

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

Printed: 03/05/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E242</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>03/05/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>COMMUNITY HOSPITAL ONAGA LTCU</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>206 GRAND AVE ST MARYS, KS 66536</b>
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(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) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	<p>The following citations in the above named facility represent the findings for complaint # 73149.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 35 residents. The</p>	F 157		

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

TITLE

(X6) DATE

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

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F 157	<p>Continued From page 1</p> <p>sample included 3 residents. The facility failed to notify the resident's responsible party of a change in the resident's condition. (#1)</p> <p>Findings Included:</p> <ul style="list-style-type: none"> <li>- Resident # 1's physician's order sheet, dated 2/1/14, indicated Resident # 1 had diagnoses including congestive heart failure ( a condition when the heart output is low and the body becomes congested with fluid), venous insufficiency ( a condition in which the veins have problems sending blood from the legs back to the heart), chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminshed lung capacity and difficulty or discomfort in breathing), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and anxiety ( a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).</li> </ul> <p>The annual (MDS) Minimum Data Set 3.0 assessment, dated 1/8/14, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 8 which indicated moderately impaired cognition and he/she required total assistance with bed mobility, transfers and toilet use. The MDS further indicated the resident was at risk for developing pressure ulcers, had pressure reducing devices for the bed and chair, on a turning and repositioning program, and had no current pressure ulcers. The quarterly MDS, dated 10/9/13, indicated the resident had no pressure ulcers, was on a turning and repositioning program and pressure reducing devices were used for the bed and chair.</p> <p>The 1/9/14 Activities of Daily Living care</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>assessment summary (CAA), revealed the resident required a mechanical lift for transfers and wheelchair mobility. The CAA also indicated the resident needed assistance with bed mobility and repositioning.</p> <p>The 1/9/14 care plan review revealed the resident at risk for alteration in skin integrity related to peripheral vascular disease and a mobility problem. The care plan directed the staff to assist the resident with repositioning when he/she was in bed.</p> <p>The 1/7/14 Braden (a predicting pressure ulcer risk tool that helps establish if a resident is at risk for developing a pressure ulcer) assessment revealed a score of 16 which indicated the resident high risk for the development of pressure ulcers.</p> <p>The 1/11/14 at 5:00 AM, nurse's notes revealed the staff found the resident on a fracture bed pan and he/she had been on the bed pan for an extended period of time which caused indentions on his/her buttocks from the bed pan. The staff cleansed the resident's perirectal area and applied lantiseptic ointment ( a skin protectant with high lanolin formula for preventing skin breakdown and to help treat red skin areas)and applied the ointment to the red areas on the resident's bottom.</p> <p>The 1/12/14 facility skin assessment documentation revealed the resident had red areas which were firm to touch in an outline of the fracture pan on the resident's bottom. The skin assessment also indicated a 0.5cm (centimeters) by 0.1cm blood blister on his/her right buttock.</p> <p>The 1/12/14, at 6:30 PM, nurses notes indicated</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>the area on the resident's left and right buttocks continued to be red.</p> <p>The 1/13/14 nurse's notes with no time indicated on the note, revealed the facility notified the physician regarding the area on the resident's left and right buttock which continued to be red. Further review of the nurse's notes indicated the physician ordered the wound care specialist to consult on the redness of the resident's buttocks. The physician changed the skin treatment order to Vasolex ointment (an ointment which acts as a protective covering on the skin, to prevent further skin breakdown and help heal skin).</p> <p>On 2/27/14 at 7:40 AM, observation revealed the resident, seated on a shower chair, in the shower room. Further observation revealed Nurse Aide A used the sit to stand mechanical lift to stand the resident up from the shower chair. Nurse B then measured the area on the resident's left and right buttock. Further observation revealed the resident's left buttock with a dried brown circular area which measured 26.5 cm the resident's right buttock had a dried brown circular area which measured 26.5 cm. Nurse B verified the areas on the resident's buttocks were from when the staff had left the resident on the bed pan. Measurement of the fracture bed pan revealed each side of the bed pan measured 26.5 cm.</p> <p>On 2/26/14 at 4:00 PM, Nurse Aide C verified he/she placed the resident on a fractured bed pan on 1/10/14 at 8:45 PM. Nurse Aide C revealed the resident was not taken off the bed pan and he/she did not think about the resident being left on the bed pan until he/she worked again on 1/12/14. Nurse Aide C revealed he/she thought the other Nurse Aide who was working on 1/10/14</p>	F 157			

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F 157	<p>Continued From page 4 had taken the resident off the bed pan.</p> <p>On 2/26/14 at 4:20 PM, Nurse E verified the staff notified the resident's Durable Power of Attorney (DPOA) on 1/16/14 of the resident's skin concern and the resident being placed on a bed pan on 1/10/14 for an extended period of time. (6 days after the incident)</p> <p>On 2/27/14 at 6:45 AM, Nurse Aide D verified on 1/11/14 at 5:00 AM, he/she assisted the nurse with rolling the resident over on his/her side in the bed and staff removed the bed pan under the resident.</p> <p>On 2/27/14 at 7:00 AM, Nurse F stated on the morning of 1/11/14 at 5:00 AM, he/she entered the resident's room to place a Lidocaine patch (a topical medication patch for pain management) on the resident's lower back as ordered by the physician. Nurse F verified to place the lidocaine patch on the resident, Nurse Aide D assisted with rolling the resident over on his/ her side in the bed, at that time he/she found a fracture bed pan under the resident. Nurse F the resident was probably not even aware the bed pan was under him/her.(On bed pan for approximately 8 hours)stated</p> <p>On 2/27/14 at 9:40 AM, Nurse G revealed on 1/11/14 the staff had not notified,the resident's DPOA of him/her on the bed pan for the extended period of time.(approximately 8 hours)</p> <p>The 9/2011 facility's policy for a change in a resident's condition indicated the staff are to notify the resident's responsible parties as soon as possible for a change in the resident's condition. The responsible party should be notified of any new physician orders or any injury</p>	F 157			

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F 157	Continued From page 5 of a resident.  The facility failed to notify Resident #1's responsible party of change in skin condition and of the resident being left on a bed pan until 6 days after the event occurred.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  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.  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).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		

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F 225	<p>Continued From page 6</p> <p>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 had a census of 35 residents. The sample included 3 residents. Based on observation, record review and interview the facility failed to report and thoroughly investigate 1 of 1 residents reagrding an incident of possible neglect to the state agency.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Resident # 1's physician's order sheet, dated 2/1/14, indicated Resident #1 had diagnoses including congestive heart failure (a condition when the heart output is low and the body becomes congested with fluid), venous insufficiency (a condition in which the veins have problems sending blood from the legs back to the heart), chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminshed lung capacity and difficulty or discomfort in breathing), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).</li> </ul> <p>The annual (MDS) Minimum Data Set 3.0 assessment, dated 1/8/14, indicated the resident had a (BIMS) Brief Interview for Mental Status score of an 8 which indicated moderately impaired cognition and he/she required total assistance with bed mobility, transfers and toilet use. The MDS further indicated the resident was</p>	F 225		

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F 225	<p>Continued From page 7</p> <p>at risk for developing pressure ulcers, had pressure reducing devices for his/her bed and chair, on a turning and repositioning program and he/she had no current pressure ulcers. The quarterly MDS, dated 10/9/13, indicated the resident had no pressure ulcers, on a turning and repositioning program and pressure reducing devices on his/her bed and chair.</p> <p>The 1/9/14 (CAA) Care Area Assessment Summary for (ADLs) Activities of Daily Living revealed the resident needed a mechanical lift for transfers and a wheelchair for mobility. The CAA also indicated the resident needed assistance with bed mobility and repositioning.</p> <p>The 1/9/14 care plan review revealed the resident at risk for alteration in skin integrity related to peripheral vascular disease( a condition which the veins have problems sending blood from the legs back to the heart) and problems with mobility. The care plan directed the staff to assist the resident with repositioning when he/she was in bed.</p> <p>The 1/7/14 Braden (a predicting pressure ulcer risk tool that helps establish if a resident is at risk for developing a pressure ulcer) assessment revealed a score of 16 which indicated the resident at a high risk for the development of pressure ulcers.</p> <p>The 1/11/14 at 5:00 AM, nurse's notes revealed the staff found the resident on a fracture bed pan and he/she had been on the bed pan for an extended period of time which caused indentions on his/her buttocks from the bed pan. The staff cleansed the resident's perirectal area and applied lantiseptic ointment (a skin protectant with high lanolin formula for preventing skin</p>	F 225			

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F 225	<p>Continued From page 8 breakdown and to help treat red skin areas) and applied the ointment to the red areas on the resident's bottom.</p> <p>The 1/12/14 facility skin assessment documentation revealed the resident had red areas, which were firm to touch, in an outline of the fracture pan on the resident's bottom. The skin assessment also indicated a 0.5cm (centimeters) by 0.1cm blood blister on his/her right buttock.</p> <p>The 1/12/14, at 6:30 PM, nurse's notes indicated the area on the resident's left and right buttocks continued to be red.</p> <p>The 1/13/14 nurse's notes with no time indicated on the note, revealed the facility notified the physician regarding the area on the resident's left and right buttock which continued to be red. Further review of the nurse's notes indicated the physician ordered the wound care specialist to consult on the redness of the resident's buttocks. The physician changed the skin treatment order to Vasolex ointment (an ointment which acts as a protective covering on the skin, to prevent further skin breakdown and help heal skin).</p> <p>On 2/27/14 at 7:40 AM, observation revealed the resident, seated on a shower chair, in the shower room. Further observation revealed Nurse Aide A used the sit to stand mechanical lift to stand the resident up from the shower chair. Nurse B then measured the area on the resident's left and right buttock. Further observation revealed the resident's left buttock had a dried brown circular area which measured 26.5 cm the resident's right buttock had a dried brown circular area which measured 26.5 cm. Nurse B verified the areas on the resident's buttocks were from when</p>	F 225			

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F 225	<p>Continued From page 9</p> <p>the resident had been left on the bed pan. Measurement of the fracture bed pan revealed each side of the bed pan measured 26.5 cm.</p> <p>On 2/26/14 at 4:00 PM, Nurse Aide C verified he/she placed the resident on a fracture bed pan on 1/10/14 at 8:45 PM. Nurse Aide C revealed he/she had not taken the resident off the bed pan and he/she did not think about the resident being left on the bed pan until he/she worked again on 1/12/14. Nurse Aide C revealed he/she thought the other Nurse Aide who worked on 1/10/14 had taken the resident off the bed pan.</p> <p>On 2/26/14 at 4:20 PM, Nurse E verified the staff notified the resident's Durable Power of Attorney (DPOA) on 1/16/14 of the resident's skin concern and the resident being placed on a bed pan on 1/10/14 for an extended period of time. (6 days after the incident)</p> <p>On 2/27/14 at 6:45 AM, Nurse Aide D verified on 1/11/14 at 5:00 AM, he/she assisted the nurse with rolling the resident to roll over on his/her side in the bed and staff removed the bed pan from under the resident.</p> <p>On 2/27/14 at 7:00 AM, Nurse F stated on the morning of 1/11/14 at 5:00 AM, he/she entered the resident's room to place a Lidocaine patch (a topical medication patch for pain management) on the resident's lower back as ordered by the physician. Nurse Aide D assisted Nurse F with rolling the resident over on his/ her side in the bed, at that time he/she found a fracture bed pan under the resident. Nurse F stated the resident was probably not even aware the bed pan was under him/her. (on bed pan for approximately 8 hours)</p>	F 225			

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F 225	Continued From page 10 On 2/27/14 at 9:40 AM, Nurse G stated on 1/12/14 the staff had not notified the resident's DPOA of when they found him/her found on the bed pan.  On 2/27/14 at 10:10 AM, Administrative Nurse H stated, the staff are expected to check on all residents every 2 hours or more often if needed. Administrative Nurse H indicated the resident was at risk for pressure ulcer development.  On 2/27/14 at 12:40 PM, Administrative Nurse J verified he/she was not aware the state agency had not been notified of the incident regarding the resident being left on the bed pan.  On 2/28/14 at 12:45 PM, Physician I stated, he/she was aware the resident had been left on a bed pan for an extended period of time. Physician I stated the resident was at risk for skin impairment and had received skin breakdown from being left on the bed pan. Physician I also indicated he/she was not aware the state agency was not notified of the incident.  The 1/13/09 facility's Abuse, Neglect and Exploitation policy, directed the facility to notify the state agency of any neglect of a resident which is defined as the failure or omission of a caretaker to provide goods or services which are reasonable and necessary to ensure safety and well-being of a resident.  The facility failed to thoroughly investigate and report to the state agency when staff left Resident #1 on a bed pan for approximately 8 hours.	F 225			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a	F 314			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E242</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>03/05/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>COMMUNITY HOSPITAL ONAGA LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>206 GRAND AVE ST MARYS, KS 66536</b>		
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F 314	<p>Continued From page 11</p> <p>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.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 35 residents. The sample included 3 residents. Based on observation, record review and interview, the facility failed to develop and implement interventions to prevent presure ulcer development for 1 of 3 residents who were reviewed for pressure sores. Resident #1 developed pressure areas on both buttocks from being placed on a fracture bed pan for an extended period of time. (# 1)</p> <p>Findings included:</p> <p>- Resident # 1's physician's order sheet, dated 2/1/14, indicated Resident # 1 had diagnoses including congestive heart failure ( a condition when the heart output is low and the body becomes congested with fluid), venous insufficiency ( a condition in which the veins have problems sending blood from the legs back to the heart), chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk),and anxiety ( a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).</p>	F 314			

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F 314	Continued From page 12  The annual (MDS) Minimum Data Set 3.0 assessment, dated 1/8/14, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 8 which indicated moderately impaired cognition and he/she required total assistance with bed mobility, transfers and toilet use. The MDS further indicated the resident was at risk for developing pressure ulcers, had pressure reducing devices for the bed and chair, on a turning and repositioning program and had no current pressure ulcers. The quarterly MDS, dated 10/9/13, indicated the resident had no pressure ulcers, on a turning and repositioning program and pressure reducing devices were used for the bed and chair.  The 1/9/14 Activities of Daily Living care assessment summary (CAA), revealed the resident needed a mechanical lift for transfers and wheelchair mobility. The CAA also indicated the resident needed assistance with bed mobility and repositioning.  The 1/9/14 care plan review revealed the resident at risk for alteration in skin integrity related to peripheral vascular disease and mobility problems. The care plan directed the staff to assist the resident with repositioning when he/she was in bed.  The 1/7/14 Braden (a predicting pressure ulcer risk tool that helps establish if a resident is at risk for developing a pressure ulcer) assessment revealed a score of 16 which indicated the resident at a high risk for the development of pressure ulcers.  The 1/11/14 at 5:00 AM, nurse's notes revealed the staff found the resident on a fracture bed pan	F 314			

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F 314	<p>Continued From page 13</p> <p>and he/she had been on the bed pan for an extended period of time which caused indentions on his/her buttocks from the bed pan. The staff cleansed the resident's perirectal area and applied lantiseptic ointment (a skin protectant with high lanolin formula for preventing skin breakdown and to help treat red skin areas) was applied to the red areas on the resident's bottom.</p> <p>The 1/12/14 facility skin assessment documentation revealed the resident had red areas which were firm to touch in an outline of the fracture pan on his/her bottom. The skin assessment also indicated a 0.5cm (centimeters) by 0.1cm blood blister on his/her right buttock.</p> <p>The 1/12/14 at 6:30 PM, nurse's notes indicated the area on the resident's left and right buttocks continued to be red.</p> <p>The 1/13/14 nurse's notes, with no time indicated on the note, revealed the facility notified the physician regarding the area on the resident's left and right buttock which continued to be red. Further review of the nurse's notes indicated the physician ordered the wound care specialist to consult on the redness of the resident's buttocks. The physician changed the skin treatment order to Vasolex ointment (an ointment which acts as a protective covering on the skin, to prevent further skin breakdown and help heal skin).</p> <p>On 2/27/14 at 7:40 AM, observation revealed the resident, seated on a shower chair in the shower room. Further observation revealed Nurse Aide A used the sit to stand mechanical lift to stand the resident up from the shower chair. Nurse B then measured the area on the resident's left and right buttock. Further observation revealed the</p>	F 314			

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F 314	<p>Continued From page 14</p> <p>resident's left buttock had a dried brown circular area which measured 26.5 cm (centimeters), the resident's right buttock had a dried brown circular area which measured 26.5 cm. Nurse B verified the areas on the resident's buttocks were from when the resident had been left on the bed pan. Measurement of the fracture bed pan revealed each side of the bed pan measured 26.5 cm.</p> <p>On 2/26/14 at 4:00 PM, Nurse Aide C verified he/she placed the resident on a fracture bed pan on 1/10/14 at 8:45 PM. Nurse Aide C revealed he/she had not taken the resident off the bed pan and he/she did not think about the resident being left on the bed pan until he/she worked again on 1/12/14. Nurse Aide C revealed he/she thought the other Nurse Aide who worked on 1/10/14 had taken the resident off the bed pan.</p> <p>On 2/26/14 at 4:20 PM, Nurse E verified the staff notified the resident's Durable Power of Attorney (DPOA) 1/16/14 of the resident's skin concern and the resident being placed on a bed pan on 1/11/14 for an extended period of time. (6 days after the incident)</p> <p>On 2/27/14 at 6:45 AM, Nurse Aide D verified on 1/12/14 at 5:00 AM, he/she assisted the nurse with rolling the resident over on his/her side in the bed and staff removed the bed pan under the resident.</p> <p>On 2/27/14 at 7:00 AM, Nurse F stated on the morning of 1/12/14 at 5:00 AM, he/she entered the resident's room to place a Lidocaine patch ( a topical medication patch for pain management) on the resident's lower back as ordered by the physician. Nurse Aide D assisted Nurse F to roll the resident over on his/ her side in the bed, and at that time he/she found a fracture bed pan</p>	F 314			

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F 314	Continued From page 15 under the resident. Nurse F the resident was probably not even aware the bed pan was under him/her.(On bed pan for approximately 8 hours)  On 2/27/14 at 9:40 AM, Nurse G revealed on 1/12/14 the staff had not notified, the resident's DPOA of the resident being left on the bed pan.  On 2/27/14 at 10:10 AM, Administrative Nurse H revealed the staff are expected to check on all residents every 2 hours or more often if needed. Administrative Nurse H indicated the resident was at risk for pressure ulcer development.  On 2/28/14 at 12:45 PM, Physician I stated he/she was aware the resident had been left on a bed pan for an extended period of time. Physician I revealed the resident was at risk for skin impairment and had received skin breakdown from being left on the bed pan. Physician I also indicated he/she was not aware the state agency was not notified of the incident.  The 11/2003 facility's wound and skin protocol policy indicated all residents will have appropriate wound and skin care.The prevention of pressure skin problems can be carried out by repositioning.  The facility failed to ensure appropriate care for Resident # 1 who developed pressure areas on his/her buttocks from being on a bed pan for an extended period of time. (approximately 8 hours)	F 314			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.	F 332			

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F 332	<p>Continued From page 16</p> <p>This Requirement is not met as evidenced by: The facility had a census of 35 residents. The sample included 3 residents of which 3 residents were reviewed for medications. The facility failed to prevent medication errors for 1 of the 3 residents. (#1)</p> <p>Findings Included:</p> <ul style="list-style-type: none"> <li>- Resident #1's physician's order sheet, dated 2/1/14, indicated Resident #1 had diagnoses including congestive heart failure (a condition when the heart output is low and the body becomes congested with fluid), venous insufficiency (a condition in which the veins have problems sending blood from the legs back to the heart), chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).</li> </ul> <p>The annual (MDS) Minimum Data Set 3.0 assessment, dated 1/8/14, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 8, which indicated moderately impaired cognition, and he/she required total assistance with bed mobility, transfers and toilet use. The MDS further revealed the resident received antidepressant and diuretic medications.</p> <p>The 1/9/14 Activities of Daily Living, care assessment summary (CAA), revealed the resident needed a mechanical lift for transfers and wheelchair mobility. The CAA also indicated</p>	F 332			

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F 332	<p>Continued From page 17 the resident became anxious at times.</p> <p>The 1/9/14 care plan revealed a Black Box Warning for the medication, Provigil (a medication to decrease sleep episodes). The Black Box care plan directed the staff to monitor the resident for wakefulness/sleep pattern, dependence, headache, nervousness, confusion, dizziness, diarrhea, dry mouth, anorexia, chest pain, palpitations and excessive insomnia. The care plan revealed the resident received Nexium 40 mg (milligrams)(a medication for gastroesophageal reflux disease) PO (by mouth), daily at 6:30 AM and directed the staff to administer Provigil 200 mg on 5/21/08) PO, daily at 6:30AM.</p> <p>The 1/12/14 2:30 PM, nurses notes revealed the staff administered the Provigil and Nexium to the resident when he/she was in his/her room at 7:00 AM. Further review of the nurse's notes revealed the resident seated at the dining table for the breakfast meal and the staff administered the same medication Nexium and Provigil again.</p> <p>Further review of the nurse's notes from 1/12/14 until 2/27/14 indicated no further documentation the staff reassessed the resident after he/she received the increased dose of medications.</p> <p>On 2/26/14 at 10:20 AM, observation revealed the resident, seated in a large black high backed wheelchair with his/her feet on the wheelchair foot pedals, in the facility living room.</p> <p>On 2/27/14 at 9:40 AM, Nurse G verified there was no documentation of staff follow up and reassessment of the resident after the staff administered increased doses of Nexium and Provigil.</p>	F 332			

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F 332	Continued From page 18  On 2/27/14 at 10:10 AM, Administrative Nurse H verified, staff should reassess a resident after he/she had received medication in error.  The 2/2004 facility policy indicated the staff are to sign the medication sheet immediately prior to giving the individual resident medication or immediately after giving the resident his/her medication.  The undated facility policy for Medication Administering Discrepancies and Adverse Reactions directs the staff to monitor the resident closely for 24 to 72 hours after a medication error.  The facility failed to ensure staff administered medications without medication errors and reassessed Resident #1 for 24 to 72 hours after staff administered him/her the same medications approximately 1 hour apart.	F 332		