

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

PRINTED: 11/28/2007  
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>11/09/2007</b>
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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>
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F 000	INITIAL COMMENTS	F 000		
F 314 SS=E	<p>Complaint # 13044 was substantiated (all or in part) with deficiencies cited at F314 and F323.</p> <p>483.25(c) PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13044 was substantiated (all or in part) with these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure turning and repositioning were provided at least every 2 hours in accordance with accepted standards of practice for pressure ulcer prevention for 1 (Resident #5) of 2 case mix residents with pressure ulcers (Residents #1 and #5). The facility also failed to ensure urine/feces were thoroughly cleansed from all areas of the resident's skin to decrease the potential for skin breakdown for 2 (Residents #2 and #6) of 11 case mix residents who were at risk for pressure ulcer development (Residents #1 through #4, #6, #7, #8, #16, #18, #23 and #27). The facility also failed to ensure pressure relief was provided to bony prominences, to prevent potential pressure ulcer development for 2 (Residents #5 and #6) of 11 case mix residents at risk for pressure ulcers</p>	F 314		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 314	<p>Continued From page 1</p> <p>(see identifiers above). The failed practices had the potential to affect 9 residents with actual pressure sores and 74 residents who were at risk for pressure ulcer development, as documented on a list provided by the Administrator on 11/8/07 at 9:00 a.m. The findings are:</p> <p>1. The Centers for Medicare &amp; Medicaid Services (CMS) Interpretive Guidelines at F314 documented: "...The care plan for a resident who is reclining &amp; [and] is dependent on staff for repositioning should address position changes to maintain the resident's skin integrity. This may include repositioning at least every 2 hours or more frequently depending upon the resident's condition &amp; tolerance of the tissue load (pressure). Depending on the individualized assessment, more frequent repositioning may be warranted for individuals who are at higher risk for pressure ulcer development or who show evidence ... that repositioning at 2-hour intervals is inadequate."</p> <p>2. Resident #5 had diagnoses of Dementia and Right Below the Knee Amputation. The Quarterly Minimum Data Set (MDS) dated 9/13/07 documented the resident was moderately impaired in cognitive skills for daily decision making, totally dependent on the assistance of 2 or more persons for transfers and bed mobility, totally dependent on the assistance of 1 person for locomotion, had 2 Stage II pressure sores and was on a turning/repositioning program.</p> <p>a. The Plan of Care dated as reviewed/revised by the facility on 10/30/07 documented: "Problem: St. [Stage] II to coccyx ..." A copy of this Plan of Care was made by the Surveyor on 11/6/07 and there was no documentation on the Plan of Care</p>	F 314			

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F 314	<p>Continued From page 2</p> <p>at that time to address the need for turning and repositioning to relieve pressure and prevent further development of pressure ulcers or deterioration of the current pressure sore.</p> <p>b. The Wound Record dated 11/5/07 documented the resident had a Stage II pressure sore which measured 1 centimeter (cm) long, by 0.4 cm wide, by 0.1 cm deep to the sacrum/coccyx area.</p> <p>c. On 11/6/07 at 8:15 a.m., the resident was sitting in a wheelchair in the dining room. The resident's position was marked with a yellow piece of paper under the right thigh at this time.</p> <p>d. On 11/6/07 at 9:30 a.m., the resident remained in the same marked position in the wheelchair, but had been moved to the Day Room.</p> <p>e. On 11/6/07 at 10:30 a.m., the resident remained in the same marked position in the Day Room.</p> <p>f. On 11/6/07 at 11:30 a.m., the resident was sitting in the same marked position in the wheelchair, which was now positioned next to the resident's bed.</p> <p>g. On 11/6/07 at 12:00 p.m. and 1:00 p.m., the resident remained in the same marked position in the wheelchair. At 1:00 p.m., the Director of Nursing (DON) was asked to look under the resident's right thigh for the piece of paper. She located the paper and was informed by the Surveyor that the resident had been in the same marked position since 8:30 a.m. A body audit was requested when the resident finished her</p>	F 314			

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F 314	Continued From page 3 meal.  h. On 11/6/07 at 2:15 p.m., the DON brought Certified Nursing Assistant (CNA) #5 to the Surveyor. CNA #5 stated when she transported the resident from the Day Room back to her room, she had pulled the resident's pants down while she sat in the wheelchair and the resident was dry. She stated she then went behind the resident and pulled her up in the chair. She was asked if she had laid the resident down or positioned the resident off of her buttocks for any length of time. The CNA stated, "No, I just pulled her up." The DON stated, "I thought if a resident was up in the wheelchair and could reposition themselves in the chair, it was pressure relief."  i. A physician order dated 11/6/07 documented: "Clean St. I to left buttock with wound cleanser & 4x4's [4 inch by 4 inch gauze pads]. Apply Lantiseptic BID [twice daily] and PRN [as needed]."  j. On 11/6/07 at 2:20 p.m., the Treatment Nurse stated the resident had been placed in bed immediately after lunch and that she was ready to complete the wound treatment. A layer of CombiDerm was removed from the resident's sacral/coccyx area to expose a Stage II pressure sore to the right buttock/sacral area near the gluteal crevice. The wound measured 1.2 cm long by 0.3 cm wide by 0.1 cm deep. The resident also had a Stage I pressure sore to the left lower buttock. The Treatment Nurse stated, "This was not here yesterday. We will have to keep an eye on that." The Stage I measured 1.9 cm long by 1 cm wide. The Treatment Nurse cleansed the Stage II pressure sore with wound cleanser and applied a CombiDerm dressing to	F 314			

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F 314	Continued From page 4 the wound.  k. A physician order dated 11/7/07 documented: "DC [discontinue] CombiDerm to coccyx, Clean Stage II to coccyx with wound cleanser & 4x4's. Apply PolyMem. Secure with tape. Change drsg [dressing] q [every] M-W-F [Monday - Wednesday - Friday]."  l. On 11/7/07 at 7:30 a.m. and 8:25 a.m., the resident was in bed, positioned on her right side. There was no padding between her knees and her left foot was positioned directly on the bed without any off loading device.  3. Resident #6 had a diagnosis of Dementia with Behaviors. The Quarterly Minimum Data Set dated 8/9/07 documented the resident was moderately impaired in cognitive skills for daily decision making, dependent on staff for bed mobility and transfers, required extensive assistance of staff for toilet use and hygiene, was incontinent of bowel and bladder, had no pressure ulcers, had a pressure relieving device for the bed and was on a turning/repositioning program.  a. The Plan of Care dated as reviewed/revised by the facility on 11/1/07 did not address the need for turning/repositioning.  b. On 11/6/07 at 8:10 a.m., Certified Nursing Assistants (CNA's) #2 and #5 transferred the resident from a wheelchair to bed using a mechanical lift. CNA #5 brought two wet washcloths into the room, neither of which had soap applied. The resident's pants were removed and the incontinence brief was wet with urine. CNA #2 used the first wet washcloth to cleanse	F 314			

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F 314	<p>Continued From page 5</p> <p>both sides of the groin area and the labial area. The CNA's turned the resident to her right side and CNA #2 used the second washcloth to cleanse the perianal area only. The CNA folded the washcloth, applied lotion, then wiped the perianal area again. The CNA's did not cleanse the urine from the resident's buttocks or gluteal folds. CNA stated, "We can't put Lantiseptic on her; the Nurse will have to do that."</p> <p>c. On 11/6/07 at 10:10 a.m. and 2:00 p.m., the resident was in bed, positioned on her right side. Her left knee and ankle were positioned directly on top of the right knee and ankle, with no padding between the bony prominences. Her feet were positioned directly on the bed with no offloading.</p> <p>d. On 11/7/07 at 9:30 a.m., the resident was in bed on her left side. Her right knee and ankle were positioned directly on top of her left knee and ankle, with no padding between the bony prominences. Her feet were positioned directly on the bed, with no offloading.</p> <p>4. Resident #2 had diagnoses of Rheumatoid Arthritis. The Quarterly MDS dated 9/10/07 documented the resident was independent in cognitive skills for daily decision making, totally dependent on staff for all activities of daily living (ADL's) and incontinent of bowel and bladder.</p> <p>a. The Plan of Care dated as reviewed/revised by the facility on 9/24/07 documented: "Problem: Risk factors for pressure or skin issues ... B/B inc. [bowel and bladder incontinence] ... Bed mobility ... Non compliant with care ... Bed to chair bound ... Approach: Observe for changes in skin condition ... During care report changes ... Tx</p>	F 314			

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F 314	Continued From page 6 [Treatment] nurse does weekly body audit ... Provide incontinent care after each episode." A handwritten entry dated 9/24/07 documented: "B/B [bowel/bladder] new approach - Briefs."  b. A Licensed Nurse Weekly Body Audit form dated 11/5/07 included an illustration of a human body. The pubic/thigh area of the illustration was circled and a handwritten notation documented: "Pink."  c. A CNA Resident Daily Quality Assurance (QA) Body Audit form dated 11/6/07 had a circle drawn around the pubic area with a handwritten entry which documented: "Red." The section of the form designated for a Licensed Practical Nurse's signature was left blank.  d. On 11/7/07 at 10:00 a.m., CNA's #2 and #3 provided incontinent care to the resident, who was in bed. The incontinent brief was wet with urine and soiled with feces. The CNA's removed the brief and the following observations were made:  1.) CNA #2 used a wet washcloth to wipe downward over both sides of the groin area, then down the middle of the perineal area. CNA #2 stated, "I'm using her body wash. They don't provide us a peri wash." The resident's legs were not spread to cleanse the vaginal and labial areas. CNA #3 dried the groin area with a towel. The CNA's did not apply barrier cream.  2.) The Surveyor asked the CNA's to expose the resident's groin area for observation. CNA #2 separated the skin folds at the resident's groin areas. Both sides of the groin were bright red and gaulded. CNA #2 stated, "Real bad."	F 314			

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F 314	Continued From page 7  3.) The CNA's turned the resident to her side. CNA #3 cleansed feces from the perianal and coccyx areas. The CNA's did not cleanse the buttocks or apply barrier cream. There was a white scar around the resident's coccyx area, about which the resident stated, "That is from surgery to close a bed sore."  4.) CNA #2 was asked about barrier cream or any type of protective ointment for the resident's skin. CNA #2 stated, "Nurses use Lantiseptic. We aren't allowed to use it. We tell the nurse if red or something."  e. On 11/7/07 at 10:20 a.m., Licensed Practical Nurse (LPN) #2 was asked who was responsible for providing preventative skin care. LPN #2 stated, "At one time, the CNA's, but we never got into it. Charge Nurses do ointments and powders. The Treatment Nurse does the treatments." LPN #2 was asked about skin care for this resident. LPN #2 stated, "I don't have any skin concerns on her." The LPN also confirmed that the CNA's were not allowed to apply Lantiseptic but could use Aloe Vesta skin barrier. The LPN stated the barrier creams were ordered by the facility's Stock Clerk.  f. On 11/7/07 at 10:30 a.m., the Treatment Nurse was asked how she was made aware of new skin problems. The Treatment Nurse stated, "CNA's do daily body audits on these sheets. I do weekly body audits on my sheets." The Treatment Nurse was then asked about any skin care provided to this resident. The Treatment Nurse stated, "No skin or peri area problems on her."  g. On 11/7/07 at 10:35 a.m., the LPN #2 and the	F 314			

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F 314	Continued From page 8 Treatment Nurse were asked how the Nurses were made aware of the results of the CNA's body audits. Both stated, "CNA's on night shift do them. The nurse going off looks and signs them."  h. On 11/7/07 at 10:40 a.m., the facility's Stock Clerk was asked about supply orders for barrier cream. She stated, "I ordered 6 to 8 tubes of barrier cream, but no one's asked for any lately so I haven't ordered more."  i. On 11/7/07 at 10:50 a.m., the DON was asked what system was in place for preventive skin care. The DON stated, "The CNA's have wipes with barrier in it. Should the area become red, they document on an audit sheet and refer it to the nurse. The nurse then will write an order for Lantiseptic." The DON was asked who was responsible for monitoring and supervision of skin issues/concerns. The DON stated, "The Treatment Nurse audits the body audits daily."	F 314			
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Complaint # 13044 was substantiated (all or in part) with these findings.  Based on observation, record review and interview, the facility failed to ensure planned fall	F 323			

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F 323	Continued From page 9 prevention interventions were implemented in accordance with the plan of care to prevent further falls for 2 (Residents #4 and #6) of 5 case mix residents who were at risk for falls (Residents #1, #5 and #12). The facility failed to ensure hazardous chemicals were stored in a secured area to prevent potential access by cognitively impaired residents and failed to ensure surfaces in the resident environment were kept free of sharp, jagged areas to prevent potential skin tears. The failed practices had the potential to affect 14 residents who were at risk for falls and 18 cognitively impaired, self-mobile residents, as documented on lists provided by the Administrator on 11/8/07 at 11:00 a.m. The findings are:  1. Resident #4 had a diagnosis of Alzheimer's Dementia with Behavior Disturbances. The Significant Change Minimum Data Set (MDS) dated 10/10/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance of 2 or more staff for transfers and fell in the last 30 to 180 days.  a. The Plan of Care dated 9/18/07 documented:" 9/18/07 - fell in room trying to go to BR [bathroom]. Approach: 9/18/07- PT [Physical Therapy], OT [Occupational Therapy] eval [evaluation] for transfers and bed alarm."  b. On 11/7/07 at 9:47 a.m. and 11:55 a.m. and 11/8/07 at 11:45 a.m., the resident was in bed and there was not a bed alarm on the resident's bed. Certified Nursing Assistant (CNA) 6, who provided care to the resident on 11/7/07 and 11/8/07, was asked to show the Surveyor the resident's bed alarm. CNA #6 pointed to the	F 323			

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F 323	<p>Continued From page 10</p> <p>resident's wheelchair and stated, "I didn't even know she had a bed alarm until yesterday. The reason it is not on her bed is they are looking for the control box for the alarm." The CNA was asked if the alarm had been used for the resident at all that week. The CNA stated, "No, she hasn't had it this week."</p> <p>2. Resident #6 had a diagnosis of Dementia with Behaviors. The Quarterly Minimum Data Set, which did not include a date signed, had a reference date of 8/9/07 and documented the resident was moderately impaired in cognitive skills for daily decision making, dependent on staff for bed mobility and transfers, fell in the past 180 days and sustained a fracture in the past 180 days.</p> <p>a. The Plan of Care dated as reviewed/revised by the facility on 11/1/07 documented: "Problem - At risk for falls r/t [related to] previous fx [fracture] &amp; [and] fall ... Interventions - Bed alarm added 5/17/07 r/t fall."</p> <p>b. On: 11/6/07 at 8:10 a.m., 10:10 a.m., 2:00 p.m. and 3:00 p.m. and 11/7/07 at 9:30 a.m., the resident was in bed with no bed alarm attached to the bed or the resident.</p> <p>3. On 11/7/07 at 2:10 p.m., an environmental tour of the facility was conducted, accompanied by the Maintenance Supervisor and Housekeeping Supervisor. The following observations were made:</p> <p>a. The doors to the Housekeeping closet on the Central Hall were unlocked and open. Five bottles of Liquid Comet Bleach Cleaner were stored on a shelf that was 58 ¼ inches off the</p>	F 323			

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F 323	Continued From page 11 floor. The Housekeeping Supervisor stated, "That door should have been locked."	F 323			
F 325 SS=H	<p>b. The Back Hall Nurses' Station had sharp, jagged areas under the laminate counter top. The gouge was 6 inches long on the right side facing the Nurses' Station.</p> <p>483.25(i)(1) NUTRITION</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure likes, dislikes, food allergies, Basal Energy Expenditure (BEE - determines calorie requirements per day), protein needs and fluid requirements were assessed/reassessed to facilitate the development and implementation of interventions to prevent continued weight loss, failed to implement planned nutritional interventions, failed to ensure the Registered Dietitian's recommendations were implemented to assist with weight gain or reduce continued weight loss and failed to ensure interventions were monitored, evaluated for effectiveness and revised for 1 (Resident #9) of 3 case mix residents who experienced severe, unplanned weight loss (Residents #4, #9 and #19). The facility also failed to implement documented interventions to prevent weight loss for 1 (Resident #5) of 6 case mix residents who were</p>	F 325			

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F 325	<p>Continued From page 12</p> <p>at risk for weight loss (Residents #1, #3, #4, #8, #9 and #11). The failed practices resulted in a pattern of actual harm to Resident #9 and had the potential to affect 6 residents with severe, unplanned weight loss and 56 residents at risk for weight loss, as documented on a list provided by the Administrator on 11/8/07 at 9:00 a.m. The findings are:</p> <p>1. Resident #9 was admitted to the facility on 6/8/07 with diagnoses of Dementia with Agitation and Depressive Disorder. The Minimum Data Set (MDS) dated 6/28/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required tray set up help only with eating, received a mechanically altered diet and weighed 202 pounds.</p> <p>a. The Resident Weight Record documented the resident's weight on 6/8/07 as 201.5 pounds. The Dietary Progress notes dated 6/13/07 documented: "New admission on 6/8/07. Weight 201.5 Height 6'3"[6 feet and 3 inches]. Dines in dining room. No dietary interventions needed presently. Will monitor weight weekly."</p> <p>b. The Dietary Nutritional Assessment dated 6/13/07 and signed by the Certified Dietary Manager (CDM) documented: "Diet acknowledged. Refer to RD [Registered Dietitian]." The sections of the assessment form designated for assessment and documentation of the resident's food likes and dislikes, food allergies, Basal Energy Expenditure and protein &amp; fluid requirements were not completed.</p> <p>c. The Plan of Care dated 6/21/07 documented: "Problem/Needs... Actual weight loss... Approach... Provide set-up assistance as</p>	F 325			

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F 325	<p>Continued From page 13</p> <p>needed... feeds self [after] tray set-up... Offer alternative if resident refuses meals or eats less than 50%..."</p> <p>d. The Resident Weight Record dated 7/2/07 documented the resident's weight was 188.6. This constituted a 7.39% weight loss for 1 month. <math>(201.5 - 186.8 = 14.9 \text{ pounds, divided by } 201.5 \times 100 = 7.39\%)</math>.</p> <p>e. The Dietary Progress Notes dated 7/13/07 documented: "Wt. [weight] Review: Residents current diet is mech [mechanical] soft, regular liquids. Resident on Certagen as supplement - Add super soup &amp; [and] super cereal - lunch/breakfast specifically. Keep on wkly [weekly] wt status &amp; Monitor."</p> <p>f. The Resident Weight Record dated 7/19/07 documented the resident's weight was 185.8, a continued weight loss of 2.8 pounds.</p> <p>g. The Dietary Progress Notes dated 7/21/07 documented: "Wt. Review. Current wt. 185.8 Via wch [weight chart]. Reflects a 2.8 lbs [pounds] wt. loss. Resident mostly has all meals in his own room, staff to encourage meals in Dr. [dining room] for socialization. Resident has chronic pain issues with back arms &amp; legs. Request nursing to speak with [physician] regarding pain mgmt. [management]. Continue with other interventions &amp; monitor wkly [weekly]."</p> <p>h. The Dietary Progress Notes dated 8/1/07 by the CDM documented: "Add Dietary interventions dbl [double] eggs dbl meat at breakfast."</p> <p>i. The Dietary Progress Notes dated 8/11/07 by the CDM documented: "Dietary review. Dietary</p>	F 325			

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F 325	<p>Continued From page 14</p> <p>interventions of dbl eggs and dbl meat has been accepted, takes all meals in his room. No change in dietary POC [Plan of Care]."</p> <p>j. The Resident Weight Record dated 8/14/07 documented the resident weighed 186.6 pounds. There was no documentation of weekly weights for the week of 7/22/07, 7/29/07 or 8/5/07.</p> <p>k. The 90 Day Medicare MDS dated 8/28/07 documented the resident weighed 186 pounds, had experienced a weight loss of 5% or more in the last 30 days or 10% or more in the last 180 days and had 2 Stage II pressure sores.</p> <p>l. The Resident Weight Record dated 9/9/07 documented the resident's weight was 177.3 pounds. This constituted a 4.98% weight loss for 1 month (186.6 - 177.3 = 9.3 divided by 186.6 x 100 = 4.98%).</p> <p>m. The Dietary Progress Notes dated 9/27/07 documented: "Wt Review held: Wt 177.2. Noted wt loss of 9.4 lbs. Interventions of double eggs and double meat @ [at] breakfast. Diet mechanical soft. Eats in room. Feeds self with 80-100% Intake noted. Up in wc [wheelchair]. Will continue to weigh weekly."</p> <p>n. The Resident Weight Record documented the next weight was done on 9/30/07 and was 171.2 pounds. An approximately 6 pounds of additional weight loss had occurred from 9/9/07 to 9/30/07, for a total of 8.25% weight lost in the period between 8/14/07 to 9/30/07.</p> <p>o. The Dietary Progress Notes dated 10/4/07 by the CDM documented: "Weight review. Wt. 171. Weight loss. Resident has dietary interventions</p>	F 325			

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F 325	<p>Continued From page 15</p> <p>supercereal and supersoup will add a shake. Will refer for RD consult."</p> <p>p. Dietary Progress Notes dated 10/9/07 and signed by the Registered Dietician (RD) documented: "Weight at 171.2# [pounds] (201.5 on 6/8/07). IBW [ideal body weight] 196 + - [plus or minus] 10%. Dietary interventions include super cereal., super soup, shakes at meals, double eggs &amp; double meats at breakfast. Diet order is Mech [mechanical] Soft. Feeds self in room with fair to good intakes. Skin breakdown = St. [Stage] II R [right] &amp; L [left] buttock. Est. [estimated] needs for wt. maintenance 2331 kcals [kilocalories] (30 kcal/kg. [kilocalories per kilogram of body weight]). Needs met with current diet order &amp; good p.o. [oral] intakes. Since wt. continues to go [down], suggest adding 120 cc [cubic centimeters 2Cal HN [high nitrogen] TID [three times daily] with med [medication] pass."</p> <p>q. The Resident's Weight Record dated 10/10/07 documented the resident's weight was 160.2 pounds. On 10/15/07, the weight was documented as 167.4 pounds.</p> <p>r. The Dietary Progress Notes dated 10/17/07 by the CDM documented: "Weight review wt. 167.4. Dietary interventions are working has had a weight gain. Will continue weekly weights."</p> <p>s. The Resident's Weight Record dated 10/23/07 documented the resident's weight was 163 pounds.</p> <p>t. The Dietary Progress Notes dated 10/26/07 by the CDM documented: "Weight review Wt 163.0. Dietary interventions in place. Weekly weights</p>	F 325			

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F 325	<p>Continued From page 16</p> <p>will continue meals intake is less 75%. Will continue dietary interventions."</p> <p>u. The Resident's Weight Record dated 10/30/07 documented the resident's weight was 163.2 pounds.</p> <p>v. On 11/6/07 at 7:55 a.m., the resident was served corn flakes, 1 scoop of scrambled eggs, 2 sausage links, one carton of whole milk, one slice of toast, one glass of juice and one glass of water. The Tray Identification Card did not document double eggs, double Meat, Supercereal and/or Supersoup or shake. The resident was not served double eggs or supercereal. The resident consumed 100% of the single serving of eggs, one piece of toast one and a half sausage links. The corn flakes were not opened and set up for the resident.</p> <p>At 12:15 p.m., the resident was served chopped meat, cabbage, boiled potatoes, one square of cornbread, one pat of butter, one carton of whole milk, one slice of chocolate pie and one glass of water. The resident did not want the food on the tray. The Tray Identification Card copied from the resident's tray at 12:20 p.m. did not have any documentation of super soup or shakes. The resident did not receive super soup or a health shake on his tray. At 12:35 p.m., a bowl of super soup and a health shake had been placed on the tray; however, the lid was never taken off the bowl of soup and the health shake was not opened for the resident.</p> <p>At 2:30 p.m., a re-weigh was requested. The Restorative Certified Nursing Assistant (CNA) weighed the resident in the wheelchair. The total weight was 196.8 pounds. The Restorative CNA</p>	F 325			

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F 325	<p>Continued From page 17</p> <p>stated the chair weighed 38.4 pounds; therefore, the resident's weight was 158.4 pounds. This constituted a 21.38% weight loss since the June 2007 admission to the facility (201.5 - 158.4 = 43.1 divided by 201.5 x 100 = 21.38%).</p> <p>w. On 11/6/07 at 2:50 p.m., the Plan of Care was again reviewed and copied. Handwritten interventions had been added to the Plan of Care, including: "2 Cal HN with med pass, Double meat &amp; eggs for breakfast ... resident refuses super cereal, shakes, ice cream and super soup." There was no date on these interventions to indicate when they were added to the Plan of Care. At 2:55 p.m., the Director of Nursing (DON) was asked who had added these interventions to the Plan of Care and when these interventions had been added. The DON stated she and the Nurse Consultant had updated the Plan of Care, "Today."</p> <p>Dietary Progress Notes dated 11/6/07 by the CDM documented: "Refused dietary interventions shake, super soup, super cereal, will take double eggs and meat." The Registered Dietician completed this entry with the following: "Shake, super soup &amp; super cereal refusal is reason for these items not showing up on tray card. Since he will take double eggs &amp; double meat at lunch &amp; dinner. Start 120 cc of 2 Cal HN at med pass Tid [3 times daily] ASAP [as soon as possible]! Will notify DON wt. on 10/30 was 163.2# (was 201.5# 6/8/07). IBW is ~ [approximately] 196# + or - 10%. Weight now well below IBW range. Will get double meats &amp; 2 Cal added today. Monitor wt. to see if other dietary interventions such as snacks need to be added. Have offered ice cream &amp; magic cups but pt. [patient] refuses these. Continue POC."</p>	F 325			

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F 325	Continued From page 18  x. On 11/7/07 at 7:40 a.m., the resident was served 2 scoops of scrambled eggs, one sausage link, one bowl of oatmeal, one carton of milk and one pat of butter. CNA #1 set up the resident's tray but did not open the bowl of oatmeal for the resident. At 7:45 a.m., the resident was asked, "What is in that bowl?" He stated: "I don't know." The lid was taken off of the bowl with the resident's permission. The resident looked at the contents of the bowl and stated, "I don't like oats."  At 7:57 a.m., the CDM was asked, "If a person is supposed to receive double meat, how many sausage links should they get?" He stated, "Two sausage links."  At 8:10 a.m., the resident had consumed all of the eggs and the one sausage link. The oatmeal was untouched. The resident was not offered anything else to eat.  y. As of 11/7/07 at 8:30 a.m., there was no documentation on the October and November Medication Administration Records (MARs) or elsewhere in the clinical record that the 2 Cal HN had ever been administered, as originally recommended by the RD on 10/9/07.  At 8:40 a.m., the Director of Nursing (DON) was interviewed as follows:  1.) Surveyor: "Who is responsible for monitoring weights and ensuring the Dietician's recommendations are followed?"  DON: "The CDM does the weight monitoring. We have a weekly meeting. He is also responsible for doing the dietary portion of the report. He gets	F 325			

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F 325	<p>Continued From page 19</p> <p>the report just like I do. I take care of the part such as the 2 Cal. The ADON [Assistant Director of Nursing] was responsible for that - she walked out and I just got the report back, so it's my fault that the 2 Cal didn't get started."</p> <p>2.) Surveyor: "Do you write orders for the recommendations?"</p> <p>DON: "No, we do not write orders."</p> <p>At 8:43 a.m., the Certified Dietary Manager was interviewed as follows:</p> <p>1.) Surveyor: "Do you take care of the dietary recommendations from the Dietician?"</p> <p>CDM: "Yes."</p> <p>2.) Surveyor: "Where do you document those interventions?"</p> <p>CDM: "They are all in the Progress Notes on the chart."</p> <p>3.) Surveyor: [Resident #9's] Dietary Progress Notes document he is supposed to receive double eggs, double meat, super cereal, super soup and a shake. These interventions were not on the Tray Identification Card, so how would your staff know what he was to receive?"</p> <p>CDM: "It should be on the card. We accidentally used the dinner cards at breakfast, so it wouldn't have super cereal. I don't have an order for the shakes."</p> <p>4.) The CDM was shown a copy of the dinner Tray Identification Card and was asked, "Should</p>	F 325			

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F 325	<p>Continued From page 20</p> <p>this card have had supercereal, super soup and shake for the noon meal?"</p> <p>CDM: "Yes, it should have."</p> <p>5.) Surveyor: "Do you have any documentation in your weekly weight meetings or anywhere else that documents when the interventions were implemented?"</p> <p>The CDM looked through the papers on his desk and in the file cabinet and stated, "I didn't know about the July recommendation of supercereal or super soup. I didn't know until today of the shakes."</p> <p>z. On 11/7/07 at 2:25 p.m., the Registered Dietician was asked, Have you watched the resident eat?" She stated, "No." She was then asked, "Have you seen the resident offered the supplements and the resident's refusal of these supplements?" The RD stated, "No." She was asked, "Are you aware that the CDM stated he did not know of the order for the shakes?" She stated, "No, he made the documentation and intervention of the shakes in the Progress Notes." The RD also stated the Dietary Manager had informed her that he had taken the shake and super soup to the resident at the noon meal on 11/6/07 and that the resident refused it. She was asked, "Were you aware of the shake never being opened and that the lid on the soup was never taken off?" She stated, "No, I didn't know that."</p> <p>As of 11/7/07 at 4:00 p.m., there was no assessment or re-assessment of likes, dislikes, food allergies, Basal Energy Expenditure, protein needs or fluid requirements in the Dietary Progress Notes to ensure appropriate</p>	F 325			

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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>11/09/2007</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 325	<p>Continued From page 21</p> <p>interventions were developed and implemented to prevent further weight loss.</p> <p>2. Resident #5 had a diagnosis of Dementia. The Quarterly MDS dated 9/13/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required limited assistance of one for eating, weighed 98 pounds and had 2 Stage II pressure sores.</p> <p>a. Dietary Progress Notes dated 8/27/07 by the CDM documented: "Dietary review. Weight currently 98.2. Slight weight loss. Can become very difficult to feed. Will spit out food. Dietary interventions - Super Cereal, Super Soup and shake also magic cup."</p> <p>b. Dietary Progress Notes dated 8/27/07 by the CDM documented: "Weight review: Wt. 94.0 weight loss. Dietary interventions in place will continue. Put on weekly wts. Takes awhile to eat her meals. Meal intake is 75% or greater."</p> <p>c. Dietary Progress Notes dated 10/4/07 by the RN MDS Coordinator documented: "Dietary Review: Wt. 95.4 up 1.4 lbs. Eating better, continues on Super Soup &amp; super cereal. Cont. POC &amp; review wt. next wk [week]."</p> <p>d. The Resident Weight Record dated 10/11/07 documented the resident's weight was 75.4 pounds. The Record dated 10/15/07 documented the resident's weight as 77.6 pounds.</p> <p>e. Dietary Progress notes dated 10/17/07 by the CDM documented: "Weight review. Wt. 77.6. Resident Meal intake is less than 50% continue weekly weights and current dietary POC."</p>	F 325			

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F 325	<p>Continued From page 22</p> <p>f. Dietary Progress Notes dated 10/26/07 by the RN documented: "Wt. Reviewed Wt. 99.4 lbs. Up 4 lbs from 9/30/07. Wt. on 10/11-15 an error. Continues to be a light eater but stable at this time. Continue on weekly weights."</p> <p>g. On 11/6/07 at 12:10 p.m., the resident was sitting in a wheelchair at the feeder table in the dining room. The resident was served chopped meat, boiled potatoes, cabbage, one slice of chocolate pie, one square of combread, one pat of butter, one glass of water and one glass of tea. The resident did not receive super soup, shake or magic cup as per the recommendations made in the Dietary Progress Notes. The resident consumed 100% of the food and fluids on the tray.</p> <p>h. On 11/8/07 at 12:30 p.m., the resident was served chicken, baked potato, carrots, roll, iced brownie, margarine, ice tea and water. There was no super soup, shake or magic cup on the tray. The Tray Identification Card did not include documentation for the resident to receive super soup, shakes or magic cup.</p> <p>At 12:50 p.m., the DON and Nurse Consultant read the resident's tray card. They stated the resident was, "not a weight loss" and was, "not supposed to have anything else."</p> <p>At 1:30 p.m., the DON was asked to read the Dietary Progress Notes for interventions on this resident. She stated, "In August, super cereal, super soup, shake and magic cup, same in September." She stated in October, the super cereal and super soup were decreased and would be decreased again this month. The DON stated she had asked the CDM why no super soup was</p>	F 325			

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F 325	Continued From page 23 served and he stated he, "took her off because she was back on the upswing."	F 325			
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE  The facility must store, prepare, distribute, and serve food under sanitary conditions.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the dish washer was in proper working order to effectively sanitize utensils, pans, dish ware, glasses and silverware to minimize the potential for food-borne illness. The failed practice had the potential to affect 96 residents who received meals from the Dietary Department, as documented on the Diet Roster dated 11/5/07. The findings are:  1. The Centers for Medicare & Medicaid Services (CMS) Interpretive Guidelines at F371 documented the hot water rinse cycle for dishwashing should be maintained at 180 degrees F. or higher to effectively sanitize dishes and the low temperature machine should register 120 degrees F and with 25 parts per million (ppm) hypochlorite (household bleach) on dish surface.  2. On 11/5/07 at 1:10 p.m., the following observations were made:  a. Dietary Employee #1 was washing the noon meal dishes. The wash water temperature registered 137 degrees Fahrenheit (F.) and the final rinse water registered 148 degrees F.	F 371			

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F 371	Continued From page 24  b. Dietary Employee #1 checked the litmus test strip on the dish surface and inside the machine. The strip was clear with no color change, indicating that the sanitizer was not registering above 0% in the machine.  c. Dietary Employee #1 stated, "It [dish washer] has a sanitizer on it. The test strip has been registering that there was sanitizer in the machine. I checked it this morning and it was working."  3. On 11/5/07 at 1:15 p.m., the level of sanitizer in the container was marked on the outside.  4. The Dish Machine Temperature Log, page 1 on the wall documented the rinse temperatures for 11/1/07 through 11/5/07 ranged from 154 degrees F. to 165 degrees F. Page 2 of the log documented the chlorine strip test results were 10 parts per million (ppm) from 11/1/07 to 11/5/07.  5. On 11/5/07 at 1:45 p.m., the level of the sanitizer was still at the 1:15 p.m. mark. All of the dishes from the noon meal were washed and stored for the evening meal without being sanitized.  6. On 11/6/07 at 8:45 a.m., Dietary Employee #1 was washing dishes. She stated the test strips were still registering 0% sanitizer on the dishes, as evidenced by the strip not changing color. She added that the dish machine company had been notified.  7. On 11/6/07 at 9:15 a.m., the level of the sanitizer remained at the same marked level from the day before. All dishes from the breakfast	F 371			

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F 371	Continued From page 25 meal were washed and stored for the noon meal without being sanitized.  8. On 11/6/07 at 9:30 a.m., Dietary Employee #1 stated that all pots and pans were washed through the dish machine and not by manual washing and sanitizing.  9. On 11/6/07 at 11:15 a.m., the Dietary Manager stated, "The hose in the sanitizer container was not long enough to reach the lower level of sanitizer in the container being used. I put a new full container in and it registered 200 ppm.  10. On 11/6/07 at 12:40 p.m., Dietary Employee #1 stated she had not manually added any sanitizer or bleach to the machine during this time.	F 371			
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431			

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F 431	<p>Continued From page 26</p> <p>controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations of the medication rooms and medication carts on 11/6/07, the facility failed to ensure that items which required a physician's prescription were labeled in accordance with state law and accepted principles of pharmacy labeling and storage. The failed practice had the potential to affect 59 residents who received medications from the Northeast and Southeast medication carts, as identified by the Director of Nursing (DON) on 11/7/07. The findings are:</p> <ol style="list-style-type: none"> <li>1. On 11/6/07 at 10:00 a.m., the following prescription items were stored in the Northeast medication cart without a label: <ul style="list-style-type: none"> <li>a. One Advair 250/50 Diskus.</li> <li>b. Two Serevent Diskus.</li> </ul> </li> <li>2. On 11/6/07 at 10:20 a.m., the following prescription items were stored in the Southeast medication cart without a label:</li> </ol>	F 431			

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F 431	<p>Continued From page 27</p> <p>a. One Heparin Lock 100 units/milliliter (ml) 30 ml vial.</p> <p>b. One Bacteriostatic saline 0.9% 30 ml vial.</p> <p>c. One 20 % Acetycysteine 20 ml vial.</p> <p>d. One 20 % Acetycysteine 10 ml vial.</p> <p>e. One Rhinocort Aqua 32 microgram (mcg) Nasal Spray.</p> <p>3. On 11/6/07 at 10:20 a.m., the following prescription items were not stored at the proper temperature:</p> <p>a. One Procrit 40,000 units, fill date 10/12/07 was stored in the medication cart.</p> <p>b. One Procrit 40,000 units, fill date 10/30/07 was stored in the medication cart.</p> <p>c. The prescription bags had an auxiliary label provided from the Pharmacy Provider to "store in refrigerator."</p> <p>d. According to the Pharmacy Provider label, the Procrit 40,000 unit vial dated 10/30/07 expired on 11/6/07 if not refrigerated and the Procrit 40,000 unit vial dated 10/12/07 expired on 10/19/07 if not refrigerated.</p> <p>4. On 11/6/07 at 10:20 a.m., two opened vials of Acetycysteine 20 % were stored in the top storage drawer and two opened vials were stored in the original bag from the Pharmacy Provider.</p> <p>The manufacturer's label on the vials</p>	F 431		

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F 431	Continued From page 28 documented: "...Store unopened vial at controlled room temperature 15 to 30 degrees C [Celsius] (59 to 86 degree Fahrenheit). Store opened vial in refrigerator after opening. Discard opened vial after 96 hours."	F 431			
F 490 SS=H	483.75 ADMINISTRATION  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, Dietary Administration and Nursing Administration failed to ensure likes, dislikes, food allergies, Basal Energy Expenditure (BEE - determines calorie requirements per day), protein needs and fluid requirements were assessed/reassessed to facilitate the development and implementation of appropriate interventions, failed to implement planned nutritional interventions, failed to ensure the Registered Dietitian's recommendations were implemented to assist in weight gain or reduce weight loss and failed to ensure interventions were monitored, evaluated for effectiveness and revised for 1 (Resident #9) of 3 case mix residents who experienced severe, unplanned weight loss (Residents #4, #9 and #19). The facility also failed to implement documented interventions to prevent weight loss for 1 (Resident #5) of 6 case mix residents who were at risk for weight loss (Residents #1, #3, #4, #8, #9 and #11). The failed practices resulted in a pattern of actual harm to Resident #9 and had the	F 490			

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F 490	Continued From page 29 potential to affect 6 residents with severe, unplanned weight loss and 56 residents at risk for weight loss, as documented on a list provided by the Administrator on 11/8/07 at 9:00 a.m. The findings are:  1. On 11/8/07 at 11:55 a.m., the Job Description for Food Services Director was obtained from the Administrator. The Job Description documented the following:  a. " ...General Purpose of the Food Service Director: To assist in planning, organizing, developing and directing the overall operation of the Dietary Department in accordance with current federal, state and local standards governing the facility and as may be directed by the Administrator and/or Dietary Consultant, to ensure that quality nutritional services are provided on a daily basis.  b. Essential Job Functions:  1.) Coordinate dietary services and activities with nursing services and other related departments.  2.) Assist in developing, reviewing and planning normal, special and therapeutic diet plans for resident.  3.) Ensure meals are prepared and served in accordance with menu and diet preferences and established portion control procedures.  4.) Maintain proper record to ensure that residents diets are in compliance with physician's orders.  c. Care plan & assessment functions:	F 490			

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F 490	Continued From page 30  1.) Assist in developing for each resident preliminary and comprehensive assessments or dietary needs and written dietary plans that identify the dietary problems and/or needs of the residents and the goals to be accomplished for each dietary and/or need used in providing daily dietary services to the resident.  2.) Review nurses' notes and monitor residents' weights to determine in the care plans are being followed and if the residents' needs are being met.  3.) Identify and monitor high-risk residents, ensuring that any special needs and requirements are met.  4.) Resident assessment and progress note documentation. Conduct quarterly reviews in conjunction with resident care plans on each resident documenting findings and communicating same to Dietary Consultant.  5.) Provide other documentation as needed to verify any interventions provided."  2. On 11/8/07 at 11:55 a.m., the Job Description for Director of Nursing (DON) was obtained from the Administrator. The Job Description documented the following:  a. "General Purpose: Under the direction of the Administrator plans, organized, develops and directs the overall operation of the Nursing Services Department in accordance with current federal, state and local standards governing the facility. To ensure that the highest practicable level or quality care is maintained at all times.	F 490			

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F 490	Continued From page 31  b. Essential Job Functions:  1.) Assist in developing and implementing methods for coordinating nursing services with other resident services.  2.) Implement plans of action to correct deficiencies.  3.) Monitor and ensure general resident care to including positioning, grooming, feeding.  4.) Monitor weekly and monthly weight and implement recommendations.  5.) Complete plan of correction on the following consultant's visitation, reports within 10 days: Dietary."  3. Resident #9 was admitted to the facility on 6/8/07 with diagnoses of Dementia with Agitation and Depressive Disorder. The Minimum Data Set (MDS) dated 6/28/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required tray set up help only with eating, received a mechanically altered diet and weighed 202 pounds.  a. The Resident Weight Record documented the resident's weight on 6/8/07 as 201.5 pounds. The Dietary Progress notes dated 6/13/07 documented: "New admission on 6/8/07. Weight 201.5 Height 6'3"[6 feet and 3 inches]. Dines in dining room. No dietary interventions needed presently. Will monitor weight weekly."  b. The Dietary Nutritional Assessment dated 6/13/07 and signed by the Certified Dietary	F 490			

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F 490	Continued From page 32 Manager (CDM) documented: "Diet acknowledged. Refer to RD [Registered Dietitian]." The sections of the assessment form designated for assessment and documentation of the resident's food likes and dislikes, food allergies, Basal Energy Expenditure and protein & fluid requirements were not completed.  c. The Plan of Care dated 6/21/07 documented: "Problem/Needs... Actual weight loss... Approach... Provide set-up assistance as needed... feeds self [after] tray set-up... Offer alternative if resident refuses meals or eats less than 50%..."  d. The Resident Weight Record dated 7/2/07 documented the resident's weight was 188.6. This constituted a 7.39% weight loss for 1 month. (201.5 - 186.8 = 14.9 pounds, divided by 201.5 x 100 = 7.39%).  e. The Dietary Progress Notes dated 7/13/07 documented: "Wt. [weight] Review: Residents current diet is mech [mechanical] soft, regular liquids. Resident on Certagen as supplement - Add super soup & [and] super cereal - lunch/breakfast specifically. Keep on wkly [weekly] wt status & Monitor."  f. The Resident Weight Record dated 7/19/07 documented the resident's weight was 185.8, a continued weight loss of 2.8 pounds.  g. The Dietary Progress Notes dated 7/21/07 documented: "Wt. Review. Current wt. 185.8 Via wch [weight chart]. Reflects a 2.8 lbs [pounds] wt. loss. Resident mostly has all meals in his own room, staff to encourage meals in Dr. [dining room] for socialization. Resident has chronic pain	F 490			

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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>	
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F 490	Continued From page 33 issues with back arms & legs. Request nursing to speak with [physician] regarding pain mgmt. [management]. Continue with other interventions & monitor wkly [weekly]."  h. The Dietary Progress Notes dated 8/1/07 by the CDM documented: "Add Dietary interventions dbl [double] eggs dbl meat at breakfast."  i. The Dietary Progress Notes dated 8/11/07 by the CDM documented: "Dietary review. Dietary interventions of dbl eggs and dbl meat has been accepted, takes all meals in his room. No change in dietary POC [Plan of Care]."  j. The Resident Weight Record dated 8/14/07 documented the resident weighed 186.6 pounds. There was no documentation of weekly weights for the week of 7/22/07, 7/29/07 or 8/5/07.  k. The 90 Day Medicare MDS dated 8/28/07 documented the resident weighed 186 pounds, had experienced a weight loss of 5% or more in the last 30 days or 10% or more in the last 180 days and had 2 Stage II pressure sores.  l. The Resident Weight Record dated 9/9/07 documented the resident's weight was 177.3 pounds. This constituted a 4.98% weight loss for 1 month (186.6 - 177.3 = 9.3 divided by 186.6 x 100 = 4.98%).  m. The Dietary Progress Notes dated 9/27/07 documented: "Wt Review held: Wt 177.2. Noted wt loss of 9.4 lbs. Interventions of double eggs and double meat @ [at] breakfast. Diet mechanical soft. Eats in room. Feeds self with 80-100% Intake noted. Up in wc [wheelchair]. Will continue to weigh weekly."	F 490		

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F 490	Continued From page 34  n. The Resident Weight Record documented the next weight was done on 9/30/07 and was 171.2 pounds. An approximately 6 pounds of additional weight loss had occurred from 9/9/07 to 9/30/07, for a total of 8.25% weight lost in the period between 8/14/07 to 9/30/07.  o. The Dietary Progress Notes dated 10/4/07 by the CDM documented: "Weight review. Wt. 171. Weight loss. Resident has dietary interventions supercereal and supersoup will add a shake. Will refer for RD consult."  p. Dietary Progress Notes dated 10/9/07 and signed by the Registered Dietician (RD) documented: "Weight at 171.2# [pounds] (201.5 on 6/8/07). IBW [ideal body weight] 196 + - [plus or minus] 10%. Dietary interventions include super cereal., super soup, shakes at meals, double eggs & double meats at breakfast. Diet order is Mech [mechanical] Soft. Feeds self in room with fair to good intakes. Skin breakdown = St. [Stage] II R [right] & L [left] buttock. Est. [estimated] needs for wt. maintenance 2331 kcals [kilocalories] (30 kcal/kg. [kilocalories per kilogram of body weight]). Needs met with current diet order & good p.o. [oral] intakes. Since wt. continues to go [down], suggest adding 120 cc [cubic centimeters] 2Cal HN [high nitrogen] TID [three times daily] with med [medication] pass."  q. The Resident's Weight Record dated 10/10/07 documented the resident's weight was 160.2 pounds. On 10/15/07, the weight was documented as 167.4 pounds.  r. The Dietary Progress Notes dated 10/17/07 by	F 490			

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F 490	<p>Continued From page 35</p> <p>the CDM documented: "Weight review wt. 167.4. Dietary interventions are working has had a weight gain. Will continue weekly weights."</p> <p>s. The Resident's Weight Record dated 10/23/07 documented the resident's weight was 163 pounds.</p> <p>t. The Dietary Progress Notes dated 10/26/07 by the CDM documented: "Weight review Wt 163.0. Dietary interventions in place. Weekly weights will continue meals intake is less 75%. Will continue dietary interventions."</p> <p>u. The Resident's Weight Record dated 10/30/07 documented the resident's weight was 163.2 pounds.</p> <p>v. On 11/6/07 at 7:55 a.m., the resident was served corn flakes, 1 scoop of scrambled eggs, 2 sausage links, one carton of whole milk, one slice of toast, one glass of juice and one glass of water. The Tray Identification Card did not document double eggs, double Meat, Supercereal and/or Supersoup or shake. The resident was not served double eggs or supercereal. The resident consumed 100% of the single serving of eggs, one piece of toast one and a half sausage links. The corn flakes were not opened and set up for the resident.</p> <p>At 12:15 p.m., the resident was served chopped meat, cabbage, boiled potatoes, one square of cornbread, one pat of butter, one carton of whole milk, one slice of chocolate pie and one glass of water. The resident did not want the food on the tray. The Tray Identification Card copied from the resident's tray at 12:20 p.m. did not have any documentation of super soup or shakes. The</p>	F 490			

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F 490	<p>Continued From page 36</p> <p>resident did not receive super soup or a health shake on his tray. At 12:35 p.m., a bowl of super soup and a health shake had been placed on the tray; however, the lid was never taken off the bowl of soup and the health shake was not opened for the resident.</p> <p>At 2:30 p.m., a re-weigh was requested. The Restorative Certified Nursing Assistant (CNA) weighed the resident in the wheelchair. The total weight was 196.8 pounds. The Restorative CNA stated the chair weighed 38.4 pounds; therefore, the resident's weight was 158.4 pounds. This constituted a 21.38% weight loss since the June 2007 admission to the facility (<math>201.5 - 158.4 = 43.1</math> divided by <math>201.5 \times 100 = 21.38\%</math>).</p> <p>w. On 11/6/07 at 2:50 p.m., the Plan of Care was again reviewed and copied. Handwritten interventions had been added to the Plan of Care, including: "2 Cal HN with med pass, Double meat &amp; eggs for breakfast ... resident refuses super cereal, shakes, ice cream and super soup." There was no date on these interventions to indicate when they were added to the Plan of Care. At 2:55 p.m., the Director of Nursing (DON) was asked who had added these interventions to the Plan of Care and when these interventions had been added. The DON stated she and the Nurse Consultant had updated the Plan of Care, "Today."</p> <p>Dietary Progress Notes dated 11/6/07 by the CDM documented: "Refused dietary interventions shake, super soup, super cereal, will take double eggs and meat." The Registered Dietician completed this entry with the following: "Shake, super soup &amp; super cereal refusal is reason for these items not showing up on tray card. Since</p>	F 490			

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F 490	<p>Continued From page 37</p> <p>he will take double eggs &amp; double meat at lunch &amp; dinner. Start 120 cc of 2 Cal HN at med pass Tid [3 times daily] ASAP [as soon as possible]! Will notify DON wt. on 10/30 was 163.2# (was 201.5# 6/8/07). IBW is ~ [approximately] 196# + or - 10%. Weight now well below IBW range. Will get double meats &amp; 2 Cal added today. Monitor wt. to see if other dietary interventions such as snacks need to be added. Have offered ice cream &amp; magic cups but pt. [patient] refuses these. Continue POC."</p> <p>x. On 11/7/07 at 7:40 a.m., the resident was served 2 scoops of scrambled eggs, one sausage link, one bowl of oatmeal, one carton of milk and one pat of butter. CNA #1 set up the resident's tray but did not open the bowl of oatmeal for the resident. At 7:45 a.m., the resident was asked, "What is in that bowl?" He stated: "I don't know." The lid was taken off of the bowl with the resident's permission. The resident looked at the contents of the bowl and stated, "I don't like oats."</p> <p>At 7:57 a.m., the CDM was asked, "If a person is supposed to receive double meat, how many sausage links should they get?" He stated, "Two sausage links."</p> <p>At 8:10 a.m., the resident had consumed all of the eggs and the one sausage link. The oatmeal was untouched. The resident was not offered anything else to eat.</p> <p>y. As of 11/7/07 at 8:30 a.m., there was no documentation on the October and November Medication Administration Records (MARs) or elsewhere in the clinical record that the 2 Cal HN had ever been administered, as originally recommended by the RD on 10/9/07.</p>	F 490			

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F 490	<p>Continued From page 38</p> <p>At 8:40 a.m., the Director of Nursing (DON) was interviewed as follows:</p> <p>1.) Surveyor: "Who is responsible for monitoring weights and ensuring the Dietician's recommendations are followed?"</p> <p>DON: "The CDM does the weight monitoring. We have a weekly meeting. He is also responsible for doing the dietary portion of the report. He gets the report just like I do. I take care of the part such as the 2 Cal. The ADON [Assistant Director of Nursing] was responsible for that - she walked out and I just got the report back, so it's my fault that the 2 Cal didn't get started."</p> <p>2.) Surveyor: "Do you write orders for the recommendations?"</p> <p>DON: "No, we do not write orders."</p> <p>At 8:43 a.m., the Certified Dietary Manager was interviewed as follows:</p> <p>1.) Surveyor: "Do you take care of the dietary recommendations from the Dietician?"</p> <p>CDM: "Yes."</p> <p>2.) Surveyor: "Where do you document those interventions?"</p> <p>CDM: "They are all in the Progress Notes on the chart."</p> <p>3.) Surveyor: [Resident #9's] Dietary Progress Notes document he is supposed to receive double eggs, double meat, super cereal, super</p>	F 490			

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F 490	<p>Continued From page 39</p> <p>soup and a shake. These interventions were not on the Tray Identification Card, so how would your staff know what he was to receive?"</p> <p>CDM: "It should be on the card. We accidentally used the dinner cards at breakfast, so it wouldn't have super cereal. I don't have an order for the shakes."</p> <p>4.) The CDM was shown a copy of the dinner Tray Identification Card and was asked, "Should this card have had supercereal, super soup and shake for the noon meal?"</p> <p>CDM: "Yes, it should have."</p> <p>5.) Surveyor: "Do you have any documentation in your weekly weight meetings or anywhere else that documents when the interventions were implemented?"</p> <p>The CDM looked through the papers on his desk and in the file cabinet and stated, "I didn't know about the July recommendation of supercereal or super soup. I didn't know until today of the shakes."</p> <p>z. On 11/7/07 at 2:25 p.m., the Registered Dietician was asked, Have you watched the resident eat?" She stated, "No." She was then asked, "Have you seen the resident offered the supplements and the resident's refusal of these supplements?" The RD stated, "No." She was asked, "Are you aware that the CDM stated he did not know of the order for the shakes?" She stated, "No, he made the documentation and intervention of the shakes in the Progress Notes." The RD also stated the Dietary Manager had informed her that he had taken the shake and</p>	F 490			

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F 490	<p>Continued From page 40</p> <p>super soup to the resident at the noon meal on 11/6/07 and that the resident refused it. She was asked, "Were you aware of the shake never being opened and that the lid on the soup was never taken off?" She stated, "No, I didn't know that."</p> <p>As of 11/7/07 at 4:00 p.m., there was no assessment or re-assessment of likes, dislikes, food allergies, Basal Energy Expenditure, protein needs or fluid requirements in the Dietary Progress Notes to ensure appropriate interventions were developed and implemented to prevent further weight loss.</p> <p>4. Resident #5 had a diagnosis of Dementia. The Quarterly MDS dated 9/13/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required limited assistance of one for eating, weighed 98 pounds and had 2 Stage II pressure sores.</p> <p>a. Dietary Progress Notes dated 8/27/07 by the CDM documented: "Dietary review. Weight currently 98.2. Slight weight loss. Can become very difficult to feed. Will spit out food. Dietary interventions - Super Cereal, Super Soup and shake also magic cup."</p> <p>b. Dietary Progress Notes dated 8/27/07 by the CDM documented: "Weight review: Wt. 94.0 weight loss. Dietary interventions in place will continue. Put on weekly wts. Takes awhile to eat her meals. Meal intake is 75% or greater."</p> <p>c. Dietary Progress Notes dated 10/4/07 by the RN MDS Coordinator documented: "Dietary Review: Wt. 95.4 up 1.4 lbs. Eating better, continues on Super Soup &amp; super cereal. Cont. POC &amp; review wt. next wk [week]."</p>	F 490			

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F 490	Continued From page 41  d. The Resident Weight Record dated 10/11/07 documented the resident's weight was 75.4 pounds. The Record dated 10/15/07 documented the resident's weight as 77.6 pounds.  e. Dietary Progress notes dated 10/17/07 by the CDM documented: "Weight review. Wt. 77.6. Resident Meal intake is less than 50% continue weekly weights and current dietary POC."  f. Dietary Progress Notes dated 10/26/07 by the RN documented: "Wt. Reviewed Wt. 99.4 lbs. Up 4 lbs from 9/30/07. Wt. on 10/11-15 an error. Continues to be a light eater but stable at this time. Continue on weekly weights."  g. On 11/6/07 at 12:10 p.m., the resident was sitting in a wheelchair at the feeder table in the dining room. The resident was served chopped meat, boiled potatoes, cabbage, one slice of chocolate pie, one square of cornbread, one pat of butter, one glass of water and one glass of tea. The resident did not receive super soup, shake or magic cup as per the recommendations made in the Dietary Progress Notes. The resident consumed 100% of the food and fluids on the tray.  h. On 11/8/07 at 12:30 p.m., the resident was served chicken, baked potato, carrots, roll, iced brownie, margarine, ice tea and water. There was no super soup, shake or magic cup on the tray. The Tray Identification Card did not include documentation for the resident to receive super soup, shakes or magic cup.  At 12:50 p.m., the DON and Nurse Consultant read the resident's tray card. They stated the	F 490			

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F 490	Continued From page 42 resident was, "not a weight loss" and was, "not supposed to have anything else."  At 1:30 p.m., the DON was asked to read the Dietary Progress Notes for interventions on this resident. She stated, "In August, super cereal, super soup, shake and magic cup, same in September." She stated in October, the super cereal and super soup were decreased and would be decreased again this month. The DON stated she had asked the CDM why no super soup was served and he stated he, "took her off because she was back on the upswing."	F 490			
F 502 SS=F	483.75(j)(1) LABORATORY SERVICES  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure laboratory supplies were disposed of upon expiration to ensure quality of laboratory services. This failed practice had the potential to affect all 98 residents with physician's orders for laboratory services, as identified by the Administrator on 11/5/07. The findings are:  1. On 11/6/07 at 10:25 a.m., the following expired laboratory supplies were stored in the medication room on the Front Hall:  a. One red top tubes - expired 5/05.  b. Seven red top tubes - expired 11/06.	F 502			

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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 502	Continued From page 43 c. Five red top tubes - expired 12/06. d. Ten blue top tubes - expired 5/06. e. Twelve purple top tubes - expired 11/06.	F 502		
F 514 SS=E	2. On 11/6/07 at 10:25 a.m., Licensed Practical Nurse (LPN) #2 was asked if the facility nursing staff drew blood specimens for lab services. The LPN stated, "They do draw stat lab, if needed." <b>483.75(I)(1) CLINICAL RECORDS</b> The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Medication Administration Records (MAR's) and physician order updates were accurate and complete for 2 (Residents #13 and #14) of 19 case mix residents with physician orders for medications (Residents #1 through #19). The failed practice had the potential to affect 96 residents with physician orders for medications, as identified by the Administrator on 11/8/07. The findings are:	F 514		

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F 514	Continued From page 44 1. Resident #13 had a physician order dated 8/7/07 for Prozac 20 milligrams (mg) by mouth (po) every day.  a. The physician order for Prozac was transcribed to the August 2007 Medication Administration Record (MAR), which documented the Prozac was administered from 8/8/07 through 8/30/07, with the exception of 8/11/07, 8/12/07 and 8/31/07.  b. The September 2007 Physician's Orders sheet did not include the Prozac order in the computer-generated list of medication orders; however, the Prozac order was handwritten on this form.  c. The September 2007 MAR did not include any the physician order for Prozac. There was no documentation on this MAR that the Prozac was administered at any time during the month of September 2007.  d. The October 2007 Physician's Orders sheet did not include the Prozac order in the computer-generated list of medication orders, nor was there a handwritten entry regarding the Prozac.  e. The October 2007 MAR did not include the Prozac order and there was no documentation on this MAR that the Prozac was administered at any time during the month of October 2007.  f. As of 11/6/07, the November 2007 Physician's Order sheet did not include the physician order for Prozac.  g. As of 11/6/07, the November 2007 MAR included a handwritten entry which documented	F 514			

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F 514	<p>Continued From page 45</p> <p>the Prozac order. This MAR documented the Prozac was administered daily from 11/1/07 through 11/6/07.</p> <p>h. On 11/6/07 at 8:14 a.m., Licensed Practical Nurse (LPN) #1 administered the Prozac 20 mg. in the presence of the Surveyor.</p> <p>i. According to the Pharmacy Provider, the Prozac 20 mg was dispensed to the facility for this resident on 8/18/07, 9/5/07, 10/5/07 and 11/5/07.</p> <p>j. On 11/6/07 at 3:10 p.m., LPN #1 stated, "I know the resident is on Prozac. I have given the resident the Prozac on the days I worked."</p> <p>2. Resident #14 had a physician's Telephone Order dated 10/17/07 to discontinue PhosLo 667 mg and start Renagel 800 mg, 2 by mouth three times daily after meals.</p> <p>a. The November 2007 Physician Orders sheet documented the order for PhosLo 667 mg as a current order, instead of discontinued as ordered by the physician on 10/17/07. There was no documentation on the November 2007 Physician Orders sheet regarding initiation of the Renagel. The second page of the November 2007 Physician Orders sheet included a handwritten entry which documented: "D/C [discontinue] Renagel."</p> <p>b. The November 2007 MAR documented the resident was to receive Renagel. The PhosLo order was not included on this MAR.</p>	F 514			