

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145919</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROCKFORD HEALTHCARE &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1920 NORTH MAIN STREET</b> <b>ROCKFORD, IL 61103</b>		
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F 000	INITIAL COMMENTS  Complaint Investigations #0814047/IL37182 - F223, F226, F323, F490  #0814073/IL37205 - F157, F224, F246, F279, F281, F314, F325, F333, F490  #0814161/IL37305 - F225, F490	F 000			
F 157 SS=D	A partial extended survey was conducted. 483.10(b)(11) NOTIFICATION OF CHANGES  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157			
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 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to notify the physician and obtain treatment orders for Stage II pressure ulcer on admission to the facility, and failed to notify the family of the pressure ulcer.</p> <p>This applies to 1 resident admitted with a Stage II pressure ulcer. (R1)</p> <p>The example includes:</p> <p>The facility admission notes document R1 was admitted to the facility on 8/25/08. The initial skin assessment (8/25) shows R1 had a 1 cm open area to the right buttock. The nurses' notes on 8/26/08 at 2:02 PM states, "Resident has small stage II ulcer of coccyx discovered by the Certified Nursing Assistant after lunch. Dr. in the building today, but did not see patient today."</p> <p>The admission (8/25/08) physician orders for R1 does not list treatment orders for the Stage II wound on R1's coccyx. The treatment record does not show any treatment orders for R1's Stage II pressure ulcer.</p> <p>On 9/8/08 at 1:00 PM, R1 was observed in bed lying on a soiled incontinence pad. The coccyx area was uncovered, no treatment was in place to the wounds on the buttocks. E4 (Licensed Practical Nurse - LPN) stated, "I need to call the</p>	F 157			

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F 157	Continued From page 2 doctor to get treatment orders (for the wounds). I have been off, and I'm not the regular nurse up here."  On 9/9/08 at 2:40 PM, E6 (Corporate Nurse) stated, "The nurse could have initiated treatment for R1 right away."  Review of R1's medical record did not have any documentation of R1's family being notified of the resident's wound.	F 157			
F 223 SS=G	483.13(b), 483.13(b)(1)(i) ABUSE  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review the facility failed to prevent a cognitively impaired resident (R2) from being physically abused and injured by a roommate. The roommate (R4) has a documented history of physical aggression. This failure resulted in R2 being hit in the head by R4 causing bleeding and lacerations to the head and R2 requiring emergency treatment at the hospital. This applies to 1 resident who was abused (R2).  Findings include:  1. The facility incident report dated 9/3/08 at 4:30 PM states, " (R2 ' s) roommate (R4) broke off the	F 223			

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F 223	<p>Continued From page 3</p> <p>control lever on the recliner and was hitting resident in the head with the controller repetitive times. The roommate (was) redirected away from this resident so the nurse could assess. Upon assessment, noted 3 lacerations to left lateral/posterior aspect of the head. R2 complained of pain to the left lateral side of his head and left hip pain. Nurse to continue to monitor and stay with resident until ambulance arrives, 911 called for transport due to bleeding and (resident receiving) Coumadin (anticoagulant/blood thinner).</p> <p>The Emergency Department Record dated 9/3/08 documents, "R2 presented to the hospital last night after his roommate hit him in the head with a TV controller. Because the patient is on Coumadin, there is concern about his excess bleeding."</p> <p>On 9/9/08 at 3:15 PM, E9 (Licensed Practical Nurse-LPN) stated, "The hospice nurse had been in the room and closed the door when she came out to the desk to ask a few questions. He (R2) was in the recliner between the beds. The hospice nurse went back, opened the door and yelled to come right away." E9 continued, "R2 had 3 cuts on the forehead temple area. I was worried about the bleeding because he is on Coumadin and Lovenox. There was a lot of blood on his shirt and a large spot on the recliner. I just wanted to get him out right away." E9 stated, "R4's behavior could be like that. He gets agitated with surrounding changes. He maybe got upset the hospice nurse was in the room. We have to approach him differently when in the room. He can easily get aggressive when approached in his room." E9 continued, "When he is difficult we leave him alone in the room and</p>	F 223			

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F 223	<p>Continued From page 4</p> <p>reapproach later. If R4 returned, I would worry about the other resident's safety. He is a big man. He was intimidating to others, especially when aggressive. We usually would leave him alone and come back later."</p> <p>Nurses notes on 1/14/08 state R4 was admitted after a stay at a psychiatric hospital. The facility nurses' notes show that R4 had 7 documented aggressive behaviors between 1/19/08 and 6/6/08 which include:</p> <p>Notes on 1/19/08 document, "R4 was wandering throughout the facility...started following resident. ..Resident made it down the stairs and attempted to push this writer out of the way to go out the outside door...resident was insistent on going out the door...this writer and CNA were blocking the stairs so resident couldn't go back down...Resident grabbed this writer very firmly by the arm and tried to move me out of the way....returned to hall...resident went into empty room and sat there for a few minutes."</p> <p>Nursing notes dated 3/2/08 document, "Resident is uncooperative, is combative swinging hands/fists with (at) staff, at times in the PM. And swing on (at) staff when attempting to assist with care. One minute resident is okay with assistance and then all of a sudden will get very agitated with staff and resist care."</p> <p>Nursing Notes dated 3/14/08 document, "Resident is being sent to (psychiatric hospital) today." The notes show R4 returned to facility on 3/28/08.</p> <p>Nursing Notes on 3/30/08 at 10:55 PM document, "Resident very upset after dinner, went out south door, could not redirect."</p> <p>Nursing Notes 4/1/08 at 9:53 PM, "Resident wanders unit, becomes upset easily and has be redirected."</p>	F 223			

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F 223	<p>Continued From page 5</p> <p>Nursing notes 4/24/08 at 4:16 PM, "Reported to writer that resident was verbal to a female. Both resident sitting chairs away from each other, near nurses' station."</p> <p>Nursing notes 5/12/08 at 1:58 PM, "Resident very aggressive and refusing care. Putting diapers in the toilet and BM (bowel movements) all over his room. Refused shower 4 four times today."</p> <p>Nursing Notes late entry for 6/6/08 at 1600, "Patient for unknown reason became very verbally argumentative and aggressive by body language it was very apparent he would get physically violent if approached."</p> <p>On 9/8/08 at 1:45 PM, E2 (Director of Nurses-DON) stated, "The incident happened at 4:30 PM on 9/3/08. There were no previous incidents with R4. This was a very serious incident." E2 stated R4 was questioned if he did it and R4 stated, "Damn right I did". E2 stated R2 and R4 have been roommates for quite some time and there were no previous issues. E2 described R2 "He is about 168# and gets around in a wheelchair. He has Dementia and is unable to make decisions." E2 stated R4 is 6 foot something and pretty big. He is ambulatory, gets around by himself. He needs cueing for daily care."</p> <p>On 9/8/08 at 1:45 PM, E1 (Administrator) stated, "I was not aware of any problems with R4. He is now at a (Psychiatric) Hospital and we do not plan for him to return. He needs a locked Alzheimer unit." E1 stated it was R4's typical behavior to sit at the nurses station. I am unaware of any triggers for this behavior. This was a serious aggressive incident." E1 was not certain of where the recliner was located in the room. E1 stated, "He has had no previous</p>	F 223			

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F 223	<p>Continued From page 6</p> <p>incidents of aggression with his roommate. This happened out of the blue. He has been stable."</p> <p>R4's Physician Order Sheet (POS) of 9/1/08 shows he was admitted to the facility on 1/14/08. R4's diagnosis is documented as Dementia, Alzheimer type with aggressive behavior. R4's MDS of 4/2/08 R4 demonstrates wandering that is not easily altered and repetitive physical movements. The Resident Assessment Protocol (RAP) dated 8/7/08 documents, "Resident has diagnosis of dementia with behaviors, depression and anxiety. Resident's mood fluctuates and manifests itself in behaviors of wandering, restlessness, agitation and self isolation." The care plan dated 1/16/08 does not identify R4's risk factors to be abused or interventions to use when R4 is aggressive toward others.</p> <p>R4 was admitted to the facility on 1/14/08 after discharge from a psychiatric hospital. A psychiatric evaluation dated 12/28/07, completed at the psychiatric hospital prior to his discharge documents, "R4 was admitted because of aggressive behavior." The history of present illness on the physician's report states, "R4 was sent to us because of physical aggression. On 12/26/07 he became physically aggressive towards staff, threatening to kill staff and attempted to leave the facility. He is unable to be redirectable. He is wandering, going into other resident's rooms demanding that they leave because he stated it is his house. Residents and staff become fearful of him and because of that he was sent to the hospital for treatment".</p> <p>The history and physical report at the psychiatric hospital dated 3/14/08 documents, "R4 is admitted from the nursing home due to increased</p>	F 223			

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F 223	<p>Continued From page 7</p> <p>confusion and physical and verbal aggression towards other residents. The patient was wandering everywhere on the unit, grabbing on and twisting and pacing in the hallway. The problem has been going on for days."</p> <p>R4's September 2008 behavior tracking sheet shows monitoring for restlessness, wandering on the unit and self isolation.</p> <p>The Physician Order Sheet of 9/1/08 documents R2 has a Dementia diagnosis and receives Coumadin (Anticoagulant) and Lovenox (low molecular weight heparin) Injections daily. R2 does not ambulate, requires assistance of two staff to transfer and uses a wheelchair as the primary mode of transportation. The care plan dated 6/3/08 does not identify R2's risk factors to be abused or interventions for safety from abuse.</p> <p>On 9/8/08 at 12:45 PM, R2 was observed. R2 was awake, but quiet. Healing lacerations were noted to the left temple forehead area. A resolving yellow-green bruise was noted around the left eye, upper cheek and temple area.</p> <p>On 9/9/08 at 3:00 PM, R2 was observed in bed resting. R2 was smiling and pleasant. R2 was asked about the injury to his head. R2 stated, "I got in a fight. I don't know who the guy was. Not sure what the fight was about."</p> <p>On 9/8/08 at 1:05 PM, E3 (Certified Nursing Assistant) stated, "You never know about his (R4) mind, he was usually nice but you never know. He might go off on any body, he just gets set off. He won't let us give him a shower, then later it would be OK." E3 stated, "R2 can't protect himself, he is dependent on staff for care,</p>	F 223			

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F 223	Continued From page 8 he needs prompts and cues. Set up to eat, and he can feed himself."	F 223			
F 224 SS=G	483.13(c) STAFF TREATMENT OF RESIDENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to follow their policy and procedures for preventing neglect by not providing nursing care to avoid physical harm. The facility neglected to follow their skin care policies and procedures for pressure ulcer prevention and treatment and enteral feeding. The facility neglected to provide nutritional support to provide calories to meet estimated needs via enteral feeding for 8 days 8/27- 8/28 and 9/4/08 through 9/9/08 (R1). R1 developed new pressure areas during this time.  Findings include:  1. The Resident Skin Check Sheet dated 8/25/08 (Admission date) shows that R1 had a 1 centimeter open area on the right inner buttock. No further description of the wound was documented. R1's Minimum Data Set (MDS) Assessment of 9/8/08 shows that R1 was incontinent of bowel and bladder and had a stage I pressure ulcer  The Resident Skin Check Sheet dated 8/25/08 (Admission date) shows that R1 had a 1 centimeter open area on the right inner buttock.	F 224			

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F 224	<p>Continued From page 9</p> <p>R1's Braden Scale for Pressure Ulcer Prediction dated 8/25/08 showed a score of 13 ( moderate risk.).</p> <p>On 9/8/08 at 1:00 PM, R1 was observed. R1 had an open area on the right buttock On each side of R1's coccyx area, areas of purple discoloration were observed. Another open area was observed on R1's left buttock. R1 had no dressings to the open areas.</p> <p>R1's August, 2008 and September, 2008 Physician's Order Sheet does not show any treatment orders for R1's open areas.</p> <p>R1's Care Plan for Tissue Integrity Impairment dated 8/28/08 does not identify any open areas on R1's skin.</p> <p>The facility Pressure Ulcer Protocol documents the following: pg. 2) no 3: All nursing assistants will report any change in a residents skin condition. The licensed staff will document such changes in the medical record.</p> <p>5.) If an ulcer is present on admission or when it first occurs, the licensed nurse who will document a complete assessment on admission assessment/nurses notes will assess it. Assessment must include, site, size depth, drainage, odor and condition of the surrounding skin. Documentation in the nurses notes will include notification of the physician immediately and family members within a reasonable amount of time as determined by the professional judgement of the licensed nurses.</p> <p>6.) The charge nurse will do a weekly assessment of each pressure ulcer on the skin assessment form/treatment sheet. This assessment will include site, stage, size, depth, drainage, odor, healing process and condition of</p>	F 224			

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F 224	<p>Continued From page 10 surrounding skin.</p> <p>page 3) no.4 Inspection of the resident's skin should be included in the daily routine.</p> <p>R3 ' s Skin Assessment Profile dated 8/27/08 shows R3 had a 2.5 cm x 2.5 cm fluid filled blister to the right heel. A hospital Discharge/Transfer form dated 8/27/08 documents an order to obtain an wound care consult, to assess R3's heels when he returns to the nursing home, and R3 is to wear waffle boots to both feet.</p> <p>On 9/15/08 at 9:45 AM, Z3 was interviewed. Z3 said " R3 returned to the nursing home from the hospital sometime in August, at that time he had a big blister on his right heel. When he went back to the hospital in September, they noticed several more areas on him, they showed them to me. The second heel ulcer (left ) occurred at the nursing home.</p> <p>The hospital document entitled Hospitalist History and Physical dated 9/1/08, R3's left heel was found to have a half-dollar size circular area of slight ecchymoses and swelling. The right heel has a very large vesicular blister covering most of the heel posteriorly and inferiorly bilaterally with what appears to be deep ecchymosis. Buttocks and sacrum are red."</p> <p>R3's care plan entitled Tissue Integrity Impairment dated 8/28/08 does not identify the location of R3's pressure area, or R3's specific risk factors. (decline in condition, poor oral intake, immobility, incontinence).</p> <p>No evidence was documented to show that the facility had assessed R3's left heel or sacral/ coccygeal area from return to the facility on 8/27/08 until R3 was readmitted to the hospital on</p>	F 224			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145919</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2008</b>
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F 224	Continued From page 11 9/1/08.  2. R1 did not receive nutritional support through the tube feeding to meet his estimated calorie needs on 8/27, 8/28/ and 9/4 thorough 9/9. The facility failed to identify the etiology of R1's 28 pound unplanned weight gain in 2 weeks. R1 developed 2 deep tissue injuries and an additional stage II pressure ulcer.  According to the dietitian note of 9/9/08 States the tube feeding of Jevity 1.5 at 40 cc for 22 hours provides 1320 calories and 56 grams of protein per day. R1's estimated nutritional needs on 9/9 were determined to be 1850-2220 calories per day and 77 grams of protein based on a weight of 163 pounds. The dietitian states that the current tube feeding does not meet resident's nutritional needs.  R1's physician orders for 8/27-28 are for Jevity 1.5 at 40 cc for 22 hours. The Physician's Order Sheet and September, 2008 MAR shows an order on 9/4/08 to decrease R10's tube feeding to 40 cc/hr for 22 hours. These orders were in place until 9/9/2008.  R10's Treatment Administration Record shows an order to obtain a weekly weight on Fridays. The same record shows that a weight was to be taken on 8/29/08 and no weight is recorded.  The facility policy entitled Enteral Feeding shows: Adequate nutritional support through enteral feeding will be provided to residents unable to consume adequate nutritional intake by mouth.	F 224			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS	F 225			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 225	<p>Continued From page 12</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 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</p>	F 225			

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

PRINTED: 09/26/2008  
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F 225	<p>Continued From page 13</p> <p>by: Based on observation, record review, and interview the facility failed to thoroughly investigate bruises on a residents arms, and a foot fracture of unknown origin. The facility failed to thoroughly investigate a residents allegations of being slapped, and report of staff stepping on her toes. The facility failed to interview the charge nurse and remove the accused staff from resident care until an investigation had been completed.</p> <p>This applies to 1 cognitively impaired resident with injuries of unknown origin. ( R10)</p> <p>The examples include:</p> <p>R10's September, Physician's Order Sheet documents that her diagnoses include Alzheimers, Progressive Dementia, Arthritis, and Depression.</p> <p>R10's Minimum Data Set (MDS) Assessment of 7/24/08 identifies R10 as having short and long term memory problems, with modified independence in cognitive skills (some difficulty in new situations only). The same MDS shows that R10 had behavioral symptoms of wandering that was not easily altered. R10 required extensive assistance of 2 or more for transfer and toilet use. R10 was identified to have limitation of range of motion of both legs with partial loss of voluntary movement. The MDS shows that R10 is lifted manually for transfer.</p> <p>R10's Nursing Notes for 8/29/08 at 7:25 AM documents that R10 said a Certified Nursing Assistant (CNA) stepped on her toes/ foot when she was transferring her into bed. R10 said that it</p>	F 225			

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

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F 225	<p>Continued From page 14 was not the day CNA.</p> <p>An X-ray report dated 8/29/08 shows that R10 had a Fracture of the third Metatarsal (toe)of the Left Foot.</p> <p>On 9/11/08 at 3:15 PM, E2 said that she had conducted an investigation and found it to be inconclusive. E2 submitted for review her interview statement conducted to complete the investigation. The document submitted showed on 9/2/08, E2 conducted an interview with only 2 CNAs (E16,E17). E2 confirmed that there were no further interviews conducted. E2 said " R10 could not identify the person. She used to take dance, and also had a horse step on her foot. "</p> <p>R10's Nursing Notes on 9/6/08 entry for 10:31 PM, documents that R10 had increased anxiety and stated that some one had slapped her.</p> <p>On 9/6/08 Z5 was interviewed. Z5 stated that R10 had made an allegation that she had been slapped. E18 CNA had been in the room with R10 prior to the allegation. Z5 said that E18 was not removed from resident care and continued to work. Z5 said that no investigation was conducted because R10 is delusional and hallucinates.</p> <p>On 9/11/08 at 1:40 PM, E4 Licensed Practical Nurse (LPN) was interviewed. E4 said the R10 sundowns and accuses people of being out to get her. E4 said "I have not heard her accuse anyone of slapping her. If I had seen her and she reported she had been slapped, I would not investigate it because I knew her whereabouts. If I did not know where she was or what she was</p>	F 225			

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

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F 225	<p>Continued From page 15</p> <p>doing and she reported to me she had been slapped , I would have looked into it. I know she gets into it with her room mate over the bathroom."</p> <p>E1, Administrator was interviewed on 9/11/08 at 2:00 PM. E1 said " R10 has a long history of accusing people of doing things to her. A nurse was terminated for charting the whole thing the way it was charted and she didn't report it. I would have been out of my time frame to investigate it. Is an investigation even necessary? It is pretty clear, somebody was terminated for it."</p> <p>On 9/12/08 at 3:10 PM, E1 (Administrator) was interviewed. E1 said "R10 was in her room all alone when she said someone slapped her. There was not specific person named in the allegation. I talked to the nurse who documented it."</p> <p>Review of document entitled Investigation Summary Form dated 9/8/08 shows " R10 came out of a room where she was alone and stated someone had just slapped her." Page 2 of the same document shows that no interviews were conducted (blank) and no records were reviewed (blank).</p> <p>On page 3 under "Conclusion) it is documented "Individual has a diagnoses of psychosis and a history of false reports. No bruising or redness."</p> <p>The document entitled Resident Skin Check Sheet dated 7/14/08 identifies that R10 had irregular shaped purple/green/brown bruise to the back of her left arm. One bruise was 10 cm x 11 cm and the other 11 cm x 8 cm. R10's right arm had a 11.4 cm x 9.4 cm green/brown/purple bruise. The right hand has a light green/brown</p>	F 225			

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

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F 225	<p>Continued From page 16 bruise near the thumb. There was no evidence of an investigation of these bruises.</p> <p>R10 was observed on 9/11/08 seated in a wheel chair near the nursing station. R10 was then pushed in the wheelchair into the lounge area to watch the birds. R10 said " Oh don't let them outside they will get killed."</p> <p>The facility Abuse Prevention Program Policy and Procedure documents the following:</p> <p>Page1 defines Physical Abuse as "hitting, slapping, pinching, kicking, punching, and other forms of battery upon a resident."</p> <p>Page 6 of the same document shows: "Facility management regularly reviews concern identification reports, accident reports, incident reports and missing item reports to assess possible patterns or trends, including but not limited to incidents of suspicious bruising of residents, unexplained incidents or accidents, or other such occurrences that may constitute abuse, neglect, or misappropriation of property on this review, facility management will further investigate and /or determine whether a change in facility practices is warranted and the direction of any investigation.</p> <p>Page 7 shows under "Investigation" Upon learning of a suspected incident or accident, whether through a report or otherwise, the Director of Nursing or the Administrator will initiate and supervise an incident investigation.</p> <p>If the Administrator or Director of Nursing determines that there is a reasonable possibility</p>	F 225			

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

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F 225	Continued From page 17 that Abuse, Neglect and or Misappropriation of resident property has occurred, the Administrator or the Director of Nursing shall designate an individual to fully investigate all the allegations. The designated investigator will obtain a copy of all documentation relating to the alleged incident and will interview, when possible the person who made the allegation or initiated the incident report, co-workers of the accused employee, .... other residents on the same assignment, the employee or other individual in the alleged abuse...., the charge nurse and any other individuals who might have knowledge concerning the allegations.  Page 9 shows Employees who have been accused of Abuse, Neglect, or Misappropriation of resident property will be removed from resident contact immediately and may if appropriate be suspended pending the outcome of the investigation. Accused employees will not be allowed to complete their current shift as a direct care provider to residents.	F 225			
F 226 SS=G	483.13(c) STAFF TREATMENT OF RESIDENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review the facility failed to follow their policy for preventing abuse which includes assessing and identifying residents at risk for abuse, identifying behaviors and problems that can increase the risk of abuse. The facility also failed to implement	F 226			

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

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F 226	<p>Continued From page 18</p> <p>interventions to protect residents from being abused or from abusing others. These failures resulted in a cognitively impaired resident being abused by another resident with a history of physical aggression. R2 was hit in the head by the roommate causing lacerations to the head and resulted in R2 needing emergency treatment at a local hospital.</p> <p>Findings include:</p> <p>1. On 9/3/08 at 4:30 PM R2 ' s roommate (R4) broke off the control lever on the recliner and hit R2 in the head with the controller repetitive times according to the facility incident report. Upon assessment, noted 3 lacerations to R2 ' s left lateral/posterior aspect of the head. R2 complained of pain to the left lateral side of his head and left hip pain. 911 was called for transport due to R2 was bleeding and was (resident receiving) Coumadin (anticoagulant/blood thinner).</p> <p>On 9/8/08 at 1:45 PM, E2 (Director of Nurses-DON) stated, "The incident happened at 4:30 PM on 9/3/08. There were no previous incidents with R4. This was a very serious incident." E2 stated R2 and R4 have been roommates for quite some time and there were no previous issues. E2 described R2 "He is about 168# and gets around in a wheelchair. He has dementia and is unable to make decisions." E2 stated R4 is 6 foot something and pretty big " .</p> <p>On 9/8/08 at 1:45 PM, E1 (Administrator) stated, "I was not aware of any problems with R4. He is now at a (Psychiatric) Hospital and we do not plan for him to return. He needs a locked Alzheimer's unit." I am unaware of any triggers</p>	F 226			

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

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F 226	<p>Continued From page 19</p> <p>for this behavior. This was a serious aggressive incident." E1 stated, "He has had no previous incidents of aggression with his roommate. This happened out of the blue. He has been stable." On 9/10/08 at 3:15 PM E1 stated, "I am shocked that this happened. R2 and R4 have never had a problem before. I never imagined he would do that to R2. There is no way we could have known. He was unpredictable, and his aggression before has always been toward staff."</p> <p>On 9/8/08 at 1:05 PM, E3 (Certified Nursing Assistant) stated, "You never know about his (R4) mind, he was usually nice but you never know. He might go off on any body, he just gets set off. He won't let us give his a shower, then later it would be OK." E3 stated, "R2 can't protect himself, he is dependent on staff for care, he needs prompts and cues. Set up to eat, and he can feed himself."</p> <p>On 9/9/08 at 3:15 PM, E9 (Licensed Practical Nurse-LPN) stated, "R4's behavior could be like that. He gets agitated with surrounding changes. He maybe got upset the hospice nurse was in the room. We have to approach him differently when in the room. He can easily get aggressive when approached in his room." E9 continued, "When he is difficult we leave him alone in the room and re-approach later. If R4 returned, I would worry about the other resident's safety. He is a big man. He was intimidating to others, especially when aggressive. We usually would leave him alone and come back later."</p> <p>The care plan dated 1/16/08 does not identify R4's risk factors or show interventions to prevent R4 from abusing others when he becomes agitated/aggressive (residents or staff).</p>	F 226			

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

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F 226	<p>Continued From page 20</p> <p>The care plan dated 1/16/08 does not identify R4's risk factors or show interventions to prevent R4 from abusing others when he becomes agitated/aggressive (residents or staff). defines Physical Abuse to include hitting, slapping, pinching, kicking, punching and other forms of battery upon a resident (page 1). The screening section does not address any component for screening prospective residents as a potential abuser . The training component (page 4) does not address training or education of residents and family on the facility ' s abuse policy.</p> <p>The facility Abuse Prevention Program states on page 5, "As a part of the resident care plan process, professional staff will approach all residents as having increased vulnerability for Abuse, along with those who have needs and behaviors that might lead to conflict or neglect. During this process, staff will attempt to identify any problems or goals or approaches which would reduce the chances of abuse, neglect or misappropriation of resident property of such residents."</p> <p>R4's Physician Order Sheet (POS) of 9/1/08 shows R4's diagnosis is documented as Dementia, Alzheimer type with aggressive behavior. R4's behavior tracking records show he is monitored for restlessness, wandering on the unit and self-isolation. R4's MDS of 4/2/08 documents R4 demonstrates wandering that is not easily altered and repetitive physical movements. The Resident Assessment Protocol (RAP) dated 8/7/08 documents resident's mood fluctuates and manifests itself in behaviors of wandering, restlessness, agitation and self isolation."</p>	F 226			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	<p>Continued From page 21</p> <p>R4 was admitted to the facility on 1/14/08 after discharge from the psychiatric hospital. A psychiatric evaluation dated 12/28/07 that was completed at the psychiatric hospital prior to his discharge documents, "R4 was admitted because of aggressive behavior." The history of present illness on the physician's report states, "R4 was sent to us because of physical aggression. On 12/26/07 he became physically aggressive towards staff, threatening to kill staff and attempted to leave the facility. He is unable to be redirectable. He is wandering, going into other resident's rooms demanding that they leave because he stated it is his house. Residents and staff become fearful of him and because of that he was sent to the hospital for treatment".</p> <p>The history and physical report at the psychiatric hospital dated 3/14/08 documents, "R4 is admitted from the nursing home due to increased confusion and physical and verbal aggression towards other residents. The patient was wandering everywhere on the unit, grabbing on and twisting and pacing in the hallway. The problem has been going on for days."</p> <p>On 9/10/08 at 11:15 AM, E2 (Director of Nurses-DON) stated, "Social Services reviews all new admissions, looks at medications and if they have a previous history of abuse. They look at resident's diagnoses. A high risk diagnosis would be Psychosis without dementia. Dementia residents can have periods of problems too We avoid Subpart S residents. We collect information when we get the referral, if they are subpart S, we don't take them. The screening process is informal, no screening forms are used. No specific abuse assessment is done." E2</p>	F 226			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145919</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROCKFORD HEALTHCARE &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1920 NORTH MAIN STREET</b> <b>ROCKFORD, IL 61103</b>		
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F 226	<p>Continued From page 22</p> <p>informed R4 was admitted to the facility after a psychiatric hospitalization. E2 stated she was not here when R4 was admitted.</p> <p>On 9/10/08 at 10:50 AM, E12 (Licensed Practical Nurse-LPN) stated, "I did work in social services from July 7, 2008 till August 23, 2008. Resident assessments on admission include talking to family to find out what the resident is like. We watch for problems with roommates, most new admissions have an adjustment period getting used to their roommate. The resident assessment is informal. If I found concerns, I would report it to the nurse so she can address the issues." E12 was asked about assessing risk factors for abuse, E12 responded, "It is informal, I review the history and physical. The mood and behavior care plans are generated from the pharmacy when the resident takes psych medications." On 9/10/08 at 11:40 AM, E12 (LPN) stated, "The administrator was my go to person when I was doing social services. I think she had done social services in the past. I did not have any training per se, it was on the job, learn as you go. I talked with the marketing person when things came up that I didn't know how to handle."</p> <p>On 9/10/08 at 11:45 AM, E1 (Administrator) stated, "E7 (LPN) was hired last week. She will be doing social services and the resident assessments on admission. Yes, I would be considered the go to person for social services. I'm the Q." E1 stated the Q meant she was a "Qualified Mental Health Professional." E7 (LPN) was asked about her role in social services. E7 stated, "I was hired to assist the social service person." E1 (Administrator) then stated, "E14 was hired this week for social services."</p>	F 226			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145919</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2008</b>
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F 246 SS=D	<p><b>483.15(e)(1) ACCOMMODATION OF NEEDS</b></p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide a wheelchair wide enough to accommodate a resident's body size.</p> <p>This applies to 1 new admission requiring a wheelchair for mobility. (R8)</p> <p>The example includes:</p> <p>The Physician Order sheet states R8 was admitted to the facility on 9/8/08 with diagnoses of Congestive Heart Failure, Pulmonary Edema, and Chronic Obstructive Pulmonary Disease. The admission care plan (09/08) states R8 has impaired Physical mobility, requires assistance with mobility due to weakness and recent hospital stay.</p> <p>On 9/10/08 at 10:30 AM, R8 was observed seated in a wheelchair near room 234, she was crying and said she needed to lay down. R8 was slouched down in the chair and holding on to the arm rests for support. There were no foot rests on the wheel chair. The wheelchair was too small for R8's body size. R8's thighs were observed to be indented by the sides of the wheelchair. The</p>	F 246			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145919</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2008</b>
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F 246	Continued From page 24 wheelchair arm rests were pressing into R8's waist line.	F 246			
F 279 SS=D	On 9/10/08 at 10:30 AM, E13 (Registered Nurse-RN) stated, "We were just talking about that chair, it's too small. She needs a different chair." 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  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 services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review the facility failed to develop approaches to address a resident's (R5) behavior related to cutting his foot callus with sharp instruments which causes bleeding and increased potential	F 279			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145919</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2008</b>
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F 279	<p>Continued From page 25</p> <p>for infection, and failed to care plan R5's skin breakdown risk factors and implement interventions to prevent skin breakdown.</p> <p>This applies to 1 resident with a diabetic foot ulcer. (R5)</p> <p>The example includes:</p> <p>The August 2008 Physician Order Sheet lists R5's diagnoses as Diabetes, Chronic Renal Failure, Anxiety, Congestive Heart Failure and Coronary Heart Disease. The physician progress note dated 4/29/08 states, "R5 has had a blister on his left foot for some time." The physician states, "R5 is diabetic with Peripheral Neuropathy. Will get an x-ray of his foot to rule out the possibility of osteomyelitis.</p> <p>The Minimum Data Set of 8/1/08 shows R5 does not have any memory impairment and is independent in decision making for daily living. The Resident Assessment Protocol (RAP) dated 8/1/08 does not identify R5's specific behaviors. The RAP states, "Behavioral symptoms which interfere with resident's self performance, resident treatment regimes, mood problems, illness/condition and impaired communication." The Rap states the staff will "Observe for patterns in behavior." Specific behaviors are not identified. R5's care plan identifies R5 as "Pacing in the halls, and cursing at nurses". R5's skin care plan states, "Remind resident to allow physician to treat foot." No other behaviors, specific interventions, or risk factors for skin breakdown are identified for R5.</p> <p>Nursing documentation on the weekly skin sheet on 5/15/08 states, "Resident did "surgery" on the</p>	F 279			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145919</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2008</b>
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F 279	<p>Continued From page 26</p> <p>left foot with scissors to get the pressure off the foot."</p> <p>On 9/9/08 at 4:00 PM, R5 was observed sitting in a chair outside the facility. R5 was alert and pleasant, he was wearing orthotic shoes. R5 stated, "I have a sore on my foot. It has a lot of drainage and pain, it gives me a lot of trouble. Something is growing from the bone out and the foot doctor said I need to have surgery. It (wound) just keeps healing and re-opening. The doctor said I need surgery or I could loose my foot. I remove the dry skin around the sore with my nail clippers. Sometimes I cut it too deep and it bleeds."</p> <p>On 9/8/08 at 3:45 PM, E2 (Director of Nurses) stated, "R5 digs at his foot, he thinks there is something draining out of it and he tries to cut it. The foot doctor has told him to leave it alone. He is diabetic and wears diabetic shoes. We call it a pressure sore because that's what it started out as." E2 was questioned regarding interventions tried to prevent R5 from cutting at his foot or gaining access to sharp instruments. E2 responded, "R5 is a very resourceful man, I'm not sure what he is cutting his foot with, maybe toenail clippers. It's just one of those things that he has to keep picking on."</p> <p>On 9/9/08 at 4:05 PM, E11 (Licensed Practical Nurse - LPN) stated, "We've caught him cutting his foot, he uses his nail clippers."</p> <p>According to Bryant, Acute and Chronic Wounds, Third Edition, 2007: page 324, "The person with diabetes is more prone to infection than the person without diabetes."</p>	F 279			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145919</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2008</b>
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F 279	Continued From page 27 page 325, "Diabetic neuropathy is associated with a reduced blood supply to the nerves." page 326, "At least 50% of all amputations due to diabetic neuropathy are preventable with early interventions....It is incumbent upon the health care professional to identify patients with lower-extremity peripheral neuropathy (LEND) as early as possible so that preventative interventions can be implemented. Preventative interventions for the patient with LEND must become a routine that the patient incorporates into everyday life. Specific instructions concerning inspection of the foot, bathing, nail care, care of corns and calluses, shoes, socks and circulation should be enforced in writing and verbally. Clearly one of the most important components of the clinicians role is to provide patient education."	F 279			
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 interview and record review the facility failed to follow the physician orders to perform blood glucose monitoring at 6:00 AM daily for a diabetic resident.  This applies to 1 diabetic resident who required insulin (R1).  The example includes:  The admission History and Physical dated 9/9/08 shows R1 has Diabetes Mellitus. The admission	F 281			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145919</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2008</b>
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F 281	Continued From page 28 Physician Order Sheet dated 8/25/08 documents R1 is to have his blood glucose level checked every morning at 6:00 AM. R1 is prescribed to receive Novolin R insulin on a sliding scale dosage schedule based on R1's blood glucose level.  According to the blood glucose monitoring log and the medication administration record from 8/25/08 through 9/10/08 there were 11 errors in blood glucose monitoring for R1. On 8/26/08 R1's blood glucose level was not checked at 6:00 AM. On 8/27/08 R1's blood glucose level was checked at 11:30 AM. On 8/29/08 R1's blood glucose level was checked at 11:30 AM. On 9/2/08 R1's blood glucose level was checked at 11:30 AM. On 9/3/08, R1's blood glucose level was checked at 11:30 AM and 5:30 PM. On 9/6/08 R1's blood glucose level was not checked at 6:00 AM. On 9/8/08 R1's blood glucose level was not checked at 6:00 AM. On 9/9/08 R1's blood glucose level was not checked at 6:00 AM, but was done at 5:00 PM. On 9/10/08, R1's blood glucose level was not checked at 6:00 AM,  On 9/11/08 at 3:50 PM, E2 (Director of Nurses) was informed of the blood glucose monitoring errors. E2 had no comment or additional information to provide.  The facility procedure for Blood Sugar Monitoring states, "Document procedure in the medical record."	F 281			
F 314	483.25(c) PRESSURE SORES	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 314 SS=G	Continued From page 29  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, record review, and interview the facility failed to routinely assess resident skin conditions, identify new open areas, document skin conditions, and obtain treatment orders (R1, R3). The facility failed to prevent a resident at low risk for skin breakdown from developing deep tissue injury and further skin breakdown (R3). The facility failed to ensure a dressing was in place and that the wound was protected, and failed provide pressure reduction (R8). The facility failed to implement pressure relieving devices to avoid skin breakdown for at risk residents (R6, R7). This applies to 5 of 5 residents identified with pressure ulcers (R1, R3, R8, R6, R7).  Findings include:  1. R1's September, 2008 Physician's Order Sheet documents diagnoses including Parkinson's Disease, Aspiration Pneumonia, Dementia, and Osteoarthritis.  R1's Admission Minimum Data Set (MDS) Assessment of 9/8/08 identified R1 with short and	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145919</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROCKFORD HEALTHCARE &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1920 NORTH MAIN STREET</b> <b>ROCKFORD, IL 61103</b>		
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F 314	<p>Continued From page 30</p> <p>long term memory problems. R1 was assessed to have moderately impaired cognitive skills. The same MDS shows that R1 was totally dependent on staff for bed mobility and transfer. R1 was assessed to have range of motion limitation with partial loss of voluntary movement that involved his arms and legs. The assessment shows that R1 was incontinent of bowel and bladder, is fed by a feeding tube, and had a stage I pressure ulcer.</p> <p>R1's Braden Scale for Pressure Ulcer Prediction dated 8/25/08 showed a score of 13. (13-14 is moderate risk.)</p> <p>The document entitled Resident Skin Check Sheet dated 8/25/08 (Admission date) shows that R1 had a 1 centimeter open area on the right inner buttock. No further description of the wound was documented.</p> <p>R1's Nursing Notes on 8/26/08 at 2:02 PM, documents that R1 had a small, stage II ulcer of the coccyx discovered by the Certified Nursing Assistant (CNA). No further documentation regarding R1's skin condition is documented until 9/8/08. The entry for 9/8/08 at 3:43 AM documents that "multiple open areas noted on coccyx". No further wound assessment information is documented.</p> <p>On 9/8/08 at 1:00 PM, R1 was observed in his bed. R1's head of the bed was elevated approximately 60 degrees, R1 had slid down toward the foot of the bed and was positioned on his back. E4 Licensed Practical Nurse (LPN) was asked to assist in observing R1's skin. E4 removed a saturated incontinent brief from R1 and rolled him onto his right side. R1 was</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	<p>Continued From page 31</p> <p>observed to have an open area on the right buttock The wound margins were attached and the wound bed was obscured with yellow tissue. The surrounding wound areas were outlined with bright red tissue. On each side of R1's coccyx area, areas of purple discoloration were observed. Another open area was observed on R1's left buttock. R1 had no dressings to the open areas. E4 was interviewed and stated " I need to call the Dr. and get a treatment order. I have been off and I am not the regular nurse on this unit."</p> <p>The entry for 1:17 PM on 9/8/08 documents "left lower buttock, 1.5 centimeters (cm) x 1 cm, and right lower buttock 1 cm x 0.5 cm.</p> <p>R1's August, 2008 and September, 2008 Physician's Order Sheet does not show any treatment orders for R1's open areas.</p> <p>R1's Care Plan for Tissue Integrity Impairment dated 8/28/08 documents the risk factor of immobility, and includes the following approaches: assess skin status, encourage and assist to reposition, inspect skin daily, and avoid rubbing. The goal is documented as "ulcerated areas healed".</p> <p>The care plan does not identify any open areas on R1's skin.</p> <p>Another care plan entitled Potential for Impairment of Skin Integrity dated 8/27/08 documents the following approaches: instruct on the importance of good skin care, assess skin condition weekly and as needed notify the Medical Doctor (MD) of skin changes. The goal is documented as " no skin breakdown".</p> <p>E2, Director of Nursing (DON) was interviewed</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145919</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2008</b>
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F 314	<p>Continued From page 32</p> <p>on 9/8/08 at 3:45 PM. E2 said, " I assessed R1's skin and it looks like shearing, someone pulled him. The yellow area blanched when I touched it. Today was the first time I saw it. He had a variety of different colored scar tissue with abrasions on top of scar tissue. I'm going to contact the Advanced Practice Nurse and she will be here in the morning. His entire coccyx has various stages of red/pink tissue, We are waiting for the Dr. to give us a treatment. Somebody's been pulling the pads out from under him. R1 has been healed/damaged repeatedly. Damage can present as dark purple if it has been damaged enough. It was probably bright red around the surrounding wound because he was wet and laying on it."</p> <p>E6 Corporate Nurse was interviewed on 9/9/08 at 2:40 PM. E6 said that the nursing assistants were to be doing weekly skin checks when the resident had baths. E6 said "This just fell through the cracks. The nurse could have notified R1's Dr. and initiated treatment for R1 right away.</p> <p>E7 LPN, was interviewed on 9/9/08 at 3:40 PM. E7 said " I was not aware that R1 had any pressure ulcers, I got any order for a hydrocolloid and gave him a mattress and chair cushion today. The nurses are supposed to fill out a "profile" sheet to identify skin problems."</p> <p>The facility Pressure Ulcer Protocol documents the following: pg. 2) number 3: All nursing assistants will report any change in a residents skin condition. The licensed staff will document such changes in the medical record.</p> <p>5.) If an ulcer is present on admission or when it</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145919</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2008</b>
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F 314	<p>Continued From page 33</p> <p>first occurs, the licensed nurse who will document a complete assessment on admission assessment/nurses notes will assess it. Assessment must include, site, size depth, drainage, odor and condition of the surrounding skin. Documentation in the nurses notes will include notification of the physician immediately and family members within a reasonable amount of time as determined by the professional judgement of the licensed nurses.</p> <p>6.) The charge nurse will do a weekly assessment of each pressure ulcer on the skin assessment form/treatment sheet. This assessment will include site, stage, size, depth, drainage, odor, healing process and condition of surrounding skin. page 3) number 4, Inspection of the resident's skin should be included in the daily routine.</p> <p>2. R3's Physician's Order Sheet for August, 2008 documents that R3's diagnoses include Alzheimer's with Dementia, History of Polio, Weakness and Depression.</p> <p>R3's (MDS) Assessment of 8/22/08 assessed R3 to have short and long term memory problem with modified independence in cognitive skills. R3 was assessed to require supervision and one person physical assist for bed mobility, transfer, toilet use, and personal hygiene. R3 was identified to be usually continent of bowel and bladder, and no skin conditions.</p> <p>R3's Braden Scale for Predicting Pressure Sore Risk dated 8/28/08 documents a score of 15. (15-18 if over 75 years old is low risk) R3's birth date according to his demographic sheet is</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145919</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2008</b>
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F 314	<p>Continued From page 34 4/17/15. (93 years old)</p> <p>A hospital Discharge/Transfer form dated 8/27/08 documents an order to obtain a wound care consult, to assess R3's heels when he returns to the nursing home. R3 is to wear waffle boots on both feet.</p> <p>A document entitled Skin Assessment Profile dated 8/27/08 shows R3 had a 2.5 cm x 2.5 cm fluid filled blister to the right heel.</p> <p>A document entitled Bath Check Form, dated 8/28/08 shows a body diagram with a blister to the right heel.</p> <p>The document entitled Wound Care Evaluation and Treatment Plan dated 8/28/08 documents to, "paint the skin with skin prep on the heel daily, cover with a sock or foam boot, no dressing, and float the heels off the bed with pillows.</p> <p>R3's Physician Order Sheet for August, 2008 does not show any order for R3's right heel treatment.</p> <p>On 9/15/08 at 9:45 AM, Z3 was interviewed. Z3 said " R3 returned to the nursing home from the hospital sometime in August, at that time he had a big blister on his right heel. When he went back to the hospital in September, they noticed several more areas on him, they showed them to me. The second heel ulcer (left ) occurred at the nursing home. The nursing home was used to him being up and about, but when he got weaker and was staying in bed they left him lay on his back."</p> <p>Nursing Notes for R3 document the following: 8/27/08 R3 returned from hospital. Entry for 8:10 PM shows that R3 had a waffle boot on the right</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	<p>Continued From page 35</p> <p>foot. R3 had a fluid filled blister on the right heel, no further wound assessment is documented. The nursing notes did not show any assessment of R3's skin to include other potential areas of breakdown, or R3's left heel.</p> <p>The hospital document entitled Hospitalist History and Physical dated 9/1/08, documents ""some bilateral heel decubitus, need to consider any heel sources of infection. Check right heel x-ray and wound consult. Given the severity of the right heel changes may consider need for surgical debridement." The same document shows that R3 can not accomplish eating on his own and needs to be fed. R3's sacral area was observed to be red on exam.</p> <p>R3's left heel was found to have a half-dollar size circular area of slight ecchymoses and swelling. The right heel has a very large vesicular blister covering most of the heel posteriorly and inferiorly bilaterally with what appears to be deep ecchymosis. Buttocks and sacrum are red."</p> <p>The hospital document entitled Medical Admission Physician's Orders dated 9/1/08 documents that R3 has bilateral heel decubitus. The same document shows an order for the wound nurse to assess R3's heels and buttocks. Another order shows "patient needs to be fed, needs 100% assistance with eating."</p> <p>The hospital Nursing Notes dated 9/1/08 shows that R3 was examined by the admitting physician at 6:45 PM. R3's family was present during the exam. Nursing Notes for 7:35 PM, show the following: " Pt. appears emaciated, paled, bilateral heels noted with bruised areas, nonblanchable, left heel has half dollar size reddish blue area. The right heel has a reddish</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	<p>Continued From page 36</p> <p>blue area approximately the size of a tennis ball. A nonblanchable area noted to the sacrum, butterfly shaped approximately 6 inches by 3 inches on the coccyx/ sacral area. Wound Consult was ordered. Treatment was applied per Dr's orders."</p> <p>The hospital Wound Care Consult dated 9/2/08 documents the following: " Initial visit to evaluate skin. Patient presents to our facility with deep tissue injury pressure ulcers to heels and sacrum. These wounds are not stageable yet but will probably evolve into full thickness wounds. At this time surgical intervention would not be helpful, there is no visible necrotic tissue. Skin has been damaged. Black/Purple tissue under left heel 5.0 cm x 5.0 cm. Right heel with blister and purple tissue underneath 5.0 cm x 10.0 cm. Right outer ankle 1.5 cm x 1.0 cm purple, Sacrum 5.0 cm x 9.0 cm deep purple black with small intact blister. Recommend to relieve pressure, turning schedule, and Xeroderm to improve perfusion. These are present upon admission pressure ulcers. "</p> <p>Z2 (Hospital Enterostomal Therapist Nurse) was interviewed on 9/15/08 at 9:30 AM. Z2 said that it would not be likely that R3's skin condition occurred in the emergency room. The emergency room uses pressure redistribution mattresses. Z2 stated that Z3 had some concerns she shared with me regarding his care at the nursing home.</p> <p>Z4 (hospital nurse) was interviewed on 9/8/08 at 10:00 AM. Z4 said " I was concerned when I saw all the pressure sores on him. He looked like he had deep tissue injury. He looked like he had not been getting repositioned. When I fed him he was so hungry and he kept saying " I'm sorry I will be</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	<p>Continued From page 37</p> <p>good." I felt I needed to notify someone regarding this patient. R3's condition improved after he was hydrated and he went to another nursing facility.</p> <p>Review of R3's care plan entitled Tissue Integrity Impairment dated 8/28/08 does not identify the location of R3's pressure area, or R3's specific risk factors. (decline in condition, poor oral intake, immobility, incontinence) The approaches include: Assess skin status, assess nutrition status, encourage resident to reposition, inspect skin daily and report changes.</p> <p>Another care plan with the same date of 8/28/08 entitled Potential for Impairment of Skin Integrity does not address R3's specific risk factors. The care plan problem documents that R3 returned from the hospital with bruises from Intravenous Therapy, and bilateral feet swelling, dusky. The same care plan shows Right Heel skin prep and dry dressing, wrapped with gauze and a waffle boot in bed. There is no documentation concerning how the facility would prevent skin breakdown to R3's left heel. The approaches include: Ensure adequate hydration, assess skin condition weekly and as needed.</p> <p>E6 (Corporate Nurse) was interviewed on 9/9/08 at 2:40 PM. E6 said that R3 was not a reflection of their quality of care. E6 said that R3's Deep Tissue Injury probably occurred in the hospital emergency room.</p> <p>E1 Administrator, was interviewed on 9/9/08 at 2:35 PM. E1 said that "We didn't do anything wrong, R3's Deep Tissue Injury occurred in the Emergency Room, my understanding of Deep Tissue Injury is that it occurs momentarily."</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	<p>Continued From page 38</p> <p>Record review shows no evidence that the facility had assessed R3's left heel or sacral/ coccygeal area from return to the facility on 8/27/08 until R3 was readmitted to the hospital on 9/1/08.</p> <p>3. R8's September, 2008 Physician's Order Sheet documents that R8's diagnoses include Diabetes Mellitus, Congestive Heart Failure, and Chronic Renal Failure.</p> <p>R8's Braden Scale for Predicting Pressure Ulcer completed on 9/8/08 shows a score of 18. ( 16-20 = moderate risk)</p> <p>R8's Nursing Notes for 9/8/08 at 9:31 PM documents that R3 was admitted to the facility at 9:30 PM . R8 had open areas to the right buttock 1 cm x 0.5cm , and left buttock 2 cm x 1.5 cm. No further description of R8's wounds were documented.</p> <p>The next day nursing notes for 9/9/08 at 10:20 PM, documents that Z1 was notified for a treatment order for the open areas.</p> <p>R8's Physician Order for 9/9/08 documents that R8 should have a hydrocolloid dressing to the right buttock, left buttock, and coccygeal fold and sacrum.</p> <p>On 9/10/08 Nursing Notes show a late entry for 9:00 AM on 9/9/08. The notes show that R8 was found to have stage II areas to buttocks. The areas were 3.0 cm x 1.5 cm to the left buttock, and 3.0 cm x 1.0 cm to the coccygeal fold, 0.2 cm x 0.3 cm stage II to the sacrum. The right inner buttock had dark purple discoloration to the right inner buttock 2 cm x 1 cm. This area was not open.</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	<p>Continued From page 39</p> <p>On 9/10/08 at 10:30 AM, R8 was observed seated in a wheelchair near room 234, she was crying and said she needed to lay down. R8 was slouched down in the chair and holding on to the arm rests for support. There were no foot rests on the wheel chair. The wheelchair was too small for R8's body size. R8's thighs were observed to be indented by the sides of the wheelchair. The wheelchair arm rests were pressing into R8's waist line.</p> <p>E8 Registered Nurse (RN) was interviewed at 10:30 AM on 9/10/08. E8 said "she (R8) is depressed today, I just gave her some Tylenol. We were just talking about her chair, it is too small and she needs a different one."</p> <p>E8 (RN) was asked to assist in checking R8's skin condition. E8 and E15 Certified Nursing Assistant (CNA) transferred R8 into her bed with a mechanical lift device. She (R8) was moaning and crying. She was placed in the bed and turned on her left side. A wrinkled plastic incontinent brief was removed. A hydrocolloid dressing was rolled up and stuck to the incontinent brief. An open area on the right buttock was uncovered and adhered to the plastic incontinent brief. Deep creases were observed on her thighs and buttocks. A flattened yellow vinyl cushion was observed on the wheel chair seat.</p> <p>Review of R8's care plan entitled Potential for Impairment of Skin Integrity does not document R8's specific risk factors for skin breakdown, or treatment to be provided. There are no individual approaches related to R8's risk factors. The goal for R8 is "no skin breakdown".</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	<p>Continued From page 40</p> <p>4. R6's Physician Order Sheet for 9/1/08 documents that R6's diagnoses include Diabetes Mellitus, and Dementia.</p> <p>R6's Minimum Data Set (MDS) assessment of 8/1/08 identified R6 to have a short and long term memory problems with modified independence in cognitive skills. The same MDS shows that R6 required limited assistance of one person for bed mobility and transfer. R6 was assessed to have occasional bowel and bladder incontinence. R6 did not have any skin conditions.</p> <p>R6's Braden Scale for Predicting Pressure Ulcer Risk documents a score of 15. (The form shows that 16 and less is high risk and also that 16 -20 is moderate risk )</p> <p>R6's September, 2008 Physician's Order Sheet shows an order for Santyl Ointment (Enzymatic debriding agent) ordered on 7/22/08 to be applied to the right lateral thigh daily with a hydrogel gauze 2 x 2 and a 4 x 4 foam dressing.</p> <p>R6's Treatment Record for August, 2008 documents only an order for Triple Antibiotic ointment to the right upper thigh daily until healed.</p> <p>The document entitled Skin Assessment Profile shows the following: Onset date 7/12/08 stage II pressure ulcer 4.0, no depth, odor, or drainage. 7/15/08 Stage II 3.0 cm x 0.2 cm. wound condition is red/yellow, apply Triple Antibiotic Ointment daily. The next wound documentation is 30 days later on 8/14/08 and shows Stage II 0.6 cm x 0.6 cm, wound condition yellow, Santyl.</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	<p>Continued From page 41</p> <p>8/21/08 documents stage II 0.3 cm x 0.3 cm, wound condition yellow, Santyl.</p> <p>8/28/08 documents stage II 0.3 cm x 0.3 cm, wound condition yellow, Santyl.</p> <p>The next wound documentation on 9/3/08 shows "healed".</p> <p>R6's Care Plan entitled Impaired Skin Integrity dated 7/12/08 shows an order for Santyl and dressing. The care plan does not identify the location of the open area or specific risk factors for R6.</p> <p>E2 Director of Nursing was interviewed on 9/9/08 at 3:35 PM. E2 said that R6 developed the pressure ulcer to her thigh from sitting in a wheelchair that was too small.</p> <p>5. The Physician Orders for R7 dated 9/4/08 states, "Apply triple antibiotic ointment to the right foot laceration and change every day. Protective boot on the right foot at all times for 7 days."</p> <p>The nurses' notes dated 9/2/08 at 11:37 AM documents, "R7 has 1+ foot problem-e.g... corn, callous, bunion, hammer toe, overlapping toe, pain, structural problem Has open lesions on the foot. Receives application of dressings. NEW AREA** Location: F, H, 0.5 cm circular. Wound Tissue: pink-reddened, Drainage: heavy red, Surrounding Tissue: normal skin color for bottom of foot, warm, slightly edematous, Procedure done: cleansed, measured, steri strips, dressing gauze and Telfa wrapped with stretched gauze."</p> <p>The nurses' notes dated 9/3/08 at 12:34 PM documents, " New orders received on 9/2/08, Right foot cleanse with normal saline, steri strip and dry dressing." No wound assessment</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	<p>Continued From page 42 documented.</p> <p>On 9/4/08 at 12:55 PM the nurses' notes document, "R7 has 1+ foot problem-e.g... corn, callous, bunion, hammer toe, overlapping toe, pain, structural problem. Received preventative or protective foot care (e.g. used special shoes, inserts, pads, toe separators.)Receives application of dressings (with or without topical medications) other than to feet. Has pressure relieving device for bed. Treatment done to foot Antibiotic ointment applied, Bunny boot to right foot. No edema noted to leg/foot/ankle or toes."</p> <p>On 9/10/08 at 11:00 AM, R7 was observed sitting in a wheelchair across from the nursing station wearing tennis shoes. E12 (Licensed Practical Nurse-LPN) stated she was not aware of any skin treatment orders for R7's foot. E12 reviewed the physician orders and stated the 7 days was not up and she should still have protective boots. E12 confirmed R7's foot wear was tennis shoes and not protective boots. R7 was taken to her room and the tennis shoe was removed for skin observation. An adhesive bandage was on the ball of the right foot directly under the great toe. A dark spot on the pad of the bandage was noted. E12 (Licensed Practical Nurse-LPN) replaced the tennis shoes and returned R7 to the nursing station.</p> <p>On 9/10/08 AM, R7 was observed wearing a protective boot on the right foot. E12 (LPN)stated she went back to the resident's room and changed the foot dressing and applied the protective boot. E12 described the wound, "It is closed, there is no open area. The skin is intact with a small bruise about the size of a pencil eraser, there is no wound drainage. The</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145919</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/17/2008</b>
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F 314	<p>Continued From page 43</p> <p>ointment must cause the dark spot on the bandage. I'm not sure what's wrong with her foot." No additional skin assessments (other than previously identified nursing notes) were available in the medical record. The care plan for R7 was a non-individualized plan and did not identify skin risk factors and specific interventions for R7's skin breakdown.</p> <p>According to Bryant, Ruth, et, al in Acute and Chronic Wounds, Third Edition, 2007 on pps. 136. The type of tissue in the wound bed should be assessed and documented. Viable tissue must be distinguished from nonviable tissue. Many wounds contain combination of tissue types and should be described in percentages. For example "50 % of the wound bed contains eschar and 50% contains granulation tissue." Type and amount is important because it indicates to what extent the wound is healing. Nonviable tissue can be yellow slough or black eschar.</p> <p>pps. 144 documents, " Once the patients is stable in long-term care the "at risk" patients skin should be monitored daily but may only require a full wound assessment on admission and weekly."</p> <p>on pps.131-137 the following principles apply to pressure ulcer assessment: Accurate wound staging requires knowledge of anatomy of skin and deeper tissue layers, the ability to recognize these tissues, and the ability to differentiate between them. Careful evaluation of the wound bed facilitates accurate staging.</p> <p>All patients require a routine and systematic skin assessment, which includes daily evaluation of</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	<p>Continued From page 44</p> <p>the integrity, temperature, texture, and presence of lesions on the skin.</p> <p>Suspected Deep Tissue Injury : Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and or shearing. The area may be preceded by tissue that is painful, firm, mushy, boggy, or warmer or cooler as compared to adjacent tissue.</p> <p>Evolution of deep tissue injury may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.</p> <p>A stage II pressure ulcer is defined as a Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.</p> <p>A stage III is defined as a Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss.</p> <p>Slough is defined as soft, moist, avascular( necrotic/ devitalized) tissue; tissue may be white, yellow, tan or green; may be loosely adhered or firmly adhered.</p> <p>Wound Assessment should include the following: Anatomic location of the wound, extent of tissue loss ( i.e. stage), characteristics of wound base, type of tissue, percentage of wound containing each type of tissue observed, dimensions in</p>	F 314			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	Continued From page 45 centimeters, exudate, odor, wound edges, periwound skin, presence or absence of local signs of infection, and wound pain.  The facility Pressure Ulcer Protocol does not contain the current 4-stage classification system for pressure ulcers developed by the Wound Ostomy Continence Nurse Society (2003) and the National Pressure Ulcer Advisory Panel (NPAUP) in 2007. The same facility protocol does not define Suspected Deep Tissue Injury or how the staff will identify it.	F 314			
F 323 SS=D	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, interview and record review the facility failed to ensure R2's chair alarm was turned on and operational on 9/3/08, prior to leaving a resident who is at high risk for falls.  This applies to 1 witnessed resident fall. (R2)  The example includes:  1. Nursing notes dated 9/3/08 at 6:45 AM states, "Resident was sitting in wheelchair in hallway at 6:37 AM and fell forward in wheelchair. Fall was witnessed by staff at a distance, unable to	F 323			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 323	<p>Continued From page 46</p> <p>prevent fall, sensi (chair) alarm intact to wheelchair, not activated."</p> <p>On 9/9/08 at 3:15 PM, E9 (Licensed Practical Nurse-LPN) stated, "I was here when R2 fell. He fell face forward onto the floor. The alarm had not been turned on. The aides had just gotten him up for the day and brought him out in the hallway by the nurses' station. R2 had stood up and fell forward. He caught himself with both arms. He must have bumped his head on the way down."</p> <p>The Physician Order Sheet of 9/1/08 documents R2 has a Dementia diagnosis and receives Coumadin (Anticoagulant) and Lovenox (low molecular weight heparin) Injections daily. R2's Minimum Data Set of 6/30/08 documents R2 has long term memory deficit and is cognitively impaired in daily decision making. R2 does not ambulate, requires assistance of two staff to transfer and uses a wheelchair as the primary mode of transportation. The MDS shows R2 has fallen in the past 31-180 days of the assessment period.</p> <p>A standardized high risk for falls care plan lists a chair alarm as an intervention. The plan does not identify fall risk factors and specific interventions to prevent falls for R2.</p> <p>On 9/9/08 at 3:02 PM, E8 (Certified Nursing Assistant-CNA) stated, "If they're not working you know it. There is an off-on switch on the side." E8 demonstrated the operation of the chair pad and chair clip alarms.</p> <p>On 9/8/08 at 12:50 PM, E4 (LPN-Charge Nurse) stated, "I was working the morning R2 fell out of his wheelchair. I was on the other side the girls</p>	F 323			

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

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F 323	Continued From page 47 called me to come over. When I got here he was on the floor by the nurses station.  The facility incident investigation dated 9/3/08 states, "Alarm batteries were tested and were working. Alarm looked in normal working function. Alarm deemed defective and replaced." Only a statement from E4 (charge nurse) was used for the incident investigation.  The facility policy, "Resident Fall Prevention and Management" states, "Upon completion and review of the fall risk assessment, a fall safety care plan will be initiated with fall safety interventions based on the residents risk factors and individual needs. The care plan will be updated with the new individualized fall safety prevention interventions (after a resident fall)."  The facility policy, "Safety Alarm Usage" states, "Upon placement of the alarm the staff placing the alarm will ensure the proper working order and that the alarm is turned on and properly in place."	F 323			
F 325 SS=G	483.25(i) NUTRITION  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) 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; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325			

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

PRINTED: 09/26/2008  
FORM APPROVED  
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F 325	<p>Continued From page 48</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that R1 received nutritional support through the tube feeding to meet his estimated calorie needs on 8/27, 8/28/ and 9/4 thorough 9/8. The facility failed to identify the etiology of R1's 28 pound unplanned weight gain in 2 weeks. These nutritional failures contributed to R1 developing 2 deep tissue injuries and an additional stage II pressure ulcer. This applies to 1 resident receiving tube feeding. (R1)</p> <p>Findings include:</p> <p>R1's September, 2006 Physician's Order Sheet documents diagnoses to include Aspiration Pneumonia, Parkinson's Disease, and Dementia.</p> <p>R1's Minimum Data Set (MDS) assessment of 9/8/08 identifies short and long term memory problems with moderately impaired cognitive skills. The MDS identifies that R1 is dependent on staff for eating and receives 76-100% of total calories by tube feeding. R1's weight is recorded as 163 pounds. The assessment shows that R1 had 1 stage I pressure ulcer.</p> <p>R1's Nursing Admission Notes dated 8/25/08 documents that R1's enteral feeding was Jevity 1.2 running at 60 cc/hour ( cubic centimeters per hour) continuously. The same note shows that when Jevity 1.5 is available the rate should be changed to 40 cc/hr continuously.</p> <p>On the same date (8/25) the entry for 2:02 PM documents that R1 had a "small stage II ulcer of</p>	F 325			

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

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FORM APPROVED  
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F 325	<p>Continued From page 49 the coccyx."</p> <p>On 8/26/08 a Registered Dietician assessment note shows R1's estimated needs were calculated using the weight of 135 pounds/61.4 kilograms(kg). The 61.4 kilograms of body weight x 25 -30 calories per kg = 1535-1842 calories daily. Fluid needs were calculated to be 1535- 1842 cc daily. R1's estimated protein needs were estimated to be 70 grams/day.</p> <p>R1's physician orders for 8/27-28 are for Jevity 1.5 at 40 cc for 22 hours. The Physician's Order Sheet and September, 2008 MAR shows an order on 9/4/08 to decrease R1's tube feeding (Jevity 1.5) to 40 cc/hr for 22 hours. These orders were in place until 9/9/2008.</p> <p>According to the dietitian note of 9/9/08 the tube feeding (Jevity 1.5) to 40 cc/hr for 22 hours provides 1320 calories and 56 grams of protein per day. R1's estimated nutritional needs on 9/9 were determined to be 1850-2220 calories per day and 77 grams of protein based on a weight of 163 pounds. The dietitian states that the current tube feeding does not meet resident's nutritional needs.</p> <p>On 9/8/08 at 1:00 PM, R1 was observed in his bed. R1's head of the bed was elevated approximately 60 degrees. R1 was observed to have an open area on the right buttock The surrounding wound areas were outlined with bright red tissue. On each side of R1's coccyx area, areas of purple discoloration were observed. Another open area was observed on R1's left buttock (4 areas).</p> <p>Review of R1's Treatment Administration Record</p>	F 325			

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 325	Continued From page 50 shows an order to obtain a weekly weight on Fridays. The same record shows that a weight was to be taken on 8/29/08 and no weight is recorded.  Review of R1's Care Plan entitled Potential for Nutritional Complications dated 8/27/08 shows that R1 receives Jevity 1.5 at 40/cc hour continuous. The goal is "no nutritional complications."  Review of the facility policy entitled Enteral Feeding shows: Adequate nutritional support through enteral feeding will be provided to residents unable to consume adequate nutritional intake by mouth.	F 325			
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to obtain and monitor a resident's blood sugar results to ensure that the accurate amount of insulin was administered. The facility failed to administer the sliding scale insulin at the prescribed times.  This applies to 1 diabetic patient requiring insulin (R1).  The example includes:  The admission History and Physical dated 9/9/08 shows R1 has Diabetes Mellitus. The admission Physician Order Sheet dated 8/25/08 documents	F 333			

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 333	<p>Continued From page 51</p> <p>R1 is to have his blood glucose level checked every morning at 6:00 AM. R1 is prescribed to receive Novolin R insulin on a sliding scale dosage schedule based on the blood glucose level. The sliding scale insulin order starts with 2 units of insulin for blood glucose levels of 150-200. R1 is prescribed to receive 4 units for blood glucose levels 201-250, 6 units for blood glucose level 251- 200, 8 units for blood glucose levels 301-350, and to call the doctor if the blood glucose level is greater than 350.</p> <p>According to the blood glucose monitoring log and the medication administration record from 8/25/08 through 9/10/08 there were 10 errors in blood glucose monitoring and insulin administration for R1.</p> <p>On 8/26/08 R1's blood glucose level was not checked and no insulin was given.</p> <p>On 8/27/08 R1's blood glucose level was checked at 6:00 AM and 11:30 AM. R1 received an extra dose of 2 units insulin at 11:30 AM.</p> <p>On 9/1/08 R1's blood glucose level was 148 and 2 units insulin were given.</p> <p>On 9/2/08 R1's blood glucose level at 6:00 AM was not done. The blood glucose was done at 11:30 and 2 units of insulin were given.</p> <p>On 9/3/08, R1's blood glucose level was 151 at 6:00 AM, no insulin was given.</p> <p>On 9/6/08 R1's blood glucose level was not checked, and 2 units of insulin was given.</p> <p>On 9/8/08 R1's blood glucose level was not checked, and 7 units of insulin was given.</p> <p>On 9/9/08, R1's blood glucose level was not checked at 6:00 AM, no insulin was given.</p> <p>The blood glucose was checked at 5:00 PM and 2 units was given for a blood glucose of 142..</p> <p>On 9/10/08, R1's blood glucose level was not checked, and 2 units of insulin was given.</p>	F 333			

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

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F 333	Continued From page 52	F 333			
F 490 SS=F	<p>On 9/11/08 at 3:50 PM, E2 (Director of Nurses) was informed of the medication errors. E2 had no comment or additional information to provide.</p> <p>The facility procedure for Blood sugar monitoring states to "Check the physician's order for blood sugar testing frequency."</p> <p>According to the Drug Information Handbook, for Nursing, Lexi-comp, 2009, page 647, "Multiple daily doses guided by blood glucose monitoring are the standard of diabetes care."</p> <p><b>483.75 ADMINISTRATION</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to be administered in a manner to ensure policies and procedures were implemented in the areas of Pressure Ulcer prevention and treatment, a comprehensive Abuse prevention program and failed to ensure that nutritional requirements were accurately assessed for residents solely fed by tube feedings. This applies to 5 of 5 residents with pressure areas, all residents with the potential to abuse or be abused by others and 4 residents fed by gastrostomy tube.</p> <p>The examples include:</p>	F 490			

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

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F 490	<p>Continued From page 53</p> <p>E1(Administrator) submitted a copy of the facility Administrator job description on 9/ 11/08 at 3:30 PM. which stated the following: A licensed Administrator is responsible for the day-to-day functions of the facility.</p> <p>1. The governing board of this facility has appointed an Administrator who is duly licensed in accordance with current federal and state requirements. The Administrator is responsible for, but not limited to:</p> <p>d.) Implementing established resident care policies, personnel policies, safety and security policies, and other operational policies and procedures necessary to remain in compliance with current laws, regulations, and guidelines governing long-term care facilities.</p> <p>h.) Ensuring that the facility admits only those residents for whom it can provide adequate care.</p> <p>2. On 9/ 11/08 at 3:30 PM, E1 was interviewed. E1 said that she ensures resident needs are being met by attending house report in the mornings. E1 said the nurses are doing the care plans to see if the facility policies and procedures are being carried out.</p> <p>E1 said that E2 Director of Nursing (DON) was responsible for the ensuring the Skin Care Prevention and Treatment Program was being done.</p> <p>E1 said that she felt the facility had attempted and tried to the best of their ability to ensure resident care policies and procedures were carried out. E1 said R3 was ok when he left here, something must have happened in the Emergency Room. Deep Tissue Injury can occur</p>	F 490			

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

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FORM APPROVED  
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F 490	<p>Continued From page 54</p> <p>momentarily. E1 said that she was not sure that "we did anything wrong" related to R1. We have put new procedures in place and will be starting a policy and procedure for pressure ulcer prevention."</p> <p>E1 said that E7 Licensed Practical Nurse (LPN) and E10 (LPN/ Care Plan Coordinator) are responsible for the Abuse Prevention Program. They ensure that resident behaviors monitored. They are to identify which residents are at risk, and will be developing a criteria or tool to use to ensure resident safety.</p> <p>When E1 was asked about how the facility effectively implemented its policies and procedures related to abuse, E1 stated they review the psychological history on admission. When a significant change occurs and we need behavior modification we use 1:1 (staff/ resident). We assess on site for any history of aggression before admission and we don't admit them. E1 said I believe R5 is cutting his foot for attentions. E1 said R5's behavior care plan is on the unit, E1 said that R5's attention seeking behavior had not been put on the care plan. E1 said there are no tools in place for this.</p> <p>2. The Resident Skin Check Sheet dated 8/25/08 (Admission date) shows that R1 had a 1 centimeter open area on the right inner buttock. The Resident Skin Check Sheet dated 8/25/08 (Admission date) shows that R1 had a 1 centimeter open area on the right inner buttock..</p> <p>R1's Braden Scale for Pressure Ulcer Prediction dated 8/25/08 showed a score of 13 ( moderate risk.). On 9/8/08 at 1:00 PM, R1 was observed. R1 had</p>	F 490			

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F 490	<p>Continued From page 55</p> <p>an open area on the right buttock On each side of R1's coccyx area, areas of purple discoloration were observed. Another open area was observed on R1's left buttock. R1 had no dressings to the open areas.</p> <p>R1's August, 2008 and September, 2008 Physician's Order Sheet does not show any treatment orders for R1's open areas.</p> <p>R1's Care Plan for Tissue Integrity Impairment dated 8/28/08 does not identify any open areas on R1's skin.</p> <p>The facility Pressure Ulcer Protocol documents the following: pg. 2) no 3: All nursing assistants will report any change in a residents skin condition. The licensed staff will document such changes in the medical record.</p> <p>R3 ' s Skin Assessment Profile dated 8/27/08 shows R3 had a 2.5 cm x 2.5 cm fluid filled blister to the right heel. A hospital Discharge/Transfer form dated 8/27/08 documents an order to obtain an wound care consult, to assess R3's heels when he returns to the nursing home, and R3 is to wear waffle boots to both feet.</p> <p>The hospital document entitled Hospitalist History and Physical dated 9/1/08, R3's left heel was found to have a half-dollar size circular area of slight ecchymoses and swelling.</p> <p>R3's care plan entitled Tissue Integrity Impairment dated 8/28/08 does not identify the location of R3's pressure area, or R3's specific risk factors. (decline in condition, poor oral intake, immobility, incontinence).</p> <p>No evidence was documented to show that the facility had assessed R3's left heel or sacral/ coccygeal area from return to the facility on</p>	F 490			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490	<p>Continued From page 56</p> <p>8/27/08 until R3 was readmitted to the hospital on 9/1/08.</p> <p>3. The Emergency Department Record dated 9/3/08 documents, "R2 presented to the hospital last night after his roommate hit him in the head with a TV controller. Because the patient is on Coumadin, there is concern about his excess bleeding."</p> <p>On 9/9/08 at 3:15 PM, E9 (Licensed Practical Nurse-LPN) stated, "R2 had 3 cuts on the forehead temple area. I was worried about the bleeding because he is on Coumadin and Lovenox. There was a lot of blood on his shirt and a large spot on the recliner. I just wanted to get him out right away." E9 stated, "R4's behavior could be like that. He gets agitated with surrounding changes. He maybe got upset the hospice nurse was in the room. We have to approach him differently when in the room. He can easily get aggressive when approached in his room." E9 continued, "When he is difficult we leave him alone in the room and reapproach later. If R4 returned, I would worry about the other resident's safety. He is a big man. He was intimidating to others, especially when aggressive. We usually would leave him alone and come back later."</p> <p>Nurses notes on 1/14/08 state R4 was admitted after a stay at a psychiatric hospital. The facility nurses' notes show that R4 had 7 documented aggressive behaviors between 1/19/08 and 6/6/08</p> <p>A psychiatric evaluation dated 12/28/07, completed at the psychiatric hospital prior to his discharge documents, "R4 was admitted because</p>	F 490			

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F 490	<p>Continued From page 57 of aggressive behavior." The history of present illness on the physician's report states, "R4 was sent to us because of physical aggression. On 12/26/07 he became physically aggressive towards staff, threatening to kill staff and attempted to leave the facility. He is unable to be redirectable. He is wandering, going into other resident's rooms demanding that they leave because he stated it is his house. Residents and staff become fearful of him and because of that he was sent to the hospital for treatment".</p> <p>On 9/8/08 at 1:05 PM, E3 (Certified Nursing Assistant) stated, "You never know about his (R4) mind, he was usually nice but you never know. He might go off on anybody, he just gets set off. He won't let us give him a shower, then later it would be OK." E3 stated, "R2 can't protect himself, he is dependent on staff for care, he needs prompts and cues. Set up to eat, and he can feed himself."</p> <p>The care plan dated 1/16/08 does not identify R4's risk factors or show interventions to prevent R4 from abusing others when he becomes agitated/aggressive (residents or staff). The care plan dated 1/16/08 does not identify R4's risk factors or show interventions to prevent R4 from abusing others when he becomes agitated/aggressive (residents or staff).</p> <p>The screening section does not address any component for screening prospective residents as a potential abuser . The training component (page 4) does not address training or education of residents and family on the facility ' s abuse policy. The facility Abuse Prevention Program states on page 5, "As a part of the resident care plan</p>	F 490			

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F 490	<p>Continued From page 58</p> <p>process, professional staff will approach all residents as having increased vulnerability for Abuse, along with those who have needs and behaviors that might lead to conflict or neglect.</p> <p>4. R1 did not receive nutritional support through the tube feeding to meet his estimated calorie needs on 8/27, 8/28/ and 9/4 thorough 9/9. The facility failed to identify the etiology of R1's 28 pound unplanned weight gain in 2 weeks. R1 developed 2 deep tissue injuries and an additional stage II pressure ulcer.</p> <p>According to the dietitian note of 9/9/08 States the tube feeding of Jevity 1.5 at 40 cc for 22 hours provides 1320 calories and 56 grams of protein per day. R1's estimated nutritional needs on 9/9 were determined to be 1850-2220 calories per day and 77 grams of protein based on a weight of 163 pounds. The dietitian states that the current tube feeding does not meet resident's nutritional needs.</p> <p>Review of R1's Care Plan entitled Potential for Nutritional Complications dated 8/27/08 shows that R1 receives Jevity 1.5 at 40/cc hour continuous. The goal is "no nutritional complications."</p> <p>R1's physician orders for 8/27-28 are for Jevity 1.5 at 40 cc for 22 hours. The Physician's Order Sheet and September, 2008 MAR shows an order on 9/4/08 to decrease R1 's tube feeding to 40 cc/hr for 22 hours. These orders were in place until 9/9/2008.</p> <p>The facility policy entitled Enteral Feeding shows: Adequate nutritional support through enteral feeding will be provided to residents unable to consume adequate nutritional intake by mouth.</p>	F 490			

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