

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

PRINTED: 12/22/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/02/2008
NAME OF PROVIDER OR SUPPLIER FOREST VIEW REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD DURHAM, NC 27705	
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F 000	INITIAL COMMENTS	F 000		
F 281 SS=D	<p>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility performed wound care treatment without a physician's order for 1 of 1 residents with a new skin graft donor site. (Resident #7)</p> <p>Findings include:</p> <p>Review of the medical record for Resident #7 documented that Resident #7 was admitted to the facility on 02/26/08 with diagnoses that included left femur fracture, left tibia fracture and left fibular fracture.</p> <p>The Admission Minimum Data Set (MDS) dated 03/07/08 documented that the Resident had no problems with memory or with cognitive skills for daily decision making. There were no communication problems documented for the Resident. The MDS revealed that the Resident had surgical wounds.</p> <p>A review of the Nurse's Notes for Resident #7 documented "04/01/08 at 3 PM Resident returned from surgery (c with a line over it) new orders for Vicodin (medication used for pain management) 2 tabs (tablets) po (by mouth) Q (every) 6 (symbol</p>	F 281		4/28/08

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 281	<p>Continued From page 1</p> <p>for hours) + (and) Keflex (antibiotic) 500 mg (milligrams) po QID (four times daily) X (times) 5 days. Only 50 tabs (tablets) ordered for Vicodin per plastic surgeon".</p> <p>A review of the Daily Skilled Nurses Notes for Resident #7 revealed documentation by nurse #2 that stated "04/02/08 7:00 AM Pt (Resident #7) returned from appt (appointment) with a skin graft done right thigh. Pt (Resident #7) expressed 10/10 (pain scale with 10 out of 10 being highest level of pain) and received oxycodone (pain medication) along with meds (medications). Pt (Resident #7) @ (at) 0445 (4:45 AM) had a dressing change to RT (right) thigh to cover graft site by (nurse #1). Site was CDI (clean, dry and intact) redness, (illegible word)".</p> <p>The Resident's medical record contained no documentation regarding physician orders or care prescribed for the graft donor site on the Resident's right leg.</p> <p>On 04/02/08 at 2:00 PM an interview was conducted with the facility's Treatment Nurse. The nurse stated that Resident #7 went out to an appointment with a plastic surgeon on 04/01/08. The nurse said that as she was leaving the facility "around 8:00 PM" she saw the Resident and the Resident had "blood" on his right thigh area. The nurse said that on assessment she saw that there was no dressing in place on the right thigh and that the thigh showed a new skin graft donor site. The nurse stated that the donor site was bleeding and that she applied a gauze dressing to the donor site and topped the dressing with an elastic dressing to the site. The nurse stated that she did not check the Resident's record for any physician orders or recommended care to the</p>	F 281			

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F 281	<p>Continued From page 2</p> <p>donor site. The nurse said that she did not contact the Plastic Surgeon or the Resident's Attending Physician for orders regarding care to the donor site.</p> <p>On 04/02/08 at 2:25 PM an interview was conducted with the facility's Director of Nursing. The Director of Nursing stated that it was her expectation that all licensed nurses follow physician orders for wound care. The Director of Nursing stated that it was her expectation that a licensed nurse would contact a physician for specific wound care orders prior to providing care to the wound if no orders were on the resident's medical record.</p> <p>At 04/02/08 at 3:05 PM an interview was conducted with Resident #7. The Resident stated that he saw the Plastic Surgeon on 04/01/08 and that the doctor removed skin from his right thigh to use as donor skin on his (Resident #7) injured (left) leg. The Resident stated that after he returned to the facility the donor site bled through the dressing that had been applied at the Plastic Surgeon's office. The Resident said that "blood was dripping down my leg and the dressing was soaked". The Resident said "I pulled the bloody one off and put it in the trash can". The Resident said that his leg was "redone" (did not identify who did the dressing) around 8 or 9 PM. The Resident said that on 04/02/08 "around 4 or so in the morning" the dressing on the right thigh (donor site) had rolled down and the "raw meat" was showing. The Resident said that the "night nurse" (nurse #1) helped him (Resident #7) to remove the soiled dressing and applied a new dressing. The Resident added that nurse #1 cleaned the "raw" area (donor site) with "saline". The Resident said that nurse #1 "put one of those</p>	F 281			

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F 281	<p>Continued From page 3</p> <p>(petroleum jelly covered gauze) on it (donor site). The gauze was not big enough to cover the whole raw place but one was all that there was in my room at that time, then he (nurse #1) wrapped my leg in that white gauze and put this ace bandage on top". The Resident stated that the Plastic Surgeon did not give him (Resident #7) any care instructions for the donor site and did not tell him (Resident #7) to change the dressing.</p> <p>On 04/02/08 at 3:20 PM an interview was conducted with the Nursing Supervisor for the unit where the Resident resided. The Nursing Supervisor stated that when a resident returned to the facility from a doctor's/clinic appointment the nurse that received the resident back into the facility was responsible for assessing the resident, reviewing new physician orders and obtaining orders for needed care if no orders were sent back with the resident. The Nursing Supervisor stated that she was familiar with Resident #7. The Nursing Supervisor said that the Resident went to an appointment with a Plastic Surgeon on 04/01/08. The Nursing Supervisor stated that the Plastic Surgeon did not send any orders for donor site care to the facility. The Nursing Supervisor stated that she was the nurse that accepted the Resident back into the facility on 04/01/08 following his (Resident #7) appointment with the Plastic Surgeon. The Nursing Supervisor stated that she made attempts at contacting the Plastic Surgeon (04/01/08) but was unable to reach him (Plastic Surgeon) by telephone "but didn't chart that". The Nursing Supervisor said that she did not contact the Resident's Attending Physician regarding orders for donor site care. The Nursing Supervisor stated that she would contact the Resident's Physician for orders for the care of the</p>	F 281			

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F 281	<p>Continued From page 4 donor site.</p> <p>On 04/02/08 at 4:45 PM the Resident's medical record revealed an addition to the Nurse's noted that documented "04/02/08 3:40 PM Tried to call Plastic Surgeon on call for clarification of orders. Unable to reach anyone. Will F/U (follow- up) with (Physician)". The notes showed documentation on 04/02/08 at 4:00 PM "R (right) thigh skin graft (arrow pointing to the right) apply Benzoin tincture compound to skin graft then cover with tegaderm (no adhering dressing) Q (every) 3 days and PRN (as needed). Resident made aware that (Physician) was called and this order obtained".</p> <p>On 04/03/08 at 6:10 AM an interview (by telephone) was conducted with nurse #1. Nurse #1 said that he worked the third shift on 04/01/08 (from 11:00 PM on 04/01/08 to 7:00 AM on 04/02/08). The nurse said that he was familiar with Resident #7. Nurse #1 said that on the morning (no time given) of 04/02/08 Resident #7 had pulled most of the dressing off his (Resident #7) right leg. Nurse #1 said that the Resident's right upper leg showed dried blood and that the soiled dressings showed dried blood. Nurse #1 said that he helped to remove the remainder of the dressing from Resident #7's right thigh and applied a new dressing. Nurse #1 stated that he (nurse #1) "cleaned the donor site on the right thigh with saline, placed (petroleum jelly covered gauze) over the open area, covered the area with (gauze dressing) and topped it with an elastic dressing to hold it in place". Nurse #1 said that he did not have a physician's order for the dressing change and that he did not contact the Resident's Physician regarding donor site care.</p>	F 281			

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F 281	Continued From page 5 On 04/03/08 at 2:15 PM an interview was conducted with Resident #7's Attending Physician. The Physician stated that as long as the donor site was still viable and no sloughing occurred there was no damage to the site from the care that the Resident received prior to initiating physician's ordered care for the donor site.	F 281			
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to apply a lap buddy and failed to provide supervision to prevent a fall for 1 of 1 sampled residents reviewed for falls. (Resident # 5). Findings include: A review of Resident #5's medical record revealed that Resident #5 was admitted to the facility on 04/19/07 with multiple diagnoses that included Alzheimer's disease, dementia with behavior disturbances, abnormality of gait, muscle/ligament disease and lack of coordination. The Resident's medical record documented a Fall Risk Assessments dated 04/19/07 with a total score of 14 (total score of 10 or above represents	F 323		4/28/08	

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F 323	<p>Continued From page 6</p> <p>high risk for falls) The record revealed a Fall Risk Assessment dated 08/26/07 with a total score of 10, a Fall Risk Assessment dated 10/15/07 with a total score of 13 and a Fall Risk Assessment dated 01/03/08 with a total score of 13.</p> <p>A Significant Change Minimum Data Set (MDS) Assessment dated 01/04/08 documented that the Resident had problems with short and long term memories and that she (Resident #5) had severely impaired (never/rarely made decisions) cognitive skills for daily decision making. The MDS documented that the Resident rarely/never understood others and was rarely/never understood. The MDS revealed that the Resident was easily distracted, had periods of altered perception or awareness of surroundings and that her (Resident # 5) mental function varied over the course of the day. The MDS documented that the Resident had severely impaired vision (no vision or sees only light, colors or shapes; eyes do not appear to follow objects). The MDS documented that the Resident had difficulty with standing and sitting balance. The MDS documented that the Resident was totally dependent on facility staff for bed mobility and transfers and that the Resident required extensive assistance for ambulation. The MDS documented that the Resident had an unsteady gait and that she (Resident #5) had a history of falls (fell in the past 30 days and fell in the past 31 to 180 days). The MDS showed that the Resident received antipsychotic medications and that she was incontinent of bowel movements and urine. The MDs documented the use of a trunk restraint for Resident #5.</p> <p>A review of the Resident Assessment Protocol Summaries (RAPS) dated 01/04/08 documented that falls triggered for Resident #5 and that falls</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>was referred to the comprehensive Care Plan for the Resident.</p> <p>The Comprehensive Care Plan dated 01/04/08 addressed the problem of "potential for fall d/t unsteady gait with kyphotic type stance, and cognitive impairment with poor safety awareness. She also has a history of wandering and exit seeking with a use of a wander guard placed and is on a locked unit. Fall noted on 12/31/07". The care plan documented an update on 03/15/08 with the addition of "lap buddy to w/c (wheel chair) due to poor safety awareness hx (history of) falls, unsteady gait cognitively impaired and lack of coordination" to the documented approaches.</p> <p>A review of the Physician orders for Resident #5 revealed that on 03/15/08 the Physician ordered the use of a "lap buddy while the Resident was up in the wheel chair d/t (due to) poor safety awareness, history of fall, unsteady gait, cognition impairment, and lack of coordination. Dx: (diagnosis) dementia with disturbance and Alzheimer's".</p> <p>The Resident's record documented a Fall Risk Assessment dated 03/17/08 with a total score of 14 (high risk).</p> <p>The Resident's record documented an update to the Comprehensive care plan dated 03/18/08 "clarification: lap buddy to w/c (wheel chair) d/t (due to) poor safety awareness, history of fall, unsteady gait, cognition impairment, lack of coordination. Dx: (diagnosis) include dementia with disturbance and Alzheimer's".</p> <p>A review of the Resident Status Sheet (daily flow sheets used by nursing assistants that contained</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>information regarding care required for each resident) for Resident #5 included "wheel chair with lap buddy".</p> <p>A review of the Nurse's Notes for Resident #5 documented "03/20/08 0430 (4:30 AM) Pt (Patient) was transferred from (room number) to (room number) because the roommate is unable to get sleep from patient screaming all night. (Director of Nursing) was called and notified of the situation. The Patient was placed in (room number). Pt is sleeping quietly at this time". At 9:00 AM the nurse documented "(at) approx. (approximately) 7 AM CNA (nursing assistant #1) was giving Pt (patient) care. CNA turned around when Pt jumped out of the chair injuring her nose and forehead. Doing neuro checks. Pressure dressing placed. (Physician) was called gut (no) answer-left a message. (Family member) notified. 10:00 AM An x-ray has been ordered". The notes documented that the Resident was sent out to the Emergency Room for evaluation with a return diagnosis of skin tear to the nose and facial bruising.</p> <p>A review of the facility's Resident Incident Reports revealed that on 03/20/08 at 7:00 AM the Resident had an unwitnessed fall. The description of the incident was documented "CNA (nursing assistant #1) was giving Pt (Patient) care, placed Pt in w/c (wheel chair) went to dispose of linen--Pt jumped out of the chair". The Incident Report documented a description of the injures as "gash in midnose/puncture to L (left) forehead". The Incident Report included statements from nursing assistant #1 and the licensed nurse that was working on the unit where the Resident resided (nurse #3).</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>Nursing assistant #1 documented "went to get res (Resident #5) up, put res in chair, walked out to throw linen away, res jump out chair, when I returned she was hollering on the floor and bleeding from nose area". Nursing assistant #1 documented that she was aware of the assistive device (lap buddy) used by the Resident.</p> <p>Nurse #3 documented "CNA (nursing assistant #1) reported that she (nursing assistant #1) was getting the Pt (Resident #5) from bed to chair then turned away to get some linen and the Pt (Resident #5) jumped out of the chair". Nurse #3 documented that she was aware of the assistive device (lap buddy) used by the Resident.</p> <p>On 04/02/08 at 1:15 PM an interview was conducted with the facility Nursing Supervisor that was assigned to the unit where the Resident resided. The Nursing Supervisor stated that information regarding resident care was relayed to nursing assistants verbally by nursing staff and documented on the Kardex (Resident Status Sheets). The Nursing Supervisor was familiar with Resident #5 and stated that the Resident required the use of a lap buddy.</p> <p>On 04/03/08 at 2:15 PM an interview was conducted by telephone with nurse #3. The nurse stated that nursing assistants were informed of the care required for each resident verbally by nursing staff and in the Kardex (Resident Status Sheets). Nurse #3 stated that she was familiar with Resident #5 and that she (nurse #3) was aware that the Resident required the use of a lap buddy when up in the wheel chair. The nurse recalled the incident on 03/20/08. Nurse #3 said that she had worked the 11:00 PM to 7:00 AM shift on 03/19/08. The</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>nurse said that around 7:00 AM (03/20/08) she (nurse #3) was approached by nursing assistant #1 and told that Resident #5 had fallen and was in the floor. Nurse #3 said that she went to the Resident's room and found the Resident on the floor lying in front of the wheel chair. Nurse #3 stated that the Resident had blood on her face around the nose area. The nurse said that she assessed the Resident, treated the injury and assisted her (Resident #5) back to bed. Nurse #3 stated that she (nurse #3) did not see the lap buddy in the room with the Resident.</p> <p>On 04/04/08 at 6:10 AM an interview was conducted by telephone with nursing assistant #1. The nursing assistant stated that she worked the 11:00 PM to 7:00 AM shift on 03/19/08. The nursing assistant said that she (nursing assistant #1) was familiar with Resident #5 and that the Resident required the use of a lap buddy when up in the wheelchair. The nursing assistant stated that she recalled the incident on 03/20/08. Nursing assistant #1 said that during the early morning hours on 03/20/08 Resident #5 was transferred to a different room because of her (Resident #5) yelling and screaming out bothering the roommate. Nursing assistant #1 stated that nurse #1 asked her to get Resident #5 up and dressed around 6:00 AM. Nursing assistant #1 said that she transferred Resident #5 into the wheelchair after her (Resident #5) bath. Nursing assistant #1 stated that she (nursing assistant #1) did not apply a lap buddy to the Resident's wheel chair after getting her (Resident #5) up because there was not a lap buddy in the Resident's room. Nursing assistant #1 said that she left the Resident alone in the room, sitting in the wheel chair to take the soiled linen to the hamper in the corridor. The nursing assistant stated that she</p>	F 323			

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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	
F 323	Continued From page 11 (nursing assistant #1) heard a "thump" and returned to the Resident's room. Nursing assistant #1 stated that when she (nursing assistant #1) returned to the Resident's room the Resident was lying on the floor in front of the wheel chair. The nursing assistant stated that the Resident was "hollering" and her (Resident #5) nose was bleeding. The nursing assistant said that she left the Resident and reported the fall to nurse #3.	F 323			