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Utah Dept. of Health

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 8/26/20
FORM APPROVE
2567

SEP 16 2002
Bur. of Medicare/Medicaid Prog.
Certification and Res. Assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465064	A. BUILDING _____ B. WING _____	8/15/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GEORGE CARE AND REHAB CTR	1032 EAST 100 SOUTH ST GEORGE, UT 84770

acceptable POC 9/17/02 Shauna Kimel RN

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F 164 SS=E	483.10(d)(3) FREE CHOICE The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. This REQUIREMENT is not met as evidenced by: Based on observations and a resident group interview, it was determined that the facility was not providing residents privacy during personal cares. (Residents 41,43,44 and 83.) Findings include: 1. On 8/7/02 an observation of resident 41 was made at 7:40 AM. Resident 41 could be seen from the hallway outside her room. Resident 41 was observed to be lying on the bed, on her back, uncovered. Resident 41 was observed to be wearing a a hospital type gown and an incontinent brief. Resident 41 was also observed to be restrained to the bed with a soft	F 164	This plan of correction is prepared and submitted as required by law. St. George Care and Rehab Center by submitting this plan of correction does not admit that deficiencies listed on the CMS 2567L form exist, nor does the facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiencies cited. F164E Free Choice **Corrective Action for Identified Residents** All residents including #41, 43, 44 and 83 are to be provided privacy during cares by pulling privacy curtains around the bed area and/or closing the door to the room. All residents including #41, 43, 44 and 83 will be provided a cover when in nightclothes and in bed. And, when observed to not be using the cover the residents will be encouraged and assisted to use the cover. Shower curtains were put in each shower room during time of survey. This is to provide privacy if the door to the shower room is opened. Resident #83 was discharged to home on 8-31-02. **Identification of residents potentially affected.** All residents have the potential to be affected. **Measures to prevent recurrence.** The nursing staff will be inserviced by the Director of Nursing or Designee by 9-12-02 on the right of residents to be provided privacy during personal cares. There will be further inservice education for any identified non-compliant staff.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-13-02

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 164	Continued From page 1 waist restraint. The gown was up around resident 41's waist, exposing resident 41's brief and legs. 2. On 8/7/02 an observation of resident 43 was made a 7:35 AM. Resident 43 could be seen from the hallway outside her room. Resident 43 was observed to be lying on a mat on the floor next to her low bed, uncovered. Resident 43 was in a hospital type gown . The gown was open at the back exposing resident 43 from the waist down. Resident 43 had on an incontinent brief. 3. On 8/7/02, an observation of resident 44 was made at 7:35 AM. Resident 44 could be seen from the hallway outside her room. The privacy curtain was pulled half way from the wall to the middle of the bed. Resident 44 was observed to be lying on her bed exposed from the waist down. Resident 44 was observed being given incontinence care by a nursing assistant. 4. On 8/8/02, an observation of resident 83 was made at 4:30 AM. Resident 83 could be seen from the hallway outside his room. The overbed light was on above resident 83's bed. Resident 83 was observed lying on his bed, uncovered, and with out any clothing on. A nursing assistant was observed to be standing in the room next to resident 83's bed holding linen. 5. During a resident group interview, on 8/13/02, 6 of the 10 residents participating in the group interview stated that there was no privacy in the shower rooms. Each resident stated that when they were being showered, nursing assistants walked in and out of the shower room. The residents stated that there were no shower curtains in the shower rooms and when the door to the hall was opened, any one in the hall had full view of them in the shower room. The residents stated that this occurs every time they receive a	F 164	**Monitoring/Quality Assurance** An audit tool to monitor compliance with provision of privacy for residents during personal cares will be developed by 9-11-02 by the Director of Nursing or Designee. The Director of Nursing (DNS) or Designee will do audits weekly for 6 weeks. At the completion of the audits the DNS or Designee will report to the Performance Improvement Committee (Quality Assurance). Further audits and reports will then continue as may be directed by the Performance Improvement Committee. The Director of Nursing will be responsible for continued compliance. Completion Date: 9-13-02	

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F 164	Continued From page 2 shower.	F 164		
F 221 SS=K	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, resident record review, facility policy review and facility staff interviews, it was determined that the facility failed to assess residents medical symptoms that would necessitate the implementation and use of physical restraints for 9 of 9 sample residents (residents 9,17,18,41,45,78, 80, 96 and C1) and 1 supplemental resident, (resident 52), resulting in harm to 1 resident (resident 41). Due to the lack of assessment, the facility was found to be in Immediate Jeopardy. Findings include: Facility Policy A review of the facility "Physical Restraint Management" program was done on 8/8/02. The policy stated," Residents will be provided an environment that is restraint-free, unless a restraint is necessary to treat a medical symptom, in which case the least restrictive measures will be used. Except in emergency situations, a physical restraint will be used only after the interdisciplinary team has performed an assessment, attempted alternatives, determined the need for restraint and identified the least restrictive device."	F 221 OK 9/10/02 AM	F221K Physical Restraints **Corrective Action for Identified Residents** Residents #9, 17, 18, 41, 45, 78, 80, 96 and 52 were all reassessed by the interdisciplinary team (IDT) for the least restrictive measures and the medical symptoms that would necessitate the implementation and use of physical restraints. On 8-8-02 Resident #41 was reassessed for restraint reduction by the interdisciplinary team (IDT). The soft waist restraint (SWR) in bed was removed #41 was put on a low bed and mat. Side rails were removed. The soft waist restraint in the wheelchair was replaced with a lap buddy. Resident #18 was reassessed by the IDT for restraint reduction on 8-9-02. Resident #18's SWR in bed and wheelchair was discontinued. #18 was put on a low bed and mat and a lap buddy is used along with a seating device in the wheelchair. Resident #96 was reassessed by the IDT on 8-9-02 for restraint reduction. #96 continues on a low bed and mat and uses a lap buddy when up in the wheelchair. The SWR in wheelchair was discontinued. #96 was assessed by the Occupational Therapist and a wheelchair positioning device was implemented on 8-14-02	

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F 221	Continued From page 3 Resident Review 1. Resident 41 was admitted to the facility on 12/5/97 with diagnoses of Alzheimer's dementia. Observation of resident 41 on 8/7/02 at 7:40 AM, revealed resident 41 lying on her back in bed. Resident 41 was observed to be restrained in the bed with a soft waist restraint (SWR). The restraint was secured to the frame of the bed. Resident 41 was observed to have dark purple bruising on her forehead, left eye, left cheek and both arms. A review of resident 41's medical record was done on 8/7/02 at 7:45 AM. A Minimum Data Set (MDS) assessment completed by facility staff on 7/9/02, documented that resident 41 had short and long term memory problems and her cognitive skills for daily decision making were severely impaired. The facility staff also documented that resident 41 wandered, seemingly oblivious to needs or safety. The facility staff documented that resident 41 was able to transfer with limited assistance and was able to ambulate with supervision. No documentation could be found in resident 41's medical record that the interdisciplinary team had performed an assessment, attempted alternatives,determined the need for the restraint or identified the least restrictive device for resident 41, previous to initiating the SWR on 8/5/02. Review of the nurses' notes revealed that resident 41 had been residing in the facility SCU (Special Care Unit), a secured unit, until 8/5/02. Further review of resident 41's medical record revealed the following nurses' notes and physicians	F 221	Resident #9 was reassessed for restraint reduction by the IDT on 8-9-02. The SWR in bed and wheelchair were discontinued. #9 now uses a low bed and mat with an alarm and a lap buddy in the wheelchair. The mat was assessed by IDT to be more of an obstacle than an accident preventive measure when resident #9 attempted to stand from the mat. Therefore, the mat was removed on 9-6-02. Resident #78 was reassessed for restraint reduction by the IDT on 8-9-02. The SWR in bed and chair were discontinued. #78 now uses a low bed and mat and a lap buddy when in the wheelchair. Resident #17 was reassessed for restraint reduction by the IDT on 8-9-02. #17's SWR in the wheelchair was discontinued. #17 now uses a low bed and mat and a lap buddy with an alarm when in the wheelchair. Resident #80 was reassessed for restraint reduction by the IDT on 8-9-02. The SWR in bed was discontinued. #80 now uses a low bed and mat. He was assessed as to still need the SWR in the wheelchair due to his high fall risk related to decreased cognition and safety awareness. His ability to remove the lap buddy made this alternative ineffective. #80 returned from a planned hospitalization on 9-5-02 and was reassessed by IDT to now be a candidate for use of a lap buddy in the wheelchair. #80 presently uses a lap buddy in the wheelchair and continues use of a lowboy bed and mat. Resident #45 was reassessed for restraint reduction by the IDT on 8-9-02. The SWR in the wheelchair was discontinued. #45 continues in a low bed and mat and now uses a lap buddy with an alarm in the wheelchair.	

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F 221	Continued From page 4 orders: On 8/4/02 at 5:00 PM, a facility nurse documented, "Called to Unit- [resident 41] missed the seat of the chair she was going to sit in and sat on the floor-no apparent injuries...." On 8/4/02 at 6:00 PM, a facility nurse documented, "Called to Special Care Unit found Pt [patient] on floor &[and] head with lrg [large] gash-skin tear on (L) [left] elbow-sent to E.R. [emergency room] via ambulance-returned via amb [ambulance] [with] stitches (5) in (l) forhead-lrg bruise on forehead, sister at bed side-Physician notified...unresponsive when first arrived...responded by squing (sic) CNA's hand @ [at] 2200 [10:00 PM]...." On 8/4/02 at 11:00 PM, a facility nurse documented, "...unresponsive. Involuntary movements noted in hands. Forehead (L) bruised et [and] swollen...." On 8/4/02 at 12:00 AM, a facility nurse documented, "...Remains unresponsive." On 8/5/02 at 3:00 AM, a facility nurse documented, " Vomited...unresponsive..." On 8/5/02 at 4:15 AM, a facility nurse documented, "...Pt. unresponsive...Vomited...." On 8/5/02 at 7:00 AM, a facility nurse documented, "Lethargic, responds to painful stimuli...." On 8/5/02 at 8:00 AM, a facility nurse documented, "Mod [moderate] amt [amount] green emesis....Opens eye when name called...." On 8/5/02 at 10:00 AM, a facility nurse documented, "[Physician] notified of the emesis...Moans @ times	F 221	Resident #52 was reassessed on 8-9-02 by the IDT for restraint reduction. #52 continues with a lap buddy in the wheelchair. Resident C1 is a closed record so no current intervention was possible. C1 was discharged on 7-31-02. **Identification of residents potentially affected.** All residents who are restrained have the potential to be affected. **Measures to prevent recurrence.** The Director of Nursing and Assistant Director of Nursing were inserviced by 8-23-02 by the facility's corporate District Director of Clinical Operations on the facility's physical restraint management program. No physical restraint is to be used except in an emergency until there has been a documented interdisciplinary assessment to determine the medical need and least restrictive alternatives have been first attempted. Soft waist restraints will not be used in bed. Soft waist restraints will not be used in the wheelchair unless least restrictive measures such as lap buddies have been tried first and assessed by IDT as ineffective. The Director of Nursing or Designee will inservice the licensed nurses by 9-12-02 on the facility's policy: 1) to be restraint free unless a restraint is necessary to treat a medical symptom. 2) To use the least restrictive measure. 3) to not utilize restraints, except in emergency situations, until after the	

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F 221	Continued From page 5 when moved, unable to eat @ present time, lethargic...." On 8/5/02 at 12:30 PM, a facility nurse documented, "...Meds given at 1200, able to drink glass of water..." On 8/5/02 at 5:00 PM, a facility nurse documented, "Pt. attempting to get out of bed [without] assist multiple times. Pt. unsteady. Pt. is [increased] fall risk. Phoned daughter...to inform about mothers [decrease] in condition. Permission granted for pt. to be moved to 300 hall so that SWR can be implemented to prevent falls. On 8/6/02 at 11:30 AM, a facility nurse documented, "A/O [alert and oriented] X [times] 1 [to self]. Ate breakfast in the dinning room [with] help...Pt has SWR on while [up] in bed. Tolerates well." On 8/6/02 (actually 8/7/02) at 1:15 AM, a facility nurse documented, "Pt found fallen from bed, hanging from restrain (softwaist). Was hanging approx [approximately] 1 inch above floor. Brown semi-formed emesis on floor...Bruise below (R) [right] eye. Ice applied. Reddend area around waist from SWR. SWR reapplied more secure [with] 2 fingers width. MD [physician] notified orderes (sic) received to monitor pts status Q [every] 1 hr [hour] for any [changes] from present neuro status..." A physician telephone order for resident 41, dated 8/5/02, un-timed and unsigned, documented, "Use lap buddy while in w/c [wheelchair] and SWR while in bed. Remove q 2 [hours] for cares. Restraints d/t [due to] fall hx [history] [with] head injury...." A second physician order for resident 41, dated 8/7/02 at 12:30 AM, also unsigned, documented, "Monitor	F 221	interdisciplinary team has performed an assessment, attempted the least restrictive measure, and determined the medical need for restraint use and 4) no soft waist restraints are to be used in beds. A specific nurse, presently it is the Assistant Director of Nursing, is to be in charge of the restraint interdisciplinary team. Every resident with a restraint was reassessed by the interdisciplinary team for medical necessity, the least restrictive measure and the medical need for use of a restraint. **Monitoring/Quality Assurance** Director of Nursing or Designee will develop an audit tool by 9-12-02. This tool will monitor compliance with completion of an interdisciplinary team assessment for the medical necessity and use of the least restrictive measures prior to the implementation of a restraint. Director of Nursing (DNS) or Designee will complete audits weekly for 6 weeks. At the conclusion of the audits the DNS will report to the Performance Improvement Committee (Quality Assurance). The Performance Improvement Committee (PIC) will direct audits and reports based on the percent of compliance as indicated by the audits. If the audits indicate attainment of 100% compliance then audits and reports will be done quarterly for two quarters and then as directed by the PIC. If the audits indicate less than 100% compliance at completion of the first six weeks of auditing, then audits and reports will be done monthly until audits indicate attainment of 100% compliance. Then audits and reports will be done quarterly for two quarters.	

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F 221	Continued From page 6 neuro status q 1 [hour]/24 hr. Notify MD of any [change] from present condition, Ice pack to (R) eye 20 min [minutes] on , 20 min off x 24 hrs." On 8/7/02 at 11:30 AM, a facility nurse documented, " At 6:10 Pt is alert but doesn't verbalize. Neuro [check] done...pupil are equal [and] react to light. Pt has SWR on while in bed....Pt awake, responds to pain stimuli...Pupils equal [and] react to light at 930/A [AM]...Called MD got order to DC [discontinue] neuro check for next 24 [hours] as pt didn't fall to floor was hanging from restraint...." Observations of resident 41, done at different times on 8/7/02 and 8/8/02, revealed the following: On 8/7/02 at 7:40 AM and 8:15 AM, resident 41 was observed to be lying in bed, on her back with a SWR in place secured to the frame of the bed. On 8/7/02 from 8:40 AM to 9:10 AM, resident 41 was observed to be in the dining room, up in a wheel chair with a SWR in place. On 8/7/02 at 9:20 AM, 10:15 AM, 10:50 AM and 11:20 AM, resident 41 was observed to be lying in bed, on her back with a SWR in place secured to the frame of the bed. On 8/7/02 at 12:20 PM, resident 41 was observed to be in the dining room, up in a wheel chair with a SWR in place. At 12:25 PM a facility nurse removed resident 41's SWR. On 8/7/02 at 1:15 PM, resident 41 was observed to be taken from the dining room, a lap buddy was placed on her wheelchair and resident 41 was placed in the hall. On 8/8/02 from 4:00 AM to 5:00 AM, resident 41 was	F 221	As the facility's vehicle for quality assurance, the PIC will then direct any further audits as the PIC may assess as to be or not to be further indicated. The Director of Nursing will be responsible for continued compliance. Completion date: 9-13-02.	

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observed to be lying in bed, on her back with a SWR in place secured to the frame of the bed.

An interview was held with a facility staff nurse on 8/7/02 at 3:00 PM. She stated that resident 41 had been moved to the 300 hall on 8/5/02 because she had fallen in the SCU and needed to be restrained. She stated that residents could not be restrained in the SCU because it was considered a "double restraint." The facility nurse also stated that the nursing staff were not doing anything for resident 41 other than making sure she did not fall.

An interview was held with a second facility nurse on 8/7/02 at 3:15 PM. She stated that resident 41 was moved from the SCU because she was no longer an AWOL (absent without leave) risk. She stated that resident 41 needed to be restrained due to her fall, and residents could not be restrained in the SCU. She also stated that the nursing staff were not doing anything special for resident 41 except trying to prevent her from falling again.

An interview was held with a third facility nurse on 8/8/02 at 4:00 AM. The nurse stated that the facility had not tried resident 41 on a low bed because resident 41 might try to stand up and could fall again.

Resident 41's physician was interviewed by phone on 8/8/02. The physician stated that he could not recall for sure if the facility had contacted him to initiate the SWR in bed. The physician did state that he had not been made aware that resident 41 had been found hanging from the SWR on 8/7/02.

The facility could not provide any documentation that resident 41 had been assessed for the appropriateness of the SWR after resident 41 had been found hanging by the SWR from bed on 8/7/02.

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2. Resident 18 was admitted to the facility on 4/6/99, with diagnoses of Alzheimer's dementia, hypertension, diabetes mellitus and hypothyroidism.

Review of resident 18's medical record was done on 8/7/02.

A significant change MDS assessment for resident 18 was completed by facility staff on 6/14/02. The staff assessed resident 18 as being severely cognitively impaired with short and long term memory problems. Resident 18's bed mobility was assessed as needing no assistance and he required total dependence with his transfers. The staff assessed resident 18 as needing no restraints.

Review of resident 18 's plan of care revealed that the use of or the need for soft waist restraints was not on the care plan.

The recertification of physician orders dated July 2002, documented that since 4/18/02, resident 18 was to have a low bed with a mat on the floor for safety. The physician's recertification orders documented that since 6/12/02, resident 18 was to have a chair alarm.

A physician telephone order dated 6/3/02, documented that resident 18 was to have a lap buddy while in the wheelchair and if not effective, to use a soft waist restraint for safety.

A physician telephone order dated 7/17/02, documented that resident 18 was to have a soft waist restraint in bed and in wheelchair. The order described the purpose of the soft waist restraint was for resident 18's safety related to him trying to get up

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by himself and a history of falling.

No documentation could be found in resident 18's medical record that the interdisciplinary team had performed an assessment, or determined the need for the SWR previous to initiating the SWR on 7/17/02.

An occupational therapy evaluation note dated 7/17/02 documented, "... Pt was found to slide out of the chair under soft waist restraint on the floor often times getting restraint wrapped around his neck...."

A nurse's note dated 5/29/02, documented, " Pt got out of bed and fell, judging from the way he fell, he may have tripped over mat by bedside...."

A nurse's note dated 5/30/02 documented, "...Shows no further injury r/t (related to) fall, mat removed from bedside to avoid any further accidents...."

On 8/7/02 at 9:00 AM and 9:30 AM, resident 18 was observed in the hallway in a wheelchair with a soft waist restraint on.

On 8/7/02 from 10:00 AM through 11:00 AM, resident 18 was observed to be in bed, with the door closed and had a soft waist restraint on tied to the frame of the bed.

On 8/7/02 at 12:15 PM and 12:30 PM, resident 18 was observed to be in the dining room, in a wheelchair, with a soft waist restraint on.

An interview with a facility nurse was done on 8/8/02 at 4:00 AM. She stated that resident 18 was no longer on a low bed because resident 18 was trying to get up and walk away from his bed.

3. Resident 96 was admitted to the facility on 8/24/01

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F 221	Continued From page 10 with diagnoses of stroke, left side hemiparesis and anxiety. On 8/7/02 at 8:00 AM, resident 96 was observed in the dining room, in a wheelchair, wearing a soft waist restraint. Resident 96 was observed to have a large contusion on her forehead. A review of resident 96's medical record was done on 8/7/02. A nurse's note dated 8/6/02 at 9:30 AM, documented that resident 96 was found outside of the facility, in the parking lot, with her wheelchair tipped over on her. The nurses' note also documented that resident 96 had a large hematoma to her forehead with bruising to her left elbow and hand. An incident report dated 8/6/02, documented that resident 96 had a soft restraint on when she tipped over in her wheelchair. The assistant director of nursing (ADON) was interviewed on 8/8/02 at 9:45 AM. The ADON stated that when they found resident 96 tipped over in her wheelchair outside, she had a soft waist restraint on. No documentation could be found in resident 96's medical record that the interdisciplinary team had performed an assessment, attempted alternatives, determined the need for the restraint or identified the least restrictive device for resident 96, previous to initiating the lap buddy or the SWR on 4/8/02. The recertification of physician orders dated July 2002, documented that since 4/8/02, resident 96 was to have a lap buddy while in wheelchair and a low height bed with a mat. The order described the purpose of the lap buddy was because she had a fall history and	F 221		

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F 221	Continued From page 11 was trying to get up by herself. There was no physician order for a soft waist restraint for resident 96. A nurse's note dated 7/4/02 at 6:40 PM, documented a soft waist restraint was being used while resident 96 was in her wheelchair and that she had a low bed present in her room. A nurse's note dated 7/18/02, documented that resident 96 may have a lap buddy or a soft waist restraint on while in her wheelchair. A annual MDS assessment for resident 96 was completed by staff on 5/18/02. The staff assessed resident 96 as being moderately cognitively impaired with a short term memory problem. Resident 96's bed mobility was assessed as needing limited assistance and requiring extensive assistance with her transfers. The staff assessed resident 96 as needing a trunk restraint that was to be used on daily basis. Resident 96 was care planned for potential for trauma on 9/5/01. One of the nursing interventions was to have resident 96 wear a lap buddy while in wheelchair and lay in a low height bed with mat because she falls. There was no documentation in the care plan for the use of or the need for a soft waist restraint while resident 96 was in her wheelchair. 4. Resident 9 was admitted to the facility on 1/31/02 with diagnosis of fractured hip, hypertension, hypothyroidism and osteoarthritis. On 8/7/02 at 10:50 AM, resident 9 was observed to be on her bed with a SWR in place, secured to the frame of the bed. Resident 9 was observed to be sliding towards the edge of the bed attempting to put her feet on the floor. Resident 9 also had a motion detector bed alarm at the foot of the bed which was set off by	F 221		

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resident 9's legs. Resident 9 continued to try and slide under the SWR and get out of the bed until the nursing staff responded to the alarm.

A review of resident 9's medical record was done on 8/7/02.

A Significant Change MDS assessment completed by facility staff on 7/4/02, documented that resident 9 had short and long term memory problems and her cognitive skills for daily decision making were severely impaired. The facility staff documented that resident 9 had periods of altered perception or awareness of surroundings and periods of restlessness. The facility staff documented that resident 9 was independent with bed mobility and needed limited assistance with transfers. The facility staff also documented that resident 9 used trunk restraints on a daily basis.

A physician order for resident 9 dated 7/1/02 documented, "Soft waist restraint on while in bed and in w/c for safety R/T falls [check] q 20 min...."

No documentation could be found in resident 9's medical record that the interdisciplinary team had performed an assessment, attepted alternatives, determined the need for the restraint or identified the least restrictive device for resident 9, previous to initiating the SWR on 7/1/02.

Review of the nurses notes for resident 9 revealed the following:

On 6/28/02 at 10:30 AM, a facility nurse documented, "Pt came into DR [dining room] [with] rt [right] arm bleeding--stated, 'she fell in BR [bathroom]'...."

On 6/29/02 at 1:30 PM, a facility nurse documented,

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"...Able to untie bed restraints...."

On 7/5/02 at 10:00 AM, a facility nurse documented, "Pt has SWR in bed [and] w/c et [and] cont [continues] to get out of SWR...."

On 7/8/02 at 4:00 PM, a facility nurse documented, "Pt cont to have SWR while in w/c et in bed. Is put on properly and yet resident is able to get out of restraint and is found on toilet or in room changing her clothes."

On 7/8/02, a nurse's note un-timed and unsigned documented, "...Manages to release her SWR and to slip out of the bed restraint- a bed alarm has been ordered...."

On 7/16/02 at 2:00 PM, a facility nurse documented,"Gets out of restraints while in w/c or in bed...."

The facility could not provide any documentation that resident 9 had been assessed for the appropriateness of the SWR even though resident 9 continued to get out of the restraints.

5. Resident 78 was admitted to the facility on 7/17/02 with diagnoses that included glioblastoma (tumor) of the brain, pneumonia, seizure disorder, and renal insufficiency.

Observation of resident 78 on 8/8/02 at 4:30 AM revealed that resident 78 was laying in his bed with a soft waist restraint in place. The bed was elevated at a 45 degree angle and resident 78 was observed to be slouching down in the bed and the soft waist restraint was observed to be around resident 78's chest area. The restraint was secured to the frame of the bed. The 1/2 side rails on the bed were in the up position.

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A review of resident 78's medical record was on 8/7/02 and again on 8/13/02. This review revealed the following documentation.

The MDS admission assessment, dated 7/27/02, documented in Section P.4. "Devices and Restraints", that resident 78 did not use side rails or restraints.

A physician's order, dated 7/18/02, documented, "SWR [soft waist restraint] while in bed per family request for safety R/T [related to] fall risk".

A physician's order, dated 7/28/02, documented, "SWR while in bed [and] chair. Off q [every] 2 [hours] for cares-R/T [related to] High Risk fall".

An "Interdisciplinary Physical Restraint Assessment" form, dated 7/17/02, documented that resident 78 was assessed as needing 1/2 side rails for turning and positioning. There was no "Interdisciplinary Physical Restraint Assessment" form for the use of a soft waist restraint found.

A nurse's note, dated 7/18/02 at 4:00 PM, documented, "SWR while in bed per family request R/T high fall risk.

A nurse's note, dated 7/29/02 at 11:00 PM, documented, "...SWR R/T high fall risk...".

A nurse's note, dated 8/3/02, documented, "...1/2 SR [side rail] x [times] 2 for turning and repositioning...".

A review of resident 78's comprehensive care plan revealed no care plan problem for the use of 1/2 side rails or a soft waist restraint while in the bed or chair.

6. Resident 17 was admitted to the facility on

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F 221	Continued From page 15 11/30/02 with diagnosis of fractured hip, and Alzheimer's disease. On 8/7/01 at 1:15 PM, resident 17 was observed to be in the dining room, in a wheel chair with a SWR in place. A review of resident 17's medical record was done on 8/7/02. A quarterly MDS assessment completed by facility staff on 5/28/02, documented that resident 17 had short and long term memory problems and her cognitive skills for daily decision making were severely impaired. The facility staff documented that resident 17 had an unsteady gait and had fallen in the past 31 to 180 days. The facility staff also documented that resident 17 used a chair that prevented rising on a daily basis. The comprehensive plan of care for resident 17 dated 7/16/02, documented under problem 6, that resident 17 was to have a SWR in the chair. No physician order could be found in resident 17's medical record for the SWR restraint. No documentation could be found in resident 17's medical record that the interdisciplinary team had performed an assessment, attempted alternatives,determined the need for the restraint or identified the least restrictive device for resident 17, previous to initiating the SWR. Nurses' notes for resident 17 dating from 5/5/02 through 8/4/02, consistently document that resident 17 had a SWR in place when up in the wheelchair. 7. Resident 80 had several admissions to the facility	F 221		

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and was readmitted to the facility on 7/26/02 with diagnosis of fractured hip, staph infection, delirium, osteoarthritis and osteoporosis.

A review of resident 80's medical record was done on 8/8/02.

The history and physical for resident 80, completed by the residents physician documented that resident 80 had had several falls, fracturing his right hip twice, which had required surgical intervention twice.

A physician telephone order dated 7/26/02, unsigned, for resident 80 documented to use a SWR while in bed and w/c d/t high fall risk.

Review of the nurses' notes for resident 80 dating from 7/26/02 through 7/31/02, consistently document that resident 80 had a SWR in place while in bed.

No documentation could be found in resident 80's medical record that the interdisciplinary team had performed an assessment, attempted alternatives,determined the need for the restraint or identified the least restrictive device for resident 80, previous to initiating the SWR on 7/26/02.

An interview with a nursing assistant who provided care to resident 80 was held on 8/8/02 at 4:30 AM. The nursing assistant stated that resident 80 had been observed with his feet and legs off the bed, attempting to get out of bed. The SWR was around his waist and tied to the frame of the bed.

8. Resident 45 was admitted to the facility on 4/20/02, with diagnoses of dementia, streptococcal septicemia, hyposmolarity, gastroenteritis, gastroesophageal reflux disease, hyponatremia and dysphagia.

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F 221	Continued From page 17 Review of resident 45's clinical record was done on 7/7/02. A significant change MDS assessment for resident 45 was completed on 6/14/02 by the facility staff. The staff assessed resident 45 has being severely cognitively impaired. Resident 45's bed mobility was assessed as needing no assistance and requiring limited assistance with her transfers. The staff assessed resident 45 as needing a trunk restraint that would be used on a daily basis. Resident 45 was care planned for potential for trauma on 6/3/02. One of the nursing interventions was a low bed with a mat and lap buddy while she was in her wheelchair. The care plan for resident 45 also documented that the lap buddy in her wheelchair was to be discontinued on 6/5/02 and was to have a soft waist restraint in her wheelchair. A physicians's telephone order dated 5/8/02, documented that resident 45's side rails were to be discontinued and resident 45 was to be placed in a low bed with a alarm. The physician orders also documented that a lap buddy was to be used while resident 45 was in her wheelchair. A physician's telephone order dated July 2002, documented since 6/5/02, resident 45 was to have her lap buddy discontinued and to have her wear a soft waist restraint while in wheelchair for safety. No documentation could be found in resident 45's medical record that the interdisciplinary team had performed an assessment or determined the need for the lap buddy or the SWR for resident 45, previous to initiating the restraints on 6/4/02 and 6/5/02. A nurse's note on 6/5/02,documented that resident 65	F 221		

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had learned to take off her lap buddy while in her wheelchair and an order was obtained to place resident 45 in a soft waist restraint.

On 8/7/02 at 7:15 AM, resident 45 was observed in her wheelchair with a lap buddy in place.

9. Resident 52 was admitted to the facility on 5/22/97 with diagnosis of hypertension, arthritis, and dementia.

On 8/7/02 at 1:15 PM, resident 52 was observed to be up in a wheel chair in the hall with a lap buddy in place.

A review of resident 52's medical record was done on 8/7/02.

The physician recertification orders for resident 52 dated 7/1/02 through 7/31/02, documented an order for a lap buddy while in W/C that had been initiated 1/21/02.

A quarterly MDS assessment completed by facility staff on 7/2/02 documented that resident 52 used a chair that prevented rising on a daily basis.

A comprehensive care plan dated 5/9/02 for resident 52 documented under problem 15, that resident 52 was to use a lap buddy while in the wheel chair for safety.

Nurses' notes for resident 52 dating from 3/8/02 through 8/2/02, consistently document that resident 52 had a lap buddy in place while up in the wheel chair.

No documentation could be found in resident 52's medical record that the interdisciplinary team had performed an assessment, attempted alternatives,determined the need for the restraint or identified the least restrictive device for resident 52,

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previous to initiating the lab buddy on 1/21/02.

10. Resident C1 was admitted to the facility 7/2/02 with diagnosis of myocardial infarction, unstable angina, osteoporosis and dementia.

A review of resident C1's medical record was done on 8/7/02.

A physician telephone order dated 7/2 , untimed, documented, "Soft waist restraint while in bed and w/c x 12 [hours] for safety."

An admission MDS assessment completed by facility staff on 7/9/02, documented that resident C1 had short term memory problems and her cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident 9 had an unsteady gait and had fallen in the past 30 days. The facility staff also documented that resident C1 used trunk restraints daily.

The care plan for resident C1 did not address the use of restraints.

No documentation could be found in resident C1's medical record that the interdisciplinary team had performed an assessment, attempted alternatives,determined the need for the restraint or identified the least restrictive device for resident C1, previous to initiating the SWR on 7/2/02.

Review of the nurses' notes for resident C1 revealed the following:

On 7/2 at 11:00 PM, a facility nurse documented, "Pt is alert and disoriented. Family into visit. Pt trying to ambulate [and] leave. Very agitated, tearful and agrees to soft waist restraint while in bed and

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F 221	Continued From page 20 w/c....Haldol IM [intermuscular] given for [increased] agitation...." On 7/3/02 at 11:00 PM, a facility nurse documented, "...SWR while in bed for safety...." On 7/4/02 at 2:45 PM, a facility nurse documented, "...Has SWR while in bed et while in w/c...." On 7/8/ at 11:00 PM, a facility nurse documented, "...SWR while in bed for safety...." From 7/9/02 through 7/21/02 facility nurses documented resident C1 had SWR when in bed and up in w/c on a daily basis. On 7/28/02 at 2:30 AM. a facility nurse documented, "pt was found on floor next to bed [without] injury noted, SWR applied...." A physician telephone order, unsigned, for resident C1 dated 7/28/02 at 2:30 AM documented, "SWR while in bed, w/c. Pt fell this AM. Dx [diagnosis] dementia." Resident C1 was discharged to home on 7/31/02. INTERVIEWS An interview with the director of nursing (DON) was held on 8/7/02 at 2:30 PM. The DON stated that she knew that the facility was using a lot of restraints. The DON stated that the facility had a really good restraint program but she had not yet organized the program. The DON further stated that this was an area that she knew the facility was lacking in. The DON stated that	F 221		

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F 221	Continued From page 21 the facility did not have a formal restraint committee, however during monthly "Performance Improvement Meetings" residents that were being restrained were discussed. On 8/8/02, the minutes from the facility's 7/16/02 "Performance Improvement Meeting" were reviewed. The documentation in those minutes revealed that the facility had identified a high percentage of residents that were being restrained. The minutes documented that each resident would be reviewed and the review would be completed by 8/16/02. A second interview was held with the DON on 8/8/02 at 9:45 AM. The DON was asked if the facility had implemented the plan to review the restraints as documented in the "Performance Improvement Meeting." The DON stated that the plan was to train a facility nurse to implement the facility restraint management program and to date the program had not been started.	F 221		
F 242 SS=E	483.15(b) QUALITY OF LIFE The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, individual interviews and a confidential interview with a group of alert and oriented residents, it was determined that for 2 of 22 sample residents and 4 supplemental residents the facility did not allow the residents the right to make	F 242	OK 9/17/02 DD F242 E **Corrective Action for Identified Residents** The residents are served meals prepared specifically for each resident by the dietary staff. Tray cards for Residents # 11, 21, 51, 57 and 86 will be higlighted to bring attention to the likes and dislikes. Dietary and nursing staff will be inserviced as identified below. #83 was discharged to home 8-31-02. **Identification of residents potentially affected.** All residents have the potential to be affected.	

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F 242	Continued From page 22 choices about aspects of their life in the facility that was significant to them. Specifically, residents were served foods that the residents had informed the facility that they did not like. Resident identifiers: 11, 21, 51, 57, 83, and 86. Findings include: 1. During the lunch and meals, on 8/13/02, observations were made in dining room one and dining room four. The following resident trays were observed: a. Resident 11's meal card documented dislikes of "all apples." Cinnamon apples were observed on her tray, she stated she did not ask for them and she did not like them. b. Resident 86's meal card documented a no concentrated sweets diet with likes recorded of extra margarine and gravy. There was no margarine observed on her tray, she stated that she received no margarine and she could not eat her corn muffin without it. c. Resident 57's meal card documented dislikes including watermelon. Watermelon was observed on her tray, she stated she did not want the watermelon. d. Resident 51's meal card documented likes of extra margarine and soup in mugs. Observations of his tray revealed no margarine and his soup in a bowl. He stated that he wanted margarine for his muffin and that he could not hold his soup to eat it. e. During an interview on 8/13/02 with resident 83's wife she stated that "he is always getting ice cream and he doesn't want it. He likes sherbet." She produced a cup of melted ice cream with a sticker on it that read	F 242	**Measures to prevent recurrence.** The dietary staff will be inserviced by 9-12-02. by the Consultant Registered Dietician or Designee on the requirement to serve residents their likes and to not serve residents their dislikes. The nursing staff and department heads will be inserviced by 9-12-02 by the Director of Nursing or Designee on the requirement to serve all residents their likes and to not serve residents their dislikes. The dietary staff, nursing staff and department heads will be inserviced at these inservices, to read and follow the tray cards that list residents' likes and dislikes. **Monitoring/Quality Assurance** The Dietary Service Manager or Designee will develop an audit tool to monitor compliance with serving residents their food likes and not serving them their food dislikes. The Dietary Service Manager (DSM) or Designee will do weekly audits for six weeks. At the completion of the audits the DSM or designee will report compliance to the Performance Improvement Committee (Quality Assurance). Audits and reports will then continue as may be directed by the PIC. The Dietary Service Manager will be responsible for continued compliance. Completion date: 9-13-02.	

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	465064	A. BUILDING _____ B. WING _____	8/15/2002

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F 242	Continued From page 23 "sherbet." A review of resident 83's meal card revealed his likes including sherbet. Ice cream was not listed. f. On 8/13/02 at 5:30 PM, resident 11 was observed to receive a glass of lemonade with her dinner meal. Resident 11 stated to facility staff that she did not like lemonade. Review of the meal card that accompanied resident 11's dinner meal revealed the following documentation, "Beverage: 8 oz [ounce] sugar free drink (no lemonade)...". g. On 8/13/02 at 1:00 PM, resident 21 was observed to receive spiced apples with his lunch meal. On 8/13/02 at 5:30 PM, resident 21 was observed to receive a large bunch of grapes with his dinner meal. Review of the meal card that accompanied resident 21's lunch and dinner meals revealed the following documentation, "Dislikes: Fruit/fruit/juice, raw veggies". h. During a confidential group meeting with facility residents, on 8/13/02 at 11:00 AM, eight of ten residents stated that they were served foods that they had informed the facility that they did not like.	F 242		
F 278 SS=E	483.20(g) - (h) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the	F 278	OK 9/1/02 SB F 278 E Resident Assessment **Corrective Action for Identified Residents** The Minimum Data Set (MDS) for residents # 18, 69, 71, 78 and 80 were corrected.	

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F 278	Continued From page 24 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly-- Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to complete MDS (Minimum Data Set) assessments that accurately reflected the resident's status for 5 of 22 sample residents. Resident identifiers: 18, 69, 71, 78, and 80. Findings include: 1. Resident 69 was re-admitted to the facility on 6/24/02 with diagnoses that included, pneumonia, Parkinson's, atrial fibrillation, hypothyroidism, benign prostatic hypertrophy, and depression. a. On 8/13/02, resident 69's significant change in status/medicare readmission MDS assessment, dated 6/28/02 was reviewed and revealed the following documentation: Section G. "Physical Functioning and Structural	F 278	A correction request form was completed for Resident # 69 on 8-13-02 requesting a change on the MDS, with an assessment reference date (ARD) of 7-7-02, to reflect the use of an indwelling catheter. Resident # 69's 14-day Medicare MDS with ARD of 7-7-02 reflected dehydration . However the 30-day Medicare MDS with an ARD of 7-15-02 reflected a correction of the dehydration. Resident # 69 had a 60-day Medicare MDS that was also a significant change in status MDS with an ARD of 8-13-02. The indwelling catheter was removed on 8-17-02 and this MDS reflected this change in continence to now be incontinent. Also # 69 was now using a scooter which was reflected in a change in locomotion. There was a correction request form completed on 9-6-02 for the MDS with ARD of 8-13-02 to add the use of siderails. ½ rails were used as an enabler. A correction request form was completed for Resident # 71 on 8-19-02 requesting a change on the MDS, with an ARD of 8-5-02, to accurately reflect #71's aphasia. Siderails were used as an enabler and MDS was hand corrected to reflect this use. Resident #71 expired on 8-28-02. A correction request form was completed on 9-5-02 for Resident # 78 requesting a change on the MDS, with ARD of 8-15-02, to accurately reflect use of a restraint. Siderails and use of soft waist restraint were discontinued on 8-9-02. #78 was changed to a lap buddy in the wheelchair and to a low boy bed. A correction request form was completed on 8-14-02 for resident # 78 requesting a change on the MDS, with ARD of 7-27-02, to accurately reflect use of an indwelling catheter.	

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Problems" documented that resident 69 required extensive assistance with bed mobility and bathing. The assessment documented that resident 69 was totally dependent on staff for ambulation, dressing, eating, toilet use, and personal hygiene.

Section H. "Continence In Last 14 Days" documented that resident 69 was frequently incontinent of bladder and had no indwelling catheter.

Section P.4. "Devices and Restraints" documented that resident 69 did not require side rails or restraints.

b. On 8/13/02, resident 69's medicare 14 day MDS assessment dated 7/7/02, was reviewed and revealed the following documentation.

Section G. "Physical Functioning and Structural Problems" documented that resident 69 required limited assistance with bed mobility, eating and transfers. The assessment documented that resident 69 required extensive assistance with ambulation, dressing, toilet use, personal hygiene and bathing.

Section H. "Continence In Last 14 Days" documented that resident 69 was frequently incontinent of bladder and had no indwelling catheter.

Section J. "Health Conditions" documented that resident 69 had exhibited problems with dehydration in the last 7 days.

Section P. 4. "Devices and Restraints" documented that resident 69 did not require side rails or restraints.

c. On 8/13/02, resident 69's Medicare 30 day assessment dated 7/15/02, was reviewed and revealed the following documentation.

A correction request form was completed on 8-14-02 for Resident # 18 requesting a change on the MDS, with ARD of 6-11-02, to accurately reflect use of a restraint. Soft waist restraint was discontinued on 8-9-02 and # 18 was changed to a lap buddy in the wheelchair with a positioning device. Also # 18 was put on a low boy bed.

Resident # 80 was discharged to the hospital on 8-27-02 for planned surgery. He was readmitted on 9-5-02. A comprehensive admission MDS will be completed to accurately reflect his present condition.

Identification of Residents Potentially Affected

All residents have the potential to be affected.

Measures to Prevent Recurrence

Nursing management including the Director of Nursing, Assistant Director of Nursing and Utilization Coordinator will be inserviced by the facility's corporate District Director of Clinical Operations, DDCO, by 9-12-02 on:

1. definition of a comprehensive MDS assessment
2. Definition of a significant change in condition necessitating a significant change in condition MDS.
3. Use of the MDS 2.0 Manual by Briggs to determine how to interpret and accurately answer the MDS questions.
4. The importance of viewing and communicating with the resident, according to the residents ability to communicate, before completing the MDS Assessment.

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F 278	Continued From page 26 Section G. "Physical Functioning and Structural Problems" documented that resident 69 required limited assistance with bed mobility, transfers and eating. The assessment documented that resident 69 required extensive assistance with ambulation, dressing, toilet use, personal hygiene and bathing. Section H. "Continence In Last 14 Days" documented that resident 69 was frequently incontinent of bladder and had no indwelling catheter. Section P.4. "Devices and Restraints" documented that resident 69 did not require side rails or restraints. d. On 8/13/02, review of resident 69's medical record revealed the following documentation. A nurse's note dated 6/24/02 at 12:30 PM, documented that resident 69 had an indwelling catheter in place. Nurse's notes dated 6/30/02, 7/1/02 and 7/6/02 documented that resident 69 had no sign and symptoms of dehydration. A nurse's note dated 6/28/02 at 5:00 PM, documented, "...Refused to be on low boy bed, low boy bed Dc'd [discontinued] by DON [director of nurses], has two 1/2 side rails for positioning, turning..." A physician's order, dated 6/28/02, documented, "D/C low boy bed - Begin 1/2/ SR [side rail] x [times] 2 for turning and repositioning". e. Observation of resident 69 during an interview with the resident on 8/12/02 at 5:15 PM, resident 69 was observed to have an indwelling catheter and drainage bag in place. Resident 69 stated that he had the indwelling catheter for a long period of time. When asked if he had the indwelling catheter when he was	F 278	The staff designated to complete and fill out sections of the MDS will be inserviced by the Utilization Coordinator or Designee by 9-12-02 on the same topics discussed in the inservice presented to the nursing management by the DDCO. The Utilization Coordinator will register and attend one of the all day training sessions on the MDS presented by the State of Utah with the first session scheduled for 9-25-02. **Monitoring/Quality Assurance** An audit tool will be developed by the Director of nursing, DNS, or Designee by 9-11-02 to monitor MDS accuracy related to continence/incontinence, indwelling catheter use, restraint use, change in physical functioning, hydration status and the use of siderails. The completion of comprehensive MDS assessments when indicated will also be monitored. The DNS or Designee will do weekly audits for 6 weeks. At then completion of the audits the DNS or Designee will report compliance to the performance Improvement Committee (quality assurance). Audits and reports will then continue as may be directed by the Committee. The Director of Nursing will be responsible for continued compliance Completion date: 9-13-02	

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F 278	Continued From page 27 admitted to the facility he stated, "yes". f. In an interview, with the facility nurse that completed the MDS assessment on resident 69, on 8/14/02 at 3:30 PM, she stated that she had not done a significant change MDS when resident 69 had an improvement in his physical functioning status as required. The facility staff did not accurately assess resident 69's indwelling catheter, hydration status or his need of 1/2 side rails. The facility staff did not assess the significant change in resident 69's physical functioning. 2. Resident 71 was re-admitted to the facility on 7/30/02 with diagnoses that included, cerebral vascular accident with right hemiparesis, hypertension, seizure disorder, and atrial fibrillation. a. On 8/14/02, the Medicare 5 day assessment was reviewed and revealed the following documentation. Section C "Communication/Hearing Patterns" documented that resident 71 was understood when expressing self, and used distinct, intelligible, clear speech. Section P.4. "Devices and Restraints" documented that resident 71 did not require the use of side rails or restraints. b. During an interview with resident 71 on 8/14/02 at 10:00 AM, resident 71 was observed laying in her bed with a 1/2 side rail in the up position on both sides of the bed. Resident 71 was able to answer yes and no questions and use hand gestures to communicate.	F 278		

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F 278	Continued From page 28 c. On 8/14/02, resident 71's medical record was reviewed and revealed the following documentation. The admission nursing assessment, dated 7/30/02, documented that resident 71 did not speak and was aphasic (absence or impairment of the ability to communicate through speech). A nurse's note, dated 7/30/02 at 11:00 PM, documented, "Pt. [patient] it alert, no verbal but responds to yes and no questions..." A "Speech-Language Pathology Evaluation", dated 7/30/02, documented, "...Pt. presents [with] relative global aphasia-[with] [no] functl [functional] verbal skills [and] ability to follow only single step basic directions..." Resident 71's comprehensive care plan documented a problem of "Trauma potential for falls". The approaches for this problems included, " 1/2 Siderails x 2 for T&R [turning and positioning] while in Bed". The facility staff did not accurately assess resident 71's communication status or resident 71's use of side rails. 3. Resident 78 was admitted to the facility on 7/17/02 with diagnoses that included glioblastoma (tumor) of the brain, pneumonia, seizure disorder, and renal insufficiency. a. On 8/13/02, the MDS admission assessment, dated 7/27/02 was reviewed and revealed the following documentation. Section H. "Continence In Last 14 Days" documented that resident 78 was frequently incontinent of bladder and had an indwelling catheter.	F 278		

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The instruction for section H. states that a resident should be considered continent when they have complete control of their bladder or when an indwelling catheter is used.

Section P.4. "Devices and Restraints" documented that resident 78 did not use side rails or restraints.

b. Observation of resident 78 on 8/8/02 at 4:30 AM revealed that resident 78 was laying in his bed with a soft waist restraint in place. The 1/2 side rails were in the up position.

c. On 8/14/02, resident 78's medical record was reviewed and revealed the following documentation.

A physician's order, dated 7/18/02, documented, "SWR [soft waist restraint] while in bed per family request for safety R/T [related to] fall risk".

An "Interdisciplinary Physical Restraint Assessment" form, dated 7/17/02, documented that resident 78 was assessed as needing 1/2 side rails for turning and positioning.

A nurse's note, dated 7/18/02 at 4:00 PM, documented, "SWR while in bed per family request R/T high fall risk."

The facility did not accurately assess resident 78's use of an indwelling catheter, side rails or a soft waist restraint.

4. Resident 18 was admitted to the facility on 4/6/99, with diagnoses of Alzheimer's dementia, hypertension, diabetes mellitus and hypothyroidism.

Review of resident 18's medical record was done on

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F 278	Continued From page 30 8/7/02. A physician telephone order, dated 6/3/02, documented that resident 18 was to have a lap buddy while in his wheelchair and if not effective to use a soft waist restraint for his safety. A nurse's note, dated 6/4/02, documented that resident 18 had a lap buddy while in his wheelchair for safety. The nurse's note, dated 6/9/02, documented that resident 18 was in his wheelchair with a soft waist restraint in place. A significant change MDS assessment for resident 18 was completed by staff on 6/14/02. The staff assessed resident 18 as being severely cognitively impaired with a short and long term memory problem. Resident 18's bed mobility was assessed as needing no assistance and he required total dependence with his transfers. The staff assessed resident 18 as needing no restraints. 5. Resident 80 was readmitted on 7/26/02 with diagnoses of MRSA (methicillin resistant staph aureus) infection right hip wound, s/p right hip fracture, delirium, history of cancer of the prostate, osteoporosis, and osteoarthritis. a. Review of resident 80's medical record, on 8/12/02, revealed the following: The admission Nursing Assessment, dated 7/26/02, documented the presence of an indwelling catheter and PICC (IV) line. The physician's Patient Physical Examination, dated 7/26/02, documented that resident 80 had a PICC line right upper arm, a white heel, a leg brace in place, an indwelling catheter in place and contact precautions	F 278		

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F 278	Continued From page 31 for MRSA. A nurse's note, dated 7/26/02, documented that resident 80 was readmitted to the facility with a hard plastic brace, right knee/femur MRSA, and high risk for heel break down bilaterally, PICC line in place for antibiotic treatment. Resident 80 was transferred to a hospital on 7/12/02 and readmitted to the facility on 7/26/02 with no documentation that a compressive assessment was done upon re-admission to the facility. The MDS Re-Entry Form, dated 7/26/02, was the only assessment form on the medical record. b. In an interview with a MDS nurse, on 8/12/02 at 12:20 PM, she said "I guess I should have done a significant change".	F 278		
F 279 SS=E	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4).	F 279	F 279 E Resident Assessment OK 9/17/02 AD **Corrective Action for identified Residents** Careplans for residents # 18, 28, 69, 71, 78 and 80 have been updated in areas cited to meet their medical, nursing, mental and psychological needs. Resident 69's careplan was updated to reflect the use of an indwelling catheter and further updated on 8-17-02 when the indwelling catheter was discontinued. Skin integrity impaired was updated to reflect skin integrity impaired, actual. Resident # 71's careplan was updated on 8-19-02 to reflect 71's difficulty in communication/aphasia. Resident # 71 expired on 8-28-02.	

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F 279	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not develop comprehensive care plans that met the medical, nursing, mental and psychosocial needs for 6 of 22 sample residents. Resident identifiers: 18, 28, 69, 71, 78, and 80. Findings include: 1. Resident 69 was re-admitted to the facility on 6/24/02 with diagnoses that included, pneumonia, Parkinson's, atrial fibrillation, hypothyroidism, benign prostatic hypertrophy, and depression. a. Observation of resident 69 during an interview with the resident on 8/12/02 at 5:15 PM, resident 69 was observed to have an indwelling catheter and drainage bag in place. Resident 69 stated that he had the indwelling catheter for a long period of time. When asked if he had the indwelling catheter when he was admitted to the facility he stated, "yes". b. In an interview with a facility treatment nurse on 8/13/02 at 10:00 AM, she stated that resident 69 had an open area on his right buttock and she was treating the area and changing the dressing every 3 days as ordered. c. On 8/13/02, the medical record for resident 69 was reviewed and revealed the following documentation: The admission nursing assessment, dated 6/24/02, documented that resident 69 was assessed as having an indwelling catheter on admission to the facility. A nurse's note, dated 6/24/02 at 12:30 PM, documented that resident 69 had an indwelling catheter in place.	F 279	The restraint interdisciplinary team reassessed Resident # 78 and the side rails and soft waist restraint were discontinued on 8-9-02. Resident # 78's careplan was updated to reflect the use of a low boy bed and a lap buddy in the wheelchair. Resident # 18's soft waist restraint in bed and in wheelchair were discontinued on 8-9-02. Resident # 18 uses a positioning device with a lap buddy in the wheelchair and a low boy bed. Resident 18's careplan was updated to reflect this change. Resident # 28's careplan was updated to reflect the target behaviors of hitting, slapping, punching and wandering. Resident # 28 expired on 9-9-02. Resident # 80 was discharged to the hospital on 8-27-02 for planned surgery. # 80 was readmitted to the facility on 9-5-02 and a comprehensive admission MDS Assessment and careplan will be completed. **Residents Potentially Affected** All residents have the potential to be affected. **Measures to Prevent Recurrence** The licensed nursing staff and Social Service Director will be inserviced by the Director of Nursing or Designee by 9-12-02 on developing a comprehensive careplan to reflect the resident's needs related to his/her medical, nursing, mental and psychological needs that are identified in the comprehensive assessment.	

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(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 279	Continued From page 33 A nurse's note, dated 7/23/02 at 11:00 PM, documented, "1 cm [centimeter] open area on (R) [right] buttocks. Tx [Treatment] c [with] Comfeel [wound dressing]. Patient told nurse he doesn't like to change position...". The "Wound Assessment Flow Sheet" documented on 7/23/02 that resident 69 had an open red area on the right buttock. A physician's order, dated 7/23/02, documented, "Right Buttocks: Cleanse [with] NS [normal saline] [and] put Comfeel dressing over open area. [Change] Q [every] 3 [days] [and prn [as needed] until healed." d. The comprehensive care plan for resident 69 was reviewed on 8/13/02. There was no care plan problem relating to resident 69's indwelling catheter. Care plan problem 6 documented, "Skin integrity, impaired: Potential". The documented goal for this problem was "Will have skin intact". The documented approaches included turning and repositioning every 2 hours, pressure relieving devices to the bed and/or chair, and report any red or open areas. There was no care plan problem addressing resident 69's actual skin integrity impairment found. 2. Resident 71 was re-admitted to the facility on 7/30/02 with diagnoses that included, cerebral vascular accident with right hemiparesis, hypertension, seizure disorder, and atrial fibrillation. a. During an interview with resident 71 on 8/14/02 at 10:00 AM, resident 71 was observed lying in her bed with a 1/2 side rail in the up position on both sides of	F 279	**Monitoring/Quality Assessment** An audit tool will be developed by the Director of Nursing (DNS) or Designee by 9-11-02 to monitor compliance with developing a comprehensive careplan to reflect the residents' needs related to his/her medical, nursing, mental and psychological needs identified in the comprehensive assessments. The DNS or Designee will do weekly audits for 6 weeks. At the completion of the audits, the DNS or Designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then direct any further audits and reports. The Director of nursing will be responsible for continued compliance. Completion Date: 9-13-02	

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F 279	Continued From page 34 the bed. Resident 71 was able to answer yes and no questions and use hand gestures to communicate. b. On 8/14/02, resident 71's medical record was reviewed and revealed the following documentation. The admission nursing assessment, dated 7/30/02, documented that resident 71 did not speak and was aphasic (absence or impairment of the ability to communicate through speech). A nurse's note, dated 7/30/02 at 11:00 PM, documented, "Pt. [patient] it alert, no verbal but responds to yes and no questions..." A "Speech-Language Pathology Evaluation", dated 7/30/02, documented, "...Pt. presents [with] relative global aphasia-[with] [no] functl [functional] verbal skills [and] ability to follow only single step basic directions..." c. On 8/14/02, a review of the MDS admission assessment, dated 8/9/02, revealed that resident 71 was assessed as being "Usually understood-difficulty finding words or finishing thoughts" and had "Unclear speech-slurred mumbled words". The assessment further documented that resident 71's communication had deteriorated within the last 90 days. d. On 8/14/02, a review of resident 71's comprehensive care plan revealed no care plan problem addressing resident 71's difficulty in communication or aphasia. 3. Resident 78 was admitted to the facility on 7/17/02 with diagnoses that included glioblastoma (tumor) of the brain, pneumonia, seizure disorder, and renal insufficiency.	F 279		

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a. Observation of resident 78 on 8/7/02 at 4:20 AM revealed that resident 78 was lying in his bed with a soft waist restraint in place. The 1/2 side rails were in the up position.

b. On 8/14/02, resident 78's medical record was reviewed and revealed the following documentation.

A physician's order, dated 7/18/02, documented, "SWR [soft waist restraint] while in bed per family request for safety R/T [related to] fall risk".

A physician's order, dated 7/28/02, documented, "SWR while in bed [and] chair, off q [ever] 2 [hours] for cares. R/T High Risk falls".

An "Interdisciplinary Physical Restraint Assessment" form, dated 7/17/02, documented that resident 78 was assessed as needing 1/2 side rails for turning and positioning.

A nurse's note, dated 7/18/02 at 4:00 PM, documented, "SWR while in bed per family request R/T high fall risk.

A review of resident 78's comprehensive care plan revealed there was no documented care plan problem for resident 78's use of 1/2 side rails of soft waist restraint.

4. Resident 18 was admitted to the facility on 4/6/99, with diagnoses of Alzheimer's dementia, hypertension, diabetes mellitus and hypothyroidism.

a. Review of resident 18's medical record was done on 8/7/02.

The recertification of physician orders dated July

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2002, documented that since 4/18/02, resident 18 was to have a low bed with mat on the floor for his safety. The physician's recertification orders also documented that since 6/12/02 resident 18 was to have a chair alarm on his wheelchair.

A physician telephone order, dated 6/3/02, documented that resident 18 was to have a lap buddy while in his wheelchair and if not effective to use a soft waist restraint for his safety.

A physician telephone order, dated 7/17/02, documented that resident 18 was to have a soft waist restraint in his bed and while in his wheelchair. This order described the purpose of the soft waist restraint was for resident 18's safety related to him trying to get up by himself and a history of falling.

A nurse's note, dated 6/4/02, documented that resident 18 had a lap buddy while in his wheelchair for his safety.

A nurse's note, dated 6/9/02, documented that resident 18 was in his wheelchair with a soft waist restraint on.

A significant change MDS assessment for resident 18 was completed by staff on 6/14/02. The staff assessed resident 18 has being severely cognitively impaired with a short and long term memory problem. Resident 18's bed mobility was assessed as needing no assistance and he required total assistance with his transfers. The staff assessed resident 18 as needing no restraints.

Resident 18 's plan of care did not document the use of or the need for a soft waist restraint while in his wheelchair or while in bed.

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5. Resident 28 was admitted to the facility on 1/31/01, with diagnoses of Alzheimer's dementia, alcoholism and nicotine dependence.

a. Review of resident 28's clinical record was done on 8/7/02.

A quarterly MDS assessment for resident 28 was completed by facility staff on 6/25/02. The staff assessed resident 28 as having wandering behaviors that occurred daily and were not easily altered in the last seven days.

The care plan dated 2/14/01 and last updated 7/30/02 documented, a care plan problem of "psychoactive medication, Thorazine related to alzheimer's dementia." The approaches for this problem included the following:
1. "Discus test every six months."
2. "Dose reduction per policy"
3. "Administer medication as ordered: Thorazine"
4. "Report behaviors seen."

The psychotropic medication review, dated 7/9/02, documented resident 28's target behaviors were hitting, slapping, punching peers and staff.

Resident 28's target behaviors of hitting, slapping, punching and the wandering behavior were not addressed in resident 28's comprehensive care plan.

6. Review of resident 80's medical record, on 8/12/02, revealed the following:

Resident 80 was readmitted on 7/26/02 with diagnoses of MRSA (methicillin resistant staph aureus) infection right hip wound, s/p right hip fracture, delirium, history of cancer of the prostate, osteoporosis, and

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F 279	Continued From page 38 osteoarthritis. a. Observation while resident 80 was asleep, on 8/12/02 at 4:10 PM, revealed an indwelling catheter connected to a drainage bag, and a hard plastic brace on his right leg. Observation on 8/14/02 at 9:45 AM, with the treatment nurse and a CNA (Certified Nurse Aide), revealed resident 80 had a hard plastic brace in place on the right leg. Three pressure sores, located on resident 80's right heel, right calf and coccyx. Resident 80 also had a PICC (IV) line in place in the right forearm, and an indwelling catheter to a drainage bag. b. A review of resident 80's medical record, on 8/14/02, revealed the following documentation. Resident 80's admission care plan, which was not dated, did not address the following care needs of resident 80. i. MRSA wound infection with contact isolation, ii. Pressure sores and treatment, iii. Brace on resident 80's right leg, iv. PICC line for antibiotic treatment, and v. Indwelling catheter. There was no documentation of a comprehensive plan of care in the medical record.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F 309 D Quality of Care **Corrective Action for Identified Residents** Residents # 7 and # 39 were Reassessed by the Dining Committee for table placement. They were placed at a lower table on 8-16-02 to facilitate their ability to see and reach their food.	

OK 9/17/02 DD

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F 309	Continued From page 39 Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that the facility did not make accommodations for 2 sample residents who used small wheelchairs, to be seated at lower tables in the dining room enabling the residents to comfortably reach their food. (Residents 7 and 39) Findings include: Resident 39 was admitted to the facility on 6/1/01 with diagnosis of congestive heart failure, arthritis dementia and osteoarthrosis. A review of resident 39's medical record was completed on 8/14/02. A quarterly Minimum Data Set (MDS) assessment completed by facility staff on 8/6/02, documented that resident 39 was dependant on staff for eating. The MDS also documented that resident 39 was 61 inches tall. No documentation could be found in resident 39's medical record that resident 39's height was assessed prior to table placement in the dining room. A comprehensive plan of care for resident 39, dated 6/20/01, documented under problem 20 that resident 39 had a feeding deficit related to confusion. The goals were that resident 39 would eat 75% of meals with minimal supervision and would maximize ability to feed self. The approaches to the problems were to assess environment for optimally appropriate place to	F 309	**Identification of Residents Potentially Affected** All residents who use small wheelchairs and are short in stature have the potential to be affected. **Measures to Prevent Recurrence** The Dining Committee was reestablished on 8-16-02 and will assess residents for proper seating. Nursing staff and Department Heads will be inserviced by 9-12-02 by the Director of Nursing or Designee to be aware and observe for residents who may need to be placed at lower tables. The Director of Nursing or Designee will be notified of residents who can't see or reach their food. **Monitoring/Quality Assurance** An audit tool will be developed by the Director of Nursing or Designee by 9-11-02 to audit for proper table height for resident dining. The Director of Nursing or Designee will do weekly audits for 6 weeks with a compliance report to the Performance Improvement Committee (Quality Assurance) at the completion of the audits. Further audits and reports will then be as directed by the Committee. The Director of Nursing will be responsible for continued compliance. Completion Date: 9-13-02	

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F 309	Continued From page 40 eat, place in upright, appropriate position all meals, prepare food for resident, evaluate for assistive device and supply as needed and allow time to feed self. Supervise with prompting and verbal cueing. Assist as needed to complete task. Observations of resident 39 were done on 8/13/02 at breakfast, lunch and dinner. Resident 39 was in a small wheelchair. The seat of the wheelchair measured 16 inches above the floor. The table resident 39 was seated at measured 33 inches above the floor. When seated at the table in her wheelchair, resident 39's chin was at the same level as the top of the table. Resident 39 was observed to be able to reach and pick up a mug off of the edge of the tray closest to her. Resident 39 was observed not to be able to reach anything else on the tray. During the three meals, resident 39 was assisted by nursing staff to eat, but could not reach anything on the tray, therefore was unable to attempt to feed herself. Review of resident 7's medical record, on 8/14/02, revealed the following: Resident 7 was admitted on 5/29/01 with diagnoses of cerebral vascular accident, cardio vascular disease, arthritis, bradycardia, dysphasia, and macular degeneration. Review of the quarterly MDS (Minimum Data Set), dated 8/3/02, documented in section K2 a. Ht. (in.) 59. No documentation was found in the medical record that resident 7's height was assessed prior to table placement in the dining room. Dining observations on 8/13/02 during lunch and dinner revealed that resident 7 was placed at a table	F 309		

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F 309	Continued From page 41 that was tall enough to touch the resident's chin. The resident was observed sitting in a small wheelchair and to lean her head forward with her hair touching the food on her plate. The resident was also observed having difficulty getting food that was farther away from her on the plate and the tray.	F 309		
F 312 SS=D	483.25(a)(3) QUALITY OF CARE A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation of 3 meals on 8/13/02, and record review, it was determined that 1 of 22 sample residents did not receive the supervision and assistance with meals as care planned by the facility to maintain good nutrition. (Resident 17) Findings include: Resident 17 was admitted to the facility on 11/30/02 with diagnosis of fractured hip, and Alzheimer's disease. A review of resident 17's medical record was completed on 8/13/02. An Admission Minimum Data Set (MDS) assessment completed by facility staff on 12/6/01, documented that resident 17 had problems with short and long term memory and her cognitive skills for daily decision making were severely impaired. The facility also documented that resident 17 weighed 133 pounds, required extensive assistance of one person to eat, and left 25% or more of food uneaten at most meals.	F 312 OK 9/17/02 DD	F 312 D Quality of Care **Corrective Action for Identified Resident** On 8-16-02 in response to the Dining Committee's recommendation Resident # 17 was moved to a table with other residents where # 17 will receive the supervision, cueing and assistance as needed with meals. **Identification of Residents Potentially Affected.** All residents who need supervision, cueing and assistance as needed with meals have the potential to be affected. **Measures to Prevent Recurrence** The nursing staff will be inserviced by 9-12-02 by the Director of Nursing (DNS) or Designee on the importance of providing supervision, cueing and assistance as needed with meals to all residents who need such help. The Dining Committee will meet monthly and as needed to assess dining room and table placement for residents.	

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F 312	Continued From page 42 A quarterly MDS assessment completed by facility staff on 5/28/02, documented that resident 17 had problems with short and long term memory and her cognitive skills for daily decision making were severely impaired. The facility also documented that resident 17 weighed 122 pounds, had a weight loss, and did not require any assistance with eating. A comprehensive care plan for resident 17, dated 7/16/02, documented under problem 1, that resident 17's "nutrition altered potential R/T [related to] leaves 25% or more of meals uneaten R/T 10% Wt. [weight] loss X [times] 6 mos. [months]." The approach for problem 1 was to supervise dining and encourage to eat, and assist with meals as necessary. The care plan also documented under problem 12. that resident 17 had a feeding deficit and would eat 100% of meals with minimal supervision.. The approach to problem 12 was to allow time to feed self and supervise with prompting and verbal cueing and to assist as needed to complete task. On 8/13/02 at 7:10 AM, resident 17 was observed to be seated at a table in the dining room. No other residents were seated at the table with resident 17. At 7:20 AM, resident 17 was served her tray. The tray consisted of a bowl of hot cereal, scrambled eggs, a small bowl of melon, toast, 240cc of milk and 120cc of juice. The tray was set up by the nursing staff and resident 17 was left to eat on her own. Resident 17 was observed to take several spoonfuls of cereal and drink approximately 60cc of juice and then quit eating. At 8:05 AM the director of nursing approached resident 17 and encouraged her to keep eating and then walked away. At 8:35 AM a nursing assistant warmed	F 312	**Monitoring/Quality Assurance** By 9-11-02 the Director of Nursing (DNS) or Designee will develop and audit tool to measure staff compliance with the provision of supervision, cueing and assistance as needed to residents at meals. The DNS or Designee will do weekly audits for 6 weeks. At the completion of the audits the DNS or Designee will report compliance to the Performance Improvement Committee (Quality Assurance). Further audits and reports will then continue as may be directed by the Committee. The Director of Nursing will be responsible for continued compliance. Completion Date: 9-13-02	

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up the cereal and attempted to feed resident 17. Resident 17 took two spoonfuls of the cereal and would not take anymore. Resident 17's tray was removed from the table at 8:45 AM. Resident 17 had consumed approximately 25 % of the cereal and drank the juice. Resident 17 was not observed to be assisted or encouraged to eat from 7:20 AM to 8:05 AM and from 8:05 AM to 8:35 AM.

On 8/13/02 at 12:20 PM, resident 17 was observed to be seated at a table in the dining room. No other residents were seated at the table with resident 17. At 12:23 resident 17 was served her tray. The tray consisted of ground pork, rice, cooked zucchini, a roll, a small bowl of apples and 240cc of juice. The tray was set up by the nursing staff and resident 17 was left to eat on her own. Resident 17 was observed to pick up her napkin with her left hand and place it on the left edge of her plate. Resident 17 was then observed to use her fork in her right hand and scoop the rice onto the fork using the napkin. At 12:35 the director of nursing approached resident 17 and encouraged her to eat and then walked away. Resident 17 was observed to eat 3 bites of rice and ground pork, no zucchini, and one half of the roll. Resident 17 was not observed to receive any assistance or cueing from 12:35 PM to 1:00 PM.

On 8/13/02 at 5:35 PM, resident 17 was observed to be seated at a table in the dining room. No other residents were seated at the table with resident 17. Resident 17 had already been served her tray which consisted of a bowl of soup, a corn muffin, a small bowl of cottage cheese and a small bowl of melon. Resident 17 was observed to eat half of the muffin. Resident 17 was then observed to place the rest of the food on the tray into the bowl of soup. Resident 17 was taken out of the dining room at 6:10 PM. Resident 17 was not observed to receive any assistance

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F 312	Continued From page 44 or cueing from 5:35 PM to 6:10 PM. On 8/14/02 at 1:05 PM, resident 17 was observed to have piled all the food from her meal into the center of her plate and had taken the artificial flowers off of the table and placed them in pile of food on her tray.	F 312		
F 325 SS=D	483.25(i)(1) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility did not ensure that one of 22 sampled residents maintained acceptable nutritional status, such as body weight, as evidenced by: Resident 83 weighed 116 pounds on 7/13/02. On 7/31/02, resident 83 weighed 107 pounds. Resident 83 had a 7.76% weight loss in a two- week period. Resident identifier: 83. Findings include: Resident 83 was a 92-year-old male admitted to the facility on 7/2/02, with diagnoses of coronary heart failure, cardiomyopathy, chronic renal failure and osteoarthritis. Resident 83's 14-day MDS (minimum data set) assessment dated 7/13/02 documented a weight of 116 pounds. Resident 83's enteral feeding worksheet dated 7/11/02	F 325 OK 9/17/02 JMJ	F 325 D Quality of Care **Corrective Action for Identified Resident** Resident # 83 was discharged to home on 8-31-02. Prior to discharge #83 continued on supplemental tube feedings and was taken to the dining room for meals except when he/she requested to remain in his/her room. Resident # 83's weight loss was arrested/stabilized prior to the survey process. **Identification of Residents Potentially Affected** All residents who are tube fed have the potential to be affected. **Measures to Prevent Recurrence** There will be timely follow up for any resident, such as a resident receiving tube feedings and a resident demonstrating weight loss, on recommendations made by the Registered Dietitian (RD). Ongoing monitoring to identify residents who may be at high nutritional risk (enteral residents) will be completed by the IDT (interdisciplinary team) WIND (weights, intake, nutrition and decubitus) meeting.	

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F 325	Continued From page 45 documented resident 83's ideal body weight at 155 pounds and that resident 83 was currently at 26% below DBW (desired body weight). Recommended daily needs were estimated at 1762 calories with 70 grams of protein. These needs were to be met by po (by mouth) intake and a tube feeding of Jevity at 40cc's (cubic centimeters) per hour. A nutritional note dated 7/11/02 stated " G-tube (gastrointestinal) running at 40 cc /hr (per hour) x 24° (times 24 hours) to yield approximately 1017 calories. PO remains poor, nutritional needs are not met. Recommend increase to 60 cc per hour to yield approximately 1526 calories; po would then only have to supply approximately 275 calories ..." Resident 83's care plan dated 7/12/02 documented problems of decreased intake and inability to meet nutritional needs with oral intake. The goals included: " will have desirable wt gain of 1-5# (pounds) per month" and " nutritional needs will be met by tube feeding." The approaches for the care plan included "diet as ordered and tube feeding as ordered" an update to the care plan dated 8/13/02 included "provide 250cc (1 can) jevity bolus if intake [is] less than 50%." A review of the medical record revealed no orders to increase the tube feeding as recommended. Further review revealed a nurse's note dated 7/17/02 stating, "we will stop sending trays." Resident 83's 30-day MDS assessment dated 7/31/02 documented a weight of 107 pounds. This is a 9-pound weight loss, which represents a 7.76% decrease in 18 days. During an interview with resident 83's wife on 8/13/02 at 12:30 PM she stated, " ...yesterday his tube feeding	F 325	Tube- Feeding Residents will be placed on weekly weights. The RD will attend the weekly WIND meetings at least monthly and will review the WIND meeting notes on times when RD is not in attendance. Residents of nutritional concern will have nutritional interventions implemented, as appropriate, in a timely fashion. The Dietary Service Manager (DSM) and RD will be notified by the Director of Nursing or Designee whenever a resident has a change of condition/status. The RD will reevaluate the nutritional parameters, which may include adjustments to the tube-feeding regime. The Consultant RD will provide the DNS or Designee with reports of plan of service recommendations upon exit of visit. If the RD's findings require a change in the resident's nutritional plan of care, the DNS or Designee will be responsible for assuring that all nutritional recommendations submitted are addressed in a timely fashion. The Consultant Registered Dietitian will be inserviced by the Director of Nursing (DNS) or Designee by 9-12-02 on following this Process. Residents who are tube fed will be care planned to be observed for formula leakage from the tube. Formula leakage will be charted and reported to the physician and to the WIN Committee. The licensed nurses will be inserviced by 9-12-02 by the DNS or Designee to follow this process. **Monitoring/Quality Assurance** By 9-11-02 the DNS or Designee will develop and audit tool. This audit tool will	

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F 325	Continued From page 46 was empty and when I lifted the covers it had leaked all over his bed. This is the third time that has happened..." A review of the nursing notes revealed no documentation that this had been reported to the dietitian. A nutritional assessment completed by the corporate dietitian on 8/13/02 stated, "... visited with resident and wife in room. [Wife] reports tubing often disconnects and drips on clothing.... Weight loss may also be 2° (secondary) to tube disconnecting...."	F 325	monitor compliance with weekly weights, RD assessments, care planning and staff follow-up on RD recommendations. The DNS or Designee will do weekly audits for 6 weeks. At the completion of the audits, the DNS or Designee will report to the Performance Improvement Committee (Quality Assurance). Further audits and reports will continue as may be directed by the Committee. The DNS will be responsible for continued compliance. Completion Date: 9-13-02	
F 329 SS=D	483.25(l)(1) QUALITY OF CARE Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on medical record review it was determined that the facility did not ensure that a resident was free from unnecessary drugs. Resident 45 was administered 74 doses of an antihypertensive medication when the physician had ordered the medication to be discontinued. Findings include: 1. Resident 45 was admitted to the facility on 4/20/02, with the diagnosis of dementia, hypertension, streptococcal septicemia; hyposmolarity, esophogeal reflux, gastroenteritis and dysphagia.	F 329	OK 9/17/02 F 329 D Quality of Care **Corrective Actions for identified Resident** Resident # 45's antihypertensive, HCTZ, was discontinued and removed from the medication administration record (MAR) and the remaining medication that was in the medication cart was removed on the date the surveyor informed the Facility of the problem. **Identification of Residents Potentially Affected** All residents have the potential to be affected. **Measures to Prevent Recurrence** The process for recertification of physicians' orders was reassessed and revised by the Director of nursing and the Medical records Supervisor. A new policy and procedure was developed to give the nurses time to review the recertifications for accuracy.	

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F 329	Continued From page 47 Review of resident 45's clinical record was done on 8/13/02. A physician telephone order, dated 5/17/02, documented that an antihypertensive medication called hydrochlorothiazide (HCTZ) was to be discontinued for resident 45. There were no other physician telephone orders to continue HCTZ after 5/17/02. The recertification of physician orders, dated July 2002, documented that since 4/20/02 resident 45 was receiving HCTZ. The Medication Administration Record (MAR) documented on May 2002, that resident 45's HCTZ was to be discontinued on 5/18/02. The MAR for June 2002, July 2002, and August 2002 had nursing initials that documented the nurses had administered resident 45's HCTZ medication. Resident 45 received 74 doses of HCTZ when the physician had ordered the medication to be discontinued.	F 329	The recertifications for September were all reviewed by the nursing management for accuracy. The licensed nurses will be inserviced on this policy and procedure by 9-12-02 by the Director of Nursing or Designee. The licensed nurses will then be responsible to review the physician's recertification orders and MAR's for accuracy on a monthly basis with nursing management oversight. **Monitoring/Quality Assurance** The Director of Nursing (DNS) or Designee will develop an audit tool to monitor accuracy of the physician recertification orders and of the MAR. The DNS or Designee will do audits weekly for 6 weeks with a report to the Performance Improvement Committee (Quality Assurance) at the completion of the audits. The Performance Improvement Committee will then direct any further audits and reports. The Director of Nursing will be responsible for continued compliance. Completion Date: 9-13-02.	
F 490 SS=K	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on a recertification survey with subsequent extended survey, conducted 8/7/02 through 8/15/02, and resultant finding of Immediate Jeopardy and Sub-Standard Quality of Care, it was determined that the facility was not being administered in a manner that enabled it to use its resources either efficiently or	F 490 dc 9/17/02 DS	F 490 K Administration **Corrective Actions for identified Residents** Refer to F221, F164, F242, F278, F279, F309, F312, F325 and F329. **Identification of Residents potentially affected** Refer to F221, F164, F242, F278, F279, F309, F312, F325 and F329.	

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F 490	Continued From page 48 effectively to ensure that residents were provided the opportunity to attain or maintain their highest practicable physical, mental and psychosocial well-being. Specifically the facility did not ensure that residents were free from any physical restraints not required to treat the resident's medical symptoms. Additionally, the facility was found to be non-compliant in the following areas: 1. Residents were not provided privacy during personal cares; 2. Residents were served foods that the residents had informed the facility that they did not like; 3. Residents were not assessed accurately; 4. Comprehensive care plans did not meet the medical, nursing, mental and psychosocial needs of the residents; 5. The facility did not provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for residents with special needs for dining; 6. Residents who were unable to carry out activities of daily living did not receive the necessary services to maintain good nutrition; 7. The facility did not ensure that residents maintained acceptable nutritional status, such as body weight; and, 8. The facility did not ensure that residents did not receive unnecessary drugs. Findings include:	F 490	**Measures to Prevent Recurrence** Refer to F221, F164, F242, F278, F279, F309, F312, F325 and F329. **Monitoring/ Quality Assurance** The Administrator will be responsible for continued compliance along with the designated position identified in each F tag plan of correction for above tags cited. Completion Date: 9-13-02.	

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F 490	Continued From page 49 On 8/7/02, a recertification survey was initiated. On 8/8/02, facility administration was noticed of the elements of Immediate Jeopardy and Sub-Standard Quality of Care. The determination of Immediate Jeopardy and Sub-Standard Quality of Care was based on the findings of significant non-compliance in the area of Resident Behavior and Facility Practices [42 Code of Federal Regulations (CFR) 483.13 (a) Tag F-221]. 1. Facility administration failed to ensure residents were free from physical restraints not required to treat a residents medical symptoms. (Scope and severity "K", refer to Tag F-221) 2. In addition to the area of Immediate Jeopardy and Sub-Standard Quality of Care, the facility administration failed to effectively and efficiently use its resources to ensure that each resident attained or maintained their highest practicable, physical, mental and psychosocial well-being in the following areas of deficient practice cited during the annual and extended survey completed 8/15/02. a. Facility administration did not ensure that residents were provided privacy during personal cares. (Scope and severity "E", refer to Tag F-164) b. Facility administration did not ensure residents were not served foods that the residents had informed the facility that they did not like. (Scope and severity "E", refer to Tag F-242) c. Facility administration did not ensure that residents were assessed accurately. (Scope and severity "E", refer to Tag F-278) d. Facility administration did not ensure that resident comprehensive care plans met the medical, nursing,	F 490		

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F 490	Continued From page 50 mental and psychosocial needs of the residents. (Scope and severity "E", refer to Tag F-279) e. Facility administration did not ensure that the facility provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for residents with special needs for dining. (Scope and severity "D", refer to Tag F-309) f. Facility administration did not ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition. (Scope and severity "D", refer to Tag F-312) g. Facility administration did not ensure that residents maintained acceptable nutritional status, such as body weight. (Scope and severity "D", refer to Tag F-325) h. Facility administration did not ensure that residents did not receive unnecessary drugs. (Scope and severity "D", refer to Tag F-329)	F 490		
F 521 SS=K	483.75(o)(2)&(3) ADMINISTRATION The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 521	F 521 K Administration **Corrective action for Identified Residents** Refer to F 221 **Identification of Residents Potentially Affected** All residents have the potential to be affected.	

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F 521	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on a review of the facility "Performance Improvement Meeting" minutes, (the facility Quality Assurance Committee) and interviews with the facility Administrator and director of nursing (DON), it was determined that the facility did not ensure that the quality assurance committee effectively developed and implemented appropriate plans of action to correct identified quality deficiencies. Findings include: 1. During an interview with the facility administrator on 8/14/02 at 5:00 PM, he stated that the facility had a quality assurance committee consisting of the administrator, director of nursing, assistant director of nursing, all department heads, a pharmacist and medical director. He stated that the meetings were held on a monthly basis. 2. A review of the facility "Performance Improvement Meeting" minutes was done on 8/8/02. The documentation indicated that the facility had identified a high percentage of residents that were being restrained. The minutes documented that each resident would be reviewed and the review would be completed by 8/16/02. 3. An interview was held with the DON on 8/8/02 at 9:45 AM. The DON was asked if the facility had implemented the plan to review the restraints as documented in the "Performance Improvement Meeting." The DON stated that she planned to train a facility nurse to implement the facility restraint management program and to date the nurse had not been trained and the program had not been started.	F 521	**Measures to Prevent Recurrence** The facility's District Director of Clinical Operations will inservice the Facility's Performance Improvement Committee (Quality Assurance) on the process of developing and implementing appropriate plans to correct identified quality deficiencies. The Facility's **Performance Improvement Manual** will be used as the source of the information presented. Also see plan of correction for F 221. **Monitoring/Quality Assurance** The Facility's monthly minutes of the Performance Improvement Committee meetings will be reviewed and critiqued by the corporation's Regional Quality Compliance Consultant (QCC) for three months and then as may be directed by the QCC. Also see plan of correction for F 221. The Administrator will be responsible for continued compliance. Completion Date: 9-13-02	