

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

PRINTED: 03/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2016
NAME OF PROVIDER OR SUPPLIER ABERDEEN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 17500 W 119TH STREET OLATHE, KS 66061		
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F 000	INITIAL COMMENTS	F 000			
F 225 SS=D	<p>The following citations represent the findings of complaint investigations # 95728, 96345, 97795.</p> <p>A revised copy of the 2567 was sent to the facility on 3/11/16.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated</p>	F 225			

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

TITLE

(X6) DATE

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

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F 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: The facility's census totaled 54 residents with 5 sampled. Based on record review and interviews the facility failed to report allegations of neglect to the state regulatory and certification agency for 1 of 3 residents (#3) related to accidents that resulted in a subdural hematoma (bleeding on the surface of the brain).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #3 admitted to the facility on 1/8/16 at 6:16 P.M. after hospitalization related to urinary tract infection and weakness. <p>The hospital transfer records dated 1/5/16 documented the resident used a walker most of the time for gait and had several falls.</p> <p>The nurses' notes documented on 1/8/16 at 8:45 P.M. the resident suffered a fall with injury. Staff found the resident on the floor of his/her room. The resident developed a hematoma (a collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) to his/her left temporal area (the bone beside the eye). Staff notified the doctor of the fall, and he/she ordered for the resident sent to the hospital for computerized tomography (CT scan) - (test that used x-ray technology to make multiple</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>cross-sectional views of organs, bone, soft tissue and blood vessels) of his/her head immediately. The resident transferred to the hospital per ambulance at 9:15 P.M.</p> <p>The nurses' notes documented on 1/9/16 at 1:00 A.M. the hospital admitted the resident for a head injury.</p> <p>The nurses' notes documented the resident readmitted to the facility on 1/10/16 at 3:30 P.M. with a diagnosis of a subdural hematoma from a fall.</p> <p>On 2/23/16 at 9:30 A.M. the resident sat in a recliner in his/her room with call light button in his/her lap.</p> <p>On 2/24/16 at 10:40 A.M. interview with administrative nursing staff D stated the facility should have reported the resident's fall which resulted in a subdural hematoma to the state agency.</p> <p>On 2/24/16 at 2:30 P.M. interview with physician assistant V stated the facility should have reported this resident's fall which resulted in a subdural hematoma to the state survey agency.</p> <p>The revised November 2014 facility policy "ANE: Abuse Prevention, Intervention, Reporting and Investigation - Staff Treatment of Residents" instructed the facility to notify the regulatory and state agencies of suspected abuse (verbal, physical, neglect) and what immediate action was taken by the facility.</p> <p>The facility failed to report to the state regulatory and certification agency, an incident with resident</p>	F 225			

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F 225	Continued From page 3 #3 who fell and went to the hospital, with a subdural hematoma.	F 225			
F 280 SS=D	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: The facility reported a census of 54 and 5 residents were sampled. Based on observation, interview, and record review the facility failed to review and revise the care plan fro 2 of 5 residents sampled. (#3, #4) Resident #3's care plan was not updated to reflect a healed wound, and resident #4's care plan was not updated to reflect the development of pressure ulcers, pressure ulcer interventions, and nutritional	F 280			

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F 280	<p>Continued From page 4 supplements.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of a physician order sheet for resident #4 dated 2/1/2016 documented the following diagnoses: dementia (a progressive mental disorder characterized by failing memory and confusion) and hemiparesis (muscular weakness of one half side of the body). <p>Review of the admission assessment dated 2/8/2016 documented a BIMS (Brief Interview for Mental Status) score of 10, which indicated moderate cognitive impairment. The resident required extensive assistance of 2 or more staff with bed mobility, transfers, dressing, toileting, and personal hygiene; he/she did not walk; was dependent on one staff with bathing; required supervision of one staff with locomotion on and off the unit; and supervision with set up assistance for eating. The resident was identified at risk for the development of pressure ulcers and had no pressure ulcers. Staff provided the resident a pressure reducing device for his/her bed and chair and he/she was not on a turning/repositioning program.</p> <p>Review of the Cognitive Loss CAA (Care Area Assessment) dated 2/9/2016 documented the resident had sequencing problems, was sometimes confused, and needed cueing.</p> <p>Review of the ADL (Activities of Daily Living) CAA dated 2/9/2016 documented the resident had a history of a cerebrovascular accident (poor blood flow to the brain, which resulted in cell death), hemiparesis, and dementia, used a wheelchair which he/she propelled with his/her feet, and</p>	F 280			

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F 280	<p>Continued From page 5 required extensive assistance with ADLs.</p> <p>Review of the Pressure Ulcer CAA dated 2/9/2016 documented the resident was at risk for skin breakdown due to impaired bed mobility and left and right sided weakness. His/her skin was intact.</p> <p>Review of the care plan dated 2/10/16 documented the resident had cognitive loss, required assistance with ADLs, and was at risk for the development of pressure ulcers. The care plan directed staff to provide extensive assistance of 1-2 staff with ADLs to include repositioning every two hours and as needed, and to use a wheelchair cushion. The care plan did not identify the resident acquired one unstageable pressure ulcer and one suspected deep tissue injury pressure ulcer, identify interventions and treatments for wounds, or include physician ordered Carnation Instant Breakfast (CIB).</p> <p>Review of physician orders dated 2/12/16 documented an order to cleanse the resident's left and right heels with wound cleanser, apply aquacel (a special dressing which helped keep the wound clean and promoted healing), and secure with kerlix daily.</p> <p>Review of physician orders dated 2/15/16 documented an order for CIB (carnation instant breakfast; a nutritional shake) twice daily with lunch and dinner.</p> <p>Review of a nursing progress noted dated 2/11/16 at 9:39 P.M. documented staff found a pressure sore to his/her right heel, which measured 2 cm (centimeters) x (by) 3 cm x 0.1 cm and also a left heel pressure sore, which measured 2 cm x 3 cm</p>	F 280			

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F 280	<p>Continued From page 6</p> <p>x 0.1 cm caused from his/her shoes rubbing.</p> <p>Review of left heel pressure reports documented the following: On 2/11/2016 staff first observed a suspected deep tissue injury to the resident's left heel. The wound had no odor, had yellowish drainage, and slough. The wound measured 0.5 cm x 0.4 cm x 0.1 cm. Staff taught the resident to shift his/her weight every 15 minutes when up, provided prafo boots (special boots worn to prevent pressure on the heels) to be worn at all times, and updated the plan to reflect the new interventions.</p> <p>During an observation on 2/24/16 at 6:59 A.M. the resident laid in bed, eyes open and Prafo boots on both feet. The resident's heels rested on the boot and against the mattress.</p> <p>During an interview on 2/23/16 at 5:14 P.M. the resident said he/she did not know how long he/she had wounds on his/her feet and did not like wearing boots because they slid when he propelled in his/her wheelchair.</p> <p>During an interview on 2/23/2015 at 2:31 P.M. direct care staff Q said the resident propelled him/herself in a wheelchair, had pressure ulcers on his/her heels, and wore special boots on his/her feet.</p> <p>During an interview on 2/24/2016 at 6:59 P.M. direct care staff R said the resident wore extra-large boots on both feet and was told the facility ordered him/her a different pair.</p> <p>During an interview on 2/23/2016 at 3:51 P.M.</p>	F 280			

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F 280	<p>Continued From page 7</p> <p>licensed nursing staff I said the resident had wounds to both heels.</p> <p>During an interview on 2/24/2016 at 8:06 A.M. administrative nursing staff E said the staff who discovered wounds were responsible for revising the care plan. Staff E said he/she did not have time to review care plans for revisions due to the numerous amount of orders written daily.</p> <p>During an interview on 2/24/2016 at 10:59 A.M. administrative nursing staff D said he/she expected nursing staff to review and revise the care plan when staff discovered the wounds, and he/she was responsible for ensuring the care plan was current.</p> <p>The facility provided the Resident Assessment Instrument (RAI) dated June 2010 chapter 4 "CAA Process and Care Planning" which documented the care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident received.</p> <p>The facility failed to review and revise the care plan to include the develop of pressure ulcers, pressure ulcer interventions, and physician ordered nutritional supplements.</p> <p>- Resident #3's admission Minimum Data Set assessment (MDS) dated 1/20/16 documented the Brief Interview for Mental Status (BIMS) score 9 which indicated the resident with moderately impaired cognitive status. The MDS further documented the resident required total dependence on 2 staff members with toilet use, extensive assistance of 2 staff members with bed mobility, transfers, and dressing and extensive assistance of 1 staff member with walking and</p>	F 280			

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F 280	<p>Continued From page 8</p> <p>locomotion. The MDS also documented the resident with 1 Stage 2 pressure ulcer and 2 unstageable pressure ulcers.</p> <p>The pressure ulcer Care Area Assessment (CAA) dated 1/23/16 documented the resident required assist of 1-2 staff members with bed mobility, lacked initiation and required verbal, visual and tactile cues for basic needs including repositioning, and incontinent of bowels and wore a brief. The resident currently had deep tissue injury (DTI) to bilateral heels and a Stage 2 pressure ulcer to his/her coccyx with a dressing change every 3 to 7 days and as needed, turn schedule every 2 hours, air mattress on the bed, cushion in his/her wheelchair and recliner, heels up bench in bed, and Prafo boots (specialty boot that relieves pressure on the resident's heels) on at all times.</p> <p>The Medicare 30 day MDS dated 2/6/16 documented the resident with 2 unstageable pressure ulcers.</p> <p>The revised care plan dated 1/23/16 documented the resident with impaired skin integrity; pressure ulcer on buttocks was a stage 2 and deep tissue injury to his/her bilateral heels. The approaches included: use an air mattress to reduce pressure, please assist with reposition every 2 hours and as needed, Prafo boots to bilateral lower extremities at all times, positioning devices - heels up bench in place per physician's orders, wound treatments per physician orders, monitor the pressure ulcers on the bilateral heels (with dry eschar and no dressing in place) daily, documented absence of edema, erythema, bogginess or drainage, and a pressure reducing cushion in the recliner/wheelchair. Added on 1/25/16 the</p>	F 280			

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F 280	<p>Continued From page 9</p> <p>approach of Carnation Instant Breakfast (CIB) shakes 120 milliliters between meals for wound healing.</p> <p>The nurses' notes dated 2/1/16 at 1:09 P.M. documented the pressure ulcer to the resident's buttocks was now healed. The care plan was not revised to show this.</p> <p>On 2/23/16 at 1:30 P.M. observation revealed the resident's buttocks intact at this time.</p> <p>On 2/23/16 at 11:40 A.M. interview with direct care staff O stated the resident's buttocks wound healed.</p> <p>On 2/23/16 at 11:48 A.M. interview with licensed nursing staff H stated the resident's coccyx wound healed and the resident had a raised area where the pressure ulcer was.</p> <p>On 2/24/16 at 1:53 P.M. interview with administrative nursing staff D stated staff updated the care plans when staff noted any changes. Administrative nursing staff D stated the care plan for this resident was not updated when the pressure ulcer healed.</p> <p>The facility provided the Resident Assessment Instrument (RAI) dated June 2010 chapter 4 "CAA Process and Care Planning" which documented the care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident received.</p> <p>The facility failed to update the care plan to reflect this resident's pressure ulcer on his/her coccyx healed.</p>	F 280			

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F 314 F 314 SS=G	Continued From page 10 483.25(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: The facility reported a census of 54 and 5 residents were sampled. Based on observation, interview, and record review the facility failed to develop and implement timely interventions to prevent and promote healing of one unstageable pressure ulcer (full thickness tissue loss in with the base of the ulcer covered by slough (dead tissue) and one suspected deep tissue pressure ulcer (underlying deep tissue damage caused by pressure) for 1 of 3 resident's sampled for pressure ulcers. (#4) Both pressure ulcers increased in size. Findings included: - Review of a physician order dated 2/1/2016 documented the following diagnosis for resident #4: dementia (a progressive mental disorder characterized by failing memory and confusion) and hemiparesis (muscular weakness of one half side of the body). Review of the admission Minimum Data Set	F 314 F 314			

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F 314	<p>Continued From page 11</p> <p>(MDS) assessment dated 2/8/2016 documented a BIMS (Brief Interview for Mental Status) score of 10, which indicated moderate cognitive impairment. The resident required extensive assistance of 2 or more staff with bed mobility, transfers, dressing, toileting, and personal hygiene; he/she did not walk; was dependent on one staff with bathing; required supervision of one staff with locomotion on and off the unit; and supervision with set up assistance for eating. He/she did not reject cares and used a wheelchair for mobility. The resident was at risk for the development of pressure ulcers and had no pressure ulcers. Staff provided the resident a pressure reducing device for his/her bed and chair. The resident was not on a turning/repositioning program.</p> <p>Review of the Cognitive Loss CAA (Care Area Assessment) dated 2/9/2016 documented the resident had sequencing problems, was sometimes confused, and needed cueing.</p> <p>Review of the ADL (Activities of Daily Living) CAA dated 2/9/2016 documented the resident had a history of a cerebrovascular accident (poor blood flow to the brain, which resulted in cell death), hemiparesis, and dementia, used a wheelchair which he/she propelled with his/her feet, and required extensive assistance with ADLs.</p> <p>Review of the Pressure Ulcer CAA dated 2/9/2016 documented the resident was at risk for skin breakdown due to impaired bed mobility and left and right sided weakness. His/her skin was intact.</p> <p>Review of a Braden Skin Risk assessment documented the resident scored a 15, which</p>	F 314			

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F 314	<p>Continued From page 12 indicated a low risk for pressure ulcers.</p> <p>Review of the care plan dated 2/10/16 documented the resident had cognitive loss, required assistance with ADLs, and was at risk for the development of pressure ulcers. The care plan directed staff to provide extensive assistance of 1-2 staff with ADLs to include repositioning every two hours and as needed, and to use a wheelchair cushion.</p> <p>The medical record lacked an admission care plan. (There was no plan in place to direct care for the resident from admission on 1/29/16 until the development of the comprehensive care plan on 2/10/16)</p> <p>Review of physician orders dated 2/12/16 documented an order to cleanse the resident's left and right heels with wound cleanser, apply aquacel (a special dressing which helped keep the wound clean and promoted healing), and secure with kerlix (a dressing) daily.</p> <p>Review of physician orders dated 2/15/16 documented an order for CIB (carnation instant breakfast; a nutritional shake) twice daily with lunch and dinner.</p> <p>Review of the MAR (medication administration record) dated 2/2016 documented the resident did not receive CIB at noon on 2/21/2016, indicated by a blank box.</p> <p>Review of a nursing progress note dated 1/29/16 at 9:18 P.M. documented the resident's skin was pink and warm with no breakdown.</p> <p>Review of right heel pressure ulcer reports</p>	F 314			

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F 314	<p>Continued From page 13 documented the following:</p> <p>On 2/11/16 staff first observed a right heel pressure ulcer. The wound had no odor or drainage. The wound measured 2.2 cm (centimeters) x (by) 2.5 cm x 0.1 cm and had slough (dead tissue).</p> <p>On 2/19/16 the wound measured 3.2 cm x 1.8 cm, had no odor, necrotic (dead tissue), and was unstageable.</p> <p>On 2/23/16 the wound measured 3.3 cm x 2.6 cm, had scant drainage, and necrotic tissue.</p> <p>Review of left heel pressure reports documented the following:</p> <p>On 2/11/2016 staff first observed a suspected deep tissue injury to the resident's left heel. The wound had no odor, had yellowish drainage, and slough. The wound measured 0.5 cm x 0.4 cm x 0.1 cm. Staff taught the resident to shift his/her weight every 15 minutes when up, provided prafo boots (special boots worn to prevent pressure on the heels) to be worn at all times, and updated the care plan to reflect the new interventions.</p> <p>On 2/19/2016 staff documented the wound as an intact necrotic left heel blister wound with no odor or drainage, which measured 1.4 cm x 0.8 cm.</p> <p>On 2/23/16 the wound measured 4.0 cm x 3.6 cm, had no odor or drainage, and was necrotic.</p> <p>Review of a nursing progress noted dated 2/11/16 at 9:39 P.M. documented staff found a pressure sore to his/her right heel, which measured 2 cm x 3 cm x 0.1 cm and also a left heel pressure sore,</p>	F 314			

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F 314	<p>Continued From page 14</p> <p>which measured 2 cm x 3 cm x 0.1 cm caused from his/her shoes rubbing.</p> <p>During an observation on 2/23/2016 at 11:20 A.M. the resident propelled him/herself back and forth in his/her wheelchair. The resident used the heel of his/her boots to propel and as he/she propelled his/her feet slid in the boots.</p> <p>During an observation on 2/23/2016 at 12:40 P.M. the resident sat in his/her wheelchair at the dining room table and staff served him/her soup, milk, and water. He/she ate 100% of soup, drank 50% of milk, and a few sips of water. Staff did not offer the resident CIB as ordered.</p> <p>During an observation on 2/23/2016 at 4:57 P.M. licensed nursing staff I and direct care staff P assisted the resident from his/her wheelchair to bed using a mechanical sit to stand lift. Staff removed the dressing from the resident's left heel, cleansed with wound cleanser and applied skin prep (a protective barrier). Observation revealed necrotic tissue to the left heel, which measured 4.0 cm x 3.6 cm. Staff I removed the dressing to the right heel, cleansed with wound cleanser, applied aquacel, wrapped with kerlix, and secured with tape. Observation revealed necrotic tissue to the right heel and the wound measured 3.3 cm x 2.6 cm. Staff applied the Prafo boots, assisted the resident back to his/her wheelchair using the mechanical sit to stand lift, and the resident self propelled with his/her feet sliding back and forth.</p> <p>During an observation on 2/23/2016 at 5:30 P.M. staff served the resident carrot cake with cream frosting, soup, ice water, and milk. The resident ate 100% (percent). Staff did not offer CIB during</p>	F 314			

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F 314	<p>Continued From page 15 observation as ordered.</p> <p>During an observation on 2/24/16 at 6:59 A.M. the resident laid in bed, eyes open and Prafo boots on both feet. The resident's heels rested on the boot and against the mattress.</p> <p>During an interview on 2/23/16 at 5:14 P.M. the resident said he/she did not know how long he/she had wounds on his/her feet and did not like wearing boots because they slid when he/she propelled in his/her wheelchair.</p> <p>During an interview on 2/23/2016 at 2:31 P.M. direct care staff Q said the resident propelled him/herself in a wheelchair, had pressure ulcers on his/her heels, and wore special boots on his/her feet.</p> <p>During an interview on 2/24/16 at 7:15 A.M. direct care staff R confirmed staff did not provide the resident CIB with lunch yesterday.</p> <p>During an interview on 2/24/2016 at 6:59 P.M. direct care staff R said the resident wore extra-large boots on both feet and was told the facility ordered him/her a different pair.</p> <p>During an interview on 2/23/2016 at 3:51 P.M. licensed nursing staff I said the resident needed assistance with ADLs and had wounds to both heels, which were not caused from pressure. Staff I said staff changed the resident's dressings to the wounds on the evening shift so he/she was not sure of the wounds.</p> <p>During an interview on 2/24/16 at 7:24 A.M. licensed nursing staff I said he/she did not give the resident CIB yesterday at lunch because staff</p>	F 314			

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F 314	<p>Continued From page 16</p> <p>tried to fill him/her up with foods and not drinks. Staff I said he/she documented on the MAR the resident received CIB at lunch on 2/23/2016 and should not have.</p> <p>During an interview on 2/24/16 at 9:15 A.M. therapy consultant Y said nursing asked him/her to assess the resident for Prafo boots because the boots he/she wore did not fit properly and the resident dragged his/her toes when he/she propelled in a wheelchair. Staff Y said he/she ordered different Prafo boots for the resident less than a week ago, which he/she currently wore. Staff Y said the resident already had heel wounds when staff ordered the extra-large Prafo boots, and the boots did not come with traction. Staff Y stated he/she ordered traction, which he/she expected to arrive in 2-3 days. Staff Y said traction helped keep the feet from sliding when propelling. On 2/24/2016 at 10:38 A.M. staff Y said he/she assessed the resident's Prafo boots and noted the bladder of the boot (portion of the boot that provided offloading) was 2 inches high on the left boot and a little less than 2 inches high on the right boot. Staff Y said he/she positioned the bladder correctly and was unaware who was responsible for ensuring correct position of the bladder for offloading pressure to the heels.</p> <p>During an interview on 2/24/2016 at 10:59 A.M. administrative nursing staff D said the resident had no pressure ulcers when he/she admitted to the facility and confirmed the resident developed one unstageable pressure ulcer and one suspected deep tissue injury to his/her heels. Staff D said the resident wore Prafo boots once staff observed the wounds and the Prafo boots were replaced within the past week due by therapy. Staff D said he/she expected therapy to</p>	F 314			

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F 314	<p>Continued From page 17</p> <p>educate the nursing staff on the correct positioning of the boot and he/she was not aware the boots needed repositioned. Staff D said the facility believed the resident developed the pressure ulcers due to his/her increased wheelchair mobility and the facility should have been more aware. Staff D said he/she was aware staff in (AL) Assisted Living elevated the resident's heels on pillows prior to his/her admission to long term care and was not aware the facility staff were not elevating the resident's heels since admission. Staff D said he/she expected staff to provide CIB as ordered by the physician. Staff D confirmed the medical record lacked an admission care plan and said he/she expected staff to initiate an initial care plan and include interventions to prevent pressure ulcers.</p> <p>During an interview on 2/24/2016 at 2:13 P.M. practitioner consultant V said the resident had no pressure ulcers when he/she admitted to the facility and currently had one suspected deep tissue injury and one unstageable pressure ulcer. Staff V said the wounds developed due to the resident's increased propelling in his/her wheelchair. Staff V said he/she knew the and resident's previous residence in AL used an offloading pillow and facility staff should offload the resident's heels at all times. Staff V said he/she expected staff to provide CIB as ordered by the physician.</p> <p>Review of the facility's Skin Integrity policy dated 7/2013 documented the facility implemented preventative measures to maintain intact skin.</p> <p>The facility failed to prevent the development of one unstageable pressure ulcer and one suspected deep tissue injury pressure ulcer for</p>	F 314			

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F 314	Continued From page 18 this cognitively impaired resident who was identified at risk for the development of pressure ulcers, required extensive assistance with mobility, and had intact skin on admission. The facility also failed to develop and implement interventions to promote healing and prevent worsening of the pressure ulcers once they developed. Both wounds increased in size.	F 314			
F 323 SS=G	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. This REQUIREMENT is not met as evidenced by: The facility reported a census of 54 residents and there were 5 sampled residents. Based on observation, interview, and record review the facility failed to provide adequate supervision and implement timely and appropriate interventions, and failed to provide interventions as planned (toileting every 2 hours) to prevent a fall with a neck fracture (broken bone) and subdural hematoma (an injury when blood collects on the brain's surface beneath the skull as a result of a head injury) for 1 of 3 residents (# 1) sampled for accidents. Findings included: - Review of resident #1's physician order sheet	F 323			

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F 323	<p>Continued From page 19</p> <p>dated 1/4/16 documented the following diagnoses: osteoporosis (an abnormal loss of bone density and deterioration of bone tissue with an increased risk for fractures) and a history of falling.</p> <p>Review of the annual MDS (Minimum Data Set) dated 1/9/2016 documented a BIMS (Brief Interview for Mental Status) score of 8, which indicated moderate cognitive impairment. The resident required extensive assistance of 2 or more staff with transfers; extensive assistance of one staff with bed mobility, walking, dressing, and toileting; had poor balance; and used a walker and a wheelchair for mobility. He/she was occasionally incontinent of bowel and bladder. The resident had 1 non injury fall and 1 injury fall.</p> <p>Review of Fall CAA (Care Area Assessment) dated 1/11/2016 documented the resident had falls prior to admission, was at continued risk for falls, and had a history of a fracture prior to admission. The resident had impaired balance, an unsteady gait, confusion, forgot to use his/her call light for assistance, and used a wheelchair for long distances due to he/she forgot to use his/her walker.</p> <p>Review of a quarterly MDS dated 10/8/2015 documented the a BIMS score of 9, which indicated moderate cognitive impairment. The resident required extensive assistance of one staff with toileting and personal hygiene; limited assistance of 1 staff with bed mobility, transfers, walking, locomotion on and off the unit, dressing; had poor balance; and used a walker and wheelchair for mobility. He/she was frequently incontinent of urine. The resident had 2 non injury falls.</p>	F 323			

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F 323	Continued From page 20 Review of the care plan dated 12/13/2015 documented the resident had a history of falls with fracture, osteoporosis, unsteady gait, impaired balance, incontinence, confusion, and forgetfulness. The care plan directed staff to ensure the resident's call light was within reach and remind him/her to use the call light for assistance, monitor the resident hourly for attempts to get out of bed by him/herself, and check on the resident every 15 minutes to one hour and re-educate the resident on call light use. The care plan revealed the resident required extensive assist with transfers, and ambulation/locomotion. The care plan further instructed staff to monitor for scooting, crawling from bed to recliner, toilet, and keep walker in reach, and do not leave unattended in living room area, especially during time of restlessness. The care plan further directed the staff to offer toileting every two hours. Review of a fall risk assessments on 3/2/15, 6/2/15, 10/7/15, and 12/19/15 all revealed the resident was at high risk for falls. Review of fall risk investigations documented the following: Staff found the resident on the floor in his/her room on 4/11/15, 6/17/15, and 7/23/15. Staff found the resident on the floor outside his/her room on 8/29/15. Staff found the resident on the floor in the living room area on 6/1/15 and 10/13/2015. On 6/1/15 the facility educated staff to supervise the resident, especially in the living room. On 6/17/15 staff documented the resident had multiple falls from bed. Review of a nursing progress note dated	F 323			

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F 323	<p>Continued From page 21</p> <p>1/4/2016 at 5:31 A.M. documented a nurse entered the resident's room at 4:20 A.M. and found the resident lying on the floor beside his/her bed. The resident laid on his/her left side with his/her face down. The resident's pajama pants were soiled and he/she wore socks. Staff asked the resident what happened and the resident said he/she heard dogs barking and woke up. Staff observed swelling and a hematoma to the resident's right eye, abrasion to the corner of the right eye and left cheek, a laceration above the right eye, which measured 1.5 cm (centimeters) x 1.5 cm, and a bite to the top of the right lip. Staff provided first aide, administered Tylenol for complaints of face and neck pain, and notified the physician. Staff received orders for an X-ray of the cervical spine and face. Staff informed the resident's family member of the fall in the A.M.</p> <p>Review of a physician progress note dated 1/4/16 documented the resident was cognitively impaired, had known gait instability, was high risk for falling if he/she attempted to transfer without assistance, and fell. Staff obtained a CT (computerize tomography) scan of the head, which revealed a subdural hematoma and a cervical 2 fracture (broken bone in the neck).</p> <p>Review of a fall investigation dated 1/4/2016 documented the resident's call light was activated by movement towards the edge of his/her bed. Staff responded to the resident and he/she was awake. At the same time, a neighboring room call light activated and staff informed the resident they would return in a few moments. Ten minutes later, staff returned and found the resident on the floor with his/her head near the foot of the bed.</p> <p>The Occurrence Summary Report for Caretracker</p>	F 323			

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F 323	<p>Continued From page 22</p> <p>dated 1/4/16 revealed the nurse found the resident on the floor at 4:20 A.M. The resident had soiled clothing.</p> <p>The Occurrence Statement Sheet dated 1/4/16 revealed staff last saw the resident asleep at 3:30 AM. The statement sheet further revealed staff last toiled the resident at 1:00 A.M. (3 hours and 20 minutes before the fall. This was 1 hour and 20 minutes longer than the time frame the care plan directed staff to toilet the resident).</p> <p>The resident discharged from the facility on 1/4/2016 and was not interviewed or observed.</p> <p>During an interview on 2/23/2016 at 11:45 A.M. direct care staff O said the resident was frequently restless, confused, and staff placed the resident in a recliner at the nurse's station to keep an eye on him/her.</p> <p>During an interview on 2/23/16 at 5:20 P.M. direct care staff S said the resident required total staff assistance with cares and staff checked on him/her a lot because the resident was restless.</p> <p>During an interview on 2/23/16 at 11:50 A.M. licensed nursing staff H said the resident required total staff assistance with cares and if restless would be placed in a recliner at the nurse's station to be watched closely.</p> <p>During an interview on 2/23/16 at 5:25 P.M. licensed nursing staff J said the resident was confused, required total staff assistance with cares, and staff watched him/her closely. Staff J said sometimes staff brought the resident to the recliner when he/she did not sleep and staff watched him/her closely.</p>	F 323			

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F 323	<p>Continued From page 23</p> <p>During an interview on 3/2/2016 at 1:48 P.M. administrative nursing staff D said he/she completed an investigation for a fall the resident had on 1/4/16. Staff D said the resident had a flat call light placed at the edge of the bed, hip level, to alert staff when the resident moved towards the edge of the bed. Staff D said this resident and another resident were high risk for falls and both needed help at the same time. Staff D said the nurse had to prioritize and asked this resident if he/she could wait so staff could care for another resident. Staff D was not aware if the nurse asked the resident what he/she needed before he/she left the room. Staff D stated looking back now, it was not safe to leave the resident unattended.</p> <p>Review of the facility's Fall policy dated 1/2016 documented residents identified at risk for falls had implemented interventions to reduce fall risk.</p> <p>The facility failed to adequately supervise and provide services to meet the needs of this cognitively impaired resident, including toileting as planned, who required staff assistance, fell, sustained a subdural hematoma and a neck fracture.</p>	F 323			