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	145919	A. BUILDING _____ B. WING _____	12/22/2008

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F 520	Continued From page 130 concerning her role as a QA committee member. E27 said that she was not aware of and has not attended any quarterly QA meetings. E27 could not give any examples of specific QA activities she was responsible for. On 12/4/08 at 8:45 AM, E38 was interviewed concerning her role as a QA committee member. E38 was unable to explain or give examples of what the QA committee's responsibilities are. E38 could give no examples of what QA activities she is responsible for as the Activity Director or when the committee meets. On 12/5/08 at 8:30 AM, E1 was asked what actions were put in place after the facility was cited on 9/17/08 for pressure sores. E1 was unable to provide evidence/documentation showing any policy and procedure changes that were made to correct the deficient practice. E1 could not produce any pressure ulcer specific tools that were created to correct the deficient practice. Review of the Quality Assurance Meeting Agenda/Attendance Minutes dated 1/10/08, 3/31/08 and 6/5/08 document that the Medical Director was not present at the QA meeting. During the Annual Certification Survey conducted on 12/2/08 through 12/22/08 the following deficient practices were identified to be at harm level: Residents right to exercise rights and be free of reprisal, Notification of changes in resident condition, Dignity of residents, Activities, Pressure Sores, Services to increase range of motion, Supervision, Administration, and Medical Director. The facility had 39 additional deficient practices identified during the survey	F 520		

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F 520	Continued From page 131 The surveyor confirmed the facility took the following steps to correct the the Immediate Jeopardy: 1. On 12/16/08 at 11:40 a.m. the facility had a Quality Assurance meeting with the Medical Director, Corporate Nurse, Nurse Practitioner, Clinical Administrator, Director of Nursing, new Infection Control Coordinator, Social Service Director, Activity Director, Restorative Supervisor, Admissions/Marketing Coordinator, current list of all potential deficiencies, policies and procedure manuals related to the issues of those deficiencies. We reviewed all quality indicator areas and other areas of concern and discussed action plans and plans of corrections for all areas of concern. 2. The facility Administrator will meet with the Medical Director bi-weekly on all medical and clinical concerns. 3. The facility Quality Assurance Team will meet 1/13/08 at 12:00 PM, 2/10/08 at 12:00 PM and 3/10/08 at 12:00 PM and quarterly thereafter. 4. On 12/16/08 at 3:30 PM all facility Department Managers were inserviced by the Corporate Nurse on Quality Assurance, including auditing, completing action plans, implementing corrective actions, re-evaluation of problem and corrective action, continued monitoring for improvement and daily, monthly and quarterly QA meetings.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a)	F9999		

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F9999	Continued From page 132 300.1210b)2)3)5) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24 hour, seven day a week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.	F9999		

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F9999	Continued From page 133 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These REGULATIONS were not met as evidenced by: Based on observation, interview and record review the facility failed to monitor the skin integrity and condition of a resident with a history of and a current pressure ulcer on her left heel. The left heel ulcer became worse over a period of 3 days. The wound was documented on 12/1/08 as a 5cm X 5cm blister and advanced to a 9 X 7.5 cm necrotic area of the left heel on 12/4/08. The facility failed to notify R12's physician of the change in the wound. The facility failed to ensure that a resident at high risk for skin breakdown was repositioned every 2 hours as stated on her careplan. The facility also failed to identify and treat a newly developed stage II pressure ulcer of the inner left buttock. This is for one of 15 residents reviewed, R12. Findings include: R12 is a 78 year old resident whose diagnoses include Dementia, Anemia, Alzheimer's Disease, Neuropathy, Rheumatoid Arthritis, Osteoporosis, History of Cerebral Vascular Accident, and Incontinence according to the 12/08 Physician Order Sheet. The resident's 9/29/08 MDS shows that the resident requires extensive assistance with transfers and mobility. R12's 11/24/08 Skin Prevention Careplan shows	F9999		

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F9999	Continued From page 134 that the facility has identified the resident as being at moderate risk for skin breakdown. The careplan states that daily skin assessments are to be done by the CNAs during routine care giving. The careplan states that the physician is to be notified of all new skin issues. On 12/2/08 and 12/3/08 when R12 was observed up in her wheelchair, she had on a pressure relieving boot to her left leg. On 12/4/08 at 9:00 AM, the resident was observed to have a heel protector on her left heel. E22 (CNA) was asked if the resident was to have on the heel protector or the pressure relieving boot. E22 said she was not sure what the resident was supposed to have on, she was just doing what she had seen done before. E22 said that there is no system in place to communicate to the CNAs what special care the residents need. R12's Skin Prevention Careplan of 11/24/08 shows that the resident is to have the boot on her left foot at all times. The resident's 12/08 Treatment Record shows that the resident is also to have elbow protector to her right elbow at all times. On 12/2 and 12/3/08 the resident did not have an elbow protector on her right elbow. On 12/2/08, R12 was observed seated in her wheelchair from 8:00 AM until 1:25 PM. At 2:00 PM (same day) E22 verified that the resident had not been repositioned since 8:00 AM when she was put into the chair. At 1:25 PM on 12/2/08, E21 & E22 were observed transferring the resident from her chair to the bed. A large, black, necrotic area was observed to the resident's left heel. The resident's Skin Assessment Profile shows	F9999		

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F9999	Continued From page 135	F9999		

that on 11/23/08 the resident had a left heel blister that measured 2 1/2 X 3/4 inches and was reddish-purple in color. A telephone physician order was obtained to leave the area open to the air and apply Skin Prep twice daily. On 12/1/08 the wound is documented as a purple blister 5cm X 5cm. There is no physician orders or documentation of the wound and the facility could not provide information showing that the resident's physician had been notified of the worsening wound.

On 12/4/08 at 5:34 PM, Z5 (MD) said that he was not aware that R12's left heel was necrotic. On 12/5/08 at 10:00 AM, Z4 (Nurse Practitioner) said that she had not been made aware that the resident's heel wound had worsened.

On 12/4/08 at 6:00 PM, the facility provided a telephone order showing that the physician was notified on 11/23/08 of the blister. The facility could not provide any other communication to the physician showing that he had been made aware of the worsening wound.

On 12/4/08 at 2:00 PM, a skin check was performed by E17 & E6 (LPN). R12 was observed to have a large black necrotic area to her left heel. E17 said that the area was a blister and the treatment was skin prep twice daily. E17 measured the necrotic area to be 9cm X 7.5cm. During the skin check R12 was observed to have a stage II pressure ulcer on her left inner buttock. E17 said that she was not aware of this new open area.

R12's MAR shows that the resident is to have skin prep applied to her left heel twice daily. The Treatment Record shows that her treatments

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F9999	Continued From page 136 were missed 5 times from 12/1 through 12/3/08. The facility's Pressure Ulcer Protocol states, "...Pressure ulcer prevention will be the responsibility of all nursing staff. CNA's will follow turning schedules, apply heel protectors as ordered, report reddened or bruised areas to nurse...The physician will be contacted promptly with assessment results and specific orders for treatment obtained. There will be further physician notification with changes of condition or when treatment is not effective...A turning schedule and positioning schedule will be instituted...A resident should not remain in any one position for a long time as this may cause increased pressure to an area. Therefore, the resident's position should be changed at least every two hours or more often, if necessary. Residents in wheelchairs or chairs for several hours at a time should have a change of position...." (A) 300.1210a) 300.1210b)6) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and	F9999		

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F9999	Continued From page 137 personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These REGULATIONS were not met as evidenced by: Based on observation, interview, and record review the facility failed to supervise and ensure the safety of two confused residents on 12/12/08. R22 and R24 entered the second floor elevator with a visitor, rode to the first floor and exited the front door without staff supervision. The receptionist on duty was not familiar with R22 and R24 and gave R22 cigarettes and allowed both residents to go out of the facility without the supervision of staff. These failures resulted in R24 leaving the facility grounds unknown to staff and walking 0.2 (two-tenths) of a mile along a heavily traveled four lane street (state highway), while it was dark outside and being scared. The outside temperature was 36.0 Fahrenheit, wind speed was 19 miles per hour and the wind chill was 29 degrees Fahrenheit with rain. R24 was not wearing a coat. This applies to two confused residents (R22 and R24). R24 was identified as having wandering behaviors. Findings include: R24's December 2008, POS documents that	F9999		

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F9999	Continued From page 138 R24's diagnoses include Alzheimer's Disease, and Emphysema. R24's MDS of 10/31/08 shows that R24 has a short term memory problem with moderately impaired cognitive skills for decision making. The same assessment documents that R24 has wandering behavior. The assessment documents that R24 had a fall in the past 30 days. The facility assessment entitled Community Survival Skills, dated August 2008 showed that R24 is not sufficiently oriented and coherent to afford him/her the potential for independent pass privileges. R24's Care Plan was reviewed. No behaviors of wandering or specific interventions for the behavior are documented before or after 12/13/08. R24's Elopement Risk Assessment dated 11/6/08 documents that R24 is not a risk for elopement. R24's Physician Progress Notes dated 11/25/08 document that R24 had increasing wandering and pacing. On 12/17/08 at 10:15 AM E17 was interviewed. E17 said that R24 got onto the second floor elevator with an unknown family member. E17 said that R22 and R24 came down in the elevator and the receptionist let them go outside. E17 said that she had left the building shortly after 6:00 PM and was notified around 6:45 PM that R22 and R24 were back in the building. E17 said that E44 (Receptionist) was new and thought that R24 was R22's family member. E2 was interviewed on 12/18/08 at 12:30 PM. E2 said "R22 and R24 were never in an area that we did not know where they were. I think we documented it on R22's care plan but I do not know about R24."	F9999		

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F9999	Continued From page 139 E47 (LPN) was interviewed on 12/18/08 at 11:25 AM. E47 said that she had heard that R24 and R22 got out of the facility with a family member. E47 said that R22 came back into the building and that R24 did not. E47 said she was not sure how far R24 had gotten from the building. R24's Nursing Notes were reviewed with E47, no documentation concerning R24 leaving the building unattended was documented. E29 (CNA) was interviewed on 12/18/08 at 11:15 AM. E29 said that R24 is confused and does not know where she is. E29 said "when I take R24 to the toilet I have to tell her sit down and she will, then she will stand up and urinate on the floor." E29 said that R24 paces back and forth and you cannot stop her. E29 said " R24doesn't know how to use the elevator, unless she follows someone. R24 has Alzheimer's, very confused." E48 (Receptionist Supervisor) was interviewed on 12/18/08 at 11:50 AM. E48 said that E44 (receptionist) called her and told her that R22 and R24 came down to the door by the receptionist area with a family member. E48 said that E44 had never seen R24 before and it was her first night working alone. E48 said that E44 thought that R24 was a family member. E48 said that R22 is to have supervised smoking only, and E44 thought that R24 was R22's family member so she gave R22 her cigarettes. E45 (CNA) was interviewed on 12/22/08 at 10:45 PM. E45 said she did not witness R24 leave the building. E45 said "It was on a Friday, one of the girls called off, it was hectic. I was coming down the hall and the receptionist said to me she needed my help because 2 ladies went outside. I saw R22 at the end of the ramp, within the closed	F9999		

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F9999	Continued From page 140 doors and she was smoking. I said to R22 "Where is the other lady that was with you?" and R22 said "Oh she left." E45 said it was dark outside and because she did not know who she was looking for, she took R22 back upstairs and told the second floor nurse (E46) that there was another lady outside. E45 said that E46 and E9, Certified Nursing Assistants went to look outside. E9 (CNA) was interviewed on 12/22/08 at 11:05 AM. E9 said that she saw E46 going out and that she followed her to help. E9 said that she had overheard that someone was outside. It was between 6:45 PM and 7:15 PM. E9 said "I fell on the ice on the side walk while I was outside looking for R24." E9 said that when she found R24 she was at the park and she looked confused. E9 said that R24 said she was cold. E9 said that R24 is a wanderer and someone would have had to "coach" her into the elevator because otherwise she would not go. E9 said that maybe R22 told her to get into the elevator with her." E32 (LPN) was interviewed on 12/18/08 at 2:40 PM. E32 said that R24 got out sometime in the evening. E32 said that a CNA (E45) came to me and told me that R22 and R24 had followed family into the elevator and got out. E32 said "I'm confused about the whole thing." R24 was observed in an activity on 12/18/08 at 11:00 AM. R24 was playing a parachute game and repeating what the activity leader was saying. R24 was interviewed at 11:10 AM. R24 was asked about the night she went outside. R24 said "It was nothing bad or anything. I pressed on one of the elevator buttons, got on the elevator and went home. It was cold out, I had no coat on	F9999		