

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

PRINTED: 03/13/2008  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                    |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>045357</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>02/29/2008</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 RICHARDS ROAD</b><br><b>NO LITTLE ROCK, AR 72117</b>           |   |
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| F 000   | INITIAL COMMENTS<br><br>Complaint #13334 and 13352, unsubstantiated.<br><br>Complaint #13333, substantiated (all or in part) with deficiencies cited at F157, F333, and F425.<br>Complaint #13344, substantiated (all or in part) with a deficiency cited at F253, F312 and F315.  | F 000   |   |   |
| F 157<br>SS=E   | 483.10(b)(11) NOTIFICATION OF CHANGES<br><br>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).<br><br>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.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. | F 157   |   |   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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| F 157   | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Complaint #13333, substantiated (all or in part) in these findings.<br><br>Based on observation and record review, the facility failed to ensure the physician was consulted about continuous complaints of nausea and vomiting, the need to recollect a stool specimen and the continued use of medication before stopping its administration for 1 (Resident #2) and newly identified lesions for 1 (Resident #4) of 4 (Resident's #1 through #4) case mix residents who had a change in condition. These failed practices had the potential to affect all 115 residents according to the Resident Census and Conditions of Residents report dated 2/27/08. The findings are:<br><br>1. Resident #2 had diagnoses of Pulmonary Fibrosis, Chronic Obstructive Lung Disease, Gastritis and Duodenitis. The Medicare 14 Day Assessment Minimum Data Set (MDS) dated 2/18/08 documented the resident was moderately impaired in cognitive skills of daily decision making and required oxygen therapy.<br><br>a. The Nurses Notes dated 2/23/08 at 7:01 p.m. documented, "...Resident state "I don't really want anything to eat, I cant keep anything down, ...Will report to oncoming nurse with changes". There was no documentation in the nurse notes that the physician was consulted about the resident's complaint of not being able to "keep anything down."<br><br>1) The Nurses Notes dated 2/26/08 at 11:30 p.m. | F 157   |   |                      |   |

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| F 157   | <p>Continued From page 2</p> <p>documented, "...Complaint of upset stomach, vomited small amt (amount) of emesis after coughing episode..." There was no documentation in the nurses notes that the resident's physician was notified of the vomiting.</p> <p>2) On 2/27/08 at 5:03 p.m., the resident complained to the nurse accompanying the surveyor that she was sick and not feeling well.</p> <p>3) On 2/27/08 at 6:15 p.m., the resident complained to the surveyor that she had been getting nauseated and vomiting.</p> <p>4) On 2/28/08 at 8:25 a.m., the resident stated, "My stomach's upset." She also stated she had told the nurse.</p> <p>5) The Nurses Notes dated 2/28/08 at 12:40 a.m. documented, "...Complaint of upset stomach, vomited small amt of emesis after coughing episode..." There was no documentation in the nurses notes that the physician was notified of the vomiting.</p> <p>b. Nurses notes dated 1/30/08 documented, "Resident c/o irritation when she had a BM (bowel movement) previous shift noted some blood in stool stool for CDiff ordered..."</p> <p>1) A physician order dated 1/30/08 documented, "Start Flagyl 250 mg (milligrams) po (by mouth) TID (three times a day) until stool culture available."</p> <p>2) Nurses Notes dated 1/31/08 at 4:39 p.m. documented, "...Stool specimen collected @ (at) 0910 a.m. and placed specimen in refrigerator for pickup. Relief nurse notified..."</p> | F 157   |   |                      |   |

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| F 157   | Continued From page 3<br><br>3) A laboratory report with a collection date 1/31/08 documented, "Rejected: Test requested CDIFF (Clostridium difficile). Specimen older than 72 hours must be frozen. If test is still needed, please recollect and submit with a new requisition.... Spec: Incorrectly collected/stored/transported..." Handwritten on the report was documentation of "lab called 2/4/08; Nurses informed 2/5/08."<br><br>4) The February 2008 Medication Administration Record (MAR) documented the resident received the last dose of Flagyl on 2/4/08, but there was no documentation the stool specimen was recollected.<br><br>5) As of 2/27/08, there was no documentation in the clinical record that the physician was consulted about the need to recollect the stool specimen and how long to continue administering the Flagyl.<br><br>2. Resident #4 had diagnoses of Alzheimer's Dementia, Late Effects of Cerebrovascular Disease, and Malignant Neoplasm of Prostate. The Quarterly MDS dated 1/24/08 documented the resident was severely impaired in cognitive skills for daily decision-making.<br><br>a. On 2/27/08 at 5:00 p.m., during initial rounds with the Assistant Director of Nursing (ADON), the resident complained of having a sore mouth and had 2 scab-like lesions on the left side of the lower lip.<br><br>b. Nurses Notes dated 2/5/08 through 2/28/08 were reviewed and there was no documentation that the physician was consulted about the | F 157   |   |                      |   |

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| F 157   | Continued From page 4<br>resident's complaint of a sore mouth or the lesions on the resident's lower lip.<br><br>c. On 2/28/08 at 3:30 p.m., the Director of Nursing (DON) was interviewed and asked about documentation of the resident's complaint about sore mouth and what caused the lesions on his lip. The DON stated, "Let me look. I think he's taking something. Let me look." The DON was unable to provide any information that the resident was being treated for mouth sores.<br><br>3. The facility procedure titled Notification of Change in Resident Health Status received 2/29/08 at 9:10 a.m. from the Administrator documented, "The facility will consult the resident's physician, nurse practitioner or physician assistant, and if known the resident's legal representative or an interested family member when there is:... (B) Acute illness or a significant change in the resident's physical, mental or psychosocial status (i.e. a deterioration in health, mental, psychosocial status in either life-threatening conditions or clinical complications)... (C) 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)." | F 157   |   |                      |   |
| F 253<br>SS=E   | 483.15(h)(2) HOUSEKEEPING/MAINTENANCE<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Complaint #13344, substantiated (all or in part) in these findings.  | F 253   |   |                      |   |

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| F 253   | Continued From page 5<br><br>Based on observation, the facility failed to ensure the shower chairs, shower stalls, the floor and wall tiles in shower rooms and the multi-resident use equipment was clean and whirlpool tubs were clean and free of litter. These failed practices had the potential to affect 54 residents on the 200 Hall and 58 residents on the 300 hall that used the shower rooms per documentation received from the Administrator on 3/4/08. The findings are:<br><br>1. On 2/28/08 at 5:40 p.m., the following observations were made on the 200 Hall Shower:<br><br>a. The 2 shower chairs in the first stall on the left side of the room had brownish-green material on the seats of the chairs. The shower chair in the second (middle) stall had a dark greenish substance smeared on the seat and the left arm.<br><br>b. The whirlpool tub contained clothes hangers, empty petroleum jelly tubes, 2 bottles of roll-on antiperspirant, a dirty wooden orange stick, a dirty hair brush, dirty wheelchair accessories, a bottle of prescription shampoo labeled, "ketoconazole" dated 12/29/06, and dust and dirt in the bottom of the tub.<br><br>c. The tiles in each shower stall had brown soiled areas in the corners and on the tiles at the base of the shower stalls.<br><br>d. The mechanical lift stored in the 200 Hall shower room had dirty foot-rest.<br><br>2. On 2/28/08 at 6:00 p.m., the following observations were made on the 300 Hall Shower Room: | F 253   |   |                      |   |

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| F 253   | Continued From page 6<br>a. The right wall of the middle stall had an approximate 12 to 18 inch long line of brown material at waist height on the tiles of the right side.<br>b. There was dried brown material on the tiles of the base and corners of each shower stall.<br>c. The whirlpool tub of the 300 Hall shower room contained alcohol sponge wrappers, clothes hangers, paper, and had dust and debris in the bottom and on the seat.  | F 253   |   |                      |   |
| F 282<br>SS=D   | 483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure the correct diet was served for 1 of 1 (Resident #3) with soft diet orders. This failed practice had the potential to affect 36 residents that received a soft diet per documentation received from the Administrator on 3/4/08. The findings are:<br><br>Resident #3 had diagnoses of Diabetes, Functional Digestive Disorder, Failure To Thrive, Congestive Heart Disease, Multiple Upper Respiratory Infections, and Constipation. The Minimum Data Set dated 2/27/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance for eating and oxygen therapy. | F 282   |   |                      |   |

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| F 282   | Continued From page 7   | F 282   |   |   |
| F 309<br>SS=D   | <p>a. A physician order dated 2/22/08 documented a Soft Consistent Carbohydrate diet.</p> <p>b. The Plan of Care dated 1/23/08 documented, "Problem: Hyper/hypoglycemic episodes r/t (related to) Diabetes" with interventions of "Diet as ordered... Problem: Resident is at risk for altered nutrition d/t (due to) Dx's (diagnosis) involving digestive system" with interventions of "Diet will be served as ordered by physician."</p> <p>c. On 2/28/08 at 6:13 p.m., the resident was served a regular diet. CNA (Certified Nursing Assistant) #1 was asked about the regular diet and she said, "That's what she always gets."</p> <p><b>483.25 QUALITY OF CARE</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, record review and interview, the facility failed to ensure there was a physician order to discontinue the use of a Foley catheter for 1 of 1 case mix resident (Resident #1) who had a urinary catheter. This failed practice had the potential to affect 7 residents who had a urinary catheter according to the Resident Census and Conditions of Residents form dated 2/27/08. The findings are:</p> | F 309   |   |   |

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| F 309   | <p>Continued From page 8</p> <p>Resident #1 had diagnoses of Encephalopathy, Insulin Dependent Diabetes Mellitus, and Late Effects of Cerebrovascular Disease. The Quarterly Minimum Data Set dated 12/14/07 documented the resident was severely impaired in cognitive skills for daily decision making, required total dependence on staff for activities of daily living, and had an indwelling catheter.</p> <p>a. A physician order dated 3/6/06 documented Foley catheter. The February 2008 Physician Order sheet documented, "Foley cath 20 fr (French) 30 bulb. Change monthly and as needed if occluded or dislodged. Foley cath care with soap and water daily. May irrigate Foley with 60cc (cubic centimeters) NS (normal saline) prn (as needed) occlusion. Foley cath: leg strap, privacy bag and tubing in place every shift."</p> <p>b. The Physician Progress Notes dated 12/27/07 documented, "...f/c (Foley catheter)..."</p> <p>c. Nurses Notes dated 1/10/08 at 19:45 (7:45 p.m.) documented, "...Foley cath patent..."</p> <p>d. Nurses Notes dated 1/22/08 at 18:25 (6:25 p.m.) documented, "...incontinent of bowel and bladder..."</p> <p>e. The February 2008 Treatment Record documented, "3/6/06 Foley cath care..." and under the date 2/8/08 documented, "Foley out".</p> <p>f. As of 2/28/08, there was no documentation in the clinical record to discontinue the Foley catheter.</p> <p>g. On 2/28/08 at 2:20 p.m., the resident received incontinent care and there was no Foley catheter</p> | F 309   |   |   |

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| F 309   | Continued From page 9 in place.<br><br>h. On 2/29/08 at 4:40 p.m., the Director of Nursing (DON) was asked about the Foley catheter being out. She stated, "Well it's common knowledge she had a problem with leakage. LPN (Licensed Practical Nurse) called hospice and they told her it was no longer their responsibility to bring catheters. The Supervisor told her to leave it out." The DON was then asked if the Supervisor was employed by the facility and she stated, "Yes. [Registered Nurse #3].<br><br>i. On 2/29/08 at 5:00 p.m., Registered Nurse (RN) #3 was asked why the catheter was removed. She stated, "It was leaking." She was then asked when did this take place and she answered, "I'm not sure about the date." The RN was then asked if a catheter can be inserted without an order and she stated, "You have to have an order to place it... I'll just take the responsibility of taking it out and failing to put it back in." The RN was then asked if there was not an order to discontinue the catheter what should be done. She stated, "I did not put it back." RN #3 was then asked does the doctor need to be notified if a catheter is going to be left out and she stated, "Yes." When asked what date the catheter was taken out she could not give a date. | F 309   |   |                      |   |
| F 312<br>SS=D   | 483.25(a)(3) ACTIVITIES OF DAILY LIVING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced  | F 312   |   |                      |   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                    |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>045357</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>02/29/2008</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 RICHARDS ROAD</b><br><b>NO LITTLE ROCK, AR 72117</b>           |                      |   |
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| F 312   | Continued From page 10<br>by:<br>Complaint #13344, substantiated (all or in part) in these findings.<br><br>Based on observation and record review, the facility failed to ensure the groin and labia area were cleaned to during incontinent care for 1 (Residents #3) of 6 (Residents #1, #2, #3, #4, #5 and #6) case mix residents who were dependent on staff of incontinent care. This failed practice had the potential to affect 86 residents who were occasionally or frequently incontinent of bladder control and 78 residents who were occasionally or frequently incontinent of bowel control as documented on the Resident Census and Conditions of Residents report dated 2/27/08. The findings are:<br><br>Resident #3 had diagnoses of Diabetes, Failure To Thrive, Congestive Heart Disease, and Constipation. The Minimum Data Set dated 2/27/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance for toilet use, hygiene, was incontinent of bowel and bladder and had no urinary tract infections.<br><br>a. The Plan of Care dated 1/23/08 documented, "check on rounds and prn and give incontinent care as needed. Apply skin barrier after each episode... Incontinent Care q(every) 2 hours, preventive care after each episode."<br><br>b. On 2/28/08 at 3:05 p.m., CNA (Certified Nursing Assistant) #2 did not cleanse the resident's groin areas and the labia was not separated and cleansed during incontinent care. | F 312   |   |                      |   |
| F 315<br>SS=D   | 483.25(d) URINARY INCONTINENCE  | F 315   |   |                      |   |

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| F 315   | <p>Continued From page 11</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Complaint #13344, substantiated (all or in part) in these findings.</p> <p>Based on observation and record review, the facility failed to ensure a clean area of the cloth was used to clean the groin and vaginal area during incontinent care to prevent the potential for urinary tract infections for 1 (Resident #1) of 6 (Residents #1-6) case mix residents who were incontinent of bowel and/or bladder. This failed practice had the potential to affect 86 who were incontinent of bladder and 78 residents who were incontinent of bowel according to the Resident Census and Condition of Residents form dated 2/27/08. The findings are:</p> <p>Resident #1 had diagnoses of Encephalopathy, Insulin Dependent Diabetes Mellitus, Late Effects of Cerebrovascular Disease, Aphasia, and Gastrostomy. The Quarterly Minimum Data Set dated 12/14/07 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for incontinent care, and was continent of bowel and bladder.</p> | F 315   |   |                      |   |

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| F 315   | Continued From page 12   | F 315   |   |   |
| F 322<br>SS=D   | <p>a. On 2/29/08 at 2:30 p.m., CNA (Certified Nursing Assistant) # 4 provided incontinent care. The CNA wiped the resident's right groin area, spread the labia, then wiped the urinary meatus and the perineum with the same cloth used to cleanse the groin area.</p> <p>483.25(g)(2) NASO-GASTRIC TUBES</p> <p>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, 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:<br/>Based on observation, record review, and interview, the facility failed to ensure only licensed personnel restarted feeding tube pumps and the head of the bed was elevated when feeding tube formula was infusing for 1 of 1 (Resident #1) case mix resident who had a feeding tube. These failed practices had the potential to affect 10 residents who had a feeding tube as documented on the Resident Census and Conditions of Residents form dated 2/27/08. The findings are:</p> <p>Resident #1 had diagnoses of Encephalopathy, Insulin Dependent Diabetes Mellitus, Late Effects of Cerebrovascular Disease, Aphasia, and Gastrostomy. The Quarterly Minimum Data Set dated 12/14/07 documented the resident was severely impaired in cognitive skills for daily decision making, required total dependence on</p> | F 322   |   |   |

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| F 322   | Continued From page 13<br>staff for activities of daily living, and had a feeding tube.<br><br>a. A physician order dated 7/8/07 documented, VHN @ 64 ml (milliliters)/hr (hour), continuous, via g (gastrostomy)-tube..."<br><br>b. On 2/28/08 at 2:35 p.m., Certified Nursing Assistant (CNA) #7 assisted with cleaning the resident of bowel movement that had leaked from the colostomy bag. The CNA removed turned the pump on to resume the tube feeding at a rate of 64cc (cubic centimeters) per hour and then left the resident's room. The CNA did not inform a licensed nurse that the pump needed was restarted.<br><br>c. On 2/28/08 at 2:55 p.m., CNA #7 was asked if CNA's could turn feeding pumps on and she stated, "Yes, I did where I use to work."<br><br>d. The facility's procedure titled, Enteral Feeding Tube, Care of, received on 2/28/08 documented, "Basic Responsibility Licensed Nurse..."<br><br>e. On 2/29/08 at 2:38 p.m., RN (Registered Nurse) #1 turned the feeding tube pump to the on position to infuse the formula at 64 cc/hour while the head of the bed (HOB) was lowered. The pump started beeping and the RN looked at the tubing, looked at the pump, but did not notice the HOB was lowered with the pump infusing the formula.<br><br>f. On 2/29/08 at 2:40 p.m., LPN (Licensed Practical Nurse) entered the room to provide wound care. The head of the bed was still lowered, the feeding tube was infusing and RN #1 left the room without informing LPN #1 that she | F 322   |   |                      |   |

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| F 322   | Continued From page 14<br>had turned the pump on. The LPN provided wound care to the coccyx with the HOB lowered. After 13 minutes, the surveyor informed the LPN that the RN had restarted the pump. LPN #1 turned the pump to the off position, continued with the treatment for an additional 8 minutes. After completing wound care, the LPN raised the head of the bed and restarted the feeding tube pump.  | F 322   |   |                      |   |
| F 323<br>SS=D   | g. On 2/29/08 at 5:15 p.m., the DON was asked what the nurses should have done after being informed of the HOB level with the pump infusing the formula. The DON said, "The resident should have been assessed, the placement of the tube checked, and the HOB raised."<br><br>483.25(h) ACCIDENTS AND SUPERVISION<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, the facility failed to ensure the key to the shower room was not left in the door and prescription shampoo was not left unsecured in the shower room. These failed practices had the potential to affect 62 cognitively impaired mobile residents as identified by the Administrator on 2/28/08. The findings are:<br><br>On 2/28/08 at 5:40 p.m., the 200 Hall Shower Room had the key in the door lock. The shower room was located in a common resident area that | F 323   |   |                      |   |

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| F 323   | Continued From page 15<br>was accessible to residents and residents were present in the dining room adjacent to the room. In the whirlpool tub there was a 4 ounce bottle of ketoconazole shampoo with a prescription label.   | F 323   |   |   |
| F 328<br>SS=D   | a. On 2/29/08 at 9:10 a.m., the Material Safety Data Sheet received from the Administrator documented, "...Section VI-Health Hazard Data ...Emergency/First Aid Procedures: Eyes: Flush immediately with large amounts of water for at least 15 minutes. If redness or irritation persists, contact a doctor. Ingestion: Contact a doctor immediately; never give anything by mouth to an unconscious person. Inhalation: Remove to fresh air. Support breathing (give oxygen or artificial respiration). Skin: Flush with mild soap and water; if irritation persists, contact a doctor..."<br>483.25(k) SPECIAL NEEDS<br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and interview, the facility failed to ensure nebulizer updraft treatments were administered in accordance with the plan of care for 1 of 1 (Resident #2) case mix resident who required | F 328   |   |   |

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| F 328   | Continued From page 16<br>nebulizer updraft treatments. The facility failed to ensure the correct oxygen flow rate was administered and the filter to the oxygen concentrator was cleaned daily for 1 (Resident #3) of 3 case mix residents (Resident #1, 2 and 3) who received oxygen therapy. These failed practices had the potential to affect 20 residents who received nebulizer updraft treatments per a list provided by the Administrator on 3/4/08 and 7 residents who received oxygen therapy according to the Resident Census and Conditions of Residents form dated 2/27/08. The findings are:<br><br>1. Resident #2 had diagnoses of Pulmonary Fibrosis, Chronic Bronchitis and Chronic Obstructive Pulmonary Disease. The Medicare 14 Day Assessment Minimum Data Set dated 2/18/08 documented the resident was moderately impaired in cognitive skills for daily decision making and required oxygen therapy.<br><br>a. A Physician Order dated 1/29/08 documented, "Albuterol sulfate 0.083% sol. 1 inhalation two times per day."<br><br>b. The Medication Administration Record (MAR) dated 2/1/08-2/29/08 documented, "Albuterol sulfate 0.083% sol 1 inhalation two times per day" scheduled at 9:00 a.m. and 5:00 p.m.<br><br>c. On 2/29/08 at 9:18 a.m., Licensed Practical Nurse (LPN) #2 was asked if there were updraft treatments to be given and if so when. LPN #2 stated, "Yes, I do [other resident] at 12:00 noon and [Resident #2]. It's at 9:00."<br><br>d. On 2/29/08 at 10:55 a.m., the resident was asked if she had received the updraft treatment yet and she stated, "No, but I need it." The | F 328   |   |                      |   |

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| F 328   | <p>Continued From page 17</p> <p>resident was then asked if she had received any updraft treatment this morning and she stated, "No not for this morning."</p> <p>e. On 2/29/08 at 11:00 a.m., LPN #2 was at the medication cart outside of the resident's room. She was asked when the resident was to have her breathing treatment and she stated, "9". The surveyor then stated the time was now 11:00 a.m.. The LPN gave no response.</p> <p>f. The facility's Medication Administration General Guidelines policy received on 2/29/08 at 12:15 p.m. documented on page 4 and page 5, "...14. Medications are administered within 60 minutes of scheduled time, except before or after meal orders, ...Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the nursing care center..."</p> <p>2. Resident #3 had diagnoses of Failure To Thrive, Congestive Heart Failure, and Multiple Upper Respiratory Infections. The Minimum Data Set dated 2/27/08 documented the resident was moderately impaired in cognitive skills for daily decision making and required oxygen therapy.</p> <p>a. A physician order dated 2/25/08 documented, "Oxygen at 2 LPM (liters per minute) per nasal canula."</p> <p>b. The February 2008 Medication Administration Record (MAR) documented, Oxygen at 2 LPM per nasal canula."</p> <p>c. On 2/27/08 at 4:35 p.m. and 6:25 p.m., and 2/28/08 at 8:47 a.m. and 2:20 p.m., the resident's</p> | F 328   |   |                      |   |

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| F 328   | Continued From page 18<br>oxygen was administered at 2.5 LPM via nasal canula and the oxygen concentrator filter area and the framed area had a significant amount of dusty lint covering the filter and the surrounding areas of the frame.<br><br>d. The facility's policy and procedure for Oxygen Therapy documented, "deliver flow per physician's order."<br><br>e. On 2/29/08 at 10:10 a.m., the DON was asked if there were orders for the concentrator to be cleaned daily. The DON said, "yes," The DON was asked if they kept a cleaning log on the concentrators. She said, "actually it's documented on the MAR (Medication Administration Record)." She was asked who's responsibility it was to clean them, she said "it's the nurses' responsibility." The February 2008 MAR documented the filters were cleaned daily. | F 328   |   |                      |   |
| F 333<br>SS=D   | 483.25(m)(2) MEDICATION ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Complaint #13333, substantiated (all or in part) in these findings.<br><br>Based on record review and interview, the facility failed to follow physician's orders to ensure that residents were free of significant medication errors for 1 (Resident #4) of 4 (Resident #1 through #4) case mix residents who received medications. This failed practice had the potential to affect 112 residents who received medications as identified by documentation   | F 333   |   |                      |   |

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| F 333   | <p>Continued From page 19</p> <p>received from the Administrator on 3/4/08. The findings are:</p> <p>Resident #4 had diagnoses of Alzheimer's Dementia, Late Effects of Cerebrovascular Disease, and Malignant Neoplasm of Prostate. The Quarterly Minimum Data Set dated 1/24/08 documented the resident was severely impaired in cognitive skills for daily decision-making.</p> <p>a. A Physician Order dated 11/23/07 documented, "Doxycycline 100 mg (milligrams) cap (capsule)1 oral two times per day." The physician order did not document the Doxycycline was time limited.</p> <p>b. The Medication Administration Record (MAR) dated 12/1/07-12/31/07 and 1/1/08-1/31/07 documented, "Doxycycline 100 mg cap 1 oral two times per day." and was administered daily.</p> <p>c. The MAR dated 2/1/08-2/29/08 did not document the physician order or administration of Doxycycline.</p> <p>d. The February 2008 Physician Order sheet did not document an order for the Doxycycline to be discontinued.</p> <p>e. The February 2008 Nurses Notes did not document that the physician discontinued the doxycycline or that the physician was notified about the medication being stopped.</p> <p>f. The Shipping Manifest of Pharmaceuticals received from the pharmacy on 3/3/08 documented that the medication Doxycycline was filled in 11/07, during the month of 12/07 and 1/08, and on 2/11/08 refilled with 60 capsules and</p> | F 333   |   |                      |   |

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| F 333   | Continued From page 20<br>delivered to the facility with signed receipt from a licensed nursing staff member. The pharmacy stated they did not have any documentation to discontinue the Doxycycline.  | F 333   |   |                      |   |
| F 425<br>SS=D   | g. As of 2/28/08, there was no documentation in the resident's clinical record that the medication was administered after 1/31/08.<br><br>h. This was a significant medication error due to the frequency.<br><br>483.60(a),(b) PHARMACY SERVICES<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Complaint #13333, substantiated (all or in part) in these findings. | F 425   |   |                      |   |

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| F 425   | Continued From page 21<br><br>Based on record review and interview, the facility failed to ensure an antibiotic was administered when ordered for 1 (Resident #3) of 2 (Resident #4 and #5) case mix residents who a physician order for antibiotic therapy. This failed practice had the potential to affect 31 residents who received antibiotic therapy as documented on the Resident Census and Conditions of Residents form dated 2/27/08. The findings are:<br><br>Resident #5 had diagnoses of Bradycardia with Pacemaker, Bacterial Conjunctivitis, and Osteoporosis. The Medicare 30 day Minimum Data Set dated 1/29/08 documented the resident had modified independence in cognitive skills for daily decision-making.<br><br>a. A Physician Order dated 2/20/08 documented, "Levaquin 500 mg (milligrams) 1 PO (by mouth) q (every) d (day) X (times) 10 days."<br><br>b. The February 2008 Medication Administration Record documented, "Levaquin 500 mg tab (Levofloxacin) 1 oral daily 1st dose given from ER (Emergency) box Give next 9 days." The first dose administered was documented as given on 2/21/08 at 1:30 p.m. There was no documentation that a dose of Levaquin was given on the date of the physician's order.<br><br>c. The Phone-In pharmacy order form was dated 2/21/08 and the shipping manifest from the facility's pharmacy provider was dated 2/21/08 and documented the pharmacy sent 9 tablets of Levaquin 500 mg on 2/21/08.<br><br>d. On 2/29/08 at 3:50 p.m., the Emergency stock box located on the 200 Hall was viewed with the | F 425   |   |                      |   |

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| F 425   | Continued From page 22<br>assistance of Licensed Practical Nurse (LPN) #3. The stock box was kept locked in the medication room and contained various medications that included Levaquin antibiotic tablets. LPN #3 stated that Levaquin was available in the box and that they can call the pharmacy after hours if needed.<br><br>e. The facility's Medication Ordering and Receiving Medications policy received on 2/29/08 at 5:10 p.m. documented on page 2, "...Timely delivery of new orders is required so that medication administration is not delayed. If available, the emergency kit is used when the resident needs a medication prior to pharmacy delivery..."   | F 425   |   |                      |   |
| F 444<br>SS=E   | 483.65(b)(3) PREVENTING SPREAD OF INFECTION<br><br>The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and record review, the facility failed to ensure employees washed their hands after providing colostomy care and incontinent care and before performing other tasks for 2 (Resident #1 and 3) of 4 (Resident #1 - 4) case mix residents who was dependent on staff for personal hygiene This failed practice had the potential to affect all 115 residents. The findings are:<br><br>1. Resident #1 had diagnoses of Encephalopathy, Insulin Dependent Diabetes | F 444   |   |                      |   |

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| F 444   | <p>Continued From page 23</p> <p>Mellitus, Late Effects of Cerebrovascular Disease, Aphasia, and Gastrostomy. The Quarterly Minimum Data Set dated 12/14/07 documented the resident was severely impaired cognitive skills for daily decision making, required total dependence on staff for activities of daily living, had a feeding tube, and colostomy.</p> <p>On 2/28/08 at 2:35 p.m., Certified Nursing Assistant (CNA) #7 assisted with cleaning the resident of bowel movement that had leaked from the colostomy bag. The CNA removed her gloves and turned the feeding tube pump on at a rate of 64cc (cubic centimeters) per hour, then left the resident's room. The CNA did not wash her hands after providing colostomy care.</p> <p>2. Resident #3 had diagnoses of Failure To Thrive and Multiple Upper Respiratory Infections. The Minimum Data Set 2/27/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with personal hygiene and was incontinent of bowel and bladder.</p> <p>On 2/28/08 at 3:05 p.m., CNA (Certified Nursing Assistant) #2 provided incontinent care of feces. After the CNA completed incontinent care, she repositioned the resident's head and hair on her pillow, the pillows at her side, the bed controls, side rails and repositioned the resident in the bed without removing the contaminated gloves.</p> <p>3. The facility's Standard Precautions policy received on 2/29/08 at 11:01 a.m. documented on page 13, "Handwashing Handwashing should be done: ...Before and after each patient/resident contact Before clean procedures After dirty procedures...Before and after removing gloves..".</p> | F 444   |   |                      |   |

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| F 502<br>SS=D   | <p>483.75(j)(1) LABORATORY SERVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation and record review, the facility failed to ensure a unacceptable stool specimen was recollected for 1 of 1 case mix resident (Resident #2) who had a physician order for a stool specimen. This failed practice had the potential to affect all 115 residents according to the Resident Census and Conditions of Residents report dated 2/27/08. The findings are:</p> <p>Resident #2 had diagnoses of Pulmonary Fibrosis, Chronic Obstructive Lung Disease, Gastritis and Duodenitis. The Medicare 14 Day Assessment Minimum Data Set (MDS) dated 2/18/08 documented the resident was moderately impaired in cognitive skills of daily decision making.</p> <p>a. Nurses notes dated 1/30/08 documented, "Resident c/o irritation when she had a BM (bowel movement) previous shift noted some blood in stool stool for CDiff ordered..."</p> <p>b. A physician order dated 1/30/08 documented, "Start Flagyl 250 mg (milligrams) po (by mouth) TID (three times a day) until stool culture available."</p> <p>c. Nurses Notes dated 1/31/08 at 4:39 p.m. documented, "...Stool specimen collected @ (at) 0910 a.m. and placed specimen in refrigerator for</p> | F 502   |   |                      |   |

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| F 502   | Continued From page 25<br>pickup. Relief nurse notified..."<br><br>d. A laboratory report with a collection date 1/31/08 documented, "Rejected: Test requested CDIFF (Clostridium difficile). Specimen older than 72 hours must be frozen. If test is still needed, please recollect and submit with a new requisition.... Spec: Incorrectly collected/stored/transported..." Handwritten on the report was documentation of "lab called 2/4/08; Nurses informed 2/5/08."<br><br>e. The February 2008 Medication Administration Record (MAR) documented the resident received the last dose of Flagyl on 2/4/08, but there was no documentation the stool specimen was recollected.<br><br>f. As of 2/27/08, there was no documentation in the clinical record that the physician was consulted about the need to recollect the stool specimen. | F 502   |   |                      |   |