

Deficiency Puzzle
Long-Term Care Learning Activity

Item	Description
Objective:	Given excerpts from various versions of a deficiency statement, surveyors will choose the best written statements to build a good deficiency statement.
Prerequisite:	Principles of Documentation for Long Term Care.
Prior to Class:	Print one copy of each of the puzzle pieces and cut out each piece. Print the directions for the exercise and the puzzle tips. Number each “set” of puzzle pieces as indicated in the directions. Read through the Preceptor Directions Worksheet to gain an understanding of the flow of this activity.
Materials Needed:	Blank wall or white board, tape, puzzle pieces numbered on the back, printed Preceptor Direction Sheet
Total Time for Activity:	60 minutes (The time given is approximate.)
Set-Up:	Have surveyors pull their chairs in front of a white board or empty wall in a semi-circle.

Step:	Preceptor Instructions:	Activity Time:
1.	Place all of the puzzle pieces in the center of the table. Instruct surveyors to pick up puzzle pieces and return to their seats. They should have at least a number 1, 2, 3, 4, and 5. They may have multiples of any number. All pieces must be picked up from the table.	5 min.
2.	Tape the Puzzle Piece F314—Pressure Ulcers up, high enough for all the others to follow underneath. Read the Set the Stage section of the Preceptor Direction Worksheet to the surveyors.	10 min.
3.	Ask your surveyors to find and read through the text on all of their puzzle pieces identified as “1.” Tell them to raise their hands if they feel that their statement is a good one.	10 min.
4.	Tape that volunteer’s “1” on the wall below your scenario. Ask the class to read and compare their version of “1.” Then ask if anyone has a better “1.” Continue through the entire version 1s and discuss the differences, pointing out why each is not the	10 min.

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Step:	Preceptor Instructions:	Activity Time:
	“best answer.” Leave the “best answer” “1” taped to the wall.	
5.	Continue this process until you have the “best answers” for all sections.	20 min.
6.	Debrief by asking a volunteer to read through the full deficiency practice statement. Answer any questions and reinforce the concepts where indicated as a result of the discussion.	5 min.

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 Preceptor Directions Work Sheet

Set The Stage:

This deficiency is focused on the facility failing to turn and reposition the resident.

During one of the interviews, a staff member says they hesitate to position him on his side because of the various tubes.

Another nurse claims that the resident was in and out of the hospital and developed the pressure ulcer during one of the acute stays.

All of these things must be considered when writing the deficiency. Now, using our puzzle pieces, let's put together the best deficiency statement we can with the information provided.

Puzzle Tips (correct pieces have an asterisk (*))

Number	Statement	Issues
1	Based on record review, and family and staff interviews, the facility failed to turn and reposition one of four sampled residents (Resident #4) who was totally dependent on staff for bed mobility. Resident #4 had an unstageable pressure ulcer to the sacrum.	The resident is still in the facility; the sources should include observations.
1	Based on observations, interviews, and record reviews, the facility failed to provide the necessary care and treatment to prevent and promote healing of pressure ulcers for a resident with a known history of pressure ulcers (Resident #4). Findings included:	It should not repeat the Regulation. Also, the interviews should be specified and it lacks the extent and universe.
1*	Based on record review, observations, and family and staff interviews, the facility failed to turn and reposition one of four sampled residents (Resident #4) who were totally dependent on staff for bed mobility. Resident #4 had an unstageable pressure ulcer to the sacrum. Findings included:	This practice statement has all the sources of evidence. It has the: <ul style="list-style-type: none"> • Specific deficient practice that does not repeat the regulation • Specified universe • Resident identifier
2	A record review for Resident #4 revealed the resident was admitted to the facility on 04/02/20XX. The resident had admitting diagnoses of congestive heart failure, coronary artery disease,	This piece should be rejected because it has too many diagnoses. The purpose for a resident identifier is to

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	hypertension, mitral regurgitation, gout, morbid obesity, dementia, depression, history of scrotal abscess with right orchiectomy and traumatic hematuria. An assessment dated 04/09/20XX indicated the resident was severely cognitively impaired and dependent on staff for all activities of daily living.	<p>maintain confidentiality. If someone (family or visitor) somehow figured out who this person is, then providing unnecessary diagnoses releases confidential information.</p> <p>It would be nice to know what kind of an assessment was done and that the Minimum Data Set (MDS) indicated there was no pressure ulcer at admission.</p>
2*	Record review showed Resident #4 had diagnoses including anoxic brain damage, ileostomy, and diabetes mellitus. The admission Minimum Data Set (MDS) dated 04/09/20XX indicated the resident was severely cognitively impaired and totally dependent on staff for all activities of daily living. The MDS indicated the resident did not have a pressure ulcer.	This piece introduces the resident. The survey process is resident-centered and the deficiency statement is in the order in which issues occurred for the resident, not how the surveyor discovered it. The only diagnoses included here are those pertinent to the issue. The assessment establishes what the facility knew about the resident.
2*	Resident #4's record showed that he was sent out to the hospital on 04/17/20XX for fever and dehydration and returned to the facility the same day.	This piece is necessary to show that the resident went out to the hospital and returned within a few hours.
3	Resident #4's care plan, dated 04/20/20XX, stated the resident was at risk for impaired skin integrity due to decreased mobility and bladder incontinence. The goal for this problem was that the resident would be free of "abrasions, pressure areas, skin tears, and excoriations through next review."	If a quote is used in the middle of the sentence then it should sound grammatically correct and if the sentence ends with a quote, the period goes inside the quotation marks.
3*	The Care Area Assessment (CAA) summary for Pressure Ulcers, dated 04/19/20XX, showed the	This is a good piece. It gives the preceptor an opportunity to

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	<p>resident did not have any open pressure areas at admission. The CAA indicated there was a small area of redness on the resident’s back that cleared shortly after being admitted. The CAA also showed Resident #4 was at risk for developing pressure ulcers because he required total assistance with bed mobility and was bed bound. The CAA indicated the resident would be care planned to “provide turning and repositioning q2h (every two hours) and prn (as needed), two-person assist with turning and repositioning (T&R), specialty mattress, weekly skin assessment”.</p>	<p>talk about the importance of asking the facility for any CAA related to the area of concern. If the CAA triggered from the MDS (only with the comprehensive assessments), then it should give more detail than the MDS and will show the thought process of the interdisciplinary team. This CAA says that the red area on the resident’s back resolved shortly after admission. Remind surveyors that the statement needs to be in sequential order by date of occurrence for the resident.</p>
3	<p>The Care Area Assessment (CAA) summary for Pressure Ulcers dated 04/19/20XX showed the resident did not have any open pressure areas at admission. The CAA indicated there was a small area of redness on the resident’s back that cleared shortly after being admitted.</p>	<p>This is the same CAA as the one on the prior slide but this one gives much less information.</p>
3	<p>A record review of the physician orders dated 04/12/20XX included, “(1) Multivitamin by mouth every day. (2) Vitamin C 500 mg twice a day by mouth per wound protocol. (3) Zinc 220 mg by mouth times 14 days per wound protocol. (4) Check albumin level and total protein level in AM.”</p>	<p>Unnecessary. This would be in the surveyor’s notes but there was no problem with the dressing change, and it does not help prove the practice statement.</p>
3*	<p>Resident #4’s care plan dated 04/20/20XX revealed a problem of impaired skin integrity due to decreased mobility and bladder incontinence. The goal was that the resident would be “free from pressure areas, skin tears, and excoriations through next review.” The care plan directed the staff to turn and reposition the resident every two hours and as needed. Approaches also included that two or more persons should provide bed mobility to</p>	<p>This is an example of how to use a quote in the middle of a sentence that is still grammatically correct. It does repeat what was in the CAA, but it drives home that staff should have known the resident needed to be repositioned.</p>

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	raise the resident’s buttocks completely off the bed during repositioning to prevent shearing.	
4*	On 05/04/20XX, the care plan was updated. The problem was identified as “skin impairment actual: ulcer to sacral area.” Approaches for this problem included turning and repositioning every two hours and that pillows should be used if necessary.	This shows that the pressure ulcer occurred while the resident was in the facility. It shows that the facility updated the care plan but did not change the interventions/ approaches.
4	The care plan was updated. The problem was identified as skin impairment actual: ulcer to sacral area.” Approaches for this problem included turning and repositioning every two hours and that pillows should be used if necessary.	There is no date for when the care plan was updated. The words “impairment” and “Approaches” are misspelled.
4	A record review of the physician orders dated 05/06/20XX revealed, “Apply mupirocin ointment (Bactroban 2% topical ointment) to sacral area three times a day.	Turning and repositioning is the focus of this deficiency. There were no concerns with nutrition, physician orders, treatments, monitoring, etc. This is probably in the surveyor’s notes but is not necessary to the citation.
4*	The record showed Resident #4 was sent to the hospital on 06/02/20XX for sepsis and dehydration and then returned to the facility on the same day.	This is necessary to track the resident in and out of the hospital. Later a nurse will claim in an interview that the resident developed the pressure ulcer while he was out at the hospital. As the surveyor, it is important to anticipate arguments in case the facility decides to dispute the deficiency in Informal Dispute Resolution (IDR).
4*	On 06/04/20XX, the care plan was updated. The problem identified was, “skin impairment actual: Stage II ulcer to sacral area due to decreased mobility and deconditioning and weakness.” The care plan directed staff to “turn and reposition	This paragraph establishes that the pressure ulcer developed in the facility. There was no ulcer noted when the resident returned from the hospital.

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	every two hours and use pillows as needed to assist.”	
5	An interview with the direct care staff member (caring for the Resident) on 6/7/20XX at 3:45 PM revealed she was given shift report by the prior shift direct care staff member on each resident and if she needed to know something else, the nurse would also give her report.	This gives no information pertinent to the citation.
5	<p>During the initial tour of the facility on 06/19/20XX, the Resident was observed lying on his back in bed. There was a pressure-relieving mattress on his bed. His eyes were open but he did not respond to verbal communication. There was a sign on the door to encourage fluids.</p> <p>At 12:15 PM on 06/19/20XX, the Resident was observed lying on his back in the same position.</p> <p>At 1:10 PM on 06/19/20XX, the Resident was lying on his back.</p>	These are three separate observations that do not prove the facility failed to reposition the resident.
5*	During initial tour of the facility on 06/19/20XX at 11:50 AM, Resident #4 was observed lying on his back in bed. There was a pressure-relieving mattress on his bed. His eyes were open, but he did not respond to verbal communication. He was moving his head from side to side.	This is okay as an independent observation.
5*	<p>Continuous observation of Resident #4 began on 06/19/XX from 12:15 PM through 3:30 PM. At 12:15 PM the resident was observed lying on his back.</p> <p>During an interview at 12:30 PM on 06/19/20XX, Nursing Assistant (NA) #1 indicated that he/she was not assigned to Resident #4, but had taken care of the resident in the past. The NA indicated the resident was to be turned and repositioned every two hours and pillows were to be used to help support the resident while in the side-lying position.</p>	<p>Here the surveyor begins a continuous observation. This is a good time to stop and explain the value of a legally defensible continuous observation.</p> <p>During the continuous observation, some interviews were conducted with staff members and a family member.</p>

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5*	<p>On-going observation at 1:10 PM on 06/19/20XX revealed the resident continued in the same position on his back.</p> <p>At 1:20 PM on 06/19/20XX, an interview was held with the nurse who was assigned to Resident #4. The nurse indicated Resident #4 was to be turned every two hours. The nurse further indicated the staff was to use pillows to help support the resident. The nurse added that Resident #4 was mostly positioned on his back and his left side because of the ileostomy.</p>	<p>Even though there may not be any activity in the resident's room, it can be a good idea to make a note every 15-20 minutes.</p>
5*	<p>At 2:00 PM on 06/19/20XX, a family member entered the room and was interviewed. The family member indicated she had visited one day last week and spent seven hours with Resident #4 and that no staff person had come in the room to turn or reposition the resident. The family member also stated that Resident #4 had an ulcer on his back.</p>	<p>This paragraph attempts to keep the identity of the family member confidential. Alone, this interview does not prove anything, but it does indicate the resident may not have been turned for extended periods on other occasions. During interviews with residents or family, it is important to ask permission to share information that was provided.</p>
5*	<p>At 2:50 PM on 06/19/20XX, NA #2 entered Resident #4's room with towels. NA #2 indicated she was passing linen to all residents on the hall prior to starting care. NA #2 indicated Resident #4 was to be turned every two hours and that two staff members were needed. NA #2 left Resident #4's room at 2:53 PM and indicated she would return in a few minutes with another staff person to assist in repositioning the resident. The resident continued on his back in the same position.</p>	<p>It is important to interview front-line staff.</p>
5	<p>At 3:30 PM on 06/19/20XX, the treatment nurse and NA #2 entered the room, positioned the resident onto his left side, and removed the sacral dressing. Resident #4's sacral area was reddened</p>	<p>This observation provides a description of the wound with measurements showing the ulcer had increased in size</p>

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Number	Statement	Issues
	<p>with partial thickness of skin loss. There were areas of dark brown to black within the wound borders. The area measured 8 centimeters (cm) wide at the top and 5 cm wide at the bottom. The borders of the wound were irregular. There was no drainage or odor. The nurse indicated the area was “unstageable” and pointed to the areas of eschar. The nurse cleaned the area with saline, applied the protective dressing, and the resident was positioned onto his back at 3:44 PM. The nurse indicated the area had become larger each time the resident had returned from the hospital. Neither the treatment nurse nor NA #2 knew the last time the resident had been repositioned.</p>	<p>from the size originally noted on the care plan.</p>
5	<p>At 3:30 PM on 06/19/20XX, treatment nurse and an NA entered the room, positioned the resident onto his left side, and removed the sacral dressing. Resident #4’s sacral area was reddened with partial thickness of skin loss. There were areas of dark brown to black within the wound borders. The nurse cleaned the area with saline, applied the protective dressing, and the resident was positioned onto his back at 3:44 PM. The nurse indicated the area had become larger each time the resident had returned from the hospital. When questioned by the surveyor, neither the treatment nurse nor NA knew the last time the resident had been repositioned.</p>	<p>This piece is much like the previous piece but it does not provide a measurement for comparison to the size on the care plan when the breakdown was first noted.</p>
5	<p>At 3:50 PM on 06/19/20XX, the Director of Nursing (DON) and administrator were interviewed. Both the DON and the administrator indicated it was their expectation that Resident #4 would be turned and repositioned every two hours as indicated on the resident’s plan of care.</p>	<p>This final interview with administrative staff establishes expectations for care.</p>
5	<p>On 06/19/20XX at 4:04 PM, this writer requested the facility obtain an order from the MD for the resident to be positioned to the right side as well as the left, even though he had an ileostomy.</p>	<p>This piece should not be used because the surveyor should not tell the facility what to do.</p>

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Puzzle Pieces

Number 1

Based on record review, and family and staff interviews, the facility failed to turn and reposition one of four sampled residents (Resident #4) who were totally dependent on staff for bed mobility. Resident #4 had an unstageable pressure sore to the sacrum.

Based on observations, interviews, and record reviews, the facility failed to provide the necessary care and treatment to prevent and promote healing of pressure ulcers for a resident with a known history of pressure ulcers (Resident #4).
Findings included:

Based on record review, observations, and family and staff interviews, the facility failed to turn and reposition one of four sampled residents (Resident #4) who were totally dependent on staff for bed mobility. Resident #4 had an unstageable pressure ulcer to the sacrum.
Findings included:

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Number 2

A record review for Resident #4 revealed the resident was admitted to the facility on 04/02/20XX. The resident had admitting diagnoses of congestive heart failure, coronary artery disease, hypertension, mitral regurgitation, gout, morbid obesity, dementia, depression, history of scrotal abscess with right orchiectomy and traumatic hematuria. An assessment dated 04/09/20XX indicated the resident was severely cognitively impaired and dependent on staff for all activities of daily living.

Record review showed Resident #4 had diagnoses including anoxic brain damage, ileostomy, and diabetes mellitus. The admission Minimum Data Set (MDS) dated 04/09/20XX indicated the resident was severely cognitively impaired and totally dependent on staff for all activities of daily living. The MDS indicated the resident did not have a pressure sore.

Resident #4's record showed that he was sent out to the hospital on 04/17/20XX for fever and dehydration, and returned to the facility the same day.

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Number 3

The Care Area Assessment (CAA) summary for Pressure Sores, dated 04/19/20XX, showed the resident did not have any open pressure areas at admission. The CAA indicated there was a small area of redness on the resident's back that cleared shortly after being admitted. The CAA also showed Resident #4 was at risk for developing pressure sores because he required total assistance with bed mobility and was bed bound. The CAA indicated the resident would be care planned to "provide turning and repositioning q2h (every two hours) and prn (as needed), two-person assist with turning and repositioning (T&R), specialty mattress, weekly skin assessment."

Resident #4's care plan dated 04/20/20XX stated the resident was at risk for impaired skin integrity due to decreased mobility and bladder incontinence. The goal for this problem was that the resident would be "abrasions pressure areas, skin tears and excoriations through next review."

The Care Area Assessment (CAA) summary for Pressure Sores dated 04/19/20XX showed the resident did not have any open pressure areas at admission. The CAA indicated there was a small area of redness on the resident's back that cleared shortly after being admitted.

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Resident #4's care plan dated 04/20/20XX revealed a problem of impaired skin integrity due to decreased mobility and bladder incontinence. The goal was that the resident would be "free from pressure areas, skin tears, and excoriations through next review." The care plan directed the staff to turn and reposition the resident every two hours and as needed. Approaches also included that two or more persons should provide bed mobility to raise the resident's buttocks completely off the bed during repositioning to prevent shearing.

A record review of the physician orders dated 04/12/20XX included, "(1) Multivitamin by mouth every day. (2) Vitamin C 500 mg twice a day by mouth per wound protocol. (3) Zinc 220 mg by mouth times 14 days per wound protocol. (4) Check albumin level and total protein level in AM."

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Number 4

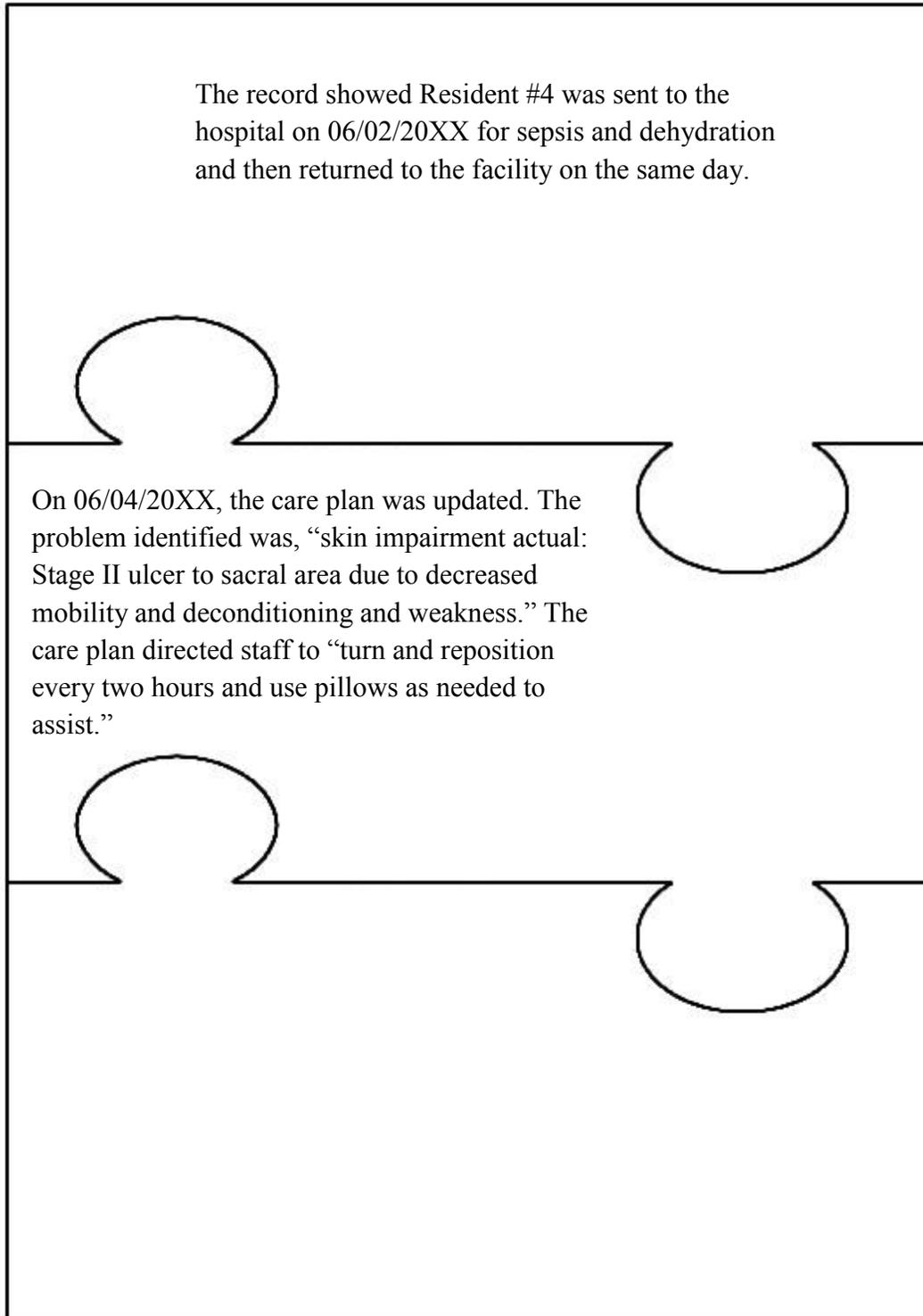
On 05/04/20XX, the care plan was updated. The problem was identified as “skin impairment actual: ulcer to sacral area.” Approaches for this problem included turning and repositioning every two hours and that pillows should be used if necessary.

The care plan was updated. The problem was identified as skin imparment actual: ulcer to sacral area.” Appraoches for this problem included turning and repositioning every two hours and that pillows should be used if necessary.

A record review of the physician orders dated 05/06/20XX revealed, “Apply mupirocin ointment (Bactroban 2% topical ointment) to sacral area three times a day.”

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Number 4



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Number 5

An interview with the direct care staff member (caring for the Resident) on 6/7/20XX at 3:45 PM revealed she was given the shift report by the prior shift direct care staff member on each resident and if she needed to know something else the nurse, would also give her report.

During initial tour of the facility on 06/19/20XX at 11:50 AM, Resident #4 was observed lying on his back in bed. There was a pressure-relieving mattress on his bed. His eyes were open, but he did not respond to verbal communication. He was moving his head from side to side.

During the initial tour of the facility on 06/19/20XX, the Resident was observed lying on his back in bed. There was a pressure-relieving mattress on his bed. His eyes were open but he did not respond to verbal communication. There was a sign on the door to encourage fluids. At 12:15 PM on 06/19/20XX, the Resident was observed lying on his back in the same position. At 1:10 PM on 06/19/20XX, the Resident was lying on his back.

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Continuous observation of Resident #4 began on 06/19/XX from 12:15 PM through 3:30 PM. At 12:15 PM the resident was observed lying on his back. During an interview at 12:30 PM on 06/19/20XX, Nursing Assistant (NA) #1 indicated that he/she was not assigned to Resident #4, but had taken care of the resident in the past. The NA indicated the resident was to be turned and repositioned every two hours and pillows were to be used to help support the resident while in the side-lying position.

At 2:00 PM on 06/19/20XX, a family member entered the room and was interviewed. The family member indicated she had visited one day last week and spent seven hours with Resident #4 and that no staff person had come in the room to turn or reposition the resident. The family member also stated that Resident #4 had a sore on his back.

At 2:50 PM on 06/19/20XX, NA #2 entered Resident #4's room with towels. NA #2 indicated she was passing linen to all residents on the hall prior to starting care. NA #2 indicated Resident #4 was to be turned every two hours and that two staff members were needed. NA #2 left Resident #4's room at 2:53 PM and indicated she would return in a few minutes with another staff person to assist in repositioning the resident. The resident continued on his back in the same position.

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At 3:30 PM on 06/19/20XX, the treatment nurse and NA #2 entered the room, positioned the resident onto his left side, and removed the sacral dressing. Resident #4's sacral area was reddened with partial thickness of skin loss. There were areas of dark brown to black within the wound borders. The area measured 8 centimeters (cm) wide at the top and 5 cm wide at the bottom. The borders of the wound were irregular. There was no drainage or odor. The nurse indicated the area was

“unstageable” and pointed to the areas of eschar. The nurse cleaned the area with saline, applied the protective dressing and the resident was positioned onto his back at 3:44 PM. The nurse indicated the area had become larger each time the resident had returned from the hospital. Neither the treatment nurse nor NA #2 knew the last time the resident had been repositioned.

At 3:50 PM on 06/19/20XX, the Director of Nursing (DON) and administrator were interviewed. Both the DON and the administrator indicated it was their expectation that Resident #4 would be turned and repositioned every two hours as indicated on the resident's plan of care.

At 3:30 PM on 06/19/20XX, the treatment nurse and NA #2 entered the room, positioned the resident onto his left side, and removed the sacral dressing. Resident #4's sacral area was reddened with partial thickness of skin loss.

There were areas of dark brown to black within the wound borders. The area measured 8 centimeters (cm) wide at the top and 5 cm wide at the bottom. The borders of the wound were irregular. There was no drainage or odor. The nurse indicated the area was “unstageable” and pointed to the areas of eschar. The nurse cleaned the area with saline, applied the protective dressing, and the resident was positioned onto his back at 3:44 PM. The nurse indicated the area had become larger each time the resident had returned from the hospital. Neither the treatment nurse nor NA #2 knew the last time the resident had been repositioned.

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On 06/19/20XX at 4:04 PM, this writer requested the facility obtain an order from the MD for resident to be positioned to the right side as well as the left even though he had an ileostomy.

