

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

PRINTED: 06/09/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045267</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/26/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEGACY HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3310 NORTH 50 STREET</b> <b>FORT SMITH, AR 72904</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 157 SS=D	<p>483.10(b)(11) NOTIFICATION OF CHANGES</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 157			

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 157	<p>Continued From page 1</p> <p>by:</p> <p>Complaint #11751 was substantiated (all or in part) in these findings.</p> <p>Based on record review and interview the facility failed to ensure a Physician was immediately consulted after a significant change in condition with the potential to require Physician intervention for 1 (Resident #1) of 2 (Residents #1 and #4) case mix residents. This failed practice had the potential to affect all 92 residents in the facility, according to the facility Roster Matrix received on 5/25/06. The findings are:</p> <p>Resident #1 was admitted on 5/16/06 and had diagnoses of Urinary Retention with Foley Catheter, Hypertension, Pain, Respiratory Failure with Tracheostomy, Head Injury due to Motor Vehicle Accident (MVA), Gastrostomy Tube (G-Tube) and Fracture of Femur Neck and Lumbar Vertebrae. An Initial Minimum Data Set had not been completed for this resident.</p> <p>a. Informal notes written by the Director of Nursing (DON) dated 5/16/06 documented the nursing report she received prior to the resident's transfer from a hospital to the facility. The notes documented the resident had a tracheostomy with Pseudomonas organisms in the trach secretions, a G-tube, was non-responsive, non-verbal, had a shearing brain injury, no lower extremity movement, "breaks out in diaphoretic sweats - keep fan on him all the time" and a Foley catheter.</p> <p>b. Admission Physician orders dated 5/16/06 documented: Jevity at 90 cc (cubic centimeters)/hour via pump." A Telephone Order</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>dated 5/17/06 documented: additional orders to flush the G-tube with 150 cc water every shift and 30 cc water before and after medications.</p> <p>c. Nurse's Notes dated 5/16/06 at 10:00 a.m., 5/17/06 at 2:15 a.m., 9:30 a.m. and "3-11 [3:00 p.m. - 11:00 p.m.], 5/18/06 at 2:45 a.m. and 10:15 a.m., 5/19/06 at 1:47 a.m. and 11:00 a.m., 5/20/06 at 2:10 p.m. and 5/21/06 at 3:00 a.m. did not document diaphoresis or increased temperatures for this resident.</p> <p>d. A late entry Nurse's Note dated 5/21/06 at "3-11" and signed by Licensed Practical Nurse (LPN) #1 documented, at approximately 6:00 p.m. the resident was diaphoretic [profuse sweating] and the urine output was a dark yellow color. She documented she flushed the resident's gastrostomy tube with 120 cc's of water. She documented she also flushed the gastrostomy tube with 120 cc's of water at 8:00 p.m. and 10:30 p.m.</p> <p>There was no documentation the nurse notified the physician of the profuse sweating, dark urine or the administration of an additional 360 cc's of water administered in a 4.5 hour period.</p> <p>e. On 5/26/06 at 11:09 a.m., LPN #1 stated she had cared for the resident prior to 5/21/06; the LPN also stated the resident had "slight temp, gave Tylenol, it [temperature] went down, I don't know where they [vital signs] are, probably at home."</p> <p>When LPN #1 was asked if she had considered contacting a physician she stated, "No, cause that was just him. He had a brain injury that caused the flushing." The LPN was also asked when</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>Tylenol was given for a temperature and she stated, "I give around 101.0 [degrees], so his temp had to be at least 101, but I know it went down." The LPN stated she took the resident's temperature "axillary [under the arm, which is at least one degree less than actual body temperature]."</p> <p>f. Nurse's Notes dated 5/21/06 at 12:00 a.m., [midnight] and signed by LPN #2, documented the resident had a temperature of 98.9 degrees Farenheit and "is restless but afebrile at this X [time]. Will cont. [continue] to monitor."</p> <p>g. The next Nurse's Note entry dated 5/22/06 at 5:00 a.m., and signed by LPN #2 documented: "Res [resident] temp is 103.2 ax [axillary]. Dr. [Physician name] called, new order to send res to [Name of Hospital] ED [emergency department]for eval &amp; tx [treatment] if indicated."</p> <p>1) A DMS-762 witness statement dated 5/24/06 and signed by LPN #2 documented: "Res was diaphoretic early in the shift. I told my CNA's to use a cool damp cloth &amp; wipe res down [arrow down]. At approx 0100 [1:00 a.m.] I flushed peg [Percutaneous Endoscopic Gastrostomy] tube c H2O [water]," "Numerous X's [times] during the shift my CNA's wiped [resident] entire body down." LPN #2 was not available for interview during the survey dates.</p> <p>2) A DMS-762 witness statement dated 5/24/06 and signed by Certified Nursing Assistant (CNA) #1 (who worked 5/21/06 -5/22/06, 11:00 p.m. - 7:00 a.m.) documented, "Doing walk-thru round when we came on. Prior shift said he had a temp. so we checked him every hour and monitored his temp. When doing so we washed his face &amp; chest</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>&amp; back with cool wash cloth," "we made sure his linens were dry, because of his sweating" and "noticed that he was having bladder spasms, made sure and told EMT [Emergency Medical Technician] that he was having them, and also informed charge nurse of this and every thing we had done to [Resident #1] thru out the night."</p> <p>3) There was no documentation of hourly temperatures between 12 midnight and this entry at 5:00 a.m. or attempts to notify the Physician of the resident's change in status in this entry. A period of approximately 11 hours had passed since documentation of the change in the resident's urine output and presence of abnormal body temperature.</p> <p>h. A hospital Emergency Report dated 5/22/06 and signed by a Physician documented the resident had a trach with dried secretions "that look to be infected," "oral mucosa appears very dry," UA [urinary analysis] results with small amount blood, specific gravity of 1.030 (normal - 1.010 - 1.020), white blood cells of 5-10 (normal - none), blood chemistries of a white blood cell count of 13.8 (high, normal, 0-5), Sodium of 155 (high, normal 136-145), Chloride of 113 (high, normal 98-107) and BUN of 34 (high, normal 6-20).</p> <p>A hospital History and Physical dated 5/22/06 documented the resident was admitted to the Intensive Care Unit with diagnoses of Probable Pneumonia, Mild Dehydration and Probable Urinary Tract Infection.</p> <p>i. On 5/26/06 at 12:09 p.m., the DON and Administrator were asked if they had knowledge of the failure to notify a Physician in a timely</p>	F 157			

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F 157	Continued From page 5 manner after the resident's change in condition; they both stated, "No."	F 157		
F 309 SS=D	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 #11751 was substantiated (all or in part) in these findings.  Based on observation, record review and interview the facility failed to ensure that staff evaluated and responded appropriately to an acute change in condition for 1 (Resident #1) of 2 (Residents #1 and #4) case mix residents who had changes in condition that required timely evaluation and treatment. This failed practice had the potential to affect all 92 residents in the facility, according to the facility Roster Matrix received on 5/25/06. The findings are:  Resident #1 was admitted on 5/16/06 and had diagnoses of Urinary Retention with Foley Catheter, Hypertension, Pain, Respiratory Failure with Tracheostomy, Head Injury due to Motor Vehicle Accident (MVA), Gastrostomy Tube (G-Tube) and Fracture of Femur Neck and Lumbar Vertebrae.  a. The immediate Plan of Care dated 5/16/06 did	F 309		

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F 309	<p>Continued From page 6</p> <p>not document problems or planned interventions for care of the Foley catheter, G-tube or Tracheostomy.</p> <p>The Plan of Care did document a problem, "Potential for Dehydration" with interventions, "offer &amp; [and] encourage fluids on meal trays," care rounds and med pass "as needed," "Report to charge nurse poor skin turgor, sunken eyeballs, lethargy, confusion" and "Vital signs per schedule and PRN [as needed] report to Nurse increase in blood pressure, temperature, or heart rate."</p> <p>The Plan of Care did not document interventions for frequency of assessment for possible signs of dehydration or specific interventions for this resident who was dependent upon a G-tube for all nutrition and hydration.</p> <p>b. Informal notes written by the Director of Nursing (DON) and dated on 5/16/06 documented the nursing report she received prior to the resident's transfer from a hospital to the facility. Those notes documented the resident had a tracheostomy with Pseudomonas organisms in the trach secretions, a G-tube, was non-responsive, non-verbal, had a shearing brain injury, no lower extremity movement, "breaks out in diaphoretic sweats - keep fan on him all the time" and a Foley catheter.</p> <p>c. Admission Physician's orders dated 5/16/06 documented Jevity at 90 cc (cubic centimeters) / hour via pump. An admission physician's order documented the resident was to be administered tube feedings and receive nothing by mouth. A Telephone Order dated 5/17/06 documented additional orders to flush the G-tube with 150 cc</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>water every shift and 30 cc water before and after medications.</p> <p>d. Nurse's Notes dated 5/16/06 at 10:00 a.m., 5/17/06 at 2:15 a.m., 9:30 a.m. and "3-11 [3:00 p.m. - 11:00 p.m.], 5/18/06 at 2:45 a.m. and 10:15 a.m., 5/19/06 at 1:47 a.m. and 11:00 a.m., 5/20/06 at 2:10 p.m. and 5/21/06 at 3:00 a.m. did not document assessment of the resident's hydration status.</p> <p>e. A late entry Nurse's Note dated 5/21/06 at "3-11" and signed by Licensed Practical Nurse (LPN) #1 documented, "Foley intact to [arrow down] drain c [with] yellow urine @ [at] 1630 [4:30 p.m.]" and "Urine noted @ apprx [approximately] 1800 [6:00 p.m.] to be dk [dark] yellow et [and] resident to be diaphoretic [profuse sweating]. Nurse flushed peg tube c 120 cc H2O [water]. Nurse again flushed c H2O @ 2000 [8:00 p.m.] c 120 cc et apprx. 2230 [10:30 p.m.] c 120 cc H2O. No distress noted. Checked [check mark] frequently."</p> <p>That Nurse's Note did not document vital signs for the resident during the 3:00 p.m. - 11:00 p.m. shift, attempts to notify a physician of a change in status or further assessment of the resident's urine output. The Medication Administration Record (MAR) dated 05/2006 did not document administration of medications for an increased temperature.</p> <p>f. On 5/26/06 at 11:09 a.m., LPN #1 stated she had cared for the resident prior to 5/21/06 and when asked if she had assessed the resident's hydration status during her shift on 5/21/06 she stated, "No, he was flushing, diaphoretic, would pass hand-mitts over trach, restless." When</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>asked if she had been given instructions about what specific assessments were necessary for this resident, she stated, "No." The LPN also stated the resident had "slight temp, gave Tylenol, it [temperature] went down, I don't know where they [vital signs] are, probably at home."</p> <p>When asked why she had not conducted assessments of the resident's status with diaphoresis present, the LPN stated, "Just knew he would get that way." The LPN was asked to look at the resident's clinical record (which began on 5/16/06) and locate documentation of other diaphoretic episodes and she could not locate other documentation.</p> <p>The LPN also stated she could not remember seeing the resident's urine or conducting an assessment of his urine output after the water flushes were administered.</p> <p>When asked if she had considered contacting a Physician, the LPN stated "No, cause that was just him. He had a brain injury that caused the flushing." LPN #1 was also asked when Tylenol is given for a temperature and she stated, "I give around 101.0 [degrees], so his temp had to be at least 101, but I know it went down." The LPN stated she took the resident's temperature "axillary [under the arm]" and did not document information about the resident's change in status on the Nursing 24 Hour report for the next shift.</p> <p>g. Nurse's Notes dated 5/21/06 at 12:00 a.m., [midnight] and signed by LPN #2, documented the resident had a temperature of 98.9 degrees Farenheit and "is restless but afebrile at this X [time]. Will cont. [continue] to monitor."</p>	F 309			

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F 309	<p>Continued From page 9</p> <p>h. A DMS-762 witness statement dated 5/24/06 and signed by Certified Nursing Assistant (CNA) #1 (who worked 5/21/06 -5/22/06, 11:00 p.m. - 7:00 a.m.) documented, "Doing walk-thru round when we came on. Prior shift said he had a temp. so we checked him every hour and monitored his temp. When doing so we washed his face &amp; chest &amp; back with cool wash cloth," "we made sure his linens were dry, because of his sweating" and "noticed that he was having bladder spasms, made sure and told EMT that he was having them, and also informed charge nurse of this and every thing we had done to [Resident #1] thru out the night."</p> <p>i. The next Nurse's Note entry dated 5/22/06 at 5:00 a.m. and signed by LPN #2 documented, "Res [Resident] temp is 103.2 ax [axillary]. Dr. [Physician Name] called, new order to send res to [Name of Hospital] ED [emergency department]for eval [evaluation] &amp; tx [treatment] if indicated."</p> <p>There was no documentation of hourly temperatures between 12 midnight and this entry at 5:00 a.m., assessments of the resident's urine output or his hydration status in this entry. A period of approximately 11 hours had passed since the resident's initial signs of a condition change that included darkened urine and increased body temperature.</p> <p>j. A DMS-762 witness statement dated 5/24/06 and signed by LPN #2 documented, "Res was diaphoretic early in the shift. I told my CNA's to use a cool damp cloth &amp; wipe res down [arrow down]. At approx 0100 [1:00 a.m.] I flushed peg tube c H2O," "Numerous X's [times] during the shift my CNA's wiped [Resident #1] entire body</p>	F 309			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 10</p> <p>down" and "F/C [Foley catheter] care was done &amp; linens were changed along c [with] mouth care being done."</p> <p>k. A hospital Emergency Report dated 5/22/06 and signed by a Physician documented the resident had a trach with dried secretions "that look to be infected," "oral mucosa appears very dry," UA [urinary analysis] results with small amount blood, specific gravity of 1.030 (normal - 1.010 - 1.020), white blood cells of 5-10 (normal - none), blood chemistries of a white blood cell count of 13.8 (high, normal, 0-5), Sodium of 155 (high, normal 136-145), Chloride of 113 (high, normal 98-107) and BUN of 34 (high, normal 6-20).</p> <p>l. A hospital History and Physical dated 5/22/06 documented the resident was admitted to the Intensive Care Unit with diagnoses of Probable Pneumonia, Mild Dehydration and Probable Urinary Tract Infection.</p> <p>m. A Culture and Sensitivity report for tracheal secretions collected on 5/22/06 and reported on 5/24/06 documented the presence of Acinetobacter baumannii, a gram negative rod organism.</p> <p>An Internet website (WebMD) documented "there are at least 25 different species of Acinetobacter, and a few of these, particularly a species called Acinetobacter baumannii, can cause infections in hospital patients who are already unwell. Such infections can include pneumonia, bacteremia, skin and wound infections, or urinary tract infection."</p> <p>n. On 5/24/06 at 3:10 p.m., the resident was</p>	F 309			

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

PRINTED: 06/09/2006  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	Continued From page 11 observed in the hospital ICU, was awake, alert, non-verbal, in Contact Isolation, had IV's and piggy-back antibiotics infusing, a Foley catheter was draining clear, amber urine and Oxygen was on at 3 liters per minute.  o. On 5/26/06 at 12:09 p.m., the Director of Nursing and Administrator were asked if they had knowledge of the failure to ensure a Physician evaluated/treated the resident in a timely manner after the resident's change in condition; they both stated, "No."	F 309			