United States General Accounting Office

GAO

Report to the Special Committee on Aging, U.S. Senate

June 1999

NURSING HOMES

Proposal to Enhance Oversight of Poorly Performing Homes Has Merit

GAO/HEHS-99-157

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-283084

June 30, 1999

The Honorable Charles E. Grassley
Chairman
The Honorable John B. Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

A persistent concern about the quality of care in our nation's nursing homes is the number of homes that are cited for serious and repeat deficiencies. The federal government, in partnership with states, is responsible for ensuring that the 1.6 million elderly and disabled Americans in nursing homes receive adequate quality of care. However, as we previously reported, 1 in 4 of the nation's nursing homes have serious deficiencies that harm residents or place them at risk of death or serious injury. Although most homes correct these deficiencies, 40 percent of these homes with serious deficiencies were cited for repeat deficiencies.[1]

The Health Care Financing Administration (HCFA), the primary federal entity responsible for overseeing the quality of nursing home care, has announced initiatives intended to strengthen enforcement for homes that are found to have repeatedly harmed residents. This includes an initiative to expand the definition of homes classified as "poor performers." In response, nursing homes raised concerns that some deficiencies that were cited as involving harm to residents were actually trivial in nature—the result of "overzealous" surveyors—and that HCFA's initiative would result in an increased and unwarranted regulatory burden. You asked that we examine whether deficiencies reporting actual harm to residents represent serious problems and the implications of HCFA's proposed action.

To assess the seriousness of deficiencies that state surveyors cited as actual harm, we reviewed a random sample of 107 homes' annual and complaint surveys that included deficiencies of actual harm to one or more residents—classified in HCFA's regulatory framework as "G-level" deficiencies. These 107 surveys, selected from 10 large states based on data from fiscal year 1998, contained a total of 201 isolated actual harm deficiencies.[2] Our information about the potential impact of HCFA's

[1]Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards (GAO/HEHS-99-46, Mar. 18, 1999).

[2]These states represented the state within each of HCFA's 10 regions with the most certified nursing home beds: California, Colorado, Florida, Illinois, Massachusetts, Missouri, New York, Pennsylvania, Texas, and Washington. These states represent 46 percent of all nursing home beds nationwide.

proposed action comes from an analysis of HCFA's nationwide database of survey results, the On-Line Survey, Certification, and Reporting (OSCAR) system as of April 1999. We conducted our work between March and June 1999 in accordance with generally accepted government auditing standards. Appendix I contains a more detailed explanation of our scope and methodology.

Results in Brief

HCFA's proposed expansion of the poor-performer criteria to include homes with repeated isolated actual harm deficiencies would substantially increase the number of homes that would be subject to immediate sanctions without a grace period to correct deficiencies. If this revised definition had been in effect for the most recent 15-month period ending April 1999, we estimate that the number of homes meeting HCFA's poor-performer criteria for imposing immediate sanctions would have increased from about 1 percent to nearly 15 percent of homes nationwide.[3]

Nearly all of the deficiencies we examined represented serious care issues resulting in harm to residents. Of the 107 surveys with G-level deficiencies in our sample, 98 percent (all but 2) documented that actual harm had occurred to one or more residents. Survey reports depict recurring examples of actual harm such as pressure sores, broken bones, severe weight loss, burns, and death. Another 8 of the 107 surveys with G-level deficiencies had a deficiency that did not clearly document harm, but other G- or higher-level deficiencies on the same survey resulted in harm to residents.

Two-thirds of these 107 nursing homes had repeated violations—OSCAR data showed they were also cited for isolated actual harm (G-level) or higher deficiencies in a prior or subsequent survey. Therefore, they would be subject to immediate sanction if HCFA's revised poor performer definition had been adopted, whereas the current definition allows an opportunity to correct deficiencies without sanctions. Most of the repeat violators (56 percent) were cited for the same deficiency, and 34 percent were cited for closely related deficiencies. These findings suggest that HCFA's enhanced enforcement of homes found to repeat these serious care problems has merit.

[3]Our analysis is based on the number of homes meeting HCFA's minimum federal criteria. States have the option to establish criteria that are more stringent than the federal criteria.

Background

Over the past year, joint efforts by the administration and Congress have resulted in a series of initiatives intended to improve the quality of care in our nation's nursing homes. Since July 1998, the President and HCFA, which administers Medicare and Medicaid, have announced major changes in nursing home oversight and enforcement.[4] One of the most controversial proposed changes relates to the revised definition of homes that would be categorized as "poorly performing" and subject to immediate sanctions without a grace period to take corrective action.

States determine whether to refer a nursing home to HCFA for possible sanction on the basis of HCFA's scope and severity grid, which classifies nursing home deficiencies by their scope—the number of residents potentially or actually affected—and severity—the potential for more than minimal harm, actual harm, or actual or potential for death or serious injury ("immediate jeopardy"). This grid places the deficiency in one of 12 categories, labeled "A" through "L." The most serious category (L) is for a widespread deficiency that causes actual or potential for death or serious injury to residents; the least serious category (A) is for an isolated deficiency that resulted in no actual harm and has potential only for minimal harm. (See table 1.) Homes with deficiencies that do not exceed the C level are considered in "substantial compliance" and, as such, to be providing an acceptable level of care.

[4]See Nursing Homes: HCFA Initiatives to Improve Care Are Under Way but Will Require Continued Commitment (GAO/T-HEHS-99-155, June 30, 1999).

Table 1: HCFA's Scope and Severity Grid for Medicare and Medicaid Compliance Deficiencies

	Scope			Sanction[a]	
Severity category	**Isolated**	**Pattern**	**Widespread**	**Required**	**Optional**
Actual or potential for death/serious injury[b]	J	K	L	Group 3	Group 1 or 2
Other actual harm	G	H	I	Group 2	Group 1[c]
Potential for more than minimal harm	D	E	F	Group 1 for categories D and E; group 2 for category F	Group 2 for categories D and E; group 1 for category F
Potential for minimal harm (substantial compliance)	A	B	C	None	None

[a]Group 1 sanctions are directed plan of correction, directed in-service training, and/or state monitoring. Group 2 sanctions are denial of payment for new admissions or all individuals and/or civil monetary penalties of $50 to $3,000 per day of noncompliance. Group 3 sanctions are temporary management, termination, and/or civil monetary penalties of $3,050 to $10,000 per day of noncompliance.

[b]This category is referred to in regulations as "immediate jeopardy."

[c]Sanctions for this category also include the option for a temporary manager.

The federal government has the authority to impose sanctions if homes are found not to meet these standards, including fines, denying payment for new or all residents with Medicare or Medicaid, or ultimately terminating the home from participation in Medicare and Medicaid. The scope and severity of a deficiency determine the types of applicable enforcement sanctions, which may be required or optional. Under their shared responsibility for Medicare-certified nursing homes, state agencies identify and categorize deficiencies and make referrals for proposed sanctions to HCFA. Under HCFA's current policies, most homes are given a grace period, usually 30 to 60 days, to correct deficiencies. States do not refer homes to HCFA for sanctions unless the homes fail to correct their deficiencies within the grace period. Exceptions are provided for homes with deficiencies at the highest level of severity (J, K, or L) and for homes that meet HCFA's definition of a "poorly performing facility"—a special category of homes with repeated serious deficiencies. HCFA policies call for states to refer these homes immediately for sanction. HCFA does provide a 15-day notice period before the sanction takes effect. If a home comes into compliance within that time, the sanction is waived.[5]

[5]Only civil monetary penalties can be assessed retroactively even if a home corrects the problem. For homes found to have a deficiency at the highest severity level (J, K, or L), HCFA may put a sanction into effect after a 2-day notice period.

In July 1998, we recommended that HCFA eliminate the grace period for homes cited for repeated serious violations and impose sanctions promptly. HCFA modified its policy accordingly by altering its definition of a poorly performing facility to include homes with repeated actual harm (levels G, H, or I) or worse deficiencies. It initially included only homes with repeated actual harm deficiencies that were a pattern or widespread in scope (levels H or I) or worse. HCFA postponed until later in 1999 including homes with consecutive G- or higher-level deficiencies because it recognized the significant increase in the number of homes that would be affected and the associated additional costs it would have entailed. Thus, HCFA's current practice is that any home that had been cited with a deficiency for pattern of actual harm to several residents (H-level) or worse in two consecutive annual surveys or any intervening revisit or complaint investigation would be considered a poorly performing facility and referred immediately for sanction. Nursing homes given this designation are automatically denied an opportunity to correct deficiencies before sanctions are applied. Some homes, however, claim that such deficiencies are not of sufficient magnitude to warrant immediate sanction and increased scrutiny.

Including Homes With Repeated G-Level Deficiencies Would Significantly Increase the Number Classified as Poor Performers

HCFA's proposed expansion of the definition of a poorly performing facility would greatly increase the number of homes that are immediately referred to HCFA for sanction without a grace period to correct deficiencies. Expansion of the federal criteria to include G-level deficiencies could create a significant increase in the number of homes denied a grace period to correct deficiencies before sanctions are imposed. Applying the various criteria to recent OSCAR data,

- 146 homes (1.0 percent) would have been sanctioned immediately, based on the former poor-performer criteria;
- 137 (1.0 percent) would have been sanctioned immediately, based on the current revised criteria (H-level or higher); and
- 2,275 (15.2 percent) would have been sanctioned immediately, based on the proposed expanded criteria (G-level or higher).[6]

Some states are concerned that this sharp increase in the number of homes facing immediate sanction will also increase the number of deficiencies that nursing homes contest through the informal dispute resolution process between states and nursing homes. States have several

[6]Over 600 homes had a combination of a G-level and an H-level or higher deficiency in their current, prior, or intervening surveys.

mechanisms available to them, including supervisory review of a surveyor's deficiency citations and the informal dispute resolution process, that they believe result in few if any unsupported actual harm deficiencies. Furthermore, nursing homes can formally appeal sanctions resulting from deficiency citations to the Department of Health and Human Services' (HHS) Departmental Appeals Board.

Nearly All Surveys Documented Actual Harm to Residents

Nearly all of the 107 surveys of nursing homes with G-level deficiencies we reviewed— 98 percent (all but 2 surveys)—documented actual harm that had occurred to one or more residents. Survey reports depicted repeated examples of actual harm, including pressure sores, broken bones, severe weight loss, burns, and death. The five most commonly cited deficiencies involved

- failure to prevent or treat pressure sores (23 percent);
- failure to prevent accidents (14 percent);
- failure to ensure adequate nutrition (8 percent);
- failure to provide acceptable quality of care (6 percent); and
- failure to prevent mistreatment, neglect, or abuse (4 percent).

Quality-of-life deficiencies, such as preserving residents' dignity and self-determination, accommodating residents' needs, or providing needed social services, were cited in only 9 cases (4 percent). Another 8 of the 107 surveys contained a G-level deficiency for which we did not find adequate documentation to show that a resident had been harmed. However, in each of these eight surveys, the home also had another G- or higher-level deficiency that documented harm to the resident.

In many instances, "isolated" deficiencies actually affected multiple residents. HCFA defines isolated deficiencies as affecting a single or a few residents. While most deficiencies affected only 1 or 2 residents, our sample also included several deficiencies that harmed as many as 10 to 16 residents (see table 2).

Table 2: Residents Affected by G-Level Deficiencies

Number of residents affected	1	2	3	4	5	6	7	8	10	13	14	16
Number of deficiencies we reviewed	91	50	31	11	5	3	3	2	2	1	1	1

Appendix II provides summary statistics on the 201 deficiencies we reviewed, and appendix III contains a brief abstract of each deficiency.

Most Sampled Homes Have Serious and Repeated Deficiencies

Additional OSCAR data revealed that about two-thirds of our sampled homes (71 of 107) had another G-level or higher deficiency in either a prior or subsequent survey—often the same, or closely related, deficiency. Specifically, of the 71 repeat violators,

- 40 homes (56 percent) were cited for the same deficiency (the same federal deficiency code, known as an "F-tag"),
- 24 (34 percent) were in the same category of deficiencies (such as quality of care or dietary services), and
- 7 (10 percent) were cited in different categories.

These results are consistent with our March 1999 report that found that each year more than 25 percent of the nation's nursing homes had deficiencies that caused actual harm to residents or put them at risk of death or serious injury. Although most homes eventually returned to compliance, many did not maintain this status. About 40 percent were cited for deficiencies at the same or higher level of severity in subsequent surveys. We found that HCFA's enforcement mechanisms did not deter such "yo-yo" patterns of compliance. HCFA's proposal to enhance enforcement of homes with repeated serious deficiencies that resulted in harm to one or more residents is intended to better deter this pattern of repeated noncompliance.

Concluding Observations

Despite state and federal efforts to improve the quality of care in the nation's nursing homes, many homes continue to be cited for deficiencies that cause significant harm to residents. In the 107 surveys we reviewed, nearly all deficiencies documented serious harm to one or more residents, including pressure sores, broken bones, severe weight loss, and burns. Survey data show that these are not isolated incidents—two-thirds of these homes were cited for deficiencies at the same or a higher level of severity in prior or subsequent surveys. The controversy with HCFA's proposal to expand the criteria for defining poor performers and impose sanctions on homes with serious and repeat violations centers on the industry's contention that state surveyors are at times overzealous in their findings. Some states are also concerned that this initiative could result in more actual harm deficiencies being contested through the informal dispute resolution process and subsequent sanctions being appealed to the HHS

Departmental Appeals Board, and that the proposal would also result in increased enforcement activity for the states and HCFA. However, our analysis indicates that increased scrutiny of homes with repeated serious deficiencies has merit. And for those few cases in which harm to a resident is uncertain, mechanisms are in place for homes to request reconsideration of the initial surveyor's deficiency citations.

Agency Comments

We provided a draft of this report to HCFA officials for comment. The Deputy Director for the Center for Medicaid and State Operations generally concurred with our findings.

We will send copies of this report to the Honorable Nancy-Ann Min DeParle, Administrator of HCFA, and to others who request them.

If we can be of further assistance or if you have any questions, please call me at (202) 512-7118 or John Dicken, Assistant Director, at (202) 512-7043. Gloria Eldridge, Terry Saiki, and Peter Schmidt prepared this report; Mary Ann Curran and Kathleen Kendrick provided additional clinical review of the documented deficiencies; and Evan Stoll conducted the analysis of the OSCAR data.

William J. Scanlon
Director, Health Financing and
Public Health Issues

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Abbreviations

HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OSCAR	On-Line Survey, Certification, and Reporting

Scope and Methodology

To determine the extent to which isolated actual harm deficiencies clearly documented actual harm to residents, we analyzed a random sample of survey reports from 10 states. First, we identified the state in each of HCFA's 10 regions with the most certified nursing home beds—California, Colorado, Florida, Illinois, Massachusetts, Missouri, New York, Pennsylvania, Texas, and Washington. Next, we obtained and extracted all surveys (standard and complaint) from these 10 states that included at least one G-level deficiency from HCFA's On-Line Survey, Certification, and Reporting (OSCAR) system. We selected 110 surveys from this group for our analysis. The sample was not drawn to be representative for each state but rather for the 10 states as a whole.

After preliminary review, we excluded 3 of the 110 surveys because G-level deficiencies had been reduced to lower-level deficiencies by supervisory review or informal dispute resolution, although these changes were not reflected in HCFA's data system. None of the three had higher-level deficiencies; thus, they contained no documented actual harm or immediate jeopardy.

We reviewed the remaining 107 survey reports to determine

- the number of G-level deficiencies,
- the highest-level deficiency cited in each survey,
- the specific deficiency code cited,
- the number of residents affected, and
- whether the narrative clearly documented actual harm to one or more residents.

The 107 surveys contained a total of 201 G-level deficiencies. Surveys averaged almost two G-level deficiencies per survey, but some ranged as high as 7 or 10 such deficiencies per survey (see table I.1 for the distribution).

Table I.1: Number of G-Level Deficiencies per Survey

									Total
Number of G-level deficiencies	1	2	3	4	5	6	7	10	201
Number of surveys in our sample	61	24	10	7	1	2	1	1	107

Where survey reports did not clearly document actual harm to one or more residents, we had registered nurses from our team conduct a secondary review. We determined actual harm was documented in all but 10 cases. For 8 of these 10, there were other G-level or higher deficiencies

in the survey that documented actual harm to one or more residents. In only two instances did we find isolated examples of G-level deficiencies that did not clearly document actual harm to residents.

To determine the extent to which our sampled homes had prior or subsequent surveys with G-level or higher deficiencies, we extracted all standard and complaint survey results for these homes from OSCAR. We then compared the sampled survey with deficiencies cited in prior surveys (limited to the previous standard survey, or about 1 year earlier) and subsequent surveys.

To determine the impact of HCFA's proposed expansion of the poorly performing facility criteria, we extracted all standard and complaint surveys using April 1999 OSCAR data. Next, we created a data set of current (later than October 1997), prior, and complaint surveys. We then applied the former criteria, current criteria, and proposed criteria for poorly performing facilities to the data set we constructed.

We conducted our work between March and June 1999 in accordance with generally accepted government auditing standards.

Federal Standards Cited in Analysis of Isolated Actual Harm Deficiencies

The following table provides the federal standards, known as "F-tags," that were used by HCFA and the states to document federal deficiencies for the surveys we sampled. These standards are arrayed within broader categories, such as resident rights, quality of care, and quality of life. The table includes a brief description of each standard as well as how frequently the standard was cited in our random sample of 201 G-level deficiencies in 107 nursing homes.

The most frequently cited category was quality of care, which represented three-fourths of all documented G-level deficiencies in our sample. The three most frequently cited standards, relating to failure to prevent pressure sores, failure to prevent accidents, and inadequate nutrition, were quality-of-care deficiencies.

Table II.1: Description and Frequency of Federal Standards Cited in GAO Sample of Isolated Actual Harm, G-Level, Deficiencies

Federal standard (F-tag) cited as a deficiency[a]	Description	Frequency of G-level deficiency in GAO sample
Resident rights (3.0 percent)		
157	Facility must promptly notify resident's family and physician of any accidents or significant change in status.	5
164	Residents have the right to personal privacy and confidentiality.	5
Resident behavior and facility practices (11.0 percent)		
221	Residents have the right to be free from unnecessary chemical or physical restraints.	2
223	Residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	4
224	Facility must develop and implement written policies and procedures that prohibit the mistreatment, neglect, and abuse of residents.	9
225	Facility must not employ individuals found guilty of mistreatment, abuse, or neglect; must investigate all allegations of mistreatment, neglect, or abuse; and must report results of all investigations to proper authorities.	7
Quality of life (4.5 percent)		
241	Facility must provide care in a manner that maintains or enhances each resident's dignity.	1
242	Residents have the right to self-determination and participation.	3

(continued)

Federal standard (F-tag) cited as a deficiency[a]	Description	Frequency of G-level deficiency in GAO sample
246	Facility must provide reasonable accommodation of individual needs and preferences.	1
250	Facility must provide medically related social services to attain or maintain the highest practicable well-being of each resident.	4
Resident assessment (3.0 percent)		
272	Facility must make a comprehensive assessment of each resident's needs.	1
276	Facility must examine each resident and review resident assessments no less than every 3 months.	1
279	Facility must develop a comprehensive care plan for each resident.	1
281	Facility must provide services that meet professional standards of quality.	3
Quality of care (75.1 percent)		
309	Facility must provide the necessary care and services for each resident to attain or maintain the highest practicable well-being.	12
310	A resident's abilities in the activities of daily living must not diminish unless clinical conditions make it unavoidable.	5
311	Facility must provide appropriate treatment and services to maintain or improve residents' abilities in the activities of daily living.	2
312	Residents who are unable to perform activities of daily living must receive necessary services to maintain good nutrition, grooming, and hygiene.	7
314	Facility must ensure residents entering facility without pressure sores do not develop sores and that residents with sores receive necessary treatment to promote healing, prevent infection, and prevent new sores.	47
316	Incontinent residents must receive treatment and services to prevent urinary tract infections and restore as much normal function as possible.	5
317	Residents who enter the facility without a limited range of motion must not experience a decline, unless clinical conditions make it unavoidable.	2
318	Residents with a limited range of motion must receive appropriate treatment to increase range of motion or prevent further decline.	5

(continued)

Federal standard (F-tag) cited as a deficiency[a]	Description	Frequency of G-level deficiency in GAO sample
319	Residents who display mental or psychosocial problems must receive appropriate treatment and services to correct assessed problems.	4
321	Residents who have been able to eat alone or with assistance must not be fed by nasogastric tubes, unless clinical conditions make it unavoidable.	1
322	Residents who are tube fed must receive appropriate treatment to prevent aspiration, vomiting, and other complications; if possible, restore normal eating skills.	1
323	Facility must ensure resident environment is as free of accident hazards as is possible.	3
324	Facility must ensure each resident receives adequate supervision and assistance devices to prevent accidents.	29
325	Facility must ensure each resident maintains acceptable parameters of nutritional status, such as body weight.	17
328	Facility must ensure residents receive necessary treatment and specialized services.	1
329	Residents have the right to be free from unnecessary drugs.	4
330	Residents must not be given antipsychotic drugs unless needed to treat a specific condition diagnosed and documented in the clinical record.	1
333	Facility must ensure residents are free of any significant medication errors.	2
353	Facility must have sufficient nursing staff to provide services to attain or maintain the highest practicable well-being for each resident.	3
Dietary services (0.5 percent)		
365	Facility must ensure residents receive food prepared in a form that meets each resident's individual needs.	1
Physician services (0.5 percent)		
389	Facility must provide or arrange for the provision of physician services 24 hours a day.	1

(continued)

Federal standard (F-tag) cited as a deficiency[a]	Description	Frequency of G-level deficiency in GAO sample
Dental services (0.5 percent)		
411	Facility must provide or obtain from outside sources, routine and emergency dental services to meet the needs of each resident.	1
Pharmacy services (0.5 percent)		
429	Pharmacists must report any irregularities to the attending physician and the director of nursing.	1
Infection control (0.5 percent)		
441	Facility must establish and maintain an infection control program to provide a safe, sanitary, and comfortable environment.	1
Physicial environment (0.5 percent)		
456	Facility must maintain all essential mechanical, electrical, and patient care equipment in a safe operating condition.	1
Administration (0.5 percent)		
492	Facility must operate in compliance with federal, state, and local laws, and with accepted professional standards.	1

[a]"F-tag" refers to HCFA's code for federal deficiency citations.

Abstracts of 201 Sampled G-Level Deficiencies

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
1	G	314	2	The nursing home did not ensure that residents with pressure sores were assessed in a timely manner and received treatment and services to promote healing. The nursing home failed to identify and treat a resident's pressure sore and to provide planned treatment for a pressure sore for another resident.	Y	Quality of care
2	G	324	1	The nursing home failed to ensure that devices designed to prevent accidents were available to residents and to ensure that residents received adequate supervision. A resident with a history of falls was under physician's orders to have a lap tray as a restraint when sitting in a chair, unless under supervision. During one activity, the resident did not have a lap tray in place, and the supervisor left the room. The resident slipped out of her chair, twisted her leg, and fractured her hip.	Y	Quality of care
3	G	328	1	Nursing home staff failed to provide foot care to one resident, resulting in an undetected and untreated infected sore on the resident's right foot.	Y	Quality of care
4a	G	314	3	The nursing home did not intervene to prevent rapid development of pressure sores in three residents. One was hospitalized with infected pressure sores.	Y	Quality of care
4b	G	324	1	The nursing home failed to provide adequate supervision to prevent one resident from falling and suffering a broken hip. An aide tried to transfer the resident alone, contrary to the resident's plan of care, which called for two people to assist in transferring the resident.	Y	Quality of care
5	G	314	3	The nursing home did not ensure that three residents with pressure sores were assessed in a timely manner and received treatment and services to promote healing and prevent the development of new sores. All three developed pressure sores while in the home, and the sores worsened. In two cases, a dietitian did not assess the residents for nutritional status for at least 1-1/2 years. In one case, a registered dietitian assessed the resident, but the dietitian's recommendations were not acted upon.	Y	Quality of care
6a	G	314	1	The nursing home failed to ensure that residents admitted without pressure sores did not develop them. Following a fall, a resident became frightened of walking and stayed in bed most of the day. Within a month of the fall, she developed a pressure sore on her left heel. The home had not ordered a pressure-reducing mattress or heel protectors to prevent skin breakdown.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
6b	G	324	1	The nursing home failed to ensure that a resident received adequate supervision and assistive devices to prevent accidents. The resident was sitting on the edge of her bed while a nurse's aide put on her shoes. She suddenly bent over and struck her nose on the side rail. Her nose was swollen and bleeding, and X rays showed a possible fracture of her nasal bone. Although medical records showed she had a history of involuntary head motion and lip biting, there was no system in place to prevent injury when she exhibited involuntary movements of the head.	Y	Quality of care
7	H	316	4	The nursing home lacked a program to prevent bladder incontinence and to restore functional continence. This failure contributed to the decline in continence of two residents; for two other incontinent residents there was no evidence of intervention to restore normal continence. The director of nursing confirmed that the home did not have such a program, although 50 residents were occasionally or frequently incontinent. None of these 50 residents were on an individually written bladder training program.	Y	Quality of care
8a	G	311	3	The nursing home failed to ensure that three residents with swallowing difficulties were fed appropriately according to their plans of care. Surveyors observed the three residents being fed inappropriate foods and drinks. In one case, a resident was fed while in the wrong position. One of the three residents had previously been hospitalized twice as a result of choking on a meal.	Y	Quality of care
8b	G	314	7	The nursing home failed to ensure that seven residents who required considerable assistance in the activities of daily living received necessary care to prevent development of pressure sores. The surveyor observed that the residents had not been repositioned every 2 hours as required in their plans of care. In some cases, the documented interval was as long as 4 hours. In one case, the resident had a deep, open pressure sore. No actual harm was documented for the other 6 residents, although several had a history of pressure sores.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
9	G	324	5	The nursing home failed to provide adequate supervision to three residents of the Alzheimer's unit who were at risk for falls. Each of the three residents had fallen repeatedly. A fourth resident was improperly restrained when the one nurse's aide assigned to the unit had to leave the resident's room in order to provide care to a resident in another room. A fifth resident, also left unsupervised because of the staff shortage, physically abused another resident. Both the nurse's aide and a family member stated that there was usually only one nurse's aide on this unit during the evening shift, although the nursing home's policies call for two to be present.	Y	Quality of care
10a	G	310	3	Residents who needed physical therapy were not provided the interventions designed in their care plans to prevent a decline in walking. One resident, who had made "significant progress," was subsequently discharged from physical therapy to the restorative nursing program for daily walking. There was no evidence that this restorative service was provided, and 2 months later nursing documentation indicated that the resident was unable to walk "even with assistance."	Y	Quality of care
10b	G	324	2	A resident sustained hip fractures, a sprained wrist, and numerous abrasions from six documented falls since her admission 4 months earlier. The nursing home failed to reassess her and implement preventive measures to ensure her safety. She was cognitively impaired, and four of her falls were a result of her attempting to use the toilet herself. In addition, the surveyor found a resident with brain damage to have long jagged nails even though an earlier investigation by the home determined that his nails were to be kept "clipped." Five months earlier, the resident's long nails caused him to lacerate his penis, requiring transfer to a hospital for 12 sutures.	Y	Quality of care
11a	I	157	2	The nursing home failed to ensure that the physicians of two residents experiencing serious respiratory difficulties were informed of their patients' deteriorating conditions. Both residents subsequently died.	Y	Resident rights

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
11b	I	250	2	The nursing home failed to provide appropriate interventions to two verbally and physically abusive residents to manage their behavioral symptoms, as specified in their plans of care. This deficiency was originally cited during an earlier complaint survey. The nursing home submitted a plan of correction to the state, indicating that it would reevaluate these residents and notify their physicians of the behaviors for further intervention. However, the home had not implemented the plan at the time of this survey over 2 months later. Both residents were abusive to staff. The nursing home's documentation noted that the residents' behaviors had continued over many months without the home reassessing the need for different interventions, including medication.	Y	Quality of life
11c	I	309	1	The nursing home failed to provide appropriate care to a resident with increasing respiratory distress for 2 days. When the nursing home sent the resident to a dialysis clinic for scheduled dialysis, the dialysis facility determined that the resident was too sick to undergo dialysis and sent the resident to a hospital. The hospital diagnosed pneumonia, and the resident subsequently died.	Y	Quality of care
12	G	312	4	Nursing home staff failed to provide prompt incontinence care to four totally dependent residents, leaving them in their body wastes for between 1 and 3 hours. In one case, staff failed to cleanse a resident even when other care was being provided.	Y	Quality of care
13	D	N/A	N/A	A state supervisor reduced two isolated actual harm deficiencies to a lower severity level of a pattern for potential for more than minimal harm. Therefore, this case was dropped from our sample.	N/A	N/A
14a	G	224	2	The nursing home failed to ensure that two residents were free from verbal abuse. In the first instance, an employee verbally intimidated a resident after accusing her of failing to return an inhaler. The resident said that she was terrified and complained to an ombudsman. The resident was still afraid and uneasy at the time of the survey a few days later. In the second instance, a resident had been repeatedly told that he had to wait for incontinence care despite repeated requests for assistance. The resident had a moderate pressure sore.	Y	Resident behavior and facility practices

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
14b	G	242	3	The nursing home failed to honor personal choices for three residents. Two residents stated that they would prefer to get up earlier to do activities, but the staff was not getting them up when requested. The surveyor observed one such case. In the third case, an oxygen-dependent resident with chronic obstructive pulmonary disease was not permitted to get his shower at his preferred time, which was just after he had used his inhaler to reduce shortness of breath. The one time he had been showered, he was not showered at his preferred time, and he was extremely short of breath afterwards. He declined subsequent offers of showers at his nonpreferred time and he was told that he could not receive a shower at another time. Also, the home refused to permit the resident to bring his wheelchair into the home, alleging lack of space. Because he was unable to carry portable oxygen equipment and unable to walk, he was unable to leave his room.	Y	Quality of life
14c	G	310	3	The nursing home had not provided programs to enable residents who could walk independently to do so. As a result, two residents became unable to walk independently, and a third became able to walk only 15 feet.	Y	Quality of care
14d	G	324	10	The nursing home failed to ensure that residents received adequate supervision and assistance to prevent accidents. One resident in the Alzheimer's unit fell 16 times in the 2-month period prior to the survey, sustaining numerous injuries that included a broken wrist. Except for one intervention during the resident's first month at the home, the resident's plan of care was not revised to prevent further falls. The 10-patient Alzheimer's unit was understaffed and therefore could not prevent falls and other accidents or answer residents' call lights promptly.	Y	Quality of care
14e	G	325	2	For two residents, the nursing home failed to provide adequate assistance, appetizing food, and appropriately timed snacks and supplements to enable them to maintain nutritional status. As a result, both residents experienced significant unplanned weight loss over the months before the survey.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
14f	G	329	1	A resident was on a hypnotic medication when readmitted from the hospital. The nursing home began to decrease this medication and discontinued it on January 20. The home's documentation indicated that the resident began to be anxious on the day the medication was discontinued, even to the point of abusing other residents. On January 22, the home's staff obtained a physician's order for an antianxiety medication for the resident. The surveyor cited the home for not documenting that the discontinuation of the hypnotic medication might have been a reason for the resident's behavior. The surveyor also stated that the home's documentation did not indicate that the staff had tried any interventions (other than medication) to alleviate the resident's agitation. Further, the surveyor noted that the home placed the resident on an antianxiety medication without showing the need for such medication.	N	Quality of care
15	G	324	14	The nursing home failed to provide supervision and assistance to prevent accidents for 14 residents. Six residents hit other residents, two left the building without the staff's knowledge, and eight were found on the floor of their rooms from falls of unknown origin. Four residents sustained multiple falls, and one other resident sustained a broken hip.	Y	Quality of care
16	G	309	1	The nursing home failed to provide a totally dependent resident with the care and assessment he needed. He suffered a fracture of his right leg, as well as other leg injuries, but was not sent to the hospital for treatment for about 13 hours. The home failed to follow the care plan or the physician's orders and did not perform a full body assessment when an injury was suspected.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
17a	G	314	2	The nursing home failed to ensure that residents with pressure sores received appropriate treatment and services to promote healing and prevent infection and that new residents without pressure sores did not develop them. One resident with multiple pressure sores was not properly monitored and did not receive treatment in accordance with physician orders. Although dressings were ordered for both heels, the surveyor observed that the right heel did not have a dressing and that the dressing on the left heel was stuck to the pressure sore. Another resident was admitted in August 1997 without pressure sores but was identified as being at high risk for pressure sores. By October, the resident was noted to have developed a moderate pressure sore on her sacral area. In mid-November, the resident was transferred to an acute care hospital with a high fever and loss of consciousness resulting from a systemic infection caused by the infected pressure sore.	Y	Quality of care
17b	G	324	1	The nursing home failed to ensure that a resident received adequate supervision to prevent accidents. A resident was diagnosed with a seizure disorder that placed her at a high risk for falls. However, the nursing home failed to provide the supervision she required during toileting as a result of this risk. In one instance, she had fallen after being left on the toilet and suffered a laceration on her right eyebrow. The resident stated that she had a seizure but that nursing home staff had not witnessed it.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
17c	G	325	4	The nursing home failed to ensure that residents were properly nourished (as reflected by appropriate body weight and protein levels). One resident experienced a 60-pound weight loss—22 percent of her weight—in a 6-month period. She was on a 1,500-calorie reduction diet (a very low-calorie diet). The resident's laboratory test indicated that she had a very low protein level as a result of this diet, which increased the risk of her developing pressure sores. At the time of the survey, the resident had a pressure sore. Another resident with a history of skin breakdown had a breakdown of the left buttock area at the time of the survey. This resident's nutritional notes indicated a loss of protein due to weight loss and poor oral intake, which decreased her resistance to infection and contributed to other complications. A third resident with kidney failure lost 13.3 pounds in 2 weeks. The home failed to provide a sack lunch or make other provisions to ensure that the resident received adequate nutrition while she was away from the home receiving dialysis for 7 hours three times each week.	Y	Quality of care
18a	G	314	1	The nursing home failed to provide devices for pressure relief, consistent and accurate skin assessment, and treatments as ordered for one resident. These failures contributed to the resident's developing a pressure sore on one heel.	Y	Quality of care
18b	G	324	3	The nursing home failed to ensure that bed rails were in good operating condition and used safely. As a result, two residents fell out of bed after having the bed rail collapse while they were leaning on it. One sustained injuries requiring emergency room treatment. In addition, a surveyor observed a resident smoking unsupervised in the smoking room with an oxygen bottle on the back of his wheelchair. The home failed to ensure that smoking residents were supervised and that combustibles were not present. These failures created the risk of fire or explosion.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
19	G	314	2	The nursing home failed to ensure that residents with pressure sores received appropriate treatment and services to promote healing and prevent infection. One resident's pressure sores deteriorated to the point that they became infected with extensive drainage. Although the physician was aware of these symptoms, additional evaluation or treatment was not ordered. Interviews with family and staff indicated that the resident was not turned in bed on a consistent basis and that the home was not aggressive in its approach and treatment. Another resident was found to have similar problems with pressure sore care.	Y	Quality of care
20a	G	250	2	For two residents, a nursing home failed to follow the plan of care and provide regular social service contact. One terminally ill resident would sit in a wheelchair in a room or lie in bed all day facing the wall, without facial expression. The plan of care called for 1 to 12 monthly visits by the home's social worker to provide support and monitor this resident, but no visits were documented. The clinical record for another resident documented that the resident had increased restlessness and anxiety exhibited by 42 episodes of repetitive calling out, anxiety, agitation, and altercations with other residents in a 3-month period. This resident's plan of care called for social service staff to visit twice weekly, but social service staff said they thought they were to visit twice monthly. No visits were documented for more than 1 month.	Y	Quality of life
20b	G	312	1	The nursing home staff did not provide nail care to a resident who was totally dependent on staff for his care. This resident was observed lying in bed with long fingernails with dark material underneath them. Two days later, the resident was observed with dried brown matter underneath the nails and on the outside of the nails. Licensed staff said the resident was very weak due to a terminal diagnosis and was unable to do his own nail care. (Lacking further documentation regarding the home's practices in performing other personal grooming of this resident, such as bathing, we could not determine whether this example constitutes actual harm.)	N	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
20c	G	314	3	A nursing home failed to provide necessary treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. An initial wound assessment for one resident revealed two areas of severe pressure sores. More than 2 days passed, however, before a medicated ointment was ordered. Two other residents did not receive pressure-relief devices or sufficient repositioning to facilitate healing and prevent worsening of their sores.	Y	Quality of care
20d	G	325	2	The nursing home failed to ensure the proper nutritional status of two residents. Over a 10-day period, one resident lost 7 percent of her body weight, placing her 5 pounds below her minimum weight goal and 16 pounds below the lowest ideal body weight. Her medical record contained no information to explain this weight loss. Although her care plan called for her to be weighed weekly, there was no record of her weight during one 2-week period. Although a second resident lost 5 percent of his/her weight in one month, the home failed to seek nutritional intervention.	Y	Quality of care
21a	H	312	3	Three incontinent residents were not given the services necessary to maintain good personal hygiene. They were not promptly given incontinence care after episodes of incontinence and were not completely cleansed when given care. One resident was given incontinence briefs that were too small and developed multiple open areas on the left hip.	Y	Quality of care
21b	H	314	3	The nursing home did not provide three residents with adequate care to prevent and heal pressure sores. All three developed pressure sores. Despite this, the need for pressure-relieving devices was not addressed in their care plans.	Y	Quality of care
22	G	309	1	A resident was burned by a heating pad left on his/her back for 9 hours and 15 minutes. A nurse's aide had placed the pad on the resident's back, even though professional staff was required to do this. The physician's order had not specified the duration of treatment, although instructions for the heating pad warned that a physician should prescribe the temperature setting and duration of the treatment. The staff had not requested clarification of this order.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
23	H	314	4	The nursing home did not ensure that all residents with pressure sores were assessed in a timely manner and received treatment and services to promote healing and prevent the development of new sores. Four residents had a total of five pressure sores, all of which developed while the residents lived in the home.	Y	Quality of care
24	G	314	2	The nursing home failed to ensure that residents without pressure sores did not develop them and that residents with pressure sores received appropriate treatment and services to promote healing. Pressure sores developed on residents because of wet bed linens, failure to assess residents to prevent skin breakdown, and failure to provide treatment after there was skin breakdown.	Y	Quality of care
25	G	250	1	A resident demonstrated increasingly abusive verbal behavior for about 1 month. The nursing home did not initiate any psychosocial intervention until after the resident physically abused and hurt her roommate. The roommate was found with a swollen right breast and a bruise on her chest and alleged that the resident had struck her.	Y	Quality of life
26	G	365	2	The nursing home failed to ensure that two residents received special diets as ordered by their physician because of swallowing problems. One resident choked on a piece of ham and had to be hospitalized.	Y	Dietary services
27	G	324	3	The nursing home failed to ensure that three residents received adequate supervision and assistive devices to prevent accidents. One man fell seven times before his situation was reevaluated. His final fall resulted in 12 sutures.	Y	Quality of care
28a	G	224	1	The nursing home failed to notify a physician of a resident's worsening condition. The resident had a severe pressure sore with drainage and a strong odor as well as yellow, irritated open areas with yellow/green drainage on his scrotum and penis. He was admitted to a hospital.	Y	Resident behavior and facility practices

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
28b	G	314	1	The nursing home failed to ensure a resident received appropriate treatment of his infected pressure sores. The resident had a severe pressure sore with tunneling and drainage with a strong odor as well as yellow, irritated open areas with yellow/green drainage on his scrotum and penis. He was admitted to a hospital. Hospital personnel described him as dry and dehydrated on admission, with a large wound with odorous drainage on the left hip, necrosis on the back of his scrotum, thick purulent drainage from around his catheter, and feces caked on the soles of his feet. One hospital staff person described his condition as a "picture of neglect."	Y	Quality of care
29	G	314	1	The nursing home failed to ensure that a resident received appropriate treatment to prevent and heal a pressure sore. He had a developing pressure sore on his right heel, which was not treated because nursing home staff were not aware of it until informed by the surveyor.	Y	Quality of care
30	E	N/A	N/A	This home was determined to have no isolated actual harm deficiencies (G-level deficiencies) after it contested the state surveyor's findings.	N/A	N/A
31	G	324	1	The nursing home failed to ensure that its residents received adequate supervision to prevent accidents. While being turned in bed by a nursing assistant, a resident sustained a laceration above the left eye requiring sutures. According to the resident's care plan, two people were required to turn the resident safely.	Y	Quality of care
32	G	323	1	The nursing home failed to maintain an environment as free from accident hazards as possible by failing to ensure that heating units in residents' rooms did not present a burn risk to residents. One resident burned his hand. The surveyor found that the heating units in 59 rooms had hot surfaces that were a burn hazard. In addition, wheelchairs for five residents had nonworking brakes.	Y	Quality of care
33	G	324	2	The nursing home failed to provide adequate supervision to prevent accidents to two residents who sustained falls. One resident sustained a scalp injury requiring sutures, and the other fell numerous times.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
34a	G	314	2	The home failed to monitor a chronic pressure sore, follow its own procedures on pressure sore care, document the status of sores, and plan approaches and intervention for treatment for two residents. For one resident, the surveyor found that a pressure sore determined by the home to be healed had reopened and was not reported; the status of another resident's pressure sore was not documented for a 3-week period, during which time it grew worse.	Y	Quality of care
34b	G	325	2	The nursing home failed to intervene in a timely manner to prevent the substantial weight loss of two residents. Both residents' weight fell well below their ideal body weight.	Y	Quality of care
34c	G	411	2	The nursing home failed to obtain needed dental care for two residents. Both residents had bad teeth, and one had a very painful lower jaw.	Y	Dental services
35	G	323	1	The nursing home failed to ensure that it was free from accident hazards by not properly positioning beds away from electric baseboard heater units, failing to maintain heater guards in good repair, and failing to monitor the temperature settings of the units to prevent excessive heat. As a result, one resident sustained second degree burns, and other residents were put at risk of burns.	Y	Quality of care
36	G	225	3	The nursing home failed to investigate and notify responsible parties and agencies of sexual assault on female residents. A male resident was responsible for five assaults on three nonconsenting residents. The program director was aware of the first three incidents but did not notify any of the families, responsible parties, or authorities. The home failed to follow its own policy on reporting sexual abuse.	Y	Resident behavior and facility practices
37	G	319	1	The nursing home failed to obtain needed psychiatric services for a resident who exhibited aggressive, violent, and bizarre behavior. The resident jumped or fell out of a third-floor window and died from his injuries.	Y	Quality of care
38	G	281	1	A resident with diagnoses including diabetes, hypertension, and Alzheimer's disease complained of not feeling well and had a blood sugar level of 215. (Normal blood sugar ranges from 70 to 110.) There was no follow-up assessment or documentation of vital signs being taken until the resident had declined further. Emergency care was provided incorrectly by the nurse. The resident was transferred to a hospital, where he died.	Y	Resident assessment

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
39a	G	312	2	The nursing home did not provide two residents who needed oral and personal care with timely assistance. One resident with a feeding tube did not receive proper mouth care. As a result, she choked and gagged on her mouth secretions and had to be suctioned. The next day she was whimpering and had rapid shallow respiration and a temperature of 103 degrees. The second resident did not receive incontinence care for 1-1/2 hours even though she was calling for help.	Y	Quality of care
39b	G	353	10	The nursing home did not have sufficient staff to provide timely and necessary care and supervision of residents. Five residents complained that they had to wait long periods for their call lights to be answered. When they were answered, the staff member would come into the room, turn off the call light, leave, and not return. One resident's call light was not answered for nearly 4 hours one night, resulting in a delay in her receiving needed pain medication. Also, one resident wandered into rooms of other residents without staff supervision or notice. Another resident did not receive antibiotic medication for an eye infection as ordered.	Y	Nursing services
40	J	225	1	The nursing home administrator was not notified until the next morning of an unusual and untimely death of a resident that occurred on Monday, February 16, at approximately 7:55 p.m. Interviews of administration and staff revealed confusion as to how this incident occurred. The surveyor noted at the completion of the survey on Thursday, February 19, that the home also did not notify appropriate authorities as required. This deficiency relates to investigating and reporting incidents of potential abuse or neglect of residents. However, HCFA's requirement is that a nursing home has 5 working days to complete its investigation and to notify the appropriate authorities. The fifth working day would have been Monday, February 23.	N	Resident behavior and facility practices
41	G	224	1	The nursing home failed to implement written policies and procedures prohibiting mistreatment, neglect, and abuse of residents. One resident required total assistance in being transferred from the bed to the chair. A physical therapist assessed the resident for transfer assistance and determined that the resident needed a mechanical lift for all transfers. When a nurse's aide attempted to manually lift the resident, the resident's leg became caught between the bed rail and the bed, resulting in multiple leg fractures.	Y	Resident behavior and facility practices

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
42a	H	314	2	The nursing home failed to ensure that residents who entered the home without pressure sores did not develop them and that residents with pressure sores received appropriate treatment and services to promote healing and to prevent infection. One new resident had no history of pressure sores and had no sores upon admission. Three months later, nursing notes showed that the resident had a severe pressure sore on his/her right heel. The notes also described unsuccessful attempts to contact a physician. Not until 7 days after the sore's initial discovery did the physician give orders for treatment to begin. Another resident was assessed with multiple pressure sores within 8 days of admission. Although this resident's care plan indicated that he was at risk for skin breakdown, there were no preventive measures, other than keeping him clean and dry, until after the second and third sores developed.	Y	Quality of care
42b	H	319	1	The nursing home failed to ensure that residents displaying mental adjustment difficulties received appropriate treatment for these problems. One resident was admitted with multiple complications, including chronic anxiety that was being treated with antianxiety medication. Over the next 19 months, she experienced nutritional decline, skin breakdown, and multiple indicators of depression. The clinical record failed to document treatment of her depression until her health had become severely compromised, as indicated by a weight loss of 42-1/2 pounds, multiple pressure sores, and a decline in both physical and social functioning.	Y	Quality of care
43	G	314	7	The nursing home failed to ensure that three residents who were observed to have pressure sores received timely assessment and treatment as ordered by the physician. The home also failed to ensure that five dependent residents who were observed for incontinent care and skin conditions were provided pressure-relieving pads on their beds.	Y	Quality of care
44	D	N/A	N/A	Two isolated actual harm deficiencies were deleted, and another deficiency was reduced from actual harm to potential for more than minimal harm after the nursing home disputed the state surveyor's findings. Therefore, this home had no isolated actual harm deficiencies on this survey.	N/A	N/A

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Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
45a	H	164	3	A surveyor observed over 22 different residents during a survey of a nursing home and found 3 residents who were not ensured rights to personal privacy. One female resident was observed going to and returning from a shower in a shower-chair which "allowed for exposure of the resident's naked buttocks." While being placed on a bedpan, another female resident was exposed because bedcovers were thrown back and curtains were not drawn to provide privacy to the resident. A third resident was observed sitting on the toilet in the bathroom with both the bathroom and bedroom doors open. A nursing assistant working in the resident's room at the time had neglected to close the doors.	Y	Resident rights
45b	H	225	3	The nursing home failed to record and report injuries that warranted notification to the state agency. One resident, documented as being at high risk for falls, sustained an unwitnessed fall and was found bleeding from her nose and with laceration on her forehead. Further evaluation at the hospital revealed the resident had also sustained a fractured neck. Another resident's care plan documented prior falls and indicated she was at risk for falls. She was found lying on the floor of her room bleeding from two lacerations on the right side of her forehead. The unwitnessed fall required her to be taken to a hospital, where she received sutures. A third resident alleged abuse by a staff member resulting in a bruise on her nose. None of the three incidents were documented in the home's incident log or reported to the state agency, as required.	Y	Resident behavior and facility practices
45c	H	241	6	The nursing home failed to provide care in a manner that maintained each resident's dignity. A nursing assistant shampooed a resident's hair by holding the sprayer directly over her head and allowing the shampoo and water to pour down over her eyes, nose, and mouth. The assistant then proceeded to vigorously scrub the resident while the resident cried audibly. Despite the resident's distress, the assistant offered no reassurance or comfort. Also, five residents were observed in hospital gowns so worn and so thin that they failed to provide sufficient coverage to maintain resident dignity; that is, breasts were visible through the thin material.	Y	Quality of life

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
45d	H	314	2	The nursing home failed to provide necessary treatment for pressure sores in a timely and consistent manner: assessment was not timely, preventive measures were not taken, and monitoring and treatment were not initiated as needed. One resident was admitted with reddened heels, but no skin breaks. The home did not immediately initiate measures to protect the resident's heels. Three months later, the resident developed advanced pressure sores that required surgery. Another resident with a history of pressure sores did not receive timely treatment of a severe pressure sore.	Y	Quality of care
46	G	314	2	A nursing home resident was discovered in bed surrounded by a foul-smelling, ammonia-like odor. When the charge nurse pulled back the resident's covers, the incontinence pad was observed to be completely saturated with urine. The resident was soiled with feces and had developed three moderate pressure sores. A skin assessment 5 days earlier had revealed that the resident's skin was intact with no breakdown. There were no orders to treat the pressure sores. Also, another resident was not properly treated for pressure sores.	Y	Quality of care
47	G	325	1	The nursing home failed to implement recommended dietary interventions that were recommended by the home's dietitian for one resident with continuing unplanned weight loss.	Y	Quality of care
48	H	311	4	The nursing home failed to provide four residents with restorative swallowing programs ordered by a therapist to prevent them from aspirating food into their lungs. This resulted in two of the residents requiring emergency hospitalization for aspiration pneumonia.	Y	Quality of care
49a	I	246	1	The nursing home did not accommodate the needs of one resident with severe respiratory problems. There was a strong, pungent odor of urine in the room (because of her incontinent roommate) that the resident complained brought on her "asthma" attacks. The resident had been hospitalized numerous times for her respiratory condition. On the second day of the survey, this problem was discussed with the home's social services staff. As of the fourth day of the survey, the staff had neither discussed this problem with the resident nor made an attempt to accommodate her respiratory care needs.	Y	Quality of life

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Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
49b	I	250	1	The nursing home did not provide psychosocial services for a resident who complained of problems with her roommate. The resident alleged that the roommate invaded her privacy and would leave dirty incontinence pads in the bathroom. The resident had complained to the nursing home social worker and administrator with no success. She was told that she would have to move out of the room, which she did not want to do because she had lived there for almost 2 years. The resident said that she was "upset all the time" over this problem. Interviews with the social worker confirmed this problem. The nursing home did not provide any type of counseling for the two roommates.	Y	Quality of life
49c	I	325	1	The nursing home did not ensure that a resident maintained acceptable nutritional status. The resident lost more than 6 percent of her body weight in less than 2 months. A dietary review recommended supplementary feedings for added nourishment. However, 2 weeks later, the home was not providing these supplements.	Y	Quality of care
49d	I	242	2	The nursing home did not allow the resident the right to choose activities and schedules consistent with his interests and make choices about aspects of his life in the home that were significant to the resident. A family member of a resident complained that the resident was no longer allowed to eat in the main dining room because he needed assistance with eating. Instead, the resident was told he would have to eat in one of the small dining rooms on the units. The family member explained that the resident enjoyed music and the main dining room had a piano player on certain days of the week. In addition, residents in the main dining room were offered soup, while residents who ate on the units were not offered soup. The surveyor noted that the soup was kept in the kitchen and if residents who ate in the unit wanted it, the nursing home staff would have to call the kitchen to get the soup for the resident.	N	Quality of life
50	G	309	1	A resident was admitted to the nursing home with diagnoses including chronic schizophrenia and diabetes. She often refused medications, treatments, and weight checks. She also fired her physician and refused to see another physician. During her stay, the home did not always notify her physician of her refusals. In addition, the home did not always notify her physician, as ordered, if her blood sugar level was below 60. No adverse outcome to the resident was noted in the documentation.	N	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
51a	G	309	3	Three residents experienced injuries from falls. One was identified to be at risk for falls and had a care plan developed to prevent them. Clinical documentation did not show that the care plan was implemented before she experienced a fall and fractured her hip. Another resident did not have a care plan to prevent falls, even though she suffered a fractured wrist a week earlier from a fall.	Y	Quality of care
51b	G	324	3	Upon admission, a resident was assessed by the nursing home to be at minimal risk for falls. Her care plan reflected interventions such as bed and chair monitor alarms. There was no evidence that the home had assessed or identified the need for supervision in order to prevent accidents. Two weeks after her admission, she was found lying on the floor with her wheelchair behind her. It was later learned that she had fractured her leg. Another resident dislocated her shoulder as a result of a fall. However, at the time of admission, there was no evidence that a risk assessment for falls had been done.	Y	Quality of care
52a	G	316	3	A resident who was continent upon admission deteriorated to being consistently incontinent. He complained to the surveyor of being unable to make it to the toilet in time because he could not remove the diaper that the nursing home staff had put on him. There was no evidence that the staff had evaluated his decline or had implemented interventions to prevent or address this decline. His current care plan stated that the nursing home staff was to “provide incontinence care after each incontinence episode.” Two other residents had similar problems with continence care: one resident remained continent only if a 2-hour toileting schedule was maintained, and another was not assisted in the bathroom despite her declining status. Instead, the only intervention provided by the nursing home was to clean this resident after each episode.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
52b	G	325	2	Within 1 month after readmission, a resident lost 14-1/2 pounds, 9 percent of his body weight. There was no evidence to indicate that this weight loss had been evaluated or that interventions had been attempted. For another resident, who was being tube fed, the dietitian recommended increasing the caloric and fluid intake. Six days later, the physician ordered a product with more calories in it for feeding and instructed the home's staff to flush the feeding tube as recommended by the dietitian. However, a week after this order was given, no changes had been made to the resident's feeding or flushes. The nursing staff stated that they were waiting for the necessary product, which was on order. The dietitian had not been notified that the product was unavailable. An evaluation of alternative methods to provide additional nutrients and fluid had not been conducted.	Y	Quality of care
52c	G	492	1	A resident was admitted to the nursing home and provided therapies that were covered by Medicare and other insurance for about 2 months. The home determined after 2 months that the resident would not improve with continued therapies and therefore stopped them. The home notified the resident's family that the therapies were discontinued. Less than 3 weeks after the therapies were discontinued, the resident's family requested that the home resume them and send the bill to the fiscal intermediary (Medicare's contractor) to see if it would approve payment of the therapies. The home failed to send the bill to the fiscal intermediary. Instead, the home inappropriately charged the resident and the family. The documentation is not clear about whether therapies were continued during this period. It also does not state whether there was any adverse effect to the resident.	N	Administration

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
53a	K	224	1	A resident suffering from anxiety, a depressive disorder, and an obstructive pulmonary disease had a history of agitation. He also experienced episodes of anxiety because of shortness of breath and abdominal discomfort. The physician had ordered medication to be given every 4 hours as needed for the abdominal discomfort. The resident asked a nurse for this medication and was told he could not have it, and was provided no explanation. The resident became agitated and hit the nurse. The nurse, when questioned by the surveyor about why the resident could not have the medicine, replied that the home's policy was to give "those kinds of medication during the evening shift." The resident asked for the medicine on a shift other than the evening shift and was inappropriately denied.	Y	Resident behavior and facility practices
53b	K	314	1	The nursing home failed to ensure that residents received necessary care and treatment to promote healing of pressure sores and to prevent new sores from developing. An assessment of one resident revealed clear skin and no pressure sores in January 1998. Treatment records showed healed pressure sores in February and March and a moderate pressure sore in April that healed in May. The resident developed another moderate sore in June, which deteriorated to a severe sore within 2 weeks. This resident's plan of care did not address this pressure sore until it had deteriorated to a severe sore.	Y	Quality of care
53c	K	322	1	The nursing home failed to ensure that tube-fed residents received treatment and services to prevent vomiting. Physician's orders for a new tube-fed resident called for a maximum flow rate of 70 cc's per hour. The following day, in direct conflict with the physician's orders, her flow was increased to 90 cc's per hour. In subsequent episodes, the resident experienced repeated vomiting and eventually required hospitalization.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
53d	K	389	3	The nursing home failed to ensure that physician services were available to residents. One resident received a new prescription to treat his gastric upset caused by his history of gastrointestinal bleeding, but the new medication was not covered under Medicaid. Attempts to contact the physician were unsuccessful for 4 days, during which time the resident did not receive necessary medication to address his history of gastrointestinal bleeding. The staff repeatedly attempted to call a physician to report another resident who had a decreased level of consciousness, was not swallowing, and had fluid in both lungs. Almost 3 hours later, the physician responded and ordered tests. Three hours later, the staff again attempted to contact this physician because the resident's oxygen status had decreased. Over an hour later, the physician called back and the resident was transferred to an acute care hospital with congestive heart failure. The nursing home staff made six attempts to contact the attending physician and two attempts to contact the medical director to report a third resident with severe vomiting. The record shows neither the physician nor the medical director ever returned the calls. Staff indicated that it was a common occurrence for physicians not to return calls from the home.	Y	Physician services
54a	G	314	1	The nursing home failed to ensure that a resident who entered the home without pressure sores did not develop them or received appropriate treatment and services to promote healing. One month after admission, a resident with no previous pressure sores developed a blackened area on the right heel. Several months later, the sore had not healed, and another moderate sore was discovered on the resident's left heel. Despite some interventions to treat the sores, the right heel deteriorated to a severe sore with a small area of bone clearly visible in the wound.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
54b	G	324	2	The nursing home failed to ensure that residents received adequate supervision and assistive devices to prevent accidents. One resident with an "extremely high" risk of falls continued to climb out of bed and out of chairs despite past falls and injuries. In one instance, he was found lying on his back with the side rail on his face and a gash on his cheek. Another cognitively impaired resident was admitted with no history of falls or of needing restraints. Following admission, the resident had a series of eight falls within 2 months, some resulting in injuries. The home failed to provide adequate interventions to prevent accidents for both residents.	Y	Quality of care
55	G	314	1	A cognitively impaired resident developed a pressure sore on his coccyx while in the nursing home. The resident was also incontinent of bowel and bladder. The nursing home's staff did not consistently cover the opened pressure sore with a dressing to protect the sore from feces and urine, thereby not promoting the healing of the sore.	Y	Quality of care
56a	G	314	4	The nursing home failed to ensure that residents without pressure sores did not develop sores. One resident developed a severe pressure sore with a thick yellow covering. Another resident's care plan did not identify the need for preventive foot care, nor were any measures taken to prevent pressure sores. The resident developed a sore on the heel that was covered with a thick, black tissue. At least two other residents did not receive the treatment and services necessary to prevent new sores from developing.	Y	Quality of care
56b	G	318	2	A physician's order required that a resident wear a hand splint for 4 hours during each nursing shift to decrease the risk of further deterioration of range of motion of the hand. Observers during all 3 days of the survey concurred that the nursing home staff did not apply the splint as ordered. The same resident also was assessed to be lacking in range of motion in both knees. The resident was required by physician's order to be seated in a recliner to relieve a pressure sore and to wear a restrictive device on both legs. During each day of the survey, the resident was observed to have never left the bed. The device remained stored in the seat of the recliner. Another resident was observed with mitts on both hands. The home's staff did not remove the mitts every 2 hours for 10 minutes as documented in the resident's care plan. Instead, the surveyors stated that the resident wore the mitts during all days of the survey.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
57a	G	318	1	The nursing home failed to ensure that a resident with limited range of motion received appropriate treatment and services in order to prevent further deterioration. A baseline mobility assessment for one resident indicated minimal to moderate reduction in range of motion in the hips, knees, elbows, wrists, fingers, shoulders, and ankles. Three months later, during the survey, a reassessment found that the fingers, shoulders, and one knee had declined to severe loss of range of motion. The nursing home staff failed to identify these problems and failed to develop a plan of care to address them.	Y	Quality of care
57b	G	329	3	The nursing home failed to ensure that the drug regimens of its residents were free of unnecessary drugs. Residents were given combinations of drugs including narcotics, hypnotics, sedatives, psychotropic, antidepressants, antipsychotics, and tranquilizers, with insufficient evaluation of the need for medication, the response of residents to the medication, or the effectiveness of the medication. One resident developed permanent, serious side effects from the medication.	Y	Quality of care
58	G	316	2	The surveyors noted that the nursing home improperly handled the catheter bags and tubing of two residents with urinary tract infections. The surveyors stated that the home's improper handling of the catheters and tubing (allowing the catheter bag to be raised above a resident's bladder and allowing the tubing to drag on the floor) created a risk of contamination of the catheter and, therefore, did not promote healing of the residents' infections. However, the home stated that its catheter bags have an antireflux valve that prevents the backflow of urine into the resident's bladder when the catheter bag is raised above the resident's bladder. In addition, the catheter system that the home had is a sealed system so that there can be no contamination from dragging the tubing on the floor.	N	Quality of care
59	G	314	2	The nursing home failed to ensure that residents with pressure sores were repositioned every 2 hours to promote healing and to prevent new sores from developing. One totally dependent resident was observed sitting in a wheelchair for over 3 hours without being repositioned. Additionally, the medical record indicated that the resident had a sore on her coccyx due to pressure from sitting in the wheelchair. Another totally dependent resident was observed lying flat in bed for more than 5 hours without repositioning. The resident's medical record indicated that the resident had a pressure sore.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
60	G	314	7	For seven residents with pressure sores, the nursing home failed to (1) provide proper care after incontinence, (2) report and document changes in skin condition, (3) follow physicians' orders in making dressing changes to pressure sores, (4) follow care plans regarding reporting changes in pressure sores, (5) use clean cloths to cleanse open areas on the skin, (6) reposition residents at least every 2 hours, and (7) keep dressings clean, dry, intact, and completely covering pressure sores. Moreover, the home failed to review and revise the care plan for one resident regarding her worsening condition relating to her pressure sores, and to apply protective boots as ordered for another resident.	Y	Quality of care
61	H	441	2	The nursing home did not ensure that measures were taken to prevent the spread of infection for two residents. A surveyor observed a nurse's aide continuing to wear the same gloves while cleaning a resident of stool, dressing the resident, transferring the resident to a chair, and combing the resident's hair. The aide did not wash her hands after removing the gloves. The home did not ensure that another resident's catheter was positioned correctly to aid in the flow of urine. The resident had a diagnosis of a urinary tract infection. Documentation does not support actual harm occurred to either resident. However, it does support potential for harm. Additionally, most catheter systems are closed systems and have an anti-reflux valve that prevents the risk of infection because of the back flow of urine. The documentation does not indicate the type of catheter system used and whether it had an anti-reflux valve.	N	Infection control
62	G	333	1	The nursing home failed to ensure that residents were free from significant medication errors. The staff failed to administer an antipsychotic drug to one resident diagnosed with chronic schizophrenia for 19-1/2 days. A psychiatrist's notes indicated an increase in the resident's irritability and agitation, also resulting in increased episodes of aggressive and loud verbalizations.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
63	G	312	8	Residents in a nursing home who were unable to perform activities of daily living did not receive proper care and services. Residents unable to leave their beds did not receive proper turning and repositioning, which left a purple bruise on one elbow and an old long yellow bruise on the upper chest of one resident. Incontinent residents were left in urine-soaked and feces-stained linens, which caused skin breakdown and rashes in at least one resident. Residents who were unable to groom themselves were not bathed; had long, jagged, dirty fingernails; dirty teeth; and dirty clothes.	Y	Quality of care
64a	G	221	5	The nursing home failed to properly implement therapeutic interventions for five residents. One resident was given hand mitts in order to prevent her from scratching herself. However, she was observed to be improperly wearing these hand mitts at meal times, which hindered her ability to eat. In another instance, the home used a self-releasing belt on a resident in a wheelchair without trying other alternatives. Two other residents were similarly not evaluated for the appropriateness of a self-release belt. A fifth resident had a physician's order for a specific type of chair to be used when the resident was out of bed. The occupational therapist at the nursing home stated that the resident slid out of this chair when she required toileting. The nursing staff never assessed whether the resident's toileting program was adequate. Instead, they tied the resident in her chair with a sheet so she would not slide out of it.	Y	Resident behavior and facility practices
64b	G	309	5	A resident had an increase in episodes of choking and coughing when eating. In response to this, the resident's physician ordered a swallowing evaluation. This evaluation was completed and the therapist recommended that the resident be placed on thickened liquids to prevent the risk of aspiration pneumonia. Due to the resident's daughter's past refusal to accept this treatment, the nursing home did not immediately implement it, pending discussion with the daughter. The surveyor noted that the home's administrator stated that staff had discussed this with the resident's daughter. However, the administrator could not produce evidence that this had been done. The resident was ultimately admitted to the hospital with probable aspiration pneumonia 10 days after the treatment had been recommended. The nursing home also failed to follow the plan of care for several residents.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
64c	G	324	1	The nursing home did not reevaluate the appropriateness of certain devices used to prevent a resident from sustaining further injury. The home used two padded side rails and an electric eye sensor on the bed of a resident who was at risk of falling out of bed. While these devices were in use, the resident sustained numerous falls resulting in lacerations. Documentation revealed that the resident would climb over the padded side rails to get out of bed. Although the sensor was supposed to sound when the resident tried to get out of bed, it did not sound on seven separate occasions.	Y	Quality of care
65	G	353	13	The nursing home did not have sufficient staff to provide nursing services to assist residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The home failed to monitor residents on a feeding program to assess amounts of food eaten and eating habits, and at least one resident lost weight. The resident lost nine pounds in one month (a significant weight loss is five pounds in one month). The home also failed to properly groom four residents and to provide assistance with activities of daily living for totally dependent residents on a timely basis.	Y	Nursing services
66a	G	309	2	The nursing home did not provide or arrange timely diagnostic evaluations that were required to manage the conditions for two residents. A resident had difficulty swallowing solid food and thickened liquids. The nursing home's documentation indicated that the resident ate a small amount of food and that the resident was dehydrated. A gastroenterologist examined the resident and recommended that a feeding tube be inserted into the resident to meet his nutritional and hydration needs. The nursing home staff did not notify the resident's physician of the gastroenterologist's recommendation. Another resident had severe choking episodes while drinking liquids at breakfast and lunch. Although a speech therapist recommended an X ray be taken the next day to determine whether the resident had a swallowing problem, the X ray had not been done by the time of the survey 2 weeks later because of equipment malfunction. There was no documentation to indicate that the physician was made aware that a delay in service had occurred for this resident.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
66b	G	314	2	The nursing home failed to ensure that residents admitted without pressure sores did not develop them. A resident who was at high risk for pressure sores required turning and repositioning every 2 hours as noted in both the care plan and the physician's order. The resident developed several pressure sores in different locations. There were numerous blanks and omissions on the record showing how frequently a resident is turned in bed during a 2-month period. Another resident with a history of resolved pressure sores had a current physician's order for heel protectors. The heel protectors were not available in the resident's room, and staff interviews revealed an inability to recall how long the heel booties were unavailable. Additional staff interviews revealed that the home lacked a system for staff to ensure that each resident's special needs, such as the need for heel booties to be available and utilized, are met.	Y	Quality of care
67	G	325	2	The nursing home failed to ensure that residents maintained acceptable parameters of nutritional status, such as body weight. One totally dependent resident lost 11.7 percent of her body weight in the first 18 days following admission. The staff failed to follow dietitian and physician's orders on the level of nutrition this resident was to receive. Another resident lost 4.2 percent of her body weight in 10 days (weight loss of 2 percent in one week is considered severe). Her severe weight loss was noted only after the surveyors found that she consumed only 20 to 50 percent of her meals, and they requested that she be weighed.	Y	Quality of care
68	G	325	1	One resident experienced a severe weight loss of 20 pounds in 1 month. Staff did not inform the dietitian of the resident's poor intake and did not feed the resident enough calories, even though the dietitian's notes stated "Tolerates foods well." The home also failed to inform the physician of the resident's poor food intake and to develop a care plan to address the issue.	Y	Quality of care
69a	G	224	1	The nursing home failed to ensure that residents were not neglected. One resident was left on a bedpan throughout the 8-hour night shift until the resident was discovered on the bedpan in the morning by the day shift.	Y	Resident behavior and facility practices

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
69b	G	314	1	The nursing home failed to ensure that residents did not develop pressure sores while in the home. One resident was left on a bedpan overnight and developed pressure areas on both buttocks, consistent with the upper edge of the bedpan. This area subsequently deteriorated to a deeper wound and was reclassified by the home as a severe pressure sore.	Y	Quality of care
70a	G	223	1	The nursing home failed to protect a resident from sexual abuse. During interviews with nursing home staff, a surveyor learned that a resident had reported that a male employee had raped her and hit her in the face. The home's staff did not believe the resident even though they admitted during interviews with the surveyor that the resident's face was swollen. Therefore, they did not immediately investigate the incident, and the male employee continued to work and take care of some of the home's other female residents. The home's staff also did not document that the resident's face was swollen. Two days later, the resident told her granddaughter about the abuse, and the granddaughter reported it to the nursing home. At that time, the home conducted an investigation.	Y	Resident behavior and facility practices
70b	G	224	1	The nursing home failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. The home did not implement policies and procedures when investigating an allegation of physical and sexual abuse by a staff member (incident above).	Y	Resident behavior and facility practices
70c	G	225	1	The nursing home failed to report to the State Nurse Aide Registry an individual who had a conviction of assault and battery of his sister. The home was aware of this conviction. This aide was involved in the physical and sexual abuse of the resident mentioned in 70a.	Y	Resident behavior and facility practices
70d	G	272	1	The nursing home failed to develop a comprehensive plan of care to meet residents' needs. One newly admitted resident was identified as at high risk for pressure sores; however, a comprehensive care plan for the prevention of pressure sores was not developed for this resident. The resident developed moderately severe pressure sores on both heels, which progressed to a severe stage within 4 weeks.	Y	Resident assessment
70e	G	314	1	The nursing home failed to ensure residents admitted without pressure sores did not develop any. A resident developed moderately severe pressure sores on both heels, which progressed to a severe stage within 4 weeks.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
70f	G	316	1	The nursing home failed to provide treatment and services to restore as much normal bladder function as possible. The home's staff failed to carry out physician's orders to provide bladder training for one resident. Training would have promoted healing of pressure sores on the resident's buttocks.	Y	Quality of care
71a	G	314	6	The home failed to provide necessary care to prevent or promote healing of pressure sores for six residents with pressure sores by (1) not repositioning the residents every 2 hours as called for by the plan of care, (2) not using pressure-relieving devices, (3) not applying protective skin barriers, and (4) not providing complete care after incontinence. New pressure sores were noted for several of these residents.	Y	Quality of care
71b	G	324	1	The home failed to investigate, address, and modify the plan of care to prevent injury to one resident's knee and ankle, which were found to be seriously bruised and scabbed over.	Y	Quality of care
71c	G	325	2	The nursing home failed to maintain adequate nutritional levels for two residents by not (1) identifying parameters for weight gain for one resident and weight loss for the other, (2) including in the dietary assessment specific factors related to accurate monitoring of food intake, and (3) addressing the impact of tube feeding formula on one resident's blood sugar level. One resident's nutritional status as measured by lab results was subnormal despite a small weight gain, and the second resident had lost weight steadily and was below ideal body weight.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
72	G	225	1	The nursing home failed to fully investigate and report possible abuse or neglect to the facility administrator. A nurse and a nurse's aide escorted a resident to the whirlpool room for a bath. The nurse returned to the station and the nurse's aide was left to bathe the resident. The nurse stated that she twice heard an attempt to open the door to the whirlpool room. She started to go back to the room, but the noise stopped. Later, the nurse's aide leaned his head out of the door and requested a diaper for the resident. The nurse stated she got the diaper and when she arrived at the room, she saw the nurse's aide dabbing the resident's ear with a towel. The nurse noted that the resident's ear appeared to be freshly swollen and discolored with two small open areas. On the following day, the resident was seen by a nurse practitioner, who documented that the resident had a contusion with a laceration to the ear and skull with swelling and infected tissue. The director of nursing spoke to the nurse's aide about this incident and requested a written statement from the nurse. However, the director of nursing stated that she failed to obtain the statement from the nurse and to notify the home's administrator of the alleged abuse.	Y	Resident behavior and facility practices
73	G	324	2	The nursing home failed to provide one resident with adequate visual supervision and failed to provide one resident with adequate supervision to prevent falls. The second resident was found on the landing of an interior stairwell, having fallen down 10 steps and sustaining a bruise and a facial laceration, which required sutures.	Y	Quality of care
74	G	324	1	The nursing home failed to put into place a care plan to address a resident's pattern of falls. After being discharged from physical therapy, the resident had numerous falls over more than a 2-month period. One fall resulted in a fractured hip.	Y	Quality of care

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Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
75	G	314	1	The nursing home failed to ensure that residents admitted without pressure sores did not develop sores. A resident was assessed by the home to be at high risk for developing pressure sores. Nursing documentation revealed the measure implemented to prevent skin breakdown was to turn and reposition the resident. However, documentation and interviews with nursing staff revealed this intervention was ineffective because of the resident's resistance and noncompliance with repositioning. No additional preventive measures were implemented, and the resident developed two blisters on the coccyx area 3 weeks later. It was not until approximately 1 week after this that additional measures such as cushions or bed overlays were put in place. At that time, nursing documented that the sore had worsened. Also, there was no assessment of the resident's change in nutritional requirements as a result of the skin breakdown until after the area had severely worsened. At that time, the dietitian assessed the resident's nutritional needs, determined the resident was not receiving adequate protein to promote healing, and recommended a supplement. There was no evidence of follow-up to this recommendation. Nursing documented that the pressure sore continued to deteriorate, including exhibiting tunneling and copious drainage.	Y	Quality of care
76a	G	309	1	A physician's orders for one resident called for thickened liquids, and a speech therapist's notes confirmed the resident was on thickened liquids for maximum safety. The surveyor observed the medication nurse giving the resident unthickened apple juice. The resident started coughing and choking when given the liquid. The nurse raised the head of the resident's bed and started oxygen.	Y	Quality of care
76b	G	324	4	The nursing home failed to ensure that residents received adequate supervision to prevent accidents. One resident was observed with a bloody gauze above her left eye. Her record showed multiple falls and injuries, with ineffective intervention by the home's staff. Three residents—one had limited range of motion of her fingers and a diagnosis of manic depression, the second was observed to be confused and disoriented at times and had a history of numerous falls, and the third was blind—were smoking unsupervised outside the home.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
77	G	324	2	The nursing home failed to provide adequate supervision to prevent accidents for two residents, both sustained falls with resulting injuries, and one exited the home in his wheelchair. The resident was found overturned in his wheelchair in a nearby alley. This resident had left the nursing home twice 5 days earlier.	Y	Quality of care
78a	G	314	1	The nursing home failed to ensure residents with pressure sores received appropriate treatment and services to promote healing and prevent infection. One resident who developed two moderately severe pressure sores on the coccyx was not repositioned regularly and did not receive a therapeutic mattress to promote healing of the sore.	Y	Quality of care
78b	G	316	3	The nursing home failed to provide incontinence training to restore as much normal function as possible. For three residents, the home did not determine the cause of residents' incontinence or evaluate them for bladder retraining.	Y	Quality of care
79a	G	314	3	Three residents were found to have developed pressure sores, and all were having severe nutritional problems. The residents' problems were not addressed in the care plans, nor were the residents identified to be at risk for developing pressure sores in consideration of the changes in nutritional status.	Y	Quality of care
79b	G	325	4	The nursing home failed to ensure residents maintained acceptable parameters of nutritional status. Several residents experienced severe weight loss, but the home did not intervene with aggressive nutritional and other interventions to prevent further decline.	Y	Quality of care
80	H	325	3	The nursing home failed to weigh residents weekly as ordered, to accurately document nutritional intakes, to document that supplements or snacks were offered, and failed to provide diets as ordered. Further, the home failed to have a system in place to notify the dietitian of relevant changes in condition, including abnormal lab results, and failed to follow dietary recommendations or responded very late to them. As a result, three residents experienced significant weight loss in a 3-month period. In addition, one of these residents had an abnormally low test for blood protein levels and had developed pressure sores.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
81	I	314	2	The nursing home failed to prevent pressure sores from developing and to properly treat pressure areas for two of three sampled residents with pressure areas. For one resident, the home failed to carry out preventive measures in the plan of care, resulting in development of a moderately severe pressure sore. Despite this pressure sore, the surveyor observed on three occasions that the preventive measures in the plan of care were not carried out for this resident. In addition, the resident had another open area that was not documented in the chart on 7/6. However, on 7/9, there was documentation of this sore in the chart dated 7/4.	Y	Quality of care
82	G	157	1	The nursing home failed to notify the physician of a significant change in one resident's physical condition. The resident was noted to have reddened eyes with yellow drainage present. The physician was notified, and an antibiotic was ordered. One week later, documentation indicated eyes were still red with a large amount of pus. The resident's eyes were still draining 10 days after the antibiotic treatment was started, yet the physician was not notified.	Y	Resident rights
83	G	314	1	The nursing home failed to ensure that residents who entered the home without pressure sores did not develop any and residents with pressure sores received appropriate treatment and services to promote healing and prevent infection. One resident developed a severe pressure sore on his right ankle while in the home. His care plan called for a foam pad and sheepskin for pressure relief. In four observations during the survey, he did not have the sheepskin in place. In two of these observations, he did not have the foam in place, and his sore rested directly on the bed. Weekly reports showed the depth of the wound increased from .25 cm to .50 cm during the week of the survey.	Y	Quality of care
84a	G	309	1	The nursing home failed to provide appropriate care to a resident experiencing severe pain. The resident, as documented in the nurse's notes, was experiencing consistent severe right leg and hip pain. However, the home did not have the resident reevaluated for the pain for 8 days, causing unnecessary physical and mental distress. Several times the resident was found "screaming out in pain with positioning" and "unable to bear weight."	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
84b	G	317	2	The nursing home failed to identify existing reduction in range of motion in one resident or measure the range of motion in another resident to be able to evaluate whether range of motion had declined. One resident's left wrist was flexed at a 90-degree angle and dangled from a splint while the resident was in his wheelchair. The resident interacted with many staff and therapy personnel throughout all days of the survey; however, no one noted the improper positioning of the residents' left wrist and hand. Another resident was noted to have reduced range of motion of her extremities upon admission, and the resident was at high risk for decreased range of motion because of neurological deficits related to a severe head injury. No assessment, however, indicated which specific joints were affected, nor were any of the affected joints measured.	Y	Quality of care
85	G	242	1	The nursing home failed to give one resident the right to make decisions about a significant aspect of her life in the home. Fearful of falling out of bed, the resident requested side rails on both sides of her bed. Family members also requested side rails for her protection. Four days later, while attempting to get out of bed, the resident fell, suffering multiple fractures. Side rails had not been installed as requested.	Y	Quality of life
86a	G	224	1	The nursing home did not prevent the neglect of one resident, who was left unsupervised in the bathroom and fell, sustaining a broken shoulder. The home also failed to promptly obtain an X ray when signs of the injury appeared.	Y	Resident behavior and facility practices
86b	G	324	2	The nursing home did not provide adequate supervision to one resident to prevent accidents, as a result of which she fell in the bathroom, sustaining a broken shoulder. The home also failed to provide one resident with adequate supervision to prevent the resident from leaving the home while unsupervised. Several times, she was found on busy highways as much as 3 miles from the home. On several occasions, staff did not know resident was gone until informed by outside people, although resident had been documented as being in the home at 15-minute checks.	Y	Quality of care
86c	G	325	1	The nursing home failed to ensure that one resident maintained acceptable nutritional status. It failed to follow dietitian's recommendations and physician's orders regarding the resident's weight loss and pressure areas, resulting in continuous weight loss and pressure sores.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
87a	G	281	1	The nursing home failed to provide services that met professional standards of quality. One resident with metastatic bone cancer suffered "horrible or excruciating" pain on a daily basis. Staff did not perform adequate pain assessment or provide medication to control the pain.	Y	Resident assessment
87b	G	312	8	The nursing home failed to ensure residents received necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Surveyors cited multiple instances of poor hygiene, such as a resident with copious secretions from a tube in the trachea on a bib and running down the side of her neck, disheveled and dirty hair, and a strong smell of urine. Another resident identified as needing assistance for meals received assistance with only one bite of cereal and a sip of nutritional supplement before staff removed the rest of her uneaten meal.	Y	Quality of care
87c	G	314	2	The nursing home failed to ensure residents who entered the home without pressure sores did not develop any and residents with pressure sores received appropriate treatment and services to promote healing and prevent new sores. After readmission from repair of a hip fracture, one resident was assessed as being at high risk for skin breakdown. Within 5 months, she developed severe pressure sores on her coccyx and right heel. Another resident with a moderately severe to severe pressure sore on his sacrum was observed lying flat on his back for extended periods.	Y	Quality of care
87d	G	323	1	The nursing home failed to ensure the environment was as free of accident hazards as possible. One resident with Alzheimer's disease wandered almost constantly around the home. She had a history of falls, including one when she attempted to sit in a chair that rolled away under her because its wheels were left unlocked and another when she tripped over a piece of equipment left in the hall. Surveyors cited several other hazards, such as exposed medications, in the area of the wandering resident.	Y	Quality of care
87e	G	324	2	The nursing home failed to ensure residents received adequate supervision to prevent accidents. One resident with Alzheimer's disease and a history of wandering was found by police walking in circles in a nearby street. Another resident was observed unsupervised, wandering throughout the home in her wheelchair. Her record showed a history of falls and minor injuries.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
87f	G	333	1	The nursing home failed to ensure residents were free from significant medication errors. Staff failed to follow physician's orders for one diabetic resident. She became unresponsive and was transferred to the emergency room.	Y	Quality of care
87g	G	353	16	The nursing home failed to ensure sufficient staffing to meet residents' needs. Surveyors cited a number of examples of insufficient staffing. One resident did not receive pain medication as requested. The surveyor observed this resident calling out for pain medication, and observed that the resident's call bell was out of reach. The resident stated he had pain in his side and that he had asked several staff for pain medication, but no one had provided any. In addition, one resident with a moderately severe to severe pressure sore was not repositioned to relieve pressure on the sore, at least one resident did not receive walking therapy, call bells were not answered for 45 to 50 minutes, several residents exhibited poor hygiene, and wandering residents were not properly supervised.	Y	Quality of care
88a	G	224	1	The nursing home failed to implement written policies and procedures that prohibited mistreatment, neglect, and abuse of residents. Following an enema, one resident was left on a bedpan for 18 hours. The resident usually had results within 1 to 5 minutes and was to be assisted to the bathroom or placed on the bedpan and then cleansed after its use. Although the home had policies and procedures in place, staff failed to implement and follow these policies.	Y	Resident behavior and facility practices
88b	G	309	1	A resident who had been left on a bedpan for 18 hours following an enema treatment developed two pressure sores as a result of the incident. While the resident was at risk for pressure sores, they did not exist prior to the incident. The incident resulted in two moderately severe pressure sores and both continued to deteriorate over the next 6 weeks.	Y	Quality of care
88c	G	324	1	The nursing home failed to ensure residents received adequate supervision and assistive devices to prevent accidents. One resident was found repeatedly on the floor after falling and sustained a fracture of the pelvis during one fall. Occupational therapy recommended the use of a bed alarm when in bed at all times. There was no evidence that the recommendation had been acted upon for at least 5 days after readmission to the home following a hospitalization for the fractured pelvis.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
89a	K	157	1	A resident, who was not able to make any decisions, was admitted to the nursing home with multiple pressure sores. The sores continued to worsen to a severe stage with greenish black tissue and a foul odor. The nursing home did not inform the resident's legal guardian that the resident's condition was deteriorating. The resident was discharged to the hospital and subsequently died. The documentation does not indicate whether the resident's physician was notified so that appropriate interventions could have been taken.	N	Resident rights
89b	K	310	2	The nursing home failed to ensure that two residents were provided adaptive equipment and assistance to maintain function in eating, walking, and transferring. One resident with severe Parkensonian tremor was not provided with assistance in eating or assessed for assistive devices. As a result, the resident lost 9 pounds in 3 months. A second resident able to walk independently was not provided with rehabilitative services after a fall, and as a result lost the ability to walk independently.	Y	Quality of care
89c	K	312	3	The nursing home failed to ensure that three dependent residents received the assistance necessary and called for in their plans of care to maintain adequate nutritional status. Significant weight loss was documented for one resident.	Y	Quality of care
89d	K	314	5	The nursing home failed to ensure that three residents received adequate incontinence care and were repositioned every two hours to avoid development of pressure sores. Two of these residents developed pressure sores, and the third was at high risk of them. One resident with pressure sores did not receive a high-calorie, high-protein diet to promote healing as called for in the plan of care.	Y	Quality of care
89e	K	325	4	The nursing home failed to ensure that three residents received adequate nutrition by failing to assist them in eating, or by using poor feeding technique. All three residents had unplanned weight loss. For one resident on tube feeding, the home failed to order a nutritional assessment until after a 6-pound weight loss in 13 days. When the assessment documented that the resident was receiving less than one-half of his/her nutritional needs, the home failed to contact the physician on call for the resident's attending physician, who was on vacation.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
90	G	325	1	A resident lost 15 percent of body weight over a 6-month period, yet no attempts were made by staff to assist or encourage this dependent resident to eat during the mealtimes witnessed by the surveyor. The resident required total assistance to eat, yet one evening she was not seated with those requiring assistance to eat, and she ate nothing. The following morning, she received no assistance and ate none of her breakfast.	Y	Quality of care
91a	G	223	1	The nursing home failed to ensure one resident was free from abuse. A nursing home employee verbally abused an alert, oriented resident over a long period of time. The resident was frightened and apprehensive of this employee. The nursing home was aware of this problem but continued to permit the employee to enter the resident's room on a regular basis to care for the resident's totally dependent, noncommunicative roommate. After this survey, the employee was discharged. (Note: This complaint investigation occurred 6 months after the original incident.)	Y	Resident behavior and facility practices
91b	G	309	1	An alert, oriented resident was verbally abused by and forced to stand by a nursing home employee, causing the resident intense pain. Resident was upset and afraid of employee. (Note: employee involved was the same as in F223 citation—different resident.)	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
92	G	314	2	The nursing home failed to ensure that residents received necessary care and treatment to promote healing and prevent new sores from developing. A resident who had been declining in activities of daily living skills for more than a month developed a small open area. Prior to the development of this open area, there was no evidence of any assessment of this resident to identify her as potentially at risk for skin breakdown. The resident's care plan did not show interventions for pressure-relieving devices in bed as per the home's policy. Another resident was identified as having a moderately severe pressure sore on her hip. A surgical consultation prescribed a "flexicare bed if possible, otherwise an air mattress." The air mattress was not provided for seven days. The resident was using an "egg crate" mattress prior to the development of the pressure sore and up until the time the air mattress was received. There was no evidence the resident was reassessed for the appropriateness of the continued use of the egg crate mattress, nor was there evidence that any alternative interventions were planned for a pressure-relieving device until the prescribed air mattress was received from the supplier.	Y	Quality of care
93	G	314	1	The nursing home did not ensure that one resident received necessary treatment and services to prevent and heal pressure sores. This resident developed moderately severe pressure sores while in the home. Despite this, a surveyor observed on two consecutive days that the resident was not being turned in bed every 2 hours as required in the plan of care.	Y	Quality of care
94	G	314	1	The nursing home failed to properly assess and treat a resident's pressure sore. As a result, the resident's pressure sore increased in size. One resident was readmitted with diagnoses including dementia and a fractured right leg. On the day of readmission, a nurse's note stated that there was a "3.0 cm by 2.0 cm black area below the 5th toe." There was no evidence, however, that a physician was notified of the pressure sore and therefore no treatment was ordered; this was later confirmed by the physician. Further, staff did not institute any monitoring to evaluate the progress of the pressure sore. Several weeks later, the sore had grown and deteriorated to a severe stage.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
95	G	321	1	The nursing home failed to provide prompt dental care to a resident who refused to eat because of a poor dental condition, and inserted a nasogastric tube for feeding. Before this problem arose, the resident was documented as eating well and having a good appetite. The resident had to have a feeding tube inserted to obtain nutrition.	Y	Quality of care
96a	H	223	1	The nursing home failed to ensure residents were free from abuse. One resident required extensive assistance and experienced excruciating pain daily due to multiple conditions. She alleged that one evening when she asked a staff member to move her about 2 inches, he threw her over to the side rail, and when she made a fist, he left her uncovered.	Y	Resident behavior and facility practices
96b	H	224	1	The nursing home failed to implement written policies and procedures that prohibited abuse of residents. A resident said she informed the medication nurse of abuse. The record showed no evidence that the medication nurse had informed the director of nursing or nursing home administrator as required by the home's policies and procedures. Twenty-four hours after being informed of the abuse incident by the survey team, the home had not begun an investigation of the abuse or other procedures as required by its policy relating to abuse.	Y	Resident behavior and facility practices
96c	H	225	3	The nursing home failed to ensure that three allegations of abuse were investigated and reported to the appropriate authorities within 5 workdays after the incident, as required by HCFA. In one case, the home had not reported to authorities the alleged abuse of a resident by an employee until 7 days after the incident. Additionally, the employee continued to work at the home. In a second case, the home had not reported to authorities the alleged abuse of a resident who was hospitalized and diagnosed with a dislocated shoulder for more than 6 months after the incident. Furthermore, the home could not produce evidence that it had investigated this incident. In a third case of alleged resident-to-resident abuse, the home could not provide evidence that an investigation was conducted for almost 1 year after the incident.	Y	Resident behavior and facility practices

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
96d	H	279	2	The nursing home failed to develop comprehensive care plans for two residents. A resident received an abrasion on her leg while being put to bed. Although the wound deteriorated, the home did not develop a care plan to address the wound, and 2 months later, a physician determined that poor circulation to the leg might require surgery, including amputation. Another resident developed two moderately severe pressure sores within 12 days of admission. Despite a history of pressure sores and a diagnosis of poor circulation, the home did not develop a comprehensive care plan to prevent new pressure sores from developing.	Y	Resident assessment
96e	H	281	3	The nursing home failed to provide nursing services that meet professional standards of quality. Nursing staff failed to (1) identify signs and symptoms of infection for two residents (resulting in the amputation of a finger and possibly a leg), (2) initiate neurological assessment of a resident with a potential head injury, and (3) follow physician's orders for blood pressure monitoring for a resident who was potentially hemorrhaging.	Y	Resident assessment
96f	H	310	2	The nursing home failed to ensure that residents' abilities in activities of daily living did not diminish, unless this was unavoidable. Two residents went from being continent of bowel and bladder to incontinent within 3 months. Health records showed that neither received assessment or treatment to promote normal function.	Y	Quality of care
96g	H	314	2	The nursing home failed to ensure that residents who entered the home without pressure sores did not develop them and that residents with pressure sores received appropriate treatment and services to promote healing and prevent infection. A resident with a history of pressure sores (but none on admission) developed a moderately severe pressure sore on each heel within 12 days of admission. Within 19 days of a readmission 2 months later, the resident developed a moderately severe pressure sore on the coccyx. Another resident was admitted with a sore on her right heel, which healed. Staff failed to monitor the area as required by the home's policy, resulting in a moderately severe sore recurring in the same area.	Y	Quality of care
96h	H	329	1	The nursing home failed to ensure that residents' drug regimens were free from unnecessary drugs. Within a 3-month period, one resident developed severe side effects from a series of antipsychotic medications.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
96i	H	429	1	The nursing home failed to report the deterioration of a resident to the attending physician and the director of nursing. Also, the pharmacist consultant did not monitor and report the deterioration of a patient experiencing severe side effects from a drug, despite warnings in drug literature that certain medications should be discontinued if such side effects occurred. (Same case as F329.)	Y	Pharmacy services
96j	H	456	1	The nursing home failed to maintain all essential mechanical patient care equipment in a safe operating condition. One resident was struck in the chest by a malfunctioning piece of equipment used to transfer the resident from a wheelchair into bed, causing chest pain and requiring observation and an X ray. The equipment had malfunctioned earlier, and records showed that no repairs were done.	Y	Physical environment
97	G	225	2	The nursing home failed to report possible abuse or neglect to state officials and investigate possible neglect. One resident was found on the floor next to her bed with a superficial laceration to the upper lip and a nosebleed. The home's investigation found that (1) the family had reported a defective side rail, which had not been fixed, and (2) the resident was told she could only go to the bathroom once an hour; at the time of the accident she was attempting to go to the bathroom. Another resident fell out of a wheelchair and sustained a skin tear to the right forearm. The resident's plan of care called for a seat belt while in the wheelchair, but the nursing assistant could not find a soft belt restraint, so the resident was not wearing a belt. These instances of possible neglect and abuse were not reported to state officials as required.	Y	Resident behavior and facility practices
98a	H	157	2	The nursing home failed to notify the residents' physicians and/or family members in a timely manner of significant changes in medical condition. One resident exhibited changes in behavior, including slurred and garbled speech, a lack of verbalization, and a noninjury fall. When symptoms continued for 8 days, a physician was notified. The physician indicated a temporary reduction in blood supply to brain. The physician was not notified in a timely manner to initiate treatment. Another resident experienced repeated clogging of her feeding tube, which at one point staff were unable to unclog. The physician and family were not notified for 6 days. This resident also developed moderately severe pressure sores on two toes, but 18 days later there was still no evidence the physician and family had been notified.	Y	Resident rights

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
98b	H	223	1	A nurse's aide verbally abused one resident. The resident reported the incident to a nurse, who failed to report the allegation to the administrator. No investigation was done. Records showed that 2 months earlier the nurse's aide was counseled for using abusive language in the presence of residents and family members.	Y	Resident behavior and facility practices
98c	H	314	1	The nursing home failed to ensure that one resident without pressure sores did not develop sores, and when sores did develop, failed to ensure that the resident received treatment and services to promote healing. A resident developed multiple, moderately severe pressure sores on her buttock and coccyx over a 3-month period. The resident's plan of care did not address the turning assistance or frequency needed to provide pressure relief.	Y	Quality of care
98d	H	330	1	The nursing home failed to ensure that residents were free from unneeded antipsychotic drugs. Soon after admission, a 96-year-old resident with Alzheimer's disease became agitated, periodically resisted care, and sometimes threatened other residents. The resident was then given Haldol twice daily. He became lethargic and unresponsive as a result of the Haldol. The home did not attempt other interventions before using Haldol.	Y	Quality of care
99a	G	157	1	The nursing home first documented that a resident had open blisters on his thigh 1 day before a surveyor noticed the blisters. The surveyor determined that the nursing home's staff had not notified the physician or the resident's family of the blisters and asked the home's staff to contact them. The documentation does not note the extent and severity of the blisters. Therefore, it is not evident that a 1-day delay was unacceptable.	N	Resident rights
99b	G	314	3	The nursing home failed to provide regular repositioning and other care needed by three residents at high risk for skin breakdown. Two of the three developed pressure sores.	Y	Quality of care
100a	G	314	1	The nursing home failed to ensure that residents with pressure sores received appropriate treatment and to provide services to promote healing and prevent new sores from developing. One resident was admitted with a moderately severe pressure sore on the coccyx. Within 2 weeks, the resident had developed three new pressure sores and the moderately severe sore had progressed to a severe stage. Recommendation by the dietitian to increase the resident's protein intake to promote healing was not implemented for over 2 months.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
100b	G	318	1	The nursing home failed to ensure that a resident with a limited range of motion received appropriate treatment and services to prevent a further decrease in range of motion. One resident was admitted with a reduction in range of motion to both hands and one arm. Surveyors observed that the resident's range of motion in both the arm and the legs had decreased since admittance.	Y	Quality of care
101a	G	314	3	Based on review of 3 of 28 clinical records, staff interviews, and observation, the surveyor documented that the home failed to identify new pressure sores in a timely manner and failed to implement preventive measures for existing pressure sores. In one case, nursing documentation noted that the resident had developed a pressure sore on the left posterior thigh that was not found until it had deteriorated to a severe stage.	Y	Quality of care
101b	G	317	1	A resident was documented as having freely mobile upper and lower extremities before experiencing a decline in the mobility of the lower extremities. A physical therapy evaluation recommended that a knee separator be worn between the knees at all times and that the resident be provided range-of-motion therapy, with repositioning, prior to the application of the knee separator. Within a month and a half, another physical therapy screening was performed because of a decreased range of motion in the resident's upper extremities, which revealed upper extremity range-of-motion deficiencies that could be improved with repetitive exercises. Recommendations were to refer the resident to the restorative nursing program for upper extremity range of motion and that passive range-of-motion exercises be done during every nursing shift. Documentation was lacking to support that any range-of-motion exercise was provided to this resident. On three separate occasions, with the resident in different positions, the surveyor found the knee separator not in use. A review of the resident's care plan showed that prevention of the reduction in range of motion was not addressed.	Y	Quality of care
101c	G	324	4	Based on 4 of 28 clinical records reviewed and observations, the nursing home failed to provide adequate supervision and/or preventive measures for residents at high risk for falls. In one case, a resident was found on the floor on 11 occasions over a 4-month period, having experienced unwitnessed falls while walking. Another resident experienced 16 falls over a 9-month period; 13 were unwitnessed and 2 resulted in fractures.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
102a	K	276	3	The nursing home failed to reassess in a timely manner three residents for risk of falls and one of the three for nutritional needs, and failed to develop interventions to deal with the three residents' changing needs. All three residents had repeated falls with injuries, and one of the three also experienced significant weight loss over a 3-month period; no reassessment or intervention was performed to deal with these problems.	Y	Resident assessment
102b	K	310	3	The nursing home failed to ensure that three residents' ability to walk did not decline unless the residents' clinical conditions made this unavoidable. Although all three residents had goals for daily walking with assistance in their plans of care, none were being walked. Two of these residents had experienced declines in their ability to walk.	Y	Quality of care
102c	K	318	5	The nursing home failed to provide appropriate range-of-motion treatment and services to five residents, as called for by physicians' orders and/or plans of care. Two of these residents experienced documented declines in their functional range of motion.	Y	Quality of care
102d	K	324	2	The nursing home failed to provide adequate supervision for two residents to prevent falls. One resident fell five times in 2 months, sustaining several injuries, including fractures to the wrist. The other fell 13 times over a 7-month period, sustaining several injuries, one of which required hospitalization.	Y	Quality of care
103	G	309	1	The nursing home failed to obtain prompt treatment for a resident following a fall that resulted in an injury. The resident was not treated and was in pain for 21 hours because the home failed to obtain prompt treatment for a fractured hip.	Y	Quality of care
104	G	324	1	The nursing home failed to ensure the health and safety of a resident by not providing adequate supervision. A clinical record review revealed that a resident fell down an open stairwell and sustained injuries that required emergency transport to the hospital.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
105a	G	314	4	The nursing home failed to ensure that residents with pressure sores received appropriate treatment and to provide services to promote healing and prevent new sores from developing. One resident was discovered with a severe pressure sore on her left heel—indicating that skin areas were not being checked regularly and that services were not provided to prevent this area from breaking down. Another resident was found with a moderately severe pressure sore on his coccyx—the sore had been misidentified as an abrasion and was not properly treated. Two other residents did not receive proper care to promote healing of their pressure sores.	Y	Quality of care
105b	G	324	1	The nursing home failed to ensure that residents received adequate supervision and assistive devices to prevent accidents. One resident was observed straddled across his bed with his legs across the arms of his wheelchair. He had hit his head on the side rail and was calling for help. Staff were noted walking by his room without coming to his aid until the presence of the surveyors was noted. Despite the resident's history of falls and injuries, the home did not assess or evaluate the circumstances of his falls or take preventive measures.	Y	Quality of care
105c	G	325	2	The nursing home failed to ensure that residents maintained acceptable parameters of nutritional status, such as body weight. One resident lost 16 percent of her body weight in less than 3 months (considered a severe loss), particularly significant because the resident also had a newly discovered severe pressure sore. Another morbidly obese resident was admitted to recover from knee surgery. Although the resident needed guidance in nutrition, she was never referred to or seen by a dietitian during her 25-day stay.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
106a	G	314	1	The nursing home failed to ensure that residents with pressure sores received appropriate treatment and services to promote healing. A resident's initial assessment indicated that the resident was dependent on staff for all care needs. A pressure area on the buttock was present on admission. A month later, nursing documentation noted that the resident had an "open area" on the left buttock. A pressure sore risk assessment had not been done at that time. Observation 2 months after admission revealed that the resident had two moderately severe pressure sores on the left buttock. The nurse, who was present during the observation, stated that she was unaware of the existence of the resident's pressure sores. An interview with the director of nursing noted that the licensed staff had not notified the physician or provided treatment for the resident's pressure sore.	Y	Quality of care
106b	G	324	2	The nursing home failed to provide supervision, assistive devices, or other interventions for residents who had experienced frequent falls. Based on medical records review and staff interviews, the home did not provide adequate care for two residents. This resulted in multiple skin tears and bruises for one resident and a fall resulting in a fractured left clavicle for another resident.	Y	Quality of care
107	G	319	1	The nursing home did not comply with physician's orders for a psychiatric evaluation for a male resident despite at least six sexual incidents over a 6-month period. At least two female residents were unwillingly exposed to the genitalia of this resident.	Y	Quality of care
108a	K	314	3	The nursing home failed to provide three residents with necessary services and devices to prevent and heal pressure sores. All three residents developed severe pressure sores, yet the home did not provide any pressure-relieving devices to promote healing of the sores. One resident's sore was so deep that bone was exposed.	Y	Quality of care
108b	K	319	1	The nursing home failed to ensure that a resident displaying aggressive behavior toward other residents received appropriate services and treatment to prevent this aggression. This resident struck seven other residents. The home failed to develop effective behavioral interventions to deal with this resident's aggressiveness.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
109	G	325	2	The nursing home failed to ensure that two residents with diagnosed protein energy malnutrition received appropriate nutrition as recommended by a registered dietitian. Nursing staff were unaware of these recommendations. A doctor's order was required for one resident's diet to be changed because the resident had a feeding tube inserted into the stomach. The dietitian reported that the resident was not receiving the amount of protein that she required and recommended that the nursing home staff notify the physician. This was not done.	Y	Quality of care
110a	G	221	6	The nursing home failed to ensure that six residents were free from unnecessary use of restraints. One resident had falls from the bed when side rails were used and sustained bruises. After these incidents, the home did not address the risk of raised side rails and attempt to use other measures for this resident. The resident again fell from the bed (and sustained a hip fracture) when side rails were elevated.	Y	Resident behavior and facility practices
110b	G	318	2	The nursing home failed to ensure that residents with a limited range of motion received appropriate treatment and services to increase their range of motion and/or prevent further decline. Clinical records indicated that one resident had limited range of motion of her right elbow and wrist. Interventions listed in the current plan of care included using hand and elbow splints according to schedule and passive range-of-motion exercises seven times a week to prevent further decline. The resident was observed without the splinting device in place per the plan of care. The resident had experienced further decline in range of motion during a 6-month period the previous year. Another resident's physical therapy screening noted that the resident required a splint to support her right ankle while walking. The physician's order and resident's care plan indicated that the splint was to be worn when out of bed. Observations on two separate days noted that the resident did not have a splint on when out of bed. The nurse was unaware that the splint was missing until the surveyor informed her. The splint could not be located in the resident's room and was replaced by the physical therapy department.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
110c	G	324	3	The nursing home failed to provide adequate supervision and assistive devices to prevent accidents. A resident had a history of falling while on her way to the bathroom, and the home's planned preventive interventions included encouraging the resident to use the call bell for assistance. The resident was observed seated in her room unattended with the call bell out of reach. In addition, the resident received a psychoactive medication. The resident fell, but there was no assessment in the medical record of whether the resident's psychoactive medication contributed to the fall. During a separate incident, the resident fell, receiving a laceration to the forehead that required sutures. Another resident, who had a history of falling from bed, had an intervention that a low bed be used when available. This was also included in the plan of care. There was no documentation to support follow-through with this recommendation. The resident had four additional falls from bed during a 2-1/2-month period. It was not until after the 2-1/2-month period that the lack of a low bed was addressed, and the resident's mattress was placed on the floor at that time. A third resident, who had a history of falls while going to and from the bathroom, had a care plan directing that staff were to provide assistance to the resident while transferring and walking. The resident was observed on 2 separate days walking from the bathroom without assistance or supervision. Additionally, four residents interviewed during the survey complained of staff leaving them in the bathroom and not returning promptly (up to 20 minutes). Observations of the noon meal in the main dining room noted that 26 residents were eating lunch with no nursing staff supervision for 10 minutes. One of these residents was receiving continuous oxygen.	Y	Quality of care

(continued)

Survey number[a]	Most severe rating	F-tag	No. of residents affected	Deficiency abstract	Was documented harm done?	Category
110d	G	329	1	A nursing home had no documentation to justify the use of a long-acting psychoactive drug for a resident's anxiety without attempting to use a short-acting drug first. Also, the home gave the resident a sleep-inducing drug for 3 months, although the home did not address possible causes of sleeplessness. The resident had two falls, one resulting in a laceration requiring sutures, and the medication regimen was not evaluated for possible causal contribution.	Y	Quality of care

[a]Some homes had multiple G-level deficiencies. These are reflected by the letters following the survey number.

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