

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

PRINTED: 10/13/2008
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 08/08/2008
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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		
	This Statement of Deficiencies was amended on 09/02/08 to show the immediate jeopardy was removed on 8/2/08 and not 8/8/08.			
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES	F 157		
	<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</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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>by:</p> <p>Based on observations, resident and staff interviews, and record reviews, the facility failed to notify the physician of a resident experiencing pain for 1 (Resident #2) of 2 sampled residents with pain symptoms.</p> <p>Findings include:</p> <p>Resident #2 was re-admitted to the facility on 4-3-08 with diagnoses to include Advanced Dementia and anemia.</p> <p>Review of the resident's careplan, dated 4-08-08, revealed a problem identified as "Pain (related to) non healing wounds". An intervention on the careplan included "Report increased pain trend to physician".</p> <p>The resident's most recent Minimum Data Set (MDS), a significant change assessment dated 6-29-08, revealed the resident had long and short-term memory problems and was severely impaired in daily decision-making. The MDS coded the resident as being able to sometimes understand others and sometimes being understood by others. The resident was coded to have a stage IV decubitus ulcer.</p> <p>Review of the resident's medical record revealed physician's orders for August 2008. Review of pain medications revealed an order for Tylenol 650mg (milligrams) every 6 hours as needed. Review of the Medication Administration Record for May, June, and July of 2008 indicated Tylenol had not been given.</p> <p>Review of the resident's medical record revealed a Weekly Nursing Summary, dated 6-2-08, that</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>revealed a pain assessment. Review of Section B of the pain assessment documented (as needed) medications relieved pain. Movement/pressure was documented as causes of what made the pain worse. Frequency of pain was documented as less than daily. Origin of pain was documented as "sacral".</p> <p>Review of the resident's medical record revealed a Wound/Skin Healing Record. An assessment, dated 6-25-08, revealed a pain assessment related to treatment of the resident's wound. The resident's pain response was documented as a "6" on a scale of 0 through 10 (0 being no pain, 10 represented worst possible pain).</p> <p>Review of the Wound/Skin Healing Record, dated 7-2-08, revealed the pain assessment portion was not completed. The treatment nurse who documented on the Wound/Skin Healing Record no longer worked at the facility.</p> <p>Review of the resident's medical record revealed a Weekly Nursing Summary, dated 7-3-08. Section B of the pain assessment documented (as needed) medications relieved pain. Movement/pressure was documented as causes of what made the pain worse. Frequency of pain was documented as less than daily. Origin of pain was documented as "sacral".</p> <p>Review of the resident's medical record revealed a Weekly Nursing Summary, dated 7-10-08. Section B of the pain assessment documented signs and symptoms of pain as facial grimaces/winces. Relief of pain was documented as (as needed) medications. Pressure/movement were documented as conditions for making the pain worse. Frequency</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>of pain was documented as less than daily. Origin of the pain was documented as "sacral".</p> <p>Review of the resident's medical record revealed Weekly Nursing Summaries, dated 7-17-08 and 7-24-08. Review of the pain assessment section of the summaries revealed the same assessment as documented on the 7-10-08 assessment.</p> <p>During an interview on 7-31-08 at 4 p.m., Nurse #3 reported the resident had facial grimacing when she was turned. The nurse stated she occasionally performed the resident's treatment to the sacrum. The nurse stated the resident's face was turned away while the treatment was done. The nurse stated she asked the resident if she was in pain while the nurse did treatment care. The nurse reported the resident's answers did not "correlate to the question".</p> <p>An observation of the resident's pressure wound on 7-31-08 at 10:17 a.m. revealed the resident had a Stage IV (a deep ulcer extended into muscle, tendon, and/or bone) wound. During the observation, the resident was turned onto her right side, the treatment nurse removed the adult brief, then the dressing. The treatment nurse began to clean the wound with a liquid and gauze. An observation of the resident's face did not indicate signs of pain with the cleaning of the wound. The resident reported the treatment "hurt, but not that bad, I can handle it" The resident then reported she wanted something for pain before the treatment was done. Nurse #3 stated she would notify the resident's physician and get an order for a pain medication to be given 1/2 hour before the treatment was done. The treatment nurse reported he asked the resident if the resident experienced pain every day he</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>performed the treatment. The treatment nurse stated the resident denied pain and did not have any facial expression of pain. The treatment nurse stated he expected the resident would have pain with the wound the resident had on her sacrum.</p> <p>During an interview on 7-31-08 at 11:53a.m., nursing assistant (NA) #1 reported the resident frowned when she was moved. The NA stated "it was like she was sore". The NA reported the resident was "ok" once the resident was still. The NA stated she provided care slowly, and very easy because she frowned like she was in pain. The NA stated she reported the information to Nurse #2.</p> <p>During an interview on 8-1-08 at 10:30a.m., NA #1 reported when she turned the resident to provide care, the resident hurt. The NA stated she frowned at times. The NA stated she reported signs of the resident's pain to the nurse.</p> <p>During an interview on 8-1-08 at 3:35 p.m., NA #6 reported there have been times when turned the resident, the resident would say "whoa, whoa, that hurt". The NA stated she would reposition the resident until she was comfortable.</p> <p>During an interview on 7-31-08 at 10:58 a.m., Nurse #2 reported the resident's physician gave a telephone order for pain medication. The nurse reported she never did the resident's treatment and did not recall staff telling her the resident was in pain.</p> <p>Review of nurse notes revealed no documentation that the physician was notified that the resident was experiencing pain.</p>	F 157			

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F 157	Continued From page 5	F 157			
F 242 SS=B	<p>483.15(b) SELF-DETERMINATION AND PARTICIPATION</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews, the facility failed to honor preferences of smoking opportunities for 6 (Residents # 13, 14, 15, 16, 17, and 18) of 6 sampled residents who were assessed as safe smokers.</p> <p>Findings include:</p> <p>Review of the facility's "Safe Smoking" policy, dated October 1, 2007, revealed, "In an effort to further promote fire and resident safety, this facility will provide supervision for residents that smoke." Review of the Procedure portion of the policy, #5 was stated as "while smoking, the resident must be accompanied by a responsible</p>	F 242			

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F 242	<p>Continued From page 6</p> <p>adult, other than another resident. The person accompanying the resident must remain with the resident until they have finished smoking."</p> <p>Residents # 13, # 14, # 15, # 16, # 17 and # 18 were assessed by the facility as being alert and oriented and able to smoke safely. Interviews with these residents revealed the following: Resident #14, during an interview on 8-5-08 at 10:48 a.m., reported he was told all residents were supervised when smoking. The resident reported there were times he went outside and smoked by himself. Resident #17 stated, during an interview on 8-8-08 at 3:55 p.m., that he only smoked 2 or 3 cigarettes daily. The resident reported smokers were supposed to have someone with them to supervise while they were smoking. The resident stated he was given that information when he was admitted to the facility Resident #18 stated, during an interview on 8-8-08 at 3:45 p.m., that he smoked outside with staff members present.</p> <p>During an observation on 7-29-08 at 10:08 a.m. of the designated smoking area, Residents #14 and 18 were observed among other smoking residents with lit cigarettes. A staff member had a clear box on a table that contained various cigarettes.</p> <p>During an interview on 8-8-08 at 4:10 p.m., the Admissions Coordinator reported she reviewed the Smoking Policy with residents determined to have been a smoker. The Coordinator stated she reviewed the policy and explained cigarettes and lighters were locked at the nurse station and staff supervised residents at designated times during the day.</p>	F 242			

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F 242	<p>Continued From page 7</p> <p>During an interview on 8-1-08 at 9:10 a.m., the Administrator reported all smoking residents were supervised while smoking. The Administrator reported there have been times when staff has been late to supervise residents during a designated smoking break. The Administrator stated he was aware the smoking program needed attention for consistency and safety compliance. The administrator stated he had met with the residents who smoked and reviewed the facility's policy on smoking.</p> <p>The Administrator had meetings with staff on 6-30-08 and 7-8-08 to review the smoking program. Notes of the meetings were provided for review. Review of notes, dated 6-30-08, revealed in part "every (resident) is designated unsafe."</p> <p>During an interview on 8-2-08 at 11:45 a.m., the Administrator restated residents identified as safe smokers must be supervised and referred to Procedure #5 of the facility's smoking policy. The Administrator reported he was unaware until 8-1-08 that the 8 a.m. designated smoking break time was often missed due to lack of staff supervision.</p> <p>During an interview on 8-2-08 at 12:35 p.m., the Regional Vice President (RVP) reported all smoking residents were supervised while smoking for safety reasons. The RVP stated the smoking policy was a facility policy. The RVP reported smoking assessments were completed to alert staff to the smoking residents who are more at risk for injury and unsafe smoking behaviors.</p> <p>During an interview on 8-2-08 at 1 p.m., Nurse #4</p>	F 242			

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F 242	Continued From page 8 reported residents who smoked were supervised. Nurse #4 stated the residents' cigarettes and lighters were kept locked in a supply room on the unit when residents were not smoking. The nurse presented a copy of a sign off sheet that was used for each smoking break. The nurse reported residents who attended the breaks were signed off as being present. The nurse reported when nursing staff were scheduled to supervise smoking, there have been times when nursing staff were late. The nurse stated there were times when nursing staff had been involved in patient care and could not stop what they were doing. The nurse stated the assigned nursing staff completed their task, and then reported to the designated smoking area. The nurse stated it had been some time since the facility had the 8 a.m. smoking break. The nurse reported smoking breaks occurred at 10 a.m., 12 p.m. and 2 p.m. for the 7 am to 3 p.m. shift. The nurse reported she was unaware of the reason the 8 a.m. smoking break was no longer scheduled. During an interview on 8-4-08 at 4:30 p.m., the RVP stated he had concerns with the smoking program in the facility related to the supervision of safe smokers. The RVP stated he planned to review the policy for changes.	F 242			
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

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F 309	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews, the facility failed to assess and treat 1 (Resident #2) of 2 sampled residents with pain symptoms.</p> <p>Findings include:</p> <p>Resident #2 was re-admitted to the facility on 4-3-08 with diagnoses to include Advanced Dementia and anemia.</p> <p>Review of the resident's careplan, dated 4-08-08, revealed a problem identified as "Pain (related to non healing wounds". The goal for the problem was documented as "resident will show no (signs or symptoms) of pain at least 1 hour after pain medication is given (times) 90 days". An intervention on the careplan included "assess location, frequency, duration, and intensity of pain. Document assessment. Report increased pain trend to physician".</p> <p>The resident's most recent Minimum Data Set (MDS), a significant change assessment dated 6-29-08, revealed the resident had long and short-term memory problems and was severely impaired in daily decision-making. The MDS coded the resident as being able to sometimes understand others and sometimes being understood by others. Review of the MDS revealed the resident required extensive assistance of one staff member for dressing, eating, hygiene, and bathing. The resident was coded to have a stage IV decubitus ulcer. The MDS assessed the resident's pain as not having occurred in the past 7 days.</p>	F 309			

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F 309	<p>Continued From page 10</p> <p>Review of the resident's medical record revealed physician's orders for August 2008. Review of pain medications revealed an order for Tylenol 650mg (milligrams) every 6 hours as needed. Review of the Medication Administration Record for May, June, and July of 2008 indicated Tylenol had not been given.</p> <p>Review of the resident's medical record revealed a Weekly Nursing Summary, dated 6-2-08, that revealed a pain assessment. Review of the pain assessment, Section A (Wong-Baker FACES Pain Scale Rating) was not completed. Section B of the pain assessment documented (as needed) medications relieved pain. Movement/pressure was documented as causes of what made the pain worse. Frequency of pain was documented as less than daily. Origin of pain was documented as "sacral".</p> <p>Review of the resident's medical record revealed a Wound/Skin Healing Record. An assessment, dated 6-25-08, revealed a pain assessment related to treatment of the resident's wound. The resident's pain response was documented as a "6" on a scale of 0 through 10 (0 being no pain, 10 represented worst possible pain). Review of the Wound/Skin Healing Record, dated 7-2-08, revealed the pain assessment portion was not completed.</p> <p>Review of the resident's medical record revealed a Weekly Nursing Summary, dated 7-3-08, that revealed a pain assessment. Review of the pain assessment, Section A, was not completed. Section B documented (as needed) medications relieved pain. Movement/pressure was documented as causes of what made the pain worse. Frequency of pain was documented as</p>	F 309			

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F 309	<p>Continued From page 11</p> <p>less than daily. Origin of pain was documented as "sacral".</p> <p>The weekly wound assessment for 7-8-08 was documented as "hospital".</p> <p>Review of nurse notes revealed no documentation that the physician was notified that the resident was experiencing pain. The treatment nurse who documented on the Wound/Skin Healing Record no longer worked at the facility.</p> <p>Review of the resident's medical record revealed a Weekly Nursing Summary, dated 7-10-08, that revealed a pain assessment. Review of the pain assessment, Section A, was not completed. Section B documented signs and symptoms of pain as facial grimaces/winces. Relief of pain was documented as (as needed) medications. Pressure/movement were documented as conditions for making the pain worse. Frequency of pain was documented as less than daily. Origin of the pain was documented as "sacral".</p> <p>Review of the resident's medical record revealed Weekly Nursing Summaries, dated 7-17-08 and 7-24-08. Review of the pain assessment section of the summaries revealed the same assessment as documented on the 7-10-08 assessment. The Weekly Nursing Summaries were documented by Nurse #3.</p> <p>During an interview on 7-31-08 at 4 p.m., Nurse #3 reported the resident had facial grimacing when she was turned. The nurse stated she occasionally performed the resident's treatment to the sacrum. The nurse stated the resident's face was turned away while the treatment was done.</p>	F 309			

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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 08/08/2008
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 309	<p>Continued From page 12</p> <p>The nurse stated she asked the resident if she was in pain while the nurse did treatment care. The nurse reported the resident's answers did not "correlate to the question".</p> <p>An observation of the resident's pressure wound on 7-31-08 at 10:17 a.m. revealed the resident had a Stage IV (a deep ulcer extended into muscle, tendon, and/or bone) wound. The treatment nurse was observed setting dressings and supplies on the resident's overbed table. Nurse #3 entered the room and explained to the resident the treatment nurse was going to change the dressing on the resident's sacral wound. During the observation, the resident was turned onto her right side, the treatment nurse removed the adult brief, then the dressing. The treatment nurse began to clean the wound with a liquid and gauze. An observation of the resident's face did not indicate signs of pain with the cleaning of the wound. The resident reported the treatment "hurt, but not that bad, I can handle it" The resident then reported she wanted something for pain before the treatment was done. Nurse #3 stated she would notify the resident's physician and get an order for a pain medication to be given 1/2 hour before the treatment was done. The treatment nurse reported he asked the resident if the resident experienced pain every day he performed the treatment. The treatment nurse stated the resident denied pain and did not have any facial expression of pain. The treatment nurse stated he expected the resident would have pain with the wound the resident had on her sacrum.</p> <p>During an interview on 7-31-08 at 11:53a.m., nursing assistant (NA) #1 reported the resident frowned when she was moved. The NA stated "it</p>	F 309			

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F 309	Continued From page 13 was like she was sore". The NA reported the resident was "ok" once the resident was still. The NA stated she provided care slowly, and very easy because she frowned like she was in pain. The NA stated she reported the information to Nurse #2. During an interview on 8-1-08 at 10:30a.m., NA #1 reported when she turned the resident to provide care, the resident hurt. The NA stated she frowned at times. The NA stated she reported signs of the resident's pain to the nurse. During an interview on 8-1-08 at 3:35 p.m., NA #6 reported there have been times when turned the resident, the resident would say "whoa, whoa, that hurt". The NA stated she would reposition the resident until she was comfortable. During an interview on 7-31-08 at 10:58 a.m., Nurse #2 reported the resident's physician gave a telephone order for pain medication. The nurse reported she never did the resident's treatment and did not recall staff telling her the resident was in pain. During an interview on 8-1-08 at 5 p.m., the Director of Nursing (DON) reported the nurses were expected to do pain assessments for indications of pain during a treatment. The DON stated she expected the nurse to assess for pain during a treatment and to notify the physician. The DON was unaware the resident had experienced any pain with the treatment.	F 309			
F 315 SS=E	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315			

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F 315	<p>Continued From page 14</p> <p>indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to obtain physician's orders for the use of indwelling urinary catheters for 5 (Residents #s 2, 5, 6, 13, and 19) of 10 sampled residents with indwelling urinary catheters; the facility failed to provide care and services to prevent urinary tract infections for 3 (Residents #2, 6, and 19) of 10 sampled residents with indwelling urinary catheters; the facility failed to prevent infection of an ostomy site for 1 (Resident #6) of 1 sampled residents with a suprapubic indwelling catheter; the facility failed to provide adequate indwelling urinary catheter care for 2 (Residents #2 and #19) of 2 sampled residents with indwelling urinary catheters.</p> <p>Findings include:</p> <p>1) Resident # 6 was admitted to the facility on 2-5-08 with diagnoses to include End Stage Renal Disease, chronic pain, and Diabetes Mellitus Type II.</p> <p>Review of the resident's most recent Minimum Data Set (MDS), a quarterly assessment dated 5-18-08, the resident was assessed as having required extensive assistance of one staff member for personal hygiene and bathing. The</p>	F 315			

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F 315	<p>Continued From page 15</p> <p>resident was coded as continent of bladder and had an indwelling catheter.</p> <p>Review of the resident's medical record revealed a urine culture and sensitivity, dated 6-16-08, that identified Escherichia coli (bacteria that live in the intestines) as result #1, and Psuedomonas Aeruginosa (a germ in the environment) as result #2. The resident was treated with the antibiotic Fortaz.</p> <p>Review of the resident's careplan, dated 7-4-08, revealed a problem identified as "At risk for UTI (urinary tract infection)." Intervention #12 read "Catheter care (every) shift and (as needed)."</p> <p>Review of the resident's medical record revealed a nurse note, dated 7-15-08 (no time indicated), that read in part "MD (medical doctor) saw resident, noted wound at suprapubic site."</p> <p>Review of a physician's progress note dated 7-15-08 revealed an assessment documented as "A patient with suprapubic catheter appears to have surrounding evidence of infection and cellulites (acute inflammation of the connective tissue of the skin)."</p> <p>Review of physician's orders dated, 7-15-08, revealed an order for Cipro (antibiotic) 500mg (milligrams) twice daily for 7 days, and orders to clean the wound with wound cleanser, pat dry, apply triple antibiotic ointment, and cover with calcium alginate (form of debridement), and a 4" by 4" gauze covering.</p> <p>Review of the resident's July 2008 Treatment Administration Record (TAR) revealed the treatment was completed on 7-13-08 and</p>	F 315			

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F 315	<p>Continued From page 16</p> <p>7-14-08. The treatment was marked "(discontinued)" after the 7-14-08 signature. The treatment nurse no longer worked in the facility and was not available for interview during the survey</p> <p>Review of the resident's August 2008 physician's orders revealed no orders written for use of a suprapubic (an indwelling catheter that is placed directly into the bladder through the abdomen) urinary catheter. Review of the August 2008 physician's orders revealed no orders were written for care of the catheter site. Review of the resident's Medication Administration (MAR) and Treatment Administration Record (TAR) for August 2008 did not reveal documentation of the catheter having been changed.</p> <p>Observation of the resident on 8-5-08 at 2:46 p.m. and again at 5:55 p.m., revealed a urinary drainage line extended from the end of the resident's pant leg and the drainage bag hung inside a privacy bag on the back of the wheelchair. The line had visible clear yellow urine. The resident was seated in his wheelchair and an observation of the ostomy site was not made.</p> <p>During an interview on 8-5-08 at 4:45 p.m., Nurse #1 reported the 11 p.m. to 7 a.m. shift usually changes indwelling urinary catheters once monthly. The nurse stated when the resident complained of any discomfort, the nurse irrigated the catheter. The nurse stated she changed the catheter when it did not drain with irrigation. Nurse #1 reported NAs were expected to wash around the site with the resident's daily bath. The nurse stated NAs reported any redness or discomfort from the site. The nurse stated the</p>	F 315			

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F 315	<p>Continued From page 17</p> <p>resident has an appointment with the urologist 9-16-08.</p> <p>During an interview on 8-5-08 at 4:52 p.m., nursing assistant (NA) #2 reported NAs cleaned the suprapubic catheter site with soap and water with evening care, incontinent care, and bathing. The NA stated any signs of redness or complaint of pain was reported to the nurse immediately. The NA reported the resident had a dressing on the site approximately one week ago. The NA stated the last time she cared for the resident, she did not observe any problems with the site.</p> <p>During an interview on 8-5-08 at 5 p.m., the Unit Coordinator of "C" hall reported NAs were expected to wipe around the suprapubic catheter site daily with the resident's bath. The Unit Coordinator stated catheter care was ordered and documented on the nurses' Medication Administration Record (MAR) and nurses were responsible to sign off that daily care had been done.</p> <p>During an interview on 8-1-08 at 5 p.m., the Director of Nursing (DON) reported nurses were expected to assess each resident for a medical need for an indwelling urinary catheter, obtain physician's orders for the use of a catheter, orders for catheter care, and orders for changing catheters. The DON stated she was unaware residents in the facility did not have orders for indwelling urinary catheters. The DON reported she had not reviewed catheter use in the facility prior to the survey. The DON reported she needed to obtain medical orders to include medical necessity, frequency of changes, and care for residents with indwelling urinary catheters.</p>	F 315			

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F 315	Continued From page 18 During an interview on 8-1-08 at 9:55 a.m., the resident's physician reported he expected any resident with an indwelling urinary catheter had orders for the catheter, orders to change the catheter, and orders for care. 2) Resident #2 was readmitted to the facility on 4-3-08 with diagnoses to include Advanced dementia and anemia. Review of the Resident Assessment Protocol (RAP) for urinary incontinence and indwelling catheter dated 4-3-08, revealed staff notes documentation of a recent diagnoses of UTI (urinary tract infection) (no date was given for the infection). Review of the most recent Minimum Data Set (MDS), a significant change assessment dated 6-29-08, revealed the resident required extensive assistance of one staff member for dressing, eating, hygiene, and bathing. The MDS coded the resident as continent of bladder and had an indwelling catheter. Review of the resident's medical record revealed a problem on the resident's careplan documented as "short term: Urinary tract infection foley (indwelling urinary catheter) cath use (related to) pressure ulcer stage IV and non healing surgical wound". Review of the resident's medical record revealed a nurse note, dated 7-17-08 at 5:30 p.m. that read in part "observed tea colored urine in foley bag. (Resident) was seen by (nurse practitioner) today. New orders received. "	F 315			

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F 315	<p>Continued From page 19</p> <p>Review of the resident's medical record revealed physician's orders, dated 7-17-08, that read: "2) Change foley catheter, 3) once foley (changed), obtain (urinalysis, culture and sensitivity)."</p> <p>Review of the resident's medical record revealed a urinalysis result, dated 7-18-08, and documented the microscopic analysis of White Blood Cells as 10-20/hpf (normal results were documented as "none seen"). The result of the urine culture was reported as "no growth."</p> <p>A nurse note, dated 7-18-08 at 10 40 a.m., revealed the resident was transported to the emergency room of a local hospital.</p> <p>Review of a nurse note dated 7-18-08 at 6 p.m., revealed the resident returned to the facility with a diagnoses of UTI and orders were received for an antibiotic.</p> <p>Review of the resident's medical record revealed a physician's order, dated 7-19-08, for Bactrim DS (an antibiotic) 800mg (milligrams) orally every 12 hours for a UTI. A physician's order, dated 7-24-08 revealed a clarification of the antibiotic order to be given for 10 days.</p> <p>Review of the resident's medical record revealed physician's orders for August 2008. The physician had not ordered the use of a catheter, routine change of the catheter, or catheter care.</p> <p>During an observation on 8-2-08 at 10:55 a.m., indwelling urinary catheter care was provided to the resident by nursing assistant (NA) #1. The resident was turned onto her right side and the adult brief was opened. The brief revealed a small amount of soft, light colored brown stool.</p>	F 315			

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F 315	<p>Continued From page 20</p> <p>The NA washed the resident's rectal area and buttocks and had a small amount of the stool on the washcloth. The NA put the washcloth into a basin of soapy water, dried the resident's buttocks with a dry towel. The NA removed the adult brief from the resident and the resident rested on her back. The NA took the washcloth (the same washcloth that the NA used to clean the stool) from the basin of soapy water and began to wipe down the indwelling urinary catheter. The NA reported she used the same washcloth as she used for the incontinent care for stool. The NA stopped momentarily and put the washcloth in the basin and went to the resident's bathroom. The basin was emptied, rinsed, and filled with water. The NA returned the basin to the resident's bedside and used another dry washcloth to wipe down the catheter. The NA held the catheter at the urinary meatus (urinary duct) and pulled down the catheter with the washcloth two times. The NA reported it was painful for the resident when her legs were separated to wash the resident's labia. The NA reported she washed the area from the back of the resident.</p> <p>During an interview on 8-2-08 at 1:30 p.m., the Director of Nursing (DON) reported NAs were expected to use warm water and soap for cleaning around indwelling urinary catheters. The DON expected NAs to explain to the resident what they were going to do, position the resident properly, and to have wiped the catheter from the urinary meatus downward. The DON stated NAs were expected to clean the labia from front toward the back and use clean washcloths for catheter care.</p> <p>During an interview on 8-1-08 at 5 p.m., the</p>	F 315			

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F 315	<p>Continued From page 21</p> <p>Director of Nursing (DON) reported nurses were expected to assess each resident for a medical need for an indwelling urinary catheter, obtain physician's orders for the use of a catheter, orders for catheter care, and orders for changing catheters. The DON stated she was unaware residents in the facility did not have orders for indwelling urinary catheters. The DON reported she had not reviewed catheter use in the facility prior to the survey. The DON reported she needed to obtain medical orders to include medical necessity, frequency of changes, and care for residents with indwelling urinary catheters.</p> <p>During an interview on 8-1-08 at 9:55 a.m., the resident's physician reported he expected any resident with an indwelling urinary catheter had orders for the catheter, orders to change the catheter, and orders for care.</p> <p>3) Resident #19 was readmitted to the facility on 8-5-08 with diagnoses to include neurogenic bladder, spina bifida, urinary retention, and UTI.</p> <p>Review of the resident's Minimum Data Set (MDS), a quarterly assessment dated 5-11-08, revealed the resident required extensive assistance of one staff member for personal hygiene and two staff members for bathing. The resident was coded as being continent of bladder and had an indwelling catheter.</p> <p>Review of the resident's medical record revealed physician's orders for August 2008 for "foley cath care every shift" and as needed and orders to change the catheter every month and as needed. Review of nurse notes dated 1-25-08, 3-16-08, and 6-26-08 revealed the resident's indwelling</p>	F 315			

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F 315	<p>Continued From page 22</p> <p>catheter was changed by a nurse.</p> <p>Review of the resident's care plan, last dated 3-26-08, revealed a problem identified as "Potential for urinary traction infection with history of urosepsis (a condition caused by bacteria from urine seeping into the blood stream)" Urinary tract infections were documented on the care plan as having occurred 12-21-07, 2-20-08, and 3-26-08. The care plan revealed the resident's indwelling urinary catheter had been changed on 6/26/08.</p> <p>During an observation of indwelling urinary catheter care on 8-1-08 at 11:40 a.m., NA #3 prepared for catheter care by using a clean, wet, soapy washcloth. The NA placed the resident on her back and pulled the resident's legs apart. The resident stated she had multiple sclerosis and had spasms in her legs. The resident stated there were times when it was difficult to keep her legs apart for care. The NA was observed wiping the catheter from the insertion site down the tubing twice. The resident's legs began to spasm and the NA turned the resident on her right side. The NA wiped the resident's perineum from front to back with the washcloth turning the washcloth with each wipe. The NA dried the resident with a towel and began to position an adult brief under the resident. The NA was asked to separate the resident's labia from around the catheter. A moderate amount of yellow/tan colored matter was present in the folds in front of the catheter and behind the catheter. The NA stated "oh" and wiped the areas clean. Observation of the washcloth revealed a moderate amount of tan matter.</p> <p>During an interview on 8-2-08 at 1:30 p.m., the</p>	F 315			

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F 315	<p>Continued From page 23</p> <p>Director of Nursing (DON) reported NAs were expected to use warm water and soap for cleaning around indwelling urinary catheters. The DON expected NAs to explain to the resident what they were going to do, position the resident properly, and to have wiped the catheter from the urinary meatus downward. The DON stated NAs were expected to clean the labia from front toward the back and use clean washcloths for catheter care.</p> <p>4) Resident #13 was admitted to the facility on 7-8-08 with diagnosis to include hyperglycemia (elevated blood sugar), chronic muscle pain and spasms, T-8 thoracic spine #8, paraplegia, recurrent UTI, and systemic inflammatory disease. Review of the resident's most recent MDS, an admission assessment dated 7-8-08, revealed the resident required extensive assistance of one staff member for personal hygiene and total care of two or more staff members for bathing. The MDS coded the resident as continent of bladder and had an indwelling catheter. The MDS coded the resident as having had a urinary tract infection in the past 30 days.</p> <p>Review of the resident's medical record revealed physician's orders for August 2008 with no orders for an indwelling catheter, frequency of changes, or catheter care.</p> <p>Review of the resident's medical record revealed physician's orders dated 7-11-08 for Zyvox (antibiotic) 600mg every 12 hours for 10 days (per urinalysis). Review of the urinalysis, dated 7-11-08, revealed the urine was positive for nitrites (normal is negative), White blood cell count was 5 - 10 (normal results were none seen), Red blood</p>	F 315			

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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 08/08/2008
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 315	<p>Continued From page 24</p> <p>cell count was 0 - 5 (normal results are negative), and bacteria was 1+ (normal results are negative).</p> <p>During an interview on 8-1-08 at 5 p.m., the Director of Nursing (DON) reported nurses were expected to assess each resident for a medical need for an indwelling urinary catheter, obtain physician's orders for the use of a catheter, orders for catheter care, and orders for changing catheters. The DON stated she was unaware residents in the facility did not have orders for indwelling urinary catheters. The DON reported she had not reviewed catheter use in the facility prior to the survey. The DON reported she needed to obtain medical orders to include medical necessity, frequency of changes, and care for residents with indwelling urinary catheters.</p> <p>During an interview on 8-1-08 at 9:55 a.m., the resident's physician reported he expected any resident with an indwelling urinary catheter had orders for the catheter, orders to change the catheter, and orders for care.</p> <p>5) Resident #5 was admitted to the facility on 7-9-08 with diagnoses to include Hypertension, Cerebrovascular Accident (stroke), and hemiparesis. Review of the resident's MDS, an admission assessment dated 7-22-08, revealed the resident required total assistance of two or more staff members for personal hygiene and bathing. The MDS coded the resident as continent of bladder and had an indwelling catheter.</p> <p>Review of the resident's medical orders revealed</p>	F 315			

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F 315	Continued From page 25 physician's orders for August 2008 had no orders for the use of an indwelling catheter, orders for changing the catheter, and no orders for care of the catheter. The resident had experienced no urinary tract infections since admission 7-9-08. During an interview on 8-1-08 at 5 p.m., the Director of Nursing (DON) reported nurses were expected to assess each resident for a need for an indwelling urinary catheter, obtain physician's orders for the use of a catheter, orders for catheter care, and orders for changing catheters. The DON stated she was unaware residents in the facility did not have orders for indwelling urinary catheters. The DON reported she had not reviewed catheter use in the facility prior to the survey. The DON reported she needed to obtain medical orders to include medical necessity, frequency of changes, and care for resident's with indwelling urinary catheters. During an interview on 8-1-08 at 9:55 a.m., the resident's physician reported he expected any resident with an indwelling urinary catheter had orders for the catheter, orders to change the catheter, and orders for care.	F 315			
F 323 SS=J	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:	F 323			

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F 323	<p>Continued From page 26</p> <p>Based on observations, record review, and staff interviews, the facility failed to supervise a cognitively impaired resident (Resident # 1) who was having falls, behavioral problems and was bit by fire ants. The facility failed to secure a resident's power chair (Resident # 6) safely in the facility van resulting in the resident's chair tilting against the wall of the van during transport and putting the resident in jeopardy of serious harm for a 2 of 2 residents. This constituted Immediate Jeopardy (IJ) for Resident #6 beginning on 7/3/08 through 8/2/08. The IJ was identified on 8/5/08 at 7:48 PM. The facility provided a credible allegation of compliance on 8/8/08 at 4:30 PM. Although the immediate jeopardy was removed on 8/2/08 the facility remains out of compliance at isolated deficiencies for Resident # 1 that constitutes actual harm that is not immediate jeopardy (G). Findings include:</p> <p>1. Resident # 6 was admitted to the facility on 2/5/08 with multiple diagnoses of End Stage Renal Disease, Hypertension, Diabetes II, bilateral below the Knee Amputee and Personality Disorder. The minimum data set (MDS) dated 5/19/08 revealed Resident # 6 had no short or long term memory impairment and was independent in making decisions for tasks of daily living. Resident # 6 needed extensive assistance from nursing staff for activities of daily living and resisted care.</p> <p>Review of the facility Resident Incident Report dated 7/3/08 at 4:25 PM was conducted. The report revealed Resident # 6 was being transported back to facility from dialysis via facility van on 7/3/08. The van driver # 3 called the facility and reported that he was on the side of the</p>	F 323			

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F 323	<p>Continued From page 27</p> <p>road on the highway. Driver # 3 revealed he had missed his exit, exited at the next exit and made a U-turn to get back on the highway. Driver # 3 indicated while making a U-turn, Resident # 6 was "tilted over in his wheelchair, leaning up against the window." The report indicated the resident was lowered to the floor, repositioned in the chair and transported back to facility. The Director of Nurses (DON) documented on the report she and the Administrator arrived on the scene approximately 30 - 40 minutes later and found EMS (Emergency Medical Services) had assessed the resident lying on the floor of the van and were repositioning and assisting Resident # 6 to his wheelchair. The DON assessed Resident # 6 and found no "bruising or skin tears and the resident (Resident # 6) denied pain." The report indicated interventions to the van were "reconfigured by dealership for placement of all needed straps; staff training."</p> <p>Review of facility's investigation, dated 7/3/08, revealed a documented interview with Driver # 3. Driver # 3 stated Resident # 6's "wheelchair (power chair) tipped (to the right on front and rear wheels) towards one side (on two wheels) while he (the driver) was making a U-turn." Resident # 6's "shoulder was pushed up towards his head, leaning on the window - (Resident #6) was complaining of the glass being hot." The driver stated he "tried to pull the chair (power wheelchair) back to straighten it up, but the way the wheel on front was turned, (the driver) could not move it. Found a blanket in the van and attempted to put it under his (Resident #6) head, but was unable to do so." The driver then called the facility and EMS. The driver "had laid chair (power wheelchair) on the ground (floor of van) to reposition him (Resident #6) due to the way his</p>	F 323			

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F 323	<p>Continued From page 28 neck was pushed up."</p> <p>Review of the investigation conclusions documented by the DON on 7/3/08 was conducted. The report revealed "chair (power wheelchair) had been strapped on the front left and back right (wheel). There were only 2 straps available." Driver # 3 "was shown to strap in with 4 straps on a regular (wheel) chair." A note made at the end of the investigation revealed administrative staff "noted some straps were missing. Van taken out of use until replaced and reconfigured." The driver was suspended pending an investigation.</p> <p>Record review of nurse's notes dated 7/3/08 at 7:00 PM revealed Resident # 6 had no bruising and an "indention to upper back shaped like head rest but area blanching without any problems. Right stump with old dry scabbed areas, nothing new."</p> <p>Record review of a van product company's invoice dated 7/18/08 was conducted. The invoice revealed "3 shoulder belts, 3 lap belts and 3 tie down sets" were purchased. An interview was conducted with a van product representative on 8/6/08 at 2:33 PM. The representative could not recall if the back rear wheelchair transport position or any other wheelchair transport position on the facility van was missing straps but stated they did bring the van up to current federal standards for manual wheelchairs.</p> <p>An interview was conducted with NA # 7 (regular van transporter) on 8/5/08 at 11:15 AM. NA # 7 stated she had trained Driver # 3 for the van on 7/2/08 before she left on vacation. NA # 7 stated Driver # 3 spent the day with her learning routes</p>	F 323			

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F 323	<p>Continued From page 29</p> <p>and watching and asking questions regarding securing residents for transport in the van. NA # 7 stated Driver # 3 was not trained on securing and transporting power chairs on the day of his training. NA # 7 was not aware there were straps missing in the rear right wheelchair transport position in the transport van. NA # 7 stated she had transported Resident # 6 in the facility van in the past and stated he would not go to dialysis unless he went in his power chair. NA # 7 stated there was a half circle hitch (empty center) in the front of Resident # 6's wheelchair and a rectangular bar in the back that extended the width of the chair. NA # 7 stated she hooked one of the floor straps on the half circle hitch in the front of the power chair, adjusting the strap to the tight position. NA # 7 stated she tied the two back wheel straps to the bar in the back of the wheelchair in a double knot. NA # 7 stated Resident # 6 used his power chair seat belt to secure himself in the wheelchair.</p> <p>An interview was conducted with the DON on 8/5/08 at 2:46 PM. The DON stated it was "not the normal practice" to transport more than one resident in the facility van. The DON stated it was her expectation that van transporters report to the administrative staff if anything was out of the ordinary or there were not 5 straps to secure residents in place in the facility van. The DON stated Driver # 3 on 7/3/08 did not give a return demonstration to her before driving the van. The DON stated the van had been parked and will be towed away and put in storage. The DON reported the keys for the van were with a company representative in South Carolina.</p> <p>Observations with NA # 7 of Resident # 6's power chair was conducted on 8/5/08 at 3:05 PM.</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>Observations revealed the front hitch for Resident # 6's wheelchair was not there. NA # 7 stated "it must have broke, but I double knot the straps for the back wheels to the square bar above the rear wheels because the hooks on the straps are not big enough to open and latch on to the bar."</p> <p>An interview was conducted with NA # 8 (regular van transporter) on 8/5/08 at 12:55 PM. NA # 8 was on vacation on 7/3/08 and was not aware there were missing straps in the right rear wheelchair transport position of the van. NA # 8 stated the driver should always use 5 point restraints and if straps were missing it should be reported to Administrative staff immediately.</p> <p>An interview was conducted with Driver # 3 on 8/5/08 at 2:06 PM. The driver stated he was responsible for driving the van on 7/3/08. The driver stated NA # 7 trained him on 7/2/08 by showing him the operation of the rear lift, how to safely use 5 point restraints on a manual wheelchair. The driver stated he transported Resident # 6 and another resident to dialysis separately on the morning of 7/3/08. The driver stated they were transported in the position behind the driver that had all 5 point restraints. The driver revealed in the afternoon he picked up the other resident at dialysis and placed him in the position behind the driver's seat in a 5 point restraint. The driver stated he was going to be late picking up Resident # 6 so he did not go back to the facility to drop off the other resident. The driver picked up Resident # 6 at dialysis in another city and placed him in the rear of the van in the rear wheelchair transport position on the passenger's side. The driver stated there was "no strap to secure the left rear wheel of the power chair." The driver revealed he secured the</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>"other three wheels on the power chair indicating the left front wheel strap may have been loose or stretched when the power chair tipped toward inside van window." The driver revealed he "did secure the chest strap to the power chair" because Resident # 6 had a lap belt to secure him on his power chair. The driver stated after the power chair tipped to the right, toward the window on two wheels he could not reposition Resident # 6 or the power chair because of his (the resident) large body size. The driver stated Resident # 6 complained of his face burning against the window and his neck hurting because of the awkward position he was in. The driver was unable to get a sheet between his face and the van window. The driver revealed Resident # 6's "right arm was hanging down between the power chair and the inside wall of the van, his shoulder was pushed up toward his head and the inside of the van." The driver removed the 3 point restraints, had Resident # 6 cross his arms, pulled the chair away from the window and lowered the power chair and Resident # 6 towards the right to the floor. The driver stated the other resident was still positioned behind the driver's seat and strapped into his 5 point restraint. The driver stated he called the facility and EMS. The driver stated Resident # 6 was assessed by EMS and the DON and driven back to the facility by the Administrator while he stood next to Resident # 6 as a "spotter."</p> <p>The facility's administrator was notified of the Immediately Jeopardy on 8/5/08 at 7:48 PM.</p> <p>On 8/8/08 at 4:30 PM the facility presented the following acceptable credible allegation of compliance:</p>	F 323			

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F 323	<p>Continued From page 32</p> <p>"The facility alleges that there was no threat of immediate jeopardy to residents being transported by the facility on 8/2/08 because the keys were secured by a Corporate Representative and moved off site. The facility ceased to provide transport on 7/4/08 by the use of the facility van on this date due to facility investigation of 7/3/08 occurrence. The facility authorized transport by special exception, on one occasion after that date, due to resident special event on 7/28/08. This was after the facility van had been properly evaluated and up fitted with the Sure-Loc Wheelchair Securement system by vendor "Van Safety Products" and the driver had been properly trained. As this training was "event-specific", no further reporting or educational components were required or initiated at that time. Though the facility proceeded with evaluation of the van on 7/16/08; the final decision to discontinue transportation via facility van remains in effect. The educational and Quality Assurance components have been incorporated in accordance with this plan of correction.</p> <p>1. Corrective action was accomplished for the resident found to have been affected by the alleged deficient practice by:</p> <ul style="list-style-type: none"> · Investigation was conducted by the Administrator to determine root cause of 7/3/08 event. · Investigation revealed that resident's chair tilted against the side of the van. · Driver pulled over and attempted to straighten out the chair but was unable. · Driver called facility Director of Nursing (DON) and was instructed to notify 911. · DON notified the Administrator and both immediately drove to the scene. 	F 323			

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F 323	Continued From page 33 <ul style="list-style-type: none"> · EMS arrived at the scene; resident was repositioned to the floor of the van by the driver and then assessed by the EMT (Emergency Medical Technician) upon arrival, and subsequently by the DON. No injury was noted per the EMT, DON and resident's verbalization. · Resident further denied injury to the Administrator. · Resident was re-secured in the facility van on 7/3/08 by the Administrator using 5-Point Securement system in the facility van; the Administrator then drove the van back to the facility. · The Administrator drove the facility van back to the facility. The Administrator was trained on the 5-Point Securement system on 5/7/08. This training included the 5-Point Securement system with successful return demonstration to the Regional Director of Operations. · Body audit was completed by the Unit Coordinator for B Unit on resident's return on 7/3/08 to the facility with no injury noted. · Medical Director and Responsible Party were notified of the event on 7/3/08. · Follow-up assessment was completed on 7/3/08 at 7:30pm by the Unit Coordinator for B Unit and at 10pm by the Charge Nurse for B Unit to assess potential late effects related to the event. There was no evidence of injury and the resident continued to deny pain. · The driver of the van was suspended on 7/3/08 pending the results of the investigation. · Driver was formally disciplined on 7/4/08 related to his failure to apply the tie down straps securely enough to support the weight of the resident and wheelchair. Driver was removed from eligibility to drive the van on 7/4/08. · Use of the van was discontinued on 7/3/08. 	F 323			

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F 323	<p>Continued From page 34</p> <p>Keys were secured by the Administrator who would remain the sole authority for further use of the van.</p> <p>Note: A pre-planned activity was scheduled for 7/28/08. The facility had erroneously omitted pre-scheduling this event with the outside vendor. When reminded of the event; the Administrator reviewed the situation and determined that the residents should not be disappointed. The Administrator identified a facility employee, who was known to him from a prior facility as providing transportation services without incident. The Administrator supervised the employee's viewing of the Securement video and return tie down demonstration was completed. This employee transported residents to and from the baseball game without incident. This was the ONLY time the van was driven since the 7/03/08 event. This was a one time exception due to the potential impact to the residents. Keys were given to the Regional Director of Operations to be maintained off-site on 8-2-08. If and when the provision of facility based transportation services are re-instated, the facility must undergo comprehensive training procedures held by the Regional Director of Operations.</p> <p>2. Residents requiring transportation to appointments or errands outside the facility have the potential to be impacted. It was determined that the facility van would not be used for this purpose. Administrator informed staff on 7/3/08 that facility would no longer provide intermittent transports and that all non-emergent transportation would be provided as specified in existing agreement with outside vendor. (This vendor historically provides majority of resident transports) Van Drivers were reassigned on</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>7/4/08, performing various duties by the Administrator until permanent assignments could be determined. "Non-emergent transportation" is defined as transportation provided to a resident whose condition does not meet the definition of emergency transportation. In addition, all scheduled transports, and all transports to a non-acute healthcare facility would be considered non-emergent. "Emergency transportation" is defined as transportation provided after the sudden onset of a medical condition manifesting itself by the acute symptoms of sufficient severity such that the absence of immediate medical transport for immediate medical attention could reasonably be expected to result in any of the following: 1) Placing the patient's health in serious jeopardy, 2) Serious impairment of bodily functions, or 3) Serious dysfunction of any body organ or part. Emergency transportation is typically provided by local EMS service. If a resident is scheduled for a non-emergent transport, and the transportation provider is late, this would not constitute a requirement for "emergency transportation", unless it meets the definition of "emergency transportation" provided above.</p> <p>3. The measures that have been put into place or systemic changes made to ensure that the alleged deficient practice will not occur include:</p> <ul style="list-style-type: none"> · Discontinuance of the use of the facility van on 7/3/08, with the single exception of the special activity described above. · Reassignment of facility van drivers on 7/4/08 to various duties. · Van was taken to Van Safety Products for assessment of current wheelchair securement system on 7/16/08. It was recommended that the van be outfitted with the Sure-Lock wheelchair 	F 323			

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F 323	Continued From page 36 securement system including installation of new straps and track system. Approval for the recommended replacement system obtained and installation completed on 7/18/08. (Note: this system was in place and the driver was fully trained when the residents were transported to the baseball game on 7/28/08. (The driver) viewed the instructional DVD provided by the vendor for the Sure-Lok Wheelchair Securement and Occupant Restraint Training Program, including the 5-point securement system, and provided successful return demonstration to the Administrator on 7/28/2008.) The former approved van drivers were also trained by watching instructional video when the upfit was completed to the van on 7/18/08; however, they have not transported residents to date. · The facility has suspended the use of the van indefinitely and will continue to utilize the services of outside vendor for outside transportation as implemented after the 7/3/08 event. The facility was previously supplementing the services of the outside vendor who has been under contract with the facility since 2003. · In the event of accident during transport. Vendor contract specifies notification to the facility. Any occurrence in this regard would be treated in accordance with facility incident reporting guidelines as would any unusual event. · As an additional measure: on 8/6/08 signage illustrating the 5-point securement system was placed at the nurses station and in the ADL record keeping books for reference by the Certified Nursing Assistants who may assist in transport by an outside contractor. Nursing staff were inserviced beginning on 8/6/08 by the Unit Coordinators regarding the 5-point securement system. · As an additional measure on 8/6/08, nursing	F 323			

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F 323	<p>Continued From page 37</p> <p>staff is being inserviced by the Unit Coordinators on their responsibilities related to transportation services provided by outside vendors, including visual verification of securement by the contractor when assisting residents to transportation vehicle, and in review of incident reporting requirements in the event an incident occurs. This visual aide has been placed in the orientation packet (8/6/08) for review with all newly hired staff members.</p> <ul style="list-style-type: none"> · As an additional measure on 8/6/08, review of securement systems was presented to resident council to enhance awareness of their safety. Review of the importance of reporting injury or event while being transported was stressed in this inservice. · The Incident Reporting policy has been updated (8/6/08) to include events which are reported that happen off of facility property to residents of the facility. This amendment has been implemented and inservice initiated on 8/6/06. All staff will be inserviced as they report for duty in order that we may remain in substantial compliance with this initiative. <p>4. The facility will monitor its performance to make sure that solutions are sustained by:</p> <ul style="list-style-type: none"> · Maintaining the keys to the facility van off-site. The keys are in the possession of the Regional Director of Operations in Columbia, South Carolina. · Facility will maintain log of transportation to be reviewed weekly by the Director of Nursing to determine effectiveness of transportation services. The logs will be maintained by the Director of Nursing. Missed or late appointments will be tracked to be reviewed by the facility Quality Assurance Committee. Members of the facility Quality Assurance Committee include: The Administrator, 	F 323			

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F 323	<p>Continued From page 38</p> <p>Medical Director or RNP in his absence, Director of Nursing, Social Services Director, Activities Director, Care Planning Coordinator, Dietary Manager, and Therapy Director.</p> <p>· Facility Quality Assurance Committee will review transportation logs monthly or as needed to evaluate effectiveness of plan and need for amendment to the plan for three consecutive months unless otherwise determined by the Quality Assurance Committee."</p> <p>The credible allegation of compliance was validated on 8/8/08 at 4:30 PM. The facility provided evidence of in-services of nursing staff regarding verification of safe transportation and correct strap place of residents transported by private transportation companies. The facility van was locked and keys were verified by a company representative to be in South Carolina. Interviews with nursing staff revealed evidence of in-services reinforcing safe transportation and staff accountability for all facility residents.</p> <p>2. Resident # 1 was admitted to the facility on 8/10/07 with multiple diagnoses including Cerebral Vascular Accident, right sided Paralysis, Dementia, Aphasia and Behaviors.</p> <p>The Minimum Data Set (MDS) dated 5/2/08 revealed Resident # 1 had short and long term memory impairment and was severely impaired for making decisions for tasks of daily living. The MDS indicated Resident # 1 required extensive assistance for activities of daily living and had persistent anger with himself and others. Resident #1's vision was severely impaired.</p> <p>Record review of the Comprehensive Care Plan for Resident # 1 dated 4/23/08 was conducted.</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>The care plan identified that Resident # 1 was "At risk for falls and injury," related to:</p> <ul style="list-style-type: none"> · Hemiplegia · Cognitive impairment · History of falls · Vision impairment <p>Approaches included "monitor resident closely when in wheelchair and chair alarm as ordered." Another hand written entry dated 6/30/08 indicated "observed (Resident # 1) sitting on floor by bed."</p> <p>The care plan also identified a problem that "Resident # 1 has ADL function deficit" due to "weakness and right side hemi pareses." The care plan revealed Resident # 1 was to be up in a "wheelchair with a lap buddy."</p> <p>Nurses' notes dated 6/26/08 at 2:00 PM revealed Resident # 1 "tipped his wheelchair over and fell out onto his low bed with both lower extremities hitting the floor." The nurse noted Resident # 1's was in his room and lap buddy was in place. No injuries to Resident # 1 were documented.</p> <p>Nurses' notes on 6/30/08 at 7:00 PM revealed a nurse observed Resident # 1 "sitting on the floor beside his bed." Nurse's notes indicated the roommate stated Resident # 1 "slid out of his wheelchair and crawled to the side of his (Resident # 1's) bed." The nurse noted the lap buddy was lying on the floor and the roommate stated "he took that off (lap buddy), and threw in the floor." Nurses' notes revealed Resident # 1 had no injuries.</p> <p>Nurses' notes dated 7/1/08 at 10:00 PM revealed Resident # 1 "was found on the floor in his room</p>	F 323			

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F 323	<p>Continued From page 40</p> <p>at 8:45 PM sitting at the front of his wheelchair." The nurse's notes revealed no injuries were found on Resident # 1.</p> <p>Review of the Resident Incident Accident Report dated 7/1/08 at 8:45 PM was conducted. The report revealed Resident # 1 was sitting on the floor in his room in front of his wheelchair with his lap buddy hanging off the side of his wheelchair. No injuries were noted.</p> <p>Record review of nurses' notes dated 7/10/08 at 7:45 PM revealed Resident # 1 fell in his room while the Nursing Assistant (NA) went to the bathroom. Nurses' notes indicated Resident # 1 was on his right side and his roommate stated "he (Resident #1) got up to walk and fell on the floor." Nurses' notes revealed Resident # 1 was placed back into his low bed and facility staff placed a floor mat next to the bed. Resident # 1 received no injuries from the fall.</p> <p>3. Resident # 1 was admitted to the facility on 8/10/07 with multiple diagnoses including Cerebral Vascular Accident, right sided Paralysis, Dementia, Aphasia and Behaviors.</p> <p>The Minimum Data Set (MDS) dated 5/2/08 revealed Resident # 1 had short and long term memory impairment and was severely impaired for making decisions for tasks of daily living. The MDS indicated Resident # 1 required extensive assistance for activities of daily living and had persistent anger with himself and others. Resident #1's vision was severely impaired.</p> <p>Review of the Nurse Practitioner notes dated 7/17/08 was conducted. The notes revealed Resident # 1 "ate a bar of soap when sitter was</p>	F 323			

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F 323	<p>Continued From page 41</p> <p>out in the bathroom herself, took two bites. Within 15 - 20 minutes lips have swollen significantly, increased drooling. No evidence of strider/respiratory distress. Patients eats anything he gets his hands on."</p> <p>Review of the facility transfer form dated 7/17/08 revealed Resident # 1 was transferred to a local hospital emergency room because Resident # 1 "ate ½ bar of _____ (name) soap. Lips and tongue swelling."</p> <p>Review of nurses' notes on 7/17/08 at 1:30 PM was conducted. Nurse's notes revealed Resident # 1 was "seen by a CNA (nursing assistant) eating a regular bar of _____ (name of soap). Resident (Resident # 1) was foaming around mouth. Was assessed and seen by Physicians Assistant" while onsite at the facility. Resident # 1 was sent to a local hospital emergency room for an evaluation.</p> <p>Review of a hospital emergency room report dated 7/17/08 was conducted. Resident # 1 presented in the emergency room "from a nursing home after staff reportedly witnessed him eating a half bar of _____ (name of soap) per report. At that time, they (facility staff) noticed his lips swelling and gave him Benadryl (anti-histamine)." The physicians' history and physical revealed "no lip swelling " and Resident # 1 was kept for observation overnight to monitor him for signs and symptoms of allergic reaction and for the administration of Solu-Medrol (Corticosteroid).</p> <p>An interview was conducted with Nurse # 1 on 7/31/08 at 11:45 AM. Nurse # 1 revealed she was on Resident # 1's hall passing medications to</p>	F 323			

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F 323	<p>Continued From page 42</p> <p>other residents when Nursing Assistant (NA) # 4 and NA # 5 brought Resident # 1 to her and stated "he (Resident # 1) had eaten soap." Nurse # 1 instructed the NAs to take Resident # 1 back to his room and obtain his vital signs. Nurse # 1 stated Resident # 1's "lips were red and she could see soap shavings on his front teeth." Nurse # 1 revealed she observed Resident # 1 had eaten approximately 1/3 of a 3/4 inch thick bar of soap. Nurse # 1 stated Resident # 1 "grabs (and) puts anything in his mouth." Nurse # 1 revealed she "had taken paper out of his (Resident # 1) mouth, (Resident #1) had attempted to put a rubber glove in his mouth" Nurse # 1 stated there were "times when he (Resident # 1) had no sitter during the day because no one came in to supervise him."</p> <p>An interview was conducted with NA # 5 on 7/30/08 at 10:05 AM. NA # 5 stated she used Resident # 1's bathroom in the morning (could not remember time) of 7/17/08. NA # 5 stated she had asked for relief from other staff members so she could use the bathroom. NA # 5 waited for help for "30 minutes " and could not wait any longer or she would "pee her pants." NA # 5 stated Resident # 1 "was sitting near his bed" and "she closed the bathroom door." NA # 5 indicated she was in the bathroom 3 - 5 minutes and when she came out, Resident # 1 had small pieces of soap in his front teeth. NA # 5 stated she had been instructed to never leave Resident # 1 alone and call someone to relieve her for lunch and other breaks. NA # 5 stated she did not use the call bell for alerting staff when she needed help. NA # 5 revealed some time ago Resident # 1 grabbed a bottle of body wash and tried to put it in his mouth. NA # 5 stated she thought "10:00 AM to 6:00 PM 7 days a week</p>	F 323			

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F 323	<p>Continued From page 43</p> <p>was not enough 1 on 1 supervision for (Resident # 1.)" NA # 5 stated Resident # 1 will "kick or hit you for no reason, will fight you to do what he wants to do, was aggressive and agitated."</p> <p>An interview was conducted with the Director of Nursing (DON) on 7/29/08 at 3:36 PM. Resident # 1 had 1 on 1 supervision 24 hours a day 7 days a week. The DON stated Resident # 1 had a medication change for behaviors (increase of Thorazine- for behavior disorders) and 30 days later he seemed to "calm down some" and his (Resident #1's) 1 on 1 supervised hours were changed to 10:00 AM - 6:00 PM 7 days a week. The DON stated the theory was Resident # 1 was up for breakfast at approximately 8:00 AM and went to bed at 6:00 PM. The DON stated she was not aware there were times when Resident # 1 did not want to go to bed at 6:00 PM. The DON stated facility staff had met with the family and the ombudsman for an alternate placement plan. The family refused to have Resident # 1 placed in a more appropriate setting for his particular needs. The DON stated NA # 5 was the sitter on the day Resident # 1 ate a partial bar of soap. The DON stated NA # 5 was scheduled to be with Resident # 1 from 10:00 AM to 6:00 PM on 7/17/08. The DON stated NA # 5 and Resident # 1 were in his room and she had to use the bathroom. The DON stated when NA # 5 came out of the bathroom; Resident # 1 had soap in his mouth. The DON stated the duties of the sitter were to assist him with feeding, talk to him, engage him in activities and "the sitter is to never leave the resident alone." The DON revealed she discussed sitter duties with NA # 5 and stated her expectation was she should use the call bell to call for other facility staff to stay with Resident # 1 while she took a break.</p>	F 323			

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F 323	Continued From page 44 An interview was conducted with NA # 6 on 8/1/08 at 10:56 AM. NA # 6 stated Resident # 1 "puts things in his mouth." NA # 6 worked some nights at the facility and had seen Resident # 1 up in his wheelchair until 11:00 PM without a sitter. NA # 6 revealed ideally a sitter was needed from 9:00 AM to 10:00 PM for Resident # 1. An interview was conducted with NA # 4 on 8/1/08 at 12:11 PM. NA # 4 stated he used to sit for Resident # 1 at least two to three times a week. NA # 4 stated one day he observed Resident # 1 in the dining room. NA # 4 stated he watched the assigned sitter turn her back on Resident # 1 while she reached for his meal tray. NA # 4 stated in that short time Resident # 1 grabbed a plastic flower from the center of the table was just about to put it in his mouth when he (NA # 4) retrieved the plastic flower from Resident 1. NA # 4 stated, "You have to keep your eyes on him at all times." NA # 4 stated Resident # 1 will resist care and approximately 3 times a week he will not lie down at 6:00 PM. NA # 4 stated Resident # 1 needs supervision from 7:00 AM to 11:00 PM instead of 10:00 AM to 6:00 PM 7 days a week. 4. Resident # 1 was admitted to the facility on 8/10/07 with multiple diagnoses including Cerebral Vascular Accident, right sided Paralysis, Dementia, Aphasia and Behaviors. The Minimum Data Set (MDS) dated 5/2/08 revealed Resident # 1 had short and long term memory impairment and was severely impaired for making decisions for tasks of daily living. The MDS indicated Resident # 1 required extensive assistance for activities of daily living and had	F 323			

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F 323	<p>Continued From page 45</p> <p>persistent anger with himself and others. Resident #1's vision was severely impaired.</p> <p>Record review of nurses' notes dated 7/19/08 at 8:30 AM revealed a nursing assistant (NA) notified a nurse that Resident # 1 "had ants in his bed and bite marks on his back." Nurses' notes revealed "raised areas to right side (of torso) and right hand." Resident # 1 was given Benadryl (anti-histamine).</p> <p>Record review of the facility transfer form dated 7/19/08 revealed Resident # 1 was transferred to a local hospital emergency room for "ant bites to back and right hand. Welts noted to right side of back."</p> <p>Record review of a hospital emergency room report dated 7/19/08 was conducted. The report stated Resident # 1 came from the facility with "hives felt to be due to ant bites." "They (nursing home staff) also noted his penis appeared larger than normal." The physicians' notes revealed "hives (location not noted) likely due to ant bites" and his "penis appears normal." Resident # 1 was administered Prednisone (prevention of allergic reaction) and was discharged back to the facility.</p> <p>An interview was conducted with Nurse # 7 on 7/30/08 at 4:35 PM. Nurse # 7 stated she did not observe ants on Resident # 1 but saw ants coming from a corner near the floor in his room on 7/19/08 (after staff members discovered ants crawling on Resident #1). Nurse # 7 stated she gave Benadryl (anti-inflammatory agent) because he (Resident # 1) had a rash and hives on his entire right arm and the upper 1/2 part of his back. Nurse # 7 revealed Resident # 1 had broken skin</p>	F 323			

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F 323	<p>Continued From page 46 on both sides of his ring finger.</p> <p>An interview was conducted with NA # 6 on 8/1/08 at 10:56 AM. NA # 6 stated he was responsible for the care of Resident # 1 on the 7:00 AM to 3:00 PM shift on 7/19/08. NA # 6 stated he was making rounds at 7:45 AM and found the resident in his bed under his sheet. NA # 6 revealed he pulled back the sheet and observed "fire ants" crawling on Resident # 1's right arm, chest and in the front of his adult brief. NA # 6 stated under Resident # 1's two middle fingers of his right hand "it looked like the ants were eating flesh under the finger nails and between the two middle fingers." NA # 6 stated "approximately 150 red ants" were on Resident # 1's body and "he was lying there in the bed mumbling."</p> <p>An interview was conducted with Nurse # 1 on 7/31/08 at 11:45 AM. Nurse # 1 stated she was responsible for the care of Resident # 1 on 7/19/08 on the 7:00 AM to 3:00 PM shift. Nurse # 1 stated she was called to Resident # 1's room by a Nursing Assistant (NA) shortly after shift change at 7:00 AM. Nurse # 1 stated she saw a trail of "reddish colored ants" from a corner in the wall inside Resident # 1's room. Nurse # 1 stated she observed "reddish colored ants" on Resident # 1's "right hand and arm (right arm paraplegia), right side and on the front edge of his (adult brief)." Nurse # 1 stated there were "traces of blood" on the small webbed area between finger digits 2, 3 and 4. Nurse # 1 revealed she saw two "dime size spots of blood on the bed pad near (Resident # 1's) right side." Nurse # 1 stated Resident # 1's side had an area of "welts" measuring "approximately 8 inches wide and extended from his arm pit to his waist." Nurse # 1</p>	F 323			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 08/08/2008
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 323	<p>Continued From page 47</p> <p>stated Resident # 1 was "very agitated and his eyes were red."</p> <p>Record review of the report from the exterminating company dated 7/19/08 was conducted. The report revealed an exterior wall of the facility was treated for fire ants.</p> <p>An interview was conducted on 7/29/08 at 4:33 PM with a representative of the exterminating company contracted by the facility. The representative stated he found a fire ant mound near a garbage dumpster located in the back of the building. The representative stated an ant trail lead from the dumpster, to a smoking receptacle and to the exterior wall of Resident # 1's room. The representative stated the dumpster and the smoking receptacle were cleaned and the exterior wall to Resident # 1's room was treated for fire ants.</p> <p>Observations of the dumpsters behind the facility and the smoking receptacle in the courtyard was conducted on 7/30/08 at 11:23 AM. One dumpster in the back of the facility was found to have a dark, wet appearing, odorless large puddle on one side of the dumpster. The smoking receptacle had two empty soda cans lying next to it. Observations revealed no pests at the dumpster or smoking receptacle.</p> <p>5. Resident # 1 was admitted to the facility on 8/10/07 with multiple diagnoses including Cerebral Vascular Accident, right sided Paralysis, Dementia, Aphasia and Behaviors.</p> <p>The Minimum Data Set (MDS) dated 5/2/08 revealed Resident # 1 had short and long term memory impairment and was severely impaired</p>	F 323			

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F 323	<p>Continued From page 48</p> <p>for making decisions for tasks of daily living. The MDS indicated Resident # 1 required extensive assistance for activities of daily living and had persistent anger with himself and others. Resident #1's vision was severely impaired.</p> <p>Nurses' notes dated 7/1/08 at 2:50 PM was conducted. Nurses' notes revealed Resident # 1 "struck his roommate in the face with the bathroom door as he (roommate) was leaving the bathroom." Resident # 1 grabbed his roommate and caused a scratch on his (roommate's) right forearm.</p> <p>Observations and interview with Nurse # 2 was conducted on 7/29/08 at 9:27 AM. Nurse # 2 stated she could not watch Resident # 1 and pass medications to other residents. Nurse # 2 stated she had Resident # 1 with her at the present time during medication pass because (Nursing Assistants (NAs) were busy with other residents. Nurse # 2 stated. "I cannot do it all, what if I make a mistake while passing medications to other residents?" Nurse # 2 stated Resident # 1's behaviors were "aggression, pulling and grabbing other people, puts his hands in inappropriate places on female residents" and "grabs for anything in reach." Nurse # 2 stated she had told the DON (Director of Nurses) there were problems with Resident # 1 from 7:00 AM to 10:00 AM. Nurse # 2 revealed Resident # 1 needed 1 on 1 supervision from 7:00 AM to 11:00 PM 7 days a week.</p> <p>An interview was conducted with Nurse # 4 on 7/29/08 at 10:03 AM. Nurse # 4 stated it was "hard to have a plan for monitoring and keeping him (Resident # 1) safe." Nurse # 4 stated Resident # 1 was "grabbing anything and</p>	F 323			

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F 323	<p>Continued From page 49 anybody."</p> <p>An observation and interview was conducted with Nurse # 1 on 7/31/08 at 11:45 AM. Nurse # 1 stated Resident # 1 was "very aggressive, grabs and will grab the breasts of women." Nurse #1 stated Resident #1 "almost pulled a resident out of his wheelchair." Nurse # 1 stated there are "times when he (Resident # 1) had no sitter during the day because no one came in to supervise him." During the interview Resident # 1 grabbed Nurse # 1 and would not let go of her. Nurse # 1 stated Resident # 1 required 1 on 1 supervision at all times and should never be left alone because "he was into everything and had his hands on other residents and their body parts."</p> <p>An interview was conducted with Nurse # 6 on 7/29/08 at 12:55 PM. Nurse # 6 stated Resident # 1 was "combative, anxious, removes his lap buddy and gets out of his wheelchair, was sexually aggressive and touches female staff and residents in private places."</p> <p>An interview was conducted with NA # 6 on 8/1/08 at 10:56 AM. NA # 6 stated Resident # 1 "grabs other people." NA # 6 works some nights at the facility and had seen Resident # 1 up in his wheelchair until 11:00 PM without a sitter. NA # 6 revealed ideally a sitter was needed from 9:00 AM to 10:00 PM for Resident # 1.</p> <p>An interview was conducted with a psychiatric nurse on 8/1/08 at 9:42 AM. The nurse stated Resident # 1 was sexually aggressive and explicit, grabs and hits other people, curses, was anxious and wanders. The nurse stated she believed Resident # 1 needed a sitter when he</p>	F 323			

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F 323	<p>Continued From page 50</p> <p>aroused at 7:00 AM in the morning rather than 10:00 AM. The nurse recommended to the family the use of the facility locked unit to decrease sensory stimulation but Resident # 1's family refused. The nurse stated Resident # 1 was "not appropriate for the long term care setting."</p> <p>An interview was conducted with the facility Social Worker (SW) on 8/1/08 at 11:00 AM. The SW stated Resident # 1 requires 1 on 1 care because he "does not understand what he is doing, was physically and verbally abusive and grabs at people and will put things (soap) in his mouth." The SW stated initially he looked at a closed head unit or a group home but the family did not want Resident # 1 to leave the facility.</p> <p>An interview was conducted with NA # 4 on 8/1/08 at 12:11 PM. NA # 4 stated he used to sit for Resident # 1 at least two to three times a week. NA # 4 stated, "You have to keep your eyes on him at all times." NA # 4 stated Resident # 1 will hit other residents but most of the time he grabs other residents. NA # 4 stated Resident # 1 will resist care and approximately 3 times a week he will not lie down at 6:00 PM. NA # 4 stated Resident # 1 needs supervision from 7:00 AM to 11:00 PM instead of 10:00 AM to 6:00 PM 7 days a week.</p>	F 323			