POC approved & accepted
By Karen Moffitt RN 8/21/00

DEPARTMENT OF HEALTH AND HUM/ SERVICES
HEALTH CARE FINANCING ADMINISTRATION

ATG
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465137	A. BUILDING _____ B. WING _____	7/13/00

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED CLIFFS REGIONAL	1745 EAST 280 NORTH ST. GEORGE, UT 84770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 225 SS=D	483.13(c)(1)(ii) Requirement STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by: Based on review of documentation and interview with	F 225 OK'd Kam 8/21/00	The facility will ensure that all alleged violations involving mistreatment and abuse are reported immediately to the Administrator of the facility and to the State Survey and Certification agency. With reference to the alleged abuse to resident 21: the staff member in question was suspended immediately by the facility upon report of the allegation (7-13-00). The Administrator of the facility and the Social Services designee initiated an investigation immediately and notified the appropriate agencies concerned. Upon completion of the investigation by the Administrator, Social Services designee, Adult Protective Services and the Long-Term Care Ombudsman, abuse was unsubstantiated. Follow-up reports were forwarded to all agencies. The Social Services designee and the Director of Staff Development will inservice facility staff on appropriate procedures for reporting allegations of mistreatment and abuse on 8-09-00 and at least quarterly thereafter. This inservice training will also be included in the orientation process for all new employees. The Administrator will monitor inservice training. All allegations of mistreatment and abuse will be referred immediately to the Administrator or the D.O.N. as per facility policy. Upon receipt of the initial report the Administrator, will notify the offices of the State Survey and Certification Agency and other appropriate offices, of the allegation. The Administrator will immediately begin an investigation into	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8-11-00

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 after 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 225	Continued From page 1 facility staff, it was determined that the facility did not ensure that all alleged violations involving mistreatment and abuse were reported immediately to the administrator of the facility and to the State Survey and Certification agency for 1 of 1 reported incident of abuse. Resident identifier; 21 Findings include : On 7/12/00, during an interview regarding the facility's policy and procedure relating to abuse prevention, recognition and reporting, the nursing assistant being interviewed mentioned that she had reported to the charge nurse an incident of staff to resident verbal abuse which had occurred on or about 6/26/00. The resident involved was resident 21. The nursing assistant stated that the RN charge nurse had requested documentation of the incident which the nursing assistant provided. On 7/12/00-7/13/00, the facility's documentation pertaining to allegations of abuse was reviewed. There was no record or documentation of the incident involving resident 21. On 7/13/00, at approximately 10:00 am, the facility Social Worker was interviewed. During the interview, the surveyor related the incident reported by the nursing assistant to the social worker. He stated that he had not heard any reports of the incident. He further related that after the charge nurse had received the report of abuse it would have normally been forwarded to him. He stated that he would then notify Adult Protective Services (APS) and the area's Ombudsman. When asked if he would also report the alleged incident to the State Survey and Certification Agency (SA), he replied that he did not routinely do so, because APS	F 225	will notify the offices of the State Survey and Certification Agency and other appropriate offices, of the allegation. The Administrator will immediately begin an investigation into the allegations which may include immediate suspension of any staff members implicated in the allegations. Upon completion of the investigation, or within 5 days (whichever is earliest), results of the investigation will be reported to the State Survey and Certification Agency by the Administrator. All allegations of abuse, the investigation and results will be reviewed by the Quality Assurance Committee at least quarterly and make recommendations as necessary.	9-11-00

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F 225	Continued From page 2 had told him that they notify the SA. On 7/13/00 at 3:00 PM, the Director of Nurses (DON) was interviewed concerning the alleged incident of verbal abuse involving staff to resident 21. She stated that the facility had contacted the staff involved and had determined that the RN charge nurse had given the documentation of the alleged incident to the Unit Manager. At this point the incident did not move any farther through the system. It was not reported to the social worker or the Administrator, nor was it reported to any of the required outside authorities. In addition no investigation had been done by the facility. The nursing assistant accused of the verbal abuse had continued to work with residents. The DON stated that once the facility became aware of the incident, on 7/13/00, the nursing assistant was put on suspension until the investigation could be completed.	F 225		
F 248 SS=D	483.15(f)(1) Requirement QUALITY OF LIFE The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: Based on observation, interviews and record review, it was determined that the facility did not provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being for 2 of 18 residents on the special needs unit. Resident identifiers: 52, 84	F 248	The facility will provide for an ongoing program of activities designed to meet, the accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of the residents. The "Personal Interest/Hobbies" section of resident 84's psychosocial assessment will be completed after interviewing resident's family. Country music will be provided for this resident during the day except at meal times, and during any other schedule activities. Staff interviews indicate that this resident prefers having her radio on all night and will become upset if it is off (she has no roommate at this time). This will also be provided for her. Recreation staff will direct resident 84 into all	

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F 248	Continued From page 3 Findings include: 1. Resident 84 was a 59 year old female with diagnoses of Alzheimer disease with depressive features and a seizure disorder. Resident 84 was admitted to the facility on 4/28/00 and resided in the locked special needs unit. Assessments: A review was made of resident 84's MDS (Minimum Data Set) dated 5/9/00. A review of Section B.4. Cognitive Patterns revealed that resident 84's cognitive skills for daily decision making were "3. severely impaired-never/rarely made decisions". A review of MDS Section C.4 and C.5 Communication/Hearing Patterns revealed that resident 84's ability to make self understood was "rarely/never understood" with " unclear speech-slurred, mumbled words". A review of MDS Section N.1,2,3 and 4 Activity Pursuit Patterns that resident 84 was "usually awake in mornings and afternoon" and that she had "1/3 to 2/3 of her awake time (when not receiving treatments or ADL care) to be involved in activities," the preferred setting for activities was the "day/activity room" and that resident 84 preferred "music activities". A review was made of the Activity Assessment on resident 84 dated 5/2/00. The review revealed that the area of past and current interest indicated that resident 84 actively participated in country music with no other areas marked except on the line of exercise/sports was written "unable to fully assess". A review of the comment section of the assessment revealed "....Unable to verbalize desires. Appears to enjoy having make up on et (and) will occasionally	F 248	scheduled activities and encourage to to participate with other residents. Staff will redirect resident 84 when wandering in other resident rooms and will offer alternatives (music, etc.). Recreation staff will walk with this resident around the facility and out of doors as weather permits. Resident 52 will be provided with activities to meet his interests or needs. Recreation staff and direct care staff will direct resident 52 into scheduled activities and encourage him to participate. Recreation staff will provide "Talking Books" for use by this resident and as a redirection tool when this resident is wandering. Recreation staff will walk with this resident around the facility and out of doors as weather permits. Another full-time recreation staff member has been employed at this time. The activities calendar has been reviewed and updated to reflect new programs and activities specifically designed for residents in the Special Needs Unit. In addition to the activities scheduled in the Unit, recreation staff will assist Unit staff in bringing residents into the activities in the main activity room as appropriate. Staff in the Special Needs Unit have been inserviced on the special needs of residents, the results of the Standard Survey, the regulations involving resident activities, and the new activity schedule for the SNU. Further; the staff was involved in creating activities and developing re-directional tools for all residents in the SNU. Recreation staff will complete all areas of the psychosocial assessment that are appropriate	

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allow rec. (recreation) staff to do hair et face."

A review of resident 84's psychosocial assessment dated 5/7/00 revealed no comments in the "Personal Interest/Hobbies" section and in the "Communications and Social Skills" section revealed that resident 84 had poor self esteem and required "much" encouragement to attend activities. Other areas marked in the communication and social skills section indicated resident 84's speech was not understandable, she did not make her needs known, and did not interact in groups nor start conversations. A review of the psychosocial assessment revealed resident 84 had minimal interaction with staff and residents and did respond to others.

A review of resident 84's care plan problem 2 dated 4/28/00 revealed that resident 84 was at "risk for social isolation r/t (related to) Alzheimer with depressive features". The goal of the care plan was "resident (84) will have 5-6 hours of bright affect in 24 hours for next 90 days". The approach was : "1. Monitor hours of bright affect q (each) shift. 2. Encourage resident (84) to come out of room and socialize as much as possible q shift. 3. encourage resident (84) to attend activities. 4. 1:1 with Social Services to assess feelings and listen..."

A review of resident 84's care plan problem 11 dated 5/9/00 revealed that resident 84 was at "risk for social isolation" with the goal as "resident (84) will attend 2 act (activities) per week et make eye contact during 1:1 x (times) 90 days." The actions/approaches were: "1-invite et assist resident (84) to activities. 2-Promote positive interaction. 3-provide positive communication. and 4-Visit with resident (84) 1:1."

to their area in order to create and implement a care plan that addresses the needs and interests of all residents of this facility. The Interdisciplinary Team will review and approve care plans and make recommendations as necessary.

The Quality Assurance Committee will review the activities calendar at least quarterly and make recommendations as appropriate. The Administrator will monitor for compliance. 9-11-00

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Observations:
On 7/11/00 observations were made on the special needs unit of resident 84 from 2:07 PM to 3:00 PM and from 4:12 PM to 4:38 PM (total of 1 hour and 19 minutes). During the observations resident 84 was observed to be walking in the hallway in front of the nurses' station and up and down the residential areas. Resident 84 was observed to enter various bedrooms that were not hers 8 times. Facility nursing staff were observed to redirect resident 84 only once, when she entered the dining room and another resident began screaming that resident 84 was bothering her. Facility staff were not observed to offer resident 84 any activities and no observable activity was being conducted on the special needs unit.

On 7/12/00 observations were made of resident 84 from 9:00 AM until 11:30 AM (a total of 2 hours and 30 minutes). During the observation from 9:00 AM until 9:17 AM resident 84 was observed walking in the hallway and entered 3 different resident bedrooms. Facility direct care staff and nursing staff were present in the area and made no attempt to redirect resident 84 from other residents' bedrooms or to provide her with anything to do. At 9:17 AM the activity staff took resident 84 with her into the dining room along with 11 other residents and read a story and reminisced. Resident 84 remained in the activity from 9:17 AM until 10:05 AM when the activity finished. From 10:05 AM until 11:30 AM resident 84 was observed walking up and down the hallway and in and out of other residents' bedrooms.

During the observation on 7/12/00 from 3:20 PM until 4:30 PM (a total of 1 hour and 10 minutes), resident 84 was observed to walk up and down the hallway and to enter into other residents' bedrooms 19 times.

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On 7/13/00 observations were made of resident 84 from 9:00 AM until 10:45 AM (a total of 1 hour and 45 minutes). During the observation resident 84 was observed to walk up and down the hallway and entered other residents' bedrooms. At 9:15 AM a facility direct care staff walked down the hallway and resident 84 came out of a bedroom (room 302) and the direct care staff asked resident 84, "Do you want to watch TV; want to just be out here; want to go lay down?" Resident 84 did not respond and the facility staff person walked on down the hallway. At 9:30 AM until 9:41 AM (total of 11 minutes) resident 84 was taken by a facility staff into the dining room and the facility staff put make-up on resident 84.

During the 6 hour and 34 minutes of observations, resident 84 was offered and participated in 59 minutes of activities.

Interviews:
On 7/11/00 and 7/13/00 interviews were conducted with the facility recreation staff. She stated that she was currently the only recreation staff at the facility and that she provided recreational services for the entire building. She stated that she tried to have a morning and an afternoon activity on the special needs unit, but had not been able to keep the schedule due to other demands. When asked if she individualized activities for residents such as resident 84 who are cognitively impaired and unable to make decisions of daily living, she stated that she had not and was not able to at the present time. She stated that the residents of the special needs unit could attend the building activities if they wanted to attend.

In an interview on 7/13/00, resident 84's husband

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stated that resident 84 enjoyed country western music and that he had provided a radio for her room. He stated that her radio had not been playing during any of his visits and that he visited almost daily. He, also, stated that resident 84 played ball (catch) with their small grandchildren and enjoyed activities with them.

2. Resident 52 was a 80 year old male with diagnoses of congestive heart failure, coronary artery disease, Alzheimer disease, cardiomyopathy and gastric esophageal reflux disease. Resident 52 resided on the special needs unit; his admission date was 3/17/00.

Assessments:
A review was made of resident 52's MDSs dated 6/20/00 (quarterly) and 3/28/00 (admission). A review of the MDS Section B.4. Cognitive Skills for Daily Decision Making revealed that resident 52 was "moderately impaired - decisions poor; cues/supervision required". A review of the MDS Section N. 1, 2, 3, and 4 Activity Pursuit Patterns revealed that resident 52 was awake "morning and afternoon" and his average time involved in activities (when awake and not receiving treatments or ADL care) was "some--from 1/3 to 2/3 of time", his preferred activity setting was the "day/activity room" and his general activity preferences were "music and walking/wheeling outdoors".

A review of resident 52's Activity Assessment dated 3/20/00 revealed past and current interests of resident 52 as "music, reading/writing, trips/shopping, walking/wheeling outdoors and talking or conversing". A review of resident 52's Activity Assessment revealed that he had short term and long term memory problems, was unable to make

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"consistent/reasonable decisions" and his "decisions (were) poor (with) cues/supervision required". A review of the comments on the Activity Assessment revealed, "...resident often leaves activity et needs to be redirected back. Attention span appears short."

A review of resident 52's Quarterly Activity Assessment dated 6/20/00 revealed, "assistance needed to participate. Resident appears to enjoy some act of choice, music, news of current events although will often wander away et requires redirection to activity."

A review of resident 52's care plan dated 3/17/00 and updated 6/20/00, revealed in problem 9 that resident 52 "had an alteration in activity level r/t (related to) multi (multiple) Dx (diagnoses)" with a goal of the "resident will attend 2 activities of choice q week for 90 days." The approach was: "1. invite to activity, 2. Assist to activities, 3. Provide activity of interest, 4. Orient to activities and 5. Orient to time et place."

Observations:
On 7/11/00 resident 52 was observed on the special needs unit from 2:07 PM until 3:00 PM and from 4:12 PM until 4:38 PM (total of 1 hour and 19 minutes). During the observations resident 52 was observed sitting in a chair by the nurses' station. During the observation there was no activity available on the special needs unit and no interaction with resident 52 except when he was offered a drink of juice.

On 7/12/00 resident 52 was observed from 9:10 AM, when he came from the dining room and was seated in the hallway by the nurses station, until 11:07 AM (total of 1 hours and 57 minutes). During the observation resident 52 was observed to sit in a chair

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by the nurses station. At 9:17 AM, resident 52 was asked by the recreation staff, "Do you want to come in and listen to a story and the play a game?" Resident 52 stated "no". Resident 52 remained in the chair by the nurses station until 9:21 AM when he got up and walked in the hallway and entered room 314 (bedroom which was not his). At 10:00 AM resident 52 returned to the chair by the nurses station and then got up and walked off the unit. Resident 52 was returned to the unit and sat in the chair by the nurses station. At 10:05 AM resident 52 was offered a drink or shake. At 10:13 AM resident 52 was in the hallway and left the unit and he was returned to the special needs unit hallway by facility staff from the east nursing unit. Resident 52 remained in the hallway either sitting in a chair by the nurses station or walking up and down the hallway until 11:07 AM. At 11:07 AM, resident 52 was taken to his bedroom by facility staff so he could take a nap.

On 7/12/00 resident 52 was observed on the special needs unit from 3:20 PM until 4:20 PM (1 hour). During the observation, resident 52 either sat in a chair by the nurses station or walked up and down the hallway. Once during the hour he left the special needs unit and was returned to the hallway by facility staff.

On 7/13/00 resident 52 was observed on the special needs unit from 9:00 AM until 10:45 AM (1 hour and 45 minutes). During the observation resident 52 was either sitting in a chair by the nurses station or walking up and down the hallway. Resident 52 left the special needs unit at 10:09 AM and 10:12 AM; both times he was return to the special needs unit hallway by facility staff.

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F 248	Continued From page 10 During the 6 hours and 1 minute that resident 52 was observed he was given snacks or water by facility staff, he was returned to the hallway when he left the unit, but he was not provided with any activities to meet his interests or needs. Interview: In an interview on 7/13/00 at 2:00 PM, the recreational therapist stated that she tried to have a morning and an afternoon activity on the special needs unit, but had not been able to keep the schedule due to other demands. When asked if she individualized activities for residents such as resident 52 who are cognitively impaired and unable to make decisions of daily living, she stated that she had not and was not able to at the present time. 3. In interview on 7/13/00 with the director of the special needs unit, the surveyor's observations of residents sitting or walking up and down the hallway were discussed. The director of the special needs unit stated that the facility did not have an activity staff assigned to the special needs unit and was in the process of hiring one. The director of the special needs unit stated that the facility did not at present have a multi-faceted program that reflected each individual resident's needs.	F 248		
F 281 SS=E	483.20(d)(3)(i) Requirement RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This Requirement is not met as evidenced by: Based on medical record review, interviews and direct observation, it was determined that the facility failed to adhere to acceptable professional standards of	F 281 OK'd Kam 8/21/00	The facility will adhere to acceptable professional standards of quality in the provision of services. Review of resident 14's medical chart showed that there was a physician's order for the treatment of the resident's cheek. This order was written on the bottom of the "Referral to Physician" form and was signed and dated	

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quality in the provision of services for 2 of 14 residents on the survey sample and 7 additional residents.
Resident identifiers; 14, 18, 20, 21, 24, 31, 47, 61, 65,

1. Medical record documentation for resident 14 was reviewed on 7/12/00. Resident 14 was admitted with the diagnosis of Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and was currently being treated for a possibly cancerous lesion on the left cheek and a skin tear on the right elbow.
Review of the July 2000, treatment sheet evidenced that the treatment being done to the left cheek was as follows: 1 Tbsp (tablespoon) white vinegar to 1 cup of warm water twice a day (BID), apply bactroban ointment after and between times with telfa until healed. The date the treatment began was 06/30/00. The treatment record indicated that the treatment was to be done in the AM and again in the PM. Documentation evidenced that 7 of the 12 AM treatments were initialed as being done. The PM treatment was initialed as being done for 12 of the 12 days. A review of the physician orders did not provide documentation of an order for this treatment. There was a notation in the nurse's notes of 06/30/00 at 2:30 PM of the above treatment being a new order.

The July 2000, treatment sheet also evidenced a treatment for a skin tear on the right elbow as follows: cleanse with Normal Saline (NS) and a 4X4 (a small gauze cloth), skin prep peri wound, apply Opsite and cover with Kerlix (a roll of stretch gauze) for extra protection, change every 5 days and as needed (PRN). The order was dated as being obtained on 06/28/00.

6-30-00. A copy of this order is attached. An order discontinuing any treatment to the skin tear on resident 14's right elbow was obtained on 7-22-00 from the physician indicating that the skin tear was resolved.

Resident 18's physician was contacted on 7-13-00 for clarification of order. Order is for treatment of 4th digit on right foot for 10 days. Telephone order was sent to physician for signature. The wound was resolved 7-23-00.

Resident 21's wound continues to resolve and is currently 4.5 cm. in length, dry and crusty. Resident 21 refuses dressing change on wound to left side of the neck and becomes verbally and physically aggressive when attempts are made to change dressing and secure with Mefix. Documentation in the resident chart reflects this. New orders from physician on 8-08-00 are to cleanse with normal saline and apply Opsite weekly.

Resident 24's ulceration on 2nd digit of left foot continues to heal. Description and nature of the ulceration is now reflected in the nursing documentation. Treatment order has been clarified and indicates time frame. Nursing Care Plan, monthly summary, treatment sheet and weekly skin sheets reflect care and documentation accurately.

Resident 31's skin tear on left upper arm was resolved on 7-29-00. Documentation in nursing notes indicate this and a physician's order to discontinue treatment due to resolution was received on 7-29-00. Nursing care plan accurately reflects this.

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This entire treatment was lined out and below was written "see new order" There was no documentation that there was a new physician order for treatment of the skin tear of the right elbow. There was no new treatment for the skin tear of the right elbow written on the July 2000, treatment record. There were no initials indicating that the treatment was done for the 12 days of July 2000,prior to the survey review on 07/13/00. There was no documentation in the nurse's notes describing the condition of the skin tear, any change of treatment for the skin tear or whether it had healed and treatment had been discontinued. Observation of the resident's right elbow on 07/12/00, evidenced a bruise where the skin tear had been, there was no open area and there was no dressing on the site. When asked if any treatment was still being done or, if not, when the wound had healed the charge nurse, who had accompanied the surveyor, replied that she was not sure.

2. On 07/12/00, the medical record for resident 18 was reviewed. Resident 18 was admitted 03/18/96 with the diagnosis of hypertension, macular degeneration and senile dementia. Review of the treatment record for July 2000, indicated the following: "neosporin ointment to the 4th digit right toe for ten days." The date of the order,according to the treatment record, was 07/12/00. The physician order, which was written on 07/11/00, was as follows: "Neosporin ointment to the 4th digit of the right hand BID for ten days." There was no documented description of what the lesion looked like or what type of a lesion was to be treated found in the medical record. Observation of the resident's 4th digit of the right hand and the right foot on 07/12/00, did not evidence a wound or open area in either location. When asked which area was being treated

In reference to residents 61, 65. 47 and 20: the nurse who completed the dressing changes on these residents has been inservice on the proper technique for dressing changes and in a manner that would keep wounds and dressings clean and prevent cross-contamination of wounds.

All nursing staff were inserviced on the findings of the survey team regarding standards of quality in documentation, continuity, monitoring and assessing, discontinuation of treatment and documentation of healed wounds, clarification of physician's orders and accuracy in transcription. These individual inservices were completed on 7-26-00.

The Director of Staff Development will conduct an inservice with the nursing staff on 8-09-00 regarding facility wound care protocols and professional standards in wound care, as well as professional standards of care related to nursing documentation.

Licensed nurses will review accuracy of documentation and physcian orders between telephone orders, order sheet, treatment sheets, nursing care plans, and nursing notes during 3-way check monthly. D.O.N. will monitor skin condition and treatments through weekly skin care meetings. Medical records will audit treatment records, nursing notes, physician orders weekly for those residents addressed in skin care meetings.

Dressing changes and use of correct technique by nursing staff will be monitored by D.O.N.

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the charge nurse accompanying the surveyor was observed to go to the nurse's station and check the treatment book. She then returned and stated that it was the right foot and that the treatment was being done on the evening shift.

3. On 07/13/00, the medical record for resident 21 was reviewed. The resident was admitted on 04/06/00, following an endarterectomy for an occluded carotid artery. Documentation in the nurse's notes on 06/05/00, indicated the resident had been "scratching" at the incision site which still had a scab and that the scab had been partly torn away. A physician's order was obtained that same day at 2:00 PM and reads as follows: " treatment to wound on neck, cover with gauze and secure with Mefix, change PRN". A multidisciplinary resident care plan was developed on 06/05/00, and addressed the risk of infection. Actions to be taken were change the dressing as ordered and monitor for signs and symptoms of infection. The only documentation in the nurse's notes referring to the wound on the resident's neck was found in a note dated 06/14/00 which read " resident continues with wound on neck which is covered with gauze" and in a note dated 07/10/00, which read "resistant to bandage change on neck." Review of the treatment record for June and July of 2000, evidenced the following: the bandage was applied on 06/05/00, it was changed on 06/08/00 (three days later), it was changed 06/13/00 (five days later), it was changed on 06/19/00 (six days later) and the next initialed documentation of the dressing being changed was on 07/10/00 (twenty days elapsed time between dressing changes).

4. On 07/11/00, the medical record for resident 24 was reviewed. An entry in the nurse's notes dated

and management nurses at least monthly. Director of Staff Development will provide additional inservices on correct wound care protocol as necessary.

Quality Assurance Committee will review weekly skin care reports and medical records audits at least quarterly and make recommendations as appropriate. The Administrator will monitor for compliance. 9-11-00

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07/05/00, at what appears to be 2:00 PM stated that the physician was in to see the resident and he debrided an ulceration on the 2nd toe of the left foot. There was no description as to the nature of the ulceration, the size or whether or not it was open. There was no documentation that indicated that the ulceration was noticed prior to the visit from the physician. There was no nursing care plan addressing the existence of the ulceration or the plan for healing. In contrast, the Monthly Summary dated 07/05/00, under the heading "skin" was designated as "intact". On 07/05/00, a physician's order was written as follows: "Apply polysporin and Band-Aid to left 2nd toe until healed". There was no time frame as to how often the treatment was to be done. The treatment record accurately reflected the order, however, there were no initials from 07/05/00 through 07/12/00, indicating that the treatment had been done.

5. On 07/12/00, the medical record for resident 31 was reviewed. Documentation in the nurse's notes indicated that the resident received a skin tear on the left upper arm on 06/28/00. There was no further documentation in the nurse's notes addressing the skin tear. On 06/28/00, a physician's order was obtained for the following treatment: "cleanse with normal saline and gauze, skin prep peri wound apply opsite, change every 5 days and PRN." Documentation on the July 2000, treatment record indicates the dressing was changed on 07/01/00 and on 07/03/00. There were vital signs written in the section for the dressing change on 07/07/00 and 07/11/00. The resident care plan lists under problem #21 skin impairment. The goal was for the skin tear to heal within two weeks. The approach was to do the dressing change. There

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was no date indicating when problem #21 was written. The site of the skin tear was not identified. The entire problem #21 was lined out with the word "resolved" written. There was no date indicating when it was resolved.

The previous 5 examples evidence poor standards of quality in documentation. There is no continuity describing the initial appearance of the various wounds and skin tears. Without the initial description the staff caring for the residents have nothing to compare current levels of improvement, nor would a worsening of the condition be easily identified. Periodic monitoring and assessing the wound is essential to evaluate the effectiveness of treatment Failure to provide comparative documentation could potentially lead to infections or deterioration of the condition that would not be identified in a timely manner to prevent complications. If wounds have healed, the acceptable standard of practice is to discontinue the treatment and document that the wounds have healed. Acceptable standards of practice also require that the facility obtain an order for any treatment a resident receives and that the transcription of a physician order be accurate. If there is a question concerning the order, such as whether the lesion is on the hand or the foot, the physician should be contacted to clarify the order.

6. Resident 61 was an 89 year old female who was admitted 7/8/00 following open reduction and internal fixation (surgical repair) of her left hip.

On 7/12/00 at 3:50 PM, an observation was made of the dressing changes for resident 61's left hip surgical incision site and for a lesion in the left crease of her abdominal apron skin fold. A nurse was observed to

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put on gloves to remove a soiled dressing from resident 61's abdominal wound. The nurse then removed the soiled gloves and put on a clean pair of gloves. Next, the nurse was observed to cleanse the open wound with a moistened gauze pad. Without washing or changing gloves, the nurse then prepared the clean dressing. The nurse was observed to arrange tape over the back of the new gauze dressing, then remove a "vaseline gauze" (adaptic type dressing) from its sealed packaging. The nurse was observed to fold and crease the "vaseline gauze", then set it on the clean side of the new dressing. The nurse smoothed the adaptic over the new dressing with her gloved fingers, then taped the new dressing over resident 61's open, abdominal wound.

The nurse was observed to put on gloves and remove the soiled dressings which were covering resident 61's left hip surgical wound. Resident 61's left hip surgical wound was observed to be steri-stripped (taped closed) and had open, draining areas at both the top and bottom ends of the linear incision. The nurse changed gloves to cleanse the wound. The nurse was observed to moisten a 2X2 gauze pad with sterile saline and wipe from left to right across the lower end of the wound. With the same moist gauze pad, the nurse was observed to wipe straight across the upper end of the wound, then wipe again across the lower end of the wound. With the same gauze pad, the nurse wiped from top to bottom along the length of the wound, first on the right side, then again on the left side of the incision line. The gauze cleansing pad had become pink with drainage from the wounds. The nurse then discarded the soiled gauze pad and changed gloves.

7. Resident 65 was a 78 year old male who was

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admitted to the facility on 7/5/00 with diagnoses including bilateral total knee arthroplasty (TKA), arthritis, and chronic obtructive pulmonary disease (COPD).

On 7/12/00 at 3:15 PM, an observation was made of the dressing changes performed by the nurse for resident 65. Wearing gloves, the nurse removed the dressing from an abrasion near resident 65's right knee surgical wound. The nurse proceeded to measure the surgical wounds over the right knee, then the left knee, using the same plastic measuring tool. Without washing or changing gloves, the nurse then used a sterile gauze pad moistened with normal saline to cleanse resident 65's right leg abrasion. The nurse changed gloves, then cleansed resident 65's right knee surgical incision. The nurse changed gloves before cleaning the residents left knee surgical incision. Without washing or changing gloves, the nurse proceeded to clean an open abrasion near resident 65's left knee surgical wound. The nurse changed gloves before applying a clean dressing to the left leg open abrasion, then without changing gloves, applied a new dressing to resident 65's left knee surgical incision.

8. Resident 47 was a 68 year old female admitted to this facility on 6/30/00. Her diagnoses were glaucoma, coronary artery disease, angina, hypothyroidism, seizures,blindness, and mental retardation.

Observations:

On 7/13/00 at 10:45 AM a nurse was observed to do a dressing change on resident 47, assisted by a CNA. The nurse was observed to glove and prepare a red biohazard bag for discarded soiled dressings. The

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nurse placed a folded towel under the right foot with the wound. She removed the replicare (adhering dressing) from the wound on the right heel of resident 47. The nurse cleansed the wound with a 4x4 gauze saturated with NS (normal saline). She dried the wound with one 4x4 gauze and applied skin prep adhesive. The nurse was observed to apply replicare and date the dressing change. The nurse did not change her gloves between the removal of the contaminated dressing, and the cleansing and application of a new clean dressing.

Interview:

An interview was conducted on 7/13/00 at 11:00 AM with the same nurse. She was asked if she was aware of the facility protocol related to glove changes during dressing changes. The nurse voiced understanding of the facility protocol. She stated "this sort of thing makes me nervous and I must have forgot."

9. Resident 20 was an 83 year old female admitted to this facility on 7/1/00. She had diagnoses of hypertension, gastric esophageal reflux, restless legs syndrome, and constipation. She was also taking coumadin for anti-coagulation. Resident 20 entered the facility with three stage II pressure sores. There was one ulcer on the left foot and one ulcer on the right foot. She also had an ulcer on her coccyx (upper tail bone).

Observations:

On 7/12/00 a nurse was observed to do a dressing change on resident 20 at 3:15 PM. The nurse gloved and preceded to remove the dressing from the wound on the right foot. She then removed the dressing from

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the wound on the left foot. The nurse removed the gloves and disposed of them. A new pair of gloves were put on. The nurse lifted resident 47's feet contaminating her clean gloves. Without changing her contaminated gloves, the nurse was observed to irrigate the wounds bilaterally with a syringe filled with NS (normal saline). Next she was observed, again without changing her gloves, to use a 4x4 gauze to wipe first the right wound dry and then with the same contaminated gauze wipe the left wound dry. The nurse then, without changing her gloves, applied bactroban, using the same Q-tip, to both wounds.

Interview:

On 7/12/00 an interview was conducted with the nurse who did the above treatment at 3:30 PM. The nurse was asked if she was aware of facility protocol on dressing changes. She stated she was aware. When further questioned concerning cross contamination and appropriate times to change gloves or wash her hands the nurse could not give a clear response.

The facility nurses were not observed to perform wound treatments in a manner that would keep wounds and dressings clean and prevent cross-contamination of wounds.

The 'Nurses's Clinical Guide, Wound Care' by Cathy Thomas Hess, Springhouse, 1995, pg. 48, sates, "For an open wound, moisten a gauze pad with the cleaning agent and squeeze out excess solution. Clean the wound in full or half circles beginning in the center and working toward the outside. Clean to at least 2.5 cm beyond the end of the new dressing or 5 cm beyond the wound margins if you are not applying a dressing. Use a new pad for each circle."

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F 281	Continued From page 20 The 'Clinical Practice Guideline, Quick Reference Guide for Clinicians, Number 15, Pressure Ulcer Treatment', Agency for Health Care Policy and Research, No. 95-0653, 1994, pg. 21, states, "Procedures to keep dressings clean and prevent cross-contamination should be established and rigorously adhered to". The reference further states, "Once the hands of the caregiver are soiled with wound secretions, they should not come in contact with the remaining clean dressings and other supplies until the gloves are removed and hands are washed."	F 281		
F 314 SS=G	483.25(c) Requirement QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This Requirement is not met as evidenced by: Based on observations, interviews and medical record review it was determined that the facility did not ensure that residents who entered the facility without pressure sores do not develop pressure sores and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for 2 of 10 residents on the focus sample and 1 additional resident. Resident identifiers: 34, 47 and 61. Findings include:	F 314	OK'd Kam 4/21/00 The facility will ensure that residents who enter the facility without pressure sores will not develop pressure sores and residents having pressure sores receive necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Resident 34 was taken to the wound clinc on 7-12-00. The wound on the right later foot was debrided and measured .8 cm by 5 cm diameter. Orders were received to treat this wound and for the resident to be in multipodus boots bilaterally. Further instructions were given regarding the boots including time frame for treatment. Resident 34 returned to wound clinic on 7-26-00 and the wound is currently at 0.2 cm x 0.1 cm diameter x 0.1 cm deep. Orders were given to continue same treatment with wound but time frame was changed to reflect healing. Weekly skin sheets are being completed on this resident as per facility protocol to accurately reflect condition of the wound. Shower	

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1. Resident 34 was an 87 year old female with a diagnosis of dementia with anxious features, CVA (cerebral vascular accident), hypertension, cholecystitis, and cataracts. Resident 34 was admitted to the facility on 02/12/98 with a history of pressure ulcers. The facility had identified resident 34 to be at risk for skin impairment evidenced by the following:

a. Review of resident 34's medical record revealed the Minimum Data Set (MDS) dated 6/13/00 in section M1 with the M section referring to skin conditions recommended that the resident needed pressure relieving devices. The Resident Assessment Protocol (RAP) summary triggered pressure ulcers.

b. Review of the Multidisciplinary Resident Care Plans dated 1/29/99, , 4/20/99, 7/20/99, 9/13/99, 1/5/00, 2/2/00, 4/5/00, 5/8/00, and 6/21/00 identified the following problems.
Problem # 7 "Risk for skin impairment R/t (related to) Incontinence et (and) immobility." The Time Measurable Goals stated "Res (Resident) will have no skin breakdown for next 90 days". The Actions/Approaches stated "Assess skin for redness et (and) breakdown q (every) shift...Reposition q (every) 2 (hours) et...Pressure Relieving devices on bed." The care plan addressing problem 7 stated "Risk for skin impairment r/t (related to) Incontinence d/t (do to) dementia and immobility related to CVA (cerebral vascular accident)." It also stated under Actions/Approaches "1. Assess skin for redness and sores q (every) shift and shower day.... 4. Reposition q (every) 2 hours and prn (whenever needed). 5. Pressure relieving devices to bed and 6. Encourage nutrition and fluids q (every) shift."

schedule has been changed to day shift ensure improved observation during daylight hours. Nursing documentation is being done to show interventions and accurately document condition of the wound. Pressure relieving mattress has been placed on resident 34's bed and a gel cushion has been placed in resident 34's geri-chair.

Resident 61's physician was contacted on 7-12-00 regarding pressure ulcers and orders were received for treatment. Dietary precautions and vitamin supplements were initiated per facility protocol on 7-13-00. Resident 61 was placed on a pressure relieving mattress. Nurses on this floor were counseled verbally by the D.O.N. regarding following facility protocols regarding skin assessment sheets and proper follow through. On 7-18-00, resident 61 saw the physician regarding wound care for wound under abdominal apron related to a yeast infection. which was discovered by nursing staff during routine care and was documented in the medical chart. On 7-31-00, resident 61 was discharged back to the hospital due to surgical complications requiring additional surgery.

Resident 47 is now on a pressure relieving mattress and a gel pad has been placed in the wheelchair. A sheepskin boot has been applied to the left heel. A pillow is being used between bony prominences to inhibit further decubitus formation. Dietary precautions and vitamin supplements have been initiated as per facility protocol. A multipodus boot has been placed on resident 47's left foot per physician's order.

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F 314	Continued From page 22 Problem 13 stated "Alteration in skin integrity R/T (right) heel pressure ulcer." The Time Measurable Goals stated "pressure ulcer will be healed in 90 days." The RRD (resident resolution date) was written "resolved 5/8/00". Problem 14 stated "Skin impairment r/t (related to) immobility." The measurable goals state "Pt. (patient) will have no skin breakdown next 90 days." It was documented as being resolved 5/7/00. c. The Treatment Record for July 2000, was reviewed 7/12/00. A treatment to the right foot beginning 7/11/00 stated "Wound (right) foot lateral: Wrap with roller gauze to protect wound till debridement via wound clinic." An additional entry regarding the above wound was written on 7/12/00, as follows: "Irrigate with NS (Normal saline) and gauze. Apply skin prep peri-wound & where dsng. (dressing) to adhere. Apply thin layer antiseptic ointment peri wound skin. Apply moistened algisite to wound bed covered with small piece of Adaptic. Cover with Opsite. Keep felt in multipodus (a pressure relieving boot which floats the heels) on (right) foot to protect from rubbing...". d. The Pressure Sore Risk Assessment sheet dated 12/28/99, 3/21/00, and 6/13/00 revealed that a "Total score of 8 or above represents High Risk" for pressure sores. Resident 34's total score was 12 for all three dates. All dates were signed and dated by the facility administration. e. The Monthly Summary dated May, 2000, stated "Skin intact...(sm. [small] scab (R) [right] heel only)." The Monthly Summary dated June, 2000, stated "Skin intact...Problem 7 goal met no breakdown...Problem	F 314	All licensed nurses have been inserviced individually by the D.O.N. regarding facility protocol for wound care, facility protocol for skin assessments, and need for accurate documentation and follow through of physician orders. Separate baskets have been put at each nursing station for shower/skin assessment sheets only, to ensure that nurses have access to these reports every day, each shift so that follow through is immediate. Nursing staff will be inserviced 8-09-00 by the Director of Staff Development on facility protocol regarding skin assessment sheets/shower sheets, procedure for filling them out, necessity of accuracy of information, necessity for immediate follow through. In addition; nursing staff will be inserviced on assessment, documentation and follow through of physician orders. Emphasis will be placed on skin integrity, pressure relieving devices and good turning and positioning. The D.O.N. will review skin assessment sheets weekly and make recommendations. Medical records will audit charts of those residents reviewed every week for accuracy in documentation and follow through of physician's orders, as well as treatments and the treatment sheets. Results of the audit will be given to the D.O.N. for follow up as necessary. The Quality Assurance Committee will review medical records audits and minutes of skin assessment committee meetings and will make recommendations as necessary. The	

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	465137	A. BUILDING _____ B. WING _____	7/13/00

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F 314	Continued From page 23 13 goal met no breakdown...". f. In the Referral to Physician Sheet dated 2/25/00 doctors orders stated "Float bilat. (bilateral) heels to relieve pressure..." "Left heel reddened, monitor daily." g. A telephone physician order obtained on 4/27/00 stated "To wound clinic for evaluation on left heel." Physician order dated 5/2/00 stated "Tx (treatment) to left heel:..." Physician order dated 5/7/00 stated "DC (discontinue) TX (treatment) to left heel d/t (do to) healed." h. Nurses notes dated 2/14/00 stated "Skin meeting stage II to right heel...Gel pad to chair." Nurses notes dated 6/14/00 stated "...put resident in Geri chair (Geriatric chair)." Physician order dated 6/14/00 stated "Geri-Chair when up..." Observation: a. Observation of a dressing change and skin check on 7/10/00 at 3:30 PM revealed a pressure sore which had not been discovered by the facility. The pressure sore was located on the right lateral foot and revealed a dry scab. The depth of the pressure sore could not be determined. The scab was dry and dark in color and attached. The facility nurse tried to debride the wound by pulling the scab off. The nurse was unable to remove the scab and stated that it was attached. The wound measured 1.7 cm. (centimeter) X (by) 1.2 cm.'s. The nurse stated it was a Stage II pressure ulcer The second wound, of which the facility was aware, on the right heel showed a dry	F 314	Administrator and D.O.N will monitor for compliance.	9-11-00

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scale measuring 1.1 cm. X 0.8 cm . with a small dark spot measuring 0.1 cm. in diameter.

b. Gel pad was recommended by the skin committee to be placed on the "resident's chair" on 2/14/00. Observation of resident 34's Geri chair on 7/13/00 at 10:00 AM revealed no Gel pad or pressure relieving device on resident 34's Geri chair. No Gel pad was observed in resident 34's room.

Interviews:

a. In an interview on 7/11/00 at 4:00 PM with a facility nurse, the nurse stated he was not aware of the newly discovered pressure sore on resident 34's right foot and would report it to the wound clinic immediately. He also stated that he would treat the pressure ulcer per verbal orders from the wound clinic until the appointment for evaluation and treatment the next day.

b. In an interview on 7/12/00 with the DON (director of nurses) she stated that she was not aware of the newly discovered pressure ulcer on the right foot of resident 34. She also stated that she was not sure how this had not been identified and that they would have to make some changes.

c. In an interview on 7/12/00 at 2:20 PM with a CNA (certified nurse assistant) the CNA stated "I don't check (resident 34's) feet all the time because they have the boots on and the nurse always checks them. I only check everything when I give her a bath."

The facility failed to follow their own processes which resulted in an undetected pressure ulcer.

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2. Resident 61, an 89 year old female, was admitted to the facility on 7/8/00 with diagnoses including Open Reduction and Internal Fixation (ORIF) of her left hip and Adult Onset Diabetes Mellitus (AODM).

Resident 61 was admitted on 7/8/00 without pressure ulcers. On 7/12/00, resident 61 was observed to have four pressure ulcers.

Observation:

On 7/12/00 at 4:00 PM, the nurse surveyor observed a skin assessment performed for Resident 61 by the Registered Nurse (RN) in charge of the resident's care. Resident 61 was observed to have a 1 centimeter (cm.) by 2 cm. open lesion on her left buttocks, a 0.5 cm. by 0.5 cm. open lesion on her right buttocks, and a 3 cm. linear lesion in the buttocks crack over her coccyx. The heel on resident 61's left foot was observed to be reddened, non-blanching, soft, and spongey.

Interviews:

In an interview on 7/13/00 at 11:55 AM, the RN in charge of resident 61's care for 7/12/00 and 7/13/00, stated she had not been aware of the wounds prior to the observation of them on 7/12/00 at 4:00 PM.

In an interview on 7/13/00 at 11:45 AM, a nurse's aide stated that he, and the certified nurse's assistant who was orienting him to the facility, had observed resident 61's buttocks wounds during her shower on 7/11/00. He stated he had noted the wounds on a shower day skin inspection form and left it at the

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nurse's station. The nurse's aide stated he "assumed (nurse) saw it (the form)", but he "can't say for sure".

In an interview on 7/13/00 at 10:15 AM with the Director of Nurses (DON) and the East Unit Manager, the DON stated that they "Just found out there is another pressure ulcer not listed". The East Unit Manager stated she had become aware of the wounds, "Just now in restraint meeting when I read the nurse's note" dated 7/12/00, which detailed resident 61's wounds.

Medical Records Review:

A review of resident 61's medical record revealed no documention of the wounds in the nurses' notes or on the physician's orders prior to 4:00 PM on 7/12/00. Resident 61 had been documented by the facility on care plan problem number two, dated 7/9/00, as having the "potential for skin breakdown" with the goal of "no skin breakdown over the next 90 days".

The admitting RN documented resident 61's nursing admission assessment as having been completed on 7/8/00. The assessment for resident 61 included a diagram of a human figure. The RN documented on the diagram that resident 61 had an "abdom. (abdominal) wound" and a "L (left) ORIF". The RN drew a line from each of the wound notations to the corresponding point on the figure which indicated the locations of resident 61's wounds. Notations on the assessment documented that resident 61's skin was dry and warm. No other skin conditions had been documented on the nursing admission assessment.

3. Resident 47 was admitted to this facility on

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6/30/00 with diagnoses of glaucoma, diabetes, coronary artery disease, angina, hypothyroidism, seizures, mental retardation and peptic ulcer disease. The admission skin assessment sheet was completed on 6/30/00 by the admitting nurse. In the section entitled "Comments" two entries were documented: a." negative for pressure sores." This entry was crossed out and the word "error" was written above it. b."pressure ulcer under blister" This entry was initialed as being made by a nurse other than the admitting nurse. In addition, the wound was identified on the drawing of a person and initialed by the second nurse.

Observations:

During observation of resident 47, it was noted that the resident had no pressure relieving device placed on the bed or wheelchair located next to her bed on 7/11/00. While observing resident 47 lying in bed on 7/11/00, it was noted that at 9:00 AM, at 10:00 AM, at 11:00 AM, and at 12:00 noon , resident 47 remained in the same position. That position was on her left side with her knees bent and her feet on top of each other. There was no sheepskin boot on either foot and no pillow between her legs. The sheepskin boot was located on resident 47's bedside table. During observation of resident 47 while lying in the bed, it was noted that the resident had no pressure relieving device placed on the bed or wheelchair located next to her bed on 7/12/00. While observing resident 47 lying in bed on 7/12/00 at 07:30 AM and at 09:30 AM resident 47 remained in the position of lying on her left side with her knees bent and her feet on top of each other. At 10:00 AM observation revealed resident 47 sitting in front of the nurses station in a large blue chair asleep. Resident 47 was

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wearing her personal slippers. Her wheelchair was located to the right of her. There was no pressure relieving device noted in the wheelchair or in the chair that resident 47 was presently sitting in. There was no sheepskin boot present on either foot.

At 1:30 PM on 7/12/2000 resident 47 was lying in bed . Resident 47 was in the same position as noted prior to the time spent in the blue chair at the nurses station. Resident 47 was lying on her left side with her knees bent and her feet on top of each other. There was no pressure relieving device noted on resident 47's bed or wheelchair. There was no pillow between her legs and no sheepskin boot on either foot.

Interview:

An interview with the DON (Director of Nursing) on 7/11/00 was conducted. She stated "(resident 47) should have a pressure relieving device on the bed and wheelchair, and should have a sheepskin for her heel" She stated "(resident 47) had one ordered on admit and I don't know why they aren't there now." When interviewing a CNA(Certified Nurse Aid) 7/11/00 on skin breakdown and protocol for treatment and prevention she stated "turn them every 2 hours in bed if we can, move them around, you know"

During an interview with the unit supervisor 7/12/00 she stated "We have ordered it, but it is not in yet, I guess."

An interview with the unit supervisor on 7/13/00 revealed that resident 47 had been transferred from the original bed in the room to the second bed in the room. The pressure relieving device had not been transferred with resident 47 to the new bed. There

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F 314	Continued From page 29 was no explanation as to why the pressure relieving device for the wheelchair was not present.	F 314		

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