

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

PRINTED: 04/15/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045158</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/04/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - HEBER SPRINGS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1040 WEDDINGFORD RD</b> <b>HEBER SPRINGS, AR 72543</b>	
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F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>Complaint #13419 was substantiated (all or in part) with a deficiency cited at F309.</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 ensure the physician's plan of care was implemented for 1 (Resident #10) of 15 case mix residents with dietary orders (Residents #1 through #13, #17 and #18). The failed practices had the potential to affect 79 residents with dietary orders, as documented on the Resident Census and Conditions of Residents form dated 4/1/08. The findings are:</p> <p>Resident #10 had diagnoses of Alzheimer's Disease and Esophageal Reflux. The Annual Minimum Data Set dated 2/11/08 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive assistance of one person for eating and had chewing and swallowing problems.</p> <p>a. A physician order dated 3/31/08 documented: "ConCho [Consistent Carbohydrate] puree diet with water only."</p> <p>b. The Dietary Communication Form dated 3/31/08 at 1:45 p.m. documented: "...ConCho</p>	F 282		

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	<p>Continued From page 1</p> <p>Puree [with] water only... Pt. [patient] requires more hydration @ [at] this time. Must be verbally directed to swallow H2O [water] + [and] repeat swallow. Will re-eval [re-evaluate] weekly until stabilized..."</p> <p>c. On 3/31/08 at 6:05 p.m., the resident was served an egg salad sandwich on white bread, stewed tomatoes, crackers, cream of potato soup, stewed plums, 8 ounces of water, 8 ounces of milk and 8 ounces of iced tea. Certified Nursing Assistant (CNA) #7 fed the resident and stated, "I gave her a couple of bites. It just runs right back out."</p> <p>d. On 4/1/08 at 1:00 p.m., the resident was served a pureed diet with 8 ounces of water and fed by CNA #8. The Speech Language Pathologist (SLP) instructed CNA #8 to give the resident water. The SLP listened to the resident's throat as the resident was given water. The resident coughed as the SLP auscultated her throat. The SLP stated, "It takes her 3 swallows to get the water down. I changed her to water only because the lungs can tolerate the water better. I changed her to a pureed diet." The SLP was asked, "When did you change this?" The SLP stated, "Yesterday."</p> <p>e. On 4/2/08 at 11:00 a.m., the SLP was asked, "When was the resident started on a pureed diet?" The SLP stated, "I assessed her Monday [3/31/08] and changed her diet because she was having trouble swallowing." The SLP produced a copy of the Dietary Communication Form dated 3/31/08 at 1:45 p.m. The SLP was asked, "Would you expect the resident to get a pureed diet for supper on 3/31/08?" The SLP stated, "Yes, I carried the slip to Dietary myself so it</p>	F 282			

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F 282	Continued From page 2 could get started."	F 282			
F 309 SS=J	483.25 QUALITY OF CARE  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Complaint #13419 was substantiated (all or in part) with these findings.  A. Based on observation, record review and interview, the facility failed to ensure necessary care and services were provided, as evidenced by failure to provide accurate, complete nursing assessments to monitor for complications following a surgical procedure, failure to monitor for complications after a urinary catheter insertion, failure to consistently and accurately assess pain symptoms to determine the cause, location, severity and response to treatment, failure to ensure symptoms including pain, swelling and decreased urine output were identified as potential post-operative complications or post-catheter insertion complications and were immediately reported to the physician and failure to ensure the correct size urinary catheter was inserted in accordance with the physician order for 1 (Resident #14) of 4 case mix residents with indwelling urinary catheters in use (Residents #6, #11, #12 and #14). The failed practice resulted in immediate jeopardy, which caused or could have caused	F 309			

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F 309	<p>Continued From page 3</p> <p>serious harm, injury or death to Resident #14, who sustained a urethral perforation which resulted in a scrotal abscess and surgical removal of the testicles. The failed practice also had the potential to cause more than minimal harm to 9 residents with indwelling urinary catheters in use, as identified on a list provided by the Administrator on 4/4/08. The facility was informed of the immediate jeopardy condition on 4/3/08 at 12:15 p.m. The findings are:</p> <p>Resident #14 had diagnoses of Spina Bifida and Lower Limb Full Thickness Skin Loss.</p> <p>a. The Plan of Care dated 1/17/08 documented: "Risk for UTI [Urinary Tract Infection] due to internal catheter - catheter due to diagnosis of Spina Bifida. Goals: No signs of UTI: fever, cloudy, bloody or discolored urine: scant output or odor. Interventions: Observe catheter. Observe urine for sediment, cloudy, odor, blood, amount. Report problems with urine or fever promptly to MD [Medical Doctor]."</p> <p>b. The Minimum Data Set (MDS) dated 2/22/08 documented the resident was independent in cognitive skills for daily decision-making, incontinent of bowel, had an indwelling catheter, required physical assistance with toileting, had mild pain less than daily and required monitoring of an acute medical condition.</p> <p>c. The Post-Operative Discharge Instructions for Cystoscopy which was sent to the facility with the resident after a Cytoscopy was performed on the resident at the Urology Clinic on 3/3/08 documented: "Voiding - Do not be alarmed if you notice a small amount of blood in your urine as it is not unusual and is temporary. You will need to</p>	F 309			

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F 309	<p>Continued From page 4</p> <p>notify your doctor if the amount becomes excessive or you have difficulty voiding. Observe the operative area for signs of excessive bleeding. Observe the operative areas for signs of infection: Increased pain, redness, swelling, foul odor. Elevated temperatures &gt; [greater than] 101 degrees. These signs and symptoms usually become apparent in 36 to 48 hours. If present, contact your physician. If you have not urinated 8 hours after arriving home, contact your surgeon." The physician orders on the Discharge Instruction sheet documented: "Levaquin 500 mg [milligrams] one daily. Other Instructions: Drink plenty of fluids. If unable to urinate - reinsert Foley Catheter - by nursing personnel."</p> <p>d. Nurse's Notes dated 3/3/08 at 6:47 p.m. and signed by Licensed Practical Nurse (LPN) #1 documented: "Foley cath [catheter] patent and draining yellow urine. ABT [antibiotic treatment] will start when med [medication] arrives from pharmacy will cont [continue] to monitor." There was no documentation of vital signs or an assessment for potential post-operative complications and no documentation of the amount of urine output the catheter bag had collected at that time. There was no documentation prior to this Nurses' Note to indicate when, and for what reason, the urinary catheter had been reinserted.</p> <p>On 4/1/08 at 4:00 p.m., the resident was interviewed. He stated he did not have a catheter on 3/3/08 when he returned to the facility after the Cytoscopy. He stated he, "kept asking them to put one in, but it was the next day before they did."</p> <p>On 4/1/08 at 4:30 p.m., the Urologist who</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>performed the Cystoscopy stated the resident did not have a catheter when he returned to the facility, but he had given instructions to re-insert one if the resident had difficulty voiding.</p> <p>e. The Narcotic Book and March 2008 Medication Administration Record (MAR) had entries dated 3/3/08 at 9:00 p.m. which documented Hydrocodone 5/500 was administered to the resident by LPN #1. There was no documentation on the MAR, in the Nurses' Notes or elsewhere in the clinical record of the location of the resident's pain or that the severity of pain was assessed. There was no documentation that the effectiveness of the Hydrocodone was assessed after it was administered.</p> <p>On 4/3/08 at 3:45 p.m., LPN #1 was asked if she had assessed the resident for post-operative complications. She stated "I don't remember." LPN #1 was informed that the physician and the resident stated there was no urinary catheter present upon the resident's return to the facility. The LPN was then asked if she had inserted the catheter. The LPN stated, "I didn't insert one, but if I charted he had one, he must have had one." The LPN stated she also did not remove a catheter from the resident. The LPN stated the resident was "fine" on her 3:00 p.m. to 11:00 p.m. shift and was not having any problems. When asked about the administration of Hydrocodone to the resident at 9:00 p.m., the LPN stated she did not remember why it was administered.</p> <p>f. Nurses' Notes dated 3/4/08 at 3:44 a.m. and signed by LPN #2 documented: "Requests F/C [Foley Catheter] be replaced but this nurse is unable to do so at this time d/t [due to] no Foley</p>	F 309			

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F 309	<p>Continued From page 6</p> <p>available in the right size. Will pass onto oncoming shift to obtain Foley and replace." There was no documentation that the resident was assessed for potential post-operative complications or that his vital signs were checked. There was no documentation of the resident's urinary output at this time.</p> <p>The Narcotic Book and March 2008 MAR documented LPN #2 administered Hydrocodone to the resident on 3/4/08 at 6:00 a.m. There was no documentation on the MAR, the Nurses' Notes or elsewhere in the clinical record of the location of the resident's pain, an assessment of the severity or an evaluation of the effectiveness of the medication after it was administered.</p> <p>On 4/3/08, several attempts were made to contact LPN #2 via telephone for an interview. On 4/3/08 at 3:10 p.m., the Corporate Nurse Consultant provided a written statement dated 4/3/08 and signed by LPN #2. The statement documented: "On 3/4/08, I failed to document that at approximately 0630 am [6:30 a.m.] resident informed me that he had a Foley in his drawer at which time I checked and found a Foley of the correct size in his drawer. I then assessed resident and found no bladder distention, no swelling to penis or scrotum. Resident was alert and oriented and stated he was not getting much [urine] out upon self cathing himself and he needed the Foley put in. I then attempted X [times] 1 using sterile technique to insert Foley and met resistance at which time I immediately stopped and alerted the 7-3 [7:00 a.m. to 3:00 p.m.] shift nurse whom had arrived by this time." The written statement did not address the administration of Hydrocodone to the resident on 3/4/08 at 6:00 a.m. There was no documentation</p>	F 309		

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F 309	<p>Continued From page 7</p> <p>in the Nurses' Notes or in this written statement to indicate that the LPN had consulted with the physician regarding the resident's decreased urine output, pain or the unsuccessful catheter insertion attempt. LPN #2 continued to be unavailable for interview after this statement was received.</p> <p>g. Nurses' Notes dated 3/5/08 at 3:03 p.m. and signed by LPN #3 documented: "Late entry for 3/4/08 03:00 AM [3:00 a.m.]. Nurse was putting cath [catheter] in for resident at his request due to he stated he is unable to void good amount. Dr. [Doctor] order to reinsert F/C if resident has problems. After cath was in and yellow urine in tubing after like 3 hours resident c/o [complained of] bulb was only 10 cc [cubic centimeters] and he is having leakage and feels like cath bulb not in place. With syringe pulled water from bulb and repositioned and refilled bulb and resident stated this felt better." (The physician's order dated 2/9/08 documented the ordered catheter size was a 14 French with a 5 cc bulb. The most recent physician order dated 2/22/08 documented an 18 French catheter with a 30 cc bulb. Neither of the orders documented a 10 cc bulb).</p> <p>On 4/3/08 at 10:00 a.m., LPN #3 was asked about the late entry Nurses' Notes dated 3/4/08 at 3:00 a.m. She stated, "I don't know why I put 3:00 a.m. I get to work around 5:45 a.m. LPN #3 was asked what size catheter she inserted. She stated that she did not know what size catheter had been used and that LPN #2 had inserted the catheter around 6:00 or 6:30 a.m. before she left. She stated the resident had complained that it, "didn't feel right and was leaking" so she repositioned it around 9:30 a.m. She stated she did not know what size the catheter was but that it</p>	F 309			

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F 309	Continued From page 8 had a 10 cc bulb. She stated she deflated the bulb, advanced the catheter further into the bladder and reinflated the bulb. The LPN stated the resident was wearing a brief which, "covered his privates" and she did not remove the brief when she repositioned the catheter.  h. The Narcotic Book and March 2008 MAR documented Hydrocodone 5/500 was administered to the resident on 3/4/08 at 10:00 a.m. by LPN #3. There was no documentation on the MAR, in the Nurses' Notes or elsewhere in the clinical record of the location of the pain, the severity or the effectiveness of the medication.  i. The Narcotic Book and March 2008 MAR documented Hydrocodone 5/500 was again administered to the resident by LPN #3 on 3/5/08 at 8:00 a.m. The MAR documented: "Pain rating - 4. Location - Scrotal. Follow up pain rating at 9:10 a.m. - 2. Wants Dr. called."  j. The Narcotic Book and March 2008 MAR documented Hydrocodone 5/500 was administered again on 3/5/08 at 1:00 p.m. by LPN #3. There was no documentation on the MAR, in the Nurses' Notes or elsewhere in the clinical record of the location or severity of the pain and no follow-up documentation of the effectiveness of the medication.  k. Nurses' Notes dated 3/5/08 at 3:10 p.m. and signed by LPN #3 documented: "Resident c/o [complains of] he is swelled up in groin area, and that the nurse last p.m. [evening] also repositioned cath and seemed better for a while but he wants Dr. called. Dr. called and talked with [physician's nurse] and explained what	F 309			

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F 309	<p>Continued From page 9</p> <p>residents c/o were and she stated she would call back. Nurse called back and N.O. [new order] to put back on Detrol 2 mg [milligrams] 1 po [by mouth] q [every] day. Resident informed and voiced understanding. Nurse stated she thought he was having bladder spasms and the Detrol would take care of this. Will continue to monitor for any changes." There was no documentation that the Nurse assessed the resident's scrotal area and no description of the swelling was documented.</p> <p>On 4/3/08 at 10:00 a.m., LPN #3 was asked about the Nurses' Notes dated 3/5/08 at 3:10 p.m. She stated the resident, "complained of being swollen and wanted the doctor called," so she, "called the doctor and got a new prescription." LPN #3 stated she had not assessed the resident prior to calling the physician, she only relayed the resident's complaints to the physician's nurse.</p> <p>l. Nurses' Notes dated 3/6/08 at 1:40 a.m. and signed by LPN #4 documented: "Resident resting quietly with no acute distress noted or c/o voiced. Eyes closed resp. [respirations] even and unlabored skin w/d [warm and dry] to touch. Level of care unchanged will continue to observe closely." There was no documentation of vital signs or an assessment of the resident for scrotal swelling or other potential post-operative complications.</p> <p>m. The Narcotic Book and March 2008 MAR documented Hydrocodone 5/500 was administered by LPN #4 on 3/6/08 at 6:30 a.m. There was no documentation on the MAR, in the Nurses' Notes or elsewhere in the clinical record of the pain location or severity or of the effectiveness of the medication.</p>	F 309			

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F 309	Continued From page 10  n. Nurses' Note dated 3/6/08 at 1:12 p.m. documented: "Resident up this a.m. propelling self around facility and laughing and talking with staff. Told LPN continues to feel like there was some swelling in scrotal area. And ask if his Detrol came in from pharmacy. Informed it was and he took all meds [medications] without problems. Talked with LPN about what [Urologist's] nurse stated about she thought he was having spasms and this was causing the leakage and resident stated well even after he starts the detrol it would be a while before this swelling feels better, there was no visual edema noted. F/C draining yellow urine, output yesterday was 1000 cc on am shift, and resident emptys [sic] this himself through out day. Resident very alert and able to voice wants. LPN called to resident room 10:45 - Resident sitting in w/c [wheelchair] and LPN noted bright red blood in F/C tubing and stated I'm swollen more showed LPN scrotal area and very swollen, called [Primary Care Physician] and new order to send to ER [Emergency Room] for eval [evaluation]. Resident helped to stretcher per EMT's [Emergency Medical Technicians] and CNA [Certified Nursing Assistant]. Alert and talking with EMT's. Family notified and going to meet resident at the hospital. Talked with nurse at [Hospital #1] and they sent resident to ER to see [Urologist]."  o. The Resident Transfer Form dated 3/6/08 documented: "Sudden onset bright red blood in catheter and scrotal areas puffed."  p. The hospital Record of Assessment, Documentation and Disposition dated 3/6/08 documented: "States he stood up and noticed	F 309			

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F 309	Continued From page 11  blood in catheter today prior to ER. Scrotal and Penile swelling observed. Started having a little swelling yesterday but worse today." The record also documented the Urologist was called and requested resident be transferred to another hospital (Hospital #2) as a direct admission.  q. The Operative Report dated 3/6/08 from Hospital #2 documented: "[Resident] developed a temperature of 101.9 and appeared to have worsening scrotal swelling and erythema tracking in the groin and possible left flank area. He had had a CT [Computed Tomography] scan earlier in the day that indeed demonstrated fluid collection and gas in the scrotal compartment. On my examination, he had a massively swollen genital package extending from the scrotum as well as to the penile area. It appeared that he had a scrotal abscess. He also had a percutaneously placed suprapubic drain, but it was draining very little and not felt to be draining effectively. He presented at this time for replacement of suprapubic catheter and incision and drainage of his scrotal abscess."  r. The History and Physical dated 3/6/08 and dictated by the Urologist documented: "I did a cysto [cystoscopy] in the office. It showed no evidence of mesh erosion. He had a catheter placed by the nursing home staff recently and either the balloon is blown up in the urethra or the catheter was pulled on and it damaged the urethra but at any rate he has a urethral perforation causing the swelling of his scrotum and penis. Impression: Urethral perforation due to Foley Catheter trauma."  s. The Infectious Disease Consultation Report dated 3/8/08 from Hospital #2 documented: "He stated that on Wednesday, March 5, 2008, he	F 309			

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F 309	<p>Continued From page 12</p> <p>began to have some pain in his scrotum. It swelled and became a hard knot. Then it worsened on Thursday March 6, 2008, so he was brought in here, where he was noted to have pain and tenderness. He had a catheter placed while in the nursing home and had damaged the urethra. he had urethral perforation causing swelling of his scrotum and penis... Extensive soft tissue edema of the lower mid pelvis extending into the upper thighs... At this time I am going to change his antibiotics to Primaxin. I have chosen this based on his previous susceptibilities. Zosyn may be adequate and once we get susceptibilities, I would like to change to that. I will be giving him 500 mg [milligrams] q.8h [every 8 hours] until we have a clearer picture, as this can be a life threatening illness with further advancement of the tissues... I believe this probably represents Meleney synergistic necrotizing fasciitis rather than a true gangrene..."</p> <p>t. The Operative Report dated 3/9/08 documented: "He has undergone previous incision and drainage approximately 36 hours ago and he continues to have redness in the flank area and inner thigh and he presents at this time for re-look as well as additional incision and drainage. There were some additional areas identified that appeared purulent and necrotic and these were debrided." The Operative Report documented additional incision and drainage was also performed on the left thigh and flank area.</p> <p>u. The Operative Report dated 3/11/08 documented: "Operation performed: Cystoscopy with wide scrotal debridement and bilateral orchiectomies. He had multiple areas of necrosis. Wide scrotal skin debridement was performed. Testicles were nonviable. The cords</p>	F 309			

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F 309	<p>Continued From page 13</p> <p>were isolated with clamps. Testicles were delivered out on the field and 0 silk was used to secure the spermatic cords bilaterally. Postoperative diagnosis: 1. Fournier's Gangrene. 2. Necrotizing fasciitis. 3. Full circumference penile urethral tear."</p> <p>v. The Operative Report dated 3/17/08 documented: "Operation performed: Closure of Urethral injury. There was a 1.5 cm bulbar urethral defect. The dorsal plate was intact, but ventrally the defect was obvious as I could see the catheter. He will be at risk for getting a stricture in this location. We will get [Plastic Surgeon] to see him regarding a skin graft."</p> <p>w. On 4/3/08 at 1:00 p.m., the Corporate Nurse Consultant stated the facility had been unaware of any problems associated with this resident's care prior to today.</p> <p>x. The Immediate Jeopardy was removed on 4/3/08 at 3:25 p.m. and the scope/severity lowered to "G" when the facility implemented the following Plan of Removal:</p> <p>1.) "Licensed Nurse [LPN #2] re-trained on 3/26/08 by Director of Clinical Services on observation, assessment and documentation of resident conditions. Licensed nurse [LPN #3] re-trained on 3/26/08 by Director of Clinical Services on observation, assessment and documentation of resident conditions. Included in in-service was head to toe assessment, correctly completing an assessment and identifying risk factors based on the data collected, demonstrating understanding of the importance of observing for changes in condition with MD [Medical Doctor] notification, discussed</p>	F 309			

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F 309	<p>Continued From page 14</p> <p>components of a narrative nurses note and charting in the medical record."</p> <p>2.) "Licensed nursing staff in-serviced by 3/26/08 by Director of Clinical Services on observation, assessment and documentation of resident conditions. Included in in-service was head to toe assessment, correctly completing an assessment and identifying risk factors based on the data collected, demonstrating understanding of the importance of observing for changes in condition with MD notification, discussed components of a narrative nurse's note and charting in the medical record. Immediately begin re-training on observation, assessment and documentation for all licensed nurses 4/3/08 at 1:30 p.m. and no nurse will work before re-training completed."</p> <p>3.) "DNS [Director of Nursing Services]/designee has assessed all residents with a catheter for any existing complications, with none being found, starting 4/3/08 at 12:50 p.m."</p> <p>4.) "DNS/designee will review 24 hour report and nurse's notes to note any resident's clinical changes and check to ensure nurses have assessed, documented and notified MD on clinical changes daily x [times] 5 days, 3x/week [3 times per week] for 2 weeks and weekly until compliance achieved. Will immediately complete 1 on 1 re-training for any negative findings. Will report findings to QA&amp;A [Quality Assessment and Assurance] for monthly review."</p> <p>B. Based on observation, record review and interview, the facility failed to ensure indwelling urinary catheters were secured to prevent potential dislodgement of the catheter or trauma to the urinary meatus during a transfer for 1</p>	F 309			

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F 309	<p>Continued From page 15</p> <p>(Resident #11) of 4 case mix residents with indwelling urinary catheters (Residents #6, #11, #12 and #14). The facility also failed to ensure the urinary catheter and perineal area were cleansed after incontinent bowel movements to prevent potential Urinary Tract Infections (UTI's) for 2 (Residents #6 and #11) of 4 case mix residents with indwelling urinary catheters (see identifiers above). The facility failed to ensure urinary catheter drainage tubing was positioned off of the floor during wheelchair locomotion to prevent contamination and to minimize the potential for dislodgement of the tubing for 1 (Resident #12) of 4 case mix residents with indwelling urinary catheters (see identifiers above). The failed practices had the potential to affect 9 residents with indwelling urinary catheters, as identified on a list provided by the Administrator on 4/4/08. The findings are:</p> <p>1. Resident #11 had diagnoses of Alzheimer's Disease and Urinary Tract Infection (UTI). The Minimum Data Set (MDS) dated 3/12/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, required extensive assistance for toileting and personal hygiene, was incontinent of bowel and had an indwelling catheter.</p> <p>a. The Plan of Care dated 3/12/08 documented: "Risk for UTI due to indwelling catheter - catheter due to bladder dysfunction. Perform pericare after each bowel movement. Catheter care q [every] shift, bathing and prn [as needed]."</p> <p>b. On 4/1/08 at 10:10 a.m., the resident was in bed. She had been incontinent of a large amount of liquid feces which had pooled underneath her on the incontinent pad. The feces covered the</p>	F 309			

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F 309	<p>Continued From page 16</p> <p>resident's anterior perineal area, the proximal half of the catheter and the upper inner thighs. Certified Nursing Assistant (CNA) #1 performed incontinent care and cleansed only the anal area and buttocks. The anterior perineal area and the catheter were not cleansed. CNA #1 unfastened the leg strap that secured the catheter to the resident's thigh prior to transferring the resident to a shower chair. During the transfer, the catheter bag was lying on the floor and CNA #1 stepped on the bag and tubing, causing the catheter to be pulled taut. The resident slid herself to the edge of the shower chair. Registered Nurse (RN) #1 stated, "You're fixing to fall out," and assisted the CNA's to reposition the resident back on the seat of the shower chair. The proximal half of the catheter was between the resident's right thigh and the shower chair seat. The resident was taken to the shower room. CNA #1 performed the resident's shower but did not reposition the catheter from under the resident's thigh and did not perform catheter care or spread the labia and wash the anterior perineal area during the shower.</p> <p>2. Resident #6 had diagnoses of Congestive Heart Failure and Neurogenic Bladder. The Quarterly Minimum Data Set (MDS) dated 1/9/08 documented the resident was usually continent of bowel, had an indwelling catheter and required extensive assistance with personal hygiene.</p> <p>a. The April 2008 Physician Orders sheet documented a physician order dated 2/13/08 for: F/C [Foley Catheter] 18 fr [French] with 30 cc [cubic centimeter] bulb, for Urinary Retention. Catheter care Q [every] shift with soap and water or peri-wash."</p>	F 309			

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F 309	<p>Continued From page 17</p> <p>b. The Plan of Care dated 3/7/07 documented: "Risk for complications such as UTI due to use of indwelling Foley catheter for neurogenic bladder. Has history of UTI's."</p> <p>c. On 4/1/08 at 10:39 a.m., the resident was in bed on her back. The catheter was draining dark yellow urine to a bedside drainage bag. Certified Nursing Assistant (CNA) #4 emptied 1500 cc's of urine from the bag. The resident's incontinent brief was removed from the front perineal area then pushed toward the buttocks. With a wet washcloth and perineal wash, the CNA cleansed the pubic area and underneath the resident's abdominal folds. With the same washcloth, the CNA wiped down both sides of the groin area. The resident was then positioned onto her right side. The incontinent brief, which was soiled feces, was pushed under the residents right buttock and leg area by CNA #3. CNA #3 then used a wet washcloth to cleanse the left buttock and anal area. The resident was positioned on her left side and the soiled brief was removed. Without cleansing the left buttock, the perineal area or the catheter, the CNA's applied a clean brief to the resident.</p> <p>3. The facility's policy and procedure for, "Catheter Care" was provided by the Director of Nursing (DON) on 4/4/08 at 11:05 a.m. and documented: "...Equipment: Basin with warm water and soap. Catheter care kit per facility procedure. Antiseptic ointment as ordered... pour warm water over perineal area. Wash perineal well with soap and water, taking care to wash from front to back. NOTE: Do not contaminate are with feces. If resident has had an involuntary bowel movement, clean this area first. Wash your hands and obtain clean equipment for</p>	F 309			

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F 309	Continued From page 18 catheter care. Cleanse area well at catheter insertion taking care not to pull on catheter or advance further into urethra. Rinse well with warm water and pat dry gently with clean towel."  4. Resident #12 had diagnoses of Congestive Heart Failure and Urinary Retention. The Quarterly Minimum Data Set (MDS) dated 3/31/08 documented the resident was incontinent of bowel, had an indwelling catheter and required limited assistance with transfers and bed mobility.  a. The April 2008 Physician Orders sheet documented an order dated 12/19/07 for: "Foley Catheter 16 French with 5cc bulb for Urinary Retention..."  b. The Plan of Care dated 12/31/07 documented: "Risk of UTI due to indwelling Foley catheter."  c. On 4/2/08 at 11:01 a.m., the resident was sitting in a wheelchair with an indwelling catheter in place. The catheter drainage bag was in a privacy cover, but the tubing was resting on the floor. The resident propelled the wheelchair down the 600 Hall, past the Nurses' Station, then down the 500 Hall to the Therapy Room. The resident passed several staff members, but no attempt was made to adjust the catheter tubing, which was dragging on the floor.  d. On 4/2/08 at 11:33 a.m., the resident was sitting in wheelchair receiving therapy. The catheter tubing remained on the floor.  e. On 4/2/08 at 12:00 p.m., the resident propelled the wheelchair from the Therapy Room to the main dining room. The catheter tubing was looped and dragging on the floor.	F 309			

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F 312 SS=E	<p>f. On 4/2/08 at 1:28 p.m., the resident propelled the wheelchair out of the dining room and down the 600 Hall with the catheter tubing dragging on the floor.</p> <p>g. On 4/4/08 at 9:15 a.m., the resident was sitting in a wheelchair in his room. The catheter tubing was touching the floor.</p> <p>483.25(a)(3) ACTIVITIES OF DAILY LIVING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure urine was cleansed from all areas of the perineum and buttocks during incontinent care for 3 (Residents #1, #2 and #6) of 8 case mix residents who required incontinent care (Residents #1 through #4, #6 through #8 and #11). The failed practice had the potential to affect 42 residents who required incontinent care, as documented on a list provided by the Administrator on 4/4/08. The findings are:</p> <p>1. Resident #2 had diagnoses of Alzheimer's Disease and Urinary Tract Infection. The Minimum Data Set (MDS) dated 2/10/08 documented the resident was severely impaired in cognitive skills for daily decision-making, incontinent, required extensive assistance with toileting and personal hygiene, was incontinent of</p>	F 312			

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F 312	<p>Continued From page 20</p> <p>bowel, had an indwelling catheter and had a Urinary Tract Infection (UTI) in the past 30 days.</p> <p>a. The Plan of Care dated 2/10/08 documented: "At risk for UTI. Keep clean and dry. Provide pericare [perineal care] after each incontinent episode."</p> <p>b. On 4/1/08 at 9:50 a.m., the resident was lying on her left side in bed and had been incontinent of a large amount of urine. Certified Nursing Assistant (CNA) #2 went into the bathroom and returned with a wet washcloth. The CNA wiped the resident's anal area only. The perineal area was not cleansed. CNA #2 was asked what was on the washcloth she had used to cleanse the resident. She stated, "Just water."</p> <p>2. Resident #1 had diagnoses of Alzheimer's Disease and Decubitus Ulcer. The Quarterly Minimum Data Set dated 3/5/08 documented the resident was incontinent of bowel and bladder and required extensive assistance for personal hygiene.</p> <p>a. The Plan of Care dated as revised by the facility on 2/13/08 documented: "Risk for skin breakdown bladder/bowel incontinence, needs total assistance for bed mobility diagnosis of Alzheimer. Approaches: ...give incontinent care as needed. Clean after each incontinent episode. Wash with soap and water."</p> <p>b. On 4/1/08 at 12:16 p.m., the resident was in bed on his left side. Certified Nursing Assistants (CNA's) #5 and #6 provided incontinent care at this time. CNA #6 removed the urine-saturated incontinent brief from the front perineal area and pushed the brief down toward the buttocks. With</p>	F 312			

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F 312	Continued From page 21 a wet washcloth and no soap or peri-wash, the CNA wiped across the pubic area and down both sides of the groin and inner thighs. The CNA did not cleanse the penis. The resident was placed on his right side and the urine-saturated brief, which was also soiled with feces, was removed. The resident had dried feces on both inner buttocks. CNA #5 used a wet washcloth to wipe the left hip/buttock area. Without drying the resident's skin, the CNA's placed a clean brief and dressed the resident. The resident's penis and right hip/buttock area were not cleansed at any time during the procedure and no soap or perineal wash was used.  3. Resident #6 had diagnoses of Congestive Heart Failure and Neurogenic Bladder. The Quarterly Minimum Data Set (MDS) dated 1/9/08 documented the resident was usually continent of bowel, required extensive assistance with personal hygiene and had an indwelling catheter.  a. The Plan of Care dated 3/7/07 documented: "Risk for complications such as UTI due to use of indwelling Foley catheter for neurogenic bladder. Has history of UTI's."  b. On 4/1/08 at 10:39 a.m., the resident was in bed on her back. The catheter was draining dark yellow urine to a bedside drainage bag. Certified Nursing Assistant (CNA) #4 emptied 1500 cc's of urine from the bag. The resident's incontinent brief was removed from the front perineal area then pushed toward the buttocks. With a wet washcloth and perineal wash, the CNA cleansed the pubic area and underneath the resident's abdominal folds. With the same washcloth, the CNA wiped down both sides of the groin area. The resident was then positioned onto her right	F 312			

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F 312	Continued From page 22 side. The incontinent brief, which was soiled with feces, was pushed under the residents right buttock and leg area by CNA #3. CNA #3 then used a wet washcloth to cleanse the left buttock and anal area. The resident was positioned on her left side and the soiled brief was removed. Without cleansing the left buttock, the perineal area or the catheter, the CNA's applied a clean brief to the resident.	F 312			
F 314 SS=E	4. On 4/4/08 at 11:05 a.m., the Director of Nursing provided the facility's Incontinence Care protocol, which documented: "Equipment: Soap and Water. Skin Lotion... Procedure: Wash all soiled areas, washing from front to back, rinse and dry very well, especially between skin folds. Apply protective skin lubricant and rub well into skin."  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 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.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure repositioning and incontinent care were provided at least every 2 hours in accordance with the Plan of Care to prevent potential skin breakdown for 1 (Resident #1) of 5 case mix residents who had or were at	F 314			

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F 314	Continued From page 23 risk for pressure ulcers (Residents #1, #2, #6, #10 and #11). The facility also failed to ensure the resident's heels were offloaded in accordance with the physician's plan of care to prevent a potential recurrence of skin breakdown for 1 (Resident #10) of 5 case mix residents who had or were at risk for pressure ulcers (see identifiers above). The failed practices had the potential to affect 29 residents with pressure ulcers, as documented on the facility's Resident Census and Conditions of Residents form dated 4/1/08. The findings are:  1. Resident #1 had diagnoses of Alzheimer's Disease and Decubitus Ulcer. The Quarterly Minimum Data Set (MDS) dated 3/5/08 documented the resident required extensive assistance for bed mobility and personal hygiene, was incontinent of bowel and bladder, had one Stage II pressure ulcer and was on a turning/repositioning program.  a. The Plan of Care dated as revised by the facility on 2/13/08 documented: "Risk for skin breakdown bladder/bowel incontinence, needs total assistance for bed mobility diagnosis of Alzheimer. Approaches: Turning/repositioning program. Reposition Q [every] two hours and position with pillows and bridge heels. Clean after each incontinent episode. Wash with soap and water."  b. On 4/1/08 at 9:00 a.m., the resident was lying in the bed on his left side. At 9:50 a.m., the resident remained on his left side. The Surveyor marked the resident's incontinent brief with blue tape in the center of the top, back edge and next to the right leg opening and also documented the date and time the brief was marked on the piece	F 314			

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F 314	<p>Continued From page 24 of tape next to the leg opening of the brief.</p> <p>c. On 4/1/08 at 12:16 p.m., the resident remained in bed in the same position on his left side and was wearing the same marked incontinent brief. Certified Nursing Assistants (CNA's) #5 and #6 entered the room and removed the marked incontinent brief. The brief was saturated with urine and there was dried fecal material on both inner buttocks. The resident's left shoulder and upper back area were reddened. The resident had been in the same position for a total of 3 hours and 16 minutes with no incontinent care provided.</p> <p>2. Resident #10 had diagnoses of Alzheimer's Disease and Decubitus Ulcer. The Annual Minimum Data Set dated 2/11/08 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive assistance of two or more persons for bed mobility and had no pressure ulcers.</p> <p>a. A physician order dated 11/20/07 documented: "Keep pressure off heels."</p> <p>b. On 3/31/08 at 2:51 p.m. and 4/2/08 at 2:00 p.m., the resident was lying in bed on her left side with a pillow between her knees. The left lateral heel and ankle were not offloaded and were pressed against the mattress with the weight of the right leg pressing down on top of the left leg.</p> <p>c. On 3/31/08 at 5:15 p.m. and 4/1/08 at 9:20 a.m., the resident was lying in bed on her right side. The right lateral heel and ankle were not offloaded and were pressed against the mattress with the weight of the left leg pressing down on top of the right leg.</p>	F 314			

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F 314	Continued From page 25	F 314			
F 323 SS=E	<p>d. On 4/2/08 at 3:45 p.m., the resident was lying on her left side with the left lateral heel and ankle pressed against the mattress. Licensed Practical Nurse (LPN) #6 turned the resident to the right side at this time. The lateral surface of the resident's left foot was reddened.</p> <p>e. On 4/2/08 at 4:10 p.m., LPN #6 was asked if the resident had a history of pressure ulcers on her feet. The LPN stated, "Yes."</p> <p>483.25(h) ACCIDENTS AND SUPERVISION</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the resident's lower body was supported during staff-assisted transfers to prevent potential injury for 1 of 1 case mix resident who required extensive assistance with transfers (Resident #11). The facility also failed to ensure a personal alarm was consistently utilized in accordance with the Plan of Care to prevent further falls for 1 (Resident #9) of 3 case mix residents who were care planned or had physician orders for personal alarms (Residents #3, #9 and #11). The failed practices had the potential to affect 16 residents who required extensive assistance with transfers and 16 residents who were to have personal</p>	F 323			

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F 323	Continued From page 26 alarms in use, as identified on lists provided by the Administrator on 4/4/08. The findings are:  1. Resident #11 had diagnoses of Alzheimer's Disease and Urinary Tract Infection (UTI). The Minimum Data Set (MDS) dated 3/12/08 documented the resident was moderately impaired in cognitive skills for daily decision-making and required extensive assistance of 2 or more staff with transfers.  a. The Plan of Care dated 3/12/08 documented: "Risk for pain and limited mobility... At risk for decline in ADL [activities of daily living] due to right hip fx [fracture], cognitive status and disease process. Assist to move around facility as needed." The Plan of Care did not address the level of assistance or number of staff required for transfers or the method by which the resident should be transferred.  b. On 4/1/08 at 10:10 a.m., Certified Nursing Assistants (CNA's) #1 and #2 transferred the resident from bed to a shower chair. Each CNA grabbed under one of the resident's axillae and pulled the resident up out of bed by lifting at the joints of her shoulders. The resident did not bear weight during the transfer and her feet dragged along the floor. The CNA's did not support the resident's torso or lower extremities, which caused the resident's entire body weight to be supported by her shoulder joints.  c. On 4/1/08 at 11:05 a.m., CNA's #1 and #2 transferred the resident from the shower chair to the wheelchair by again lifting the resident underneath her axillary area. The resident's feet again dragged along the floor during the transfer and no support was provided to her torso or lower	F 323			

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F 323	Continued From page 27 extremities.  2. Resident #9 had diagnoses of Alzheimer's Disease and History of Falls. The MDS dated 1/25/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, independently ambulatory and had an unsteady gait.  a. The Change in Condition Report dated 3/23/08 documented: "Found on floor in resident's bathroom..." The Post Fall Investigation Summary dated 3/23/08 documented: "Recommendations and interventions post fall: ...Bed/chair alarm... Sensor alarm under mattress to alert staff when resident is getting up."  b. The Plan of Care dated 1/25/08 documented: "At risk for falls related to recent fall. 3/17/08 - Fall in bathroom doorway... 3/23/08 - Fall in bathroom... 3/27/08 - Found on floor in resident's room - skin tear L [left] elbow... Sensor alarm under mattress... body alarm."  c. On 4/1/08 at 9:20 a.m., the resident was observed as she got out of bed and independently ambulated from the bed to the bathroom. The resident's gait was unsteady. The bed alarm did not sound. CNA #1 entered the room and assisted the resident to sit down on the bed but did not activate the bed alarm before leaving the room.  d. On 4/1/08 at 9:35 a.m., the resident again stood up from the bed and ambulated unsteadily to the bathroom. No alarm sounded. The resident's roommate/spouse assisted the resident back to the bed.	F 323			
F 369	483.35(g) DIETARY SERVICES - ASSISTIVE	F 369			

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F 369 SS=D	Continued From page 28 DEVICES  The facility must provide special eating equipment and utensils for residents who need them.  This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure a physician-ordered plate guard was provided to 1 of 1 (Resident #8) case mix resident with physician orders for adaptive eating equipment. The failed practice had the potential to affect 26 residents who fed themselves without assistance from staff, as documented on the Resident Census and Conditions of Residents form dated 4/1/08. The findings are:  Resident #8 had a diagnosis of Alzheimer's Disease. The Minimum Data Set (MDS) dated 6/25/07 documented the resident was moderately impaired in cognitive skills for daily decision-making and required limited assistance with eating.  a. The Plan of Care dated 10/2/07 documented: "At nutritional risk related to mechanically altered and therapeutic diet... Continue to try different interventions to increase resident intake of food and fluid."  b. A physician order dated 1/8/08 documented: "Plate guard to be used at all meals." This order was also documented as a current order on the March 2008 Physician Orders sheet.  c. On 3/31/08 at 5:30 p.m., during the supper meal and 4/1/08 at 11:55 a.m., during the lunch	F 369			

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F 369	Continued From page 29 meal, the resident's plate was not equipped with a plate guard, as the resident fed herself with staff cues and encouragement.	F 369			
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431			

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F 431	<p>Continued From page 30</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a used narcotic pain patch was disposed of upon removing it from the resident. The facility also failed to ensure a medication that required refrigeration if not used within 3 weeks after opening was not stored in the medication cart for longer than 3 weeks without refrigeration for 1 (Resident #19) of 1 case mix resident with a physician order for Desmopressin nasal spray. The failed practices had the potential to affect all 79 residents who were at risk for coming into contact with the unsecured medication or receiving improperly stored medication, as documented on the Resident Census and Conditions of Residents form dated 4/1/08. The findings are:</p> <ol style="list-style-type: none"> <li>1. On 4/3/08 at 1:10 p.m., the Surveyor attempted to review the Narcotic Book, which was lying on top of a medication cart in the hallway. A Duragesic patch fell out of the book as the Surveyor lifted the book off of the cart. Licensed Practical Nurse (LPN) #3 stated she had removed the narcotic pain patch from a resident at approximately 10:00 a.m. She stated it was facility policy to have two nurses witness the disposal of narcotics, so she placed the patch inside the Narcotic Book until she could find another nurse and then had gotten busy and forgotten about the patch.</li> <li>2. Resident #19 had a diagnosis of Congestive Heart Failure and a physician order dated 11/29/07 for: "Desmopressin Acetate 1 spray nasal two times per day for Hypertensive Heart Disease with Congestive Heart Failure."</li> </ol>	F 431			

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F 431	<p>Continued From page 31</p> <p>a. On 4/3/08 at 4:15 p.m., the 200 Hall medication cart was inspected with the assistance of Licensed Practical Nurse (LPN) #5. A box labeled Desmopressin 0.1 milligrams per milliliter (mg/ml) nasal spray was stored in a drawer of the medication cart. A date of 3/3/08 had been handwritten on the outside of the box. The medication label documented: "Keep Refrigerated." LPN #5 was asked, "Do you keep this medication in the medication cart or in the refrigerator?" LPN #5 stated, "I keep it in the medication cart." LPN #5 was asked what the 3/3/08 handwritten date indicated. She stated, "That is the day it was opened. We get new boxes every 30 days." LPN #5 was informed of the label which documented, "Keep Refrigerated." The LPN stated, "I don't know. We've always kept this in the cart. I don't know who wrote that there." Registered Nurse (RN) #1 came to the cart, read the package insert and stated, "The insert says, 'When traveling, product will maintain stability for up to 3 weeks when stored at room temperature.'" RN #1 was asked, "If the box was opened on 3/3/08, when would the 3 weeks be completed?" RN #1 stated, "3/24/08." The RN was asked how many doses had been administered after 3/24/08. The RN stated, "I don't know. I'll have to get a copy of the March MAR [Medication Administration Record] from Medical Records."</p> <p>b. The March and April 2008 MAR's documented a total of 16 doses were administered after 3/24/08.</p>	F 431			