey on 11/27/01 revealed the following hazards.

The residents' public bathroom was observed to have no protective covering over the four light bulbs.

Resident room 6, bed B, was observed to have no protective covering over one light bulb.

The bathroom between rooms 9 and 10 was observed to have no protective light covering over the four light bulbs.

Resident room 11, bed A, was observed to have no protective light covering over the light bulb.

Fall risk

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| F 323 | Continued From Page 30<br>The entrance to resident room 5 was observed to have no black plastic edging where the carpet meets the linoleum floor. The edge of carpet was observed to be lifting away from the floor.<br><br>The entrance to the resident dining room was observed to have two places where the linoleum was pealing up from the floor. Approximately 2x2 ft area was affected.<br><br>The administrator was interviewed on 11/28/01 at 10:00 AM. The administrator stated that the maintenance communication log documented all work requests and work orders.<br><br>The facility's nursing and maintenance communication log was reviewed for any documenting of light covers missing, the plastic edging of the carpet missing and the pealing of the linoleum in the dinning room and none of these hazards were documented. | F 323 | | |
| F 368 SS=E | 483.35(f)(1)-(3) DIETARY SERVICES<br><br>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.<br><br>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.<br><br>The facility must offer snacks at bedtime daily.<br><br>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack | F 368 | | |

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| F 368 | Continued From Page 31<br>is served.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, confidential resident interviews, and staff interviews it was determined that the facility did not offer snacks at bedtime daily.<br><br>Findings included:<br><br>A confidential group interview was held on 11/27/01 at 9:30 AM. Four of four residents stated that they were not offered snacks prior to going to bed at night.<br><br>A confidential resident interview was held on 11/27/01 at 10:30 AM. The resident stated that he/she was not offered a snack prior to going to bed at night.<br><br>A review of resident meal intake records revealed no documentation of bedtime snacks.<br><br>The evening cook was interviewed on 11/ 27/01 and 1:40 PM. She gave the surveyor a list of residents who received snacks. Review of the nourishment list documented that 0 of 24 residents received snacks prior to going to bed at night.<br>She stated that she made 2 eight ounce glasses of house supplement, 2 eight ounce glasses of milk, 3 glasses of juice, 2 peanut butter and jelly sandwiches and 4 to 5 packets of graham crackers. She further stated "The nurse gives bedtime snacks if someone is hungry."<br><br>A facility LPN was interviewed on 11/27/01 at 3:05 PM. She stated usually the residents that are diabetic will ask for evening snacks.<br><br>The administrator was interviewed on 11/28/01 at 10 AM. The administrator stated that she told the kitchen | F 368 | | |

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| F 368 | Continued From Page 32<br>to make only a certain amount of food items for night time snacks. | F 368 | | |

PLAN OF CORRECTION FOR SURVEY COMPLETED 11-28-2001

ALL DEFICIENCIES WILL BE MET AND IN PLACE BY JANUARY 21, 2002

TAG # F221 NO PHYSICAL RESTRAINTS WILL BE USED AT PINE RIDGE CARE CENTER UNLESS THE RESIDENT HAS A PHYSICIANS ORDER AND THE RESIDENT HAS BEEN ASSESSED TO DETERMINE MEDICAL NEED.

ok ~ addendum 1/7/02 PW

ALL SIDE RAILS HAVE BEEN REMOVED FROM ALL BEDS IN THE FACILITY. ONLY WHEN A RESIDENT HAS A PHYSICIANS ORDER AND AN ASSESSED MEDICAL NEED WILL SIDE RAILS BE USED.

THE SIDE RAILS HAVE BEEN REMOVED FROM RESIDENT #18'S BED. (REMOVED 11/26/2001)

TAG #F314 PINE RIDGE CARE CENTER HAS OBTAINED THE SERVICES OF CONSULTING R.N. AS REQUIRED IN THE DIRECTED PLAN OF CORRECTION.

ok ~ addendum 1/7/02

THE FACILITY HAS DEVELOPED A SKIN CARE POLICY AND PROCEDURE AS REQUIRED IN THE DIRECTED PLAN OF CORRECTION.

A SKIN CARE TEAM HAS BEEN ESTABLISHED AND ALL RESIDENTS HAVE BEEN ASSESSED FOR RISK.

THE D.O.N. WILL ACT AS THE HEAD OF THE SKIN TEAM AND WILL PERFORM AT LEAST TWO RANDOM SKIN CHECKS WEEKLY OF RESIDENTS WHO ARE AT RISK FOR BREAKDOWN TO ENSURE SKIN CHECKS PERFORMED BY NURSING STAFF ARE ACCURATE. SHE WILL ALSO MAKE SURE THE PHYSICIAN HAS BEEN MADE AWARE AND THAT IF ORDERS FOR TREATMENT HAVE BEEN RECEIVED, THEY ARE PLACED ON THE TREATMENT SHEET CORRECTLY. SHE WILL ALSO MONITOR DOCUMENTATION TO ENSURE COMPLIENCE.

THE FACILITY HAS ASSESSED ALL CURRENT RESIDENTS AND WILL ASSESS ALL NEW ADMISSIONS FOR PRESSURE SORE RISK. TREATMENT AND PREVENTATIVE MEASURES HAVE BEEN IMPLEMENTED ON CURRENT RESIDENTS AS INDICATED BY THE ASSESSMENT.

ALL RESIDENTS WILL BE REASSESSED QUARTERLY WHEN THE MDS IS DONE.

RESIDENT #6 IS BEING TREATED PER PHYSICIAN'S ORDER AND BEING MONITORED FOR RISK.

RESIDENT #12'S BREAKDOWN IS NOW RESOLVED RESIDENT IS BEING MONITORED FOR RISK.

RESIDENT #15 IS BEING TREATED PER PHYSICIANS ORDER AND IS BEING MONITORED BY THE SKIN CARE TEAM.
HIS MEDICATIONS HAVE BEEN REVIEWED AND CHANGED BY HIS ATTENDING PHYSICIAN. THE AMITRIPTYLINE HAS BEEN DC'D AND OTHER CHANGES HAVE BEEN MADE TO MEET RESIDENT NEEDS.

RESIDENT #18 SKIN BREAKDOWN IS NOW RESOLVED AND RESIDENT IS BEING MONITORED FOR RISK.

RESIDENT #20 IS BEING TREATED PER PHYSICIANS ORDER AND IS BEING MONITORED FOR RISK.

RESIDENT #22 IS BEING TREATED PER PHYSICIAN ORDER AND IS BEING MONITORED FOR RISK

AN INSERVICE WILL BE HELD ON JANUARY 10, 2001 BY THE R.N. CONSULTANT FOR ALL NURSING STAFF REGARDING PRESSURE SORES INCLUDING PREVENTION, TREATMENT, NUTRITION, CURRENT STANDARDS OF PRACTICE AND DOCUMENTATION.

THIS INSERVICE WILL ALSO INCLUDE ENTRAPMENT HAZZARDS.

SEE ATTACHED POLICY AND PROCEDURES, AND INSERVICE FORMAT.

TAG #F323 ALL BEDS IN THE FACILITY HAVE BEEN CHECKED FOR ENTRAPMENT RISK, AND APPROPRIATE MEASURES HAVE BEEN TAKEN TO INSURE RESIDENT SAFTY.

ok E addendum 1/7/02 Addendum

AN ENTRAPMENT CHECK WITH DOCUMENTATION WILL BE DONE EACH MONTH TO ENSURE COMPLIENCE. THE QA TEAM WILL REVIEW EACH CHECK LIST.

ALL LIGHT FIXTURES NOW HAVE PROTECTIVE COVERS.

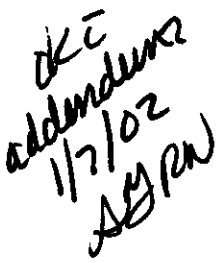
THE BLACK PLASTIC CARPET EDGING FOR ROOM 5 HAS BEEN REPLACED AND MAINTENANCE WILL DO A

MONTHLY WALK THROUGH TO ENSURE SAFTY ISSUES ARE MET.

THE LINOLEUM IN THE DINING ROOM ENTRANCE HAS BEEN REPAIRED TO INSURE SAFTY.

THE STAFF HAS BEEN INSERVICED ON THE USE OF THE MAINTENANCE LOG BOOK TO COMMUNICATE WITH THE MAINTENANCE DEPARTMENT TO ENSURE THAT ANY NECESSARY REPAIRS ARE MADE AND TO INSURE FACILITY SAFETY.

TAG # F386 ALL RESIDENTS SHALL BE OFFERED A BED TIME SNACK AND DOCUMENTATION WILL BE MADE ON THE RESIDENTS TREATMENT SHEET.




THE FACILITY SHALL CONTINUE TO HAVE ADDITIONAL SNACKS AVAILABLE FOR THOSE RESIDENTS WHO REQUEST A SNACK DURING THE NIGHT.

addendum to PDC 1/7/02

HEALTH AND HUMAN SERVICES
FINANCING ADMINISTRATION

**SURVEYOR NOTES WORKSHEET**

**Facility Name:** Pine Ridge Care Center **Surveyor Name:** [redacted]
**Provider Number:** 46A047 **Surveyor Number:** 14991 **Discipline:** RN
**Observation Dates: From** _____ **To** _____

| TAG / CONCERNS | DOCUMENTATION |
|---|---|
| | Telephone conversation with administrator [redacted] on 1/2/02 @ 3:00 PM. |
| | Addendum to POC |
| | F221 - The Director of nursing will monitor on a weekly basis<br>The Quality Assurance Committee will review on a monthly basis |
| | F-314 - The Director of nursing will monitor on a weekly basis<br>The Quality Assurance Committee will review on a monthly basis |
| | F-323 - The maint. person will do the entrapment check on a monthly basis<br>The Quality Assurance Committee will review on a monthly basis |
| | F-396 - The Director of Nursing will monitor on a weekly basis<br>The Quality Assurance Committee will review on a monthly basis. |

FORM HCFA-807 (7-95)

# *Mandatory Nursing Inservice*

## *Pressure Ulcers & Skin Care Policy/Procedure*

**To receive credit for this inservice:**

1. Read the attached *Resident Assessment Protocol: Pressure Ulcers* (pp76-78) and the revised PineRidge Skin Care Policy/Procedure .

2. Discuss with DON or RN Nurse Consultant any questions or concerns regarding reading material.

3. Tear off post-test, answer questions, sign it and return it to the DON.

## RESIDENT ASSESSMENT PROTOCOL: PRESSURE ULCERS

### I. PROBLEM

Between 3% and 5% (or more) of residents in nursing facilities have pressure ulcers (pressure sores, decubitus ulcers, bedsores). Sixty percent or more of residents will typically be at risk of pressure ulcer development. Pressure ulcers can have serious consequences for the elderly and are costly and time consuming to treat. However, they are one of the most common, preventable and treatable conditions among the elderly who have restricted mobility. Successful outcomes can be expected with preventive and treatment programs.

Assessment goals are: (1) to ensure that a treatment plan is in place for residents with pressure ulcers; and (2) to identify residents at risk for developing a pressure ulcer who are not currently receiving some type of preventive care program.

### II. TRIGGERS

***Pressure ulcer present or there is a risk for occurrence if one or more of following present (risk):***

- Pressure Ulcer(s) Present *(Present)* [a]
  **[M2a = 1,2,3,4]**
- Bed mobility problem *(Risk)*
  **[G1aA = 2,3,4,8]** [b]
- Bedfast *(Risk)*
  **[G6a = checked]**
- Bowel Incontinence *(Risk)*
  **[H1a = 1,2,3,4]**
- Peripheral Vascular Disease *(Risk)*
  **[I1j = checked]**
- Previous Pressure Ulcer *(Risk)*
  **[M3 = 1]**
- Skin desensitized to pain or pressure *(Risk)*
  **[M4e = checked]**
- Daily Trunk Restraint *(Risk)* [c]
  **[P4c = 2]**

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[a] Note: Codes 2, 3, and 4 also trigger on the Nutritional Status RAP
[b] Note: Codes 2, 3, and 4 also trigger on the ADL RAP
[c] Note: This code also triggers on the Falls RAP and Physical Restraints RAP

### III. GUIDELINES

Review the MDS items listed on the RAP KEY for relevance in understanding the type of care that may be required.

*Diagnoses, Conditions and Treatments that Present Complications.*

Consider carefully whether the resident exhibits conditions or is receiving treatments that may either place the resident at higher risk of developing pressure ulcers or complicate their treatment. Such conditions include:

**Diabetes, Alzheimer's Disease and other dementias.** An impairment in cognitive ability, particularly in severe end-stage dementia, can lead to immobility.

**Edema.** The presence of extravascular fluid can impair blood flow. If prolonged or excess pressure is applied to an area with edema, skin breakdown can occur.

**Antidepressants and antianxiety/hypnotics**. These medications can produce or contribute to lessened mobility, worsen incontinence, and lead to or increase confusion.

***Interventions/Programs to Consider if the Resident Develops a New Pressure Ulcer, or an Ulcer Being Treated is not Resolved.***

A variety of factors may explain this occurrence; however, they may suggest the need to evaluate current interventions and modifications of the care plan.

- Review the resident's medical condition, medications, and other risk factors to determine whether the care plan (for prevention or cure) addresses all potential causes or complications.
- Review the care plan to determine whether it is actually being followed (e.g., is the resident being turned often enough to prevent ulcer formation).

***Things to Consider If The Resident Is At Risk For Pressure Ulcers But Is Not Receiving Preventive Skin Care.***

Even if pressure ulcers are not present, determine why this course of prevention is not being provided to a resident with risk factors.

- Is the resident new to the unit?
- Do few or many risk factors for the development of pressure ulcers apply to this resident?
- Are staff concentrating on other problems (e.g., resolution of behavior problems) so that the risks pressure of ulcers are masked?

## PRESSURE ULCERS RAP KEY *(For MDS Version 2.0)*

### TRIGGER — REVISION

*Pressure ulcer present or risk for occurrence if one or more of following present:*

- Pressure Ulcer(s) Present (*Present*) [a]
  **[M2a = 1,2,3,4]**
- Bed mobility problem (*Risk*)
  **[G1aA = 2,3,4,8]** [b]
- Bedfast (*Risk*)
  **[G6a = checked]**
- Bowel Incontinence (*Risk*)
  **[H1a = 1,2,3,4]**
- Peripheral Vascular Disease (*Risk*)
  **[I1j = checked]**
- Previous Ulcer (*Risk*)
  **[M3 = 1]**
- Skin desensitized to pain or pressure (*Risk*)
  **[M4e = checked]**
- Daily Trunk Restraint (*Risk*) [c]
  **[P4c = 2]**

[a] Note: Codes 2, 3, and 4 also trigger on the Nutritional Status RAP

[b] Note: Codes 2, 3, and 4 also trigger on the ADL RAP

[c] Note: This code also triggers on the Falls RAP and Physical Restraints RAP

### GUIDELINES

*Other factors that address or may complicate treatment of pressure ulcers or risk of ulcers:*

- **Diagnoses or conditions:**

  Diabetes **[I1a]**, Alzheimer's disease **[I1q]**, Other dementia **[I1u]**, Hemiplegia/Hemiparesis **[I1v]**, Multiple Sclerosis **[I1w]**, Edema **[J1g]**

- **Interventions/Programs:**
  - Pressure relieving chair/beds **[M5a, M5b]**
  - Turning/repositioning **[M5c]**
  - Nutrition or hydration program to manage skin care problems **[M5d]**
  - Ulcer care **[M5e]**
  - Surgical wound care/treatment **[M5f]**
  - Application of dressings (with or without topical medications) other than to feet **[M5g]**
  - Application of ointment/medications (other than to feet) **[M5h]**
  - Preventative or protective skin care (other than to feet) **[M5i]**
  - Preventive or protective foot care **[M6e]**
  - Application of dressings to feet (with or without topical medications) **[M6f]**
  - Use of restraints **[P4c,d,e]**

- **Medications:**

  Antipsychotics **[O4a]**
  Antianxiety **[O4b]**
  Antidepressants **[O4c]**
  Hypnotics **[O4d]**

**Pressure Ulcers RAP Key 3 of 3**

# WEEKLY SKIN ASSESSMENT

(This form shall serve as the weekly narative and skin assessment on all skin problems)

RESIDENT_____ROOM #_____DATE_____

VITAL SIGNS B/P_____PULSE____RESP_____TEMP_____WT._____

NUTRITIONAL INTAKE 75-100%_____50-75%_____<50%_____

SUPPLIMENTS_____

FLUID INTAKE 75-100%_____50-75%_____<50%_____

SKIN TUGOR_____

B/B STATUS_____

AMB/MOBILITY _____

ADL PERFORMANCE_____

MOOD/BEHAVIOR PROBLEMS_____

CURRENT STATUS OF DIAGNOSIS_____

_____

ACTIVITY AND INTERACTION LEVEL_____

VISITORS_____

LIST ANY SKIN PROBLEMS I.E. SKIN TEARS, BRUSING, RASHES, EDEMA CELLULITIS PRESSURE SORES ETC. (indicate site, and appearance

_____

_____

_____

PREVENTATIVE MEASURE BEING USED:
EGG CRATE____HEEL PROTECTORS_____ELBOW PROTECTORS_____
CUSHION TO W/C_____OVERLAY_____OTHER_____

IF NEW WOUND, MAKE REFERRAL TO SKIN TEAM_____

NURSE SIGNATURE_____DATE_____

POLICY AND PROCEDURE

DECUBITIS ULCER-PREVENTION:

OBJECTIVE:

1. TO PREVENT AND TREAT PRESSURE ULCERS.

POLICY:

1. ASSESS RISK USING BRIGGS PRESSURE ULCER RISK ASSESSMENT FORM ON ALL NEW ADMISSIONS AND QUARTERLY WITH THE MDS SCHEDUAL.

2. IF SCORE OF EIGHT (8) OR GREATER THE PREVENTION PROTOCOL WILL BE IMPLEMENTED PER THE SKIN CARE TEAM

PROCEDURE:

EQUIPTMENT:

FACILITY WILL HAVE ON HAND:

1. SKIN LOTION.
2. ELBOW PROTECTORS.
3. HEEL PROTECTORS.
4. EGG CRATE MATTRESS.
5. EGG CRATE WHEEL CHAIR PAD

ROUTINE SKIN INTERVENTIONS:

1. KEEP SKIN CLEAN AND DRY BY WASHING WITH A MILD SOAP RINSING AND DRYING THROUGHLY.

2. APPLY SKIN LOTION AND MASSAGE GENTLY INTO THE SKIN.
   A. OVER BONY PROMINENCES.

3. REPOSITION PATIENT EVERY TWO HOURS AND POSITION WITH PILLOWS OR APPLY SPECIAL EQUIPTMENT OVER MATTRESS TO PROTECT BONY PROMINENCE.
   A. MAINTAIN ADEQUATE CIRCULATION.

4. INSPECT SKIN FOR REDNESS.
   A. NOTIFY CHARGE NURSE OF ANY REDNESS.

5. UTILIZE PREVENTIVE EQUIPTMENT, I.E.: EGG CRATE, ELBOW PADS, HEEL PROTECTORS, AS INDICATED.
   A. PREVENT PRESSURE FROM EXTERNAL SOURCES, SUCH AS CLOTHING, CASTS, BRACES OR ADAPTIVE DEVICES

6. MAINTAIN PROPER NUTRITION AND HYDRATION.
   A. RECORD DIET INTAKE.
   B. OFFER SNACKS AND FLUIDS AS INDICATED.
   C. BASELINE CBC AND SERUM ALBUMIN PER DR. ORDERS WITHIN 30 DAYS PRIOR TO ADMIT.

7. CNA'S NOTE CONDITION OF SKIN WITH EVERY TOILETING OR CHANGING AND REPORT TO NURSE.

8. WOUND CARE OR ULCER TREATMENT AS ORDERED BY M.D..

NURSING RESPONSIBILITY:

1. THE NURSE IS RESPONSIBLE FOR CARRYING OUT THE TREATMENT/PROTOCOL FOR THE PRESENT DECUBITIS ULCER ORDER PRESCRIBED BY THE RESIDENTS ATTENDING PHYSICIAN.

2. DOCUMENT TREATMENT ON TREATMENT RECORD AND CHART ALL PERTINENT OBSERVATIONS INCLUDING: A) DRAINAGE B) ODOR, C) APEARANCE, D) DEPTH OF ULCER, E) SIZE OF ULCER.

3. EVALUATE AND DOCUMENT EVERY WEEK ON ALL WOUND
   A. CHART DECUBITIS ULCERS INFORMATION ON THE PRESSURE ULCER REPORT FORM.

   B. ALL OTHER WOUNDS SUCH AS STASIS OR DIABETIC ULCERS ARE TO BE CHARTED ON THE SKIN CONDITION REPORT FORMS.

4. EVALUATE AND DOCUMUMENT ON WEEKLY SKIN ASSESSMENT SHEET ON ALL RESIDENTS. REPORT ANY SKIN VARIENCES TO THE NURSING SUPERVISOR.

5. THE PHYSICIAN WILL BE NOTIFIED OF ALL DECUBITIS ULCERS AND WOUNDS. THE APPROPRIATE PREVENTION PROTOCOL WILL BE INITIATED BY THE SKIN CARE TEAM AND DOCUMENTED ON THE CARE PLAN

# *Nursing Inservice Post-Test*

1. Pressure ulcers, pressure sores, decubitus ulcers and bedsores are all names for the same thing; wounds created over bony prominences due to unrelieved pressure or shearing.

   True or False

2. List 3 Triggers (risk conditions) that would indicate a potential for pressure ulcer development.

3. Dementia, edema and the use of antianxiety or sedative/hypnotic medications can contribute to the risk factors for developing a pressure ulcer.

   True or False

4. In the new PineRidge skin care policy/procedure, every residents skin should be assessed (visually checked) by a nurse:

   A. Daily
   B. Weekly
   C. Monthly
   D. When ever you get around to it

5. In the new Pine Ridge skin care policy/procedure, every resident should have the **Pressure Ulcer Skin Assessment** form done on admission then;

   A. Daily
   B. Weekly
   C. Monthly
   D. Quarterly with the MDS schedule

6. What form should be used to document the skin assessment ( visual check) on every resident?

7. Pressure ulcer treatments must be ordered by an MD and documented by nursing on the treatment sheet.

   True or False

8. Per the new facility policy, weekly documentation of existing pressure ulcers should be done using the **Pressure Ulcer Report** form.

   True or False

9. Wounds attributed not to pressure but other existing condition such as diabetes or venous stasis should be documented o the skin condition report form to differentiate them from those caused by pressure.

   True or False

10. Your name is _____ the date is _____