

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

PRINTED: 05/01/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/18/2008
NAME OF PROVIDER OR SUPPLIER LITTLE ROCK HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 5720 WEST MARKHAM LITTLE ROCK, AR 72205	
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F 000	INITIAL COMMENTS	F 000		
F 221 SS=E	<p>Complaint #13407 and #13459 was unsubstantiated.</p> <p>483.13(a) PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a least restrictive restraint device was used and before application of a more restrictive restraints and also failed to ensure pre restraint assessments were completed for 3 (Residents #2, #4 and#7) of 10 case mix residents with a restraint (Residents #2, 3, 4, 5, 7-10, 23 and 24). This failed practice had the potential to affect 22 residents in the facility with restraints according to the Resident Census and Conditions of Residents report dated 4/7/08. The findings are:</p> <p>1. Resident #7 had diagnoses of Dementia, Senile with Delusional Features and Cardiovascular Accident. The Quarterly Minimum Data Set (MDS) dated 2/16/08 documented that the resident was moderately impaired in cognitive skills for daily decision-making and had a trunk restraint.</p> <p>a. A review of an Incident and Accident report (I&A) dated 11/6/07 documented "Resident was found by CNA in another resident's room lying on floor in front of w/c, checked resident, no injury noted at the time. Assist up and assist to bed,</p>	F 221		

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 221	Continued From page 1 monitor closely." b. The care plan dated 11/8/07 and updated 1/19/08 documented, " At risk for falls or injury, related to: unsteady gait and history of falls. ... Approach ... Releasable seatbelt to remind [resident] to seek assistance prior to ambulation. ... " c. A physician order dated 1/19/08 documented, "Releasable seat belt restraint when up in W/C (Wheel Chair) to remind resident to seek assistance prior to attempting to ambulate." d. On 4/7/07 at 1:56 p.m., and 4/8/08 at 11:04 a.m., the resident was up in a wheelchair and self-release seat belt was in place. e. On 4/9/08 at 9:40 a.m., resident was up in a wheelchair and releasable seat belt restraint was in place. The resident was asked to release the restraint, the resident attempted to remove the bib instead of the releasable belt restraint that was place. f. On 4/9/08 at 9:46 a.m., Registered Nurse (RN) #2 was asked about the self-release seat belt restraint that was used for the resident. She stated they were the same, the facility only used the seat belts and had no soft belt restraints in the facility. RN #2 was also asked if any attempts had been made to reduce or eliminate restraints for the resident. The RN stated, "No." g. On 4/9/08 there was no documentation in the clinical record of a pre-assessment, evaluation or other interventions in place for a least restrictive device. 2. Resident # 2 had diagnoses of Cortical	F 221			

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F 221	<p>Continued From page 2</p> <p>Blindness, and Above the knee Amputation Right Leg. The Medicare 30 day MDS dated 2/18/08 documented the resident had short term memory deficit, had modified independent cognitive skills for daily decision making, and had no restraints.</p> <p>a. A Pre-Restraining Assessment form dated 2/14/07 documented: "Releasable seat belt to remind resident to call for assistance."</p> <p>b. A Physical Restraint Elimination Assessment form dated 2/4/08 documented: "This chair alarm is not considered a restraint " A total score of 32, (The form indicated that a score between 21-35 was a good candidate for reduction).</p> <p>c. On 4/7/08 at 12:30 p.m., Licensed Practical Nurse # 4 stated that the resident had contractures of bilateral hands and had no restraints.</p> <p>d. On 4/7/08 at 12:30 p.m., and 4:20 p.m., the resident was sitting up in a wheelchair with a Velcro alarm seat belt in place.</p> <p>e. On 4/8/08 at 6:52 a.m., 10:02 a.m., 12:45 p.m., and 1:30 p.m., the resident was sitting up in the wheelchair with a Velcro seat belt restraint in place.</p> <p>f. On 4/8/08 at 10:02 a.m., the surveyor asked the resident if he could release the seat belt, the resident stated "No I can't."</p> <p>g. On 4/11/08 after review of the clinical record there was no documentation that indicated that a least restrictive device had been assessed for use since the physical restraint elimination assessment dated 2/4/08.</p>	F 221			

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F 221	Continued From page 3 3. Resident # 4 had diagnoses of Alzheimer Disease. The Annual MDS dated 2/20/08 documented the resident had moderately impaired cognitive skills for daily decision making, and had no restraints. a. A Physical Restraint Informed Consent form dated 4/3/07 documented: "Chair Alarm, Releasable Seatbelt, Medical Symptoms, Cognitive Impaired, and weakness." b. A Pre-Restraining Assessment form dated 7/17/07 recommendations documented: "Releasable seatbelt, chair alarm." c. A Physical Restraint Elimination Assessment form dated 8/3/07 documented: A total score of 22, (The form indicated that a score between 21-35 was a good candidate for reduction). a. On 4/7/08 at 1:10 a.m., the resident was up in a wheelchair with a Velcro alarm seat belt in place. b. On 4/8/08 at 7:02, 12:10 p.m., and 1:30 p.m., the resident was sitting up in a wheelchair with Velcro alarm seat belt in place. c. On 4/9/08 at 8:30 a.m., the resident was in the day room sitting up in a wheelchair with Velcro alarm seat belt in place. d. On 4/9/08 at 10:20 a.m. the resident was asked if she could release the seat belt. The resident looked at the seat belt and attempted to release the seat belt and was unable to release it. e. On 4/9/08 after review of the clinical record	F 221			

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F 221	Continued From page 4 there was no documentation that indicated that a least restrictive device had been attempted.	F 221			
F 241 SS=E	4. On 4/10/08 at 3:40 p.m., Licensed Practical Nurse (LPN) #4 was asked what the definition was for a restraint, the LPN stated, " Anything, a belt, side rails, permanent or releasable that would inhibit the movement of a resident. " The LPN was then asked about the releasable restraints for Resident #2 and # 4, the LPN stated they were not restraints. When the surveyor asked if they (Resident #2 and 4) could release the seat belt, the LPN stated, "No", then the LPN stated, "Yes that would be a form of restraint." 483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure residents were faced forward when transported in a geri chair and/or shower chair for 2 case mix residents (Resident #2 and #18) of 8 (Residents #2, #5, #6, #7, #10, #12, #18, and #20) case mix residents that required staff assistance for transport. This failed practice had the potential to affect ----91 residents that was in the chair all or most of the time according to the Resident Census and Conditions of Residents form dated 4/7/08. The findings are: 1. Resident #18 had diagnoses of Mental Retardation and Senile Dementia with Delusional Features. The Quarterly Minimum Data Set	F 241			

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F 241	Continued From page 5 (MDS) dated 3/27/08 documented the resident had severely impaired cognitive skills for daily decision making and required assistance from staff for locomotion. a. On 4/8/08 at 7:57 a.m., Certified Nursing Assistant (CNA) #9 pulled the resident in the gerichair backwards out of the dining room located on the Second Floor into the hallway, passing the nurses station, continuing to pull the resident backwards down the hallway and into their room. The CNA pulled the resident past the Medicare Manager Registered Nurse and Licensed Practical Nurse (LPN) #1 standing at the nurse ' s station. 2. Resident # 2 had diagnoses of Cortical Blindness, and Above the knee Amputation of the Right Leg. The Medicare 30 day MDS dated 2/18/08 documented that the resident had modified independent cognitive skills for daily decision making and requires the assistance of 1 to 2 staff member for bed mobility and transfer.	F 241		
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:	F 272		

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F 272	<p>Continued From page 6</p> <p>Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that the Minimum Data Set was coded correctly for one (Resident #22) case mix resident 16 case mix residents (Residents # 2, #3, #4, # 5, # 7, #8, #9, # 10, #11, 12, # 13. # 14, # 20, #21, #22 and # 23)) that required assistance with transfers, for 1 case mix resident (Resident #4) of 10 case mix residents (Resident #2 -5, 8-10, 13, 22 and 23) that required the use of a restraint, for one case mix resident (Resident #11) of 5 case mix residents (Residents #5, 8, 10, 11 and 12) who required the use of a feeding tube and one case mix resident (Resident # 4) of 5 case mix residents (Residents # 2,# 4, # 5, # 9, and # 20) that received Antidepressants. These</p>	F 272			

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F 272	<p>Continued From page 7</p> <p>failed practices had the potential to affect 84 residents in the facility that required assistance with transfers, 48 residents that received Antidepressants according to a list provided by the Director of Nurses(DON) on 4/11/08 at 3:35 p.m., 12 residents who had restraints, and 16 residents who had a feeding tube according to the Resident Census and Conditions of Residents form dated 4/7/08. The findings are:</p> <p>1. Resident #4 had diagnosis of Alzheimer Disease. The annual MDS dated 2/20/08 documented that the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance with personal hygiene, was usually continent of bowel and bladder, had no restraints, and used no antidepressants.</p> <p>a. The February 2008 Physician order sheet documented, Effexor XR ' no crush w/o (without) PO (by mouth) 37.5 mg (milligram).</p> <p>2. Resident #11 had diagnoses of Decubitus Ulcer, Type 2 Diabetes Mellitus, and Cerebrovascular Accident. The Annual MDS dated 11/28/07 documented the resident had severely impaired cognitive skills for daily decision making, had a feeding tube and received 75 to 100 % of the time. The Quarterly Minimum Data Set (MDS) dated 2/25/08 documented the resident had severely impaired cognitive skills for daily decision-making, was totally dependent on staff for Activities of Daily Living (ADL's). The section K5 and K6 that identified enteral feeding did not document a feeding tube.</p> <p>a. The care plan dated 6/25/07 and review dates 11/27/07 and [handwritten date 3/7/08</p>	F 272			

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F 272	<p>Continued From page 8</p> <p>documented readmit cont (continue) care plan) documented, " Problem At risk for altered nutrition: Less than body requirements [related to] presence of tube feeding.</p> <p>c. On 4/11/08 at 10:40 a.m., the Medicare Manager Registered Nurse (RN) was informed that there was no documentation on the 2/25/08 MDS identifying that the resident had a feeding tube and received 75 to 100 % of the PO (by mouth) intake form it. The Medicare Manager RN stated, "She had a feeding tube. You're right."</p> <p>3. Resident #22 had diagnoses of Alzheimer's Disease with Behavioral Disturbance and Macular Degeneration. The Annual MDS dated 9/10/07 documented that the resident had moderately impaired cognitive skills for daily decision making, was independent with transfers, and walked in the room and corridor. The Quarterly MDS dated 3/5/08 documented the resident had moderately impaired cognitive skills for daily decision making, required limited assistance of one person for transfers and had walked in the room and corridor.</p> <p>a. The care plan dated 1/3/06 and review dates, 12/6/07 and 3/4/08 documented, " At risk for falls or injury, related to unsteady gait, and resident wandering continuously until fatigued ... "</p> <p>b. On 4/10/08 at 3:30 p.m., Licensed Practical Nurse (LPN) #6 was asked if the resident was ambulatory. LPN #6 stated, "We have to use a lift to transfer her up and down. The reason I know is I help the girls out." The LPN was then asked if the resident walked, she stated, "I haven't seen her walk in quite some time or even swing her legs over. I haven't seen that in</p>	F 272			

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F 272	Continued From page 9 months." The LPN was then asked if the resident transferred independently and she stated, "No."	F 272			
F 282 SS=D	<p>c. On 4/10/08 at 3:47 p.m., Certified Nursing Assistant (CNA) #13 was asked if the resident walked or transferred herself independently. The CNA stated, "No, total care."</p> <p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the physician orders were followed for one case mix resident (Resident #5) of 3 case mix residents (Residents #5, 11, and 13) that had had physician orders treatments. These failed practices had the potential to affect 8 residents in the facility that had wound care according to a list provided by the Director of Nursing on 4/11/08. The findings are:</p> <p>1. Resident # 5 had diagnoses of Dementia and Pressure Ulcers. The Quarterly Minimum Data Set (MDS) dated 3/2/08 documented that the resident had moderately impaired cognitive skills for daily decision making, and had a stage IV pressure ulcer.</p> <p>a. The April 2008 Physician ' s order sheet documented, " 2/7/08 ... Wound care cleanse R (right) foot apply A [and] D ointment. Apply</p>	F 282			

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F 282	<p>Continued From page 10</p> <p>bulky gauze dressing. For preventive measures and Wound care cleanse (R) foot W [with]soap [and] H2O (water) apply A [and] D oint.(ointment) wrap W/Kerlix for preventive measures ... Wound care cleanse L (left) lateral ankle W WND (wound cleaner) wrap W/kerlix gauze QD (every day) til healed. "</p> <p>b. The April 2008 Treatment Record documented: " 3/7/08 (the date was written over the previous date printed) ... Wound care cleanse R (right) ankle [the previous word was crossed out and ankle marked over previous word] apply Santyl [Previous word was marked out and santyl was written over the word] (ointment) apply bulky gauze DRSG (dressing). For preventive measures.</p> <p>c. On 4/8/08 at 8:50 a.m., the treatment nurse changed the dressing for the Stage III pressure ulcer located on the right ankles. The LPN cleaned the right foot pressure ulcer with wound cleaner not soap and water and failed to apply the A [and] D ointment to the right foot.</p> <p>d. On 4/10/08 at 3:45 p.m., the Treatment Nurse was asked about the A [and] D ointment. The Treatment Nurse stated, "A [and] D ointment was to keep the feet soft." The Treatment Nurse was asked if she had applied the A[and] D ointment to the feet, the Treatment Nurse stated, "No, the A&D ointment was suppose to have been discontinued, but it wasn't."</p>	F 282		

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F 282	Continued From page 11	F 282			
F 309 SS=E	<p>483.25 QUALITY OF CARE</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: Based on observation and record review the facility failed to ensure that the bowel elimination pattern was monitored and interventions implemented in a timely manner to prevent a fecal impaction for 1 (Resident #6) of 20 casemix residents (Residents #6 and 25) who had a fecal impaction. The facility also failed to ensure that catheter care was provided when providing incontinent care and/or the foley catheter tubing was secured to prevent the potential of trauma to the urinary meatus for 2 case mix residents (Resident #12 and 13) of 7 case mix resident (Residents #3, 7, 5, 10, 11, 12, and 13) who had and indwelling foley catheter. These failed practices had the potential to affect all 114 residents residing in the facility that had a potential to have a fecal impaction and 15 residents with indwelling foley catheters as identified on the Roster Sample Matrix dated 4/14/08. The findings are:</p> <p>1. Resident #6 had diagnoses of Arthritis, Alzheimer Disease, Renal Failure and Dementia with Behavioral Disturbance. The Minimum Data</p>	F 309			

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F 309	<p>Continued From page 12</p> <p>Set [MDS] dated 1/23/08 documented the resident had short term memory problems, no long term memory problems, was moderately impaired in cognitive skills for daily decision making and required no assistance with transfer.</p> <p>a. A Physician Order dated 1/10/08 documented, "Milk of Magnesia [MOM] 30 cc [cubic centimeters] PO [by mouth] QD [every day] PRN [as needed] for constipation."</p> <p>b. The Medication Administration Record [MAR] for March 2008 did not document the resident received any MOM for constipation.</p> <p>c. The Elimination Sheet for the month of March 2008 did not document a BM [bowel movement] on either shift for 6 consecutive days, 3/18-23/08.</p> <p>b. The resident was admitted to the hospital on 3/24/08 with a fecal impaction.</p> <p>2. Resident #12 had diagnoses of Subarachnoid Hemorrhage, Seizure Disorder, Hypertension and Diabetes. The Minimum Data Set (MDS) dated 3/26/08 documented the resident had moderately impaired cognitive skills for daily decision making and was totally dependent for personal hygiene.</p> <p>a. On 4/8/08 at 1:50 p.m., Certified Nursing Assistant (CNA) #1 provided incontinent care for the resident. The CNA then cleansed the drain tube of the foley catheter drainage bag with alcohol pad. The CNA was asked if she had provided catheter care for the resident, she stated, " Yes. " The CNA did not cleansed the catheter insertion site extending outward on the foley catheter tubing.</p>	F 309			

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F 309	Continued From page 13 b. On 4/9/08 at 8:25 a.m., CNA #3 was asked who was responsible for doing catheter care. She stated, "The CNA'S do the catheter care when they do pericare." c. On 4/9/08 at 12:10 p.m., the Director of Nursing (DON) was asked who was responsible for doing catheter care, she stated, "The CNA's do it when they do pericare." d. The facility's Policy and Procedure entitled ' Catheter Care Policy ' documented, "Procedure: 3. Remove any gross debris from the catheter. Always use a front to back cleaning technique, or movements are to be starting at and away from the urinary meatus." 2. Resident #13 had diagnoses of Cerebrovascular Accident with Right Sided Weakness, Diabetes Mellitus, Edema, Deep Vein Thrombosis and Seizures. The MDS dated 2/18/08 documented the resident had modified independent cognitive skills for daily decision making, was totally dependent for transfers with 2 persons to physical assist. a. On 4/8/08 at 9:10 a.m. the resident was observed in bed getting lotion applied per CNA. The resident had an indwelling catheter and the catheter was not secured.	F 309			
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312			

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F 312	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and record review the facility failed to ensure that the mon pubis, groin, labia was separated and cleansed, and inner thigh was cleansed when providing incontinent care for 3 case mix residents, (Residents #4, #5, and # 7) of 16 case mix residents (Residents #1 - 12, #19, # 21, #23 and # 24) who were occasionally or frequently incontinent of bowel and/or bladder. This failed practice had the potential to affect 98 residents in the facility that were occasionally or frequently incontinent of bowel and/or bladder according to the Resident Census and Conditions of Residents form dated 4/7/08. The findings are:</p> <ol style="list-style-type: none"> 1. Resident # 4 had a diagnosis of Alzheimer Disease. The Annual Minimum Data Set (MDS) dated 2/20/08 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance with personal hygiene and was usually continent of bowel and bladder. <ol style="list-style-type: none"> a. The care plan dated reviewed 2/20/08 documented, "Provide incontinent care following each episode, keeping resident clean, dry and odor free, maintaining dignity. b. On 4/8/08 at 7:02 a.m., Certified Nursing Assistance (CNA) # 1 performed incontinent care after the resident had been incontinent of bladder. The CNA failed to separate and clean the labia and the outer buttocks, the inner thighs and the bilateral groin area's. 2. Resident # 7 had diagnoses of Dementia and Cerebral Vascular Accident. The Quarterly MDS 	F 312			

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F 312	<p>Continued From page 15</p> <p>dated 2/16/08 documented the resident had moderately impaired cognitive skills for daily decision making, required total assistance with personal hygiene and was incontinent of bowel and bladder.</p> <p>a. On 4/8/08 at 11:20 a.m., CNA # 7 and # 8 provided incontinent care for the resident. CNA # 7 failed to clean the mons pubis, separate and clean the labia, the bilateral groin areas and inner thighs after the resident had been incontinent of bladder.</p> <p>3. Resident # 5 had diagnoses of Urinary tract infection and Dementia. The Quarterly MDS dated 3/2/08 documented that the resident had moderately impaired cognitive skills for daily decision making, total assistance for personal hygiene and was incontinent of bowel and bladder. . The resident required total dependency with personal hygiene and is incontinent of bowel and bladder.</p> <p>a. On 4/9/08 at 10:03 a.m., CNA # 5 and CNA # 6 was performing incontinent care. The resident had been incontinent of bowel and bladder. CNA # 6 failed to separate the labia, clean the bilateral groin areas and the inner thigh.</p> <p>4. The facility 's Policy and Procedure entitled ' Pericare ' received from the Director of Nursing on 4/11/08 at 3:30 p.m., documented: " Purpose ... to provide cleanliness, eliminate odor, prevent infection and prevent irritation and skin breakdown. ... Wash upper thigh-build up of secretions can contaminate surrounding skin areas. Wash labia majora (the two long lips of skin on both sides of vaginal opening). Then use one hand to move labia away from thigh and</p>	F 312			

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F 312	Continued From page 16 wash folds wiping from top to bottom using downward strokes-to reduce risk for transfer of microorganisms to urinary tract opening. Dry area thoroughly-regained moisture harbors microorganisms and promotes skin break down and irritation. ... Separate labia- vaginal opening and mats wash using downward strokes form pubic area to rectum using different section of cloth for each stroke cleanse thoroughly around labia minora (the inner lips of vagina), clitoris and vaginal opening, dry thoroughly."	F 312			
F 314 SS=E	483.25(c) PRESSURE SORES 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. This REQUIREMENT is not met as evidenced by:	F 314			

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F 314	<p>Continued From page 17</p> <p>Based on observation interview and record review, the facility failed to ensure that a pressure relieving device was used when a resident was up in a wheel chair to prevent the potential for skin breakdown for 1 case mix resident (Resident #6) and failed to ensure that repositioning was done in a timely manner to prevent the potential for skin breakdown, CNA 's (Certified Nursing Assistant 's) reported to Licensed Staff when a wound dressing was not in place and/or removed for 1 (Resident 11) case mix resident, failed to follow physician orders for wound care and failed to notify the physician when a decubitus ulcer had deteriorated from a stage II to a stage III pressure ulcer for 1 (Resident #5) of 14 case mix residents (Residents #1, #3, #5, #6, #8, #9-#13, #15, #20, #22, and #24) who were at risk for skin breakdown and/or had a pressure ulcer. These failed practices had the potential to affect 42 residents in the facility who was at risk for skin breakdown according to a list provided by the Director of Nursing on 4/10/08 and 7 residents with pressure ulcers according to the Resident Census and Conditions of Residents form dated 4/7/08. The findings are:</p> <p>1. Resident #6 had diagnoses of Arthritis, Alzheimer Disease, Renal Failure and Dementia with Behavioral Disturbance. The Minimum Data Set (MDS) dated 1/23/08 documented the resident had moderately impaired cognitive skills for daily decision making, required no assistance with transfer, and had no pressure ulcer.</p> <p>a. The care plan dated 1/24/08 documented, " At risk for skin breakdown related to incontinence ... "</p> <p>b. On 4/8/08 at 7:25 a.m., the resident was sitting</p>	F 314			

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F 314	<p>Continued From page 18</p> <p>in a wheelchair in the dining room. There was a lift pad under the resident but there was no pressure relieving device in the wheelchair.</p> <p>c. On 4/8/08 at 11:35 a.m., the resident was receiving pericare from Certified Nursing Assistant ' s (CNA ' s) #10 and #11. The resident's bottom was very red and the resident complained that the areas hurt when wiped. After the pericare was completed, the resident was assisted to a wheelchair and sat on top of a lift pad, there was no pressure relieving device placed in the wheelchair.</p> <p>d. On 4/8/08 at 12:50 p.m., the resident was sitting in the dining room in a wheelchair. The lift pad had been left in place under the resident when the resident was transferred to the wheel chair. There was not a pressure relieving device in the wheel chair.</p> <p>2. Resident # 5 had diagnoses of Urinary tract infection, Pressure Ulcers and Dementia. The Quarterly MDS dated 3/2/08 documented the resident had moderately impaired cognitive skills for daily decision making, required total assistance with personal hygiene, was incontinent of bowel and bladder and had one Stage IV Pressure Ulcer.</p> <p>a. The Physician orders dated 2/7/08 documented, " ... Wound care cleanse R (right) foot apply A [and] D ointment. Apply bulky gauze dressing. For preventive measures and Wound care cleanse (R) foot W [with]soap [and] H2O (water) apply A [and] D oint.(ointment) wrap W/Kerlix for preventive measures ... Wound care cleanse L (left) lateral ankle W WND (wound cleaner) wrap W/kerlix gauze QD (every day) til</p>	F 314			

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F 314	Continued From page 19 healed. " b. The Wound/Skin Healing record documented: "Date of onset reopen 2/7/08 site/location : Lt (left) ankle(lateral). 2/8/08 Stage III, measurement: 2.5 cm (centimeter) by 2.7 cm depth 0.5 cm, exudate: moderate, wound bed beefy red. The treatment for the pressure ulcer Santyl. 2/15/08 measurement: 2.8 cm by 2.8 cm, depth: 0.5 cm, exudate: moderate, wound bed: granulation tissue. 2/22/08 wound Stage III, measurement: 3.0 cm by 3.0 cm, depth: 0.5 cm, exudate: moderate, wound bed: granulation tissue. 2/29/08 Stage III, measurement: 3.0 cm by 3.0 cm, depth: 0.5 cm, exudate: moderate, wound bed: granulation tissue. 3/7/08 Stage III, measurement: 3.0 cm by 3.0 cm, exudate: moderate and wound bed: granulation tissue. 3/28/08 Stage III, measurement: 2.8 cm by 2.8 cm, depth: 0.3 cm, exudate: moderate and wound bed: granulation tissue. 4/4/08 Stage III, measurement: 2.8 cm by 2.8 cm, depth: 0.3 cm, exudate: moderate and wound bed: granulation tissue. c. The Wound/Skin Healing Record documented; Date of onset: Reopen 2/7/08, Site/Location Rt (right) Lateral Ankle. 2/8/08 Stage II, measurement: 2.5 cm (centimeter) by 2.5 cm, depth: 0.3 cm, exudate: small and wound bed: pink wound bed. 2/15/08 Stage II, measurement: 2.6 cm by 2.2 cm, depth: 0.3 cm, exudate: small and wound bed: pink. 2/22/08 Stage II, measurement: 2.8 cm by 2.0 cm, depth: 0.3 cm, exudate: small and wound bed: pink. 2/29/08 Stage II, measurement: 2.8 cm by 2.0 cm, depth: 0.3 cm, exudate: small and wound bed: pink. 3/7/08 Stage III, measurement: 3.0 cm by 2.5 cm, depth: 0.3 cm, exudate: moderate and wound	F 314			

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F 314	<p>Continued From page 20</p> <p>bed: pink. 3/14/08 Stage III, measurement: 2.8 cm by 2.0 cm, depth: 0.3 cm, exudate: moderate and wound bed: granulation tissue. 3/21/08 Stage III, measurement: 2.8 cm by 2.0 cm, depth: 0.3 cm, exudate: moderate, and wound bed: pink. 3/28/08 Stage II, measurement: 3.0 by 2.5 cm, depth: 3.0 cm, exudate: moderate and wound bed: granulation tissue. 4/4/08 Stage III, measurement: 3.0 cm by 3.0 cm, depth 0.3 cm, exudate: moderate and wound bed: granulation tissue. The pressure ulcer had progressed from a stage II pressure ulcer to a Stage III pressure ulcer.</p> <p>d. The April 2008 Treatment Record documented: " 2/7/08 ... Wound care cleanse R (right) foot apply A& (and) D oint (ointment) apply bulky gauze DRSG (dressing). For preventive measures. The word foot was marked out and hand written in was "foot" and A&D was marked out and Santyl had been hand written in the treatment order.</p> <p>e. On 4/8/08 at 8:50 a.m., the treatment nurse changed the dressing for the Stage III pressure ulcer located on the right ankles. The LPN cleaned the right foot pressure ulcer with wound cleaner not soap and water and failed to apply the A [and] D ointment to the right foot.</p> <p>f. On 4/10/08 at 3:45 p.m., the Treatment Nurse was asked if there had been orders obtained for changes in treatment since the wounds had not progressed. The Treatment Nurse stated that she " had obtained Santyl for the right ankle on 3/7/08. " The Treatment Nurse was then asked, since the left ankle pressure ulcer had not shown improvement had the wound been assessed for a change in the current treatment, the Treatment</p>	F 314			

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F 314	<p>Continued From page 21</p> <p>Nurse stated, "No. " The Treatment Nurse was asked regarding the A [and] D Ointment, if the Ointment had been applied during the wound care on 4/8/08. The Treatment Nurse stated, "No, the orders were suppose to been discontinued. ... "</p> <p>3. Resident #11 had diagnoses of Decubitus Ulcer, Type 2 Diabetes Mellitus, and Cerebrovascular Accident. The Quarterly MDS dated 2/25/08 documented the resident had severely impaired cognitive skills for daily decision-making, had a Stage 3 pressure sore, and was totally dependent on staff for Activities of Daily Living.</p> <p>a. On 4/8/08 at 9:10 a.m. the resident was placed in bed after she received a shower given by CNA #2. The resident was positioned on her left side to remove the lift pad. The resident had an opened wound noted on the coccyx area with no dressing. The wound was approximately 2 to 3 centimeters in diameter and had a cavity-like opening with undermining</p> <p>b On 4/8/08 at 9:20 a.m., CNA #2 assisted by CNA #12 placed a clean disposable brief and gown on the resident and transferred the resident to a gerichair.</p> <p>c. On 4/8/08 at 9:32 a.m., CNA #2 stated to Licensed Practical Nurse (LPN) #1, "...I took this off" and pointed to the residents upper chest [the resident had nitro paste applied to chest wall]. The CNA did not inform the LPN that there was no wound dressing that covered the pressure sore.</p> <p>d On 4/8/08 at 10:50 a.m., the resident continued</p>	F 314			

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F 314	Continued From page 22 to wear an incontinent brief and remained seated in the gerichair. The resident's position was marked by the surveyor. e. On 4/8/08 at 11:10 a.m., the resident remained seated in the gerichair. The marked position of the resident had not changed. f. On 4/8/08 at 11:55 a.m., the resident remained seated in the gerichair seat. The marked position of the resident had not changed. g. On 4/8/08 at 1:00 p.m., the resident was transferred by mechanical lift to the bed. There was no dressing on the resident's pressure sore. LPN #5 [Treatment Nurse] was asked, " What do the CNA's do if a dressing was off? " The LPN stated, "They are to report to the charge nurse." h. On 4/8/08 at 1:20 p.m., CNA #2 was asked if she had removed the pressure sore dressing. The CNA stated, "Yeah, I took it off when we were getting her ready for the shower."	F 314			
F 315 SS=E	483.25(d) URINARY INCONTINENCE 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. This REQUIREMENT is not met as evidenced by:	F 315			

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F 315	<p>Continued From page 23</p> <p>Based on observation the failed to ensure that incontinent care was provided in a manner to prevent the potential for urinary tract infections for 1 (Resident #5), and failed to ensure a soiled towel and a back and forth motion was not used when cleansing the vaginal area for 1 case mix resident (Resident #4) of 10 case mix residents (Residents #1-#3, #5-#10 and #12) who were dependent for incontinent care. This failed practice had the potential to affect 7 residents in the facility with indwelling catheters and 98 residents in the facility who were frequently or occasionally incontinent of bowel and bladder according to the Resident Census and Conditions of Residents form dated 4/7/08. The findings are:</p> <p>1. Resident # 4 had a diagnosis of Alzheimer Disease. The Annual Minimum Data Set (MDS) dated 2/20/08 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance with personal hygiene and was usually continent of bowel and bladder.</p> <p>a. The care plan dated reviewed 2/20/08 documented, "Provide incontinent care following each episode, keeping resident clean, dry and odor free, maintaining dignity.</p> <p>b. On 4/8/08 at 7:02 a.m., Certified Nursing Assistance (CNA) # 1 performed incontinent care after the resident had been incontinent of bladder. The CNA failed to clean the labia and the outer buttocks, the inner thighs and the bilateral groin area's.</p> <p>2. Resident # 5 had diagnoses of Urinary tract infection and Dementia. The Quarterly MDS dated 3/2/08 documented that the resident had</p>	F 315			

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F 315	<p>Continued From page 24</p> <p>moderately impaired cognitive skills for daily decision making, total assistance for personal hygiene and was incontinent of bowel and bladder. . The resident required total dependency with personal hygiene and is incontinent of bowel and bladder.</p> <p>a. The resident had history of Urinary Tract infection(UTI), was treated for UTI on 3/18/08.</p> <p>b. On 4/9/08 at 10:03 a.m., CNA # 5 and CNA # 6 was performing incontinent care. The resident had been incontinent of bowel and bladder. CNA # 5 used a wet towel to clean the rectal area without soap or peri-wash. CNA # 6 then used a soiled towel that had been used to dry the resident in the shower to clean the front vaginal area using a back and forth motion.</p> <p>3. The facility ' s Policy and Procedure entitled 'Pericare Policy ' received from the Director of Nursing(DON) on 4/11/08 AT 3:30 p.m., documented: " Purpose: to provide cleanliness, eliminate odor, prevent infection and prevent irritation and skin breakdown. Wash upper thigh - build up of secretions can contaminate surrounding skin areas. Wash labia majora (the two long lips of skin on both sides of vaginal opening). Then use one hand to move labia away from thigh and wash folds wiping from top to bottom using downward strokes-to reduce risk for transfer of microorganisms to urinary tract opening. Dry area thoroughly - regained moisture harbors microorganisms and promotes skin beak down and irritation. Separate labia- vaginal opening and mats wash using downward strokes form pubic area to rectum using different section of cloth for each stroke cleanse thoroughly around labia minora (the inner lips of vagina),</p>	F 315			

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F 315	Continued From page 25	F 315			
F 322 SS=E	<p>clitoris and vaginal opening, dry thoroughly."</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: Based on observation, record review, and interview the facility failed to ensure that Certified Nursing Assistants notified the Licensed Nurse when a gastrostomy tube dressing was removed and need for dressing to be replaced for 1 (Resident #11) of 2 (Resident #10 and #11) case mix residents that had Physician orders for dressings at the gastrostomy site. This failed practice had the potential to affect 15 residents who had physician orders for gastrostomy site care according to a list provided by the Director of Nursing on 4/11/08 at 3:30 p.m. The findings are:</p> <p>1. Resident #11 had diagnoses of Decubitus Ulcer, Type 2 Diabetes Mellitus, and Cerebrovascular Accident. The Quarterly Minimum Data Set (MDS) dated 2/25/08 documented the resident had severely impaired cognitive skills for daily decision-making, was totally dependent on staff for Activities of Daily Living, and had a feeding tube.</p> <p>a. The April 2008 Physician's order sheet</p>	F 322			

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F 322	Continued From page 26 documented, "Clean G-tube (gastrostomy) site with soap and water cover with dry dressing ..." b. On 4/8/08 at 9:03 a.m., Certified Nursing Assistant (CNA) #2 pushed the resident into the shower room. After removing the resident's gown, the CNA removed the intact dressing from around the gastrostomy site and threw the dressing away. The CNA then removed a nitropaste patch that was partially adhered and falling off, remove and thrown away with dressing. The CNA then turned the shower sprayer on and bathed the resident. c. On 4/8/08 at 9:32 a.m., Licensed Practical Nurse (LPN) #1 was in the resident's room after the resident had returned from the shower room. The CNA stated to the LPN, "...I took this off". The CNA pointed to her upper chest at the area where the nitropaste patch had been. The CNA did not inform the LPN that the gastrostomy dressing had been removed. d. On 4/8/08 at 1:00 p.m., LPN #5 checked the resident's g-tube site to change the dressing and the dressing had already been removed. The LPN was asked who usually change the dressing for the gastrostomy tube, the LPN stated, "...the charge nurse does this." e. On 4/10/08 at 4:14 p.m., the Director of Nursing (DON) was asked who should remove a dressings from a PEG (percutaneous esophageal gastrostomy) tube, she stated, "The aides when they take them to the shower." The DON was then asked if dressings can be removed by CNA's when the dressings are intact. The DON stated, "Only if they are wet and come off during care."	F 322			
F 323	483.25(h) ACCIDENTS AND SUPERVISION	F 323			

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F 323 SS=E	Continued From page 27 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure transfers were not completed by lifting under the residents axilla area and/or using the resident clothing to assist with a transfer for 3 case mix residents (Resident #6, #7, and #10), and failed to ensure interventions were put in place after a fall for 2 case mix residents (Residents #2 and 4) of 8 case mix residents (Residents #1, #5, #6, #7, #8, #10, #11, and #28) who were totally dependent on staff for transfers. This failed practice had the potential to affect 20 residents in the facility who were totally dependent on staff for transfers according to a list provided by the Director of Nursing on 4/10/08. The findings are: 1. Resident #6 had diagnoses of Arthritis, Alzheimer Disease, Renal Failure and Dementia with Behavioral Disturbance. The Minimum Data Set (MDS) dated 1/23/08 documented the resident had moderately impaired cognitive skills for daily decision making and required no assistance with transfer. a. The care plan dated 1/24/08 did not identify transfers in the plan of care. b. On 4/8/08 at 11:35 a.m., the resident was	F 323			

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F 323	<p>Continued From page 28</p> <p>transferred from the bed to a wheelchair by Certified Nursing Assistant (CNA) 10 and #11. The resident was raised to a sitting position at the bedside. The CNA ' s lifted the resident by each CNA placing one forearm under each of the resident ' s axilla and while both CNA's pulled on the back of the resident's pants to assist him to the wheelchair. The resident did not bear weight and his knee were bent as the resident was transferred to the wheel chair. Most of the residents weight was supported by the axillae.</p> <p>2. Resident #10 had diagnoses of Cerebrovascular Accident with Left Sided Weakness and Aphasia. The MDS dated 4/30/07 documented the resident had moderately impaired cognitive skills for daily decision making and was totally dependent for transfers with 2 persons to physical assist.</p> <p>a. On 4/8/08 at 2:10 p.m., the resident was transferred from the wheelchair to the bed per CNA #1 and CNA #3. The resident was lifted manually with one CNA lifting the upper portion of the residents body at the shoulders/axilla area and the other CNA lifting the lower extremities. The resident was totally lifted and placed on the bed.</p> <p>3. Resident # 7 had diagnoses of Dementia and Cerebral Vascular Accident. The Quarterly MDS dated 3/27/08 documented that the resident had moderately impaired cognitive skills for daily decision making, required total assistance with personal hygiene, and was totally dependent for transfers.</p> <p>a. On 4/8/08 at 11:20 CNA #7 and #8 transferred the resident from a wheel chair to the bed. The</p>	F 323			

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F 323	<p>Continued From page 29</p> <p>CNA ' s lifted the resident by each CNA placing one forearm under each of the resident ' s axillae and transferring the resident to the bed. The residents feet drug across the floor and the residents knees were bent during the transfer. The resident ' s weight was supported by the axilla. CNA # 7 lifted the resident back to the wheelchair by lifting under the residents arms and holding onto the back of the residents pants. The resident knees were bent and most of the residents weight was being supported by the axillae.</p> <p>4. The facility ' s Policy and Procedure entitled ' Transfer Activities ' received from the Director of Nursing (DON) on 4/11/08 documented: "If resident is non-weight bearing status must be transferred utilizing the mechanical lift. Depending upon the amount of assistance required, the nurse may either support the resident on his/her affected side or stand in front of the resident. Support may be provided by use of a waist belt. Do not support the resident under the arms as this prevents the resident form using his/here unaffected extremity. Do no allow resident to put arms around your neck."</p> <p>5. Resident # 2 had diagnoses of Cortical Blindness, and Above the knee Amputation of the Right Leg. The Medicare 30 day MDS dated 2/18/08 documented the resident had modified independent cognitive skills for daily decision making, no devices or restraints provided to the resident for more that or equal to 15 minutes per day in the past 7 days and fell in the past 30 days.</p> <p>a. The Incident/Accident Report forms dated 12/21/07, 1/12/08 and 2/1/08 had no documentation documented under the additional</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>comments and/or steps taken to prevent recurrence section for neither form.</p> <p>b. The careplan dated for review 2/18/08 documented; at risk for falls or injury related to history of falls R (Right) AKA (above the knee amputation) LE (lower extremity) weakness [and] possible S.E.(side effects) of Antidepressant med (medication) therapy. There has been no new interventions put in place when the resident had falls. There were no careplan for the velcro alarm seat belt.</p> <p>6. Resident # 4 had a diagnosis of Alzheimer Disease. The Annual Minimum Data Set (MDS) dated 2/20/08 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance with personal hygiene, was usually continent of bowel and bladder, had no restraints in use and had not used any antidepressants.</p> <p>a. The Incident/Accident Report forms dated 10/19/07, 1/11/08 and 1/30/08 had no documentation documented under the additional comments and/or steps taken to prevent recurrence section for neither form.</p> <p>b. The careplan dated reviewed 2/20/08 by the interdisciplinary team documented: at risk for falls or injury, related to recent falls, generalized weakness, unsteady gait and impaired balance r/t (related to) possible S.E.(side effects) from Antidepressant med (medication) therapy. There was no new interventions implemented after the resident falls documented on the careplan. There was no careplan for the resident alarm seat belt or the resident antipsychotic and antidepressant medications.</p>	F 323			

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F 323	Continued From page 31	F 323			
F 328 SS=D	<p>483.25(k) SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure Physicians orders were followed for the flow rate of oxygen setting, tubing was not reused after lying on the floor, and Certified Nursing Assistants (CNA) did not turn on and/or adjust the oxygen flow rate for 1 (Resident #11) of 3 (Residents #3, 5, and 11) case-mix residents who used oxygen. The failed practice had the potential to affect 22 residents in the facility who used oxygen therapy as identified on the Roster Sample Matrix dated 4/7/08. The</p>	F 328			

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F 328	Continued From page 32 findings are: 1. Resident #11 had diagnoses of Decubitus Ulcer, Type 2 Diabetes Mellitus, and Cerebrovascular Accident. The Quarterly Minimum Data Set dated 2/25/08 documented the resident had severely impaired cognitive skills for daily decision-making, was totally dependent on staff for Activities of Daily Living, and had oxygen therapy. a. The April 2008 Physician's order sheet documented, "Oxygen via NC (nasal cannula) 2L/M (2 liters per minute) PRN (as needed) for SPO2 (Oxygen saturation) below 92%. b. On 4/7/08 at 4:50 p.m., the resident was lying bed with the oxygen rate set at 1.5 liters per minute by nasal cannula. c. On 4/8/08 at 7:05 a.m., the resident was in bed with the oxygen rate set at 1.5 liters per minute by nasal cannula. d. On 4/8/08 at 7:30 a.m., the oxygen setting continued at 1.5 liters per minute through a nasal cannula. e. On 4/8/08 at 8:53 a.m., the oxygen was turned off and the oxygen tubing cannula was lying on the floor. f. On 4/8/08 at 9:10 a.m., the oxygen tubing was lying over the concentrator and the nasal prongs of the cannula were lying on the floor. The oxygen was turned off. g. On 4/8/08 at 9:27 a.m., CNA#2 picked the oxygen cannula up from the floor and placed the	F 328			

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F 328	<p>Continued From page 33</p> <p>cannula on the resident's face with the prongs in each of the resident's nostrils. The CNA then turned the oxygen concentrator on and set the rate at 1.5 liters per minute. CNA #2 was asked if CNA's put oxygen on residents. The CNA stated, "Not the feedings but we can the oxygen."</p> <p>h. On 4/8/08 at 10:50 a.m., the resident was sitting up in a gerichair. The oxygen cannula was in place and the rate was set at 1.5 liters per minute.</p> <p>i. On 4/8/08 at 11:10 a.m., the oxygen cannula remained in place on the resident and the rate set at 1.5 liters per minute.</p> <p>j. On 4/8/08 att 1:00 p.m., the oxygen cannula remained in place on the resident and the rate set at 1.5 liters per minute.</p> <p>k. On 4/9/08 at 8:19 a.m., the resident was in bed with the oxygen cannula in place and the oxygen on and set at 1.5 liters per minute.</p> <p>l. On 4/9/08 at 8:22 a.m., Licensed Practical Nurse (LPN) #1 accompanied the surveyor to the room, and was shown the oxygen rate [1.5 liters per minutes] and asked what it was to be set on. LPN #1 stated, "It's suppose to be at 2 liters." The LPN was asked what rate does the setting show to be. She stated, "It's suppose to be at 2." The LPN then adjusted the flow rate and checked the pulse oximeter. The oximeter reading was 87%.</p> <p>2. On 4/10/08 at 4:14 p.m., the Director of Nursing (DON) was asked who should place oxygen cannula on residents and turn the oxygen on. The DON stated, "Turning it on should be the</p>	F 328			

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F 328	Continued From page 34 nurse. If it's just slipped out of the nose, the aides can do it as long as they don't mess with the concentrator." The DON was then asked if the oxygen cannula should be used after it had been lying on the floor, the DON stated, "No, they are suppose to be maintained inside the plastic bag when not in use."	F 328			
F 329 SS=E	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to ensure that a resident was free of unnecessary	F 329			

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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 329	Continued From page 35 medications for excessive duration, a risk versus benefit statement was documented by the physician indicating a reason for the continued use and/or there was a documented attempt at a failed dose reduction for 1 case mix resident (Resident #4) of 5 (Resident # 2, # 4, # 5, # 9, and # 20) case mix resident who received Antidepressant, 1 (Resident #5) of 1 case mix resident who had physician orders for a H2 antagonist, and for 2 (Residents # 8 and 24) of 5 case mix residents(Residents # 8, # 9, # 19 #20, and #24) that had physician order for Proton Pump Inhibitors. The failed practices had the potential to affect 9 residents that receive Histamine 2 Receptor Antagonist (Pepcid), 48 residents that received Antidepressant Medication and 16 resident that received Proton Pump Inhibitor(Prilosec) according to list provided by the Director of Nursing on 4/11/08 at 3:30 p.m. The findings are: 1. Resident # 5 had diagnoses of GERD (Gastroesophageal Reflux Disease) and Dementia. The Quarterly Minimum Data Set dated 3/2/08 documented that the resident had moderately impaired cognitive skills for daily decision making. a. The Physician Order dated for 2/6/03 documented: " Famotidine (Pepcid) 20 mg 1 tab (tablet) PT (per tube) BID (two times daily). b. The 2007 Lippincott's Nursing Guide page 504 documented: Pepcid indications Short-term treatment of GERD, esophagitis due to GERD. GERD 20 mg for up to 6 wks (weeks). For patients with esophagitis, the does is 20-40 mg bid (two times per day) for up to 12 wks.	F 329		

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F 329	<p>Continued From page 36</p> <p>c. The Consultant Pharmacist Report dated 1/30/08 documented: "This patient has an order for Pepcid 20 mg Bid since 2-6-03. ... clinical rationale for continued need and/or documentation should support an underlying chronic disease (e.g.,GERD) or risk factors (e.g.,NSAID use) The Physician response marked: Being aware of the above guidelines my medical opinion is that the benefits of continued use of the above medications for this patient out weigh the potential risks of continued use for the following reasons. ' The pt (patient) is on tube feeding and has had numerous GI (gastrointestinal) complaints before. ' The form was signed and dated by the physician 2/5/08.</p> <p>d. The Physician Progress notes for 12/27/08, 1/31/08, 1/31/08 and 3/11/08 documented that the resident was no new findings, continue current case plan. There no documentation of gastrointestinal problems for the past 4 months.</p> <p>2. Resident # 4 had diagnoses of Alzheimer Disease (Vascular) and Biplor Disorder. The Annual MDS dated 2/20/08 documented the resident had moderately impaired cognitive skills for daily decision making.</p> <p>a. The Physician order dated 2/23/07 documented: "Effexor XR **no crush w/o (with out) PO (by mouth) 37.5 mg (milligram) QD (every day)."</p> <p>b. The Consultant Pharmacy reports was reviewed from 2/27/07 through 3/28/08. The report did not address the medication Effexor XR.</p> <p>3. Resident # 8 had diagnoses of Cerebral Vascular Accident and Psychotic Disorder. The</p>	F 329			

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F 329	<p>Continued From page 37</p> <p>Quarterly MDS dated 1/14/08 documented the resident had severely impaired cognitive skills for daily decision making.</p> <p>a. A Physician order dated 3/31/06 documented, "Prilosec 20 mg per/tube may open cap QD.</p> <p>b. The Consultant Pharmacist Report dated 1/30/08 documented: "This patient has an order for Prilosec 20 mg qd since 3/31/06. ... clinical rational for continued need and/or documentation should support an underlying chronic disease (e.g, GERD [Gastroesophageal Reflux Disease]) or risk factors (e.g., chronic NISAID use)." The Physician response dated 2/5/08 documented: "Being aware of the above guideline my medical opinion is that the benefits of continued use of the above medications for this patient outweigh the potential risks of continued use for the following reasons." [No reasons were listed].</p> <p>4. Resident # 24 had diagnoses of Gastrointestinal Bleed and Esophageal Reflux. The Quarterly MDS dated 2/15/08 documented that the resident had modified independent cognitive skills for daily decision making.</p> <p>a. A Physician Order dated 1/11/07 documented, "Prilosec 20 mg 1 po QD.</p> <p>b. The Consultant Pharmacist Report dated 1/30/08 documented: This patient has an order for Prilosec 20 mg qd since 1/11/08. Federal guidelines require that if this medications is used for greater that 12 weeks, clinical rational for continued need and/or documentation should support an underlying chronic disease (e.g. GERD (Gastroesophageal Reflux Disease) or risk factors e.g., chronic NSAID use). The Physician</p>	F 329			

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F 329	Continued From page 38 response dated 2/8/08 documented: "Being aware of the above guideline my medical opinion is that the benefits of continued use of the above medications for this patient outweigh the potential risk for continued use for the following reason: [There was no documentation listed in the comment section]. 5. The Lippincott's Nursing Drug Guide page 881 documented; "Prilosec, Proton Pump Inhibitor: "Severe erosive esophagitis or poorly responsive GERD:20 mg PO daily for 4-8 wk [weeks]. Do not use as maintenance therapy. An additional 4-8 wk course can be considered if needed. Warning: Arrange for further evaluation of patient after 8 wk of therapy for gastroreflux disorder not intended for maintenance therapy. Symptomatic improvement dose not rule gastric cancer, which did occur is preclinical studies.	F 329			
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by:	F 332			

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F 332	<p>Continued From page 39</p> <p>Based on observation, record review, and interview of the 9:00 a.m. medication pass on 4/8/08 the facility failed to ensure that the medication error rate was less than 5%. Physicians orders were not followed on 4 residents (Residents #15, #10, #16, and #17) of 5 case mix residents observed during the medication passes resulting in medication errors. Medication errors were made by 4 Licensed Practical Nurse (LPN) (LPN #1, #2, #3, and #4) of 5 licensed nurses observed administering medications in the facility. This practice had the potential to affect 94 residents in the facility on the Second and Third Floor according to the Charge Nurses on the floors on 4/9/08. The medication error rate was 10.63% based on administration of 46 medications with 1 omissions for a total of 47 with 5 medication errors observed. The findings are:</p> <p>1. Resident #15 had a physician order dated 3/31/08 for Proventil (albuterol) 2.5 mg (milligrams) = 0.5 ml (milliliters) four times a day (qid). The resident had a physician order dated 3/24/08 for Atrovent 0.5 mg = 2.5 ml updraft qid.</p> <p>a. On 4/8/08 at 8:34 a.m., during the 9:00 a.m. medication pass LPN #1 took from the 200 hall medication cart the following:</p> <ol style="list-style-type: none"> 1. Albuterol 5 mg/ml 20 ml bottle. 2. Albuterol 2.5 mg/ 3 ml vial. <p>b. On 4/8/08 at 8:34 a.m., LPN #1 went to the resident's room and place the Albuterol 2.5 mg/3 ml unit dose vial medication in the nebulizer. LPN #1 then pick up the Albuterol 5 mg/ ml 20 ml bottle and the surveyor stopped LPN #1.</p> <p>c. LPN #1 and the surveyor returned to the</p>	F 332			

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F 332	Continued From page 40 nurse's station and the resident did not have the other medication Atrovent 0.5 mg/ 2.5 ml. d. On 4/8/08 at 2:16 p.m., the pharmacy provider faxed to the facility a list of the medications for the resident for March 2008 and the facility had not received the Atrovent 0.5 mg/ 2.5 ml. 2. Resident #10 had a physician order dated 4/27/07 for Phoslo 667 mg 1 capsule PT (peg tube) twice a day (bid) with meals. a. On 4/8/08 at 8:52 a.m., during the 9:00 a.m. medication pass LPN #2 administered the Phoslo 667 mg thru the PT. b. The April 2008 Medication Administration Record (MAR) documented the time for the Phoslo 667 mg was to be administered at 7:30 a.m. and 12:00 p.m. c. On 4/8/08 at 10:30 a.m., the surveyor asked, "Does the resident eat?" The LPN #2 stated, "Yes, they do, but not much." 3. Resident #16 had a physician order dated 9/4/07 for Folic Acid 1 mg by mouth (po) every day. A physician order dated 9/4/07 for Fiber Lax 625 mg po every day. a. On 4/8/08 at 9:15 a.m., during the 9:00 a.m. medication pass LPN #3 administered all scheduled medication except the Folic Acid 1 mg. LPN #3 administered the Fiber Lax 625 mg with 5 ounces of water. b. The manufacturer label for Fiber Lax documented, to take with a full glass of water at least 8 oz. This is to prevent choking.	F 332			

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F 332	Continued From page 41 4. Resident #17 had a physician order dated 5/4/06 for Ibuprofen **No crush w/o (without) p.o. **Give w/food** 400 mg 1 tablet po every 6 hours as needed (prn) a. On 4/8/08 at 9:25 a.m. during the 9:00 a.m. medication pass the LPN #4 administered Ibuprofen 400 mg with water. b. According to the Centers for Medicare and Medicaid Services (CMS), Medications that Must be taken with Food or Antacids: The most commonly used drugs that should be taken with food or antacids are the Nonsteroidal Anti-Inflammatory Drugs (NSAIDS). There is evidence that elderly, debilitated persons are at greater risk of gastritis and GI bleeds, including silent GI bleeds.	F 332			
F 333 SS=E	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to follow physician's orders to ensure that residents were free of significant medication error for one 1 (Resident #15) of 5 case mix residents (Residents #3, 11, 13, 15, and 19) and that medication Prevacid was reduced per Physican Orders for 1 (Resident # 27) of 6 case mix residents (Residents # 2. # 8, #9, #19, #24 and # 27) who had physician orders for Proton Pump Inhibitors. The failed practice had the potential to affect 16 resident with proton pump inhibitors according to the Director of	F 333			

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F 333	<p>Continued From page 42</p> <p>Nursing on 4/11/08 and 10 residents receiving updraft medications in the facility according to the Charge Nurses on the floor on 4/9/08. The findings are:</p> <p>1. Resident #15 had a physician order dated 3/31/08 for Proventil (albuterol) 2.5 mg (milligrams) = 0.5 ml (milliliters) four times a day (qid). The resident had a physician order dated 3/24/08 for Atrovent 0.5 mg = 2.5 ml updraft qid.</p> <p>a. On 4/8/08 at 8:34 a.m. during the 9:00 a.m. medication pass the LPN #1 took from the 200 hall medication cart the following:</p> <ol style="list-style-type: none"> 1. Albuterol 5 mg/ml 20 ml bottle. 2. Albuterol 2.5 mg/ 3 ml vial. <p>b. On 4/8/08 at 8:34 a.m. the LPN #1 went to the resident's room and place the Albuterol 2.5 mg/3 ml unit dose vial medication in the nebulizer. The LPN #1 pick up the Albuterol 5 mg/ ml 20 ml bottle and the surveyor stopped the LPN #1.</p> <p>c. The LPN #1 and the surveyor returned to the nurse's station and the resident did not have the other medication Atrovent 0.5 mg/ 2.5 ml to administer to the resident.</p> <p>d. On 4/8/08 at 2:16 p.m. the pharmacy provider fax to the facility a list of medications for the resident in March 2008 and the facility had not received the Atrovent 0.5 mg/ 2.5 ml.</p> <p>e. According to the Medication Administration Record (MAR) dated 4/1/08 thru 4/30/08 days 4/1/08 thru 4/8/08 it documented: >3/31/08 Proventil (albuterol) 2.5 mg = 0.5 ml qid was signed four times a day. >Atrovent 0.5 mg = 2.5 ml updraft qid was signed</p>	F 333		

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F 333	Continued From page 43 four times a day. >3/24/08 Albuterol 2.5 mg = 0.5 ml updraft qid was signed four times a day. f. Due to the frequencies of the errors these were significant errors. 2. Resident #27 had diagnoses of Dementia, GERD (Gastroesophageal Reflux Disease). The Quarterly Minimum Data Set(MDS) dated for 3/17/08 documented that the resident had short term memory deficit with moderately impaired cognitive skills for daily decision making. The resident had required total dependency with personal hygiene. a. The Consultant Pharmacist Report dated for 1/31/08 documented: This patient has an order for Prevacid 30 mg qd[daily] since 8/16/07 Federal guidelines require that if this medication is used for greater that 12 weeks, clinical rational for continued need and/or documentation should support an underlying chronic disease(e.g., GERD) OR RISK FACTORS (e.g., NSAID use)". The Physician response [decrease] Prevacid to 15 mg QD. Dated for 2/11/08. b. The March 2008 MAR documented that the Prevacid was not reduced until 3/1/08. The resident received 18 doses after the medication was ordered to be reduced.	F 333			
F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive	F 364			

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F 364	<p>Continued From page 44</p> <p>value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure that residents who ate in their rooms or in the three upstairs dining rooms, had foods served at a palatable temperature. This failed practice had the potential to affect 89 residents who eat in their rooms and/or in the dining rooms on the second, third, and fourth floors according to information provided by the Dietary Manager on 4/10/08 . The findings are:</p> <ol style="list-style-type: none"> 1. On 4/9/08 at 12:10 p.m., the first cart with resident meals was sent to the main dining room on the first floor. There were 7 trays left on the cart and the cart was returned to the kitchen due to the residents were not in the dining room. <ol style="list-style-type: none"> a. On 4/9/08 at 12:30 p.m., there were two resident meal trays on top of a food cart from the first pass to the main dining room. These two trays were placed on the second floor food cart. b. On 4/9/08 at 12:40 p.m. the temperature of one of the trays that was placed on the second floor food cart in the dining room from the main dining room cart was taken. The spaghetti temperature was 90 degrees and the peas were 110 degrees. c. On 4/9/08 at 1:00 p.m., the temperature of the last tray served on the third floor food cart was taken. The turnip greens temperature was 90 degrees , the chopped ham was 90 degrees. 	F 364			

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F 371 SS=F	<p>483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE</p> <p>The facility must store, prepare, distribute, and serve food under sanitary conditions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure that employees washed their hands to prevent cross contamination after handling contaminated items. The failed practice had the potential to affect 102 residents who received meals from the dietary department as identified by the dietary manager on 4/9/08. The findings are:</p> <ol style="list-style-type: none"> On 4/9/08 at 10:30 a.m., the Cook #1 prepped chicken for the noon meal. She placed gloves on and seasoned the chicken. After seasoning the chicken she removed her gloves and lifted the lid of the garbage can and disposed of the gloves, she then returned to the cooks prep table and covered the pan of chicken with plastic wrap and foil and then placed the chicken in the walk in cooler. She never washed her hands. On 4/9/08 at 10:50 a.m., Cook # 1 lifted the lid of the large gray garbage can and disposed of debris from the prep table. She proceeded to stir the turnip greens that were cooking on the stove. She then entered the walk in cooler and removed pans of food without washing her hands. On 4/9/08 at 11:45 a.m., during the 12:00 p.m., meal preparation, Cook #1 lifted the lid of the garbage can and disposed of foil that she had removed from a pan of ham. She proceeded to 	F 371			

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F 371	Continued From page 46 stir the ham then placed it on a cart and transported it to the steam table without washing her hands. 4. On 4/10/08 at 9:30 a.m., Cook # 1 lifted the lid of the garbage can and disposed of debris from the cooks preparation table. She proceeded to roll a cart to the walk in cooler and transport food back to the cooks preparation table without washing her hands.	F 371			
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES 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. 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that another residents medication was not administered when	F 425			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/18/2008
NAME OF PROVIDER OR SUPPLIER LITTLE ROCK HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 5720 WEST MARKHAM LITTLE ROCK, AR 72205		
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F 425	Continued From page 47 a residents medication was not available for administration for 1 (Resident #15) of 4 case mix resident who received updrafts (Residents #3, 13, 15, 19 and 27). The failed practice had the potential to affect 10 residents who received updraft according to the Charge Nurses on each floor on 4/9/08. The findings are: Resident #15 had a physician order dated 3/24/08 for Atrovent 0.5 milligrams (mg) = 2.5 milliliters (ml) updraft four times a day. a. On 4/8/08 at 8:34 a.m., during the 9:00 a.m., medication pass, LPN #1 did not have the Atrovent 0.5 mg/2.5 ml to administer to the resident. b. On 4/8/08 at 9:48 a.m., during the 9:00 a.m. medication pass the LPN #1 administered the Albuterol 2.5 mg/ 3 ml and the Atrovent 0.5 mg/2.5 ml to the resident. c. On 4/8/08 at 10:18 a.m., the surveyor asked to see the resident's updraft medication box. The LPN #1 stated, "I used another resident Atrovent that was in the hospital because the resident's medication was not here." d. On 4/8/08 at 2:16 p.m., the pharmacy provider faxed to the facility a list of medications for the resident in March 2008 and the facility had not received the Atrovent 0.5 mg/ 2.5 ml.	F 425			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428			

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F 428	Continued From page 48 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to ensure that the Pharmacy Consultant identified irregularities for and reported to the attending physician and the Director of Nursing (DON) and they were acted upon for one case mix resident (Resident # 4) of 4 case mix residents (Residents #2, #4, #9 and #20) that took Antidepressant medications. This had the potential to affect 48 residents in the facility that received Antidepressant medications. The findings are: 1. Resident # 4 had diagnoses of Alzheimer Disease (Vascular) and Biplor Disorder. The Annual Minimum Data Set dated 2/20/08 documented that the resident had moderately impaired cognitive skills for daily decision making. a. The Physician order dated 2/23/07 documented; "Effexor XR **no crush w/o (with out) PO(by mouth) **37.5 mg QD (every day)". b. The Consultant Pharmacy reports was reviewed from 2/27/07 through 3/28/08. The report did not address the medication Effexor XR.	F 428			
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted	F 444			

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F 444	Continued From page 49 professional practice. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure staff washed their hand and gloves were changed in between task when when providing personal care for 1 case mix resident (Resident # 5) of 15 case mix residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #10, #11, #12, #19, #21, #23 and #24) that were incontinent of bowel and/or bladder. The failed practice had the potential to affect 98 residents that were occasional or frequently incontinent of bowel and/or bladder according to the Resident Census and Conditions of Residents form received from the Director of Nursing (DON) on 4/11/08. The findings are: 1. Resident # 5 had diagnoses of Urinary tract infection and Dementia. The Quarterly MDS dated 3/2/08 documented the resident had moderately impaired cognitive skills for daily decision making, required total assistance with personal hygiene and was incontinent of bowel and bladder. a. On 4/9/08 at 10:03 a.m., CNA # 1 was performing incontinent for the resident. The CNA cleaned feces off the floor without changing gloves and then continued to perform incontinent care for the resident. The CNA cleaned the rectal area, placed the residents clean incontinent brief on, applied lotion on the resident arms and placed the residents heel protectors and pants on without changing gloves. b. On 4/9/08 at 10:03 a.m. the CNA # 6 used the towel that the resident was dried with after the	F 444		

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F 444	Continued From page 50 shower, with no soap or peri-wash to clean the vaginal area.	F 444			
F 445 SS=D	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure that soild linens were not laid on a residents over bed table and all soiled areas were cleaned prior to leaving a room after providing incontinent care for 1 case mix resident (Resident # 7) of 15 case mix residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #10, #11, #12, #19, #21, #23 and #24) that were incontinent of bowel and/or bladder. The failed practice had the potential to affect 98 residents that were occasional or frequently incontinent of bowel and/or bladder according to the Resident Census and Conditions of Residents form received from the Director of Nursing (DON) on 4/11/08. The findings are: 1. Resident # 7 had diagnoses of Dementia and Cerebral Vascular Accident. The Quarterly Minimum Data Set dated 2/16/08 documented that the resident had moderately impaired cognitive skills for daily decision making, required total assistance with personal hygiene and was incontinent of bowel and bladder a. On 4/8/08 at 11:20 a.m., after performing incontinent care CNA (Certified Nursing Assistant) # 7 laid the soiled linen on the over bed table. The CNA did not clean the overbed table before leaving the room.	F 445			

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F 502 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: Based on record review and interview, the facility failed to ensure that physician orders were followed to obtain laboratory services in a timely manner for 2 of 2 (Resident #9 and #11) case mix residents that had physician orders for Clostridium Difficile (C-Diff) laboratory tests. This failed practice had the potential to affect 2 residents that had orders for Clostridium difficile scheduled laboratory services as identified by the Director of Nursing on 3/11/08. The findings are:</p> <p>1. Resident #11 had diagnoses of Decubitus Ulcer, Type 2 Diabetes Mellitus, and Cerebrovascular Accident. The Quarterly Minimum Data Set (MDS) dated 2/25/08 documented the resident had severely impaired cognitive skills for daily decision-making.</p> <p>a. A Physician Order dated 3/12/08 documented, "STAT labs. Stool for C-Diff, ..."</p> <p>b. On 4/11/08 there was no documentation in the clinical record that the lab results for the stool specimen for C Diff had been obtained.</p> <p>c. On 4/11/08 at 9:50 a.m., the laboratory report received from the Director of Nursing dated 3/12/08 documented, "...Clostridium Diff Toxins A&B Screen. Screen result: A specimen was not received for the requested test. ..."</p>	F 502			

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F 502	Continued From page 52 2. Resident #9 had diagnoses of Parkinson's Disease and Nausea with Vomiting. The Medicare 14 Day Assessment dated 3/20/08 documented the resident had moderately impaired cognitive skills of daily decision making. a. A Physician's Order dated 3/20/08 documented, "1 C-Diff of stool ..." b. The General Test Requisition dated 3/21/08 documented, "C-Diff of stool not collected...". c. On 4/11/08 there was no documentation in the clinical record that the stool specimen for C Diff had been obtained. 3. On 4/10/08 at 6:50 p.m. the Director of Nursing (DON) was asked if the C Diff lab test were done for Resident #9 and #11. The DON was stated, "No."	F 502			