The following deficiencies relate to the annual recertification revisit (including deficiencies related to facility-reported incidents #12268-I, #12569-I, #12876-I, #13282-I, #13319-I investigated during the annual survey) as well as deficiencies related to facility-reported incidents #14400-I and #14402-I. Incidents #14482-I and #14351-I were also investigated with no identified concerns. See Code of Federal Regulations (42 CFR), Part 483-Subpart B-C.

Plan of Correction Date

483.20(k)(3)(i) COMPREHENSIVE CARE PLANS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and staff interviews, the facility failed to administer medications as ordered by the physician for one of thirteen reviewed residents (Resident #10) and failed to obtain a physician-ordered stool sample in a timely fashion for one resident (Resident #13). The facility reported a census of 176 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment tool with a reference date of 10/3/07, Resident #10 had short term memory problem and some difficulty with decision-making in new situations. The MDS also indicated the resident required extensive assistance of staff for bed mobility and dressing, and as total dependent on

This is my credible allegation of compliance to F281. This allegation does not constitute guilt but that the facility is in compliance with F281.

Residents #10 & #13 are receiving medications, treatments, and labs per doctor orders.

All residents are receiving medications, treatments, and labs per doctor orders.

The facility continues to monitor orders from physicians to ensure that all orders are received, noted and carried out per the physicians’ recommendations. MAR’S, TAR’S and lab requests are updated to ensure all residents receive cares per doctor orders.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
Continued From page 1

staff for transfers, toileting, and personal hygiene. The MDS indicated the resident had pain daily, that, at times, was excruciating. The MDS reflected the resident had diagnoses including diabetes mellitus, hypertension, peripheral vascular disease, and fracture of lower leg.

Review of the resident's care plan dated 10/16/07 directed staff to administer medications per physician's orders.

Review of a physician's order dated 10/5/07 directed staff to administer Tylenol 500 milligram(mg) tabs, two tabs every 6 hours and to discontinue the Lortab (pain medication) the resident had been receiving on a scheduled basis.

Review of the resident's medication administration record summary (MARS) revealed that facility staff did not administer Tylenol as ordered on 11/5/07. Review of the resident's record history details revealed the Tylenol had not been given as ordered on 11/5/07 at 6:00 p.m. due to unavailability of the medication.

Review of the MARS revealed on 11/7/07, Tylenol was given as ordered at 12:00 a.m. and 6:00 a.m., however, review of the administration details revealed the 12:00 a.m. and 6:00 a.m. doses were not administered because the medication was not available.

Review of the medication cart on 11/7/07 at 10:00 a.m. with Staff A revealed no Tylenol in the resident's medication drawer. Staff A stated she was not aware Tylenol had been ordered for the resident. Staff A also indicated the facility had received its weekly medication refills from the

The nursing department will continue to monitor all orders to ensure they are carried out per doctor requests. If problems are noted they will be corrected at that time to ensure all residents receive everything the doctors ordered.
Continued From page 2

pharmacy the previous night, and perhaps, because it was a new order, the pharmacy missed it. Staff A indicated she didn’t know if the pharmacy had been notified of the change in the resident’s medication regime.

An interview with Staff O on 11/8/07 at 8:30 a.m. revealed that the facility’s emergency medical kits contained Tylenol, making it available at all times.

2. The hospital discharge summary dated 9/14/07 for Resident #13 indicated the resident had diagnoses of Clostridium difficile (C-Diff) colitis (bowel infection) currently being treated with the medication, Flagyl.

Record review revealed a physician's order dated 10/14/07 which directed staff to collect a stool sample to be sent to the laboratory to check for the presence of C-diff. A laboratory report dated 10/15/07 tested positive for C-diff. The physician subsequently ordered the resident to receive Flagyl 500 mg, three times a day for 14 days. A facsimile (fax) communication from the facility to the physician on 11/3/07 reported the resident had completed the antibiotic and questioned whether the physician wanted another stool specimen test for C-difficile. The physician returned the fax with an order to collect a repeat stool specimen to be tested for C-diff.

Record review indicated the resident had bowel movements every day from 11/3-11/7/07. However, there was no evidence the facility obtained a stool specimen. The Nurse’s Notes dated 11/7/07 at 2330 (11:30 p.m.) revealed the resident reported having four loose stools at 8:00 p.m. and that the resident’s son, who was at the
**HERITAGE NURSING & REHAB CENTE**

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<tr>
<th>ID</th>
<th>PREFIX</th>
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<td>(F 281)</td>
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<tr>
<td>(F 281)</td>
<td>This is my credible allegation of compliance to F309. This allegation does not constitute guilt but that the facility is in compliance with F309.</td>
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Residents #5 and #12 whom were Hospice residents are no longer at the facility.

All Hospice residents, NF residents, and SNF residents are assessed for changes in conditions. If changes in condition are noted, doctors and families are notified to ensure proper care is delivered so that the residents may continue to function at the highest practicable level. Plans of care will be adjusted so staff can deliver the proper care to all residents.

The nursing department and center disciplinary team will continue to assess all residents for changes in conditions and adjust plans of care as needed to ensure all residents continue to function at their highest practicable level.

---

1. Review of admission information revealed the facility admitted Resident #5 on 2/24/2000. A physician's note dated 8/24/07 indicated the resident had diagnoses that included failure to thrive and dehydration. Record review revealed the facility transferred the resident to the hospital on 10/28/07 for evaluation and treatment of pain. The hospital report dated 10/29/07 reported imaging studies revealed evidence of medial migration of the resident's femoral head (of hip) with a nondisplaced left inferior pubic ramus.
Continued From page 5

computerized response at 5:20 a.m. indicating the medication had been effective.

Record review revealed Nurses' Notes dated 11/3/07 at 0415(4:15 a.m.) documented the resident as in no pain at that time. The note indicated the facility staff had replaced the resident's Foley catheter. Staff H documented that on 11/5/07 at 0900(9:00 a.m. the resident had audible congestion and had suctioned thick yellow mucous from the resident's oral cavity. The notes further stated the resident would need further suctioning and that she had notified Hospice and family about the resident's condition. A facsimile communication from the facility to the physician dated 11/5/07 at 9:00 a.m. reported the resident being very congested with audible wheezing, with the presence of thick yellow mucous with suctioning. The Nurse's Notes reported the resident expired at 1022(10:22 a.m.) on 11/5/07.

An interview on 11/5/07 at 3:10 p.m. with Staff H, a charge nurse who worked the day shift (6:00 a.m. to 2:30 p.m.) on 11/5/07, revealed she had worked at the facility for about two weeks. She indicated she had been on days off from Wednesday, 10/31/07 until the morning of 11/5/07. Staff H stated she had noted a big change in the resident's condition upon her return to work. This staff stated the night nurse, Staff I, had reported to her during the change of shift that morning that Staff H may need to suction Resident #5. Staff H reported Staff I assisted her with finding the suction equipment before leaving the facility.

Review of the Nurses' Notes for the night shift of 11/4/07 to 11/5/07 revealed no documentation of the resident being in any respiratory distress.
Continued From page 6
Review of the 24 hour Nursing Report for that shift also contained no documentation of the resident being in respiratory distress.

An interview with Staff I took place on 11/5/07 at 4:20 p.m. This staff verified working the 10:00 p.m. to 6:00 a.m. shift on 11/4/07 to 11/5/07. This staff reported giving Resident #6 pain medication during the night because the resident was crying. Staff I reported before she/he left the facility the morning of 11/5/07, the resident had started to sound "gurgly" and had reported this to the oncoming nurse. When asked if this staff had conducted an assessment of the resident, this staff replied by stating she/he heard the resident gurgling. This staff reported she had tried to suction the resident but confirmed she/he did not assess the resident's vital signs or check for lung sounds, but had told the oncoming nurse the resident was gurgling. This staff, when questioned, confirmed the need to assess the vital signs for a resident who received hospice services when the resident exhibited a change in condition. When asked how this staff knew the resident needed a pain medication during the night shift, this staff replied by saying the resident had been moaning, and when asked, affirmed to being in pain. However, review of the resident record revealed Staff I had not documented any pain assessments for the night of 11/4-11/5/07.

2. The MDS assessment with an assessment reference date of 10/22/07 indicated Resident #12 had diagnoses including diabetes mellitus, arteriosclerotic heart disease, hypertension, Alzheimer's disease, Parkinson's disease, depression, asthma, emphysema, and anemia. The assessment coded the resident as having problems with short and long-term memory and
Continued From page 7

as moderately impaired cognitive skills for daily decision-making. The assessment reflected the resident did not ambulate (walk) and required extensive staff assist with transfers, dressing, personal hygiene.

The physician's note dated 10/12/07 documented the resident having advanced Parkinson's disease with hypertension, and cracking of the resident's lungs upon examination. The physician documented he/she planned to discuss the possibility of hospice care for the resident with his/her family.

A Social Service progress note dated 10/25/07 noted the resident's cognitive status had declined to the degree he/she could no longer answer questions. The note reflected the resident had recently begun receiving hospice services.

Documentation in the Nurses' Notes dated 10/28/07 at 8:00 p.m. reported the resident refused all medications and had not consumed any fluids/food. The documentation contained no further entries regarding the resident's condition by the facility nursing staff until 10/31/07 at which time staff noted the resident had refused medications. On this date, staff received an order from the physician to discontinue administration of all oral medications except Roxinal for pain. The next (and last notation in the record as of 11/5/07 at 5 p.m.) entry dated 11/2/07 at 1:40 p.m., staff recorded the resident as resting in bed. Staff noted the resident had taken Roxinal at 8:00 a.m. and again at 12:00 p.m.

Observation of the resident on Monday 11/5/07 at 12:00 p.m. revealed him/her lying in bed on his/her left side in a semi-fowlers position with...
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<th>(F 309)</th>
<th>Continued From page 8</th>
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<td>eyes closed. The surveyor noted the resident's color as pale, and breathing as shallow. An observation on 11/5/07 at 3:37 p.m. revealed the resident in the same position as of 12 noon, and upon questioning, Staff G, a corporate nurse, stated she thought the resident had experienced a health decline. An interview with Staff U, a certified nurse's aide, at 4:00 p.m. on 11/5/07, revealed the resident had not been out of bed all weekend. Facility staff assisted the resident with a position change after speaking with the surveyor. Record review of the Hospice Nursing Assessment dated 11/2/07 revealed documentation that the nurse assessed the resident's lung sounds as diminished, and that the resident presented with shallow breathing and an occasional, congested cough. The hospice nurse noted on 11/2/07 that she had made that visit because the resident had had a congested cough the previous day. According to hospice documentation, the resident had coarse lung sounds with gurgling and shallow-to-normal respirations when assessed on 11/5/07 at 10 a.m. to 11:45 a.m. The assessment noted the resident had a discolored left heel and was on bedrest. This hospice staff nurse documented calling the physician for an order for a cough medication and also noted having left a phone message for the resident's power of attorney for health care. Although the hospice nurse had identified a change in the resident's condition on 11/2/07, facility staff failed to document any assessments/interventions for the following 3 days. The record indicated the resident expired on 11/7/07 at 2:25 a.m.</td>
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### HERITAGE NURSING & REHAB CENTRE

**Street Address, City, State, Zip Code:**
200 Clive Drive SW
CEDAR RAPIDS, IA 52404

#### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID Tag</th>
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<tr>
<td>{F 309}</td>
<td>Continued From page 9 An interview with Staff P, Assistant Director of Nursing, on 11/6/07 at 4:00 p.m. revealed that facility staff was expected to assess and provide interventions for all residents, including those receiving hospice services, as needed, and to keep the physicians and families informed. 483.25(a)(3) Activities of Daily Living A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and observations, the facility failed to provide thorough incontinence care for one of 6 reviewed residents (Resident #7) who needed staff assistance with personal hygiene. The sample consisted of 13 residents and the facility reported its census as 176 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment with a reference date of 10/22/07 identified Resident #7 with diagnoses including diabetes mellitus, edema, and delusions. The MDS revealed the resident experienced short and long-term memory problems and severely impaired decision-making capabilities. The MDS further indicated the resident required assist of staff for bed mobility, transfers, ambulation, dressing, toileting, and personal hygiene. The assessment reflected the resident as incontinent of bladder and on a scheduled toileting program.</td>
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<tr>
<td>{F 312}</td>
<td>483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and observations, the facility failed to provide thorough incontinence care for one of 6 reviewed residents (Resident #7) who needed staff assistance with personal hygiene. The sample consisted of 13 residents and the facility reported its census as 176 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment with a reference date of 10/22/07 identified Resident #7 with diagnoses including diabetes mellitus, edema, and delusions. The MDS revealed the resident experienced short and long-term memory problems and severely impaired decision-making capabilities. The MDS further indicated the resident required assist of staff for bed mobility, transfers, ambulation, dressing, toileting, and personal hygiene. The assessment reflected the resident as incontinent of bladder and on a scheduled toileting program. This is my credible allegation of compliance. This allegation does not constitute guilt but that the facility is in compliance with F312. Resident #7 is receiving proper incontinence care. All residents that require incontinence care are receiving proper services to meet their needs. Direct care staff have been re-educated on proper incontinence care. Direct care staff will continue to be audited for proper incontinence care techniques to ensure all residents receive the services to best meet their needs. The facility’s nursing department will continue to monitor staff to ensure all staff are providing proper incontinence care.</td>
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The resident's care plan dated 10/19/05 identified the resident as requiring extensive to total staff assistance with toileting, and directed staff to assist the resident with perineal cares routinely and after incontinent episodes as needed, and to apply pads/brief to the resident when he/she was up, out of bed.

Observation on 11/6/07 at 8:29 a.m. revealed Staff Y assisting Resident #7 to the bathroom in the shower room with the use of a gait belt and wheeled walker. Staff Y left the resident standing unassisted to close the shower room door. Staff Y then proceeded to the sink, laid a dry towel on the side of the sink (sink had not washed prior to this) and placed two washclothes inside the sink basin. Staff Y wet the washcloths, applied periwash to them, and then laid them onto the dry towel. Staff Y did all this while the resident stood unattended behind Staff Y. Staff Y then removed the brief from the resident which was saturated with urine, placed it into a bag, and assisted the resident to sit on the toilet. Staff Y then assisted the resident to stand, and using a prepared washcloth, cleansed the front area of the resident's perineum wiping back to front, twice, without changing the washcloth areas between wipes. Staff Y did not wash the resident's lower abdominal area or the inner thigh areas. Staff Y then proceeded to cleanse the resident's rectal periare; she/he wiped from back to front a couple of time using the same cloth area. Staff Y did not wash the resident's outer buttocks.

The facility's Incontinence Care/Peri Care policy dated March 2007 included the following purpose: To keep skin clean, dry, free of irritation and odor. The policy directed staff to cleanse all soiled.
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<th>COMPLETION DATE</th>
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<tr>
<td>(F 312)</td>
<td>Continued From page 11 areas from front to back using a clean area of cloth/ wipe, especially between skin folds. Staff Y failed to cleanse the resident's abdominal folds, inner thighs, leg folds, and buttock areas. Staff Y failed to use a clean area of cloth when wiping resident during incontinence care.</td>
<td>(F 312)</td>
<td>This is my credible allegation of compliance to F314. This allegation does not constitute guilt but that the facility is in compliance with F314.</td>
<td>12/10/07</td>
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<td>(F 314)</td>
<td>483.25(c) PRESSURE SORES SS=G Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</td>
<td>(F 314)</td>
<td>Resident #4's pressure ulcer is healed. All residents are assessed to see if they are at risk for skin breakdown. If they are deemed to be at risk proper interventions are put into place to decrease the risk for skin breakdown. If a resident does develop some sort of skin breakdown, doctor and family are notified and appropriate treatment orders are obtained. The resident's plan of care is updated to ensure proper services are provided.</td>
<td>12/10/07</td>
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This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to provide treatment and services to promote healing of an open pressure area for one of four residents reviewed who had pressure sores (Resident #4). The facility identified eight residents with pressure sores and a census of 176 residents.

Findings include:

1. The most recent MDS (minimum data set) assessment with an assessment reference date of 8/29/07 identified Resident #4 with diagnoses that included hypothyroidism, atherosclerotic heart disease, congestive heart failure, hypertension, and dementia. This assessment coded the resident as having short and long-term memory.
Continued From page 12

problems and moderately impaired decision making capabilities. Section B-5 of the assessment coded the resident as being easily distracted, having episodes of disorganized speech, periods of restlessness, and varying mental functioning over the course of a day. Section G noted the resident as non-ambulatory and requiring total assistance of two staff for transfers. Section M indicated the resident with a history of resolved skin ulcers.

The RAP (resident assessment protocol) dated 8/29/07 that addressed the resident's risk of pressure ulcers development noted that although the resident's skin was currently intact, the resident had experienced ulcerated areas to bilateral buttocks that had both resolved in June. Review of the Braden Scale (for predicting pressure sore risk) assessment dated 9/11/07 revealed the resident scored 13 which indicated him/her at a moderate risk for pressure sore development.

Review of the Nurses' Notes dated 10/23/07 contained a note indicating the facility had notified the physician concerning an open area on the resident's coccyx. The note indicated the physician had ordered application of EPC (extra protection cream) to the resident's coccyx three times a day until healed. Record review revealed a facsimile communication dated 10/23/07 from the facility to the physician, informing the physician that due to computer problems, facility staff had applied the cream only one time a day for the past 3 days, but would they be doing the treatment three times a day as ordered.

Review of the resident's care plan dated 9/12/07 identified the resident as at risk for impaired skin

{F 314} The facility's interdisciplinary team will continue to monitor all residents for changes in condition.
continued from page 13

integrity and that they had noted a Stage II open area to the resident's coccyx on 10/23/07.

Interventions listed included provide treatment as ordered, avoid pressure to the area, and limit the resident's time up in the the wheel chair.

Review of the resident's weekly skin assessments beginning 10/23/07 reflected the open area to the resident's coccyx as a Stage II and measuring 0.4 cm. in length, 0.6 cm. in width and 0.1 cm. in depth. The 10/31/07 assessment recorded the measurement of the area as a Stage II that measured 0.5 cm. in length, 0.7 cm. in width and 0.1 cm. in depth. This assessment indicated the resident as being compliant with a turning schedule.

Observation on 11/7/07 at 8:00 a.m., 9:00 a.m. and 10:20 a.m. revealed the resident seated in a wheelchair in the dining room. At 10:30 a.m., Staff L and Staff C removed the resident from the dining room and wheeled the resident to his/her room for cares. The staff utilized a hoyer lift to assist the resident to bed. Staff K cleansing the resident's buttocks and perineal area and measured the open area prior to applying the cream. The area measured 1.0 cm. in length and 0.8 cm. in width with a 0.1 cm. depth. which indicated the area had increased in size from the last assessment. Upon questioning, staff reported assisting the resident out of bed at approximately 7:00 a.m. and that they had not assisted the resident with a change of position since that time for a total of approximately 3 1/2 hours.

Review of the resident's November 2007 computerized treatment record revealed staff had not applied the treatment as ordered on 11/6/07
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<td>{F 314}</td>
<td>Continued From page 14 at 10:30 p.m. On 11/07/07, Staff O ran a computer generated report for the missed treatment. The note stated: &quot;11/7/07 4:19 a.m. EPC to coccyx area scheduled for 11/6/07 at 10:30 p.m. was not administered&quot;. The note did not indicate why staff failed to provide the treatment as ordered. Review of the record revealed no documentation that staff had notified the resident's physician that the size of the pressure area had increased after conducting the 10/31/07 assessment. Record review also revealed staff had not performed the treatment as ordered several times, and observation revealed the facility failed to reposition the resident at least every two hours. The assessment performed on 11/7/07 indicated the area had increased in size from the 10/31/07 assessment.</td>
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<td>{F 314}</td>
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<tr>
<td>{F 315}</td>
<td>483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and observations, the facility failed to provide appropriate catheter care for 1 of 13 residents reviewed (Resident #10). The facility identified a</td>
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<td>{F 315}</td>
<td>This is my credible allegation of compliance to F315. This allegation does not constitute guilt but that the facility is in compliance with F315. Resident #10 continues to receive proper cares to her catheter. All residents with catheter continue to receive proper care to their catheters. Direct care staff has been in-serviced on proper catheter care.</td>
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Continued From page 15 census of 176 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment tool with a reference date of 10/3/07, Resident #10 had short-term memory problems, and had some difficulty daily decision making. The MDS indicated the resident required extensive assistance of staff for bed mobility and dressing, and was totally dependent on staff for transfers, toileting, and personal hygiene. The MDS indicated the resident had diagnoses including diabetes mellitus, hypertension, peripheral vascular disease, and fracture of lower leg. The MDS indicated the resident as usually continent of bowel and had an indwelling urinary catheter.

The resident's care plan dated 10/16/07 directed staff to provide catheter cares routinely and as needed, and to monitor the resident for signs and symptoms of urinary tract infections and report these to the physician.

Observation on 11/7/07 at 2:00 p.m. revealed Staff C and Staff AA providing cares for Resident #10. Staff C used an alcohol swab to cleanse the catheter tubing distal to the insertion site using downward twisting motions to the insertion site which Staff C wiped with a circular motion using the same alcohol pad. Staff C then cleansed the resident's abdominal folds and folds on the resident's legs, wiping towards the catheter instead of away from it. Staff C then proceeded to empty the catheter's drainage bag. Staff C cleansed the distal tip of the catheter with a alcohol pad, placed the alcohol pad on the wrapper that was lying on the paper tower placed
### Task:

**Heritage Nursing & Rehab Centre**

- **Provider Number:** 165310
- **Address:** 200 Clive Drive SW, Cedar Rapids, IA 52404

#### Summary Statement of Deficiencies

**ID Prefix Tag:** (F 315)

**Correction Date:** 11/08/2007

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Continued From page 16

- **On the floor:** Staff C emptied the urine into a graduate and using the same alcohol pad used to cleanse the distal tip of the catheter, wiped the spigot with it, and closed the port.

An interview with Staff J on 11/8/07 at 8:00 a.m. revealed the facility planned to inservice staff on catheter care that included not using alcohol swabs to cleanse any part of the tubing except the port.

2. **The current physician orders for Resident #6 included the order for a foley catheter #18 with a 30 c.c. (cubic centimeter): bulb.**

Observation of cares on 11/5/07 at 2:00 p.m. revealed Staff C and Staff M transfer the resident from the wheelchair to the bed using a howey lift. Observation noted a leg strap, which secured the catheter tubing to the resident's leg, soiled with what appeared to be urine. Staff C removed the leg strap. Observation revealed food debris on the resident's abdominal area. During cares, Staff C wiped the resident's abdomen in a downward motion toward the resident's catheter. Staff C and Staff M turned the resident to the side revealing a cloth pad under the resident soiled with a large amount of what appeared to be urine and feces. Staff G, a corporate nurse, reported the resident had a history of bladder spasms. Staff cleansed the resident's buttocks but did not cleanse the resident's perineal area. Staff then placed the resident on the bed pan as the resident continued to expel feces.

On 11/5/07 at 3:37 p.m., Staff U and Staff V reported they would be taking the resident off of the bed pan. The staff cleansed the resident's buttocks and at this time, the resident's underpad...
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<td>B. WING</td>
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<tr>
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<tr>
<td>(F 315)</td>
<td>Continued From page 17 again wet with urine. Staff cleansed the resident's buttocks but did not cleanse the resident's perineal area. Staff then used alcohol pads and wiped the resident's catheter tubing.</td>
<td>(F 315)</td>
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<td></td>
<td>Staff did not obtain a clean leg strap to secure the catheter. Observation on 11/6/07 at 9:05 a.m. revealed no leg strap to secure the catheter tubing. This information was given to Staff G, the corporate nurse. Observation on 11/6/07 at 4:30 p.m. showed the leg strap in place.</td>
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<td>Review of the facility policy for catheter care listed equipment needed as: - Basin with warm water or facility product - Towel with wash cloth - Disposable gloves - Bed protection</td>
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<td>The Procedure included the following items: - Cleanse tubing using a downward motion from the insertion site. - Wash perineum well, taking care to wash from front to back. Wash all areas that were potentially soiled or wet. - Cleanse area at catheter insertion well. - Secure catheter with leg strap to prevent trauma to the meatus.</td>
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<tr>
<td>(F 322)</td>
<td>483.25(g)(2) NASO-GASTRIC TUBES</td>
<td>(F 322)</td>
<td>This is my credible allegation of compliance. This allegation does not constitute guilt but that the facility is in compliance with F322.</td>
<td>12-14-07</td>
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<tr>
<td>SS=D</td>
<td>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</td>
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Resident #13 continues to receive medications per doctor's orders via their feeding per facility protocol.

All residents whom require medications via their feeding tubes are receiving their medications per doctor orders and facility protocol.

All nurses have been re-educated on proper medication administration via a feeding tube. Nurses will continue to be monitored and audited for proper technique of medication administration via feeding tubes.

Nursing administration will monitor nurses for proper medication administration and technique to ensure that it continues.
Continued From page 19

Staff N then took a syringe, drew up 20 cc of water along with the medications and administered the syringe contents at one time rather than administering each medication preceded by 5-10 cc of water and followed by 15-30 cc after each medication as ordered. This staff then flushed the tubing with the 150 cc of water flush that was ordered to follow the nutritional tube feeding. Observation at 11:50 a.m. revealed particles of medication still in the syringe. Staff N verified the particles of medication were from the morning medication pass.

Observation of Staff N on 11/6/07 at 11:55 a.m. revealed this staff preparing the medication Lortab 15 cc. This staff poured the liquid medication into a plastic medication cup and administered the medication into the j-tube without verifying the tube was properly placed in the resident's stomach. This staff did not flush the tube with the 15-30 cc of water as ordered, but with 120 cc of water.

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
- Based on record review, observations, and interviews, the facility failed to provide adequate nursing supervision and ensure placement of...
Continued From page 20

assistive devices to prevent accidents for one of 13 reviewed residents who was at risk for falls (Resident #7). The facility reported a census of 176 residents.

Findings include:

Review of the Minimum Data Set (MDS) assessment with a reference date of 10/22/07, Resident #7 had diagnoses including diabetes mellitus, edema, and delusions. The MDS indicated the resident experienced short and long-term memory problems and severely impaired decision-making capabilities. The MDS further identified the resident required staff assistance for bed mobility, transfers, ambulation, dressing, toileting, and personal hygiene. The assessment reflected the resident had experienced a fall in the past 30 days.

Review of the resident's fall risk assessments revealed the facility assessed the resident as at high risk for falling on 2/27/07, 5/20/07, 8/13/07, and 11/2/07.

The resident's current care plan dated 10/19/07, and updated on 11/14/07, identified the resident as at risk for injury due to a diagnosis of dementia, poor safety awareness, an unsteady gait, medication usage, and a history of falls. Intervention approaches included:

a. Monitor resident for attempts to get up with redirection.

b. Provide an assist of one, a gait belt, and a walker with all transfers and ambulation.

c. Ensure the placement of pressure alarms when the resident sat in the recliner or laid in bed.

d. Ensure the placement of a personal clip alarm except when in bed/recliner.

All residents whom require devices to assist in accident prevention have them in place and their plans of care reflect the devices to be used.

With any accident that occurs the facility will continue to implement interventions to assist in accident prevention. Any changes in accident prevention will be reflected on the resident’s plan of care.

The facilities interdisciplinary team will continue to monitor accident prevention and put new interventions into place as needed to ensure accident risks are kept low.
Continued From page 21

e. Toilet the resident routinely around meal times.

Review of an incident report dated 10/2/07 indicated staff had found the resident on the floor in his/her bedroom doorway. The report stated the resident had fallen onto his/her back, hitting his/her head of the floor. Facility staff assessed the resident, called the physician, and transferred the resident to the local emergency room for evaluation and treatment. The resident received 5 staples to the back of the head to close a laceration. The report indicated the resident had a clip alarm on prior to the fall that did not sound. The facility replaced the alarm and employed new interventions including the use of a low bed and pressure alarm.

An interview with Staff Z on 11/6/07 at 3:00 p.m. revealed that upon investigation after the resident’s fall on 10/2/07, staff determined the resident’s clip alarm had been on the resident at the time of the fall, but the pin had not disengaged from the alarm box, therefore, the alarm did not sound.

Observation of the resident on 11/6/07 at 8:43 a.m. revealed the resident sitting in a chair in the dining room with no clip or pressure alarm in place. Observation on 11/6/07 at 8:55 a.m. revealed Staff Y assisting Resident #7 ambulate with the aid of a gait belt and wheeled walker to the bathroom located in the shower room. Staff Y left the resident standing unassisted with the wheeled walker in the shower room while he/she walked away from the resident to close the shower room door. Staff Y then proceeded to the bathroom sink and prepared washcloths to be used for pericare while the resident remained standing unattended behind Staff Y.
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<tr>
<td>F 328</td>
<td>483.25(k) SPECIAL NEEDS</td>
<td>F 328</td>
<td>This is my credible allegation of compliance to F328. This allegation does not constitute guilt but that the facility is in compliance with F328.</td>
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The facility must ensure that residents receive proper treatment and care for the following special services:
- Injections;
- Parenteral and enteral fluids;
- Colostomy, ureterostomy, or ileostomy care;
- Tracheostomy care;
- Tracheal suctioning;
- Respiratory care;
- Foot care; and
- Prostheses.

This REQUIREMENT is not met as evidenced by:
- The following deficiency was identified at the time of the Survey Revisit.

Based on record review, policy review, and observation, the facility did not follow its policy and procedure for administration of respiratory therapy for one of two reviewed residents receiving respiratory treatments in an open sample of 14 residents (Resident #13). The facility identified a census of 178 residents.

Findings include:

1. The hospital discharge summary dated 9/14/07 for Resident #13 indicated the resident had diagnoses of status post respiratory failure and severe chronic obstructive pulmonary disease. The current physician orders dated 10/13/07 directed staff to administer Albuterol 0.83 mg/ml solution via nebulizer mask.

Observation on 11/6/07 at 11:50 a.m. showed Staff N preparing the Albuterol breathing
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<tr>
<td>F 328</td>
<td>Continued From page 23 treatment. Observation revealed the nebulizer machine, tubing, and mask lying on the resident's bedside stand. The staff poured the medication into the nebulizer container, started the machine, and placed the mask on the resident. At 12:05 p.m., this staff removed the mask from the resident, turned off the machine, and laid the mask and tubing on the bedside stand. This staff did not cleanse the mask before or after the treatment.</td>
<td>F 328</td>
<td>This is my credible allegation of compliance to F441. This allegation does not constitute guilt but that the facility is in compliance with F441.</td>
<td>12-14-07</td>
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<tr>
<td>F 441</td>
<td>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</td>
<td>(F 441)</td>
<td>Residents #2, #10, and #13 are receiving cares in order to provide a safe, sanitary and comfortable environment, for all residents infection control is maintained for these residents.</td>
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<tr>
<td>SS-D</td>
<td>This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and interviews, the facility failed to follow measures designed to prevent the spread of infection for</td>
<td></td>
<td>All residents are being cared for to ensure proper infection control is maintained to assist in decreasing the chance of spreading infections. Appropriate interventions are being put into place to assist in treating infections as well as infection prevention.</td>
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three of 13 reviewed residents (Resident #10, #2 and #13). The facility identified a census of 176 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment tool with a reference date of 10/3/07 indicated Resident #10 had short term memory problems and some difficulty with daily decision making. The MDS indicated the resident required extensive assistance of staff for bed mobility and dressing, and as totally dependent on staff for transfers, toileting, and hygiene. The MDS stated the resident had diagnoses including diabetes mellitus, hypertension, peripheral vascular disease, and fracture of lower leg. The MDS reflected the resident as usually continent of bowel and as having an indwelling urinary catheter.

Review of laboratory results dated 10/31/07 indicated Resident #10 tested positive for Clostridium Difficile (C-Diff) and that the physician had ordered Flagyl, 500 milligrams, three times a day for seven days to treat the bowel infection.

The care plan for Resident #10 dated 10/30/07 identified the resident with an actual infection related to C-Diff and directed staff to employ isolation precautions, and contact precautions per facility protocol.

Review of the facility's contact isolation protocol dated July 2004, directed staff to wear gloves when entering a resident room and to wear gowns when entering a resident room if contact with the resident or items in the resident room

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<td>F 441</td>
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<td>Direct care staff have been re-educated on proper infection control practices to assist in infection control. Nursing staff has been re-educated on proper accu-check procedures to also assist in infection control. The facility's nursing administration will continue to monitor for proper infection control practices, as well as proper resident interventions to assist in infection prevention.</td>
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<td>{F 441}</td>
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Observation on 11/07 at 1:55 a.m. revealed contact isolation signage on the resident's door.

Observation on 11/7/7 at 2:00 p.m. revealed Staff C and Staff AA entering the resident's room to provide care. Staff AA or Staff C did not apply gowns. Staff C washed his/her hands, and with ungloved hands, walked over to the resident's bed and touched the side table, bed, and handled the linen on the resident's bed. Staff C then applied gloves. After performing pericare, Staff AA and Staff C removed their gloves, washed their hands, and did not reglove. The staff members proceeded to remove the dirty linen from under the resident and apply clean linen.

2. The current signed physician's orders dated 10/1/07 for Resident #13 directed staff to perform Accu-checks (testing of blood sugar) four times a day.

Observation on 11/6/07 at 11:50 a.m. revealed Staff N preparing to conduct the Accucheck. This staff removed the entire container of lancets from the medication cart, took the container of lancets and placed the glucometer, lancet injector, and bottle of test strips on top of the lancets in the container. This staff then took the container to the resident's room and placed it on the over-the-bed table located next to the resident's bed. The staff placed a paper towel under the glucometer, lancet injector, and bottle of test strips as a barrier between the items and the over-the-bed table. After conducting the test, the staff nurse wiped off the lancet injector and
Continued From page 26

glucometer with an alcohol pad and placed the items in the box with the lancets. This staff then placed the container back into the medication cart without sanitizing it.

Record review of a hospital discharge summary dated 9/14/07 revealed the resident had a diagnosis of Clostridium difficile colitis treated with Flagyl. Record review indicated the resident had been diagnosed with C-Diff (clostridium difficile) again on 10/15/07 received a 14 day treatment of the medication, Flagyl. According to the facility's infection control policy the facility was to implement contact precautions when a resident presented with infection/condition C-diff. The precautions included limiting use of noncritical care equipment to a single patient/resident.

Observation on 11/6/07 during medication administration at 8:45 a.m. and 11:50 a.m. revealed this staff did not wear a gown when entering the resident's room as the Contact Precautions directed (on the infection control manual for the infection/condition of C difficile). Observation noted signage on the resident's door stating, "Isolation, Visitors-Please see charge nurse before entering this room". Upon questioning, Staff N reported the resident did have C-difficile but had been on an antibiotic for it.

Record review also documented the resident having loose stools on 11/7/07 with the physician ordering another test for C-difficile.

3. The current signed physician orders dated 10/4/07 for Resident #2 directed staff perform an Accucheck (test of blood sugar) at different times.
Continued From page 27

Observation on 11/6/07 at 12:10 p.m. showed Staff N preparing to conduct the Accucheck. This staff removed the entire container of lancets from the medication cart. Observation indicated the container as being the same container of lancets used in the room of Resident #13. This staff took the container of lancets and placed the glucometer, lancet injector, and bottle of test strips on top of the lancets in the container. This staff then placed the entire container on the sink counter without placing a barrier under the container. This staff did place a paper towel under the glucometer, lancet injector and bottle of test strips as a barrier. After conducting the test, the staff nurse wiped off the lancet injector and glucometer with an alcohol pad and placed the items in the box with the lancets. This staff then placed the container back into the medication cart without cleansing it.