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F 000	INITIAL COMMENTS The annual Federal Recertification, annual State Licensure and a Complaint Investigation surveys were conducted at this facility. State and Federal deficiencies were cited, and Substandard Quality of Care identified. An extended survey was conducted. Deficiencies were relative to the Federal Recertification, the annual State Licensure and Complaint Investigation surveys.	F 000		
F 155 SS=E	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interview, and facility policy, it has been determined that the facility failed to honor a resident's right to formulate an advance directive for 1 of 14 sample residents (ID #12), and the resident's right to refuse treatment for 1 of 1 non-sample residents (ID #32). Findings are as follows: 1. During the survey, on 2/20/12, surveyors became aware that on 2/17/12, the family of non-sample resident ID #32 reported to the facility that the resident had been sent to the hospital with paperwork that incorrectly	F 155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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documented the resident's code status as "Full Code". Resident ID #32 had requested a code status of Do Not Resuscitate (DNR).

Closed Record review revealed that non-sample resident ID #32 had a 12/16/2011 physician's order for Code Status: Full Code. On 2/10/2012, the resident was seen by the nurse practitioner, who documented the resident was a DNR/DNI (Do Not Resuscitate/ Do Not Intubate). A signed physician's order dated 2/10/2012 specified Code Status: DNI and DNR.

On 2/16/12, when the resident was noted to have a change of mental status and was transported to the emergency room via ambulance, the nurse documented "Full Code" on the Continuity of Care form that was sent to the hospital with the resident.

Review of the hospital record revealed that the ED physician noted the resident was a "Full code per today's interagency, and DNR/ DNI per last discharge."

The Emergency Department nursing note, dated 2/16/2012, documents the resident became cyanotic...and respiratory was called stat (immediately) to the room. The note further documents that no pulse was felt and chest compressions began...."nursing home called and could not confirm code status."

2. Record review for ID #12, who resides on East A unit, reveals a Continuity of Care form with the physician's discharge order, from an acute care hospital to Pawtuxet Village, for Comfort

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F 155	Continued From page 2 Measures Only (CMO). On 12/10/2011, the nurse documented that the attending physician agreed/verified the resident's status to be CMO. However, there is no code status sheet or signed attending physician's order for the resident to be CMO. Additionally, the 12/11/2011 social worker note states "Do Not Initiate Cardiopulmonary Resuscitation" (DNR), yet interview with the nurse manager on 2/20/2012 at 11:15 AM revealed that she was unaware of the code status of this resident. The nurse informed the surveyor that she needed clarification as she was uncertain of the difference between a Do Not Resuscitate order and Comfort Measures Only. Surveyor review of the facility's policy for Advance Directives, policy number CL-676-0002, does not have Comfort Measures Only listed as a choice, only Do Not Resuscitate.	F 155		
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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	F 157		

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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.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, it has been determined that the facility failed to consult the resident's physician when there was a significant change in the resident's condition for 1 of 14 residents with a significant weight loss (ID #1), and when there was a need to significantly alter the treatment plan for 1 of 3 residents relative to Hospice Services (ID #12). Both residents reside on the East A unit.

Findings are as follows:

1. Record review of resident ID #1, reveals the following weights:

11/7/2011, weight 240 lbs
11/30/2011, weight 218.7 lbs, an 8.9% loss
1/16/2012, weight 216.9 lbs

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F 157	Continued From page 4 1/24/2012, weight 186 lbs, a 14.2% loss A reweigh, at the request of the surveyor on 2/20/2012, revealed the weight was 183 lbs, an additional 3 lbs loss. There lacked evidence that the attending physician was notified of the significant weight loss of 8.9% on 11/30/2011, and 14.2% on 1/24/2012. The resident had a total weight loss of 22.5% between 11/7/2011 and 1/24/2012. A review of the attending physician's progress note for 12/30/2011 failed to reveal any documentation of weight loss. In addition, the note on 1/27/2012 again failed to document any problems with weight loss, and stated the resident is medically stable. Interview and record review, on 2/20/2012, with both the dietician and the nurse manager, failed to provide evidence that the physician had been notified until brought to the attention by the surveyor on 2/20/2012. 2. When resident ID #12 was readmitted to the facility on 12/10/11, the resident's Continuity of Care form contained a physician's order for hospice services. This order was verified with the attending physician. Although surveyor review of the facility's social work note, written on 12/12/2011, reveals that the resident and spouse declined Hospice services at that time, the clinical record lacks evidence that the attending physician was notified that the resident refused Hospice services at the time of	F 157		

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F 157	Continued From page 5 the readmission. During interview with the charge nurse and the social worker on 2/20/2012, both were unable to provide documentation that the physician was notified.	F 157		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		

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F 164	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on surveyor observation it has been determined that the facility has failed to ensure the residents' right to privacy for 4 of 20 sample residents, ID#'s 4, 11, 15,16, and 1 of 11 non-sample residents, ID #35, relative to privacy curtains not being utilized, and doors to rooms not being closed during care. Findings are as follows: 1. On 2/21/2012 at 8:10 AM the door to resident ID #16's room was ajar. The nursing assistant in the room was observed on this date and time assisting the resident out of bed with the resident's brief fully exposed. Additionally, upon entering the resident's room, the surveyor observed that the privacy curtain in the room was not drawn and the resident's roommate was in the room. On 2/24/2012 at 7:40 AM, the door to this resident's room was closed. After knocking and walking in the room, the surveyor observed two nursing assistants again providing AM care to resident ID # 16 with the privacy curtain not drawn. The resident's roommate was in the room at the time of the observation. 2. On 2/21/2012 at 8:30 AM the surveyor observed a nursing assistant providing personal care to resident ID# 15 with the privacy curtain not drawn. The resident was observed lying in bed wearing a brief. At the time of the observation, the resident's roommate was in the room and the privacy curtain was not drawn.	F 164		

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F 164	Continued From page 7 Surveyor observation on 2/24/2012 at 7:40 AM, revealed 2 nursing assistants changing the resident's brief with the privacy curtains not drawn and the resident's roommate was in the room. 3. On 2/19/2012 at 9:45 AM the surveyor, after knocking, entered the bathroom connecting rooms #10 and #12. The bathroom door in room #10 was open, and resident ID# 35 who was receiving personal care was noted exposed because the privacy curtain around the bed had not been drawn. 4. On 2/22/12 at 10:50 AM, the door to resident ID #4's room was observed open. Additionally, the door to the resident's bathroom was open revealing a 3 to 4 inch gap between the door and the door frame. Surveyor observation from the hall at the entrance to the room revealed that the resident could be viewed sitting on the toilet. 5. Surveyor observation revealed resident ID #11 was assisted to the bathroom on 2/20/12 at 11:45 AM, 2/21/2012 at 2:25 PM and on 2/22/12 at 12:45 PM. The resident's room door and the bathroom door were left open during these observations. Surveyor observation on 2/21/2012 at 2:25 PM, from the hall at the entrance to the room, revealed the resident being assisted off of the toilet.	F 164		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	F 166		

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This REQUIREMENT is not met as evidenced by:
Based on resident, staff, and family interviews, it has been determined that the facility has failed to promptly resolve grievances for 1 non sample resident, ID #30.

Findings are as follows:

Record review revealed that resident ID #30 has a diagnosis of depression. On 2/19/2012 at approximately 8 AM, during the tour of the East A unit of the facility, staff informed the surveyor that resident ID #30 resides with resident ID #8 who was admitted to the facility on 12/13/2011. Staff further informed the surveyor that resident ID #8 exhibits such behaviors as voiding and defecating on the floor in her room and in her bathroom and disrobing whenever she feels like disrobing.

Record review and numerous staff interviews verified that resident ID #8's behaviors include voiding and defecating on the floor in her room and the shared bathroom, and disrobing .

On 2/22 /2012 at 11:30 AM, resident ID #30's daughter stopped a surveyor to complain about the above situation. The daughter informed the surveyor that she has complained to staff on more than one occasion. Review of a grievance report indicates that staff are to check the room frequently and clean as needed. However, the behaviors of resident ID #8 have not been addressed and her behaviors have continued.

During an interview with ID #30 on 2/23/2012 regarding resident ID #8's behaviors, the resident

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F 166	Continued From page 9 stated, "I am sick to my stomach" and "I hope you can help me." During a subsequent interview with the social worker on 2/23/2012 at approximately 8:30 AM, she stated that she was aware of the above situation. She further stated that the only plan was to have staff check the room frequently and to clean the room as needed. There was no evidence that a behavior modification plan was in place for ID #8, or that resident ID #30's grievance has been adequately addressed.	F 166		
F 224 SS=I	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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 surveyor observation, record review and interviews with staff, residents, and family members, it has been determined that the facility has failed to implement policies and procedures that prohibit neglect for 7 of 20 sample residents (ID#'s 3, 5,7, 8, 9,16, 17), and 2 of 10 non sample residents (ID # 29 & 30), on 3 of four nursing units. Findings are as follows:	F 224		

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1. Review of the facility's 1/2010 "War on Wounds" Program, under Identifying and Reporting Pressure Ulcers, it states:

"Any new skin issue is an 'incident' which requires an investigation to determine the root cause."

It further states:

"3. Complete a Pressure Ulcer Documentation Form to document the status of the pressure ulcer.
-Assess and document the pressure ulcers at least weekly.
-Document only one area or site per form.
-Determine the stage of the pressure ulcer.
-Measure the pressure ulcer- length X width X depth.

4. Notify the physician ...and collaborate on a treatment order..."

This policy further states:

"When a pressure ulcer has been identified, reported and investigated, a licensed nurse completes a thorough evaluation to determine appropriate treatment and updates to the resident's plan of care."

Review of non-sample resident ID #29's closed record indicates an admission to the facility on 1/5/2012 from the hospital after undergoing surgery for a fracture of the left hip.

The 1/5/2012 Brief Nursing Evaluation Form failed to document any skin breakdown on the feet. Additionally, the admission note and

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admission assessment do not report any skin breakdown to the feet. A 1/6/2012, an 11 PM - 7 AM nurses note, written by the nurse who completed the 1/5/2012 admission note, now states, "left heel slight mushy, redness-necrotic. Right heel redness. ...Skin prep applied." However, further record review failed to reveal an order for a treatment to the heels until 1/18/12.

On 1/6/2012, the resident was seen by the physician, and an order was written for a podiatry consult. A physician's order was also obtained on 1/6/2012 for weekly skin checks.

On 1/14/2012, the 7AM-3 PM nurse documented "Left heel necrotic blister. Intact. Skin Prep a/o" (as ordered).

No measurements of the heel were documented until 1/18/2012 (a late entry note) written for 1/17/2012. The note documents "Paged MD re: resident's left heel opening and draining blood. Measured 2 X 2 cm with boggy center. Right heel small .5 cm X .5 cm necrotic area. See new orders." A physicians order was obtained on 1/18/2012 for Santyl to the left heel daily, apply skin prep to right heel daily.

Further record review reveals no evidence from 1/5/2012 until the 3-11 shift on 1/18/2012, that pressure relief was provided for the resident's heels. On 1/18/2012, a care plan was initiated that indicates ID #29 has impaired skin integrity related to a pressure ulcer secondary to immobility. The care plan interventions included "float heels while in bed" and air mattress as ordered.

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On 1/19/2012, the Pressure Ulcer Documentation Form was initiated for the left heel. The form documents an unstagable 5 X 5 cm broken blister. It incorrectly documents the onset as 1/19/2012 instead of 1/6/2012.

On 1/19/2012, a Pressure Ulcer Documentation Form was also initiated for the right heel. The form documents a 1 X 1 cm unstagable area.

Although the weekly skin assessment incorrectly documents the skin is intact on 1/20/2012, on 1/21/2012, the nurse documented the resident had an air mattress and a Prevalon boot.

On 2/10/2012 the physician wrote an second order for the podiatry consult because "original order 1/6/2012 has not been seen yet."

During an interview on 2/24/2012 at 7:55 AM, the staff development nurse stated the podiatrist was in the building on 1/16/12 and 2/10/12. Despite this, the resident was not seen by the podiatrist until 2/13/2012.

During a surveyor's interview on 2/24/2012 at 10:00 AM, the physician stated the resident had been admitted to the facility with the area on the left heel. He further stated that the resident had vascular disease but pressure contributed to the development of the wound on the resident's heel. He indicated pressure relief would have been indicated for the heels. The physician stated that the podiatry consult was ordered due to the skin breakdown on the resident's foot.

During an interview on 2/24/2012, the Assistant Director of Nurses stated that the wounds should

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have been measured upon discovery, and documented on the pressure ulcer documentation form. She further stated that upon discovery of the heel(s) breakdown on , the facility should have instituted pressure relief, such as offload the feet with pillows or use of a pressure relieving device. She was unable to provide evidence that pressure relief was instituted from 1/5/2012 until the 3-11 shift on 1/18/2012, or that the facility provided care in accordance with the War on Wounds program..

2. Review of resident ID #7's clinical record, who resides on the East B unit, indicates readmission to the facility on 2/16/2012, with a necrotic left heel. Review of nurses notes dated 2/16/2012 revealed "noted left outer heel 2.5 cm x 2.5 cm necrotic area...pink in the middle...no complaint of pain". Review of the Pressure Ulcer Documentation Form dated 2/16/2012 revealed "unstagable left heel pressure ulcer 2.5 cm x 2.5 cm with necrotic wound bed...no evidence of pain".

Further review revealed physician's orders dated 2/17/2012 (3 PM) for "Skin Gel Protect Dressing Wipe Pad apply to left heel 3-11 shift" and a 2/17/2012
(4 PM) order for "Skin prep to left heel ...Prevalon boots while in bed."

On 2/22/2012 at approximately 11:00 AM, in the presence of two surveyors and a Licensed Practical (agency) Nurse, Resident ID #7 was observed lying in bed. Air inflated boots were observed on the resident's lower extremities. When the surveyor questioned the agency nurse

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if this resident had a heel ulcer she initially responded "no". Subsequently she retracted her statement and indicated that she had worked the previous evening (2/21/2012) and recalled applying "Hydrogel" to to this resident's left heel.

The surveyors observed that the heel section of each air filled boot was open and both heels were resting on the mattress. The surveyors observed this resident grimace when the agency nurse removed the air filled boot from her left lower leg . When the LPN asked this resident if she had pain this resident responded "yes" and rated her pain level as 5 out of 10. The LPN nurse medicated this resident for pain and subsequently measured this resident's left heel pressure ulcer informing the surveyor it measured 3 cm x 2 cm.

During interview with the Assistant Director of Nurses (ADNS) on 2/22/2012, she indicated that the current treatment for this heel ulcer was "Hydrogel". Additionally she confirmed the air filled boots which were in use were not the Prevalon boots ordered by the physician. She further indicated Prevalon boots have a cloth texture, are blue in color, and are a stock item in the facility. During interview with this alert and oriented resident, in the presence of the ADNS, she stated, "I never had blue boots."

During a subsequent interview with the nursing assistant caring for this resident, she indicated she was not aware this resident was to have Prevalon boots applied.

Review of this resident's "Pressure Ulcer Documentation Form" dated 2/22/2012, revealed a subsequent assessment completed by the

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F 224	Continued From page 15 ADNS indicating "..unstagable left heel pressure ulcer 3 cm x 3 cm ...necrotic wound bed ...wound related pain when touched ...". Review of nurses notes dated 2/22/2012 (8 PM) revealed "...treatment to left heel changed to skin prep every shift ...". During interview with the ADNS on 2/23/2012 at approximately 8 AM, she indicated Resident ID #7's physician order of 2/17/2012 was incorrectly entered into the resident's electronic medication record as "skin gel" and should have been entered as "skin prep." 3. Resident ID # 16 resides on East A unit. A review of the resident's Annual MDS dated 11/14/2011 indicates the resident was admitted with a functional limitation in range of motion on one side for the upper extremity. A review of the comprehensive assessment for this resident indicates extensive assistance is required with activities of daily living and the resident has balance problems during transfers. A review of Physical Therapy notes from 11/15/2010 (a year prior) indicate the resident was admitted with left sided weakness due to a right cerebral vascular accident. Therapy notes dated 12/15/2010 revealed staff received education in the use of the splint (comfy splint) and a restorative program was established with the nursing assistants. As part of this education, nursing assistants were informed that the comfy splint was in place to help prevent contractures. A physician order dated 11/30/10 specifies that the resident may wear the splint as tolerated.	F 224		

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Occupational Therapy notes dated 07/11/2011 indicate the resident was again evaluated for use of the splint. The plan again was for the resident to wear the splint as tolerated, for tone and contracture management. An 8/22/2011 Occupational Therapy progress note indicates as a consequence for not wearing the upper extremity orthotic the resident will experience an increase in spasticity, decreased muscle tone and an increase in contractures.

A review of the care plan initiated for this resident since 5/01/2010 to the present time, indicates the resident requires assistance with activities of daily living. The plan further indicates the resident will need help with wearing the comfy splint. The plan is to wear a comfy splint at hour of sleep and remove it in the AM as tolerated.

The resident was observed on 2/21/2012 at 7:00 AM lying in bed without the splint in place. During an interview at approximately 8:30 AM with the nursing assistant who usually cares for this resident, she stated the resident sometimes refuses to wear the splint. However, during further interview the nursing assistant stated that she has not seen the splint on the resident in quite a long time.

On 2/22/2012, with the help of a nursing assistant as an interpreter, the resident stated that no one has applied the splint in a long time. An additional interview on 2/22/2012 in the AM with a nursing assistant who has worked in this facility for 9 years, revealed that she was unaware the resident wore an arm splint (comfy splint). At approximately 8:45 AM the surveyor interviewed

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the unit manager who was unaware the resident was to wear the comfy splint.

On 2/22/2012 the resident was evaluated by the Occupational Therapist. The therapist informed the surveyor that the splint was too big for the resident and a new splint would be ordered. The therapist further stated that the resident has had a functional decline in range of motion to the left upper extremity.

During interviews on 2/22/2012, the Rehabilitation Manager and the Occupational Therapist stated they were unaware the resident was not wearing the splint. They informed the surveyor that prior to this week they had not been asked to evaluate the resident for use of the splint. They further added the resident should be receiving passive range of motion to her left upper extremity whether she wore the splint or not. Record review and interviews with staff revealed no evidence of any range of motion exercises for this resident.

Additional review of the Annual MDS dated 11/14/2011 indicates the resident was admitted with a functional limitation in range of motion on one side (left) of the lower extremity as well.

A review of a recent Occupational Therapy note dated 02/20/2012 indicates the resident's left ankle exhibits a decline in range of motion, decreased level of independence with transfers and ambulation. The note further indicates that failure to provide physical therapy could result in repeated falls.

During observations of the resident on 2/22/2012

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at 8:30 AM, and again at 10:45 AM while being ambulated with staff to the bathroom, the resident was observed without the orthotic device. At this same time the surveyor asked the nursing assistant when the resident is to use the brace. The nursing assistant stated that the resident had complained to her a few months ago that the brace hurt and that she had informed the nursing staff. During interview with the resident, with this same nursing assistant as an interpreter for the resident, the resident stated the brace has not worn for some time.

On 2/23/2012 at 2 PM the Rehabilitation Manager informed the surveyor, that staff had requested a new evaluation for this resident as staff had noted a decline in the resident's ability to transfer. Additionally, she stated the resident had a recent fall on 2/16/2012.

A review of this 2/23/2012 therapy evaluation for this resident indicates that the resident's left ankle exhibits a decline in range of motion, decreased lower extremity strength and a decrease in the level of independence.

4. Resident # 8 resides on the East A unit of the facility. A review of ID #8's initial comprehensive assessment dated 12/18/2011 indicates diagnoses which include schizoaffective and bipolar disorders. Additionally, the assessment revealed the resident is incontinent of bowel and bladder and requires limited assistance with toileting.

Record review revealed multiple Nurse's Notes indicating that the resident displayed episodes of refusing assistance with hygiene and

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incontinence. Episodes of incontinence included incidents in which the resident urinated on the floor in the room. Additionally, a Nurse's Note, dated 12/18/2011, revealed that the resident expressed concern about having to "pee so much".

A care plan, dated 12/23/2011, revealed that the resident has "feelings of anxiety and depression...characterized by ineffective coping...and non-compliance related to shizoaffective and bipolar disorder". Further review revealed that although the behaviors noted above had been identified, no interventions were implemented relative to the resident's behaviors of urinating in inappropriate areas and of the resident's own concern about being incontinent. Although the resident received assistance following her episodes of incontinence, the resident's behaviors had not been addressed.

Record review of Psychiatric Diagnostic Consultations, dated 1/26/2012, 2/3/2012 and 2/8/2012, reveal no evidence that the resident's behavior was addressed. The note dated 2/8/2012, states only, "no recent behavior issues noted".

Additionally, review of the Social Service notes dated 12/14/2011-2/14/2012 reveal no evidence that the resident's inappropriate behaviors had been assessed.

An initial interview with the resident on the first day of the survey (2/19/2012) revealed that although the resident was "relatively satisfied" residing at the facility. When asked if help comes when needed, the resident commented, "I do

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alright...I don't always make it...I just go when I have to go".

Surveyor observation during this interview and at various times during all days of the survey revealed a foul odor from the resident. In addition, multiple observations during all days of the survey revealed an odor of urine in the resident's room.

During interview on 2/23/2012 at 10:45 AM with the nursing assistant who regularly provides care to the resident, she revealed that when offered assistance, the resident refuses to accept help. Additionally, the nursing assistant confirmed that the resident is frequently wet and/or soiled and goes to the bathroom in inappropriate areas.

An interview with the Social Worker, on 2/23/2012 at 9:00 AM, revealed that the issue of maintaining a clean environment for the resident had been discussed with the nursing staff, however, the actual behavior of resident ID #8 voiding wherever/whenever, had not been assessed nor a plan developed.

5. Non sample Resident ID #30, the roommate of Resident ID #8, has resided on the East A unit of the facility since 7/24/2006, with diagnoses which include depression and anxiety.

On 2/22/2012 at 11:30 AM, the daughter of non sample Resident ID #30 summoned a surveyor into the resident's room. The daughter noted several concerns involving her mother's roommate, indicating that the roommate frequently "goes to the bathroom on the floor and walks naked in the room". Additionally, the

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daughter revealed that a foul odor of urine is constant in the room, wet and soiled clothing belonging to the roommate is left all over the room and the toilet provided for both residents' use is frequently full of waste not flushed by the roommate. When asked if her concerns were made known to the staff, the daughter revealed that she informs the nursing and housekeeping staff each time she is visiting and tells them to clean it up. In addition, the daughter indicated that she had left two previous unanswered telephone messages for the Social Worker. When asked if efforts had been made to resolve her concerns, the daughter stated they had not.

When questioned about her roommate's behavior during an interview with ID #30 on 2/23/2012 at 8:45 AM, the resident was observed to be visibly upset and disturbed by the condition of the room she shares with ID #8. The resident stated to the surveyor, "it turns my stomach...(the resident) also parades around the room naked. I hope you can help me".

6. Resident ID # 5 resides on the West A unit of the facility. A review of ID# 5's initial comprehensive assessment dated 12/12/2011, indicates the inability to transfer independently and is totally dependent on staff for personal care, including toileting. A review of the resident's 12/12/2011 care plan indicates that the skin is to be kept dry.

A review of a recent staff inservice, dated 02/15/2012, relative to answering call lights, revealed that all call lights are to be answered within 3 to 5 minutes. Additionally, the inservice noted that when someone puts a call light on,

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staff are to ask what they need and proceed to respond to the need.

However, while at the nursing station on 2/20/2012 from approximately 8:00 AM to approximately 9:30 AM, the surveyor observed the resident's call light on and no one responding to the light for 12 to 15 minutes. At at approximately 9:40 AM, at the request of the surveyor, the resident was brought back to bed. The resident was observed in a foul smelling, yellow soaked brief. This alert and oriented resident, in the presence of 2 nursing assistants, complained to the surveyor that staff do not answer the call lights in a timely manner, causing incontinence of urine and feces, and further stating that due to the staff not answering call light, the resident sits in a soiled brief for extended periods at a time. When asked by the surveyor as to the last time the resident was changed, the resident stated that it was sometime around 5:30 AM.

During this same time the resident complained to the surveyor that the resident had not received a shower since being admitted to the facility on 11/27/2011. A review of the nursing assistant's personal care records relative to showers for this resident for the month of February 2012, revealed the resident has only received bed baths.

During a interview with the nursing assistants who routinely care for the resident, they stated they do not shower this resident as AM care is performed by the night shift. However, a review of the nursing assistant personal care records for the 11 PM to 7 AM shift indicate no showers were given.

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The surveyor then requested the nursing assistant records for December 2011 and January 2012. No one could to locate these records.

After the surveyor alerted staff that this resident had not received a shower since admission, at approximately 10:00 AM on 2/20/2012, the resident received a shower. After the shower, the surveyor asked the resident if he/she was wearing a brief and he/she stated that he/she was.

At 2:50 PM, the resident informed the surveyor that he/she was wearing a brief that had not been changed since the shower at 10 AM. The resident further stated no one cares and they do not answer call lights quickly enough and "you end up going in your brief".

At 3 PM the surveyor requested the resident be put back to bed. Observation of the resident, at this time, revealed the resident's brief was soiled with both urine and feces. During an interview with the nursing assistants caring for the resident at this time, they stated they had not changed him as he did not ask them to.

7. Resident ID # 17 resides on the East A unit. A review of the current comprehensive assessment, dated 12/21/2011, indicates the resident is alert and oriented, short and long term memory is intact, requires extensive assistance in the areas of bed mobility, personal hygiene, bathing, dressing and is totally dependent for transfers. The assessment also indicates the resident is incontinent of bowel/bladder and requires a brief.

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Review of the current care plan, dated 12/21/2011, indicates resident has " incontinence...care is needed". The care plan, dated 1/13/2012, states "skin integrity related to open areas to right buttocks...check for incontinence and provide peri-care as needed before and after meals, at bedtime and on rounds during the night". A review of the resident's care card states "up for lunch, back to bed after lunch, up for dinner, back to bed after dinner and up for poker night". Hoyer lift for transfers is also required.

The resident attended the resident group meeting on 2/21/2012 at 11:00 AM. During the surveyor's questions concerning the staffing on East A, the resident stated staff told him/her to stay in bed when he/she wanted to get up. The resident further stated this has happened after breakfast and again in the afternoon at change of shift time, 3:00 PM.

On 2/22/2012 at 9:30 AM after observing bathing, dressing, and brief changing by a nursing assistant, the resident was interviewed. When questioned by the surveyor about incontinence, the resident stated he wears an incontinence brief and does know when the brief is wet stating, "When they don't change my brief when I ask, the urine soaks out of the brief and the bed is wet". The resident also stated he/she enjoys getting up in the mornings to join activities and that getting up out of bed is "very important". He/she stated he/she stays up in his wheelchair longer than he/she should as he/she is concerned that if he goes back to bed after lunch, staff will be unable to assist with getting up for dinner. The resident

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requires 2 nursing assistants and a Hoyer lift to transfer. The resident ended the interview with, "These problems are due to not enough staff."

On 2/22/2012, the resident was observed sitting up from lunchtime through the afternoon hours. When interviewed at approximately 4:00 PM, the resident stated he/she chose to stay up rather than go back to bed. Again, he/she stated he/she was concerned there would not be enough staff to help get him/her up later.

During interviews with 2 nursing assistants on 2/22/2012 at 9:15 AM on East A, they revealed they knew incontinence care should be every 2-3 hours, but when they are short of staff they are unable to do this. Furthermore, they stated transfers of residents requiring total care and Hoyer lifts take approximately 45 minutes to 1 hour to provide the care. Additionally they stated, when short of staff, they are unable to care for everybody on time and get everything done.

8. Record review revealed resident ID #3, who resides on West A, has physicians orders for Percocet 7.5-325 MG (every 8 hours as needed for moderate-severe pain). The resident also has orders for Oxycodone HCL (5 mg every six hours as needed for mild to moderate pain) and for Tylenol (2-325 mg tablets every four hours as needed for pain).

Review of the clinical record revealed that the resident received the Percocet on 2/19/2012 at approximately 10:00 AM for back pain. At 12:10 PM the resident was observed in the presence of the Occupational Therapist (OT). The resident noted receiving the pain medication earlier; but

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now had a headache. When questioned by the OT, the resident stated the headache pain was a 10 out of 10. The OT told the resident she would tell the nurse.

The resident was interviewed at 12:45 PM and stated the headache had persisted and felt like he/she needed pain medication. Again, at approximately 1:25 PM, the resident told they surveyor, he/she still had a headache (which was rated as a 6 out of 10). The resident stated no pain medication for the headache was received even though he/she had told a few staff members.

During interview on 2/20/2012 the next day) at 10:50 AM the OT stated she had not told the nurse about the resident's headache on the previous day.

During interview on 2/20/2012 at 12:00 PM the nurse stated that no one had told her about the resident's headache, or the resident being in pain, after she administered Percocet on 12/19/2012 at 10:00 AM.

On 2/20/2012 the resident was seen by the physician who diagnosed the resident with migraines and ordered 50 mg Imitrex (medication used for migraines) as needed 4 times per day.

9. Review of the 1/20/12 Minimum Data Set (MDS) assessment for resident ID#3, who resides on the West A unit revealed the resident scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS), and requires extensive assistance for toileting and is always continent of bowels.

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F 224	Continued From page 27 Review of the February 2012 Resident Functional Performance record documents six occasions when the resident had a bowel incontinence episode and then given the bed pan. During interview on 2/20/12 at approximately 3:00 PM the resident stated he/she was wearing an absorbent brief because, at times, it takes staff too long to come when toileting assistance is called for use of a bed pan. The resident stated this causes bowel incontinence. Following the interview, the resident was observed to be wearing a brief.	F 224		
F 241 SS=H	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on surveyor observations, record review, resident, staff and family interviews, it has been determined that the facility has failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity for 4 of 20 sample residents, (ID#'s 5, 8,15, & 17), and 1 of 10 non-sample residents (ID# 30) on 2 of 4 units, East A and West A. Findings are as follows: 1. On 2/21/2012 at 8:30 AM resident ID# 15, who	F 241		

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resides on the East A unit of the facility, was observed lying in bed holding the top of her pajamas closed with her hands. At the time of this observation there were two nursing assistants in the room. When one of the nursing assistants asked the resident if she wanted to get out of bed, she looked up at him and said, "no buttons". The nursing assistant proceeded to assist the resident out of bed and the resident continued to hold close the pajama top stating once again, "no buttons". Both the surveyor and the nursing assistant noted six of the seven buttons missing from the resident's pajama top.

At 8:50 AM on 2/21/2012, the surveyor brought the Administrator in the room to show her the pajama top which had been taken off of the resident. When the Administrator held up the pajama top, the resident stated, "no buttons, no buttons".

On 2/22/2012 at 7:15 AM, the surveyor again observed the resident in a pair of light green pajamas. At the time of the observation a nursing assistant was ambulating the resident back to bed. The surveyor observed an approximate six inch by six inch hole on the left backside of the resident's pajamas, exposing her brief. The surveyor then requested the unit manager accompany the surveyor to the room to observe the hole in the resident's pajama bottoms.

2. Non sample resident ID #30 resides on the East A unit and rooms with sample resident ID #8. During the initial tour of the facility on 2/19/2012 at 8:00 AM and throughout the survey days, both staff and resident ID #30's family informed the surveyors that ID #8's behaviors

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include voiding and defecating on the floor in the room. Additionally, the resident disrobes and walks around the room in view of resident ID #30.

During interview with ID #30 on 2/23/2012, resident ID# 8's behaviors were discussed. #30. When asked how these behaviors have affected resident ID #30, the resident stated "I am sick to my stomach" and "I hope you can help me".

3. Resident ID# 5 who resides on the West A unit of the facility is totally dependent on staff for all personal care including toileting. On 2/20/2012 at approximately 9:30 AM, at the request of the surveyor, the resident was brought back to bed. The resident was observed in a foul smelling, yellow soaked brief.

This alert and oriented resident, in the presence of the surveyor and two nursing assistants, complained that staff do not answer call lights in a timely manner and the resident sits in urine and feces for lengthy periods of time. When asked by the surveyor as to the last time the brief was changed, the resident stated that it was sometime around 5:30 AM.

While at the nursing station on 2/20/2012, from approximately 8:00 AM to 9:45 AM, the surveyor observed resident ID# 5's call light on and no one responding to the light for 12 to 15 minutes. During a subsequent interview with the two nursing assistants caring for the resident they informed the surveyor that the night staff changes the resident before they arrive.

At approximately 10:00 AM on 2/20/2012, the resident received a shower. The surveyor asked

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the resident if he was wearing a brief and he stated that he was. On this same date at 3 PM the surveyor requested the resident be put back to bed. Observation of the resident at this time revealed the resident's brief was not only wet, but there was feces in the brief. During an interview with the nursing assistants caring for the resident at this time, they stated they had not changed him as he did not ask them to.

On 2/21/2012 at approximately 7:00 AM, the surveyor interviewed the two nursing assistants who worked 2/19/2012 on the 11 PM to (2/20/2012) 7 AM shift. They separately informed the surveyor that the last time they provided personal care to the resident was at 5:30 AM on 2/20/2012.

4. Resident ID # 17 resides on East A unit. A review of the current comprehensive assessment, dated 12/21/2011, indicates the resident is alert and oriented, short and long term memory is intact, requires extensive assistance in the areas of bed mobility, personal hygiene, bathing, dressing and is totally dependent for transfers. The assessment also indicates incontinence of bowel/bladder and requires a brief.

Review of the current care plan, dated 12/21/2011, indicates resident is incontinent and care is needed. The care plan, dated 1/13/2012, states "skin integrity related to open areas to right buttocks...check for incontinence and provide peri-care as needed before and after meals, at bedtime and on rounds during the night". A review of the resident's care card states "up for lunch, back to bed after lunch, up for dinner, back to bed after dinner and up for poker night". He

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requires "Hoyer lift for transfers".

The resident attended the group meeting on 2/21/2012 at 11:00 AM. During the surveyor's questions concerning the staffing on East A, the resident stated he/she has been told to stay in bed when he/she wanted to get up. The resident further stated this has happened after breakfast and again in the afternoon at change of shift at 3:00 PM.

On 2/22/2012 at 9:30 AM after observing resident during bathing, dressing, and change of brief by a Nursing Assistant, the resident was interviewed. The resident stated "what you saw (referring to the AM care) was an exaggeration". And regarding the need to wear a brief and knowing when it's wet, the resident stated, "When they don't change my brief when I ask, the urine soaks out of the brief and the bed is wet". The resident continued to state he enjoys getting up in the mornings to join activities and that getting up out of bed is very important to him. The resident also stated stated he/she stays up in a wheelchair longer than he/she should as he/she is concerned that if he/she goes back to bed after lunch, staff will be unable to assist with getting up for dinner. This resident requires two nursing assistants, with a Hoyer lift, to transfer. The resident ended the interview stating "these problems are due to not enough staff".

On 2/22/2012, the resident was observed sitting up from lunchtime through the afternoon hours. When interviewed at approximately 4:00 PM, he stated he chose to stay up rather than go back to bed. Again, the resident stated he/she was concerned there would not be enough staff to

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assist with getting up later.

During interviews with two Nursing Assistants on 2/22/2012 at 9:15 AM on East A, they revealed they knew incontinence care should be every 2-3 hours, but when they are short of staff they are unable to do this. They further stated transfers of residents requiring total care and Hoyer lifts take approximately 45 minutes to 1 hour to provide the care these residents need, and that when they are short of staff, they are unable to care for everybody on time and get everything done.

5. Resident ID #8 who resides on the East A unit was admitted to the facility on 12/13/2011 with diagnoses including Bipolar Disorder and Schizoaffective Disorder. A review of the 12/18/2011 initial Minimum Data Set revealed a BIMS (Brief Interview for Mental Status) score of 13 out of 15 indicating minimal cognitive impairment. In addition, the MDS revealed the resident is frequently incontinent and requires assistance of staff for personal hygiene.

During the initial tour of the facility with the unit nurse on the morning of 2/19/2012, it was revealed that ID #8 exhibits behaviors of urinating and defecating on the floor in the room. A subsequent observation of the resident's room revealed a stale odor of urine and foul smelling clothing overflowing from a hamper under the sink. Additional record review, following the observations revealed no documentation that interventions had been implemented for this resident's behavior.

Interview with ID #8 on 2/23/2012 at 10:00 AM revealed that the resident is aware of the

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F 241	Continued From page 33 behavior. When questioned specifically about urinating and defecating on the floor, the resident stated, "I go when I have to". During this interview the surveyor noted a foul odor from the resident. When interviewed on 2/23/2012 at 9:00 AM, the social worker (SW) revealed that although she was aware of ID #8's behavior, she only addressed it to the nursing staff as a concern about incontinence. The SW revealed that when the resident went to the bathroom on the floor, the housekeepers would just clean it up.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, staff interview, and record review it was determined that the facility has failed to provide an ongoing program of activities, in accordance with the comprehensive assessment, that meets the interests and well-being for 1 of 20 sample residents, ID #11. Findings are as follows: Resident ID #11 has resided at the facility since 9/26/2011 and diagnoses include Dementia and Depression. Review of the resident's Minimum	F 248		

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Data Set (MDS) dated 11/25/2011 indicates that the resident is unable to complete the Brief Interview for Mental Status (BIMS) due to short and long term memory loss. In addition, the MDS revealed the resident requires extensive assistance with transfers, locomotion and with all activities of daily living (ADL's). The resident's current care plan for February 2012, revealed that the resident exhibits deficits in memory, judgement, decision making and thought process related to Dementia. Interventions for these deficits include providing "one to one sessions with resident for sensory stimulation and reassurance". The resident's care plan also specifies that, due to Dementia, the resident needs assistance to achieve the goal of participating in activities three times per week.

Review of the resident's February 2012 Program Participation Record revealed that from 2/1/2012 - 2/12/2012 the resident had only participated in watching television, "social/ happy hour" and in "planned wandering." From 2/13/2012 - 2/22/2012, the facility continued to include television, "social/ happy hour" and "planned wandering" as part of the ongoing activity program.

Additionally, there was evidence of a one-to-one session occurring on the February 2012 program participation record on 2/17/2012 , and three one-to-one sessions documented on the January program participation record, 1/13/2012, 1/23/2012 and 1/27/2012 .

During an interview on 2/23/2012 at 9:25 AM, the resident's program participation record for February 2012 was reviewed with the activity

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staff. The activity staff stated "planned wandering" includes pushing the resident to the dining room, back to her room, or to an activity. She stated that the "television" documented on the program participation record refers to the resident watching TV in the dining room, or in the resident's room. When questioned about "social/happy hour", she stated this program consists of meal time.
The activity staff member stated that she tries to do one-to-one activities twice a week for residents that require individualized activity programs. She stated the resident had three one-to-one activities in February. When questioning the content of the one-to-one programs for this resident, the activity staff member indicated that they had consisted only of greeting the resident and asking her if she wanted to attend a group activity.

As defined by Heath Regulation, F248, 483.15(f) , " 'Activities' refer to an endeavor, other than routine ADL's, in which the resident participates that is intended to enhance his/her sense of well-being...".

The resident was observed sitting in a wheelchair in the hallway on all days of the survey. This included 2/19/2012 at 12:00 PM; on 2/20/2012 at 8:35 AM, 10:30 AM, 11:45 AM and 2:35 PM, on 2/21/2012 from 8:45 AM-9:30 AM and 3:45 PM, and on 2/22/2012 at 9:30 AM, 10:12 AM, and from 12:45 PM to 1:25 PM. In addition, the resident was observed in the dining room eating her meals on 2/19/2012 at 9:25 AM and 12:40 PM, on 2/20/2012 at 12:15 PM, and on 2/22/2012 at 8:20 AM and 11:20 AM.

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F 248	Continued From page 36 During meal observations, the resident was seated at a far distance from the television in the dining room, with her back to the television. The resident was not observed actively watching television or engaging in social interaction with other residents The activity staff was unable to provide evidence that the resident was provided an ongoing activity program which was designed to meet the interests and well-being of the resident, ad that include activities other that routine ADL's.	F 248		
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well being for 1 of 14 sample residents (ID #8) . Findings are as follows: 1. Resident ID #8, who resides on the East A unit, was admitted to the facility on 12/13/2011 with diagnoses including Bipolar Disorder and Schizoaffective Disorder. A review of the 12/18/11 initial Minimum Data Set revealed a	F 250		

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F 250	Continued From page 37 BIMS (Brief Interview for Mental Status) score of 13 out of 15 indicating minimal cognitive impairment. During the initial tour of the facility with the unit nurse on the morning of 2/19/12 , it was revealed that ID #8 exhibits behaviors of urinating and defecating on the floor in the room. A subsequent observation of the resident's room revealed a stale odor of urine and foul smelling clothing overflowing from a hamper under the sink. Record review, following the observations, revealed no interventions had been implemented for this resident's behavior. A review of quarterly social service notes dated 12/14,12/21, 1/3, 1/6, 1/9, 1/12, 1/13, 1/17, 1/23 1/27, 1/30, 2/1 and 2/14 for this resident failed to reveal any evidence of social services provided to the resident relative to the behaviors noted above During an interview with the resident on 2/23/12 at 10:00 AM, the resident revealed an awareness of the behavior. When questioned specifically about urinating and defecating on the floor, the resident stated, "I go when I have to". During this interview, a foul odor was detected coming from the resident. When interviewed on 2/23/12 at 9:00 AM, the social worker (SW) revealed that although she was aware of resident ID #8's behavior, it was addressed with the nursing staff only in terms of keeping the resident's environment clean, and not in terms of the behavior itself. Refer to F319 Treatment for Mental/Psychosocial Difficulties.	F 250		

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F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to review and revise care plans for 3 of 23 sample residents, ID #s 2, 6, and 9. Findings are as follow: 1. Review of the clinical record for Resident ID #2, who resides on the West B unit, revealed he was admitted to the facility on 1/19/2012 with a diagnosis of dementia and aspiration pneumonia. Review of this resident's Minimum Data Set	F 280		

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(MDS) dated 1/16/2012 revealed he required extensive assistance with meals. Review of the care plan for nutrition dated 1/23/2012 revealed "feed resident" .

On 2/19/2012 at 12:50 PM, and at 2/20/2012 at 8:45 AM, the surveyor observed this resident self feeding. During interview with the unit staff nurse on 2/20/2012 at 9:30 AM she indicated that this resident's condition had improved and he requires supervision only.

Review of this resident's MDS dated 1/16/2012 revealed he required a mechanical lift for transfers. Review of care plan for fall prevention revealed "assist resident in and out of bed with two assistants using a Hoyer lift".

On 2/20/2012 at 10:45 AM the surveyor observed two nursing assistants transfer this resident out of bed without the use of a Hoyer lift.

During interview with the Occupational Therapist Assistant, on 2/21/2012 at 8 AM, she indicated this resident's condition had improved and a recent reevaluation determined the resident was safe to transfer without the Hoyer lift.

The facility failed to review and revise the care plan relative to the above changes.

2. During a surveyor observation on 2/20/2012 at approximately 11:00 AM on the West B unit, two Nursing Assistants (NA) were observed transferring Resident ID # 6 from bed to wheelchair by standing and pivoting the resident using a gait belt.

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F 280	Continued From page 40 Record review of the current care plan from 5/3/2011 indicated the intervention for transfer was "use of mechanical device and two assist at all times for transfers". However, further record review revealed the resident had been assessed by the Occupational Therapist on 6/23/2011 and found capable to have a transfer with two person assist only. During interviews on 2/20/2012 in the AM, the West B Charge Nurse and Unit Manager were unable to provide evidence the care plan had been revised. 3. Record review of Resident ID # 9, who resides on the West B unit, has a current care plan from 11/1/2011 noting "resident has a history of dysphagia", and indicated the two following interventions: "Monitor lung sounds every shift and after meals" and, "Monitor Temperature every shift and notify MD if elevated". Continued record review of the treatment record, nurses notes and NA care cards failed to produce evidence of lung sounds being monitored or temperatures being taken every shift. Lung sounds were recorded as monitored 2 times out of 314 opportunities and temperatures were monitored 15 times out of 314 opportunities from 11/1/2011 to 2/20/2012. During interviews with West B's Charge Nurse and Unit Manager on 2/20/2012 at approximately 10:00 AM, they indicated both care plans should have been revised to state these interventions should be PRN (as necessary) only.	F 280		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		

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F 281 SS=H	Continued From page 41 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, interviews with staff and residents, it has been determined that the facility failed to ensure the services provided by the facility meet professional standards of quality for 4 of 23 sample residents (ID #5, 7, 12, 15), and 2 of 12 non-sample residents (ID #29 and 33) by allowing Licensed Practical Nurses perform Pressure Ulcer Skin Assessments (ID #12), and failing to implement physicians' orders (for all other residents noted). Findings are as follows: The State of Rhode Island Rules and Regulations for the Licensing of Nurses and Standards for the Approval of Basic Nursing Education Programs (R5-34-NUR/ED), Section 1.31, defines "Nursing", and states, in part: "It provides care and support of individuals and families during periods of wellness, illness, and injury and incorporates the appropriate medical plan of care as prescribed by a duly licensed physician, dentist, podiatrist, or other health care provider licensed to prescribe." 1. Review of Non-Sample resident ID #29's closed record, revealed the resident was admitted to the facility on 1/5/12 from the hospital after undergoing surgery for a fracture of the left hip.	F 281		

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F 281	Continued From page 42 A 1/6/12, 11 PM-7 AM nurses' note, written by the nurse who did the 1/5/12 admission note states "left heel slight mushy, redness-necrotic. Right heel redness...." On 1/6/12 the resident was seen by the attending physician, and an order was written for a podiatry consult. On 2/10/12 the physician wrote an second order for the podiatry consult because "original order 1/6/12 (resident) has not been seen yet." During an interview on 2/24/12 at 10:00 AM, the physician stated he ordered the podiatry consult due to the skin breakdown on the residents foot, not due to his toenails. During an interview on on 2/24/12 at 7:55 AM, the staff development nurse stated the podiatrist was in the building on 1/16/12 and 2/10/12. Despite this, the resident was not seen by the podiatrist until 2/13/12. Refer to F 314 pressure sores. 2. Review of Resident ID #7's clinical record indicates the resident was readmitted to the East B unit on 2/16/2012 with a necrotic left heel. Review of the attending physician's orders dated 2/17/2012 (3 PM) specified, "Skin Gel Protect Dressing Wipe Pad apply to left heel 3-11 shift", and an order on 2/17/2012 (4 PM) for "Skin prep to left heel ...Prevalon boots while in bed." On 2/22/2012 at approximately 11:00 AM, in the presence of two surveyors and a Licensed Practical (agency) Nurse, Resident ID #7 was	F 281		

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observed lying in bed with air inflated boots on the lower extremities. When the surveyor questioned the agency nurse, she stated she had applied Hydrogel to the left heel on the evening of 2/21/2012. No skin prep had been applied.

During an interview with the ADNS on 2/23/2012 at approximately 8 AM, she indicated Resident ID #7's physician order of 2/17/2012 was incorrectly entered into the resident's electronic medication record as "skin gel" and should have been entered as "skin prep." Furthermore she stated the air inflated boots the resident had on were not the Prevalon boots that had been ordered by the physician..

3. Resident ID #15 resides on the East A unit of the facility. The comprehensive assessment dated 12/05/2011 indicates the resident hears adequately with the use of a hearing aid. Current physician orders dated 02/03/2012 specify, insert hearing aid in AM, remove at night. A review of the resident's care plan initiated on 07/21/2011 to the present time indicated nursing is to place hearing aid in right ear every morning.

Observation of the resident on 02/21/2012 at 8:45 AM revealed the resident sitting in a chair in the room eating breakfast without the hearing aid.

At 9:05 AM on 02/21/2012 the surveyor attempted to interview the resident. At this time the resident was observed without the hearing aid in place. The surveyor again attempted to interview the resident who stated, "I can't hear you".

Observation on 2/21/2012 at 9:45 AM revealed the resident in the therapy room without the

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hearing aid. Although the above findings were brought to the attention of the unit manager and the nursing assistant caring for the resident on 2/23/2012 at 7:45 AM, surveyor observation on 2/24/2012 at approximately 7:45 AM revealed the resident out of bed, dressed, and again without the hearing aid.

4. On 2/20/12 at 9:30 AM, non-sample resident ID #33, who resides on West A unit, was observed telling the nurse that, at times, the resident is not receiving a treatment that was ordered by the podiatrist and the feet are sore at night.

Record review revealed a diagnosis of diabetes. On 2/10/12, the podiatrist saw the resident and recommended: Lac-Hydrin 12% lotion to dry skin of feet/ legs except between toes once every other day times 60 days, and Skin Prep once daily for 14 days to the posterior heels.

It was not until 2/15/12 that a physicians order was obtained for the above podiatry recommendation.

Review of the treatment record revealed the Lac Hydrin 12% lotion was not provided from 2/15/12 though 2/18/12. Also, the resident received the skin prep three times per day on 2/15/12, 2/18/12 and 2/20/12 and then twice per day on 2/16/12, 2/17/12 and 2/19/12. The 2/15/12 order was for once per day.

During interview on 2/23/12 at 8:55 AM, the nurse was unable to produce evidence that the Lac-Hydrin lotion was provided as ordered.

During interview on 2/24/12 at 8:30 AM, the nurse

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confirmed that the resident had not received the Skin Prep as ordered. She further indicated that the facility incorrectly had the Skin Prep scheduled for three times per day.

5. Resident ID #5, who lives on the West A unit of the facility, has a diagnosis of hypertension and is administered Atenolol 5 mg every day and Ramipril 5 mg every day, (for high blood pressure). The current February physician orders for this resident specify to hold these medications for a pulse less than 60 and a systolic blood pressure less than 110. Review of the February Medication Administration Record for 2/02/2012 & 2/03/2012 revealed no evidence of the resident's pulse being taken before these 2 medications were administered. On 02/08/12, 2/09/12 and on 02 /11/12, 2/12/12 & 2/14/12, the resident was administered these medications and there is no evidence in nursing notes or on the Medication Administration Record that the resident's pulse and/or blood pressure were taken before these medications were administered.

During an interview with the unit manager, on 02/20/2012, at 7:45 AM she was unable to provide evidence the vital signs were taken before the resident's medications were administered.

The State of Rhode Island Rules and Regulations for the Licensing of Nurses and Standards for the Approval of Basic Nursing Education Programs (R5-34-NUR/ED),
under Definitions, Section 1.35, defines "Practical Nursing", and states, in part:
"Practical nursing" ... is practiced by licensed

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practical nurses (L.P.N.s). It is an integral part of nursing based on a knowledge and skill level commensurate with education. It includes promotion, maintenance, and restoration of health and utilizes standardized procedures leading to predictable outcomes, which are in accord with the professional nurse regimen under the direction of a registered nurse.
Section 1.40, defines "Professional nursing," and states, in part:
"Professional nursing" ... is practiced by registered nurses (R.N.s). The practice of professional nursing is a dynamic process of assessment of an individual's health status, identification of health care needs, determination of health care goals with the individual and/or family participation and the development of a plan of nursing care to achieve these goals.

6. Resident ID #12 resides on the East A unit of the facility. Review of the Pressure Ulcer Documentation forms for December 2011 and February 2012 reveal nine pressure ulcer assessments conducted by an LPN (Licensed Practical Nurse). The assessments lack evidence that they had been witnessed or reviewed, approved, and co-signed by a RN (Registered Nurse).

On 2/22/2012 at 10:15 AM, the surveyor observed the LPN doing a skin assessment, dressing change and wound measurements without the oversight of the RN as indicated above.

When interviewed by the surveyor on 2/22/2012 at 11:00 AM, the LPN told the surveyor that she does the wound assessments some of the time.

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F 282 SS=H	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, staff and resident interviews, it has been determined that the facility has failed to ensure resident care plans are implemented for 3 of 20 residents, ID#'s 4, 15 and 16. Findings are as follows: 1. Resident ID #16's 5/12/2011 care plan to the present time indicates the resident is to wear a comfy splint on her left upper extremity at HS (hour of sleep) and it is to be removed in the morning. The resident was observed on 2/21/2012 at 7:00 AM lying in bed without the comfy splint. During an interview on 2/21/2012 at approximately 8:30 AM, with the nursing assistant who usually cares for this resident, she stated the resident sometimes refuses to wear the splint. However, during further interview the nursing assistant stated that she has not seen the comfy splint on the resident in quite a long time. On 2/22/2012 with the help of an interpreter, the resident stated that no one has offered to put the splint on in a long time.	F 282		

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F 282	Continued From page 48 On 2/22/2012 at approximately 8:45 AM, the surveyor interviewed the unit manager who was unaware the resident was to wear the comfy splint. This resident's 5/01/2011 care plan indicates the resident has diabetes and is at risk for visual changes. The resident's comprehensive assessment dated 11/14/2011 and quarterly assessment dated 2/13/2012 indicates the resident wears glasses. Observation on 2/22/2012 at 8:25 AM , the resident was observed without glasses on. During a subsequent interview at 8:30 AM, with the nursing assistant who routinely cares for the resident, she stated that the resident does not wear glasses. During interviews with both the unit manager and the nursing assistant caring for the resident on 2/22/2012 at 8:35 AM, they revealed were unaware the resident wore glasses. Observations on 2/22/2012, and again at 9:35 AM and 10:00 AM, revealed the resident without the glasses. During interview with the Medication Technician on 2/22/2012 at 9:35 AM, she stated she has never seen the resident with glasses. The resident has also been identified as being at risk for falls. A review of the 2/17/2011 Physical Therapy assessment indicates the resident is to ambulate with a left orthotic brace.	F 282		

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F 282	Continued From page 49 During several observations of the resident on 2/22/2012 & 2/23/2012 at varied AM times, while ambulating with staff to the bathroom, the resident was observed without the orthotic device. During an interview on 2/22/2012 at approximately 8:00 AM, with the nursing assistant who usually cares for this resident, she stated she had informed the facility quite awhile ago that the resident was not wearing the brace as it hurt him/her. During an interview on 2/22/2012 at 8:30 AM with the above nursing assistant interpreting for the resident, the resident stated the brace was worn at one time, however it has not been worn for some time. 2. Record review for resident ID #15 reveals a 12/06/2010 to the present time care plan indicating the resident is at risk for falls. As part of the plan to address this issue the resident is to have a reacher with in reach at all times. Observation of the resident on 2/21/2012 at 8:45 AM, revealed the resident seated in a chair without the reacher. Observation on 2/22/2012 at 8:00 AM, 8:30 AM and 9:30 AM, revealed the resident seated in her chair without the reacher. Further review of the resident's care plan indicates the resident requires extensive assistance with most areas of care, and with functional mobility. As an intervention to address these concerns the resident is to wear glasses. Observation of this resident on 2/21/2012 at 8:45 AM noted the resident in a chair eating breakfast without glasses on. On 2/22/2012 from 8:00 AM	F 282		

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to 8:30 AM the resident was observed a chair without her glasses on. On 2/22/2012 at approximately 9:35 AM, the medication technician and the nursing assistant caring for the resident stated they were unaware the resident wore glasses.

At 9:45 AM the resident was observed in the Rehabilitation room receiving therapy without glasses on. Observations on 2/23/2012 at varied AM and PM times noted the resident without the glasses. The surveyor interviewed the resident on 2/23/2012 and the resident informed the surveyor that the glasses were in the resident's drawer, but the resident could not reach them to put them on.

This resident has also been identified as being at risk for pressure ulcers. The current February orders for the resident specify to off load heels when in bed by floating in air or via heel protectors.

Observation of the resident on 02/22/2012 from 7:00 AM to 7:20 AM revealed the resident lying in bed with heels resting on the mattress. Although the surveyor informed the unit manager on 2/22/2012 at 7:25 AM that the resident's heels were not elevated, the surveyor observed the resident again on 02/23/2012 at 7:00 AM in bed without the heels elevated.

3. Resident ID #4 resides on the East B unit of the facility. A review of ID #4's annual comprehensive assessment dated 1/13/2012, indicates she requires assistance to transfer and has a potential for skin breakdown relative to limited mobility and fragile skin.

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F 282	Continued From page 51 A review of the resident's 1/23/2012 to the present time care plan indicates that the resident's skin requires weekly skin checks and her skin is to be observed every shift for signs and symptoms of potential skin breakdown. Surveyor observation on 2/22/2012 at 9:05 AM, in the presence of the Assistant Director of Nursing (ADNS) revealed the resident in bed and noted with right and left reddened boggy heels. At the surveyor's request, the heels were elevated for approximately 20 minutes. A subsequent observation at 9:25 AM revealed that the resident's left heel remained boggy, red and non-blanchable (does not change color when pressed). During an interview on 2/24/2012 at 1:30 PM, with the nursing assistant caring for the resident at this time, she stated that although she had provided personal care, she was unaware of the condition of the resident's heels in spite of the plan to observe the resident's skin each shift.	F 282		
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by:	F 283		

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F 283	Continued From page 52 Based on clinical record review and staff interview it has been determined that the facility failed to discharge a resident with a discharge summary which included specific needs regarding wound care, for 1 of 1 non sample resident ID #26. Findings are as follows: Review of the clinical record for Resident ID #26 revealed this resident was admitted to the facility on 1/13/2012 for short term rehabilitation. Review of this resident's Pressure Ulcer Documentation Form dated 2/23/2012, revealed a Stage 2 pressure ulcer 0.1 cm x 0.1 cm and less than 0.1 cm in depth. Further review revealed a physician order dated 1/25/2012 for "Zinc Oxide apply to open area Right Buttock followed by dry sterile dressing daily". During interview with the unit staff nurse on 2/23/2012 at 1:00 PM she indicated this resident was discharged home, with home care services, earlier that day. Review of the discharge information failed to reveal an order for the continued treatment of the right buttock pressure ulcer. When brought to the attention of the Assistant Director of Nurses on 2/23/2012 at 2:00 PM, she obtained a physician order for the Zinc Oxide as noted above and informed the home care agency of the treatment order.	F 283		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		

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or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based upon surveyor observation, record review, and staff and resident interviews, it was determined that the facility failed to provide pain medication for 3 of 23 sample residents with pain, resident ID #'s 3, 5 and 17.

Findings are as follows:

1. Record review of resident ID #3, who resides on the West A unit, is alert and oriented, with a Brief Interview for Mental Status (BIMS) score of 14 out of 15, and is able to participate in the pain assessment according to the Minimum Data Set (MDS) dated 1/20/2012. The resident has a physician's order for Percocet 7.5-325 MG (every 8 hours as needed for moderate-severe pain). The resident also has orders for Oxycodone HCL (5 mg every six hours as needed for mild to moderate pain) and for Tylenol (2-325 mg tablets every four hours as needed for pain).

Review of the clinical record revealed that the resident received the Percocet on 2/19/2012 at approximately 10:00 AM for back pain.

On 2/19/2012 at 12:10 PM the resident was observed by the surveyor, in the presence of the Occupational Therapist (OT). The resident noted he had received some pain medication

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earlier, but he now had a headache. When questioned by the OT, the resident stated the headache pain was a 10 out of 10. The OT told the resident she would tell the nurse.

The resident was interviewed at 12:45 PM and stated the headache persisted and felt like medication was needed for the headache. At approximately 1:25 PM the resident stated that the headache continued (which was rated as a 6 out of 10). The resident stated the medication for the headache had not been received even though a few staff members had been told of the pain.

During interview on 2/20/2012 at 10:50 AM, the OT stated she had not told the nurse about the resident's headache on the previous day.

During interview on 2/20/2012 at 12:00 PM the nurse stated that no one had told her about the resident's headache, or the resident being in pain after she administered Percocet on 12/19/12 at 10:00 AM.

On 2/20/12 the resident was seen by the physician who diagnosed the resident with migraines and ordered 50 mg Imitrex as needed four times per day.

2. Resident ID # 5 resides on West A unit of the facility. A review of this resident's initial comprehensive assessment dated 12/12/2011 notes the resident frequently has pain, was not on a routine pain management, but received pain medication frequently, as needed. The assessment further indicates the pain limits day to day activities and that the resident struggles with pain issues. Based on the assessment a

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decision was made to initiate a care plan for pain. The care plan initiated on 11/28/2011 to the present time has a stated problem, "pain due to spinal stenosis, degenerative joint disease and lumbar spondylosis". As an approach to the pain the resident is to receive pain medications as ordered.

A physician order dated 1/25/2012 specifies the resident is to receive Tramadol HCL tablet 50 mg as needed every six hours for breakthrough pain.

A physician order dated 1/31/2012 specifies the resident is to receive Oxycontin 20 mg tablet, one tablet at 9 AM and one tablet at 9 PM. On 2/15/2012 the resident's Oxycodone 5 mg was increased to two tablets every 4 hours as needed.

During an interview on 2/19/2012 at 9:00 AM, the resident who is alert and orientated informed the surveyor that he/she does not always receive the pain medications as ordered.

During an interview with the resident's family member on 2/20/2012 at 8 AM, the surveyor was informed that the resident has complained of not always receiving pain medication as ordered.

A review of the 02/06/2012 Narcotic Log for this resident, revealed the resident only received 10 mg of Oxycontin at 8:30 AM instead of the specified 20 mg. Additional review of the medication administration record dated 02/06/2012 revealed that the resident received 50 mg of Tramadol at 4:20 PM for leg pain rated as a 10 on a scale of 0-10.

A review of the Narcotic Log and the medication

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F 309	Continued From page 56 Administration Record for 02/17/2012 revealed the resident was administered Oxycontin 20 mg at 9 AM. The next dose of Oxycontin was not administered until 11 PM instead of at the required 9 PM time. 3. Resident ID # 17, who resides on the East A unit, has an order for Tylenol 325 mg tablets, 2 tabs as needed for pain, not to exceed 4 grams per day. During an interview on 2/21/2012 in the AM, the resident who is alert and orientated reported getting his pain medication late. When he reported this to the staff, he was told by the medication staff person, that the they have 1 hour before, and 1 hour after the medication is due, to administer the medication. The resident continued to say he/she had pain at the time the Tylenol was requested and should have received the medication at this time. During an interview with the nurse on the East A unit on 2/22/2012, she stated pain medication should have been given at the time of the request as the resident was in pain.	F 309		
F 310 SS=H	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.	F 310		

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This REQUIREMENT is not met as evidenced by:
Based upon surveyor observation, staff and resident interviews and record review, it has been determined that the facility failed to ensure that activities of daily living do not diminish for 2 of 18 sample residents, ID #5 and #3 relative to toileting.

Findings include:

1. Resident ID# 5 is alert and oriented and resides on the West A unit of the facility.
A review of the resident's Minimum Data Set (MDS), dated 12/12/2011, indicates the resident is continent of bowel and bladder. A review of the resident's comprehensive assessment indicates an inability to transfer independently and requires extensive assistance from staff for all activities of daily living including toileting.

On 2/20/2012 the resident, in the presence of the surveyor and 2 nursing assistants, complained that staff do not answer call lights in a timely manner and the residents sits in urine and feces for lengthy periods at a time. He added that he/she now wears a brief so the bed does not get soiled. When asked by the surveyor as to the last time he/she was changed, the resident stated that it was sometime around 5:30 AM. During a interview with the 2 nursing assistants caring for the resident they informed the surveyor that the night staff changes the resident before they arrive.

A review of a recent staff inservice, dated

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02/15/2012 relative to answering call lights, indicated that all call lights are to be answered within 3 to 5 minutes. Additionally, the inservice noted that when someone puts their call light on, staff are to ask them what they need and proceed to answer based on their need. However, while at the nursing station on 2/20/2012 at approximately 8:00 AM and 9:45 AM, the surveyor observed resident ID #5's call light on and no one responding to the light for 12 to 15 minutes.

At approximately 10:00 AM on 2/20/12, the resident received a shower. After receiving a shower, the resident stated that he/she was wearing a brief. On this same date at 3 PM the surveyor requested the resident be put back to bed. Observation of the resident at this time revealed the resident's brief was not only wet, but there was feces in the brief. During an interview with the nursing assistants caring for the resident at this time, they stated they had not changed him as he did not ask them to.

During subsequent interviews on 2/20/12 at varied times with nursing staff, including the Director of Nursing, no one was able to determine if the resident was truly incontinent due to physiological reasons or due to waiting for help.

2. Record review revealed a 1/20/12 MDS for resident ID#3 who reside on the West A unit. The MDS documents the resident scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS), and requires extensive assistance for toileting and is always continent of bowels.

Review of the February 2012 Resident Functional

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F 310	Continued From page 59 Performance record documents six occasions when the resident had bowel incontinence episodes and was then given the bed pan. During interview on 2/20/12 at approximately 3:00 PM the resident stated he/she was wearing an absorbent brief because, at times, it takes staff too long to come when he/she uses the call light for assistance with toileting (use of a bed pan). The resident stated this causes bowel incontinence. Following the interview the resident was observed to be wearing a brief.	F 310		
F 313 SS=E	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based upon surveyor observation, record review and staff and resident interviews it has been determined the facility failed to provide assistive devices to maintain hearing and vision abilities for 1 of 1 sample residents with a hearing aid (ID #) and 2 of 4 sample residents with glasses, (ID #'s 15 & 16). Findings are as follows:	F 313		

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F 313	Continued From page 60 1. Resident ID# 15 resides on the East A unit of the facility. A review of the resident Minimum Data Set (MDS) dated 12/05/2011 indicates the resident hears adequately with a hearing aid. A review of the comprehensive assessment for this resident indicates the resident hears adequately with the use of a hearing aid and a decision was made to develop a care plan relative to the need for the hearing aid. A review of the resident's care plan, initiated on 7/21/2011 indicated the resident is hard of hearing in the right ear. The goal of the plan is for the resident to be able to communicate effectively and respond correctly. The approach to the plan is for nursing to place the hearing aid in the right ear every morning. Additionally, a physician's order dated 2/03/2012 specifies, insert hearing aid in AM, remove at night. Observation of the resident, on 02/21/2012 at 8:45 AM, revealed the resident sitting in a chair in her room, AM care had been completed and the resident was eating breakfast without the hearing aid in place. At 9:05 AM on 02/21/2012, the surveyor attempted to interview the resident. At this time the resident was observed without the hearing aid in place and stated, "I can't hear you". The surveyor spoke louder and questioned the resident if she usually has the hearing aid in place, and the resident responded, "No". Additional observation on 2/21/20102 at 9:45 AM revealed the resident in the therapy room receiving therapy without the hearing aid.	F 313		

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Although the above findings were brought to the attention of the unit manager and the nursing assistant caring for the resident on 2/23/2012 at 7:45 AM, observation on 2/24/2012 at approximately 7:45 AM revealed the resident out of bed, dressed. and again without the hearing aid. During an interview on this date and time with the nursing assistant/medication technician who cared for the resident this AM, she stated she was unaware the resident needed her hearing aid.

This resident's MDS also indicates she sees adequately with glasses. A review of the resident's comprehensive assessment dated 12/05/2011 indicates she is in need of glasses due to extensive assistance with most areas of self care. A decision was made to develop a care plan relative to the resident's need for glasses.

Review of the resident's care plan initiated on 12/16/2010, indicates the resident requires extensive assistance with most areas of self care and with functional mobility. As an intervention to address these concerns, the resident is to wear glasses. Observations of this resident, on 2/21/2012 at 8:45 AM, noted the resident sitting in her chair eating breakfast without her glasses on.

During an interview with the nursing assistant caring for the resident on 2/21/2012 at approximately 9:35 AM, she stated in order to know what the resident needs, they receive report from the nurse and also refer to the nursing assistant's Kardex. A review of the current nursing assistant's Kardex indicates the resident is to wear glasses.

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F 313	Continued From page 62 Additional observation, on 2/21/20102 at 9:45 AM, revealed the resident in the therapy room receiving therapy without glasses. On 2/22/2012 from 8:00 AM to 8:30 AM, the resident was observed up in her chair after receiving AM care without glasses on. On 2/22/12 at approximately 9:35 AM, the medication technician and the nursing assistant caring for the resident stated they were unaware the resident wore glasses. On 2/23/2012 at varied AM and PM times, the resident was observed without glasses. The surveyor interviewed the resident on 2/23/2012 and the resident informed the surveyor that the glasses were in the drawer, but that they could not reach by the resident. 2. Resident ID# 16 resides on the East A unit of the facility. A review of the resident's annual MDS dated 11/14/2011 and the quarterly MDS dated 2/13/2012 indicates the resident has impaired vision and requires glasses. A review of the resident's comprehensive assessment dated 11/14/2011 indicates the resident has visual problems and sees adequately with glasses. Based on the assessment a decision was made to develop a care plan. This resident's 5/01/2011 care plan indicates the resident has diabetes and at risk for visual changes. A review of the nursing assistant's Kardex which indicates how the nursing assistants are to care for residents, fails to note that the resident wears glasses.	F 313		

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F 313	Continued From page 63 Observation on 2/22/2012 at 8:25 AM, revealed the resident without glasses. During interview at 8:30 AM with the nursing assistant who routinely cares for the resident, she stated the resident does not wear glasses. During interviews with both the unit manager and the nursing assistant caring for the resident on 2/22/2012 at 8:35 AM both indicated that they were unaware the resident wore glasses. Observations on 2/22/2012 at 9:35 AM and 10:00 AM revealed the resident without her glasses. During interview with the Medication Technician on 2/22/2012 at 9:35 AM, she stated , "I have never seen her with glasses".	F 313		
F 314 SS=I	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, staff and resident interviews, it has been determined that the facility failed to provide necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for 3 of 9	F 314		

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residents reviewed with pressure ulcers (ID# 4, 7, 29) and 4 of 10 residents reviewed at risk for pressure ulcers (5, 14, 15, 33), on 3 of 4 units.

Findings are as follows:

1. Non-Sample resident ID #29, residing on East B unit, was admitted to the facility on 1/5/2012 from the hospital with a necrotic left heel (according to the resident's physician) after undergoing surgery for a fracture of the left hip.

Closed record review indicates the 1/5/2012 Brief Nursing Evaluation Form has no documentation of skin breakdown on the feet. Additionally, the admission note and admission assessment do not provide documentation of any skin breakdown on the feet. A 1/6/2012 nurses' note from the 11 PM-7 AM shift, written by the nurse who did the 1/5/2012 admission note states, "left heel slight mushy, redness- necrotic...Right heel redness..Skin Prep applied." Continued record review reveals no physician orders, for treatment of the necrotic left heel, were obtained until 1/18/2012.

On 1/6/2012, the resident was seen by the attending physician, and an order was written for a podiatry consult. The resident also had a 1/6/12 order for weekly skin assessments. No orders for the heel were noted. The attending physician visited the resident on 1/13/2012, and again there were no treatment orders written for the necrotic heel.

On 1/14/2012, the 7 AM-3 PM nurse documented, "Left heel necrotic blister...Skin Prep applied."

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F 314	Continued From page 65 On 1/16/2012, a care plan was initiated that identified the resident at risk for skin breakdown related to impaired mobility secondary to the left hip fracture and cardiac disease. The interventions included a pressure reducing mattress and skin observations for signs/symptoms of potential skin breakdown to be done on every shift. Although this care plan was initiated on 1/16/2012, no physician's order was obtained for heel treatment until 1/18/2012 (13 days from admission). No measurements of the heel were documented until a late entry note was written on 1/18/2012 for the assessment on 1/17/2012. The note states, "Paged MD re: resident's left heel opening and draining blood. Measured 2 X 2 cm with boggy center. Right heel small .5 cm X .5 cm necrotic area. See new orders." The new orders were not obtained on 1/17/2012 after the assessment. Santyl topical was ordered to left heel daily and Skin Prep to right heel daily on 1/18/2012. There is no evidence, from 1/5/2012 to the 3 PM-11 PM shift on 1/18/2012, that the heels were protected from pressure. On 1/18/2012, the care plan was reviewed and revised with the plan stating, "float heels while in bed", and provide air mattress. On 1/19/2012, the Pressure Ulcer Documentation Form for the left heel indicates an unstageable 5 cm x 5 cm (centimeter) broken blister. It incorrectly reports the onset as 1/19/2012, rather than 1/6/2012.	F 314		

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F 314	Continued From page 66 On 1/19/2012, a Pressure Ulcer Documentation Form indicates a 1 cm x 1 cm unstageable area on the right heel which on admission had been reported to be "red". The weekly skin assessment on 1/20/2012 incorrectly documents the skin as intact. On 2/10/2012, the attending physician wrote a second order for the podiatry consult due to "original order 1/6/12 (resident) has not been seen yet." During an interview on 2/24/2012 at 7:55 AM, the staff development nurse stated the podiatrist had been in the building on 1/16/2012 and 2/10/2012. Despite this, the resident was not seen by the podiatrist until 2/13/2012. During an interview on 2/24/2012 at 10:00 AM, the attending physician stated the resident had been admitted to the facility with the area on the left heel. He stated the resident had vascular disease but pressure contributed to the development of the wound on the resident's heel. He further stated pressure relief would have been indicated for the heels. The physician stated the podiatry consult was ordered due to the skin breakdown on the resident's foot. Review of the facility's policy, dated January 2010, "War on Wounds, Program, Identifying and Reporting Pressure Ulcers", states: "Any new skin issue is an 'incident' which requires an investigation to determine the root cause." It further specifies, "Complete a Pressure Ulcer	F 314		

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Documentation Form to document the status of the pressure ulcer.
-Assess and document the pressure ulcers at least weekly.
-Document only one area or site per form.
-Determine the stage of the pressure ulcer.
-Measure the pressure ulcer-length X width X depth.
Notify the physician ...and collaborate on a treatment order..."
The policy further states, "When a pressure ulcer has been identified, reported and investigated, a licensed nurse completes a thorough evaluation to determine appropriate treatment and updates to the resident's plan of care."

During interview with the ADNS on 2/24/2012, she stated that pressure ulcers should be measured upon discovery, documented on the Pressure Ulcer Documentation Form and upon discovery of breakdown on the heels, pressure relief, such as offloading the heels with pillows should have been instituted. She was unable to provide evidence that the resident had had his/her heels floated while in bed from 1/5/2012 until the 3-11 shift on 1/18/2012. Additionally, she was unable to provide evidence of wound treatment before 1/18/2012 when the Santyl was ordered.

2. Review of Resident ID #7's record, who resides on the East B unit, revealed the resident was readmitted to the facility on 2/16/2012 with a necrotic left heel. Review of nurses notes dated 2/16/2012 revealed "...noted left outer heel 2.5 cm x 2.5 cm necrotic area...pink in the middle...no evidence of pain...". Review of Pressure Ulcer Documentation Form dated 2/16/2012 revealed,

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"... unstageable left heel pressure ulcer 2.5 cm x 2.5 cm with necrotic wound bed...no evidence of pain...". Further review revealed a physician's order dated 2/17/2012 (3 PM) for "Skin Gel Protect Dressing Wipe Pad apply to left heel 3-11 shift", and a second order on 2/17/2012 (4 PM) for "Skin prep to left heel ...Prevalon boots while in bed."

On 2/22/2012 at approximately 11:00 AM, two surveyors and a Licensed Practical (agency) Nurse (LPN), observed Resident ID # 7 in bed with air inflated boots on the resident's feet and lower legs. When the surveyor questioned the agency nurse if this resident had a heel ulcer she initially responded "no". Subsequently, she retracted her statement and indicated that she had worked the previous evening (2/21/2012) and recalled applying "Hydrogel" to the resident's left heel. The surveyors observed the heel section of each air filled boot was open and both heels were resting on the mattress. The surveyors observed the resident grimace when the agency nurse removed the air filled boot from the left lower leg . When the LPN asked the resident if he/she had pain, the resident responded "yes" and rated his/her pain level as 5 out of 10. The LPN medicated the resident for pain and continued to measure the left heel pressure ulcer at 3 cm x 3 cm.

During an interview with the Assistant Director of Nurses (ADNS) on 2/22/2012, she indicated that the current treatment for this heel ulcer was "Hydrogel". Additionally she confirmed the air filled boots that were in use were not the Prevalon boots ordered by the physician. She further indicated Prevalon boots have a cloth texture and

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were blue in color. During this interview with the ADNS, the alert and oriented resident stated, " I never had blue boots ."

During an interview with the nursing assistant caring for this resident, she stated she was unaware this resident was to have Prevalon boots.

Review of this resident's "Pressure Ulcer Documentation Form" dated 2/22/2012 revealed an assessment completed by the ADNS indicating a worsening of the heel,."unstageable left heel pressure ulcer 3 cm x 3 cm ...necrotic wound bed ...wound related pain when touched". Review of nurses' notes dated 2/22/2012 (8 PM) revealed "...treatment to left heel changed to skin prep every shift ...".

During a follow-up interview with the ADNS on 2/23/2012 at approximately 8 AM, she indicated Resident ID # 7 physician's order of 2/17/2012 had been incorrectly entered into the resident's electronic medication record as "skin gel" and should have been entered as "skin prep". Therefore, the Hydrogel, which was previously stated by the ADNS (on 2/22/2012) to be the treatment, was the not the correct treatment.

3. Resident ID #4 resides on the East B unit of the facility. A review of ID# 4's annual comprehensive assessment dated 1/13/2012, indicates there is a potential for skin breakdown relative to limited mobility and fragile skin.

A review of the resident's 1/23/2012 care plan indicates that the resident's skin requires weekly checks and observed every shift for signs and

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symptoms of potential skin breakdown.

Surveyor observation on 2/22/2012 at 9:05 AM, in the presence of the Assistant Director of Nursing (ADNS), revealed the resident lying in bed with both heels resting directly on the mattress. Further observation revealed that the resident had right and left reddened boggy heels. At the surveyor's request, the heels were offloaded for approximately 20 minutes. An observation at 9:25 AM immediately after offloading the heels, revealed the resident's left heel remained boggy, red and non-blanchable (does not change color when pressed) indicating the heel to be at risk for a pressure ulcer. Once brought to the attention of the ADNS by the surveyor, an order for Skin Prep to the heels was obtained.

4. Resident ID #15 resides on the East A unit. Review of the comprehensive assessment indicates the resident was assessed as being at risk for altered skin integrity, relative to urinary incontinence, a need for assistance with mobility and the use of 5 or more medications. A review of the 12/16/2012 care plan states pressure relieving /reducing devices as ordered. The February 2012 physician order relative to pressure relief specifies the resident's feet are to be elevated when in bed by floating in air or heel protectors.

Observation of the resident on 2/21/2012, at 8:10 AM and 8:30 AM, revealed the resident lying in bed with heels resting directly on the mattress. Observation of the resident on 2/22/2012, at 7:05 and 7:20 AM, revealed the resident lying in bed with heels resting directly on a pillow. On 2/22/2012 at 7:25 AM, Although the unit manager

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was brought into the resident's room to observe the resident's heels lying directly on the pillow, on 02/23/2012 at 7:00 AM, the resident was again observed, by the surveyor, in bed with heels resting on the mattress.

During all above observations, the resident's heels were not noted protected by floating in air or with heel protectors as ordered.

5. Record review of resident ID #14, residing on the West A unit, revealed s/he was identified as being at risk for pressure relative to dementia, incontinence and poor mobility. A 1/13/2012 pressure ulcer care plan indicated the resident's heels will be free floated when the Prevalon boots are being laundered. On 2/12/2012, physical therapy recommended L'nard boots for pressure relief. On 2/12/2012 an order was faxed to the physician for the L'nard boots. The nurse documented "awaiting return fax."

The resident was observed by the surveyor at multiple times on 2/19/ 2/20, 2/21, 2/22, and 2/23/2012 at 8:30 AM, without the L'nard boots. Further record review indicated the attending physician had not signed the order for the L'nard boot until 2/22/2012.

It was not until 2/23/2012 at 8:45 AM that the physical therapist was observed by the surveyor delivering the L'nard boots to the resident.

6. Resident ID #5's resides on West A, and review of the comprehensive assessment, dated 12/12 2011, indicates the resident is at risk for pressure ulcers due to morbid obesity, limited self mobility and dependence on others for toileting.

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Based on the assessment, a decision was made to develop a care plan for potential skin breakdown. A review of the resident's current 12/12/2011 care plan states that in order to prevent a breakdown in skin integrity, the resident's skin is to be kept dry.

Although a review of a recent inservice dated 2/15/2012, relative to answering call lights, indicated that all call lights are to be answered within 3 to 5 minutes, while at the nursing station on 2/20/2012 from approximately 8:00 AM to 9:30 AM, the surveyor observed resident ID# 5's call light on and no one responded to the light for 12 to 15 minutes. At 9:40 AM, upon request of the surveyor, the resident was returned to bed and was observed in a wet, foul smelling brief.

During an interview with the resident on this same date and time, s/he informed the surveyor that the 11 PM to 7 AM staff had put the brief on him/her at 5:30 AM. S/he further stated that it had not been changed since then.

During an interview with the two nursing assistants caring for this resident on 2/20/2012, they informed the surveyor that they had not changed the resident's brief this AM as the night staff does his AM care.

At 2:50 PM on 2/20/2012, the resident informed the surveyor that s/he has a brief on and it has not been changed since about 10:00 AM, after the resident had received a shower. S/he further stated no one cares and staff do not answer call lights quickly enough and, "you end up going in your brief".

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On 2/20/2012 at 3:00 PM, again at the request of the surveyor, the resident was returned to bed and was observed wearing a wet brief soiled with feces. The surveyor interviewed the two nursing assistants caring for this resident at this time and they stated they had not changed the resident since about 10:00 AM as s/he had not requested to be changed.

On 2/21/2012 at approximately 7:00 AM, the surveyor interviewed the 2 nursing assistants working on the 11 PM to 7 AM shift. They each separately informed the surveyor that they provide personal care at 5:30 AM. When further asked if the resident is incontinent they answered that he is usually incontinent of feces.

7. Record review revealed that resident ID #33, who resides on West A, has diabetes. On 2/10/2012, the podiatrist saw the resident and recommended:

Lac-Hydrin 12% lotion to dry skin of feet...except between toes, once every other day times 60 days to prevent skin breakdown/ infection. Skin prep, once daily for 14 days to the posterior heels, and off-loading the heels while in bed.

However, it was not until 2/15/2012 that an attending physician's order was obtained for the above recommendations.

On 2/20/2012 at 9:30 AM, the resident was heard telling the nurse on the unit that s/he had not been getting the treatment to the feet as recommended by the podiatrist and the feet were, "sore at night".

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F 314	Continued From page 74 Review of the treatment record on 2/20/2012 revealed the Lac Hydrin 12% lotion was not provided from 2/10/2012 (when the podiatrist recommended the lotion) to 2/18/2012 (three days following the attending physician's order). Also the skin prep was not being applied as the podiatrist recommended. It was applied three times per day on 2/15, 2/18, 2/20 and two times per day on 2/16, 2/17, 2/19/2012. During an interview on 2/23/2012 at 8:55 AM, the resident's feet were observed in the presence of the nurse. The resident complained his/her left heel hurt. S/he was observed with dry skin on both heels. During this interview the nurse was unable to produce evidence that the Lac-Hydrin lotion was provided as ordered till 2/18/2012. During an interview on 2/24/2012 at 8:30 AM, the nurse confirmed the resident had not received the skin prep as ordered. She further indicated that the facility incorrectly continued to have the skin prep scheduled for three times per day when it should have been applied once a daily for 14 days.	F 314		
F 315 SS=H	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		

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This REQUIREMENT is not met as evidenced by:
Based on surveyor observation, record review and interviews with the resident and staff, it has been determined that the facility has failed to ensure that a resident who is continent receives the necessary care and services to prevent incontinence for 1 of 1 pertinent residents, ID #5.

Findings are as follows:

Resident ID #5 resides on the West A unit of the facility. A review of the resident's initial Minimum Data Set (MDS), a screening tool, dated 12/12/2011, indicates the resident needs extensive assistance of two activities of daily living. The MDS also indicates that upon admission to the facility on 11/27/2011, the resident was always continent of urine.

The comprehensive assessment for this resident relative to toileting indicates that the resident needs extensive assistance. The assessment further indicates the resident is suffering from inability to transfer and be mobile on his/her own due to severe lumbar stenosis affecting him/her in a functional way. S/he is able to communicate needs to the caregivers, so s/he is not incontinent. He is transferred to and from the toilet by two assistants most often. A decision was made to not develop a care plan.

A review of the nursing assistant Kardex, currently being used by the nursing assistants who care for the resident, indicates the resident is continent. A review of a Care Plan Conference

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Summary which occurred on 12/06/2011 indicates, "resident requesting to be in/out bed to toilet".

Although, a review of a recent inservice dated 02/15/2012 relative to answering call lights, indicated that all call lights are to be answered within 3 to 5 minutes, while at the nursing station on 2/20/2012 from approximately 8:00 AM to 9:30 AM, the surveyor observed resident ID #5's call light on and no one responding to the light for 12 to 15 minutes.

On 2/20/2012 at 10:00 AM, this alert and oriented resident in the presence of the surveyor and two nursing assistants complained that staff do not answer call lights in a timely manner and s/he sits in his urine for lengthy periods at a time. The resident indicated an incontinence brief is worn as it takes too long for staff arrive "and you have accidents". Additionally, the resident stated, "They do not care about you here." When asked by the surveyor as to the last time the resident had last been changed, the resident stated that it was sometime around 5:30 AM.

A review of the February 2012 Resident Functional Performance Record relative to bladder function indicates the resident was incontinent of urine on 02/012012 through 02/10/2012 and again on 02/10/2012, 02/13/2012, 02/16/2012 and 02/20/2012 on the 3 PM to 11 PM shift. When the surveyor asked for the Functional Maintenance records for December 2011 and January 2012, staff were unable to locate them.

During interview on 2/20/2012 at 7:00 AM with

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two nursing assistants who care for this resident, both stated that he is usually continent. Interview at 7:30 AM with the 11 PM to 7 AM nurse who floats to this unit, revealed she was aware of the resident's incontinence. During an interview with a nurse on the unit on 2/20/2012 at 9:30 AM, she stated that she was aware of the resident's incontinence, but that he is also continent at times.

In order to ensure that the resident's highest function is maintained, on 2/20/2012 at 10:05 AM the unit manager informed the surveyor that it is the responsibility of nursing to review the nursing assistants' Flow Records to assess for changes in the resident. Although this is the system utilized to identify changes in the resident's functional status, the facility has failed to consistently assess the resident's continence status.

Additionally, at approximately 10:15 AM on 2/20/2012 during an interview with the former Director of Nursing, she stated that during morning meetings any changes in a resident's functional status are discussed, i.e. incontinence, pressure ulcers, etc. When asked if resident ID #5 was ever discussed relative to recent bladder incontinence, she stated she could not recall.

On 02/20/2012 after informing the Director of Nursing of the above, she instituted a Bowel and Bladder Continence Evaluation. A review of the evaluation revealed the resident was incontinent of bladder on 2/20/2012 at 2 AM and 5 AM. On 2/21/2012 at 9 AM and 2 PM the resident was wet. On 2/22/2012 at 9 AM and 2 PM the resident was wet.

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F 315	Continued From page 78 During a subsequent interview with the Director of Nursing she stated she was not quite certain as to why the resident was incontinent.	F 315		
F 318 SS=H	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review and interviews with staff and the resident, it has been determined that the facility failed to ensure that residents entering the facility with a limited range of motion, and the use of assistive devices, receive appropriate treatment and services to prevent further decrease in range of motion for 1 of 4 sample residents that use assistive devices, resident ID# 16. Findings are as follows: 1. (A) A review of resident ID# 16's Annual MDS dated 11/14/2011 indicated the resident was admitted with a functional limitation in range of motion on one side of the upper extremity. A review of the comprehensive assessment for this resident indicates s/he requires extensive assistance with activities of daily living and s/he	F 318		

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has balance problems during transfers.

Review of therapy notes on 11/15/2010 indicate the resident was admitted with left sided weakness due to a right cerebral vascular accident. Therapy notes dated 12/15/2010 indicate staff were educated in use of the splint (comfy splint) and a restorative program was established with the nursing assistants. As part of this education, nursing assistants were informed that the comfy splint was in place to help prevent contractures.

A physician's order dated 11/30/10 specifies that the resident may wear the splint as tolerated.

Occupational Therapy notes dated 07/11/2011 indicate the resident was again evaluated for use of the comfy splint. The plan was for the resident to continue to wear the comfy splint as tolerated, for tone and contracture management. An 8/22/2011 occupational therapy progress note indicates as a consequence for not wearing the upper extremity orthotic, the resident will experience an increase in spasticity, decreased muscle tone and an increase in contractures.

A review of the care plan initiated for this resident on 5/01/2010 to the present time, indicates the resident requires assistance with activities of daily living. The plan further indicates the resident will need help with wearing the comfy splint. The plan is for the resident to wear a comfy splint at hour of sleep and remove it in the AM as tolerated.

The resident was observed on 2/21/2012 at 7:00 AM lying in bed without the comfy splint on.

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During an interview on 2/21/2012 at approximately 8:30 AM with the nursing assistant who usually cares for this resident, she stated the resident sometimes refuses to wear the comfy splint. However, during further interview the nursing assistant stated that she has not seen the splint on the resident in quite a long time.

On 2/22/2012 with the help of a nursing assistant as an interpreter, the resident stated that no one has put the splint on in a long time. An interview on 2/22/2012 in the AM with a nursing assistant who has worked in this facility for 9 years, revealed that she was unaware the resident wore an arm splint. At approximately 8:45 AM the surveyor interviewed the unit manager who was unaware the resident was to wear the comfy splint.

On 2/22/2012 the resident was evaluated by the Occupational Therapist who informed the surveyor that the splint was too big for the resident and a new splint would be ordered. The therapist further stated that the resident has had a functional decline in range of motion to her left upper extremity.

Interviews with the Rehabilitation Manager and the Occupational Therapist on 2/22/2012 revealed they were unaware the resident was not wearing the comfy splint. They informed the surveyor they had not been asked to evaluated the resident for use of the splint. They further added the resident should be receiving passive range of motion to her left upper extremity whether she wore the splint or not. Record review and interviews with staff revealed no evidence of any range of motion exercises for this

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resident.

(B) Additional review of the Annual MDS dated 11/14/2011 indicates the resident was admitted with a functional limitation in range of motion on one side of her lower extremity as well. A review of the comprehensive assessment for this resident indicates she requires extensive assistance with activities of daily living and she has balance problems during transfers.

A review of the nursing assistants' Kardex currently used to inform nursing assistants of the residents' needs incorrectly indicates the resident is to wear a a right orthotic device on her lower extremity for ambulation.

A review of a recent Occupational Therapy note dated 2/20/2012 indicates the resident's left ankle exhibits a decline in range of motion, decreased level of independence with transfers and ambulation. The note further indicates that failure to provide physical therapy could result in repeated falls.

During several observations of the resident on 2/21/2012 at 8:10 AM and on 2/22/2012 at 8:30 AM and again at 10:45 AM while being ambulated with staff to the bathroom, the resident was observed without the orthotic device. At this same date and time the surveyor asked the nursing assistant when the resident uses the brace. The nursing assistant informed the surveyor that the resident had complained to her a few months ago that the brace hurt and she had informed the nurse. During interview with the resident with the same nursing assistant as an interpreter, the resident stated s/he has not worn

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F 318	Continued From page 82 the brace for some time. On 2/23/2012 at 2 PM the Rehabilitation Manager informed the surveyor that staff had requested a new evaluation for this resident as staff has noted a decline in the resident's ability to transfer. Additionally, she stated the resident had a recent fall on 2/16/2012. A review of the 2/23/2012 therapy evaluation for this resident indicates that the resident's left ankle exhibits a decline in range of motion, decreased lower extremity strength and a decrease in her level of independence.	F 318		
F 319 SS=H	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, it is determined the facility failed to ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriated treatment and services to achieve and maintain the highest level of mental and psychosocial functioning for 1 relevant residents (ID # 8). Findings are as follows: 1. Record review revealed that resident ID #8 was	F 319		

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admitted to the facility on 12/12/2011 with diagnoses of Bipolar Disorder and Schizoaffective Disorder. Review of the Minimum Data Set (MDS), dated 12/18/2011, indicated the resident exhibited no behaviors. Review of the resident's care plan dated 12/23/2011 revealed the resident has "feelings of anxiety and depression...characterized by ineffective coping...and non-compliance related to shizoaffective and bipolar disorders". Review of the MDS also revealed that the resident was frequently incontinent and required assistance with toileting.

Upon further review of the record it was revealed that the resident displayed multiple episodes of refusing assistance with hygiene after experiencing incontinence in her room.

Nursing notes documenting the resident's incontinent episodes and exhibited behavior include:

12/16/2011- "CNA (Certified Nursing Assistant) offered three times to assist with washing and PM care but resident refused. Resident stated s/he knew her rights and that s/he didn't have to wash if s/he didn't want to."

12/18/2011- "refuses assistance with perineal care...very poor hygiene, encouraged to wear a brief ... incontinent of urine all over the floor."

12/18/2011- "Hygiene to peri area offered and refused by resident."

12/23/2011- "...refuses care from CNA's."

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F 319	Continued From page 84 12/24/2011- "...Still refuses care/hygiene assistance from CNA's for wet briefs." 12/27/2011- "Still refuses CNA assistance with personal hygiene." 12/28/2011- "...refuses CNA care for hygiene." 12/29/2011- "...not wanting assistance from CNA for hygiene..." 1/4/2012- "...refusal of hygiene care from CNA's." 1/11/2012- "Resident saturates self and bed but refuses care from CNA's for hygiene assistance. Will continue to monitor." 1/12/2012- "Refuses hygienic care from CNA's even after incontinence..." 1/20/2012- "Resident was found in room asleep in chair completely naked with urine pooled on the floor..." 1/25/2012- "Resident is followed for...increased incontinence...will follow up with MD for new recommendations related to incontinence." 2/8/2012- "CNA's have observed the resident urinating on the floor in room and sitting on the side of bed having a BM on the floor. Resident has been educated on the importance of requesting staff to assist to the bathroom". Review of resident's care plan revealed that mental and psychosocial adjustment difficulties relative to voiding in inappropriate areas was never addressed. Record review of Psychiatric	F 319		

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F 319	Continued From page 85 Diagnostic Consultations dated 1/26/2012, 2/3/2012 and 2/8/2012 reveal no evidence that the resident's behaviors have been addressed. The note dated 2/8/2012 specifically states, "no recent behavior issues noted". Review of the Social Services notes dated 12/14/2011 reveal that ID # 8 has been "in and out of several nursing facilities over the past 5 years". Additional review revealed no evidence that the resident's behaviors relative to incontinence had been addressed. When interviewed on 2/23/2012 at 9:00 AM, the social worker (SW) revealed that although she was aware of ID #8's behavior, she addressed it with the nursing staff as a concern only in relation to keeping the resident's environment clean and not in relation to the behavioral problem. There is no evidence that resident ID #8's optimal mental or psychosocial function had been assessed on an ongoing basis from the time of her admission. Behaviors have not been addressed, assessed, nor a plan of care developed for the resident since the time of admission.	F 319		
F 323 SS=E	Refer Tag F250 Medically Related Social Service 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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.	F 323		

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This REQUIREMENT is not met as evidenced by:
Based on surveyor observation, record review and staff interview, it was determined that the facility failed to provide assistive devices to prevent accidents for 2 of 5 sample residents who are at risk for falls, resident's ID#'s 15 & 16.

Findings are as follows:

1. Resident ID #16 has a history of a stroke with left sided weakness and recent falls. The resident's care plan calls for use of an ankle/foot orthotic, (AFO-a type of brace), to be worn on the left lower extremity when ambulating. A review of the comprehensive assessment for this resident indicates s/he requires extensive assistance with activities of daily living and s/he has balance problems during transfers.

A review of the nursing assistants' Kardex currently used to inform nursing assistants of the resident's needs incorrectly indicates the resident is to wear a right orthotic device on the lower extremity for ambulation.

A physical therapy evaluation conducted on 2/23/2012, (subsequent to a witnessed fall on 2/16/2012), revealed a decrease in range of motion of the left ankle. Interview with the Rehab Manager and Occupational Therapist on 2/23/2012 revealed they were unaware that the resident was not wearing the AFO and that failure to ensure use of the AFO puts the resident at risk

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F 323	Continued From page 87 for future falls. During several observations of the resident on 2/21/2012 at 8:10 AM and on 2/22/2012 at 8:30 AM and again at 10:45 AM while being ambulated with staff to the bathroom, the resident was observed without the orthotic device. At this same time the surveyor asked the nursing assistant when the resident uses the brace. The nursing assistant informed the surveyor that the resident had complained a few months ago that the brace hurt and she had informed the nursing staff. During interview with the resident and this same nursing assistant as an interpreter, the resident stated s/he has not worn the brace for some time. A review of the 2/23/2012 therapy evaluation for this resident indicates that the resident's left ankle exhibits a decline in range of motion, decreased lower extremity strength and a decrease in her level of independence. 2. Resident ID # 15 is at risk for falls. The plan of care, initiated on 12/16/2010, indicates the resident should have a reacher at all times. Surveyor observation on 2/21/2012 at 2:45 PM, 2:50 PM and 4:00 PM revealed that the resident did not have the reacher. A care plan intervention initiated on 9/2/2011 calls for non-skid strips on the floor in front of the resident's chair. Surveyor observation on 2/21/2012, at the times noted above, revealed that the resident's chair was positioned in such a way that the non-skid strips were not in front of the chair, so that if the resident were to stand, the strips would not be under the resident's feet.	F 323		

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F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		

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.

This REQUIREMENT is not met as evidenced by:
Based upon record review and staff interview it was determined that the facility failed to ensure that a resident maintain acceptable parameters of nutritional status, such as body weight, for 1 of 20 sample residents (ID #1).

Findings are as follows:

Record review of resident ID #1, who resides on the East A unit, reveals the resident is at risk for weight loss secondary to advanced dementia and muscle weakness. A Minimum Data Set dated 12/6/2011 revealed the resident has sustained a significant weight loss. Review of the resident's Weights and Vitals Summary sheet revealed the following weights:

On 1/16/2012 the residents weight was 216.9 lbs.
On 1/24/2012 the residents weight was 186 lbs.

Further clinical record review lacked evidence

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F 325	Continued From page 89 that the dietician was notified of the resident's significant weight loss of 14.2%. When interviewed on 2/20/2012 at 3:35 PM, the dietician acknowledged that the facility failed to notify her until 2/16/2012. When notified of the significant weight loss, the dietician wrote recommendations on 2/17/2012 to include a re-weigh that evening and add fortified pudding to the resident's diet. There is no evidence in the clinical record that a re-weigh was obtained on 2/17/2012 as requested. A review of calorie counts done on 2/21/2012-2/23/2012 does not reveal any evidence that the resident received the fortified pudding. On 2/20/2012, surveyor asked the nurse manager to weigh the resident. At 12:00 PM, the resident's weight was 183 lbs.	F 325		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based upon record review and staff interview it was determined that the facility failed to ensure that residents are free of any significant medication errors relative to respiratory medication treatments, for 1 of 2 relevant residents observed, resident (ID # 31). Findings are as follows:	F 333		

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F 333	Continued From page 90 Resident ID #31, who resides on the East A unit, whose diagnoses include dementia and chronic airway obstruction, has a physician's order dated 7/21/2011 for a DuoNeb Inhalation Solution 0.5-2.5 (3) milligrams/milliliter, administer 3 milliliters every 6 hours via nebulizer. On 2/22/2012 at 1:50 PM, resident ID #31's wife was observed coming out of the resident's room and telling the nurse that "there is nothing coming out" (of the nebulizer) . The unit manager, who over heard the wife, instructed the nurse that she needed to remain with the resident during the treatment. The nurse was interviewed on 2/22/2012 at 1:50 PM and indicated that she had no knowledge that she needed to remain with the resident during the treatment nor has she ever remained with the resident. Review of the February 2012 Medication Record revealed that this nurse had administered the DuoNeb treatment to this resident 11 times. Interview with the nurse manager on 2/22/2012 at approximately 1:50 PM, revealed that the facility's policy is to remain with the resident when administering medication. Review of the in-service education a mandatory inservice training titled "when administering medications it is your responsibility to observe resident until all meds are taken."	F 333		
F 353	5 483.30(a) SUFFICIENT 24-HR NURSING STAFF	F 353		

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F 353 SS=I	Continued From page 91 PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident, staff and family interviews and surveyor observations, it has been determined the facility failed to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans for care for residents on 4 of 4 units. Findings are as follow:	F 353		

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From 2008 to the present time, the facility has appointed nine Director of Nursing Services (DNS).
In addition, there has been a succession of Assistant Directors of Nursing Services (ADNS), Unit Nurse Managers and Unit Charge Nurses. During this time, the facility has had four surveys identifying Substandard Quality of Care (SQC) which have included Immediate Jeopardy in 3 of the 4 surveys.

The residents and their families have complained during surveyors' interviews and via formal complaints filed with Department of Health that no one in the facility can answer their questions (due to inconsistent staffing).

During an interview with a resident on 2/22/2012, s/he stated, "they let the help run the place...they sold the store".

A) During the residents' group meeting held by the surveyor on 2/21/2012 at 11:00 AM, ten residents were present. Seven residents, representing East A, East B, West A & West B, reported problems with insufficient and inconsistent staffing.

The concerns expressed by these residents were:
1. East A unit short of staff
2. West A resident stated s/he needed a brief change and no one was available to do this, so the resident was left in soiled briefs for approximately 1.5 hours.
3. Three residents on East A were told, "You have to hold it...or just wait a minute, we'll be

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back." Residents stated they don't come back soon enough.

4. West B resident stated, "We need more staff on days and evenings, at least 1 more...and a 1/2 person on nights."

5. West A resident spoke of ratio of resident to staff stating, "If 30 residents are on a unit and only 2 staff, ...each have 15...not enough."

6. West A resident reported, "Waiting 2-3 hours for medication and then 2-3 hrs for pain medication."

7. East A resident, "Waiting for pain medication" while in pain.

8. East A resident being told to "go in your briefs at 3 PM at change of shift time" when requested to be changed.

9. Three residents reported "accidents when waiting too long", and this occurred when one of these residents was ill with a Gastrointestinal virus. Additionally they added, call lights often get answered right away but they are told to "Wait a minute. It's more than a minute... They don't come back soon enough."

10. East A resident stated there is no supervision of the Nursing Assistants, because "Nurses are very busy."

11. A resident stated, "They (the staff) don't come back soon enough to help. The unit is short of staff."

B) Multiple interviews with staff on all days of the survey revealed the following:

1. As surveyor walked down the hall, a nurse whispered "help". The nurse then stated staffing is "really bad"..."not enough nurses to do admissions, blood sugars and treatments."

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2. Two nurses on the same unit stated they could not keep up with all the medications and treatments. A review of the time sheet hours indicate, on this unit, there are 2 Nurses on the day shift. One is the Unit Manager/Charge Nurse and the other is the treatment nurse and medication nurse. Both administer medications, do treatments as well as supervise the Nursing Assistants. One of the nurses on this same unit on another day was visibly upset when speaking to the surveyor as she could not get her assignment done.

3. During an interview with a nurse on 2/22/12, she stated she had trouble getting things done and has to "ask the charge nurse for help". Furthermore, if the unit is short one nursing assistant (NA), she also needs to help the NA staff with their assignments, turning residents in bed, repositioning them, and transferring residents out of bed.

5. An NA stated there are usually are four NA's on her unit for 33 to 36 residents. Some days only 3 NAs are on. The nurse on this unit joined in the interview and stated, "Like today, I'm trying to get my work done and help the NAs." Additionally, she added when asked about pressure ulcer assessments and treatments, "There is no wound specialist nurse in the facility." The unit nurses are responsible for the wound assessments including measurements and all daily wound treatments.

6. During an interview with two NA's, they stated it takes "45 minutes to an hour to care for someone who is totally dependent and requires a Hoyer lift transfer". They continued to note there are approximately six residents on the unit who require mechanical lifts. "We need 2 people just for these transfers."

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7. When the Social Worker was questioned about the volume of issues with residents to be dressed, she stated she has been overwhelmed and overworked. She has been the only full time Social Worker for 115 (census on entry on 2/19/2012) residents in a facility with a bed capacity of 131.

8. During an interview with an agency nurse, she stated as a float (works any nursing unit needed) she works 40 plus hours. "We do not have enough staff."

9. A nurse stated, "Too much agency because we can't keep people.....they don't stay."
Per the Administrator, told to a surveyor during the survey, 25 % of staff are from a Pool Agency.

10. Two NA's reported, "We try to change residents every 2 hrs... it's hard if we are only 2 of us...on the units with heavy care like West A and East B, it's more difficult to toilet and change residents on time."

11. A Treatment Nurse reported she was unable to complete her treatments on the unit. The facility then assigned a new nurse who was in orientation for only 2 days to complete the treatments.

C) Family interviews:

1. Interview with a resident's family member on 2/19/2012, reported not enough staff and that "s/he (the resident) sits in wet clothes."

D) Based on nurses reporting not having time to complete their shift assignment, a review of the computerized time cards for 2/17/2012 beginning with the 7 AM-3 PM shift and ending with the 11

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PM- 7 AM shift on 2/19/2012 was conducted and revealed the following hours worked in excess of the scheduled 8.5 hrs/shift in order to complete shift tasks/duties:

2/17/2012, 1st shift, LPN worked 10.25 hrs
RN Unit Manager worked 16.25 hrs

2/17/2012, 2nd shift, RN worked 10.75 hrs

2/17/2012, 3rd shift, RN worked 10.25 hrs

2/18/12, 1st shift, LPN worked 11 hrs

2/18/2012, 2nd shift, RN worked 10 hrs

2/18/2012, 3rd shift, RN worked 10.5 hrs
LPN worked 11 hrs

2/19/2012, 1st shift, LPN worked 10.25 hrs.
RN Unit Manager worked 16.75 hrs

2/19/2012, 2nd shift, RN worked 10.75 hrs

On all days of the survey, surveyors observed licensed nursing staff working later than the 8.5 required hours for a shift. They remained working beyond their scheduled time to either complete work assignments or to assist in staffing the next shift.

E) Surveyor observation of Resident ID #1 on 2/20/2012 revealed the breakfast tray had been placed in the dining room at 8:07 AM. The resident was brought into the dining room at 8:55 AM. The food was cold with eggs at 112 degrees F (Fahrenheit), cream of wheat 116 degrees F, coffee 116 degrees F and milk warm at 58

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F 353	Continued From page 97 degrees F. This resident requires total assistance with care and requires a Hoyer lift transfer. The surveyor observed four nursing assistants busy with other residents requiring the same level of care as they attempted to get these residents ready for breakfast also. Two of the nursing assistants were agency staff and were unfamiliar with the resident and the unit. REFER TO TAGS: F157, F224, F281, F282, F309, F310, F314, F315, F318, F 319, F325, F353, F490, F501, F520	F 353		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based upon surveyor observation, record review and staff interview it was determined that the facility failed to provide food prepared in a form designed to meet individual needs for 1 of 6 sample residents, relative to thickened liquids resident ID #11. Findings are as follows: Record review revealed resident ID #11's diagnoses include dementia and dysphasia. The resident was seen by a Speech Language Pathologist on 12/02/2011 who recommended honey consistency liquids. The resident had a	F 365		

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F 365	Continued From page 98 current physician's order for honey consistency liquids. Surveyor observation on 2/19/2012 at 9:25 AM revealed the resident eating breakfast. There was 4 ounces of apple juice and 4 ounces of cranberry juice on the tray. Neither liquid appeared honey thick. The resident was observed to eat the juices with a spoon. Both liquids mounded (pudding like) on the spoon. They did not pour when the surveyor tipped the glass. When the resident was questioned if she could drink the liquids, she stated she needed the spoon to get it out. An additional observation on 2/20/2012 at 12:15 PM revealed the resident drank approximately 2 ounces of cranberry juice with a straw. At 12:20 PM, in the presence of the nursing assistant, the juice was observed to quickly run off a spoon and coat the side of a cup when the cup was tipped. The nursing assistant stated that the juice was nectar thick. During interview at 12:32 PM, the Speech Language Pathologist confirmed that the cranberry juice was nectar thick, instead of honey thick.	F 365		
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was	F 387		

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F 387	Continued From page 99 required. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it has been determined that the facility has failed to ensure that residents are seen by a physician at least every sixty days for 1 of 20 sample residents (ID #14). Findings are as follows: 1. Record review for ID #14 revealed no evidence of physician visits from 9/3/2011 to 2/22/2012. When interviewed on 2/23/2012 at 9:25 AM the unit nurse stated that she could not recall when the physician had last seen this resident. Refer to tags: F 314 Treatments/Services to Prevent Heal Pressure Sores F 428 Drug Regimen Review M 765 Sec. 25.8 Resident Care Services	F 387		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 100 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to timely act upon the recommendations of the consulting pharmacist for 1 of 20 sample residents, (ID #14). Findings are as follows: Review of the clinical record for resident ID# 14 revealed two Consultant Pharmacist Medication Regimen Review forms dated 11/30/2011. One recommended the discontinuation of two as needed (PRN) medications. The second recommendation was to increase Aricept from 5 milligrams to the recommended maintenance dose of 10 milligrams. The physician acted upon the recommendations on 2/22/2012, 83 days after the recommendations were made. The Director of Nurses was interviewed on 2/23/2012 and stated they were unaware of the pharmacist's recommendations until brought to their attention by the surveyor.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		

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F 441	Continued From page 101 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on surveyor observations, staff and resident interviews it has been determined the facility failed to maintain a sanitary environment and an Infection Control Program designed to help prevent the development and transmission of disease and infection for 2 of 20 sample residents, (ID#'s 3 & 7) and provide evidence that	F 441		

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F 441	Continued From page 102 all employees are free of communicable disease prior to having contact with the residents. Findings are as follows: 1. Surveyor observation on the morning of 2/19/2012 during the initial tour of the East B unit, Room # 9 had a sign to "See Nurse" which indicates a resident residing in that room requires contact precautions, the need to wear gloves and gowns when care is given. Upon questioning by the surveyor both the unit nurse and the nursing assistant (NA) exiting the room were unable to state which of the two residents required such precautions. 2. Review of the clinical record of ID # 7 revealed this resident has Vancomycin-resistant enterococcus (VRE) positive stool. During observation of this resident on 2/22/2012 at approximately 11:00 AM, with an agency nurse in attendance, the nurse indicated that this resident was on "contact precautions". The surveyor then observed this nurse conduct a skin assessment of this resident without wearing a gown. Review of the facility policy revealed "...wear gown for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment." During an interview on 2/23/2012 at 2:00 PM, the Infection Control Nurse confirmed a gown is required when having contact with this resident. During an interview on 2/23/2012 at approximately 2:30 PM, the nursing assistant assigned to this resident indicated she did not wear a gown when providing care to this resident earlier in the day. Additionally she indicated she was not aware that this resident had VRE.	F 441		

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F 441	Continued From page 103 3. On 2/20/2012 at 9:30 AM, resident ID #3, who eats meals in his room, was observed with a urinal on the over bed table. During interview on 2/20/2012 at 3:15 PM the resident stated that staff put the urinal on the over bed table. The resident noted it bothers him. During a follow up interview on 2/22/2012 at 10:10 AM the resident, who is unable to remove the urinal himself, stated that staff do not clean off the table prior to putting his food tray on the over bed table (after the urinal was on it). 4. Surveyor review of employee L's health records, with the infection control nurse, revealed no evidence of a 2 step Purified Protein Derivative (PPD) as required. This employee has direct contact with residents. 5. According to the infection control nurse no one is allowed to work on the units unless they have evidence of having all required health immunizations. She further stated that in order to prevent the spread of infections, the facility needs to know that all staff caring for residents are free from communicable disease. During interview with the Administrator, she noted that 25% of the facility's staff come from a Nursing Pool Agency. However, the facility had no contract with this agency and no system in place to ensure employees from the Agency are free of a communicable disease.	F 441		
F 460 SS=E	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to	F 460		

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F 460	Continued From page 104 assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, staff and family interviews, it was determined that the facility failed to have ceiling suspended curtains which extend around the bed to provide total visual privacy in 15 of 18 rooms on 1 of 4 units (East A). Findings are as follows: Surveyor observation of the East A unit on 2/23/2012 at 2:00 PM revealed that privacy curtains in 14 of 18 occupied rooms had a 1-1.5 ft. vertical opening when the curtains were fully drawn. The privacy curtain in resident ID #12's room was bolted to the wall, holding it in an open position. In room 8, there was only one privacy curtain, leaving one resident without a curtain. In an interview on 2/22/2012 at 11:30 AM, a family member of a resident from this unit revealed that the curtains have not closed completely since her mother's admission in 2006. During interview on 2/23/2012 at 10 AM, the Director of Housekeeping/ Environment indicated that he was not aware of the lack of total visual	F 460		

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F 460	Continued From page 105 privacy in the above listed rooms.	F 460		
F 469 SS=C	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based upon surveyor observation, resident and family interviews it was determined that the facility failed to maintain an effective pest control program throughout the facility. Findings are as follows: During the initial tour of the kitchen on 2/19/2012 at 8:20 AM, small black flies were observed by the hand sink, by the ice machine, under the steam table and outside the kitchen by the emergency water. At 9:40 AM 2 small flies were observed by the door to the kitchen. On 2/21/2012 in the early afternoon, small black flies were observed on the East B unit, and at 3:58 PM a small black fly was observed in the hall outside of the food service directors office. During an interview with non-sample resident ID# 30's daughter on 2/22/2012 at 11:30 AM, she informed the surveyor that there were "little black bugs, flies" in the resident's room on the East A unit, on the wall and in the sink. She told a surveyor that she had reported this to nursing and that they had sprayed, but that there were still	F 469		

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F 469	Continued From page 106 flies in the room. The daughter pointed out to the surveyor that there was still a fly in the sink, which surveyor observed. On 2/23/2012 at 1:55 PM a small black fly was observed in the Social Worker's office and at 2:25 PM a small black fly was observed in the Director of Nurses office. Observations during all days of the survey revealed that small black flies were present in the room utilized by the surveyors. This room, located on the East B Rehabilitation Unit, is typically utilized as a resident's room. Interview with the Maintenance Director on 2/22/2012 at 10:30 AM revealed that although the facility is serviced for pest control on a monthly basis and treatment traps and drain solutions are used, the black flies are still evident in multiple areas of the facility. There is no effective program to control pests within the facility.	F 469		
F 490 SS=I	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined the facility is not administered in a manner that enables it to use its resources effectively and maintain the highest practicable	F 490		

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F 490	Continued From page 107	F 490		

physical and mental well-being of each resident. The failure of the facility resulted in harm to residents.

Findings are as follow:

1. As evidenced by the facility's failure to prevent neglect as referenced in F 224, with S/S at level I.

2. As evidenced by the facility's failure to ensure resident dignity and respect of individuality as referenced in F 241, with S/S at level H

3. As evidenced by the facility's failure to ensure services meet professional standards as referenced in F 281, with S/S at level H.

4. As evidenced by the facility's failure to ensure services by qualified persons in accordance with plans of care as referenced in F 282 with S/S at level H.

5. As evidenced by the facility's failure to provide care/services for residents to achieve or maintain their highest well-being as referenced in F 309 with S/S at level G.

6. As evidenced by the facility's failure to ensure activities of daily living do not decline, unless unavoidable as referenced in F 310 with S/S at level H.

7. As evidenced by the facility's failure to provide treatment/services to prevent/heal pressure sores as referenced in F 314 with S/S at level I.

8. As evidenced by the facility's failure to provide services to restore the bladder as referenced in

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F 490	Continued From page 108 F 315 with S/S at level H. 9. As evidenced by the facility's failure to increase/prevent decrease in range of motion as referenced in F 318 with S/S at level H. 10. As evidenced by the facility's failure to provide treatment/services for mental and/or psychosocial difficulties as referenced in F 319 with S/S at level H. 11. As evidenced by the facility's failure to provide sufficient 24-hr nursing staff as referenced in F 353 with S/S at level I. 12. As evidenced by the facility's failure to provide an effective Medical Director as referenced in F 501 with S/S at level I. 13. As evidenced by the facility's failure to provide an effective Quality Assurance program as referenced in F 520 with S/S at level I. From 2008 to the present time, the facility has changed Administrators 7 times.	F 490		
F 500 SS=F	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of	F 500		

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F 500	Continued From page 109 the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it has been determined that the facility has failed to ensure that arrangements pertaining to services furnished by outside resources are provided under an agreement which specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services. Findings are as follows: On 2/21/2012 the surveyor requested to review the contract between the nursing pool agency and the facility. At this time the Administrator informed the surveyors that the facility did not currently have a contract with the Pool Agency. It was not until 2/21/2012, after interviews with the surveyor, that a contract was signed between the facility and the Pool Agency.	F 500		
F 501 SS=I	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director.	F 501		

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F 501	Continued From page 110	F 501		

The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.

This REQUIREMENT is not met as evidenced by:
Based on record review, and staff interviews, it has been determined the facility failed to involve the medical director in identifying, evaluating and addressing medical and clinical concerns and issues that affect resident care, quality care and coordination of medical care in the facility.

Findings are as follow:

1. As evidenced by the facility's failure to prevent neglect as referenced in F 224, with S/S at level I.

2. As evidenced by the facility's failure to ensure resident dignity and respect of individuality as referenced in F 241, with S/S at level H

3. As evidenced by the facility's failure to ensure services meet professional standards as referenced in F 281, with S/S at level H.

4. As evidenced by the facility's failure to ensure services by qualified persons in accordance with plans of care as referenced in F 282 with S/Sat level H.

5. As evidenced by the facility's failure to provide care/services for residents to achieve or maintain their highest well-being as referenced in F 309 with S/S at level G.

6. As evidenced by the facility's failure to ensure

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F 501	Continued From page 111 activities of daily living do not decline, unless unavoidable as referenced in F 310 with S/S at level H. 7. As evidenced by the facility's failure to provide treatment/services to prevent/heal pressure sores as referenced in F 314 with S/S at level I. 8. As evidenced by the facility's failure to provide services to restore the bladder as referenced in F 315 with S/S at level H. 9. As evidenced by the facility's failure to increase/prevent decrease in range of motion as referenced in F 318 with S/S at level H. 10. As evidenced by the facility's failure to provide treatment/services for mental and/or psychosocial difficulties as referenced in F 319 with S/S at level H. 11. As evidenced by the facility's failure to provide sufficient 24-hr nursing staff as referenced in F 353 with S/S at level I. 12. As evidenced by the facility's failure to provide an effective Medical Director as referenced in F 501 with S/S at level I. 13. As evidenced by the facility's failure to provide an effective Quality Assurance program as referenced in F 520 with S/S at level I.	F 501		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514		

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F 514	Continued From page 112	F 514		

standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based upon surveyor observation, record review, and staff interview it was determined that the facility failed to maintain clinical records that are complete, accurately documented and systematically organized for 6 of 23 sample residents (ID #5, 7, 11, 12, 14, 16), and 4 of 13 non-sample residents (ID #29, 32, 33, 36), relative to skin assessments, interdisciplinary progress notes, code status, treatment records, physician's orders and meal percentages.

Findings are as follows:

1. Non-Sample resident ID # 29 was admitted to the facility on 1/5/2012 from the hospital after undergoing surgery for a fracture of the left hip.

The 1/5/2012 Brief Nursing Evaluation form, admission assessment and note failed to indicate skin breakdown on the feet.

A 1/6/2012 the 11 PM-7 AM nurses' note states, "left heel slight mushy, redness- necrotic. Right heel redness."

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F 514	Continued From page 113 The nursing notes for 1/19/2012 indicates the presence of the area on the left heel. A Pressure Ulcer Documentation Form initiated on this date for the left heel incorrectly states the onset as 1/19/2012 when the left heel pressure ulcer was identified on 1/6/2012 according to the nurses note. The weekly skin assessment on 1/20/2012 incorrectly states the skin is intact, when both heels have been noted to have pressure ulcers on 1/6/2012. During an interview on 2/24/2012 at 10:00 AM, the physician stated the resident had been admitted to the facility with the area on the left heel. He stated 1/5/2012 nursing evaluation form and the admission nursing assessment were inaccurate. 2. On 2/17/2012 the family of non-sample resident ID #32 made the facility aware that the resident had been sent to the hospital with paperwork that incorrectly documented the resident's code status as "Full Code". Resident ID #32 had requested a code status of Do Not Resuscitate (DNR). On 2/10/2012 the nurse practitioner, reported the resident was a DNR/ DNI (do not resuscitate/ do not intubate). A signed physician's order dated 2/10/2012 specified Code Status: DNI and DNR. On 2/16/2012 the resident was noted to have a change of mental status and was transported to the emergency room via a ambulance.	F 514		

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F 514	Continued From page 114 On 2/16/2012 the Continuity of Care form sent to the hospital with the resident inaccurately stated, "Full Code". 3. On 2/23/2012, an observation of the Continuity of Care form for non-sample resident ID #36 indicated the resident had a FULL CODE status. Record review in the presence of the nurse revealed a current physician's order sheet, dated 2/3/2012, did not specify a code status. However, a physician's note dated 1/16/2012 specified the resident was a DNR/ DNI. During an interview on 2/23/2012 at 2:30 PM, the director of nurses stated the resident should have an accurate code status on the physician's orders. 4. Record review revealed resident ID # 7 had two active clinical records at the nurses station, one a current record and one overflow record. Surveyor review on 2/20/2012 and 2/21/2012 of the current record did not contain the recent hospital discharge and nurses notes regarding her readmission. When brought to the attention of the Assistant Director of Nurses, she was unable to produce these documents. During the surveyor's review of the overflow record, hospital discharge summary, current nurses notes dated 2/16/2012 through 2/22/2012, and the current care plan for impaired skin integrity were found. These should have been in the residents current record.	F 514		

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Review of Resident ID # 7's records revealed nurses notes dated 2/16/2012 through 2/21/2012 indicating "skin prep" was applied to the left heel. Review of the treatment record inaccurately indicated "skin gel" was applied.

Additionally the record contained a 2/17/2012 physician's order for Prevalon Boots while in bed. Surveyor observation on 2/22/2012 revealed the Prevalon boots were not in use.
During interview with this alert and oriented resident on 2/22/2012, s/he indicated the Prevalon boots had not been used.

Review of nurse's notes dated 2/16/2012 and 2/18/2012 indicate Prevalon boots applied. Review of this resident's treatment record indicated that staff were documenting the Prevalon boots were being applied on 2/18 through 2/22/2012 on the 11 PM -7 AM shift. During an interview with the ADNS on 2/22/2012 she was unable to provide evidence that the resident had ever been given Prevalon boots.

Review of the wound tracking book for the East B unit revealed two Pressure Ulcer Documentation forms with conflicting information for Resident ID # 7. Review of one form indicates on 1/30/12, "unstageable left heel ulcer measures 1 cm x 1 cm" and on 2/6/2012, "area closed." The second form for the same dates and times indicates on 1/30/2012, "unstageable left heel ulcer 3 cm x 1.5 cm" and on 2/6/2012 "unstageable left heel ulcer 2.5 cm X 1 cm."

When questioned by surveyor, staff were unable to provide evidence as to which sheet contained accurate descriptions of the pressure ulcers.

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5. On 2/20/2012 at approximately 12:20 PM resident ID #11's lunch tray was observed with the nursing assistant, after the resident had completed her meal. The resident was observed to have eaten approximately 50% of her lunch.

Record review revealed the NA inaccurately documented on the Resident Functional Performance record (a tool used by the nursing assistants to document care) that the resident ate 100% of her lunch that day.

During interview on 2/21/2012 at approximately 8:45 AM, the NA acknowledged that the resident had not eaten 100% of her lunch on 2/20/2012.

6. Resident ID# 16 has been assessed as needing a left leg brace. A review of the nursing assistants' Kardex (used to inform nursing assistants of resident's needs) incorrectly indicates the resident wears a right leg brace.

7. Clinical record review for ID# 14 reveals confusion as to when the resident was on Hospice and which Hospice agency (#1 or #2) was providing services to the resident .

The Social Worker note dated 9/30.2011, indicates the resident was no longer receiving Hospice services (from Agency #1) since 8/26/2011.

The nurses note dated 12/18/2011 states, "Hospice (Agency #2) notified of significant change in health, nurse coming in to evaluate resident." The record does not contain an evaluation from Agency #2.

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A physician's order, dated 12/20/2011, states may have consult with Agency #2 and admit to Hospice Services if appropriate. The order further states admit to Agency #1.

A nurses note dated 1/11/12 states, "resident on Hospice."

During an interview on 2/21/2012 at 11:30 AM, the nurse stated resident has not been on Hospice "for a long time".

During an interview on 2/21/2011 at approximately 12 PM, the corporate nurse stated that the resident is not on Hospice at this time. She acknowledged that the nurses note dated 1/11/2012 was inaccurate.
She would contact Hospice #2 for the 12/18/2011 evaluation which was not in the record.

8. Record review for ID#12 revealed conflicting information as to the code status.

A physician's order dated 12/10/2011 stated, "Hospice and Comfort Measures Only" (CMO).

A social worker note dated 12/12/2011stated, "Code status DNR."

Nurses notes on 1/12/2012 and 1/25/2012 stated resident on CMO.

When questioned on 2/20/2012 at 11:15 AM, the nurse stated she would have to verify the code status. After speaking with the surveyor, the nurse contacted the physician and received

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clarification. The resident wishes to be a CMO only, and did not wish to have hospice services.

9. Resident ID # 5 resides on the West A unit. A review of the resident's initial Minimum Data Set, (MDS) a screening tool, dated 12/12/2011 indicates the resident was always continent of urine.

A review of the February 2012 Resident Functional Performance Record relative to bladder function indicates the resident was now incontinent of urine on 02/01/2012 through 02/10 2012, and again on 02/10, 02/13, 02/16 and 02/20/2012. When the surveyor asked for the Functional Performance Records , relative to bladder incontinence for December 2011 and January 2012, to determine when the incontinence began, the staff were unable to locate them.

10. Record review revealed resident ID #33, was seen by the podiatrist on 2/10/2012. The podiatrist recommended Lac-Hydrin 12% lotion to dry skin of feet, once every other day for 60 days, and Skin Prep, once daily for 14 days to the posterior heels.

Review of the February treatment record on 2/20/2012 indicated, incorrectly, the Lac -Hydrin 12% lotion was to be administered every day and the Skin Prep was to be administered three times per day.

During interview on 2/24/12 at 8:30 AM, the nurse verified that the treatment schedule was incorrect.

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F 514	Continued From page 119	F 514		
F 520 SS=H	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the Quality Assurance Program, it has been determined the facility failed to identify issues related to quality assessment activities and failed to develop and implement appropriate plans of action to correct deficiencies.	F 520		

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F 520	Continued From page 120 Findings are as follow: Although the facility's Quality Assurance committee meets monthly, there is no evidence that the current deficiencies had been identified and appropriate plans of action had been implemented. Additionally, there was no evidence that action plans of past known deficiencies had continued to be implemented . REFER TO: F224, F241, F281, F282, F309, F 310, F314, F315, F318, F319, F353, F490, F501, "You are hereby formally notified that where the above listed deficiencies also constitute non-compliance with applicable provisions of the 'Rules and Regulations for Licensing of Nursing Facilities' they are deficiencies under State Regulations and grounds for licensure sanctions."	F 520		

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M 215	ORGANIZATION and MANAGEMENT 14.14 Photo Identification Photo Identification 14.14 A health care facility shall require all persons, including students, and as directed by the nursing facility, who examine, observe, treat or assist a patient or resident of such facility to wear a photo identification badge which states, in a reasonably legible manner, the first name, licensure/registration status, if any, and staff position of such person. This badge shall be worn in a manner that makes the badge easily seen and read by the resident or visitor. This Requirement is not met as evidenced by: Based on surveyor observation the facility failed to require all persons who examine, observe, treat or assist a resident to wear a photo identification badge which states the first name, licensure/registration status, if any, and staff position of such person. This badge shall be worn in a manner that makes the badge easily seen and read by the resident or visitor. Finding are as follows: Surveyor observations on all days of the survey revealed facility staff without photo identification (ID) badges as follows: During all days of the survey, the photo ID badge of the Assistant Director of Nursing incorrectly indicated that her staff position was "DNS" (Director of Nursing). The actual DNS,and one additional staff member, ere observed with names printed on a piece of	M 215		

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M 215	Continued From page 1 paper attached to their clothing. On 2/21/2012 a photo ID of a registered nurse on the West A unit incorrectly indicated that her title was "Unit Manager",and a nurse on the West B unit was observed without a photo identification badge. On 2/23/2012 surveyor observations revealed seven nursing assistants on multiple units of the facility without an employee identification badge, or with a badge that was not worn in a manner to be easily viewed. Surveyor observation during all days of the survey revealed that multiple corporate employees displayed identification badges with no photo. In addition, during all days of the survey, multiple residents expressed concern that they did not know the names of staff and were unaware of who was caring for them.	M 215		
M 285	ORGANIZATION and MANAGEMENT 17.4 Medical Records 17.4 At time of discharge, a discharge summary, summarizing the resident's stay, shall be completed promptly and signed by the attending physician. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the facility failed ensure completion of a discharge summary for 1 of 3 closed records reviewed, sample resident ID #21.	M 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LTC00744	A. BUILDING _____ B. WING _____	C 02/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAWTUXET VILLAGE CARE AND REHABILITATION C	270 POST ROAD WARWICK, RI 02888

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 285	Continued From page 2 Findings are as follow: Resident ID #21 was discharged from the facility on 12/23/2011. A review of the closed record on 2/24/2012 failed to contain a discharge summary. The Director of Nurses was unable to provide the summary when asked on 2/24/2012.	M 285		
M 605	RESIDENT CARE SERVICES 21.4 Resident Care Policies 21.4 Resident care policies and procedures shall be developed and reviewed annually, and revised as necessary, in all facilities by a group of professional personnel including one or more physicians, a registered nurse, and other professional personnel as deemed necessary (e.g., social workers, physical therapists, etc.). Documentation of this annual review shall be made available to the licensing agency upon request. This Requirement is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to conduct an annual review of resident care policies and procedures. Findings are as follows: Review of the facility's policy and procedure manual for resident care services on 2/21/2012, revealed that the facility's policies and procedures had not been reviewed since 1/27/2011. When interviewed on 2/22/2012 at approximately 2:30 PM, the Director of Nursing Services was unable to provide evidence of annual review upon	M 605		

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M 605	Continued From page 3 request.	M 605		
M 765	RESIDENT CARE SERVICES 25.8 Administration of Drugs Administration of Drugs 25.8 Drugs shall be administered in accordance with written orders of the attending physician and procedures established in accordance with sections 28.1 and 28.2 herein. Such procedures shall include measures to assure: (1) that drugs are checked against physicians' orders; (2) that the resident is identified prior to administration of a drug; (3) that each resident has an individual medication record; and (4) that the dose of drug administered to each resident is properly recorded therein by the person administering the drug. a) Drugs not specifically limited as to time or number of doses when ordered shall be controlled by automatic stop orders or other methods in accordance with written policies. b) Physicians' verbal orders for drugs and biologicals shall be given only to a licensed nurse, a registered pharmacist or to a physician and shall be immediately recorded and signed by the person receiving the order. Such orders shall be countersigned by the attending physician within fifteen (15) days. This Requirement is not met as evidenced by: Based on staff interview and record review, it was determined that the facility has failed to ensure that physician's verbal orders are countersigned by the attending physician within 15 days for 3 of 23 sample residents (ID#'s 1, 14, and 12).	M 765		

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M 765	Continued From page 4 Findings are as follows: 1. Review of the clinical record of resident ID# 1 revealed 10 physician's orders obtained by telephone between 1/17/2012 and 2/5/2012. These orders were not countersigned by the physician. Additionally the consolidated physician orders from December 2011 through February 2012 remain unsigned. 2. Review of the clinical record of resident ID# 14 revealed 25 physician's orders obtained by telephone between 10/5/2011 and 1/30/2012. The orders were not countersigned by the physician until 2/22/2012. Additionally the consolidated physician orders from October 2011 through February 1, 2012 were not countersigned by the physician until 2/22/2012. 3. Review of the clinical record of resident ID#12 revealed physician's orders obtained by telephone between 1/14/2012 and 2/5/2012. The orders were not countersigned by the physician. Additionally the consolidated physician orders from December 2011 through February 2012 remain unsigned. When questioned on 2/23/2012 at approximately 9:30 AM, the DNS was unable to produce evidence that the above noted physician telephone orders and physician consolidated orders were countersigned by the physician within	M 765		

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M 765	Continued From page 5 15 days.	M 765		