

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

PRINTED: 01/06/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145555	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2008
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 ST MARY DRIVE EDWARDSVILLE, IL 62025	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Certification and Licensure Survey.	F 000		
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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews the facility failed to provide timely care to one (R3) of one sampled resident admitted with scabbed areas to his lower legs. Findings include: On 3/26/08, a review of R3's physician's order sheet dated 3/1/08, indicated a diagnoses in part of; Cerebral Vascular Accident, Dysphagia, and Left Hemiplegia. The most recent Minimum Data Set, dated 3/6/08, indicated R3 was moderately cognitively impaired, and needed the assist of at least one staff for all activities of daily living, bathing and hygiene. A Nursing Assessment dated 12/3/07, indicated R3 was admitted with several scabbed areas to his lower legs. On 3/26/08, at 9:20 AM, E17 and E18, Certified Nurses Aides (CNA's), provided R3 peri care as he lay in bed. At this time , R3 was noted to have an area on his right knee that appeared	F 309		4/26/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	<p>Continued From page 1</p> <p>scabbed and raised up approximately 3/4 inch off of his lower knee area. The scab appeared to be growing over on top of itself. R3 had three areas on his left leg that were scabbed. However, the scabs were all oval shaped and appeared to be shrinking back from the edges of the wounds, causing the edges to be red and one of the wounds to be re-opened. The scabbed areas appeared not to be healing properly. The right leg also had 2 or 3 scabs formation on them that appeared to be not healing properly. In an interview with E17 and E18, CNA's, they stated that R3 had been admitted with the wounds/scabs on his legs and the scabs were left open to air to heal.</p> <p>On 3/26/08, at 9:40 AM, in an interview with E6, Treatment Nurse, she stated she was aware R3 had been admitted with several scabbed areas to his lower legs, and that they were left open to air to heal. E6 stated that the nursing staff had not informed her that the wounds had not healed (since 12/3/07), and that she had not seen them herself since admission.</p> <p>On 3/26/08, at 11:15 AM, E6, stated that R3's doctor, Z1, was in the building and had gone to see about R3's legs. E6 stated that Z1 had ordered a culture of the areas and ordered R3 to be started on an oral antibiotic and triple antibiotic ointment to treat the slow healing wounds. E6 indicated that Z1 had called the areas "boils".</p> <p>On 3/26/08 at 12:00 PM, Z1 stated that she thought R3 had a an infection that had affected his legs, and Z1 felt the antibiotics and ointment to R3's legs would heal them. A review of the physician's orders dated 3/26/08 indicated "culture leg wounds, Bactrim DS / 1 tablet / 2x a day / x 10 days, and Cipro 500 mg / 1 tab / 2 x a day / x 10 days.</p>	F 309			

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F 309	Continued From page 2 On 3/26/08, in an interview with E1, Administrator and E6, they stated that staff should have informed E6 that R3's legs were not healing, so that the physician could be notified and more timely treatment started on R3's legs.	F 309			
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure heel protectors were on for one (R3) of one sampled resident with a newly healed pressure ulcer on his heel. Findings include: 1. On 3/26/08, a review of R3's physician's order sheet dated 3/1/08, indicated a diagnoses in part of; Cerebral Vascular Accident, Dysphagia, and Left Hemiplegia. The most recent Minimum Data Set, dated 3/6/08, indicated R3 was moderately cognitively impaired, and needed the assist of at least one staff for all activities of daily living, bathing and hygiene. A Nursing Assessment dated 12/3/07, indicated R3 was admitted with an open area to his left outer heel that measured 0.6 x 0.8 centimeters. The physician's orders sheet dated 3/1/08 indicated R3 was to have heel	F 314		4/26/08	

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F 314	Continued From page 3 protectors on when in bed and a weekly skin assessment. On 3/25/08, at 10:15AM during initial tour of the facility, R3 was observed lying on his back in bed. R3's pressure relief mattress cover was torn in several areas at the area where his feet rested, and R3 had no heel protectors on his feet. At 11:30 AM, and again at 1:40PM and 4:00PM, R3 lay in bed with his feet resting on the torn mattress cover with no heel protectors on his feet. On 3/26/08, at 9:20 AM, E17 and E18, both Certified Nurses Aides, (CNA's) were observed as they did peri care on R3 as he lay in bed. After peri care, R3's left heel was observed to be healed of the pressure sore, and had only a small dry scaly area on the edge of the heel where the pressure ulcer had been. During this observation R3 was still lying on the torn mattress cover (foam exposed) with no heel protectors on his feet. Throughout the morning R3 stayed in bed and was repositioned by CNA staff and was observed several times with no heel protectors on his feet. At 12:30 PM, E17 assisted R3 to feed himself while sitting in his bed, without heel protectors on his feet. On 3/26/08, at 2:45 PM, E1-Administrator, observed R3 lying in bed with the torn mattress cover under his feet and no heel protectors on his feet. E1 stated was not aware of the condition of R1's mattress, and that he would have expected staff to have informed the nurse so the mattress could be changed. Also, E1 stated that staff should be following the physician's order for heel protectors on R3's feet.	F 314			
F 315 SS=E	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a	F 315		4/26/08	

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F 315	<p>Continued From page 4</p> <p>resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide thorough and proper catheter and/or incontinent/perineal care to prevent Urinary Tract Infections (UTI) for two (R2, R9) of seven sampled residents with incontinence, failed to obtain a urine culture and sensitivity for one (R7) of one sampled resident with a UTI, and failed to position the catheter bag and catheter drainage tubing to prevent the backflow of urine for one (R5) of four sampled residents with an indwelling urinary catheter.</p> <p>Findings include:</p> <p>1. R2 is 72 years old with diagnoses (from March 2008 Physician's Order Sheet) of: End-Stage Parkinson's Disease, Dementia, Dysphagia, and Recent Gastrostomy Tube Placement. R2's current Minimum Data Set (MDS) dated 01/17/08, assessed R2 as totally dependent on staff for bed mobility, transfer, hygiene, bathing, and toilet use. R2 is incontinent of both urine and feces. R2 had a history of UTI. R2's laboratory results dated 10/6/07 documented a UTI with Escherichia Coli (E-coli) present in the urine. R2 was observed on 3/25/08 at 2:05 PM. E10 and E13, Certified Nursing Assistants (CNA),</p>	F 315			

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F 315	<p>Continued From page 5</p> <p>turned R2 onto her left side. Soft, unformed feces was observed on R2's buttocks, around her anus. E10 used toilet tissue to remove the feces, discarding the feces and toilet paper into a plastic bag. E10 again wiped this area, removing more feces with toilet paper. E10 did not change her gloves or wash her hands before turning R2 onto her back. E10 began cleaning R2's inner thighs, wiping in an upward motion, from buttocks upwards. E10 wiped both of R2's thighs in an upward motion, then wiped the labia upwards with possible fecal contamination of the meatus.</p> <p>The facility's policy for Perineal Care (undated) states (in part): "Wash perineal area. Separate labia and wash urethral area first, wipe downward from front to back..."</p> <p>2. R7 is 87 years old with partial diagnoses (from March 2008 Physician's Order Sheet) of: Spinal Stenosis, Degenerative Joint Disease, Cerebral Vascular Accident, Parkinson's Disease, and Dementia. R7's current MDS dated 3/11/08 assessed R7 as needing the extensive assistance of staff for his hygiene, bathing, and toilet use.</p> <p>R7's laboratory results dated 01/7/08 indicated a UTI with urine described as cloudy, Leukocyte Esterase - 500 (normal - negative), Protein - 30 (negative), Ketones - 5 (negative), Blood - 150 (negative), White Blood Cells - too numerous to count, and Bacteria 4+ (negative). There was no culture and sensitivity results on the chart. R7's physician ordered treatment with Bactrim DS, one tablet twice daily for 3 days. R7's UTI symptoms remained and on 01/30/08, the physician ordered Cipro 500 milligrams (mg) twice daily for 10 days. The physician also ordered a urine culture and sensitivity. These results were not on the R7's chart.</p>	F 315			

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F 315	<p>Continued From page 6</p> <p>On 3/27/08 at 2:35 PM, E3, Assistant Director of Nursing (ADON), was interviewed. E3 stated the 01/7/08 urinalysis, and urine culture and sensitivity were sent out STAT (immediately) to the area hospital. The hospital then sent the tubes of urine to the laboratory for culture and sensitivity. The laboratory did not obtain the culture and sensitivity to identify the organism. Facility staff failed to follow up with the laboratory to obtain the culture and sensitivity results to assess if the antibiotic ordered was effective for treating the causative organism.</p> <p>E3 stated the urine culture and sensitivity ordered on 01/30/08 was obtained. Laboratory results were provided dated 02/2/08, "> (greater than) 100,000 multiple bacteria morphotypes.....may indicate colonization."</p> <p>3. Per Physician's Order Sheet, dated 3/08, R9 has diagnoses, in part, of Diabetes Mellitus, Morbid Obesity, Lymphedema, and Neurogenic Bladder. The Minimum Data Set (MDS), dated 3/12/08, shows R9 is moderately impaired with decision making, requires extensive assistance of two persons for transfers and personal hygiene, is incontinent of bowel, and has an indwelling urinary catheter. The Vital Signs/Weight Record shows R9 weighs over 450 pounds for 3/08. The Norton Pressure Ulcer Scale, dated 3/18/08, scores R9 as a high risk for the development of pressure ulcers. The Current Plan of Care, dated 3/18/08, shows R9 is at risk for the development of a UTI, related to the urinary catheter, and the diagnosis of Neurogenic Bladder.</p> <p>On 3/25/08, at 2:00 PM, R9 was crying, and reported she needed to have a bowel movement. E7, and E8, Certified Nurses Aides, (CNA), responded to the call light. E8 assisted R9 to stand, to use the bedside commode. R9 had</p>	F 315			

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F 315	<p>Continued From page 7</p> <p>become incontinent of liquid bowel, covering the back of her dress, buttocks, inner thighs, and indwelling urinary catheter tubing. Fecal smears were noted on the incontinent pad.</p> <p>While R9 was sitting on the commode, E7 emptied the urinary catheter drainage bag into a graduated cylinder twice. E7 failed to cleanse the exit port after each emptying, clamped the port, and placed it back into the bag. With R9 standing and holding onto a walker, E7 removed R9's soiled dress, and placed it into a plastic bag. Without changing gloves, E7 stated, "Let me wash your back." After cleansing and drying R9's back, E7 proceeded to cleanse R9's buttocks, washing from the top, moving downward to the thighs. E7 did this numerous times to each buttock, changing the surface area of the washcloths. E7 began to wash the rectal area, from the coccyx downward to the vaginal area and indwelling urinary catheter tubing. The indwelling urinary catheter tubing was coated with feces.</p> <p>R9 began to become unsteady on her feet, and was assisted to sit on the side of the bed. No cleansing of the rectal or vaginal area was done. No catheter care was completed. R9 sat down on a clean dress and incontinent pad, while feces remained on her perineal area.</p> <p>At 2:40 PM, the evening shift CNA, E14, was in the room to assist R9. E14 placed heel protectors on R9's feet, while R9 was sitting on the side of the bed. A strong odor of feces remained in the room. R9 reported she will sit up on the side of the bed until after supper. E14 reported she would complete R9's incontinent and catheter care before the end of the evening shift. At 4:10 PM, R9 remained sitting on the side of the bed, talking with a visitor. The room still smelled of feces, and R9 was wearing the soiled</p>	F 315			

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F 315	<p>Continued From page 8</p> <p>dress.</p> <p>R9's Current Plan of Care for her urinary incontinence and catheter, does not identify how often the catheter care is to be performed. No mention is made of interventions for bowel incontinence. The facility's policy and procedure entitled, "Perineal Care", for a female resident reads, "Wash perineal area, wiping from center to thigh and from front to back...Separate labia and wash urethral area first, wipe downward from front to back. NOTE: If she has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about three inches; then gently rinse and dry the area.."</p> <p>The facility's policy and procedure, entitled, "Catheter, Daily Care", reads, "Catheter care shall be provided to residents every shift, and as often as needed thereafter." The policy fails to address emptying the catheter bag, or cleansing the exit port.</p> <p>4. R5's physician's order sheet, dated 3/08, noted she had a partial diagnosis of Morbid Obesity. R5 currently has an indwelling urinary catheter for urinary retention.</p> <p>R5's Minimum Data Set, dated 1/5/08, noted she required assistance of two staff persons with transfers and utilizes a mechanical lift.</p> <p>On 3/25/08, at 1:33 PM, E15 and E16, Certified Nurse's Aides (CNAs), were assisting R5 into bed via a mechanical lift. E15 placed the indwelling catheter bag on R5's lap. E15 and E16 lifted R5 into bed with the assistance of the mechanical lift. E15 lowered R5 into bed with the catheter bag lying on R5's abdomen. E15 removed the indwelling catheter bag from R5's abdomen and hung the bag on the bed frame.</p> <p>The facility's catheter policy, not dated, noted "Position bag lower than the bladder--NEVER on</p>	F 315			

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F 315	Continued From page 9 the floor. "	F 315			
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure staff applied a laptop cushion across the front of the wheelchair for one (R6) of three sampled residents with laptop cushions, who were assessed at high risk for falls; this failure resulted in R6 falling from her wheelchair, fracturing her right wrist and receiving a hematoma to her forehead; the facility failed to ensure the personal body alarm was on one (R12) of four sampled residents with personal body alarms; and the facility failed to ensure the proper transfer for two (R7, R9), of nine sampled residents observed for transfer activity. The findings include: 1. On 3/26/08 and 3/27/08, R6 was seen with a cast to her right forearm. R6's "NURSE'S NOTES" dated 02/12/08, at 6:00 AM, identified E23, Registered Nurse (RN), entered R6's room and found R6 laying on her right side, on the floor, with R6's wheelchair next to her, and with R6's personal body alarm sounding. These same "NURSE'S NOTES" identified R6 had a	F 323		4/26/08	

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F 323	<p>Continued From page 10</p> <p>quarter sized raised area to her right forehead, at the hairline; identified R6 had a nickel sized reddish purple area to her right knee; and that R6 complained of pain to her right wrist.</p> <p>Radiology reports dated for 02/12/08, from an area Hospital, identified the following for R6: "RIGHT FRONTAL SOFT TISSUE SWELLING AND HEMATOMA WITHOUT UNDERLYING SKULL FRACTURE OR INTRACRANIAL HEMORRHAGE", and "SEVERE OSTEOPENIA, WITH ULNAR STYLOID AND INTRA-ARTICULAR DISTAL RIGHT RADIUS FRACTURE, ASSOCIATED WITH OVERLYING SOFT TISSUE SWELLING."</p> <p>"NURSE'S NOTES" dated 02/12/08, at 8:00 PM, identified R6 had returned from the area Hospital, with an appointment for 8:00 AM, on 02/13/08, at an area Orthoclinic. "NURSE'S NOTES" dated for 02/16/08, identified R6 to have a cast to her right forearm.</p> <p>R6's "FALLS" RAP (Resident Assessment Protocol) module dated 3/20/07, identified R6 was at risk for falls related to impaired balance, incontinence, and her history of falls. This assessment identified R6 had attempted to self-transfer, and that R6 was not safe in her self-transfers. This assessment identified R6 was to have a laptop cushion when up in her wheelchair. R6's "PHYSICAL RESTRAINT ASSESSMENT" dated 7/18/07, identified R6 was to have a laptop cushion when up in her wheelchair. R6's "FALL RISK ASSESSMENT" dated 02/10/08, identified a score of "22"; this assessment identified that a total score of 10 or above represented HIGH RISK.</p> <p>R6's care plan dated 12/04/07, identified R6 to have long and short-term memory impairment, identified R6 required total assist with all her activities of daily living due to R6's confusion and</p>	F 323			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145555	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2008
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 ST MARY DRIVE EDWARDSVILLE, IL 62025		
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F 323	<p>Continued From page 11</p> <p>weakness, and identified R6 to have diagnosis (in part) of Paralysis from a Cervical cord injury. This same care plan identified R6 was at risk for falls related to R6's incontinence, decreased safety awareness, and her history of falls. Care plan approaches identified staff were to apply a laptop cushion when R6 was up in her wheelchair. This same care plan identified R6 needed a laptop cushion when up in her wheelchair related to impaired trunk control, decreased safety awareness, and identified R6 tries to transfer herself and was unsafe to self-transfer. Care plan approaches identified staff were to apply a laptop cushion when R6 was up in her wheelchair.</p> <p>Facility's investigation dated 02/12/08, and E1's, Administrator's, written statement of 3/27/08, identified E21, Certified Nurse Aide (CNA), and E22, Licensed Practical Nurse (LPN), had assisted R6 into her wheelchair the morning of 02/12/08. These two sources identified E21 and E22 left R6's room, with R6 sitting up in her wheelchair with her personal body alarm attached to R6. However, E21 and E22 did not apply R6's laptop cushion to her wheelchair before leaving R6's room. Facility's investigation identified that R6 had been left up in her wheelchair, without her laptop cushion; R6 fell onto the floor, and fractured her wrist.</p> <p>2. R7 is 87 years old with partial diagnoses (from March 2008 Physician's Order Sheet) of: Spinal Stenosis, Degenerative Joint Disease, Cerebral Vascular Accident, Parkinson's Disease, Dementia. R7's current MDS dated 3/11/08 assessed R7 as needing extensive assistance of staff for bed mobility, transfer, locomotion, eating, hygiene, toilet use.</p> <p>On 3/26/08 at 9:07 AM, E11 and E12,</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>Certified Nursing Assistants (CNA), were attempting to transfer R7 from the padded wheelchair to the bed, using a mechanical lift. The lift pad had been improperly attached to the lift arm. The CNAs had not placed the lift pad around R7's thighs. They had not attached the middle straps of the lift pad to the lift arm, with only four straps attached to the lift. As the CNAs raised the mechanical lift, R7 began leaning forward in the lift pad, with his head leaning over his knees. E12 lowered R7 back into the wheelchair. This surveyor mentioned to E11 and E12 that the straps to the lift pad were not all attached to the lift and suggested E11 and E12 obtain assistance if needed to safely transfer R7 to bed. E12 stated that R7 had just moved into that room yesterday and that they were unfamiliar with R7. E12 verified that the lift pad was "not right" but thought that it was too small. After lowering R7 back into the wheelchair, E11 and E12 replaced the lift pad around R7's thighs and properly attached all six straps to the lift bar.</p> <p>3. Per Physician's Order Sheet, dated 3/08, R9 has diagnoses, in part, of Polyneuropathy, Degenerative Joint Disease, Morbid Obesity, Peripheral Vascular Disease, and Nonpitting Edema to Legs. The Minimum Data Set, dated 3/12/08, shows R9 requires extensive assistance of staff for transfers and personal hygiene, and is moderately impaired with cognition and decision making. The current Vital Signs and Weight Record shows R9 weighs over 450 pounds. The Fall Risk Assessment, dated 3/18/08, scores R9 as a high risk for falls.</p> <p>On 3/25/08, R9 reported she used to ambulate to the bathroom with staff assistance, and the use of a walker. R9 reported she has been unable to ambulate to the bathroom for</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>three weeks, due to edema, pain, and weakness to her legs. R9 said usually only one staff assists her to standing, and walking to the bedside commode, since she no longer can use the bathroom.</p> <p>On 3/25/08, at 2:00 PM, E7 and E8, Certified Nurse Aides, (CNA), assisted R9 from sitting to standing by holding R9's hands and pulling backward. R9 had nothing on her feet, and her lower legs were very edematous. R9 immediately became unsteady, and unable to remain standing. Staff steadied R9, and assisted her to sit on the bed. E8, CNA, stated, "We should have a big blue gait belt." Staff did not look, or retrieve a gait belt. A gait belt was not observed in R9's room.</p> <p>After R9 sat on the bed a few minutes, E7 and E8 held R9's hands, and again pulled backward. R9 eventually was able to grab hold of the arms on the bedside commode, and gradually turned and sat down.</p> <p>The Current Plan of Care, dated 3/18/08, shows R9 is at risk for falls related to impaired mobility, psychotropic medication, impaired balance, unsteady gait, and history of falls. Some interventions listed are, "Assist with transfers and ambulate as needed", and "Encourage proper fitting shoes or gripper socks", "PT (physical therapy) screen PRN, (as needed), and "Document changes-balance and gait."</p> <p>A review of the clinical record for R9 shows the last Rehabilitation Screen was done 1/11/07. E9, Rehab Director, confirmed no recent assessments had been done for R9. E9 confirmed she was unaware of the decline in R9's ambulation and increased weakness. E9 stated, "I'll have her assessed this evening." E9 did report an extra large gait belt was available in</p>	F 323			

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F 323	<p>Continued From page 14 the facility to use with R9.</p> <p>The facility's policy and procedure, entitled, "Gait Belt Use" lists the Objectives as; 1. To provide assistance during ambulation. 2. To provide for safe ambulation and transfers. 3. To help assure proper body mechanics during resident transfers and ambulation." The policy reads, "The gait belt is the best place to help the resident if he or she loses his or her balance, as it is near to his or her center of gravity."</p> <p>4. R12's physician's order, dated 8/10/05, noted R12 was to wear a personal alarm in bed and in her wheelchair. R12's physician order , dated 8/07, noted she was to wear a lap buddy when in her wheelchair.</p> <p>R12's Minimum Data Set, dated 1/22/08, indicated she required extensive assistance for transfers and did not ambulate. R12's fall assessment, dated 1/22/08, noted she was at high risk for falls.</p> <p>R12's care plan, dated 1/22/08, noted she was at high risk for fall related to decreased safety awareness , incontinence, wandering and impaired balance. One intervention for this problem noted "Body alarm w/c (wheelchair) and bed.</p> <p>On 3/25/08, at 12:02 PM, R12 was in the main dining room in her wheelchair. She did not have a personal body alarm. She remained in the dining room until 1:20 PM. At 1:25 PM, R12 was observed in her bed without a personal body alarm. She remained in bed until 2:30 PM without the personal body alarm.</p> <p>On 3/26/08, at 9:22 AM, R12 was in bed without a personal body alarm. At 11:05 AM until at least 12:00 PM, R12 was in her wheelchair without a personal body alarm.</p> <p>On 3/27/08, at 9:05 AM, E1, Administrator, he</p>	F 323			

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F 323	Continued From page 15 noted R12 personal body alarm was not on as ordered.	F 323			