

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

PRINTED: 10/27/2006
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 10/13/2006
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 # 12037 Substantiated (all or in part) with deficiency cited at F312 Complaint # 12048 Substantiated (all or in part) with deficiencies cited at F157 Complaint # 12035 Substantiated (all or in part) with deficiency cited at F225, F226, F312 and F364	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)	F 156		

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 156	<p>Continued From page 1 (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p>	F 156			

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F 156	<p>Continued From page 2</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview the facility failed to ensure name, address and telephone numbers for Medicare, Medicaid and State Office of Long Term Care were posted. This failed practice had the potential to affect all 97 residents residing at the facility as documented on the Resident Census and Condition of Residents form dated 10/09/06.</p>	F 156			

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F 156	Continued From page 3 1. On 10/12/06 at 4:00 p.m. there were no information posted inside the facility with the name, address and phone number for the Office of Long Term Care, Medicare and Medicaid. 2. On 10/12/06 at 5:35 p.m. the administrator stated he thought it was posted somewhere on one of the back halls.	F 156			
F 157 SS=E	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	F 157			

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F 157	<p>Continued From page 4</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #12048 was substantiated (all or in part) with these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure that the physician was consulted immediately after changes in condition and the family was notified for 2 (Residents #4, and #7) of 17 case mix residents (Residents #1 -12, and 20-24). The failed practice had the potential to affect all 97 residents, as documented on the facility's Resident Census and Conditions of Residents form dated 10/10/06. The findings are:</p> <p>1. Resident #7 had diagnoses of Hypertension and Failure to Thrive. The Change of Condition Minimum Data Set (MDS) dated 7/5/06 documented the resident had moderately impaired cognitive skills for daily decision-making, had Hospice and required assistance with Activities of Daily Living.</p> <p>a. On 10/10/06 at 7:30 a.m. resident was sitting up in bed and had received her breakfast of a regular diet with super cereal. The resident was not eating and stated my throat is so sore I cannot swallow. At 8:10 a.m. a CNA (Certified Nurse Aide) came into the room and took the resident's tray and did not offer the resident any other food, the resident had taken 1 bite of the scrambled eggs and the resident told the CNA she could not swallow and the CNA told the</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>resident the nurse would bring her something. At 10:10 a.m. the CNA came back and asked the resident if the Nurse had brought her anything for her sore throat. She stated No.</p> <p>b. On 10/11/06 at 8:20 a.m. the Resident was sitting up in bed with her breakfast in front of her. Resident stated, I can't eat my throat is so sore. The resident was asked if she had gotten any medicine or had anyone taken her temperature or called her doctor, the resident stated, "No, I've been telling them for 3 days now."</p> <p>c. On 10/11/06 at 1 p.m., the DON (Director of Nursing) stated, "Yes, I knew she was complaining of a sore throat and had helped looked for the Chloraseptic spray. No I did not notify the Doctor or the Family.</p> <p>d. On 10/11/06 at 2:50 p.m., LPN (Licensed Practical Nurse) # 4 was asked if she knew the resident had a sore throat and had the CNA told her on 10/10/06. LPN #4 stated, "Yes, the CNA and the Hospice CNA had told me. I checked to see if she had Chloraseptic spray and it had been discontinued. I gave her a pain pill. I can't remember if I notified the Doctor, if its not documented, I guess the chart was gone and I didn't get to it. On 10/11/06 I had also given her a Darvocet (pain pill), I did not notify the Doctor or the Resident's Family."</p> <p>e. The facility's Policy and Procedure, received from DON on 10/13/06, Titled: Nursing Management Manual documented, "Policy Title: Change in Medical Condition of Residents. Purpose: To keep the physician ... family members ... informed of the resident's medical condition so they may direct the plan of care as</p>	F 157			

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F 157	<p>Continued From page 6</p> <p>needed. Standard: To keep the physician ... family ... should occur promptly, according to federal regulation ... when there is change is the resident's condition ... Defined as: ... Loss of appetite ... New Pain ... Process: Determining when to call: ... In Non-Emergency-during normal office hours ... no later than the next day ... Documenting the Change of Condition:(COC) Nurses notes should include documentation of the symptoms and observations associated with the COC. the date, the time of contact with the physician and the family ... The 24 hour report serves as a reminder to report any COC to the oncoming shift ... "</p> <p>f. As of 10/13/06 at 10:00 a.m., there were no Nurses notes documenting Physician and/or Family had been notified.</p> <p>4. Resident # 4 had diagnosis of Dementia without Behaviors and Decubitus Ulcer. The Medicare 30 day Minimum Data Set dated 8/29/06 documented the resident had severely impaired cognitive skills for daily decision making, required total assistants of 2 staff for transfer, bed mobility, dressing and required total assistants of 1 staff for hygiene, bathing and ambulation.</p> <p>a. Nurses Notes dated 10/05/06 at 1600 (4:00 p.m.) documented, "Res. [resident] returned from appt. [appointment] c [with] new orders. Message left on machine for [daughter's name] to notify of new orders ... " At 1831 (6:31 p.m.) nurses notes documented, "[daughter's name] returned my call. Very upset about mother going to appt that [daughter's name] was not aware of ... "</p> <p>b. In the front of the resident's chart taped to the</p>	F 157			

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F 157	Continued From page 7 inside of the front is a sign in large black letters that states, "DO NOT SEND [resident #4]OUTSIDE THIS FACILITY WITHOUT NOTIFYING HER DAUGHTER FIRST!!!"	F 157			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225			

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F 225	<p>Continued From page 8</p> <p>incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #12035 was substantiated (all or in part) with these findings.</p> <p>Based on interview, the facility failed to ensure an allegation of verbal abuse was immediately reported to Administration and the local law enforcement as required by state law. This failed practice had the potential to affect all 97 residents, as documented on the Resident Census and Conditions of Residents form dated 10/10/06. The findings are:</p> <p>1. On 10/10/06 at 11:30 a.m., CNA #6 stated CNA #9 " cusses around the resident's and today she was cussing in front of a family member " . She stated, " We have reported this to LPN # 1 on several occasions and there is nothing done. Today we made a formal grievance about 2 hours ago and gave it to LPN #1. That is what we are told is our chain of command.</p> <p>a. On 10/11/06 at 10:00 a.m. LPN # 4, who was the Charge Nurse on East Hall, stated she had a CNA who came to her sometime this week or the end of last week and told her she (the C.N.A) had heard another CNA talking rough and rude to a resident. The LPN stated " I told the CNA to go tell LPN #1 ...No, I did not go tell the DON or the Administrator. "</p> <p>c. On 10/11/06 at 10:30 a.m. during an interview</p>	F 225			

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F 225	Continued From page 9 with CNA #6 she stated she had been reporting rough, rude, yelling, and cussing of the resident's by another C.N.A for several weeks and nothing had been done about it. She stated " We are told to go through the chain of command and that is LPN #1, and then she reports to the DON and the DON goes to the Administrator. d. On 10/10/06 at 11:55 a.m. the surveyor reported the allegations regarding CNA #9 cussing around the residents to the Administrator. The Administrator stated, " I will have to investigate this. " He asked the DON if LPN # 1 had told her about the grievance and she stated, " No, she didn't, she has not told me " . e. On 10/11/06 at 2:10 p.m. during an interview with the Administrator and DON, the Administrator was asked what had been done regarding the allegation of verbal abuse by CAN #9. He stated he had suspended the CNA and sent a report to the State Agency. He was asked the police had been notified. He stated they had not.	F 225			
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Complaint # 12035 was substantiated (all or in part) with these findings. Based on record review and interview the facility	F 226			

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F 226	<p>Continued From page 10</p> <p>failed to ensure its Policy and procedure included Reporting Requirements according to state Law and failed to follow its Policy and Procedure regarding notification of Administration when an allegation of verbal abuse was made against 1 CAN. This failed practice had the potential to affect 97 residents, as documented on the Resident Census and Conditions of Residents form dated 10/10/06. The findings are:</p> <ol style="list-style-type: none"> 1. The facility ' s Policy and Procedure titled Abuse, Neglect and Exploitation documented " Report allegations or suspected abuse, neglect or exploitation immediately to: State Agencies, Local Ombudsman Office, Director of Nursing. " The policy did not document the facility should notify local law enforcement as required by State Law ... 2. The facility ' s Policy and Procedure section titled " Response and Reporting of Abuse, Neglect and Exploitation " documented " Anyone in the facility can report suspected abuse to the abuse agency hotline. When Abuse, neglect or exploitation is suspected the Licensed Nurse should ...Notify the Director of Nursing and Administrator. 3. On 10/10/06 at 11:30 a.m. CNA #6 stated CNA #9 " cusses around the resident's and today she was cussing in front of a family member " . She stated " We have reported this to LPN # 1 on several occasions and there is nothing done. Today we made a formal grievance about 2 hours ago and gave it to LPN #1. That is what we are told is our chain of command. 4. On 10/11/06 at 10:00 a.m. LPN # 4, who was the Charge Nurse on East Hall, stated she had a 	F 226			

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F 226	Continued From page 11 CNA who came to her sometime this week or the end of last week and told her she (the C.N.A) had heard another CNA talking rough and rude to a resident. The LPN stated " I told the CNA to go tell LPN #1 ...No; I did not go tell the DON or the Administrator. " 5. On 10/11/06 at 10:30 a.m. during an interview with CNA #6 she stated she had been reporting rough, rude, yelling, and cussing of the resident's by another C.N.A for several weeks and nothing had been done about it. She stated " We are told to go through the chain of command and that is LPN #1, and then she reports to the DON and the DON goes to the Administrator. 6. On 10/10/06 at 11:55 a.m. the surveyor reported the allegations regarding CNA #9 cussing around the residents to the Administrator. The Administrator stated " I will have to investigate this. " He asked the DON if LPN # 1 had told her about the grievance and she stated " No, she didn't, she has not told me " . 7. On 10/11/06 at 2:10 p.m. during an interview with the Administrator and DON, the Administrator was asked what had been done regarding the allegation of verbal abuse by CAN #9. He stated he had suspended the CNA and sent a report to the State Agency. He was asked the police had been notified. He stated they had not.	F 226			
F 241 SS=B	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241			

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F 241	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to maintain residents' dignity and respect by not knocking before entering residents' rooms and asking permission of the resident to enter the room. This failed practice had the potential to effect all 97 residents in the facility according to the Resident Census and Condition of Resident dated 10/09/06. The findings are: 1. The facility's policy and procedure, "Social Service Manual" documented under the Standard section, "Dignity means that in their interactions with residents, staff carry out activities, which assist the resident to maintain and enhance his/her self-esteem and self-worth. Examples may include: respecting resident's private space and property [e.g., ... knocking on doors and requesting permission to enter...]." 1. On 10/09/06 at 2:15 p.m. during initial rounds with License Practical Nurse (LPN) # 8 16 rooms were entered. LPN # 8 did not knock on any of the 16 room doors before entering the room. 2. On 10/9/06 during initial rounds 16 resident rooms were entered. RN#1 did not knock on the resident's door prior to entering the rooms. 3. A sign on all resident room doors documented, "Welcome to my home Please Knock."	F 241			
F 246 SS=E	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable	F 246			

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F 246	<p>Continued From page 13</p> <p>accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview the facility failed to ensure that problems with residents glasses were solved as soon as can be arranged for 1 (Resident # 8) of 10 (Residents #1, 2, 3, 5, 6, 7, 10, 11, 13, and 15) case-mix residents in need of glasses. This failed practice has the potential to effect all 97 residents in the facility according to the Residents Census and Condition of Residents report dated 10/9/06. The facility also failed to ensure milk preference was accommodated for 2 (Resident # 8 and # 16) of 12 (Resident # 1 through # 3 and # 6 through # 12) case-mix residents that received a diet tray from the kitchen. This failed practice has the potential to effect 95 residents in the facility that receive a diet tray from the kitchen according to the diet list dated 10/9/06. The findings are:</p> <p>1. Resident # 8 had a diagnosis of Cerebral Vascular Accident (C.V.A.), Hypertension and Congestive Heart Failure. The annual MDS (Minimum Data Set) dated 7/21/06 documented the resident had modified independent cognitive skills for daily decision making and had some difficulty in new situations only.</p> <p>a. On 10/9/06, resident # 8 stated that about 2 years ago and then again about 1 year ago he went to the eye doctor for new glasses. He stated he has never gotten the glasses. He</p>	F 246			

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F 246	<p>Continued From page 14</p> <p>stated that the Social Service Director, brought him a pair of glasses that he could not see through, everything was blurry. He brought him another pair of glasses that weren't any better. He hasn't seen any other glasses since. The resident was not wearing glasses during the initial rounds.</p> <p>b. On 10/10/06 at 11:30 a.m., the Social Service Director stated the residents that needed glasses was examined and glasses were ordered. He stated that the first batch of glasses were received about six weeks ago. The next batch of glasses were received about 3 weeks later. The last batch of glasses was received a few days ago. He stated that he was waiting for all the glasses to be delivered to the facility before he sent the glasses back to have them replaced. He stated that he had told the Director of nurses there had been a problem with the glasses but he never told the Administrator about the problem.</p> <p>c. On 10/10/06 at 11:38 a.m., the Administrator stated that he had not been informed that there was a problem with the resident's glasses. He also stated that it was not acceptable to wait all this time before some thing was done about the glasses. He stated, "This is not meeting the resident's needs".</p> <p>2. Resident # 8 had a diagnosis of C.V.A.. The annual MDS dated 7/21/06 documented the resident had modified independent cognitive status for daily decision making.</p> <p>a. A physician's order dated 2/17/04 documented, " Regular NAS (No added salt diet) Diet."</p>	F 246			

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F 246	Continued From page 15 b. On 10/10/06 at 9:45 a.m. the resident stated that he wanted 2% milk not the (whole) milk he had been served. He stated he had asked several times for 2% milk. He was told that the facility did not buy 2% milk, they only bought whole milk. 3. Resident # 16 had a diagnosis of Depressive Disorder. a. A physician's order dated 6/23/06 documented, "Regular diet". b. On 10/10/06 at 9:45 a.m., the resident stated that he liked buttermilk and had been asking for buttermilk for a long time. He stated he was told the facility did not have any buttermilk, they only bought whole milk. 4. On 10/10/06 at 4:00 p.m., the dietary manager was asked if the facility provided 2% milk or buttermilk, he said, "No we only have 2 milks, whole milk and chocolate milk". 5. On 10/13/06 at 9:40 a.m., the Dietary Manager was asked why he has not ordered 2% milk or butter milk, he stated that he stopped carrying it about 6 months ago and he wasn't going to order it if they (the residents) won't drink it".	F 246			
F 253 SS=C	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 253			

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F 253	<p>Continued From page 16</p> <p>interview the facility failed to ensure that the rooms were free of odors, bedside commodes lids were in good repair, emptied after use, free of odor and stains, incontinent briefs were disposed of and not place on the floor after use, floors in the hallways were not stained with a fecal like matter, floor tiles were not cracked and/or missing and did not have glue oozing out from around the edges and in good repair, beds were free of rust , venetian blinds were not broken and the residents night stands and chest of drawers were in good repair. The failed practice had the potential to affect all 97 residents in the facility according to the Residents Census and Condition of Residents form dated 10/12/06. The findings are:</p> <p>1. On 10/11/06 at 3:00 p.m. and 10/12/06 at 3:20 p.m. the following observations were made:</p> <p>a. There was a dried stool and urine like stains in the pot of the bedside commode in room # 24.</p> <p>b. There was yellow colored urine like liquid in the pot of the bedside commode in room # 44. There was a strong urine odor present in the room.</p> <p>c. There was a feces like stains in the pot of the bedside commode in room # 38. The lid of the bedside commode had several dried urine like stains on it.</p> <p>d. There was a dried urine stains on the lid of the bedside commode in room # 39. The lid of the bedside commode was loose.</p> <p>2. There was a broken and bent venetian blinds in room # 5 and room # 14.</p>	F 253			

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F 253	<p>Continued From page 17</p> <p>3. There was a wet incontinent brief on the floor, under the foot of the bed in room # 26. A strong urine odor was present throughout the room.</p> <p>4. There was a strong urine odor present in the bathroom of room # 10.</p> <p>5. There were 3 large (approximately 3 inches in diameter) feces like stains in the floor of the north hall.</p> <p>6. The weight chair located on the south east hall was chipped in several places and the entire chair was in need of repainting.</p> <p>7. There was a 1x1 inch square hole in the bathroom door of room # 53.</p> <p>8. There were several cracked floor tiles on the south east hallway.</p> <p>9. There was a black sticky glue like matter oozing out around approximately 1/2 of the floor tile in the large dining room.</p> <p>a. On 10/12/06 at 4:00 p.m. the Administrator stated that they had been having problem with the glue coming up between the tiles in the dining room and they have had a problem getting the man that laid the tiles to correct the problem. He stated that the corporate had told him they would probably have to sue the man to get the problem corrected.</p> <p>b. The facility Quality Assurance Committee Action form provided by the Administrator on 10/12/06 at 5:00 p.m. documented the dining room floor tiles were replaced "early" 2006 and will be repaired by 12/15/06. The documentation</p>	F 253			

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F 253	<p>Continued From page 18 indicated the floor has been in need of repair for several months.</p> <p>10. The following beds through out the facility had rust on the frames.</p> <p>a. On the north hall the beds in rooms # 4A, # 4B, #8A, # 8B, # 11A, #11B, # 12A and 12B. (8 beds)</p> <p>b. On the east hall the beds in rooms # 18A, # 20A, # 20B, # 24A, # 25A and # 25B. (6 beds)</p> <p>c. On the south hall the beds in rooms # 29A, #29B, # 34A, # 35, # 38A and # 38B. (6 beds)</p> <p>c. On the south east hall the beds in rooms # 44A, # 44B, # 45A, # 46A, # 46B, #47A, # 47B, # 48A, # 48B and # 49B. (10 beds)</p> <p>d. On north east hall the beds in rooms # 55A, # 55B, # 58A and 58B. (4 beds)</p> <p>11. The following over bed table through out the facility were rusty and broken.</p> <p>a. On the north hall in rooms # 2A and # 7A. (2 over bed tables)</p> <p>b. On the south hall in rooms # 31A, # 32A, # 32B, # 33A, # 33B, # 34, # 35, # 38A, # 38B, # 39A and # 39B. (11 over bed tables)</p> <p>c. On the south east hall in rooms # 44A, #44B, # 45A, # 45B, # 46A, # 46B, # 47A, # 47B, # 48A and # 49B. (10 over bed tables)</p> <p>d. On the north east hall in rooms # 51, # 57A, # 57B, # 58A and # 58B.</p>	F 253			

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F 253	Continued From page 19 12. The following night stands through out the facility were chipped and/or splintered: a. On the east hall in rooms # 16A, # 18A, # 18B, # 20A, # 21B, # 22B, # 23A, # 24A, # 25A and #25B. (10 night stands) b. On the south hall in rooms # 30A, # 30B, # 34B, # 35A, # 35B, # 38A, # 38B # 39A and # 39B. (9 night stands) c. On the south east hall in rooms # 44A, # 44B, # 45A, # 45B, # 46A, # 46B, # 47A, # 47B, # 48A, # 48B, # 49A and # 49B. (12 night stands) d. On the north east hall in rooms # 53A, # 57A, # 57B, # 62A and # 62B. (5 night stands) 13. The following chest of drawers through out the facility were chipped and /or splintered: a. On the north hall in room # 2A. (1 chest of drawers) b. On the East Hall in rooms # 16A, # 21A, # 21B, #23A, # 23B, # 24A, # 25A and # 25B. (8 chest of drawers) c. On the south hall in rooms # 29B, # 38A, # 38B, # 39A and # 39B. (5 chest of drawers) d. On the south east hall in rooms # 44A, # 44B, # 45A, # 45B, # 46A, # 46B, # 47A, # 47B, # 48A, # 48B. (10 chest of drawers) e. On the north east hall in rooms # 51, # 55A, # 55B, # 56A, # 57A, # 57B, # 58A, # 58B, # 62A and # 62B. (10 chest of drawers)	F 253			

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F 253	Continued From page 20 14. The following floors in resident's rooms, stained or cracked floor tiles. a. On the north hall in room # 2. b. On the east hall in rooms # 16, # 18, # 19, # 20, # 21, # 22, # 23, # 24 and # 25. c. On the south halls in rooms # 30, # 33, # 34, # 35 and # 38. d. On the south east hall in rooms # 44, # 45, # 46, # 47, # 48 and # 49. e. On the north east hall in rooms # 53, # 55, # 56, # 57, # 58, # 59, # 61, # 62, # 63 and # 64. 15. The following walls in resident's rooms and or bath rooms had gouged area, scraped wallpaper, hole in bath room door and unpainted surfaces: a. On the north hall in room #2. b. On the east hall in rooms # 18, # 20, # 22, # 23, # 24 and # 25. c. On the south hall in rooms # 33, # 34, # 35, # 37 and # 38. d. On the south east hall in rooms # 44, # 45, # 46, # 47, # 48 and # 49. e. On the north east hall in rooms # 51, # 53, # 55, # 56, # 57, # 58, # 59, # 61, # 62, # 63 and # 64. 16. In the resident dining room there were 7 dining tables, 1 feeder table and 1 regular chair	F 253		

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F 253	Continued From page 21 rickety and uneven. The facility has placed pieces of cardboard under some of the table legs to steady the tables. 17. On 10/13/06 at 10:15 a.m. the following conditions were observed in the kitchen: a. Six to 8 floor tiles were missing and the black concrete underneath was showing. b. Seams in the linoleum floor were peeling and separating under the sink and the oven and tiles were missing underneath the oven. c. Floor tiles and linoleum were stained and mismatched. d. Tiles under the handwashing sink were peeling and separating from the floor showing the black concrete underneath. e. Tiles under the cooks table were loose and showing the black concrete flooring underneath. f. The pots and pans sink and handwashing sink had loose, peeling tiles underneath with moist areas. g. Approximately 4 feet of baseboard along the walls behind the handwashing sink and the entrance to the storage room was missing and the wall was wet and crumbling. h. Six floor tiles were missing in the back of the kitchen and in the storage room.	F 253			
F 278 SS=C	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the	F 278			

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F 278	<p>Continued From page 22 resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review the facility failed to ensure than an Registered Nurse had signed and dated the Minimum Data Set Assessments, and the signed signatures and dates of any person completing any portion of the assessment were present for 2 (resident #5 and #22) of 24 (Residents #1- 24) case mix residents who required a Minimum Data Set assessments.</p>	F 278			

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F 278	<p>Continued From page 23</p> <p>This failed practice had the potential to affect 95 residents in the facility according to the Resident's Census and Conditions of Residents form dated 10/9/06. The findings are:</p> <ol style="list-style-type: none"> 1. Resident #5 had a diagnosis of Alzheimer's. The Minimum Data Set (MDS) dated 8/14/06 documented that the resident had severely impaired cognitive skills for daily decision making. <ol style="list-style-type: none"> a. On 10/11/06 at 2:00 p.m. after complete review of the clinical record these are the findings: <ol style="list-style-type: none"> a. The MDS with a Assessment Reference Date (ARD) of 8/7/05 did not have a signature or date of a Registered Nurse. b. The MDS with a ARD of 11/14/05 did not have dates beside signatures of persons who completed any portion of the assessment. c. The MDS with a ARD of 2/5/06 had no signatures. d. The MDS with a ARD of 5/5/06 did not have the dates the Registered Nurse or any persons that signed the form. e. The MDS with a ARD of 8/5/06 did not have a date beside all the signatures completing the assessment. 2. Resident #22 had a diagnosis of Cardiovascular Accident, Anemia, and Organic Brain Syndrome. The MDS dated 9/22/06 documented that the resident had severely impaired cognitive skills for daily decision making. 	F 278			

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F 278	Continued From page 24 a. On 10/13/06 at 11:00 a.m., after complete review of the clinical record the following findings were noted: b. The MDS with a ARD for 10/30/05 was not on the chart. It was printed by LPN #5 on 10/12/06 at 4:00 p.m. It had no signatures. c. The MDS with a ARD of 3/18/06 did not have a date that the Registered Nurse (RN) signed verifying the accuracy and that the assessment was complete. It does not have dates beside signatures of 4 other persons completing the assessment. d. The MDS with a ARD of 6/20/06, 4/16/06, 1/10/06 did not have dates beside the signatures of the other persons completing the assessments. e. The MDS with a ARD of 7/31/05 did not have an RN signature verifying the accuracy and that the assessment was complete. f. The MDS with a ARD of 9/20/06 did not have dates beside 2 of the signatures completing the assessment.	F 278			
F 279 SS=B	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279			

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F 279	<p>Continued From page 25</p> <p>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to ensure that the care plans had been reviewed and updated by an interdisciplinary team for 2 (Resident #8 and 11) of 24 (Residents #1-24) case mix residents who require the review and update of the care plan. This failed practice has the potential to effect 97 residents in the facility according to the Census and Condition Report provided by the facility on 10/9/06. The findings are:</p> <p>1. Resident # 8 has a diagnosis of Cerebral Vascular Accident, Congestive Heart Failure and Hypertension.</p> <p>a. On 10/10/06 at 12:30 p.m. after complete record review of the residents clinical record, there was not a Care plan Attendance Form that had been signed or dated since 7/27/05 to indicate the resident's care plan had been reviewed and updated by an interdisciplinary care</p>	F 279			

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F 279	Continued From page 26 team. 2. Resident # 11 has a diagnosis of Schizophrenia, Congestive Heart Failure, Renal Failure and Diabetes. a. On 10/10/06 at 1:30 p.m. after complete review of the residents clinical record, there was not a Care plan Attendance Form in the resident's clinical record that indicated the residents care plan had been reviewed and updated by an interdisciplinary care team. 3. On 10/12/06 at 3:35 p.m. the Director of Nursing stated that she was unable to provide a Care plan Attendance Form that documented the resident care plan had been reviewed and updated by an interdisciplinary care team.	F 279			
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that physician's orders were followed for 2 (Residents #12 and 13) of 2 case mix residents who had changes mad to the time of administration of current medication without notifying of the physician. This failed practices had the potential to affect 40 residents on the Southeast and Northeat halls that had time administrations	F 282			

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F 282	<p>Continued From page 27</p> <p>changes made according to the Director of Nursing on 10/10/06 at 10:25 a.m.. The findings are:</p> <p>1. The facility's Policy and Procedure of Medication Administration documented the time for twice of day medication administration was 9:00 a.m. and 5:00 p.m.</p> <p>a. On 10/9/06 at 5:50 p.m. review of the Medication Administration Record, the 5:00 p.m. medication time had been marked out and it had been changed to 9:00 p.m.</p> <p>2. Resident #13 had Advair 500/50, Aldactone 25 milligrams (mg), and Ferrous Sulfate 325 mg and the 5:00 p.m. marked out and changed to 9:00 p.m..</p> <p>a. Physician oder dated 4/28/06 documented, "Advair 500/50 1 puff BIB (twice daily) ... Aldactone ... 25MG (milligram) PO (by mouth) BID ... FESO4 [Ferrous Sulfate] 325 MG PO BID ... ".</p> <p>3. Resident #12 had Mag-Oxide 400 mg, Cogentin 1 mg, and Colace 100 mg and the 5:00 p.m. the marked out and change to 9:00 p.m..</p> <p>a. Admission orders dated 10/12/06 documented, " Magnesium Oxide 400 mg (milligram) PO BID ... Cogentin 1 mg PO TID ... Colace 100 mg PO BID ...</p> <p>d. On 10/10/06 at 10:25 a.m. the Director of Nursing stated, "I changed the times on the medications, I did not think I had to have an physician's order. I have only changed the resident's on Southeast and Northeast, not the</p>	F 282			

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F 282	Continued From page 28 residents in the front halls."	F 282		
F 286 SS=B	<p>483.20(d) RESIDENT ASSESSMENT - USE</p> <p>A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review the facility failed to ensure 15 months of Minimum Data Set (MDS) Assessments were in the clinical record for 2 (Resident #5 and # 22) of 24 (Residents # 1-24) case mix residents who require MDS assessments. This failed practice had the potential to affect 95 residents in the facility according to the Resident's Census and Conditions of Residents form dated 10/9/06. The findings are:</p> <p>1. Resident #5 has a diagnosis of Alzheimer's. The Minimum Data Set (MDS) dated 8/14/06 documented that the resident had severely impaired cognitive skills for daily decision making.</p> <p>a. On 10/11/06 the resident's clinical record was reviewed. There were quarterly MDS assessments with reference dates of 8/7/05, 11/14/05, 5/5/06, and 8/5/06. There were no annual assessments on the resident's chart.</p> <p>b. On 10/11/06 at 11:30 a.m. LPN # 5 was asked if there were any other assessments for the resident. She printed an annual assessment with a assessment reference date of 2/5/06.</p>	F 286		

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F 286	Continued From page 29 2. Resident #22 had diagnoses of CVA (Cardiovascular Accident), Anemia, and Organic Brain Syndrome. The MDS dated 9/22/06 documented that the resident was severely impaired in cognitive skills for daily decision making. a. On 10/12/06 at 2:00 p.m. the resident's Clinical Record was reviewed. There were MDS's Assessment with a reference dates of 7/13/05, 1/10/06, 4/16/06, 3/18/06, 6/20/06 and 9/20/06. There was no assessment on the chart for 10/05. b. On 10/12/06 at 3:45 p.m. LPN #5 was asked if there were any other assessments for the resident, she printed an assessment with a reference date of 10/30/05. c. On 10/10/06 LPN #5 stated that 15 months of MDS assessments should be kept on the Resident's Clinical Record.	F 286			
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: Based on observation, record review and interview the facility failed to ensure that the foley catheter tubing is free of kinks and not lying under the resident while in bed for 1(Resident # 4) of 4	F 309			

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F 309	Continued From page 30 (Resident # 1, 2, 4, and 12) case mix residents with indwelling catheters. This failed practice had the potential to affect 12 residents with indwelling catheters according to the Director of Nursing on 10/12/06. The findings are: Resident # 4 had a diagnosis of Decubitus Ulcer. The Medicare 30 day Minimum Data Set assessment dated 8/29/06 documented indwelling catheter. a. A physician order dated 7/28/06 documented, "Catheter 16 Fr[French]/5 cc [cubic centimeters] q [every] 15th month change." b. On 10/09/06 at 3:22 p.m., during the initial rounds with License Practice Nurse (LPN) # 8 the resident was found lying on her right side with the Foley catheter tubing under her side. The LPN remove the tubing from underneath the resident stating, "Oh, she shouldn't be lying on this [tubing]." c. The facility's policy and procedure, "Urinary Catheter Care" documents, "Purpose: Urinary Catheter care helps to prevent urinary tract infection. Process: I e. Check catheterized residents frequently for kinks in the tubing or lying on the tubing."	F 309			
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312			

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F 312	Continued From page 31 This REQUIREMENT is not met as evidenced by: Complaint #12035 was substantiated (all or in part) with these findings: Based on observation and record review the facility failed to ensure the resident received the care necessary to prevent strong B.M. odors from the colostomy for 1 (Resident # 12) of 4 case-mix residents with a colostomy. This failed practice has the potential to effect 4 residents in the facility with a colostomy according to the Director of Nurses on 10/9/06. The findings are: 1. Resident # 12 had a diagnosis of Ileus. The Minimum Data Set dated 8/14/06 documented the resident was totally dependent on staff for bathing and hygiene and had a colostomy. 2. On 10/10/06 at 7:15 a.m. a very strong over powering B.M. odor in the resident's room permeating out into the hall. Observation of the resident's colostomy bag determined the colostomy bag had detached and B.M. was spilling out on to the resident's bed linens. 3. On 10/12/06 at 1 p.m. a very strong B.M. odor was noted out in the hall that permeated to the nurse's station. Observation of the resident's colostomy determined the colostomy bag was completely full.	F 312			
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea,	F 322			

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F 322	<p>Continued From page 32</p> <p>vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation the facility failed to ensure that placement was checked prior to administration of medication and the head of bed remained elevated for 1 (resident #5) of 2 (resident #5 and #11) case mix resident's who had a gastrostomy tube used for administration of medications. This failed practice had the potential to affect 3 residents in the facility who had a gastrostomy tube according to the list provided by the Administrator on 10/12/06. The findings are:</p> <p>1. Resident #5 has a diagnosis of Alzheimer's. The Minimum Data Set dated 8/14/06 documented that the resident had severely impaired cognitive skills for daily decision making, dependent for eating and receives 75% to 100% total calories through a tube feeding.</p> <p>a. The Care Plan dated 4/6/06 documented, "Problem: 9. 9/23/03 tube. Potential for complications r/t (related to) tube feeding. Goal: Minimize the risk of complications related to tube feeding thru the following approaches thru next review Approaches: ... 3. Check tube placement prior to administering medication. ... 5. Keep HOB (head of bed) elevated least 30 degrees @ (at) all times".</p> <p>b. Physician order dated 7/12/06 documented, "Tube feeding water flush with 200 cc (cubic</p>	F 322			

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F 322	Continued From page 33 centimeters) H2O (water TID (tree times per day) flush with 30 cc H2O before [and] after meds. c. On 10/10/06 at 10:00 a.m., LPN (Licensed Practical Nurse) #4 disconnected the residents tube feeding. The LPN then flushed the gastrostomy tube with 60 cc (cubic centimeters) of water. LPN #4 did not check placement of the tube prior to flushing the tube. CNA (Certified Nursing Assistant) #4 and CNA #5 then rolled the head of the bed down flat immediately after LPN #4 disconnected the tube feeding. d. The Policy and Procedure documented, "Nursing Procedures Manual. ... Tube Feeding - Preventing Contamination ... Process ... 18. Prevent aspiration risk by keeping the head of the bed elevated; ... 19. Change syringe every 24 hours. Store in water proof bag that is also changed every 24 hours; clean and dry after each use.	F 322			
F 323 SS=B	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure that the electrical room was locked and aerosols sprays are stored in secure area. The failed practice had the potential to affect 14 resident's on the South East Hall who are ambulatory or use a wheel chair for mobility. The findings are: 1. On 10/9/06 at 2:45 p.m. and 10/10/06 at 7:15	F 323			

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F 323	Continued From page 34 a.m., the Electrical Room located on the South East Hall, was unlocked. The room is located next to the phone used by the resident's.	F 323			
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure that 1 (resident #5) of 6 case mix residents (Resident #1, #2, #4, #5, #12, 19) was transferred in a manner to prevent harm. This failed practice had the potential to affect 24 resident's in the facility who were dependent on staff for transfers according to the list provided by the Administrator on 10/12/06 at 11:00 am. The findings are: 1. Resident #5 had a diagnosis of Alzheimer's. The Minimum Data Set (MDS) dated 8/14/06 documented that the resident was severely impaired in cognitive skills for daily decision making, had functional limitation in range of motion on both sides of leg and foot and dependent on staff for transfers. a. The Care Plan dated 4/5/06 documented "Pt	F 324			

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F 324	Continued From page 35 (patient) up to g-chair (geri-chair) daily using mech (mechanical) lift x (times) 2 people." b. On 10/10/06 at 10:00 a.m., CNA #4 and #5 sat the resident up on the side of the bed. Her legs were straight out in front of her. They were facing the resident and placed their arms beneath the resident's arms. They lifted the resident, turned and placed the resident in the geri-chair. They then lifted the resident beneath the arms and repositioned her in the chair. All the resident's weight was placed in the axilla area. c. The Policy and Procedure provided by the the Administrator documented, "Nursing Procedures Manual ... Two Person Lift Transfer . . .Process: ... 3. Person #1 supports the resident's head, neck and trunk and stands behind the chair. 4. Person #1 reaches around the resident and takes the resident by the wrists close to the body and across the chest firmly. 5. Person #2 stands alongside the resident's legs and puts left and under the resident's thigh. ...".	F 324			
F 328 SS=E	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328			

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F 328	<p>Continued From page 36</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review & interview the facility failed to ensure that oxygen was administered at the rate ordered by the physician, oxygen filters were clean and free of lint 5 (Resident 11, 20, 22, 23 and 24) of 6 (Resident # 3, # 11, #20, # 22, # 23 and #24) case-mix residents that has physician orders for the use of oxygen. This failed practice had the potential to affect 14 residents in the facility that received oxygen according to a list of residents receiving oxygen provided by the Director of Nurses on 10/13/06. The facility failed to ensure that the nebulizer mask was secured to prevent possible contamination for 2 (Resident #9 and 21) of 2 case mix residents who required respiratory treatments. This failed practice had the potential to affect 13 that received respiratory therapy as identified by the Residents Census and Condition of Residents form dated 10/12/06. The findings are:</p> <p>1. Resident #20 had diagnoses of hypertension, Cardiovascular Accident and Anemia. The Quarterly Minimum Data Set (MDS) dated 7/28/06 documented the resident had modified independent cognitive skills for daily decision making and required oxygen therapy.</p> <p>a. A physician's order dated 2/16/06 documented, "O2 (oxygen) @ 3/L (Liters) via N/C (nasal canula) P.R.N. (as needed) for S.O.B.</p> <p>b. On 10/12/06 at 12 noon and at 4:20 p.m., the resident was lying in bed with nasal cannula in place and the oxygen concentrator on and set at 2/L per minute. Res</p>	F 328			

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F 328	Continued From page 37 2. Resident # 24 had a diagnosis of C.O.P.D. (Chronic Obstructive Pulmonary Disease). The annual MDS dated 8/27/06 documented the resident had modified independent cognitive skills for daily decision making and required oxygen therapy. a. A physician's order dated 9/24/05 documented, "O2 at 3 L/M PRN SOB". b. On 10/9/06 resident was lying in bed with nasal cannula in place and oxygen concentrator on at 3:27 p.m. and 10/12/06 at 2:11 p.m. and 4:15 p.m., the resident oxygen was set at 2L/M. 3. Resident # 11 had diagnoses of Respiratory Distress and Chronic Obstructive Pulmonary Disease. The Minimum Data Set dated 8/14/06 documented the resident was required extensive assistance with dressing and was totally dependent on all other Activities of Daily Living. a. A physician's order dated 7/14/06 documented, "Oxygen @ (at) 3-5 Liters via nasal canula". b. On 10/10/06 at 7:40 a.m., 9:55 a.m., 11:30 a.m. and 12:55 p.m. the resident was observed receiving oxygen at 5 Liters per minute via trach mask. Both filters on the oxygen concentrator covered with a film of light gray matter that created dust like particles when scraped with a finger. c. On 10/12/06 at 3:35 p.m. the D.O.N. (Director of Nurses) observed the filters on the oxygen concentrator. The D.O.N. stated that the filters were dirty and needed cleaning.	F 328			

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F 328	Continued From page 38 5. Resident #22 has a diagnosis of Cerebral Vascular Accident. The Quarterly Minimum Data Set (MDS) dated 9/20/06 documented that the resident was severely impaired in daily decision making and receives oxygen therapy. a. On 10/9/06 at 2:30 p.m., 10/12/06 at 2:30 p.m. and 4:00 p.m. and 10/13/06 at 8:30 a.m. and 11:00 a.m. the oxygen concentrator filters were covered with a grey dust like matter. 6. Resident #23 has a diagnosis of Congestive Heart Failure. The MDS dated 8/17/06 documented that the resident had modified independence in cognitive skills for decision making. a. The Physician's Order dated 9/1/06 through 9/30/06 documented "O2, 2l N/C SOB (Oxygen at 2 liters nasal cannula, Shortness of Breath). b. On 10/9/06 the resident had the nasal cannula in place and the Oxygen concentrator was on and set at 3 liters. The filters on right and left side had a brown dust like and white lint like material covering the filters. c. On 10/12/06 at 2:00 p.m. and 4:00 p.m. and on 10/13/06 at 8:30 a.m. and 10:45 a.m. the oxygen filters were unchanged. 7. Resident #9 had a diagnosis of Cardiovascular Accident. a. The Physician's orders dated 9/1/06 through 9/31/06 documented, "Proventil 2.5 mg. (milligram)/0.5 mg. UD (updraft) QID (four times a day) and Atrovent 0.02% UD QID".	F 328			

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F 328	Continued From page 39 b. On 10/9/06 at 3:05 p.m. there was a updraft machine at the resident's bedside. The nebulizer mask was not bagged. 8. Resident # 21 had a diagnosis of Chronic Obstructive Pulmonary Disease. The Minimum Data Set dated 10/11/06 documented the residents inability to lie flat due to shortness of breath and had Oxygen therapy. a. A physician order dated 8/01/06 documents, Albuterol 0.083 % w/ [with] Atrovent 0.02% updraft QID [four times a day]." b. On 10/12/06 at 12:10 p.m. and at 2:00 p.m., the resident's updraft mouth piece was lying in the compartment in the nebulizer machine. The mouth piece was not in a plastic bag. The mouth piece lying exposed to possible contamination.	F 328			
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview of the 4:00 p.m. medication pass on 10/9/06 and the 9:00 a.m. medication pass on 10/10/06 the facility failed to ensure that the medication error rate was less than 5%. The Physicians orders were not followed for 5 residents (Residents #13, #14, #15, #12, and #5) of 14 residents observed during medication passes resulting in medication errors. The	F 332			

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F 332	<p>Continued From page 40</p> <p>Medication errors were made by 4 Licensed Practical Nurse (LPN), (LPN #1, #2, #3, and #4) of 6 licensed nurses administering medications in the facility. The failed practice had the potential to affect 96 residents according the Administrator on 10/9/06 at 2:10 p.m. The medication error rate was 8.70% based on administration of 45 medications and 1 omittance for a total of 46 with 4 medication errors observed. The findings are:</p> <p>1. Resident #13 had a telephone order dated 8/10/06 for Lasix to increase to 60 milligrams (mg) twice a day (bid).</p> <p>a. On 10/9/06 at 4:49 p.m. the LPN #1 punched out Lasix 40 mg 1 and 1/2 tablets. The LPN threw away the 1/2 tablet and administered the 1 tablet of Lasix 40 mg.</p> <p>b. On 10/9/06 at 4:49 p.m. the LPN #1 stated, "The order is for 40 mg, so I'm wasting the 1/2 tablet".</p> <p>c. The October 2006 Medication Administration Record (MAR) documented: Lasix 40 mg by mouth (po) bid.</p> <p>2. Resident #14 had a physician order dated 7/7/06 that documented, " PHOS LO 667 mg 2 po three times a day (tid) with meals".</p> <p>On 10/9/06 at 4:54 p.m., the LPN #1 administered PHOS LO 667 mg 2 tablets with water to the resident.</p> <p>3. Resident #15 had a physician order dated 7/13/06 that documented a Low Dose sliding scale with Regular Insulin - Give orange juice if CBG (Capillary Blood Glucose) < (less than) 70,</p>	F 332			

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F 332	<p>Continued From page 41</p> <p>recheck in 15 minutes if still < 70 notify the physician;</p> <p>70 - 200 = 0 units 201 - 250 = 4 units 251 - 300 = 6 units 301 - 400 = 9 units > 400 = 12 units recheck in 2 hours still > 400 notify physician.</p> <p>a. On 10/9/06 at 5:08 p.m. the resident CBG was 293.</p> <p>b. On 10/9/06 LPN #2 administered Novolin R 4 units.</p> <p>4. Resident #12 had a telephone physician order dated 10/4/06 that documented, "Vitamin C 500 mg 1 po bid for 30 days."</p> <p>a. On 10/9/06 at 5:51 p.m. LPN #3 did not administer the Vitamin C, 500 mg.</p> <p>b. The October 2006 MAR did not have the Vitamin C 500 mg added to the MAR to be administered at 9:00 a.m. from 10/1/06 thru 10/10/06.</p> <p>c. On 10/10/06 the Director of Nursing stated, " I thought the Multivitamin with Mineral would take care of the Vitamin C and Zinc, but it does not have enough of the medication in it."</p> <p>5. Resident #5 had a physician order dated 6/3/05 for Questran light 1 package via tube bid.</p> <p>a. On 10/10/06 at 8:50 a.m., the LPN #4 crushed ASA 81 mg, Claritin 10 mg, and Centrum Silver and added to the Questran light solution and administered all by via peg tube.</p>	F 332			

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F 332	Continued From page 42	F 332			
F 333 SS=E	<p>b. According to the Mosby's 2005 Drug Consult for Nurses documented: Give other drugs at least 1 hour before or 4 to 6 hours after cholestyramine (Questran).</p> <p>483.25(m)(2) MEDICATION ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and interview of the 4:00 p.m. medication pass on 10/9/06 and the 8:00 a.m. medication pass on 10/10/06 the facility failed to follow physician's orders to ensure that residents were free of significant medication errors for three case mix resident (Residents #13, #15, and #12) receiving medications from 3 Licensed Practical Nurse (LPN), LPN #1, 2, and 3) of 6 LPN Administering medications. This failed practice had the potential to affect 96 residents receiving medications as identified by the Administrator on 10/9/06 at 2:10 p.m. The findings are:</p> <p>1. Resident #13 had a physician telephone order dated 8/10/06 documented for Lasix to increased to 60 milligrams (mg) twice a day (bid).</p> <p>a. On 10/9/06 at 4:49 p.m. the LPN #1 punched out Lasix 40 mg 1 and 1/2 tablets. The LPN threw away the 1/2 tablet and administered the 1 tablet of Lasix 40 mg.</p> <p>b. On 10/9/06 at 4:49 p.m. the LPN #1 stated, "The order is for 40 mg, so I'm wasting the 1/2</p>	F 333			

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F 333	Continued From page 43 tablet". c. The October 2006 Medication Administration Record (MAR) the Lasix is documented the resident received 40 mg of Lasix at 9:00 a.m. from 10/01/06 thru 10/10/06. 2. Resident #15 had a physician order dated 7/13/06 documented a Low Dose sliding scale with Regular Insulin - Give orange juice if CBG (Capillary Blood Glucose) < (less than) 70, recheck in 15 minutes if still < 70 notify the physician; 70 - 200 = 0 units 201 - 250 = 4 units 251 - 300 = 6 units 301 - 400 = 9 units > 400 = 12 units recheck in 2 hours still > 400 notify physician. a. On 10/9/06 at 5:08 p.m. the resident CBG was 293. b. On 10/9/06 LPN #2 administered Novolin R 4 units for the sliding scale. c. Due to the class of the drug this antidiabetic agent was a significant medication error. 3. Resident #12 had a diagnoses of wound healing. a. A telephone physician order dated 10/4/06 documented, "Vitamin C 500 mg 1 po bid for 30 days" b. On 10/9/06 at 5:51 p.m. LPN #3 did not administer the Vitamin C, 500 mg.	F 333			

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F 333	Continued From page 44 c. The October 2006 MAR from 10/1/06 thru 10/10/06 at 9:00 a.m., the Vitamin C 500 mg was not added to the MAR to be administered. d. On 10/10/06 the Director of Nursing stated, " I thought the Multivitamin with Mineral would take care of the Vitamin C and Zinc, but it does not have enough of the medication in it." e. Due to the frequency of the medication, this was a significant medication error.	F 333			
F 363 SS=C	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure that the facility's menu for the no added salt diet was followed as written. This failed practice had the potential to affect 16 residents with physician orders for no added salt diets, according to the diet list provided on 10/11/06. The findings are: 1. On 10/11/06 the menu for the regular no added salt (NAS) diet documented, regular diet with no salt packet on the tray. a. On 10/11/06 the menu for the regular diet for the noon meal documented, green beans.	F 363			

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F 363	Continued From page 45	F 363			
F 364 SS=E	<p>b. On 10/11/06 at 11:45 a.m., when the morning cook #1 was asked why there were 2 pans of green beans, she said 1 is for the regular diets and the other one is for the NAS diets. When she was asked how many NAS diets they had, she said 16.</p> <p>483.35(d)(1)-(2) FOOD</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #12035 substantiated (all or in part) with these findings:</p> <p>Based on observation, interview, and record review, the facility failed to ensure the food was attractive, and served at a palatable temperature and at the proper consistency. The failed practice had the potential to affect 95 residents receiving food from the kitchen as per the list provided on 10/9/06 by the Director of Nursing. The findings are:</p> <p>1. On 10/10/06 at 9:30 a.m. 2 of 4 residents in the group meeting complained that the food was cold when served on the halls.</p> <p>2. On 10/11/06 at 12:35 p.m. a test tray on "The Unit", on the North Hall was delivered . Temperatures were tested with the facility's thermometer. The temperatures were:</p>	F 364			

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F 364	Continued From page 46 a. Green beans were 126 degrees (they registered 190 degrees on the steam table at 11:45) b. Chicken alfredo was 116 degrees (they registered 180 degrees on the steam table at 11:45) c. Milk was 46 degrees (it registered 36 degrees in the kitchen at 11:45 a.m.) 3. On 10/11/06 at 12:25 p.m., a tray was on the cart on east hall that had not been served. CNA # 6 was asked who the tray belonged to. The CNA stated that it was for resident #18 who was out to dialysis. The CNA was asked what do they do with a tray that is left on the cart when the resident is out of the facility. The CNA said that if it's cold we'll get another one. She was asked if dietary knew that the resident was out of the facility. She said, "no she just got here yesterday". 4. Resident #18 had diagnoses of Renal failure and hypertension. a. Physician orders dated October 2006 documented a CCD (Consistent Carbohydrate Diet) Nector Thickened liquids Pureed diet. b. On 10/11/06 at 1:50 p.m., resident #18 returned to the facility from dialysis, her tray was still on the cart in front of her room with all the dirty trays that had been removed from other residents rooms after they had finished eating. A CNA attempted to take the tray into the residents room but was stopped by CNA #6. who informed the CNA that the tray was cold and she would get another tray from the kitchen. There was no	F 364			

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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 10/13/2006
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 364	Continued From page 47 attempt to warm the tray. c. On 11/11/06 at 1:57 p.m., CNA #6 returned from the kitchen with a tray for resident #18 consisting of choarsly chopped green beans instead of pureed green beans, apple sauce was served instead of pureed carrot cake. The food was soupy and ran over the plate touching the other food. The tray card and physicians order documented a pureed consistant carbohydrate diet dated 10/9/06. 5. On 10/11/06 at 12:44 p.m. a cart with 2 trays were delivered to South east Hall. Tray #1 was for resident #17's. The tray was on the cart until 1:11 p.m. The temperature of the food on the tray was tested with the facility's thermometer: the green beans were 118 degrees, the chicken alfredo was 118 degrees and the milk registered 48 degrees. Tray #2 contained the alternate menu which consisted of : broccoli temperature registering at 102 degrees, the steak and gravy temperatures registered at 110 degrees and the mashed potatoes temperatures registered at 116 degrees. 6. On 10/11/06 between 12:44 p.m and :1:11 p.m. the 2 trays sat on the cart untouched. Several staff members walked by the cart during this time but the trays were not delivered to the residents until 1:11p.m..	F 364			
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it	F 441			

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F 441	<p>Continued From page 48</p> <p>investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation the facility failed ensure that the syringe used in flushing and/or administration of medication for 1 (Resident #5) of 2 case mix residents (Resident #5 and #11) who receive tube feedings, was stored in a manner to prevent potential cross contamination. This failed practice had the potential to affect 3 residents in the facility with gastrostomy tubes according to the Resident Census and Conditions of Residents form dated 10/9/06. The facility also failed to ensure that medication was given in a manner to prevent the possibility of cross contamination for 1 (Resident # 12) of 25 (Residents #1- 24) case mix residents who receive medications. This failed practice had the potential to affect 97 residents that receive medications. The findings are:</p> <p>1. Resident #5 has a diagnosis of Alzheimer's. The Minimum Data Set dated 8/14/06 documented that the resident had severely impaired cognitive skills for daily decision making, was dependent for eating and received 75% to 100% total calories from tube feeding.</p> <p>a. On 10/9/06 at 2:50 p.m. and at 5:30 p.m. a syringe dated 10/9/06 was lying on the resident's beside table. It was not in a protective bag.</p>	F 441			

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

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F 441	Continued From page 49 2. Resident #12 has a diagnosis of Multiple Pressure Ulcers. The Minimum Data Set documented that the resident had modified independence in cognitive skills for daily decision making. a. On 10/9/06 at 5:50 p.m.during medication pass LPN #1 dropped 1 tablet on the resident's bed linens, picked it up and gave it to the resident to swallow.	F 441			