

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

PRINTED: 07/02/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145972	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/30/2008
NAME OF PROVIDER OR SUPPLIER PROVENA COR MARIAE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114		
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F 000	INITIAL COMMENTS	F 000			
F 225 SS=D	<p>Complaint Investigations:</p> <p>#0812831/IL35860 - F314 cited</p> <p>#0812947/IL35983 - F225, F281, F309, F312, F323</p> <p>An extended survey was not conducted.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must</p>	F 225			

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 225	<p>Continued From page 1</p> <p>prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to do a thorough investigation of a 8cm skin tear to a resident's arm.</p> <p>This applies to 1 resident with an injury of unknown origin (R2).</p> <p>The example includes:</p> <p>1. Physician's Order Sheet of April 2008 showed R2 was admitted on 4/5/08 with diagnoses to include: Compression Back Fracture, Back Pain, Vocal Cord Paralysis and Osteoporosis.</p> <p>Minimum data Set of 4/17/08 assessed R2 as having modified independence in cognitive skills for decision making and having short term memory problems. R2 was assessed at having daily moderate pain. Assessment showed R2 required extensive assist for bed mobility (2 siderails), toilet use and transfers. R2 did not walk during the assessment period, not able to</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>attempt standing balance without physical help and was totally dependent on staff for locomotion off the unit.</p> <p>Nurse's notes documented the following:</p> <p>4/13/08 (6:52pm), Physician notified of R2's fall this AM. Resident has skin tear with steri strips to forearm intact. Resident noted with discomfort to left side.</p> <p>4/14/08 (1:09pm), Assessed resident's skin tear of unknown origin to the left posterior forearm. Noted 8cm long, no drainage, steri strips intact.</p> <p>"Follow-up vital signs," of R2's blood pressure, oxygen sats and temperature were taken and documented on the morning of 4/14 at 8:31am.</p> <p>On 6/24/08 at 1:45pm E3 (ADON-Assistant Director of Nursing) stated, "Truthfully, I don't know anything about a fall."</p> <p>On 6/24/08 at 3pm E8 (LPN-Restorative) stated, "R2 stated she had fallen earlier that morning. She said she was having pain. I followed up with (R1's doctor) to get x-rays just in case. E3 (ADON) did a follow up to see how skin tear occurred and who put steri strips on."</p> <p>On 6/24/08 at 3:30pm E2 (RN-DON) stated, "E3 (ADON) and I followed up the last 24 hours to see who applied the steri strips to R2's arm. We couldn't determined she fell or who applied the steri strips. I don't believe we documented the interviews. We looked at it as an unwitnessed fall. Either myself or E9 (Administrator) have to be notified of falls regardless of the severity and that did not take place."</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>On 6/25/08 at 3pm Z1 stated, "When I was visiting on 4/13/08 about noon, I noticed blood on the sheet. I thought R2 had a nose bleed, I called E5 (CNA) and asked him to change the bed. When I was lifting R2's arm, I noticed a piece of tape lengthwise on her arm, looked like electrical tap, . It was not medical tape and it was bloody underneath. R2 told me she fell out of bed at 4am and said was sore and put her hands on her rib area. R2 said two people helped her back to bed. I asked the nurse (E8) what the procedure was when a patient falls. E8 said the procedure is to take vitals, exam the person, call the doctor and the family . She was not aware she fell out of bed,"</p> <p>There is no current system or policy in place for staff to follow when investigating an injury of unknown origin.</p> <p>The facility presented a document on 6/25/08 entitled Daily assignment and E2 Director of Nursing said this was the facility investigation of R2's skin tear. The document shows one statement handwritten on the bottom of the form that reads; " Followed up with staff assigned to R2 on 4/12 and 4/13 regarding steri-strips in place."</p> <p>According to the facility policy entitled Risk Management Safety/ Injuries of Unknown Origin documents under Procedure:</p> <ol style="list-style-type: none"> 1. Any staff who first observes an injury on a resident will report to the nurse on duty. 2. The nurse on duty will interview the resident and staff on duty at the time of the initial 	F 225			

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F 225	Continued From page 4 observation. The Nurse will physically assess the resident injury and document findings on the Resident Incident Report. 3. If the resident and or staff are able to explain how the injury occurred, the Nurse will finish the Resident Incident Report and send on the the DON. The incident will be factually documented in the clinical record. 4. If the observed injury is unexplainable, however, the Nurse, after completing the Resident Incident Repot, will initiate the Unknown Injury Investigation Form. 5. The Nurse will notify the DON of the incident and turn over the completion of the investigation. Interviews must be witnessed by a second person whom verifies the content of the interview by signing the Unknown Investigation form. All corrective actions will be documented on the Unknown Injury Investigation Form. 6. Review, discussion and corrective actions of any injuries of unknown origin will be reported to appropriate committees and will be made a part of resident care plan.	F 225			
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to remove nitroglycerin patches prior to the application of another patch.	F 281			

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F 281	<p>Continued From page 5</p> <p>This applies to 1 of 3 residents with nitroglycerin patch. (R2)</p> <p>The examples include:</p> <p>R2's Discharge Summary from the hospital, dated 4/5/08 documents that R2's diagnoses include Hypertension and Coronary Artery Disease.</p> <p>R2's April, 2008 Physician's Order Sheet documents an order for Nitroglycerin 0.1mg/hr., apply one patch to skin daily. The same order sheet shows that R2 receives 2 antihypertensive medications (daily) Enalapril Maleate, and Metoprolol Succinate.</p> <p>R2's Medication Administration Record for April, 2008 documents that R2's Nitroglycerin Patch is to be removed at 8:00 PM. The application site is identified 3 times from 4/6 through 4/18 (18 days) Initials are on the same Medication Administration record to indicate that R2's patch was removed at 8:00 PM on 4/7 and 4/8. There are blanks on the dates of 4/22 for application, and blanks on 4/16 and 4/18 for removal of the patch.</p> <p>Physician's Progress Notes dated 4/8/08 document the following: R2 was admitted on 4/5/08. The same document shows that " 4 Nitroglycerin patches were removed from the resident at this time, the patch dated 4/7/08 was left in place." It is also documented that R2 had a small emesis while being examined, and that nursing was made aware of the multiple nitroglycerin patches.</p>	F 281			

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F 281	Continued From page 6 On 6/25/08 at 12:50 PM, E2 Director of Nursing was interviewed. E2 said that she was not aware of the 4 nitroglycerin patches found by R2's physician on 4/8/08. According to Nursing 2005 Drug Handbook pps. 264-266; Nitroglycerin adverse reactions include headache, dizziness, weakness, orthostatic hypotension, nausea, and vomiting. Nursing considerations include: Tolerance to drug can be minimized with a 10-12 hour nitrate free interval. To achieve this, remove the transdermal system in the early evening and apply a new system the next morning. The Lexi-comp Drug Information Handbook for Nursing, 2007 shows on pps. 891 under section entitled Dosing; Adults and Elderly should have nitrate-free interval 10-12 hours a day to avoid tolerance development. Transdermal patches should be on 12-14 hours and off a period of 10-12 hours. Page 892 documents that elderly patients may be at greater risk of falling due to nitroglycerin -associated hypotension.	F 281			
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 record review and interview the facility	F 309			

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F 309	<p>Continued From page 7</p> <p>failed to evaluate the effectiveness of pain medication. The facility failed to clarify orders of when to use a residents prn (as needed) medication to control breakthrough back pain.</p> <p>This applies to 1 of 1 resident with Multiple Spinal Compression Fractures. (R2)</p> <p>The examples include:</p> <p>R2's April, 2008 Physician's Order Sheet documents R2's diagnoses to include compression Fracture, Back Pain and Osteoporosis.</p> <p>The same order sheet shows the following orders:</p> <p>Hydrocodone-APAP 5/325 milligrams (mg) Take 1 tablet every 6 hours. (1.3 grams of Tylenol) 4/5/08</p> <p>Hydrocodone- APAP 5/500 mg every 6 hours as needed. (2 grams Tylenol) 4/5/08</p> <p>Tylenol 650 mg every 4 hours as needed for pain/temperature. (3.9 grams Tylenol) 4/5/08</p> <p>Potential total Tylenol per day would be 7.2 grams of Tylenol/day.</p> <p>R2's Minimum Data Set (MDS) Assessment dated 4/17/08 assessed R2 to have a short term memory problem, no long term memory problem and modified independence in cognitive skills. The same assessment shows that R2 required extensive assistance of one person for bed mobility, transfer, and dressing. R2 was assessed to have moderate pain, daily.</p> <p>The Lexi-Comp's Drug Information Handbook for Nursing, 2007 pps.30 documents under</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>Warnings/ Precautions: Acetaminophen (Tylenol) should be limited to less than 4 grams a day. May cause severe hepatic toxicity.</p> <p>Z4 (Pharmacist) was interviewed on 6/26/08 at 10:25 AM. Z4 said that someone should have questioned the drug order related to the potential amount of Tylenol. Z4 said the amount of Tylenol exceeded the amount that R2 should have had. Z4 said this was of concern because of R2's age and the potential for respiratory depression.</p> <p>The Physician's Progress Notes of 4/8/08 documents that R2 is receiving scheduled pain medication that may need to be adjusted.</p> <p>E2 (Director of Nursing) was interviewed on 6/26/08 at 9:20 AM. E2 said she was not sure how the nursing staff would determine when to use the P.R.N. Hydrocodone for pain. (as needed medication)</p> <p>R2's Medication Administration Record for April, 2008 documents to assess for pain every shift using the 1-10 scale and record. The same record shows that from 4/5 until April 23, 2008 R2 had 2 episodes of pain evaluated as a 10 out of 10 on the 16th, and a 9 out of 10 on the 21st. No documentation concerning the effectiveness of the medication is on the record.</p> <p>On 6/24/08 at 1:35 PM, E3 Assistant Director of Nursing , was interviewed. E3 said that nursing only documents effectiveness of prn medications and not if they are scheduled pain meds.</p> <p>Review of the Therapy Weekly Progress Note/ Discharge Summary Notes for R2 on the</p>	F 309			

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F 309	Continued From page 9 following dates show: Physical Therapy Notes: 4/7/08 R2's pain was 10/10 (10 being worst pain) 4/13/08 R2's pain was 8/10 4/21/08 R2's pain was 6/10 4/22/08 R2's pain was 3/10 Occupational Therapy Notes: 4/11/08 R2's pain was 10/10 4/21/08 R2's pain was 6-8/10 4/23/08 R2's pain was 6/10 , Decreased standing tolerance secondary to back pain. R2's Hospital Discharge notes of 4/5/08 documents that R2 had Intractable back pain secondary to compression fractures. Z5 was interviewed on 6/25/08 at 2:30 PM. Z5 said that " R2 could hardly move without severe pain. R2 had so many fractures and they were extremely painful. Z5 said that she had asked about R2's pain medication and was told that she did not have any orders for prn medication. Z5 said I could not understand why they had her in therapy, any moving, turning, even getting dressed caused her pain. There were times that the pressure from her pants on her lower back was painful. " R2's Care Plan for Impaired Mobility related to Fracture and Pain dated through 7/5/08 includes the approach to offer pain medication prior to therapy. E9 Administrator was interviewed on 6/26/08 at 9:15 AM and said that the facility does not have policies and procedures or a written program on pain management.	F 309			
F 312	483.25(a)(3) ACTIVITIES OF DAILY LIVING	F 312			

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F 312 SS=D	<p>Continued From page 10</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to implement a specific plan for the transfer of a resident with multiple spinal compression fractures.</p> <p>This applies to 1 of 1 resident with Multiple Spinal Compression Fractures. (R2)</p> <p>The examples include:</p> <p>R2's April, 2008 Physician's Order Sheet documents R2's diagnoses to include compression Fracture, Back Pain and Osteoporosis.</p> <p>R2's Minimum Data Set (MDS) Assessment of 4/17/08 assessed R2 to require extensive assistance of one person for bed mobility, transfer, dressing, toilet use, and personal hygiene. R2 was assessed to be lifted manually.</p> <p>R2's Hospital Discharge notes of 4/5/08 documents that R2 had Intractable back pain secondary to compression fractures.</p> <p>Review of document entitled Lift/Movement Profile for Residents dated 4/9/08 does not identify the use of any lift/movement device.</p>	F 312			

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F 312	<p>Continued From page 11</p> <p>According to this document the resident would have been eligible for the several types of lifts based on question items that were answered yes. The same document shows that R2 the lift devices that may have been used for R2 included a Steady or Lift Walker, the Encore or Sara Lift, Tempo Lift, Maxi Slide, or Carendo lift. The portion of the document that determined which lift should be used for R2 is blank.</p> <p>R2's Fall Risk Care Plan dated through 7/8/08 includes the approach to assess for appropriate lift equipment.</p> <p>E3 Assistant Director of Nursing was interviewed on 6/24/08 at 1:35 PM. E3 said that the Lift/Movement Profile is completed by the Certified Nursing Assistant (CNA). E3 said that based on R2's Lift/Movement Profile, he was unsure how R2 was to be transferred.</p> <p>E5 CNA was interviewed on 6/24/08. E5 reviewed R2's Lift/ Movement Profile. E5 said that according to the form, it meant that R2 does not use any type of mechanical lift device. E5 said "Reading this I would say that R2 required 1 assistance to transfer with a gait belt."</p> <p>E7 CNA was interviewed on 6/24/08 at 1:45 PM. E7 said "therapy should be letting the CNA's know how to transfer a resident who is wearing a back brace."</p> <p>Z5 was interviewed on 6/25/08 at 3:00 PM. Z5 said that when she entered R2's room she observed E7 CNA lifting R2 off the bed into the air with his arms. Z5 said that R2 looked startled. Z5 said on another occasion she observed R2 being transferred on a sheet into the recliner</p>	F 312			

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PRINTED: 07/02/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145972	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/30/2008
NAME OF PROVIDER OR SUPPLIER PROVENA COR MARIAE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114		
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F 312	Continued From page 12 chair. Z5 said "the aide dropped one corner of the sheet, jolting R2, her face showed pain, all of this with a fractured spine."	F 312			
F 314 SS=D	E9 Administrator was interviewed on 6/26/08 at 9:15 AM. E9 said that they do not have any policy or procedure related to transfer/ or gait belt use. 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: The facility failed to assess and document a Stage IV pressure ulcer to the sacrum upon admission and failed to do the daily treatment as ordered. This applies to 1 resident reviewed for pressure ulcers (R1). The example includes: 1. The Physician's Order Sheet dated 6/2008 shows that R1 was admitted to the facility on 5/12/08 with diagnoses that include: Hypertension, Dementia, Clostridium Difficile and Pressure Ulcers. R1 had an treatment order for Tegaderm to pressure ulcers per wound care nurse advice/instruction.	F 314			

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F 314	<p>Continued From page 13</p> <p>Minimum Data Set (MDS) of 5/22/08 assessed R1 as having long and short term memory impairment, and moderately impaired cognitive skills for daily decision making. R1 was assessed as requiring total assistance of two staff for transfer and toilet use. R1 was totally incontinent of bowel and bladder. R1 was assessed as having 3 stage 4 pressure ulcers.</p> <p>Hospital Wound consult Notes dated 4/26/08 documented, '7x7cm unstageable (purple with loss of epidermis) pressure ulcer each buttock. Open areas with red wound beds but they are dry and surrounded by purple coloration so injury may extend below dermis. No induration, bogginess or odor. Suggest clear Tegaderm to protect in light of involuntary stool.'</p> <p>R1's Admission Skin Assessment sheet dated 5/12/08 showed, 'Groin raw and open areas, right lower leg-dry rash, Bi-lateral lower extremities-ankle edema, Bi-lateral heels small 1cm x 0.5cm black area, buttock raw with discoloration, right side of back just above hip bone swollen/hard, left knee-dry scratches'</p> <p>R1's nurse's note documented the following:</p> <p>5/13/08 (8:35am), 'Alert to person only, two plus persons for transfers, patient incontinent of bowel and bladder. Patient has raw areas between legs in groin area, dry patch of skin on right lower bilateral lower extremities ankles, 2 plus edema, has black area on both heels that measure 1cm x .05, buttocks excoriated and Alleevyn put on open areas. Scratches to left knee, she also has a very large protrusion area above.'</p>	F 314			

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F 314	<p>Continued From page 14</p> <p>5/16/08 (9:05am), 'Resident has open area on right inner thigh approx 1cm x .3cm. Spoke with E6 (RN-Wound care) concerning resident's coccyx and open area on thigh. Tegaserb applied to coccyx. Will have wound care nurse see resident to recommend treatment for right inner thigh.'</p> <p>5/19/08 (11:25am), 'Assessed resident's preadmit wounds, 'Left heel 2x 2.8cm, black, dry and hard; R heel 1 x 2cm, purple, dry and hard; Sacrum 10 x 10cm, 20% slough, 60% beefy large serosang. (drainage). She is excoriated in her groin.'</p> <p>Nurse's notes document weekly assessments by E6 on 5/27, 6/5, and 6/9.</p> <p>Nurse's note of 6/3 document the coccyx as having a malodorous smell and copious amounts of drainage.</p> <p>R1 had a physician's order dated 5/19 and 6/4/08, 'To cleanse sacrum with saline, wash and pat dry, apply accuzyme to necrotic and slough areas and apply Alleevyn q (every)day and PRN (as needed).'</p> <p>R1's nurse's note of 6/14/07 (10:38pm) showed, E10 (RN) completed R1's dressing change and noted a foul odor with brown drainage. DON (Director of Nursing) was notified. R1's physician was notified of R1's change in mental status, the lapse in time between dressing changes and that the coccyx wound was very foul smelling with brown drainage. R1 was sent to the hospital for evaluation.</p> <p>On 6/24/08 at 10:15am E6 (RN-Wound care) stated, "The nurses are doing daily treatments. I</p>	F 314			

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F 314	Continued From page 15 see the wounds 1 time a week (Mondays) and assess and evaluate." On 6/25/08 at 2:45pm, E10 was interviewed about the nursing note of 6/14/08 for R1. E10 stated, "It had been several days since the dressing had been changed. It was dated several days earlier. I told the DON about the dressing change. It was supposed to be changed daily."	F 314			
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility's pressure ulcer assessment/evaluation policy showed, 'At the time of the initial assessment the licensed nurse will document items which permit differentiating the ulcer type. Residents with pressure ulcers will have appropriate assessment/evaluation completed and documented. When a pressure ulcer is present daily monitoring will be documented' 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: The facility failed to implement a monitoring/ supervision plan for a resident at risk for aspiration. The facility failed to ensure that staff were knowledgeable regarding thickened liquids and feeding techniques to prevent aspiration.	F 323			

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F 323	<p>Continued From page 16</p> <p>This applies to 1 of 9 residents receiving thickened liquids. (R2)</p> <p>The examples include:</p> <p>R2's April, 2008 Physician's Order Sheet documents that R2's diagnoses include Vocal Cord Paralysis the same order sheet shows an order for Pureed Diet on 4/5/08.</p> <p>On 4/11/08 a Physician's Order documents to crush R3's medication.</p> <p>R2's Minimum Data Set (MDS) Assessment dated 4/17/08 assessed R2 to be independent in eating after set up help only. The same assessment shows that R2 has a swallowing problem and receives a mechanically altered diet.</p> <p>Review of a Speech Therapy document dated 4/7/08, shows that R2 had Dysphagia. (difficulty swallowing)</p> <p>The same document shows that R2 had decreased swallowing function with thin liquids and pureed food. R3 was assessed as a risk for choking and Aspiration.</p> <p>On 4/15/08 The Weekly Progress Note/Discharge Summary documents that R2 was noted to be choking/coughing on thin liquids. Small sips did not decrease the signs and symptoms of aspiration. Plan: continue to facilitate safe swallow with nectar/honey liquids.</p> <p>On 4/21/08 the Weekly Progress Note/ Discharge Summary documents special feeding techniques that include compensatory swallowing techniques, chin tuck, multiple swallow, control</p>	F 323			

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F 323	<p>Continued From page 17</p> <p>rate and amount and cues to swallow. Small sips/ nectar thick liquids with no straw. The plan documents to continue nectar thick liquids with small sips or a spoon and pureed diet.</p> <p>The document entitled Weekly Progress Note/ Discharge Summary dated 4/25/08 shows that R2 has decreased choking with nectar thick liquids. The section entitled Skilled Therapy Techniques/ Swallowing shows: Use compensatory swallow techniques/aspiration precautions. Chin tuck/multiple swallow/control rate and amount. Cues to swallow. Cues to clear throat. The same document shows R2 should use a cup and no straw.</p> <p>Nursing Notes on 4/19/08 at 8:41 Am documents that R2 choked on her medication.</p> <p>A Chest X ray report dated 4/20/09, shows that R2 had an infiltrate suspected in the left lower lobe. (substance passing into the lung tissue)</p> <p>Review of R2's Care plan entitled Potential for weight loss/ aspiration dated through 7/22/08 does not document any special feeding techniques to be used to prevent aspiration. The approaches include to allow R2 to eat in the dining room or her own room. No specific approaches as to how nursing would monitor R2 for signs and symptoms of aspiration during meals was documented.</p> <p>Z1 was interviewed on 6/24/08 at 2:30 PM. Z1 said that R2 came in from the hospital on pureed</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>food. Z1 said that " R2 was tried on thin liquids. R2 has vocal cord paralysis and anything she would drink would be a risk. I did an evaluation on 4/7 R2 could have been silently aspirating, unable to tell with a bed side evaluation. On 4/11/ I recommended Nectar thick liquids. R2 did not always follow directions, she required increased processing time.</p> <p>E5 Certified Nursing Assistant was interviewed on 6/24/08 at 2:15 PM. E5 said that R2 would eat in her room. E5 said that R2 had a refrigerator in her room with fluids that the family brought from home.</p> <p>On 6/25/08 at 3:00 PM Z1 was interviewed. Z1 said she came in to be with R2 every evening for dinner. Z1 said that Coffee came up on R2's dinner tray every night. Z1 said I told them R2 doesn't drink coffee, when they finally stopped sending it up, she got nothing. There was apple juice and a straw on her bedside table. They gave her whole pills instead of crushing them and she choked. I started bringing liquids from home and keeping them in a refrigerator in her room, I got tired of looking for fluids every night."</p>	F 323			