12 citations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7203	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 06/25/2008
NAME OF PROVIDER OR SUPPLIER **HEATHERIDGE ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **2130 SOUTH 85TH EAST AVENUE TULSA, OK 74129**		

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C 000	INITIAL COMMENTS On 06/23/08 through 06/25/08, an abbreviated survey was conducted to investigate complaint #OK00033688. The following deficiencies were cited as a result of the survey.	C 000		
C 143	310:663-3-4(b) APPROPRIATENESS OF PLACEMENT (b) The resident shall not be eligible for placement in the assisted living center under one (1) or more of the following circumstances: (1) The resident needs care or services that exceed the care or services available in the assisted living center; (2) The resident's physician determines that the resident requires physical or chemical restraints in situations other than emergencies; (3) The resident poses a threat to self or others; or (4) The assisted living center is unable to meet the resident's needs for privacy or dignity. This REQUIREMENT is not met as evidenced by: O.S. 63-1-1918.B.5. 11. Every resident shall be free from mental and physical abuse, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the	C 143		

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C 143	Continued From page 1	C 143		

resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of said physician who shall set forth in writing the circumstances requiring the use of restraint..."

Based on observation, record review and interview, the center failed to prevent the restraint by use of full-length bedrails for 1 (#1) of 2 (#1 and #3) restrained residents. Furthermore, the center failed to prevent the restraint through tucking a frail resident tightly in the bed for 1 (#3) of 2 (#1 and #3) restrained residents.

These deficient practices resulted in a safety hazard with the potential for serious harm for falling while climbing over or around bed rails for resident #1. This resulted in actual harm related to a pressure ulcer for resident #3. Findings:

RESIDENT #1

On 06/23/08 at 4:50 p.m., resident #1 was observed lying on a chaise in her room. The resident's bed was observed to have full-length side rails on the bed.

The resident's daughter was asked about the side rails on the resident's bed. She stated, "When I leave, I put the rails up. The nurse came in one day and she (resident #1) was trying to climb over the rails."

On 06/24/08 at 1:20 p.m., resident #1 was observed lying in her bed with side rails up on both sides of the bed. The resident's daughter was observed sitting at the resident's bedside.

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C 143	Continued From page 2 On 06/25/08 at 8:00 a.m., the center's director of nurses (DON) was asked if the center had determined whether the side rails were a restraint for the resident. She stated, "No. My staff doesn't put them up. Her daughter is putting them up." The DON was asked if she had talked to the resident's daughter about the side rails restraining the resident from getting out of bed. She stated, "No. Hospice brought that bed with the side rails on it and her daughter puts the rails up." At 8:15 a.m.., the center's administrator was asked for the center's restraint policy. She stated, "We don't have a policy." RESIDENT #3 On 06/23/08 at 3:30p.m., the center's director of catered living/LPN (licensed practical nurse) was asked about resident #3. The LPN said the resident went to the hospital on Wednesday (06/11/08) and passed on Thursday (06/12/08). She stated, "She was a full code." The LPN was asked about skin wounds. She stated, "She got knee wounds. Dr. (name deleted) said she got the knee wounds from shearing. She had wounds on her right knee, right foot and right heel." At 12:11p.m., via a telephone interview, (name deleted - hospice RN) was asked about resident #3. She stated, "When (name deleted - resident #3) came to us on the 19th or 20th of March (2008), I went and saw her. She had wounds on her ankles, stage I or II (stage I - redness Stage II - open wounds affecting the dermal layer of the	C 143		

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C 143	Continued From page 3 skin) and one on her right heel. It was necrotic (black tissue). She had MRSA of the wounds and foley catheter. She was eating and drinking very little. I know the sitters were telling her daughter she was eating good, but she wasn't. She got to where she couldn't sit in the chair any longer. The sore on her foot kept getting worse and worse. She mostly stayed on her back in bed. She also got a pressure sore on her right knee cap. The sitters were tucking in the blankets really tight on her bed because she was active in the bed and kept kicking her legs out of the bed. It (the sore) appeared to be from rubbing the top of her knees on the tucked in blanket." The hospice RN was asked if she had reported the use of blankets as a restraint for resident #3. She stated, "I reported it to (name deleted -LPN) and (name deleted - RN consultant)." The hospice RN was asked if the resident's worsening sores were reported to the resident's physician. She stated, "She had two doctors. (Name deleted - physician #1) followed her for awhile. He discharged her, then (name deleted - physician #2) took her over. (Name deleted - LPN) talked with him more than we did. I never talked to him."	C 143		
C 150	310:663-3-6(a) MANAGEMENT OF RISK IN ASSISTED LIVING (a) If a resident's preference or decision places the resident or others at risk or is likely to lead to an adverse consequence, the assisted living center shall advise the	C 150		

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C 150	Continued From page 4 resident and the resident's representative of such risk or consequences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to complete managed risk agreements and failed to advise residents of risks or adverse consequences for 2 of 2 (#1 and #6) residents whose preferences/decisions were likely to lead to adverse consequences. Resident #1 frequently ambulated without assistance and fell. Resident #1 was also restrained by the use of full-length bed rails and reportedly attempted to climb over the rails. Resident #6 did not follow his physician-ordered cardiac ADA diet. This deficient practice had the potential for serious harm for resident #1 and more than minimal harm for resident #6. Findings: RESIDENT #1 Resident #1 was observed to use full-length bed rails and reportedly attempted to climb over the bed rails. The findings from C143 and C401 are incorporated herein by reference. A nurse's note for resident #1 dated 06/16/08, documented, "11:20 Summoned to resident's room. Resident sitting on floor. States sat on floor instead of in wheelchair. No injuries noted..." A nurse's note dated 05/21/08, documented, "2:45 a.m., Res (resident) on floor by bed. Said	C 150		

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C 150	Continued From page 5 she was going to bathroom. Cut on end of R (right) big toe by toenail. Some blood on right ear lobe. Red area R side of back on lower ribs maybe from previous fall. Assisted res to bathroom and back to bed with no problem." A nurse's note dated 05/20/08, documented, "Resident found laying in floor beside her chaise lounge. Resident says she rolled out on floor." A nurse's note dated 05/05/08 documented, "Resident found on floor in room. Resident states she slid out of chaise lounge in room. No apparent injuries at this time." A nurse's note dated 04/10/08, documented, "5:45 a.m., Found res on floor beside bed. Res had gotten up to dress and slid off bed while pulling up slacks. No apparent injuries. She said she was ok." A nurse's note dated 04/03/08, documented, "1:15 a.m., Staff was making rounds and heard a noise. Staff found resident on the floor in the breezeway. Resident stated she fell on end table. Stated her house shoe came off. No visible injuries. Stated her left foot hurt." A nurse's note dated 03/12/08, documented, "I was standing outside of door 252, heard this little voice inside saying, I'm on the floor. Res slid off side of couch. Couldn't get up by herself. No apparent injuries note. Didn't hit her head." All the above incidents were documented on incident reports. On 06/23/08 at 1:00 p.m., the center's director of nurses (DON) was asked if the center had put interventions for falls on the resident's	C 150		

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C 150	Continued From page 6	C 150		

care/service plan. She stated, "No. We notify the family and hospice. Her daughter does not want us to do anything for her."

The DON was asked what fall risk interventions the center had put in place. She stated, "We don't have anything."

The resident's annual comprehensive assessment dated 02/19/08 documented, "Average 1-2 falls a week."

The resident's current hospice care plan dated 06/11/08, did not address the resident's falls or the use of side rails.

The resident's current care/service plan date 02/19/08, did not address the resident's falls or the use of side rails.

The DON was asked if the center had completed a negotiated risk agreement for the resident for falls. She stated, "That would be a (name deleted-administrator) question."

On 06/24/08 at 9:30 a.m., the center's quality assurance registered nurse was asked if the center had completed a fall risk assessment for resident #1. She stated, "No. We don't have one in this center. We have them in the nursing home but not here. We are starting to get more like the nursing home but we are fighting that."

At 2:38 p.m., the center's administrator was asked if the center had completed a negotiated risk agreement with the resident for falls. She stated, "We do not have a risk agreement with her."

RESIDENT #6

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C 150	Continued From page 7 On 06/24/08 at 2:15 p.m., cook #1 was asked if the center has anyone on a special diet. She stated, "No one is on a special diet that I know of. We do have diabetics but they eat the same regular diet." At 2:30 p.m., the center's DON was asked about special diets. She stated, "We have diabetics but we don't do dietary consults." She was asked what residents were diabetics. She stated, "(Name deleted-resident #6) and name deleted-resident #7). (Name deleted-resident #6), he is pretty non-compliant." On 06/24/08 at 8:15 a.m., the physician's orders for resident #6 were reviewed with the center's DON. The physician's order dated 03/01/08 contained an order for a cardiac, ADA diet. The DON was asked if the center had completed a negotiated risk agreement for the resident for diet non-compliance. She stated, "No. We think he goes and gets candy out of the machine." At 8:25 a.m., the center's administrator was asked about the diet order for the resident. She stated, "That's (name deleted-resident #6). He doesn't follow anything. The resident's current comprehensive assessment and current care/service plan, documented special diet but did not address non-compliance or consequences of non-compliance with diet.	C 150		
C 151	310:663-3-6(b) MANAGEMENT OF RISK IN ASSISTED LIVING (b) The assisted living center shall	C 151		

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C 151	Continued From page 8 specify the cause for concern, discuss the concern with the resident and representative, if any, and attempt to negotiate a written agreement that minimizes risk and adverse consequences and offers alternatives while respecting resident preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the center failed to complete managed risk agreements to include the cause for concern and failed to offer alternatives for 2 of 2 (#1 and #6) residents whose preferences/decisions were likely to lead to adverse consequences. Resident #1 frequently ambulated without assistance and fell. Resident #1 was also restrained by the use of full-length bed rails and reportedly attempted to climb over the rails. Resident #6 did not follow his physician-ordered cardiac ADA diet. This had the potential for serious harm for resident #1 and more than minimal harm for resident #6. Findings: The findings from C150 are incorporated herein by reference.	C 151		
C 152	310:663-3-6(c) MANAGEMENT OF RISK IN ASSISTED LIVING (c) The assisted living center shall document any lack of agreement and shall provide a copy to the resident and the resident's representative.	C 152		

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C 152	Continued From page 9	C 152		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined the center failed to document a lack of managed risk agreements for 2 of 2 (#1 and #6) residents whose preferences/decisions were likely to lead to adverse consequences.

Resident #1 frequently ambulated without assistance and fell. Resident #1 was also restrained by the use of full-length bed rails and reportedly attempted to climb over the rails.

Resident #6 did not follow his physician-ordered cardiac ADA diet.

This had the potential for serious harm for resident #1 and more than minimal harm for resident #6. Findings:

The findings from C150 are incorporated herein by reference.

C 180 — 310:663-5-5(2) USE OF ASSESSMENT — C 180

The assisted living center shall use the results of the resident's assessment for the following:
(2) to develop a care plan for the resident, in consultation with the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the center failed to develop and implement individualized care plans to address resident care needs as follows:

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C 180	Continued From page 10 Resident #1 - Falls and the restraint of the resident through the use of full-length bed rails; Resident #3 - Actual and potential pressure ulcers, recurrent urinary tract infections (UTI), recurrent dehydration, swallowing problems, a toileting schedule, antibiotic resistant infections, and foley catheter care; Resident #5 - Actual and potential pressure ulcers, assistance with toileting and bathing and fall prevention strategies; Resident #6 - Physician-ordered cardiac ADA diet. This resulted in a safety hazard with the potential for serious harm for falling while climbing over or around full-length bed rails for resident #1. This resulted in actual harm related to pressure ulcers for residents #3 and #5. This resulted in actual harm for resident #3 when no clear instructions regarding catheter care resulted in the failure to timely assess the resident for pain and injury for more than 3 hours when the foley catheter became displaced. This resulted in the potential for more than minimal harm related to not offering a physician-ordered diet or managed risk agreement for resident #6. Findings: RESIDENT #1 The clinical record for resident #1 documented the resident had seven falls from 03/12/08 through 06/16/08. Observation and interview verified resident #1 was restrained by the use of	C 180		

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C 180	Continued From page 11 full-length bed rails. The findings from C143 and C150 are incorporated herein by reference. On 06/23/08 at 1:00 p.m., the center's director of nurses was asked if the center had documented the falls on the resident's comprehensive care/service plan. She stated, "We notify the family and hospice. Her daughter does not want us to do anything for her." She was asked if she put that on the resident's care plan. She stated, "No. I did not. Her family took out some of her furniture but that's all." The resident's annual comprehensive assessment dated 02/19/08, documented, "Average 1-2 falls a week." The resident's current hospice care plan dated 06/11/08, did not address the resident's falls or the use of side rails. The resident's current care/service plan dated 02/19/08, did not address the resident's falls or the restraint of the resident through the use of full-length bed rails. RESIDENT #6 On 06/24/08 at 8:15 a.m., the physician's orders for resident #6 were reviewed with the center's DON. The physician's order dated 03/01/08, contained an order for a cardiac, ADA diet. Based on interviews with staff, resident #6 did not comply with a cardiac ADA diet. The findings from C150 are incorporated herein by reference. The resident's current comprehensive assessment and current care/service plan, documented special diet but did not address	C 180		

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non-compliance, managed risk or consequences of non-compliance with diet.

RESIDENT #3

The findings from C401 related to resident #3 are incorporated herein by reference.

The hospice plan of care did not address specific interventions with measurable goals and outcomes related to actual and potential pressure sores and foley catheter care for the resident.

A 'Service Plan' dated 01/04/08, for the resident documented, "...1. Mobility: pt. (patient) only uses w/c (wheel chair) for mobility...
2. Toileting: Assist X (times) 1-2...
4. Feeding: 0 (no) assist (assistance)...
7. Mental Health: Very critical of staff. C/O (complains of) care...
10. Skin condition: Pt. has extensive bruising on face due to recent fall...
15. Interventions (Treatments & Procedures): Increased care per staff. Encourage resident to help with care..."

The resident's 01/04/08 service/care plan did not address assessed needs that were identifed by the 01/04/08 assessment for:
* A specific toileting schedule for the resident dependant for care.
* Interventions and an investigation related to documented complaints of care received.
* Interventions with measurable goals and outcomes to address the resident's falls.
* Skin assessments related to extensive bruising on the face due to recent fall.
*Assessment and interventions for actual and potential dehydration.
* Specific instructions for the direct care staff

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C 180	Continued From page 13 related to the increased care as required by the resident. *Coordination of care with home health services. A comprehensive resident assessment dated 03/19/08, for resident #3 documented, "...Mobility: Does not wheel self...Toileting: Catheter (external/indwelling)...Feeding: Needs to be fed all meals...Appetite: Poor...Grooming/Shower: Total assistance needed, Totally dressed by staff daily...Mental Health: Withdrawn...Skin condition: Sore not healing...Infections: (MRSA - antibiotic resistant infection)...Treatments: (not addressed)..." The 'Service Plan' dated 03/19/08, for the resident documented, "1. Mobility: Assist X 1 - W/C (wheel chair). 2. Toileting: Assist X 1. 4. Feeding: Encourage to be independent. Assist X 1. 5. Grooming: Assist X 1... 9. Bowel/Bladder: Foley cath (catheter) (indwelling catheter used to drain urine from the bladder). 10. Skin condition: Stage II L (left) inner ankle 1.5 (centimeters) X 2.5 (centimeters). R (right) inner ankle stage II 5 (centimeters) X 2 (centimeters). R heel stage II 5 (centimeters) X 3.5 (centimeters) eschar intact and soft. HH (home health) to treat... 12. Infections: MRSA of wounds and urine..." The resident's service plan did not address: * Skin assessments related to actual and potential pressure sores. * Assessments and implementation of pressure ulcer prevention and healing strategies with measurable goals and outcomes. *Assessment and interventions for re-current	C 180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7203	A. BUILDING ______ B. WING ______	C 06/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHERIDGE ASSISTED LIVING	**2130 SOUTH 85TH EAST AVENUE TULSA, OK 74129**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 180	Continued From page 14 urinary tract infections. *Assessment and interventions for re-current dehydration * Evaluation of a specific toileting schedule for the resident taking diuretics and dependant for toileting. * Interventions related antibiotic resistant infected wounds and urine that required specific contact isolation precautions. * Specific instructions for the direct care staff related to foley catheter care. *Pressure ulcer care to include the prevention of restraint through the use of tightly tucked covers. *Nutritional consultation, assessments and interventions for malnutrition and dehydration, choking during meals and significant weight loss. *Precautions and interventions related to assistance with all feedings and need to be prompted throughout day to drink water as ordered by physician on 3/19/08. RESIDENT #5 A (name deleted - assisted living) comprehensive assessment dated 05/19/08, for resident #5 documented, "...Mobility: Walks with support of one person...Uses motor driven devices...Needs assistance with transfers...Grooming/shower: No assistance needed - hospice..." The 'Residential Care Community Service Plan' dated 05/19/08, for the resident documented, "...Mobility: motorized w/c (wheel chair)...toileting: uses urinal...Skin condition: intact..." The 'name deleted - hospice' plan of care for the resident documented, "Baths: 2x (times) per week..."	C 180		