

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

PRINTED: 04/30/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045158	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/02/2007
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER - HEBER SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 1040 WEDDINGFORD RD HEBER SPRINGS, AR 72543	
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F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>Complaint # 12365 substantiated (all or in part) with deficiencies cited at F312, F332 and F502.</p> <p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to follow a physician order for a therapeutic diet for 1 (Resident #10) of 4 (Resident #1, 2, 10 and 11) case mix residents who had orders for therapeutic diets. This failed practice had the potential to affect 40 residents on therapeutic diets as identified by a diet list provided by the dietary manager on 2/26/07. The findings are:</p> <p>Resident #10 had a diagnosis of Clostridium Difficile. The MDS (Minimum Data Set) dated 1/26/07 documented, the resident was modified independent in cognitive skills for daily decision making, had no documented chewing or swallowing problems and required limited assistance with meals and ADLs (Activities of Daily Living).</p> <p>a. A physician order dated 1/26/07 documented, "add yogurt to all meals".</p> <p>b. The resident was not served yogurt with her meals on 2/26/06 at 6:40 p.m., 2/27/07 at 8:31 a.m. and 2/27/07 at 12:35 p.m.</p>	F 282		4/1/07

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 282	Continued From page 1	F 282			
F 309 SS=E	<p>c. On 2/27/07 at 8:31 a.m., the resident informed the DON (Director of Nurses) that she wanted some yogurt because she did not feel like she could eat her breakfast. The DON left the room stating she would see if there was any yogurt in the kitchen. The DON did not return to the room with the yogurt.</p> <p>d. On 2/28/07 at 11:28 a.m., the dietary manager stated the facility was out of yogurt.</p> <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 all areas of the perineum were cleansed during Foley catheter care and Foley catheter tubing was secured to prevent potential trauma to the urinary meatus for 1 (Resident #9) of 3 (Resident #9, 11 and 12) case mix residents with catheters. This failed practice had the potential to affect 7 residents with catheters as identified by a list provided by the Director of Nursing (DON) on 3/2/07. The findings are:</p> <p>Resident #9 had diagnoses of Peripheral Vascular Disease and Urinary Retention. The MDS dated 1/5/07 documented, the resident was</p>	F 309		4/1/07	

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F 309	Continued From page 2 moderately impaired in cognitive skills for daily decision making and was continent of bowel and had an indwelling urinary catheter. On 3/1/07 at 9:30 a.m., Certified Nursing Assistant (CNA) #6 provided catheter care. The resident was positioned on her back and the groin area was cleaned with soapy water, rinsed and dried. The CNA held the urinary catheter tubing at the insertion site and washed from insertion site outward. The labia minora was not separated, washed or rinsed. The surveyor asked the CNA if she was finished providing catheter care she stated, "yes". The Foley catheter tubing was not secured to prevent potential trauma to the urinary meatus.	F 309			
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Complaint #12365 Substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure all areas of the perineum were cleaned and the area of the wash cloth was changed while providing incontinent care for 3 (Resident #2, 1 and 8) of 7 (Resident #1, 2, 4, 6, 8, 16 and 17) case mix residents who were dependent on staff for incontinent care. This failed practice had the potential to affect 32 residents dependent on staff	F 312		4/1/07	

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F 312	Continued From page 3 for incontinent care as identified by lists provided by the Director of Nursing on 3/2/07. The facility further failed to ensure 1 case mix resident (Resident #8) was assisted with meals as needed and food was mechanically altered to a consistency that was ordered by a physician. This failed practice had the potential to affect 58 residents who required staff assistance with eating as documented on the Resident Census and Conditions of Residents form 2/26/07. The findings are: 1. Resident #8 had diagnoses of Senile Dementia with Psychosis and Osteoarthritis. The Quarterly Minimum Data Set (MDS) dated 11/7/06 documented, the resident was severely impaired in cognitive skills for daily decision-making, was dependent on staff for toileting and personal hygiene and incontinent of bowel and bladder. a. The Plan of Care dated 2/7/07 documented, "Requires extensive assist with toilet use, personal hygiene". b. On 2/28/07 at 10 a.m., the resident had been incontinent of urine. Certified Nursing Assistant (CNA) #1 removed the urine saturated incontinent brief and wiped the posterior upper thighs, anal area and buttocks with a wash cloth using the same area of the cloth for each swipe. The anterior perineal area was not cleaned. A new incontinent brief was applied. c. A physician order dated 1/19/07 documented, "Regular no salt packet with finger foods". d. The Plan of Care dated 2/7/07 documented, "At nutritional risk related to recent wt. (weight) loss... Serve ice cream at lunch and supper."	F 312			

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F 312	Continued From page 4 e. On 2/27/07 at 12:30 p.m., the Dietary Tray card documented, "Red Napkin. Make sandwiches for finger foods. Right hand curved spoon for food in bowls. Fluids in sippy cup. Serve resident finger foods when possible. Ice cream at lunch and supper 1 oz.(ounce) melted margarine on food at each meal". f. On 2/26/07 at 5:15 p.m., supper consisted of red beans and rice in a bowl, mashed potatoes in a bowl, cornbread, 2 slices of light bread, margarine pat, ice cream cup and milk and water in Kennedy (sippy) cups. The tray was placed in front of the resident. The margarine pat was not placed on the food. The resident used her hands and picked up the food and attempted to put the food in her mouth. Large amounts of the food landed on the her lap and the floor. The cornbread crumbled into pieces and landed on the floor. When the resident had removed most of the food from the bowls, the staff assisted the resident to leave the dining room. The ice cream cup was not opened or offered to the resident. The meal intake record documented the resident consumed 100%. g. On 2/27/07 at 7:00 a.m., breakfast consisted of scrambled eggs, sausage patty, a biscuit with 1 oz butter and a packet of diet jelly on a regular plate, grits in a bowl, milk and coffee in sippy cups and cranberry juice in a regular 4 ounce glass. The resident attempted to use the curved spoon to eat but was unable to manipulate the utensil. The Unit Manager stated, "she probably would do better if she had a plate guard". The resident picked up the food with her fingers and ate the biscuit without difficulty. The scrambled eggs were squishing between her fingers and	F 312			

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F 312	<p>Continued From page 5</p> <p>dropping onto her lap and the floor. She attempted to eat the grits with her fingers by dipping them in the bowl and sucking her fingers. LPN #1 was assisting another resident at the table and handed her the juice in a regular glass. Her hands were shaking and approximately 1/2 of the juice sloshed out of the glass. LPN #1 added salt and pepper to the remainder of the scrambled eggs left on the plate and spoon fed the eggs to the resident. The meal intake record documented the resident consumed 100%.</p> <p>h. On 2/27/07 at 12:30 p.m., lunch consisted of fish filet, stewed tomatoes with okra, fortified mashed potatoes, cornbread, vanilla pudding, ice cream cup. The resident attempted to eat lunch with her fingers picking up pieces of food and squishing the food between her fingers. The cornbread crumbled and the majority of the food ends up on the resident, table or floor. The tablemate had a tray consisting of finger food of vegetable sticks and egg rolls. The Unit manager stated, "We need to get an order for [name of resident] to have finger foods. At 1:15 p.m., CNA #1 spoon fed the resident the pudding. The ice cream was not opened or offered.</p> <p>i. On 3/1/07 at 12:35 p.m., lunch consisted of chopped steak, chopped baked potato, roll, cake and ice cream. A plate with a plate guard which was set down in front of the resident with the plate guard along the right edge of the plate instead of in front of the resident. The majority of the food ends up on the resident, table or floor. The ice cream was melted and was spoon fed to resident.</p> <p>2. Resident #2 had diagnoses of Fracture Neck of Femur and Neurogenic Bladder. The MDS dated</p>	F 312			

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F 312	Continued From page 6 1/3/07 documented the resident was moderately impaired in cognitive skills for daily decision making and incontinent of bowel and bladder. On 2/28/07 at 10:00 a.m., CNA #5 provided incontinent care. She cleaned feces from the rectal area with Peri-wash, wiping from front to back, then rinsed and dried the area. The buttocks were not washed. The resident was turned on his back and the pubic area was washed, rinsed and dried. The penis and scrotum was not cleaned and the foreskin was not retracted. 3. Resident #1 had a diagnosis of Alzheimers Disease. The quarterly MDS dated 2/27/07 documented, the resident was severely impaired in cognitive skills for daily decision making ability, was incontinent of bowel and bladder and was dependent on staff for personal hygiene. a. The plan of care dated 2/27/07 documented: "at risk for complications such as UTI (Urinary Tract Infection) and Pressure Ulcers related to bowel and bladder incontinence". b. On 2/27/07 at 9:10 a.m., CNAs #5 and 6 provided incontinent care. CNA #5 stated that the gown was soaked with urine. She washed the rectal area but did not wash the buttocks.	F 312			
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	F 315		4/1/07	

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F 315	<p>Continued From page 7</p> <p>treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure a back to front motion was not used during incontinent care for 1 (Resident #7) of 6 (Resident #1, 2, 6, 8, 16 and 17) casemix residents who were incontinent of bowel and bladder and required extensive assistance with personal hygiene. This failed practice had the potential to affect 32 residents requiring assistance with incontinent care as identified by a list provided by the Director of Nursing on 3/2/07. The findings are:</p> <p>Resident #7 had a diagnosis of Congestive Heart Failure. The MDS (Minimum Data Set) dated 1/03/07 documented, the resident was modified independent in cognitive skills for daily decision making, incontinent of bowel and bladder and required extensive assistance for personal hygiene.</p> <p>a. A urinalysis with a culture and sensitivity dated 12/15/06 documented, the resident had a urinary tract infection with Escherichia Coli bacteria.</p> <p>b. On 2/27/07 at 2:38 p.m., CNA (Certified Nursing Assistant) #7 provided incontinent care. The CNA cleaned the rectal area and there was a brown substance on the cloth. The CNA wiped from the rectal area toward the vagina each time. The resident was positioned on her back. The CNA cleaned the vaginal and pubic area wiping from the rectal area up the vagina.</p>	F 315			

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F 332 SS=E	<p>483.25(m)(1) MEDICATION ERRORS</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # 12365 substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview of the 8:00 a.m. and 12:00 p.m. medication passes on 3/1/07, the facility failed to ensure that the medication error rate was less than 5%. Physicians orders were not followed on 4 residents (Residents #22, #12, #1 and #23) of 9 case mix residents observed during the medication passes resulting in errors. Medication errors were made by 3 Licensed Practical Nurses (LPN) (LPN #2, #3 and #4) of 3 licensed nurses observed administering medications in the facility. This failed practice had the potential to affect 103 residents according to the Administrator on 3/1/07 at 2:26 p.m. The medication error rate was 14.89% based on administration of 46 medications and 1 omission for a total of 47 medications with 7 medications observed. The findings are:</p> <p>1. Resident #22 had a physician order dated 8/16/06 for Multivitamin with Mineral one tablet by mouth (po) daily.</p> <p>On 3/1/07 at 8:02 a.m., during the 8:00 a.m. medication pass, LPN #2 administered all the schedule medications except for the Multivitamin with Minerals.</p>	F 332		4/1/07	

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F 332	<p>Continued From page 9</p> <p>2. Resident #22 had a physician order dated 8/25/06 for Magnesium 400 milligrams (mg) po (by mouth) every other day.</p> <p>On 3/1/07 at 8:50 a.m., LPN #2 administered Magnesium 3 tablet (400 mg) with Zinc 15 mg.</p> <p>3. Resident #12 had a physician order dated 5/23/05 for Advair Diskus 250/50 1 inhalation two times a day (bid) and 2/21/07 for Spiriva 18 milligrams (mg) 1 cap inhalation daily.</p> <p>a. On 3/1/07 at 9:03 a.m., LPN #3 administered the Spiriva inhaler in less than 30 seconds after administering the Advair 250/50.</p> <p>b. On 3/1/07 at 9:04 a.m., the surveyor asked LPN #2 how long she should wait between inhalations. LPN #3 stated, "1 (one) minute, which I didn't do."</p> <p>c. According to the Centers for Medicare and Medicaid Services (CMS) Medications Administered Via Metered Dose Inhalers (MDI): >If more than one puff is required, (whether the same medication or a different medication) wait approximately a minute between puffs.</p> <p>4. Resident #12 had a physician order dated 5/23/05 for Fibercon 625 mg 1 tablet po with 8 ounces of liquid bid.</p> <p>a. On 3/1/07 at 9:03 a.m., LPN #3 administered FiberCon 625 mg with 3 sips of water.</p> <p>b. According to the Goodsense brand label on the bottle documents: Warnings; Choking: Taking this product without adequate fluid may cause it to swell and block your throat or</p>	F 332			

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F 332	Continued From page 10 esophagus and may cause choking. Directions: Take each dose of this product with at least 8 ounces (a full glass) of water or other fluid. Taking this product without enough liquid may cause choking. 5. Resident #1 had a physician order dated 10/21/02 for Vitamin C 500 mg 2 tablets po every day. On 3/1/07 at 9:38 a.m., LPN #4 administered Vitamin C 250 mg 2 tablets. 6. Resident #1 had a physician order dated 2/13/07 for Artificial Tears, 2 drops in both eyes four times a day. a. On 3/1/07 at 9:36 a.m., LPN #4 administered 2 drops in the right eye and 2 drops in the left eye without allowing any time between drops. b. On 3/1/07 at 3:47 p.m., the surveyor asked the LPN #4 did you administer 2 drops in each eye? LPN #3 stated, "Yes." The surveyor asked if she waited to administer between drops, she stated., "No, I did not think you had to with the same drops." c. According to Medicare and Medicaid Services (CMS) Medications instilled into the eye, the drop must contact the eye for a sufficient period of time before the next eye drop is instilled. The time for optimal eye drop absorption is approximately 3 to 5 minutes. (It should be encouraged that when the procedures are possible, systemic effects of eye medication can be reduced by pressing the tear duct for approximately three minutes after the administration).	F 332			

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F 332	Continued From page 11 7. Resident #23 had a physician order dated 9/6/06 for Oyster Shell Calcium 500 mg 1 tablet po tid (three times a day). On 3/1/07 at 11:34 a.m., LPN #4 administered the Calcium 500 mg with Vitamin D.	F 332			
F 363 SS=B	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the planned menu as written for the breakfast meal on 2/27/07 was followed. The deficient practice had the potential to affect 82 residents receiving a tray without restricted sweets from Dietary according to the Diet Roster dated 2/26/07. The findings are: a. The menu for the breakfast meal dated 2/27/07 documented: Assorted Jelly Packet to be served for regular diets b. The Weight Changes Report dated 2/07 documented, Resident #6 who had a 22.54% weight loss in 180 days and Resident #8 who had a 20.33% weight loss in 180 days. c. On 2/27/07 at 7:30 a.m., Resident #6 and #8 received diet jelly.	F 363		4/1/07	

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F 363	Continued From page 12	F 363			
F 365 SS=E	<p>483.35(d)(3) FOOD</p> <p>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure beverages were thickened to meet the individual needs as required by the physician orders for 2 (Resident #1 and 2) of 4 (Resident #1, 2, 3 and 6) case mix residents who had a physician order for thickened liquids. The facility failed to ensure the food was prepared and served at the correct consistency for 1 (Resident #3) of 6 (Resident #1, 2, 3, 5, 6 and 7) case mix residents with physician orders for a mechanically altered diet. These deficient practices had the potential to affect 7 residents with physician ordered diets for thickened liquids and 39 residents with physician ordered mechanically altered diets as documented on the Diet Roster dated 2/26/07. The findings are:</p> <p>1. Resident #3 had diagnoses of Diabetes Mellitus and Senile and Presenile Dementia. The Quarterly Minimum Data Set (MDS) dated 1/3/07 documented, the resident was moderately impaired in cognitive skills for daily decision-making, had a chewing and a swallowing problem and required 1 person to assist for</p>	F 365		4/1/07	

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F 365	Continued From page 13 eating. a. A Functional Maintenance Plan by the physician dated 12/22/06 documented, "Facility is to maintain that the patient continues to demonstrate safe swallow strategies." Do 2 times a week x 6 weeks. b. The Plan of Care dated 2/14/06 and updated on 1/3/07 documented, "Interventions-Diet as ordered. The Plan of Care did not address the chewing and swallowing problem or the need for a pureed diet." c. A Physician order dated 1/12/07 documented, Remind unit CNAs (Certified Nursing Assistants) that resident is to take small bites, little sips, don't talk while eating. Do 2 times a week x 6 weeks. d. A Physician order dated 2/26/07 documented, "Pureed Diet. Observe for choking at meals." e. On 2/27/07 at 7:30 a.m., breakfast consisted of a mechanical soft diet of scrambled eggs, ground meat, biscuit, diet jelly, butter patty, cream of wheat. The biscuit was very hard and burned. f. The diet card on 2/27/07 at 7:30 a.m. documented, "Puree Consistent Carbohydrate Diet with Nectar Thick Liquids". 2. Resident #2 had diagnoses of Fracture Neck of Femur and Neurogenic Bladder, Organic Brain Syndrome and Dysphagia. The MDS dated 1/3/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance for eating and had chewing and swallowing problems.	F 365			

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F 365	<p>Continued From page 14</p> <p>a. The Care Plan dated 10/3/06 and updated on 1/3/07 documented: "Risk for choking and needs mechanically altered therapeutic diet due to chewing and swallowing difficulty. Nectar thick liquids".</p> <p>b. The initial Physician order dated 10/12/06 and the current orders dated 2/2007 documented, "Mech (Mechanical) Soft with Extra Protein Portions with Nectar Thix (Thick) Liquids".</p> <p>c. On 2/27/07 at 7:15 a.m., the breakfast meal consisted of coffee, juice and milk. The resident was sipping his coffee with his spoon. The coffee and juice did not appear to be thickened. During breakfast the Surveyor asked the ADON (Assistant Director of Nursing) if the coffee and juice was thickened. She stated the coffee and juice were not thickened.</p> <p>2. Resident #1 had a diagnosis of Alzheimer Disease. The quarterly MDS dated 2/27/07 documented, the resident was severely impaired in cognitive skills for daily decision making, had difficulty with chewing and swallowing and was totally dependent on staff for eating.</p> <p>a. A physician order dated 8/31/04 documented: "Puree no salt pkt (packet) w/food (with food) & (and) liquids at pudding consistency (sic)".</p> <p>b. As of 2/28/07 at 5:23 p.m., the plan of care and diet card documented: Puree NSP (no salt packet) w/pudding (with pudding) thickened liquids.</p> <p>c. On 2/28/07 at 5:23 p.m., LPN (Licensed Practical Nurse #5) started to give the resident 120 cc (cubic centimeters) of Med Pass from a</p>	F 365			

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F 365	Continued From page 15 cup without thickening the liquid. When asked by the surveyor if it should be thickened the LPN replied, "she always takes it ok this way...", "...well, I guess it should be thickened" and left the room with the Med Pass stating she would take it to the kitchen to be thickened. When the LPN returned the Med Pass had a spoon in it and the nurse was stirring it. The liquid was between nectar and honey consistency. Before the LPN gave the resident a spoon of the liquid she was asked if the liquid was pudding consistency and she stated no and started feeding it to the resident. After three spoons the liquid was dripping from the edges of the spoon and down on the resident's chin. The LPN stated she thought it needed to be thicker and took it to the kitchen to add more thickener. When she returned the liquid was not thickened to honey consistency. The LPN fed the remaining Med Pass to the resident.	F 365			
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: Complaint #12365 substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure that laboratory testing was obtained per physician orders for 3 (Resident #5, 7 and 18) of 11 (Resident #1, 3, 4, 5, 6, 7, 9, 11, 12, 14 and 18) case mix residents with physician orders for laboratory tests. This failed practice	F 502		4/1/07	

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F 502	<p>Continued From page 16</p> <p>had the potential to affect 51 residents with physician orders for laboratory testing as identified by a list provided by the Administrator on 3/2/07. The findings are:</p> <p>1. Resident #5 had diagnoses of Iron Deficiency Anemia and Cardiac Dysrhythmias. The Initial Minimum Data Set (MDS) dated 12/14/06 documented the resident was moderately impaired in cognitive skills for daily decision-making.</p> <p>a. A Physician order dated 12/26/06 documented, "Depakote level now; then in 1 month". A Depakote level was done on 12/27/06. As of 3/1/07 at 10:00 a.m., there was no documentation in the clinical record that the second Depakote level had been obtained.</p> <p>b. On 3/1/07 at 10 a.m., the Director of Nursing stated that the second Depakote level, Potassium level and BMP (Basic Metabolic Panel) "was not done".</p> <p>c. A Physician order dated 1/23/07 documented, "Potassium level / BMP 1/24/07". As of 3/1/07 at 10:00 a.m., there was no documentation in the clinical record that the laboratory tests had been obtained.</p> <p>2. Resident #18 had diagnoses of Coronary Artery Disease and Sick Sinus Syndrome. The Initial Clinical Record Assessment dated 02/21/07 documented the resident was moderately impaired in cognitive skills for daily decision-making.</p> <p>a. A Physician order dated 2/22/07 documented, "CBC (Complete Blood Count), COMP, TSH</p>	F 502			

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F 502	<p>Continued From page 17</p> <p>(Thyroid Stimulating Hormone), BNP (B-Type Natriuretic Peptide), T4 (Thyroid 4 Panel), UA (Urinalysis) on next lab draw.</p> <p>b. The clinical record documented the CBC, COMP, TSH, T4 and UA were obtained on 2/23/07. There was no documentation in the clinical record that the BNP had been obtained.</p> <p>c. On 3/2/07 at 4 p.m., the Director of Nursing stated the BNP had not been done.</p> <p>3. Resident #7 had a diagnosis of congestive heart failure. The MDS dated 1/03/07 documented the resident was modified independent in cognitive skills for daily decision making.</p> <p>a. A physician order dated 12/28/06 documented "repeat CBC (Complete Blood Count) & (and) B-NP (B-Type Natriuretic Peptide)".</p> <p>b. As of 3/1/07 the lab results for the CBC and B-NP was not documented on the clinical record. The Don (Director of Nurses) stated she could not find where the lab had been done.</p>	F 502			