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	145438	A. BUILDING _____ B. WING _____	C 01/28/2005

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F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) The facility shall notify the resident's	F9999		

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F9999	Continued From page 20 physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the treatment of such accident, injury or change in condition at the time of notification. 300.1210a) The facility must provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 300.1210b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 300.1210b)3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 300.1220b) The DON shall supervise and oversee the	F9999		

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F9999	Continued From page 21 nursing services of the facility, including: 300.1220b)2) Overseeing the comprehensive assessment of the resident's needs, which include medically defined conditions and medical function status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential,dental condition,activities potential, rehabilitation potential, cognitive status, and drug therapy. 300.3220f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of Nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. 300.3240a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by the following: Based on record review, pictorial documentation and interviews facility neglected to provide care for 1 of 6 sampled residents (R3). R3 was admitted for respite care on 12-27-04 and discharged on 1-10-05 at which time R3 was transported for approximately 45 minutes from the facility to home. On 1-10-05 at approximately 1755, R3 was admitted to the emergency unit of a local hospital. Local hospital records indicated	F9999		

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F9999	Continued From page 22 that R3's diagnoses were, in part, of Peripheral Vascular Disease, Left Foot Cellulitis, Gangrenous Toes and Urinary Tract Infection. On 1-17-05, R3's left leg was amputated above the knee. Facility failed to notify family and physician of R3's complaint of left foot pain and left heel soreness; ensure accuracy of R3's Minimum Data Set reflecting a history of pressure sore(s); perform R3's physician ordered accu-checks twice a day; specify application of R3's topical ointment; provide usual facility assessments and skin monitoring for a diabetic resident such as R3; and provide continuity of assessing and monitoring R3's left foot including changing R3's left sock. Findings include: 1. Review of R3's clinical record indicated that R3 was an 83 year old resident, admitted 12-27-04 for respite care and had diagnoses, in part, of Diabetes Mellitus with Circulatory Disorder, Cerebrovascular Accident with Left Hemiparesis, Dermatitis, Bilateral Shoulder and Hands Arthritis, and Right Below the Knee Amputation. R3's current assessment indicated that R3's cognition was moderately impaired and that R3 required limited to extensive staff assistance with activities of daily living except eating for which R3 required supervision. R3's current care plan indicated "pressure site potential: risk moderate, preventative tx (treatment), special mattress, T&P (turn and reposition), sched (?) prn (as needed)". According to R3's initial admission skin assessment, signed and dated 12-17-04 by E7 (Registered Nurse), R3 was assessed as follows: Left foot - soft heel and dry skin on toes; Bilateral inner arms with dry skin; Right sided amputation	F9999		

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F9999	Continued From page 23 with scars; and, Left lower leg and ankle with scarring. R3 was discharged on 1-10-05, at approximately 2:20p.m., at which time R3 was transported, by a transport service, from the facility to home. During interview with Z5 (Director of Operations of the transport service), on 1-19-05 at approximately 12:25p.m., Z5 indicated that no injuries or complaints from R3 occurred during the transport. According to documentation provided by E1 (Administrator), E 1 received a telephone call from R3's home at approximately 3:05p.m on 1-10-05; therefore, indicating that the time of transportation was approximately 45 minutes. According to the complaint, once R3 arrived home, R3's left foot sock was removed and toes were bloody and black. Pictures were taken of R3's left foot. Review R3's left foot pictures indicated what appeared to be the following: Large opened blister which extended from heel to mid-inner foot; Four dark blue/black toes with edema from toes extending to upper ankle; Separation of skin underneath the four toes; and, Dark to light brown crusty type matter between the the four toes. On 1-10-05, R3 was taken to a local hospital and on 1-17-05 R3's left leg was amputated above the knee according to complainant. Review indicated the following: 1. No family or physician notification of R3's complaint of foot and heel pain on 1-3-05. Interview with R3, on 1-19-05 at approximately	F9999		

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F9999	Continued From page 24 11:10a.m., R3 indicated that R3 complained, on 1-3-05, to staff member(s) that R3's foot (left) hurt and R3's left heel was sore. R3 further indicated that staff did not check R3's left foot or heel. Nursing notes did not document that R3's family or physician were notified of R3's complaint. During interview with Z4 (Physician), on 1-18-05 at approximately 11:50a.m., Z4 indicated that the facility had not called Z4. Review of R3's medication administration record indicated that R3 was administered " Acetaminophen 500mg tablet" one time on 1-7-05 by E14 (Licensed Practical Nurse). During interview with E14 on 1-19-05 at approximately 2:30p.m., E14 indicated that the medication was administered for R3's complaint of generalized pain. 2. Inaccurate assessment and no indication of possible pressure or stasis ulcer history. According to R3's Minimum Data Set, R3 did not have a history of pressure or stasis ulcer(s) within the last 90 days; however, according to interview with E7 (Registered Nurse) on 1-18-05 at approximately 1:30p.m., R3 informed E7 that R3 had, time not specified, a "sore" on left foot and buttock. R3 further informed E7 that the sore on R3's foot took a long time to heal and the foot should be watched as amputation was possible. Further, R3's medical history with an admission date indicated as 6-21-04, sent to the facility on 12-22-04, states "Past Medical History: Significant for IDDM (Insulin Dependent Diabetes Mellitus), DVD (? other information indicated PVD - Peripheral Vascular Disease), hypertensin, hypercholesterolemia, CVA (Cerebrovascular Accident) with left-sided weakness,and decubitus ulcer".	F9999		

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3. Physician orders, dated 12-04-04 and faxed to the facility, on 12-22-04, with the medical history, for "Accu-Chek (check) Comfort CV (Glucose) test strip...Use 1 strip for blood test twice a day as directed by physician" were not done.
During interview with Z2 (Veteran's Affairs Social Worker), on 1-18-05 at approximately 12:20p.m., Z2 received a call from the facility confirming R3's physician orders at which time Z2 possibly read the orders from Z2's computer generated physician orders. The computer generated physician orders indicated that accu-checks were to be done twice a day. During interview with Z4 (Physician), on 1-18-05 at approximately 11:50a. m., Z4 indicated that normally someone taking insulin, which R3 was ordered "Novolin N 100 units/ml vial inject 18 units sub every morning" does get accu-checks.
During interviews with E7 (Registered Nurse) on 1-18-05 at approximately 1:30p.m., E4 (Licensed Practical Nurse) on 1-8-05 at approximately 10: 20a.m and E8 (Licensed Practical Nurse) on 1-19 -05 at approximately 10:30a.m., E7, E4 and E8 indicated that accu-checks were not done. E8 further indicated that family did give R3 accu-checks every day. During interview with R3, on 1 -19-05, R3 indicated that R3 received R3's insulin; however, accu-check was done one time (however R3 then said accu-check not done) at the facility and that family did do accu-checks at least daily at home.
R3's medication administration records and treatment records for 12-04 and 1-05 did not state that R3 received accu-checks twice a day nor any time nor indicate parameters.

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F9999	Continued From page 26 During interview with Z3 (Veteran's Affairs Respite Coordinator) on 1-18-05 at approximately 12:10p.m., Z3 indicated that normally accu-checks were done four times day which was changed to twice a day: however, Z3 could not confirm R3's accu-check schedule at time of interview. 4. Topical ointment without destination of where the ointment was to be applied nor a medical reason for its application. R3's treatment record indicated that R3 received "Bactroban 2% ointment apply topically once daily to affected area at hs (evening)". The treatment record does not indicate what the affected area was nor does the record indicate a medical reason for the application of the ointment. During interview with E14 (Licensed Practical Nurse) on 1-19-05 at approximately 2:30p.m., E 14 applied the Bactroban ointment on R3's periarea and thigh at R3's request for light redness in those areas. Interview with R3, on 1-19-05, R3 indicated that staff put cream on "bottom", not foot, and that staff did not put petroleum jelly on R3's foot which according to R3 family did at home. According to a medication list provided by the family for the care of R3, the medication list indicated "vaseline (petroleum jelly) use on foot"; however, vaseline was not indicated on the physician orders. 5. Assessments, skin checks and monitoring not done as per normal assessment procedure for R3 as other residents who were diabetic and/ or required skin monitoring. Clinical record reviews of R1, R3, and R6 indicated that facility assessed and monitored diabetics and those who	F9999		

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required skin monitoring with follow up of notification, referrals and treatments. Review of R3's chart indicated that the facility did not do assessments as related to diabetes or potential skin problems. Surveyor asked E1 for any assessments that may have been done for R3; however, E1 did not provide any additional information for assessments that may not have been part of the record review.

6. Based on staff interviews with E11, E10, E 12, E15 (Certified Nursing Assistants) on 1-19-05 and 1-20-05 at approximately 11:18.a.m. to 12:00 p.m., and E4, E7, E8, E9 (Registered Nurse) and E14 (Licensed Practical Nurse) on 1-18-05 and 1 -19-05 at approximately 10:30a.m. to 1:30p.m., staff did not provide continuity of care in checking, monitoring or assessing R3's left foot or removing and changing R3's left sock with care. Staff interviews with E5 and E6 (Certified Nursing Assistants) on 1-18-05 from approximately 11:00a.m. to 11:20a.m., E5 and E 6 indicated that E5 and E6 provided R3 with a shoe on 1-10-05, prior to R3 leaving facility. E5 and E5 indicated that they did not notice any problems with R3's left foot.

On 1-28-05 at approximately 8:30a.m., surveyor observed R3's former room (Room 115) and men's shower room as indicated by interview with E2 (Assistant Administrator) on 1-28-05 at approximately 8:20.a.m. Room 115 consisted of three beds, two on the left side of the room and one on the right side of the room, each with a overhead light. A large window was near the middle of the room. Room 115 was not well lit, with the curtain pulled, with some shadowing observed in the middle of the room, and at the