STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	295085		C 10/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(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) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the complaint investigation conducted at your facility on 10/7/08 and was finalized on 10/30/08. Complaint #NV00019319 was substantiated. See F 157, F 225, and F 309. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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F 157	Continued From page 1 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure that the nursing staff promptly notified the physician by telephone following the discovery of a resident exhibiting symptoms of severe circulatory impairment of the left leg. Findings include: Resident #1: The resident was admitted to the facility on 7/2/08 and readmitted on 9/6/08 following a hospital admission. Her diagnoses included buttock pressure ulcer, neuropathy, constipation, urinary tract infection, anorexia, nonorganic psychosis, pain, osteoporosis, and esophageal reflux. She died on 9/22/08 at a hospital. Record review revealed that, on 9/14/08, Resident #1's left leg was found to be cold to the touch. Resident progress notes written by licensed practical nurse (LPN) #1 at 8:31 PM, revealed "Left foot cold to touch, black in color with faint pedal pulse noted. Multiple bruised areas noted to bilateral legs and upper extremities." The note indicated the nurse would continue to monitor the resident.	F 157		

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F 157	Continued From page 2 On 9/15/08 at 2:01 AM, a resident progress note written by LPN #1 revealed "Left foot remains cold to touch. Foot and toes are black in color. Lower extremity cyanotic and mottled from approximately half up calf. Unable to correctly palpate pedal pulse at this time. Fax sent to Dr.___ at this time. Will continue to monitor." On 9/15/08 at 4:34 AM, the resident progress note, again written by LPN #1, revealed that Resident #1 was resting quietly and exhibited no signs of pain. The left foot was noted to remain "cold to touch and blue/black in color." On 9/15/08 at 9:38 AM, a resident progress note written by LPN #2 read "Asked by CNA to look at resident's left leg. Noted left leg is reddish purple from the knee down to the foot, left foot and toes are black. Left foot is cold to touch past the ankle and no petal pulse present. Called Dr. @9:10 am sent to ER for eval. Called family @ 9:20 am. Squad called@ 9:22 am. Squad here and resident taken to hospital @ 9:35 am." On 10/9/08, the Director of Nurses (DON) was interviewed. She stated she was aware Resident #1 was sent to the hospital due to concerns regarding the circulation in her leg, but did not know those symptoms were identified over 12 hours before she was taken to the hospital. She stated that the nurse should have called the doctor when she discovered the leg was cold to touch, changed color and had a weak or absent pulse. She stated that she expected the nurse who noted the change in the resident's condition to call the physician. She stated that faxing the physician at 2:01 AM was not acceptable to her since the physician was most likely asleep. She	F 157		

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F 157	Continued From page 3 stated that the physician could have been contacted via phone. She stated she could have been called if the nurse could not contact the physician. She stated that the facility did not have a policy or procedure for dealing with emergencies after hours. On 10/9/08, LPN #1 was interviewed via phone. She stated that she did not call the physician because Resident #1's leg still had a pulse although she confirmed that the leg was cold and discolored. She also stated she did not call the physician because the CNA's told her the leg had been discolored and cold for a few days. She stated she did not have to call the physician since she had notified him via fax. She said that although the physician had a cell phone he never answered the phone at night.	F 157		
F 225 SS=D	Cross Reference Tag F 309, Quality of Care 483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225		

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F 225	Continued From page 4 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to report and investigate a resident's injury of unknown origin. Findings include: Resident #1: The resident was admitted to the facility on 7/2/08 and readmitted on 9/6/08 following a hospitalization admission. Her diagnoses included buttock pressure ulcer, neuropathy, constipation, urinary tract infection, anorexia, nonorganic psychosis, pain, osteoporosis, and esophageal reflux. She died on 9/22/08 at a hospital. Record review revealed a resident progress note written on 8/13/08 at 3:35 PM, documenting that	F 225		

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F 225	Continued From page 5 Resident #1 had a bruise on her left upper arm that measured 10 cm x 8 cm. The resident reported that the bruise occurred when a staff grabbed her arm. Nurse #4 wrote "no signs of hallucinations or verbal abuse." On 8/14/08 at 8:52 PM, Nurse #3 documented the presence of the 10 cm x 8 cm bruise and noted "no signs of hallucinations or verbal abuse noted." On 10/9/08, the Director of Nurses (DON) was interviewed. She reported that she was unaware of the bruise. She checked to see if there was an event form opened upon discovery of the bruise and found that a form was never opened. She stated that the facility's abuse and neglect policy required that significant bruises of unknown origin were to be reported immediately to the shift nurse and the DON. The injury was also to be reported to the Bureau of Licensure and Certification and an investigation would be conducted. On 10/10/08, LPN #3 was interviewed. She confirmed that she had not reported the bruise to the DON or to anyone in the facility administration. She stated she thought an event had already been documented when she saw the other nurses note. She acknowledged that the bruise should have been reported. On 10/20/08, LPN #4 was interviewed via phone. She stated that she did not notify the DON or anyone in administration of the bruise. She stated she did not open up the event form and thought that her note was enough to document the bruise. She did not investigate the complaint that a worker had caused the bruise by grabbing the resident's arm. Review of the facility policy number 1.13 (NV)	F 225		

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F 225	Continued From page 6 subject:abuse prohibition "serious injuries of unknown source, including, but not limited to, significant bruises, fractures, dislocations, lacerations, abrasions, contusions, lumps, and/or severe swelling shall be reported immediately to the shift nurse, the Director of Nursing and the Administrator." The policy further revealed that the facility shall notify the Bureau of Licensure and Certification (BLC) of the State of Nevada and that an investigation would be conducted by the facility. No report of the bruise was made to BLC and the facility did not investigate Resident #1's bruise	F 225		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to provide a medical evaluation and treatment following the discovery of a resident exhibiting symptoms of severe circulatory impairment of the left leg. Findings include: Resident #1: The resident was admitted to the facility on 7/2/08 and readmitted on 9/6/08 following a hospital admission. Her diagnoses included buttock pressure ulcer, neuropathy, constipation, urinary tract infection, anorexia,	F 309		

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F 309	Continued From page 7 nonorganic psychosis, pain, osteoporosis, and esophageal reflux. She died on 9/22/08 at a hospital. Record review revealed that, on 9/14/08, Resident #1's left leg was found to be cold to the touch. Resident progress notes written by licensed practical nurse (LPN) #1 at 8:31 PM, revealed "Left foot cold to touch, black in color with faint pedal pulse noted. Multiple bruised areas noted to bilateral legs and upper extremities." The note indicated the nurse would continue to monitor the resident. On 9/15/08 at 2:01 AM, a resident progress note written by LPN #1 revealed "Left foot remains cold to touch. Foot and toes are black in color. Lower extremity cyanotic and mottled from approximately half up calf. Unable to correctly palpate pedal pulse at this time. Fax sent to Dr.___ at this time. Will continue to monitor." On 9/15/08 at 4:34 AM, the resident progress note, written by LPN #1, revealed that Resident #1 was resting quietly and exhibited no signs of pain. The left foot was noted to remain "cold to touch and blue/black in color." On 9/15/08 at 9:38 AM, a resident progress note written by LPN #2 read "Asked by CNA to look at resident's left leg. Noted left leg is reddish purple from the knee down to the foot, left foot and toes are black. Left foot is cold to touch past the ankle and no pedal pulse present. Called Dr. @9:10 am sent to ER for eval. Called family @ 9:20 am. Squad called@ 9:22 am. Squad here and resident taken to hospital @ 9:35 am." On 10/9/08, the Director of Nurses (DON) was	F 309		

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F 309	Continued From page 8 interviewed. She stated she was aware Resident #1 was sent to the hospital due to concerns regarding the circulation in her leg, but did not know those symptoms were identified over 12 hours before she was taken to the hospital. She stated that the nurse should have called the doctor when she discovered the leg was cold to touch, changed color and had a weak or absent pulse. She stated that she expected the nurse who noted the change in the resident's condition to call the physician. She stated that faxing the physician at 2:01 AM was not acceptable to her since the physician was most likely asleep. She stated that the physician could have been contacted via phone. She stated she could have been called if the nurse could not contact the physician. She stated that the facility did not have a policy or procedure for dealing with emergencies after hours. On 10/9/08, LPN #2 was interviewed. LPN #2 stated she was not working Resident #1's unit on 9/15/08. She stated that one of the certified nurses assistants (CNA's) asked her to look at the leg because she was very concerned about the leg's appearance. She stated that when she examined the resident's leg she knew the resident had to be sent to the emergency room as soon as possible. On 10/21/08, LPN #1 was interviewed via phone. She stated that she did not call the physician because Resident #1's leg still had a weak pulse although she confirmed that the leg was cold and discolored. She also stated she did not call the physician because the CNA's told her the leg had been discolored and cold for a few days. Record review revealed no mention of the left leg and foot having a diminished or absent pulse or having	F 309		

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F 309	Continued From page 9 changed color or temperature. LPN #1 stated she did not have to call the physician since she had notified him via fax. She said that although the physician had a cell phone he never answered the phone at night. She stated that she did not discuss the condition of the resident's leg with a registered nurse or call the DON. She stated she did not believe the patient's condition required contact with a registered nurse or the DON. Resident #1's records from her hospital stay of 9/15/08 to her death on 9/22/08, were reviewed. The records revealed the resident had a Doppler venous ultrasound which showed "an extensive clot in the common femoral, superficial femoral, popliteal, and posterior tibial vein with trickle flow seen within the popliteal vein around the clot. The remaining deep venous system demonstrated no evidence of blood flow." An ultrasound of the left lower extremity revealed that the patient had a high grade of stenotic disease involving the left lower extremity with significant occlusive disease present. The physicians contacted two vascular surgeons who declined any revascularization surgery as the patient had contractures and little movement in her legs. Resident's #1's left leg was described as black to blue in color from the knee down. The left foot was black and gangrenous appearing. No pulses were present on the left. The physician noted that the resident did not have those physical signs when discharged from the hospital on 9/6/08, nine days before. The physician also revealed the presence of multiple ecchymotic lesions as well as an additional decubitus ulcer since her last hospitalization. The resident died on 9/22/08.	F 309		