

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012		
(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 309 SS=D	<p>483.25 QUALITY OF CARE</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure indwelling urinary catheter tubing was secured to decreased the potential for trauma to the urinary meatus for 1 (Residents #4) of 2 (Residents #4 and #6) case mix residents who had indwelling urinary catheters. This failed practice had the potential to affect 2 residents with indwelling urinary catheters, as documented on the Resident Census and Conditions of Residents form dated 12/1/08. The findings are:</p> <p>1. Resident #4 had diagnoses of Advanced Parkinson's Disease, Urinary Tract Infection, Urine Retention and Alzheimer's Dementia. The resident was admitted on 11/17/08. No Minimum Data Set was available as of 12/3/08.</p> <p>a. The Physician Order dated 11/17/08 documented, "...check cath (catheter) tubing for proper placement Q (every) shift..."</p> <p>b. On 12/3/08 at 9:00 a.m., Certified Nursing Assistant (CNA) #6 and CNA #7 pulled the sheet down and exposed the resident's catheter and tubing. The resident's catheter tubing was not secured and there was blood tinged urine coming</p>	F 309			

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012	
(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 309	Continued From page 1 out of the catheter, into the drainage tube. The CNAs were asked if the blood-tinged urine was new. CNA #7 stated, "...I just noticed that this morning when I came in. That's something new." c. On 12/3/08 at 9:22 a.m., there was bright red blood in the resident's catheter tubing and the urine was amber colored. d. On 12/3/08 at 10:15 a.m., CNA #6 and CNA #7 were asked if leg bands were used on catheter tubing. CNA #7 stated, "Yes, he [Resident #4] has one, but I didn't see it." e. On 12/3/08 at 10:22 a.m., Licensed Practical Nurse (LPN) #1 was asked if the resident had any problems that morning and the LPN stated, "Well, we noticed this morning that he had blood tinged urine. We've talked to the clinic nurse and we're to get vital signs and fax to [name of physician]." When asked if leg bands were used to secure catheters in the facility, the LPN stated, "Yes." When asked if there was a leg band used on the resident, the LPN stated, "Yes, he should have one."	F 309		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012	
(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 314	<p>Continued From page 2</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure contaminated dressing supplies were not used to perform dressing changes for 1 (Resident #5) of 5 (Residents #1, #2, #4, #5 and #6) case mix residents who received pressure ulcer/wound care. This failed practice had the potential to affect 8 residents in the facility who had pressure ulcers/wounds, as documented on the Resident Census and Conditions of Residents form dated 12/1/08. The findings are:</p> <p>Resident #5 had diagnoses of Parkinson's Disease and Anorexia. The Significant Change Minimum Data Set dated 10/20/08 documented the resident had moderately impaired cognitive skills for daily decision making.</p> <p>a. A Pressure Ulcer Risk Assessment dated 10/23/08 had a total score of 13. The form documented that a score of 8 or above represented high risk.</p> <p>b. The Physician's Orders dated 12/1/08 through 12/31/08 documented:</p> <p>1) 11/4/08 Cleanse PU, Deep tissue injury heel w/ WC Pat dry w/ 4 x 4s Apply silvadene BID (twice a day)... Monitor for s/s (signs and</p>	F 314		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012	
(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 314	<p>Continued From page 3</p> <p>symptoms) of infection to heel QS (every shift).</p> <p>2) 11/24/08 - Cleanse PU State II Lt (left) buttocks w/ WC Pat dry w/ 4 x 4s. Apply celerate and combiderm change QOD.</p> <p>c. On 12/3/08 at 11:00 a.m., Licensed Practical Nurse (LPN) #1 set up the dressing tray for the the resident's pressure ulcer care. The LPN put her left hand over her mouth and touched her lips, then opened the drawer of the treatment cart and removed a package of Combiderm dressing, opened the package with both hands, dated and initialed the dressing, picked up a 30 cc (cubic centimeter) plastic cup with the left hand and then picked up gauze sponges with the right hand. The LPN then used the left hand to separate the gauze, put gauze in the cup and then closed the cart drawer with the left hand. The LPN carried the styrofoam tray with both hands into the resident's room, placed the tray on the overbed table and opened the tray. The LPN then taped a red bag to the table and went into the bathroom and washed her hands.</p> <p>d. On 12/3/08 at 11:10 a.m., LPN #1 took the gauze sponges, that were placed in the plastic cup during the wound tray set up, and wiped the resident's wound on the left heel. The resident had an approximate 1 cm (centimeter) to 2 cm necrotic scab-like area with an adjoining red, open area that was approximately 1 cm in diameter.</p> <p>e. On 12/3/08 at 1:30 p.m., LPN #1 rubbed her nose with her left hand, reached into a box of gauze on the treatment cart and removed gauze with the left hand, putting the gauze in a plastic cup and then into a styrofoam container. The</p>	F 314		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012		
(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 314	<p>Continued From page 4</p> <p>LPN removed a tube of cellerate with the left hand and put the cellerate in a plastic cup, holding the tube in the left hand. The cup was then placed in the styrofoam container and the LPN put a Q tip in the cup of cellerate.</p> <p>A Combiderm dressing was removed by the LPN from the drawer, then opened, dated and placed into the container. The LPN then separated the dressing supplies into a second styrofoam container, closed the lids and drawer and carried the trays into the resident's room. The LPN washed her hands at 1:46 p.m., after she had touched the dressing supplies with her left hand. The LPN was asked what stage the heel wound was and she stated, "Unstageable and an open area Stage II."</p> <p>f. On 12/3/08 at 2:10 p.m., LPN #1 opened the styrofoam dressing containers, removed the gauze from the cup and wiped the pressure sore on the resident's left buttock. The wound was an open area approximately 3 cm, with an approximately 4 cm reddened area surrounding the tissue. The LPN then picked up the plastic cup with the cellerate and used the Q tip to apply the cellerate to the wound. The LPN was asked what stage the wound was and she stated, "Stage II."</p> <p>g. On 12/3/08 at 2:27 p.m., LPN #1 was asked if pressure sore/wound dressings were to be clean or aseptic when doing care; the LPN stated, "Yes." The LPN was asked if hands should be washed when the mouth or nose is touched before touching dressing supplies. The LPN stated, "Yes." When asked if contaminated supplies should be used on a resident for wound care and what should be done if the supplies</p>	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012	
(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 314	Continued From page 5 were contaminated with touch, the LPN stated, "No. They should be thrown away." h. On 12/3/08 at 3:55 p.m., the Director of Nursing (DON) was asked if the mouth or nose was touched, should dressing supplies be touched without washing or sanitizing hands. The DON stated, "You shouldn't touch the supplies." When asked if contaminated supplies should be used for pressure ulcer care and the DON stated, "Start over and get new ones." i. The facility's procedure for Aseptic Dressings, received from the DON at 3:30 p.m. on 12/3/08, documented: "...The purposes of this procedure are to provide guidelines for aseptic dressing changes to protect wounds ...and to prevent the introduction of bacteria. ...1. Wash your hands thoroughly before beginning the procedure. ...15. Using aseptic technique, open other products (i.e. prescribed dressing, gauze)..."	F 314		
F 315 SS=D	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 observation, record review and interview, the facility failed to ensure front to back	F 315		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012		
(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 315	Continued From page 6 cleansing motions were used during incontinent care to decrease the potential for urinary tract infections for 1 (Resident #2) of 5 (Residents #1, #2, # 3, #5 and #6) case-mix residents who were incontinent. This failed practice had the potential to affect 42 residents who were occasionally or frequently incontinent of bladder and 13 residents who were occasionally or frequently incontinent of bowel, as documented on the Resident Census and Conditions of Residents form dated 12/1/08. The findings are: 1. Resident #2 had diagnoses of Parkinson's Disease, Left Hip Fracture and Degenerative Disc Disease. The Minimum Data Set dated 10/28/08 documented the resident had modified independence in cognitive skills for daily decision making, was totally incontinent of bowel and bladder and required extensive physical assistance of two persons for toilet use. a. On 12/3/08 at 9:10 a.m., Certified Nurse Assistant (CNA) #3 performed urinary incontinent care for the resident. The CNA spread and cleansed the mid labia area back-to-front 3 times, cleansing from mid labia toward and over the urinary meatus. b. On 12/3/08 at 9:30 a.m., CNA #3 was asked, "How were you trained [to do incontinent care], in what direction should you cleanse?" CNA #3 stated, up in the front... I cleaned up (back to front) in the front..." When asked, "What can happen when you cleanse that way (back to front)?" the CNA stated, "Infections." 2. The facility Policy and Procedure for "Perineal Care," provided by the facility on 12/3/08, documented: "...Steps in the procedure: ...9. For	F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012	
(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 315	Continued From page 7 a female resident: ...b. Wash perineal area, wiping from front to back. (1) Separate labia and wash area downward from front to back..."	F 315		
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the head of the bed was elevated while an enteral feeding solution was infusing to decrease the potential for aspiration for 1 of 1 (Resident #6) case mix resident who had a Percutaneous Endogastrostomy (PEG) tube. This failed practice had the potential to affect 3 residents in the facility who had PEG tubes, as identified by the Resident Census and Conditions of Residents form dated 12/1/08. The findings are: 1. Resident #6 had diagnoses of Cerebrovascular Accident (CVA), Congestive Heart Failure (CHF) and Diabetes Mellitus. The Quarterly Minimum Data Set (MDS) dated 10/2/08 documented the resident was severely impaired in cognitive skills for daily decision making and was totally dependent for all activities of daily living and had a feeding tube. a. On 12/2/08 at 8:35 a.m., upon entering the	F 322		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012	
(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 322	Continued From page 8 room to observe incontinent care, the head of the resident's bed was flat and the feeding pump was infusing the feeding at 80 cubic centimeters (cc) per hour. The head of the bed remained in the flat position until the incontinent care was completed by Certified Nursing Assistant (CNA) #1 and CNA #2 at 9:05 a.m. b. On 12/4/08 at 9:50 a.m., when asked, "Do you leave the pump on when doing care on a resident with a PEG tube? CNA #1 stated, "Yes, we don't touch the pump." 2. The Policy and Procedure for Gastric Tube Feeding via Continuous Pump documented, "...Steps in the Procedure ...4. Always keep resident receiving continuous feedings in semi-Fowler's or higher position with head of bed (HOB) elevated 30 degrees..."	F 322		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION 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 observation, record review and interview, the facility failed to ensure the axillae were not used to reposition and the axillae and clothing were not used to perform transfers to decrease the potential for injury for 1 (Resident #5) of 3 (Residents #2, #3 and #5) case mix residents who required physical assistance with	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012	
(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 323	<p>Continued From page 9</p> <p>transfers. This failed practice had the potential to affect 5 residents in the facility who were non-weight bearing and required the physical assistance of two persons for transfers, as documented by the Director of Nursing on 12/4/08. The findings are:</p> <p>Resident #5 had diagnoses of Osteoarthritis, Osteopenia and Alzheimer's Disease. The Significant Change Minimum Data Set dated 10/20/08 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive physical assistance of two persons for transfers, was unable to attempt a test for balance while standing without physical assistance, had functional limitation in range of motion of bothlegs with partial loss of voluntary movment, had hip pain in the last seven days and had fallen in the last 31 to 180 days.</p> <p>a. On 12/2/08 at 8:20 a.m., the resident was seated in a wheelchair; Certified Nursing Assistant (CNA) #4 and CNA #5 each placed an arm underneath each of the resident's axillae and lifted up under the resident's arms to reposition the resident in the wheelchair. The resident's feet were sliding across the floor and the resident was not weight bearing.</p> <p>b. On 12/2/08 at 8:50 a.m., CNA #4 and CNA #6 each placed an arm underneath the resident's axillae and lifted up to transfer the resident from a wheelchair to the bed. Each CNA had their other hand on the back of the resident's pants waistband and pulled on the resident's pants when the resident was lifted up from the wheelchair. The resident's knees were bent and the resident's feet slid across the floor. The</p>	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012	
(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 323	Continued From page 10 resident made no attempt to assist with the transfer. c. On 12/3/08 at 2:40 p.m., when asked if the resident's clothing or pants waistband should be used to help lift or transfer the resident, CNA #6 stated, "If they can't really stand it might be best and then it might not be best. You don't yank hard." d. On 12/3/08 at 3:55 p.m., the Director of Nursing (DON) was asked how resident's were to be transferred if they needed physical assistance. The DON stated, "They [CNAs] are suppose to be using their gait belt and can put their hand behind them. If they [resident] are not full weight bearing, they [CNAs] should use a lift." When asked if the resident's clothing or pants waistband should ever be used to lift the resident, the DON stated, "No, that's why we've got the gait belt." e. The facility's procedure for moving a resident from chair to bed was received 12/3/08 at 3:30 p.m. from the DON and documented, "...e. If the resident cannot stand alone, two persons (one on each side) should lock arms with the resident, gently stand and turn the resident and sit him or her on the edge of the bed. f. If the the resident can assist in this procedure, stand on the resident's weak side. (Note: Encourage the resident to use his or her strong side and to assist in the procedure as much as possible.) g. Support the resident by placing a belt around the resident's waist for you to hold and steady the resident..."	F 323		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012		
(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 329	<p>Continued From page 11</p> <p>drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure dosage tapering was attempted to determine if symptoms or conditions could be managed by a lower dose or indicate clinical justification that dosage reductions were clinically contraindicated or failed to ensure residents were free of medications used for excessive duration and without adequate indications for use for 1 (Resident #1) of 3 (Residents #1, #4 and #9) case mix residents who received proton pump inhibitor medications. This failed practice had the potential to affect 14 residents in the facility who received PPI's</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012		
(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 329	Continued From page 12 according to the Director of Nursing (DON) on 12/3/08. The findings are: Resident #1 had diagnoses of Alzheimer's Disease, Osteoporosis and Parkinson's. The Quarterly Minimum Data Set (MDS) dated 9/18/08 documented the resident had modified independence in cognitive skills for daily decision making and required extensive assistance with activities of daily living. a. The Physician order dated 6/30/08 documented, Omeprazole 20 milligrams (mg) 1 per mouth (PO) every (Q) day. b. The Consultant Pharmacist Monthly Report dated 10/6/08 to the physician documented: "...Finding: This resident has been receiving omeprazole 20 QOD (every other day) since 6/30/08 for GERD (gastroesophageal reflux disease) ...Response: Cont (continue) Rx (Prescription) for GERD. c. On 12/4/08, the DON was asked what the process was for dose reductions on PPIs and who was responsible for this. She stated that a pharmacist came monthly and a letter was sent to the doctors and she was responsible for this process.	F 329			
F 333 SS=E	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to follow physician	F 333			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012		
(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 333	<p>Continued From page 13</p> <p>orders to ensure residents were free of significant medication errors for 2 (Residents #17 and #18) of 16 (Residents #1 through #14, #17 and #18) case mix residents who received medications. This failed practice had the potential to affect 4 residents who received Depakote Sprinkles and 8 residents on Xopenex Updraft medications, according to the Director of Nursing (DON) on 12/4/08. The findings are:</p> <p>1. Resident #17 had a diagnosis of Schizophrenia and a physician order dated 11/17/08 for Depakote Sprinkles 750 mg (milligrams) po (by mouth) bid (two times a day).</p> <p>a. On 12/4/08 at 7:53 a.m., during the 8:00 a.m. medication pass, LPN #1 administered Depakote Sprinkles 125 mg - 5 capsules for a total of 625 mg. The Provider Pharmacy bubble pack contained Depakote Sprinkles 125 mg - 2 capsules in one and Depakote Sprinkles 125 mg - 3 capsules in the other for a total of 625 mg.</p> <p>b. On 12/4/08 at 11:00 a.m., the DON stated, "The provider pharmacy said no, they had never sent anything except Depakote Sprinkles 125 mg - 5 capsules."</p> <p>c. This was a significant medication error due to the condition of the resident (Schizophrenia) and the frequency of the error.</p> <p>2. Resident #18 had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and a physician order dated 9/10/08 for Xopenex updraft 1.25 mg 1 updraft bid.</p> <p>a. On 12/14/08 at 9:13 a.m., during the 8:00 a.m. medication pass, LPN #3 administered Xopenex</p>	F 333			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012	
(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 333	Continued From page 14 0.63 mg. b. On 12/4/08 at 11:00 a.m., the DON stated, "The provider pharmacy said no, they had never sent anything except Xopenex 0.63 mg. c. This was a significant medication error due to the condition of the resident (Chronic Obstructive Pulmonary Disease) and the frequency of the error.	F 333		
F 364 SS=C	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure resident foods were palatable and coffee was served at a temperature acceptable to the residents. This failed practice had the potential to affect the 67 residents who received a tray from Dietary, according to the Diet Roster dated 12/1/08. The findings are: 1. On 12/2/08 at 11:00 a.m., in the Group Meeting, 4 of 6 alert and oriented residents stated that the coffee was served cold and one resident stated that she felt the cooks did not follow the recipes. a. The Resident Council Minutes for November, 2008 documented, "Temperature of coffee in dining room and after coffee reaches room on hall	F 364		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012	
(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 364	<p>Continued From page 15 cart=cold."</p> <p>b. On 12/2/08 at 12:50 p.m., the coffee on a test tray registered 130 degrees Fahrenheit (F) It was drinkable, but not hot.</p> <p>c. On 12/2/08 at 1:00 p.m., the Registered Dietitian stated that the coffee was not to be served at less than 120 degrees F. The Nurse Consultant stated that none of this group's buildings would ever serve coffee at more than 140 degrees F.</p> <p>d. The Consultant Dietitians in Health Care Facilities, a Dietetic Practice Group of the American Dietetic Association, Volume 30/ Number 2 page 3 documented, "Coffee needs to be brewed at 195 degrees to 205 degrees F to extract the full flavor. Holding coffee between 175 degrees F and 190 degrees F will maintain its fresh brewed flavor over a limited period of time."</p> <p>2. On 12/2/08 at 12:50 p.m., 5 surveyors tasted the food on a test tray; the potatoes and the carrots did not taste like they had been seasoned. The potatoes were fresh potatoes, but still tasted flat without salt and butter.</p> <p>a. At 1:15 p.m., in the dining room, 10 of 10 trays checked after the meal had the carrots left on the plate.</p> <p>b. The recipe for the New Red Potatoes documented 2 ounces of salt and 2/3 cup of margarine.</p> <p>c. The recipe for the Sliced Carrots documented 2/3 cup margarine and salt to taste.</p>	F 364		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012	
(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 364	Continued From page 16 d. On 12/2/08 at 2:00 p.m., the Dietary Manager stated that she did not know if the Cook added butter and salt or how much she added. She agreed the vegetables did not taste seasoned.	F 364		
F 502 SS=E	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure physician orders for laboratory tests were followed for 2 (Residents #2 and #5) of 8 (Residents #2 through #9) case-mix residents who had physician orders for lab. This failed practice had the potential to affect 53 residents in the facility who had physician orders for lab, as documented on a list provided by the Assistant Director of Nurses on 12/3/08. The findings are: 1. Resident #2 had diagnoses of Parkinson's Disease, Left Hip Fracture, Congestive Heart Failure and Stage II Pressure Ulcer. The Minimum Data Set dated 10/28/08 documented the resident had modified independence in cognitive skills for daily decision making. a. A Physician order dated 11/13/08 documented: "...Give Juven [one]packet in 4 [ounces] of liquid [twice a day]. Draw albumin and pre-albumin on 11/14/08." b. An untitled document dated 11/17/08 and signed by the Assistant Director of Nurses (ADON) documented: ...Lab was drawn on	F 502		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012	
(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 502	<p>Continued From page 17</p> <p>11/14/08 Albumin and Pre-Albumin with MD (medical doctor) notified of lab results...</p> <p>c. On 12/3/08 at 9:40 a.m., the Director of Nurses (DON) stated there was no pre-albumin and no albumin drawn on the resident.</p> <p>d. On 12/3/08 at 11:25 a.m., the ADON stated, "All I can say is, I wrote on the wrong person. I double checked with the lab and there was no lab on [Resident #2]."</p> <p>e. On 12/4/08 at 8:15 a.m., when asked, "What is your system for ensuring labs are drawn as ordered?" The DON stated, "We have the lab clip board [where] we put the labs that need to be drawn so when the lab comes in they look at that to see what needs to be drawn. The next morning after they [lab] come, I print the lab that was done." When asked, "Did [Resident #2] get put on the list to be done?" The DON stated, "No..." When asked, "What was the reason for the lab order?" The DON stated, "Because she had a wound."</p> <p>2. Resident #5 had diagnoses of Anorexia, Alzheimer's Disease, Pressure Sores and Skin Tear. The Significant Change Minimum Data Set dated 10/20/08 documented the resident had moderately impaired cognitive skills for daily decision making and had a recent weight loss.</p> <p>a. A Physician's Order dated 11/11/08 documented, "Draw pre-albumin and albumin level on 11/12/08..."</p> <p>b. On 12/2/08 at 3:00 p.m., review of the clinical record provided no documentation of a pre-albumin or albumin level done on the</p>	F 502		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012	
(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 502	<p>Continued From page 18</p> <p>11/12/08 date. The last albumin level documented in the record was dated 11/3/08 with a below result of total protein 5.4 (normal range 5.1-7.9) and serum albumin of 2.8 (normal range 3.5-4.8). The next lab reports were dated 11/13/08 and did not include albumin or pre-albumin levels.</p> <p>c. On 12/3/08 at 10:30 a.m., the Director of Nursing (DON) was asked if the albumin and pre-albumin ordered for 11/12/08 was done; the DON stated, "No." When asked if there was a requisition sent to the lab, the DON stated, "So far no. We have a log and [resident's spouse] is signed out." The DON was asked if the resident's spouse was also a resident and had albumin levels ordered; the DON stated, "I don't see where she has an order to get it drawn." The DON was asked how it is known if a resident had lab drawn and the DON stated, "Log."</p> <p>d. On 12/3/08 at 10:47 a.m., a laboratory requisition dated 11/12/08 was received from the DON for the resident's spouse. The requisition documented, "...added pre-albumin and albumin..." A copy titled, Diagnostic Testing Log received from the DON documented no listing for the resident for lab drawn on 11/12/08.</p> <p>e. On 12/3/08 at 12:50 p.m., when asked if there was any documentation that the lab ordered for 11/12/08 was done, the DON stated, "No, it was done on her [resident's wife]."</p> <p>f. On 12/4/08 at 8:05 a.m., the DON was asked what the diagnosis or problem the resident had to need albumin levels ordered. The DON stated, "Weight and wounds."</p>	F 502		