

Case-Based Activity Resident Ten  
Long-Term Care Learning Activity

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Item	Description
Objective:	Given a scenario, the surveyor will identify areas of concern, potential citations, related regulatory requirements, and write the deficient practice statement.
Prior to Class:	Print copies of the scenario. Have the long-term care regulations available. Have flip charts and markers available.
Total Time for Activity:	60 minutes (The time given is approximate.)
Set-Up:	Set class up for small groups as needed.*

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Step:	Preceptor Instructions:	Activity Time:
1.	Divide the class into small groups.*	5 min.
2.	Each group should select someone to take notes on the flip charts and be prepared to report to class. Groups must answer the questions provided.	5 min.
3.	Give the teams time to read and discuss the scenario.	25 min.
4.	As the groups are completing this task, walk around the room and listen to the conversations. Provide direction where appropriate. Warn the class when the time available is down to the last five minutes.	
5.	Debrief the scenario by discussing key points.	25 min.

*For individual assignment, provide direction and support where appropriate during the completion of the scenario. Once completed, review answers against the answer sheet, and discuss the key points together from the scenario.*

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Directions: Read the scenario components (*Observations, Document Review, Physician Review, and Interview*) and answer the questions at the end of each section using the resources provided by your preceptor. When completed, turn in your answer sheet to your preceptor to discuss and review.

Resident Ten (R10)—Sophia

*Observations*

Sophia Wiggins (R10) was admitted on 10/10/2009 after a hospitalization for treatment of acute herpes zoster.

R10 was seated in a wheelchair in her room on 10/27/2009 at 6:00 PM. R10 was wearing jeans with a red sweater. She had her corrective lenses (glasses) on. R10 complained of tooth and mouth pain to the nursing assistant during the dinner meal. The nursing assistant told the nurse of R10's complaints at 6:45 PM the same day.

On 10/27/2009 at 7:00 PM, the charge nurse talked with R10 about her complaints related to tooth and mouth pain. R10 stated that she had upper right tooth pain almost all of the time. She stated that she had been using Anbesol gel for comfort; however, the Anbesol was no longer controlling the pain. The nurse informed R10 that she would let her physician know the next time he makes rounds at the facility, which would be about one week from that day.

On 10/28/2009 at 8:45 AM, during observation of care, R10 refused to have her oral care completed by the nursing staff. R10 told the nursing staff that if they would set up her tooth brush, she would brush her own teeth after they finished with her other needs. The nursing staff assisted with R10's needs and left the room. R10 did receive oral care. She picked up her telephone and called her friend to make an appointment to see a dentist as soon as possible because the facility was going to wait for her doctor who was scheduled to visit on normal rounds.

Survey Scenario Questions 1:

1. What other observations should be made? (Document on the flip chart provided.)
2. What are the relevant diagnoses?

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3. Is the MDS information relevant to this observation? Are there additional items on the MDS that should be reviewed? If so, what?

*Document Review*

R10's physician's diagnoses consisted of the following:

- Acute herpes zoster, NOS
- Arthritis
- Cataracts
- Old myocardial infarction
- History of rheumatic fever with heart involvement
- Diabetes mellitus

During the document review, R10's nursing progress notes indicated the following:

- Oral assessment, dated 10/14/2009, identified debris in her mouth prior to going to bed at night, loose or carious teeth, inflamed gums, swollen gums, bleeding gums, oral abscesses, and ulcers or rashes; mouth pain.
- The nurses' notes, dated 10/19/2009, stated that R10 complained of a toothache, with duration of 3–4 days.
- The nurses' notes, dated 10/21/2009, stated that the resident had difficulty swallowing medication, swallowing water with her medications caused pain in her mouth. No further follow-up documentation was noted in the medication record.
- The most current care plan, dated 10/31/2009, identified "dental pain." Approaches included: a dental appointment 11/12/2009 identified several teeth on the maxillary that "hurt to tap." A cold check was within normal range; possible problems with maxillary sinus.

Survey Scenario Questions 2:

1. Are there any additional documents that the surveyor/survey team should look at or request? (Document on the flip chart provided.)

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*Physician Orders*

R10's physician's orders, dated 8/11/2009, are as follows:

Diet: Diabetic; one-half sandwich and six ounces of milk for HS snack

Accuchecks BID am and pm before meals (see flow sheet); Call physician if blood sugars are less than 60 or more than 400

Novulin N 100 unit/mL; seven units sq QAM 7:00 AM

Novulin N 100 unit/mL; one units sq QPM 6:00 PM

Toprol XL 50 mg BID 8:00 AM and 6:00 PM

Tylenol ES 500 mg TID PRN Q4hours (NTE 2000 mg per day)

Naproxen 250 mg po Q12 hours PRN for arthritis pain

Vitamin D 2000 units QAM—7:00 AM

Lanoxin 125 mcg QAM

Lasix 40 mg BID

Aspirin-low 81 mg QAM

Cardizem CD 240 mg QAM; Call MD if Pulse <50 or >120

Coumadin 2mg po Q Tues/Wed/Fri/Sat/Sun

Coumadin 3mg po Q Mon/Thurs

R10's Medication Administration Record (MAR), dated 10/2009, identified that R10 received the following medications for complaints of pain since admission;

10/11/2009—Tylenol 8:00 AM and 6:00 PM—ineffective

10/13/2009—Naproxen for arthritis pain x2

10/23/2009—Tylenol x2 for tooth pain

10/24/2009—Naproxen for tooth and jaw pain

10/24/2009—Tylenol x3 for jaw pain

10/25/2009—Tylenol x4 for tooth pain and Naproxen for jaw pain

10/26/2009—Tylenol x3 for jaw pain

10/27/2009—Naproxen for arthritis pain

Survey Scenario Questions 3:

1. What about the pain medications? Is there any other information? (Document on the flip chart provided.)

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*Interview*

The Nursing Assistant was interviewed on 10/29/2009 at 4:00 PM and stated that the resident usually doesn't complain of mouth pain when she eats. The NA stated, "If she does complain of pain we report to the charge nurse."

The Licensed Practical Nurse (LPN), when interviewed on 10/29/2009 at 4:15 PM, stated that R10 does not have the complained-of tooth or jaw pain. The LPN stated, "I know that there was one day when it was reported that when she was eating, R10 appeared to have some discomfort chewing the pork chop. I know that since R10 was admitted, I have not administered any pain medications to her for mouth pain. I know that she has a dental appointment next week that was scheduled by the Unit Manager." During an interview on 10/30/2009 at 8:00 AM, the Director of Nursing (DON) stated that facility policy states new admissions require an oral assessment at the time of admission. In addition, the DON stated that R10's dentist should have been notified of the resident having increased mouth pain.

Survey Scenario Questions 4:

1. What are your thoughts about these interviews? Is there anyone else you would want to interview? (Document on the flip chart provided.)

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Preceptor Answer Sheet

Directions: Preceptor, document your answers in the spaces below prior to completing this activity. Use this information during your debrief.

Survey Team Questions 1:

1. What other observations should be made? (Document on the flip chart provided.)

Suggested Answers:

Observations of the resident's teeth, gums, what condition?

2. What are the relevant diagnoses?

Suggested Answers:

- The cardiac diagnosis of rheumatic fever is relevant. Why?
- What about the diagnosis of diabetes mellitus?
- What are your thoughts about the herpes zoster diagnoses?

3. Is the MDS information relevant to this observation? Are there additional items on the MDS that should be reviewed? If so, what?

Suggested Answers:

- Pain assessment interview (Section J)?
- Swallowing/nutritional (Section K) status?
- Oral/dental status (Section L)?
- Any observation of pain, eating, cares?

Survey Team Questions 2:

1. Are there any additional documents that the surveyor/survey team should look at or request? (Document on the flip chart provided.)

Suggested Answers:

What is a cold check? Physician progress notes. Did the facility do a prompt referral—10/14/2009–11/12/2009 (29 days)? Is there a deficient practice? Do you know at this time?

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Survey Team Questions 3:

1. What about the pain medications? Is there any other information? (Document on the flip chart provided.)

Suggested Answers:

Resident has been receiving Tylenol and Naproxen for tooth and jaw pain. Jaw pain may be a sign of cardiac problems. What did staff do with this information?

Survey Team Questions 4:

1. What are your thoughts about these interviews? Is there anyone else you would want to interview? (Document on the flip chart provided.)

Suggested Answers:

- Concern that staff discounted resident's pain report
- Staff denies resident received medication, however, medication was given. If it was given during a different shift—what about shift reports and staff communication regarding resident condition
- Interviews could be expanded to include resident and doctor, and direct care staff on other shifts
- Seems to be a significant delay in responding to resident's need for a dental appointment