

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

PRINTED: 03/25/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/12/2008
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NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904
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F 000	INITIAL COMMENTS Complaint # 13250, #13341 and # 13314, unsubstantiated. Complaint #13355, substantiated (all or in part) with a deficiency cited at F157.	F 000		
F 157 SS=K	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13355, substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview the facility failed to ensure a physician was consulted regarding changes in condition for 2 of 2 case mix residents (Residents #10 and #8) when Resident #10 exhibited signs of respiratory distress and Resident #8 complained of pain following a fall. These failed practiced caused or could have caused serious harm, injury, impairment or death to Resident #8 who was hospitalized and died of acute respiratory failure and Resident #10 who had a fall and continued to complain of pain, and had the potential to affect 10 residents who had respiratory problems and 83 residents who were at risk for falls as documented by the Director of Nursing on 3/12/08. The facility was notified of the Immediate Jeopardy Condition on 3/11/08 at 5:10 p.m. The findings are:</p> <p>1. Resident #10 had diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Respiratory Distress and Congestive Heart Failure. The Quarterly MDS dated 1/10/08 documented the resident had modified independence in cognitive skills for daily decision making, inability to lie flat due to shortness of breath, shortness of breath, and required oxygen therapy.</p> <p>a. A physician order dated 3/20/07 documented, "Ativan (Lorazepam) 1 mg (milligram) PO (orally) Q (every) 8 H (hours) PRN (as needed) Anxiety."</p> <p>b. A physician order dated 3/20/07 documented,</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>"O2 (oxygen) at 3-5 L (liters) via N/C (nasal cannula) (Keep O2 sat (saturation) > (greater than) 92%)."</p> <p>c. A physician order dated 10/14/07 documented, "Updraft treatment PRN Albuterol 1 unit dose Q 6 hrs PRN DX (diagnosis): SOB (shortness of breath) Stay with Res (resident) while administering. Document time of updraft in mins (minutes)."</p> <p>d. A physician order dated 12/2/07 documented, "Oxygen 3-5 L/M (liters per minute) via N/C continuous."</p> <p>e. The plan of care dated 1/10/08 documented, "Observe for vomiting or diarrhea. Report to Dr. (doctor) immediately."</p> <p>f. The January 2008 MAR (Medication Administration Record) documented Oxygen Saturation levels of: 1/9/08 at 94%, 1/24/08 at 95% and 1/29/08 at 96%. A Nurses Note dated 2/6/08 at 7:00 p.m. documented the oxygen saturation level was 94%.</p> <p>g. Nurse Notes dated 2/10/08 at 4:00 p.m. documented, "Resident returned from visiting [with] family. As resident being wheeled into room resident vomited lg (large) amount undigested food particles et (and) very SOB. O2 [down] 68% [without] O2. Applied O2 @ 5 L/M via N/C and O2 sat [up] 89%. Assisted into bed. Cont. (continue) to holler and be very anxious. Medicated [with] po prn Ativan. Still c/o nausea." There was no documentation in the clinical record that the physician was consulted about the nausea and vomiting or low oxygen saturation.</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>h. Nurse Notes dated 2/10/08 at 6:00 p.m. documented, "Resident cont to be anxious pulling O2 off and c/o nausea. Also incont (incontinent) of urine et feces - cleaned well. This behavior not normal for resident. Updraft given per orders. O2 sat - 78%." There was no documentation in the clinical record that the physician was consulted about the low oxygen saturation, incontinence of bowel and continued complaints of nausea.</p> <p>i. Nurse Notes dated 2/10/08 at 8:00 p.m. documented, "Resident cont to intermittently pull O2 off - be very anxious." There was no documentation in the clinical record that the physician was notified of the resident's behavior of anxiousness.</p> <p>j. Nurse Notes dated 2/10/08 at 10:00 p.m. documented, "Resident hollering loudly - very anxious. O2 sat [down] 58% [with] O2 @ 3 L/M - O2 sat [up] 61% - Heart rate 126. Very limp - not supporting neck. Call placed to Dr. [physician's name] et (and) received order for transfer to [hospital]..."</p> <p>On 3/12/08, the Registered Nurse Consultant provided a note that documented the Emergency Medical Services was called at 10:46 p.m.</p> <p>k. An Emergency Physician's Record dated 2/10/08 at 11:20 p.m. documented, "Chief complaint: shortness of breath... trouble breathing/dyspnea... moderate anxious... prolonged expirations, accessory muscle use... decreased air movement... wheezes/rales/rhonchi... tachycardia... 110... Pulse ox (oximetry) 82% on 2 L at 2330 (11:30 p.m.)... clinical impression Acute Respiratory Failure."</p>	F 157			

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F 157	Continued From page 4 I. A Death Summary Report dated 2/27/08 documented, "Discharge date: 02/26/08" and "Discharge diagnosis: Adult respiratory distress with respiratory failure, noncardiogenic pulmonary edema with cor pulmonale and pulmonary hypertension secondary to chronic obstructive pulmonary disease." m. On 3/12/08 at 10:20 a.m., Licensed Practical Nurse (LPN) #1 stated, "The behavior was not normal (documented in the nurse notes) refers to the incontinent episode. She used a bed side commode. The resident was an old COPD'er. I didn't chart sometimes when the O2 sat was up. She complained of nausea one more time (after the vomiting). The family said she ate all day long. She came back around 4 to 5 o'clock." n. On 3/12/08 at 10:21 a.m., when asked at what point did she call the doctor, LPN #1 stated, "When I couldn't get the O2 sat up. Normally it should be around 90%. I kept it about 88%. The 78% result was prior to the updraft." o. The Best Practices, A Guide to Excellence in Nursing Care, Lippincott Williams and Wilkins 2003 page 342 documented, "Normal SpO2 levels for... pulse oximetry are 95% to 100% for adults... Lower levels may indicate hypoxemia that warrants intervention... Notify the physician of any significant change in the patient's condition." 2. Resident #8 had diagnoses of Cerebrovascular Accident, Insulin Dependent Diabetes Mellitus and Bilateral Leg Amputations. A Quarterly MDS dated 12/21/07 documented the resident had modified independence in cognitive skills for daily decision making, required total assistance of 2	F 157			

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F 157	Continued From page 5 persons for transfers and required total assistance of 1 person for locomotion on and off the unit. a. An Event/Incident Report dated 3/6/08 at 6:45 p.m. documented, "[Name] came and ask for this nurse to eval (evaluate) and this nurse when out front and found resident sitting on sidewalk [with] abrasion to [left upper] eyebrow and [left lower] eye ...Conclusion: Resident was taken out front to smoke [due to] rain/weather, she was rolled out in wheelchair. Apparently wheelchair was not locked and when another resident was rolled out the doorway his wheelchair hit her wheelchair and she rolled down toward driveway area, wheelchair hit dirt and resident came out of wheelchair landing in grassy area." b. Nurses Note dated 3/6/08 at 6:45 p.m. documented, "Resident out to smoke - R (resident) on front patio & (and) W/C (wheelchair) rolled & she fell out on [left] side ...Dr. (doctor) notified faxed & [Daughter] notified. C/o (complained of) [left] hip pain & [left] shoulder, Tylenol ii (2) 325 mg (milligrams) given." c. Nurses Note dated 3/6/08 at 7:45 p.m. documented, "Resident states pain better [and] [left] hip and [left] shoulder not hurting it was [right] hip ...If cont (continues) to complain 11-7 [shift] will F/O (follow up) with 7 - 3 for X rays." d. Nurses Note dated 3/7/08 at 12:00 a.m. documented, "Resident awake & alert in bed [with] eyes open ...[Complained] pain in [right] leg. Assessed and found small scratch [no] discoloration noted. No [complaint] of worsening pain when push down... Medicated with Tylenol 325 mg ii [by mouth]..."	F 157		

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F 157	Continued From page 6 e. Nurses Note dated 3/7/08 at 2:00 a.m. documented, "Still complaining of [right] leg hurting. Tylenol ineffective." There was no documentation in the nurses notes that the physician was consulted. f. The next Nurses Notes was dated 3/7/08 at 1:45 p.m. and documented, "Resident [complains] hip pain S/P (after) fall on 3/6/08 at 18:45. Family requested that she be sent to [Hospital emergency room] for examination and treatment. Resident given Tylenol 325 ii for pain... EMS to transfer for [due to] severe pain upon sitting. EMS called for transport at this time." g. Emergency Department Documentation dated 3/7/08 documented, "Diagnosis: Fall from wheelchair ...Contusion to L (left) shoulder and L hip. Discharge Plan: Stable Dispositioned: To nursing home. Prescriptions: ...Lortab 5/500 ... [as needed] 24 tablets... Limitations: Limited activity. Follow up with: Primary Care Physician, Return to ed (emergency department) if symptoms worsen." 3. The Change in Medical Condition of Residents Policy provided by the Nurse Consultant on 3/12/08 documented, "Purpose: To keep the physician.... informed of the resident's medical condition so they may direct the plan of care as needed... Notification of the physician... should occur promptly, according to federal regulations, when there is a change in the resident's condition. Change in condition is defined as:... An accident involving the resident which results in injury and has the potential for requiring physician intervention. A change in the resident's physical, mental or psychosocial status... deterioration in	F 157			

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F 157	Continued From page 7 health... or clinical complications. A need to alter treatment..." "Examples of a change in condition may include:... fall... nausea, vomiting... overall deterioration of condition... sudden incontinence... new pain... respiratory distress." "Documenting the Change of Condition a) Nurses notes should include documentation of the symptoms and observations associated with the change in condition, the date and time of contact with the physician and family member/legal representative. Notes also should include comments on the care provided by nursing personnel." 4. The Immediate Jeopardy was removed on 3/11/08 at 5:45 p.m. and lowered to a scope and severity of an " E " when the facility implemented the following plan of removal: a. Assess all residents for change of condition 3/11/08 by 5:45 p.m. by management nurses. b. Call MD (medical doctor) by 5:45 p.m. on 3/11/08 with any change of condition of any resident in the building. c. All licensed nurses will be in-serviced to contact the MD on any change of condition. The in-service will be conducted prior to the employee's next working shift by management staff. To begin immediately (3/11/08). d. 24 hour report will be reviewed by the Administrator or Director of Nurses or Weekend RN by 10 a.m. the next day.	F 157			

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F 157	Continued From page 8 e. All residents will be visited and reviewed by an RN (Registered Nurse) daily to ensure no change of condition has occurred to begin on 3/12/08 by 10 a.m. the next day.	F 157			
F 323 SS=E	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, interview and record review, the facility failed to ensure that Sharps and chemicals were stored in a secure manner to prevent possible injury and failed to ensure that a drain cover was in place to prevent possible tripping/falling. The facility failed to ensure hot water was maintained at safe temperatures to prevent possible burns. These failed practices had the potential to affect 22 residents who were self mobile, cognitively impaired and resided on the South Hall, Southeast Hall and East Hall according to the Director of Nurses on 3/12/08 and 37 residents who were self mobile and cognitively impaired who lived in the facility, including the locked unit, according to the Director of Nurses on 3/12/08. The findings are: 1. On 3/10/08 at 3:45 p.m., a drain in the East Hall shower on the right had an open drain approximately 4 inches wide and 3 inches deep. The shower door was unlocked and the door knob could not be locked. In the same shower	F 323			

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F 323	<p>Continued From page 9</p> <p>room an approximate 12 ounce bottle of Hibiclens lay on top of the Sharps' container. The label on the back of the bottle documented, "If swallowed get medical help or contact a Poison Control Center right away."</p> <p>2. On 3/10/08 at 3:46 p.m., the East Hall shower room on the left had a Sharps' container on the wall on the right when entering the room. The Sharps' container was not locked and was open approximately 1/2 inch. It contained 5 used razors. The door to the shower was not locked and did not have a locking mechanism.</p> <p>3. On 3/10/08 at 3:20 p.m., the hot water temperature in the South Hall communal handicap bathroom was 122.9 degrees Fahrenheit (F).</p> <p>a. On 3/10/08 at 4:02 p.m., the Administrator was asked how often the water temperatures were monitored and the Administrator stated, "Maintenance man rounds weekly and checks temps."</p> <p>b. At 4:25 p.m., the hot water temperature was taken again in the South Hall bathroom. The hot water temperature was 118.6 degrees. The Administrator was informed of the hot water temperatures and stated she would have to call someone about it (the hot water heaters).</p> <p>c. On 3/11/08 at 3:02 p.m., the hot water temperature in the South Hall handicap communal bathroom was 123.1 degrees F.</p> <p>d. On 3/11/08 at 3:29 p.m., the Maintenance Man was asked what he had done yesterday to correct the hot water temperatures and he stated,</p>	F 323			

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F 323	Continued From page 10 "Turned it down. Took temp this morning and it was 108. Turned it up some. Yesterday he had called someone and they had told him to." e. On 3/11/08 at 3:20 p.m., the Administrator was informed of the hot water temperature. The Administrator stated she would call someone to help the maintenance man immediately. f. On 3/11/08 at 3:25 p.m., the hot water temperature in the sink in Resident Room 34 was 122 degrees F. g. On 3/11/08 at 3:25 p.m., Resident #13 was asked about the hot water in the South Hall bathroom and the resident stated that the water had been hot "at least 6 months been very hot. It takes a minute and a half to heat up. It's boiling..." h. On 3/11/08 at 3:35 p.m., the hot water temperature in the locked unit bathroom on the left was 118.8 degrees. i. The Hot Water Testing Policy provided by the Administrator on 3/12/08 documented, "Resident rooms, shower rooms, public bathrooms, whirlpools, tubs, and any other fixtures accessible to residents...required temperatures 105-115 degrees... When water temperatures are not in required ranges, the Maintenance Supervisor should inform the Administrator and the manager of the affected department. Arrangements for repairs to the hot water system should be made as soon as possible."	F 323			