

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

PRINTED: 06/01/2007
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 05/18/2007
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 157 SS=E	<p>Complaint #12540, unsubstantiated.</p> <p>483.10(b)(11) NOTIFICATION OF CHANGES</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and</p>	F 157			

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

TITLE

(X6) DATE

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

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F 157	<p>Continued From page 1</p> <p>interview, the facility failed to ensure the physician was consulted about the deterioration in a wound in a timely manner for 1 (Resident #10) of 7 (Resident #2, 3, and 6-10) case mix residents who had a pressure sore. The facility failed to ensure the physician was consulted that the increase in the amount of tube feeding may cause elevated protein levels for 1 (Resident #2) of 6 (Resident #2, 4, 5, and 8-10) case mix residents who had a feeding tube. These failed practices had the potential to affect 14 residents who had pressure sores and 22 residents who had a feeding tube as per the Resident Census and Conditions of Residents report dated 5/15/07. The findings are:</p> <p>1. Resident #10 had diagnoses of Alzheimer and Decubitus. The 90 day Medicare Minimum Data Set dated 3/28/07 documented the resident was severely impaired in cognitive skills for daily decision making, had a Stage IV pressure sore and was on a turning/repositioning program.</p> <p>a. The plan of care developed 1/3/07 identified a problem of "Pressure ulcer on coccyx is Stage 4" with interventions that included "Assist to turn and reposition q (every) 2 hours and Monitor size, stage depth, color, odor, drainage. Record QD. (daily) and Report any significant change to physician."</p> <p>b. The wound/skin healing record dated 5/11/07 documented the resident had a Stage 4 pressure ulcer that measured 4.0 cm (centimeter) x 2.8 cm x < (less than) 0.3 cm, with serous exudate, the wound bed had granulation tissue, the surrounding skin color was normal for skin and the surrounding tissue/wound edges was normal for skin.</p>	F 157			

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F 157	Continued From page 2 c. On 5/15/07 at 12:30 p.m., the treatment nurse measured the wound as 4.5 cm x 2.5 cm x 0.4 cm. The treatment nurse measured the depth by placing a Q-tip into the wound, pulling the Q-tip out and measured the depth of the drainage on the Q-tip instead of sliding her fingers down the Q-tip to the top of the skin. After measuring the depth in the correct manner, the depth was 12 cm. There was a brown necrotic area in the left upper corner of the wound that measured 1.5 cm x 0.8 cm. The treatment nurse stated that this area was new and that she first observed this area on 5/14/07. There was also another brown necrotic area in the left lower corner of the wound that measured 0.2 cm x 2 cm. The Treatment nurse stated that this area was not there when she did the treatment on 5/14/07. The surrounding tissue was white and macerated approximately 1 cm. The treatment nurse stated that she documented this as normal for the skin because it was normal for this resident. The treatment nurse also stated that the nurse, who did the treatment on the weekend, told her there was a couple of bad spots in the wound. d. On 5/16/07 at 8:10 a.m., there was no documentation on the physician orders, treatment notes, or nurses notes that the physician was consulted about the change in the wound. e. On 5/16/07 at 9:10 a.m., LPN (Licensed Practical Nurse) #1, who did the treatment over the weekend was interviewed. She was asked to describe the wound. She stated that she saw some bruising around the wound, some dark cherry colored areas with slough on it. She stated that she did not see any brown. She was then asked, "Did you notified the physician of the	F 157			

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F 157	<p>Continued From page 3</p> <p>change in the wound?" She stated, "No, I reported it to the treatment nurse." She was also asked "Did the resident get up over the weekend?" She stated, " No."</p> <p>2. Resident #2 had diagnoses of Acute Renal Failure, Anemia, Malnutrition and Decubitus Ulcer. The Medicare 60 day MDS documented the resident was severely impaired in cognitive skills for daily decision making, required total assistance with all activities of daily living, had a weight loss in the past 180 days, and a feeding tube.</p> <p>a. The May 2007 MAR documented, "2/27/07 Fibersource HN 65 cc/hr (hour) via PEG (percutaneous endoscopic gastrostomy) continuous..." Written in the date columns was "Order [changed] 5/3/07 [increase]..." The MAR dated "May 3 -31, 2007" documented, "Fibersource HN 70 cc/hr via PEG."</p> <p>b. The Progress Notes and Dietary Enteral Assessments completed by the Registered Dietician (RD) dated 5/11/07 documented, "Notes: TF (Tube Feeding) supplies 85 gm (grams) of Pro (Protein) (2.2 gm/kg (kilogram). This is very high [with] Dx (Diagnosis) of Renal Failure."</p> <p>c. As of 5/15/07, there was no documentation in the clinical record the physician was consulted about the Registered Dieticians concerns.</p> <p>d. On 5/15/07 at 10:00 a.m., the Assistant Director of Nursing (ADON) stated she used to get a copy of the Registered Dietician's recommendations and she would then send it to the physician, but now they don't get a copy so</p>	F 157			

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F 157	Continued From page 4 they had missed some of the recommendations made by the Dietician.	F 157		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure restraint reduction/elimination assessments were conducted at least quarterly for 1 (Resident #7) of 6 case mix residents (Resident #2, 3, 6, 7, 10 and 13) who were physically restrained. These failed practices had the potential to affect 20 residents who had restraints as documented on the Resident Census and Conditions of Residents form dated 5/18/07. The findings are: Resident #7 had diagnoses of Hypertension and Dementia with Senile Delusions. The Significant Change MDS dated 4/18/07 documented the resident was moderately impaired in cognitive skills for daily decision making and used a trunk restraint daily. a. The Pre-Restraining Assessment did not document an Interdisciplinary Team Evaluation. b. The Physical Restraint Elimination Assessment dated the last assessment was completed in 2/1/07. There was no documentation in the clinical record that a Restraint Elimination Assessment was done since 2/1/07.	F 221		

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F 221	Continued From page 5 c. The May 2007 Physician Order sheet documented, Releasable Seat belt when up in chair to remind resident not to get up unassisted related to unsteady gait. d. On 5/15/07 at 9:00 a.m., 11:00 a.m. an 4:45 p.m., the resident was sitting in a wheelchair with a seatbelt restraint in place. e. On 5/16/07 at 3:20 p.m., the Medical Records staff stated the assessment for restraint reductions were put on the charts and that was all of them.	F 221			
F 241 SS=D	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, record review and interview, the facility failed to ensure dignity was maintained by requiring incontinent briefs to be worn and not offering a toileting program for 1 (Resident #12) of 1 case mix resident who was continent of bowel and bladder. This failed practice had the potential to affect 13 residents who were continent of bowel and bladder as documented on a list provided by the Director of Nursing on 5/18/07. The findings are: Resident #12 had a diagnosis of Bilateral Below the Knee Amputation. The Quarterly Minimum Data Set (MDS) dated 4/26/07 documented the resident had modified independence in cognitive skills for daily decision making, required limited	F 241			

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F 241	Continued From page 6 assistance of staff for toileting and personal hygiene, extensive assist of staff for transfers, was usually continent of bowel and occasionally incontinent of bladder and was not on a scheduled toileting program. a. On 5/15/07 at 9:55 a.m., CNA (Certified Nursing Assistant) #6 and 7) transferred the resident to and from the shower. The resident was not toileted. b. On 5/15/07 at 10:10 a.m., CNA #6 was asked about toileting this resident. CNA #6 stated, "Don't do no good to toilet her. She uses briefs." c. On 5/16/07 at 1:45 p.m., the resident was asked if they took you to the bathroom would you use it. The resident stated, "Sure. I have control of by bowel and my bladder but they use diapers on me and when I have to, I let it out. They don't take me to toilet and I gave up asking them because I couldn't hold it 'til they came. I wouldn't have to wear this diaper if I went to the bathroom but it's hard for them to get me out of this chair or the bed." d. On 5/17/07 at 1:55 p.m., CNA #6 was asked if there were any residents of the 2nd floor on a toileting schedule and CNA #6 stated, "No one on a routine toileting."	F 241			
F 246 SS=E	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246			

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F 246	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure a call light was in reach and the resident was able to activate the call light for 1 of 1 case mix resident (Resident #10) who required a round flat call light. This failed practice had the potential to affect 1 resident who had a round flat call light as per a list provided by Director of Nursing on 5/18/07. The findings are: Resident #4 had a diagnosis of Multiple Sclerosis. The Significant Change Minimum Data Set (MDS) 5/14/07 documented the resident had short/long term memory problems, was moderately impaired in cognitive skills for daily decision making, dependent on staff for all Activities of Daily Living, had full loss in range of motion of both arms, hands, legs and feet. a. The plan of care developed 5/14/07 documented a problem of "At risk for skin breakdown, muscle wasting, social isolations, increased incontinence/confusion and contractures related to restraint use: (reclining wheelchair)" with interventions that included "Place call light within reach and encourage use." b. On 5/14/07 at 3:08 p.m., the resident was in bed on her back. Both arms and hands were contracted. The resident asked this surveyor to turn her. The surveyor asked the resident to turn her light on. The resident had a flat round call light that was lying close to her left cheek. The resident attempted to turn her head to turn on the call light. She was unable to do so and the resident stated she could not use her call light	F 246			

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F 246	Continued From page 8 where it was. This surveyor turned the call light on. c. On 5/14/07 at 3:10 p.m., CNA (Certified Nursing Assistant) #3 entered the room and asked the resident what she needed. The resident asked to be turned. CNA #3 turned the resident and then left the room without placing the call light in reach or ensuring the resident could activate the call light. d. On 5/14/07 at 5:15 p.m., the resident was in bed. She stated that she had just returned from the shower. The resident's call light was lying on the left upper corner of the mattress. e. On 5/14/07 at 5:25 p.m., LPN (Licensed Practical Nurse) #2 was asked "How does this resident call for assistance?" She stated, "She has a call light by her head." f. On 5/14/07 at 5:30 p.m., CNA #3 stated that the resident had a flat call light next to her head and they check her frequently. g. On 5/14/07 at 5:35 p.m., RN (Registered Nurse) #2 was asked, "How does this resident call for assistance?" She stated, "She has a call light that lays by her head. I make rounds frequently. We monitor her more often because of her disease." h. On 5/16/07 at 8:00 a.m., the resident was in bed lying on the left side. The call light was lying near the right side of the head and the resident could not turn her head around to activate the call light. At 9:10 a.m., the resident's position was unchanged and the call light was out of reach.	F 246			

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F 246	Continued From page 9 i. On 5/16/07 at 9:20 a.m., the call light was hanging on the feeding pump. CNA #5 gave the resident a bed bath. When the bed bath was completed, the CNA was leaving the room and the call light remained on the feeding pump. The CNA was asked "Did you forget anything?" She stated, "No, I don't think so." She was then asked to place the call light so the resident could use it. j. On 5/16/07 at 10:12 a.m., the resident was lying in bed on her back with her right hand up on her neck and the index fingernail against her neck. The resident asked the surveyor to move her hand. The call light was lying on the upper corner of the mattress next to the rail. The resident was asked if she could reach the call light and she stated no. The call light was activated by the surveyor. LPN #3 entered the room and the resident ask her to move her right arm. The LPN moved the resident's hand and started to leave the room. She was asked " Did you forget anything?" She stated " No." She was then asked about the call light. The LPN then placed the call light next to the resident and had the resident activate it.	F 246			
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a recommendation to increase fluids was followed	F 282			

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F 282	<p>Continued From page 10</p> <p>for 1 (Resident #10) of 6 case mix residents (Resident #2, 4, 5, and 8-10) who had a feeding tube. The facility failed to ensure thickened liquids were given for 1 (Resident #8) of 2 (Resident #8 and 18) case mix residents who required thickened liquids. These failed practices had the potential to affect 4 residents who required thickened liquids on the 2nd floor as documented on a list provided by the Diet sheet on 5/18/07 and 22 residents who had a feeding tube as per the Resident Census and Conditions of Residents report dated 5/15/07. The findings are:</p> <p>1. Resident #10 had diagnoses of Alzheimer and Decubitus. The 90 day Medicare Minimum Data Set dated 3/28/07 documented the resident was severely impaired in cognitive skills for daily decision making and did not have a feeding tube.</p> <p>a. The Plan of care developed on 1/3/07 and updated 4/23/07 documented a problem of "Tube feeding with potential for complications and At risk for fluid volume deficit."</p> <p>b. The Nutritional Progress notes dated 4/27/07 documented, "Wt. (weight) 134#. (pounds) this is [up] 8# since Feb. Res (resident) is being treated for St (stage) IV wound which staff report is healing. She is NPO (nothing by mouth) & gets TF (tube feeding) of Diabetisource AC @ 60 cc/hr, 2 oz (ounce) Prostat QD (daily), H2O (water) 100 cc q (every) 6 hrs & 30 cc [before and after] meds. This regimen supplies (1178 +400+180) 1758 ml (milliliter) of free H2O. Rec. (recommend) add 300 ml fluid q 24 hrs."</p> <p>c. As of 5/16/07 at 11:30 a.m., there was no documentation in the nurses notes, physician progress notes or physician orders that this</p>	F 282			

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F 282	<p>Continued From page 11</p> <p>recommendation had been discussed with the physician or why the recommendation was not followed. The ADON (RN #1) was questioned about the lack of documentation. She stated that she could not remember if she called the physician or not. She was asked to provide documentation of the physician being notified of the recommendation or why the recommendation was not followed.</p> <p>d. As of 5/17/07 at 4:30 p.m., the facility had not produced any documentation as requested above.</p> <p>2. Resident #8 had diagnoses of Cerebral Vascular Accident with left side weakness and Aphasia. The Significant Change MDS dated 4/30/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required total care by staff for all activities of daily living, disease of Renal Failure and had a feeding tube.</p> <p>a. A physician order dated 3/2/07 documented, "Fibersource HN at 70cc/hr PT continuous. Thickened liquids as tolerated. D/C (discontinue) recreational meal. Pt (patient) refuses to eat."</p> <p>b. The Plan of Care dated 5/2/07 documented a problem of "Altered nutrition: Less than body requirements with weight loss related to: Presence of tube feeding" with an approach of "Tube feeding and flushes as ordered by the physician." As of 5/16/07, there was no documentation in the Plan of Care for providing or offering thickened liquids.</p> <p>c. Speech Therapy (ST) notes dated 5/8/07 documented, "...[Resident #8] was seen today to</p>	F 282			

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F 282	<p>Continued From page 12</p> <p>clarify order for thickened liquids. He was hospitalized due to [decreased] LOC (level of consciousness) & UTI (urinary tract infection). Resident received puree diet & honey thick liquids as recreational feeding and ice PRN. He usually just drank the liquids but preferred to eat ice. He is able to safely tolerate ice currently. ST recommends honey thick liquids and ice PRN."</p> <p>d. On 5/14/07 at 3:35 p.m., the ADON stated, "He is non verbal and communicates with a electronic board. He can have thickened liquids and no food."</p> <p>e. On 5/14/07 at 3:40 p.m., the resident was in bed. A red sign on the wall over the bed documented, "This resident gets nothing by mouth."</p> <p>f. On 5/15/07 at 9:05 a.m., CNA #8 was in the room and was asked what was the resident's oral status. CNA #8 stated, "Sometimes he does thickened liquids but they may have changed that."</p> <p>g. On 5/15/07 at 2:45 p.m., the treatment nurse completed the resident's wound care. The resident used the electronic communication board to state, "I am thirsty" 3 times. The treatment nurse stated, "I'll let your nurse know." As of 3:45 p.m., the treatment nurse did not tell nurse/staff of the resident's thirst.</p> <p>h. On 5/16/07 at 7:55 a.m., the resident was in bed. The resident used the electronic board to state, "I am thirsty". No staff were in the room. The surveyor asked the resident can you turn your call light on and the resident did. At 8:00 a.m., the ADON entered the room and the</p>	F 282			

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F 282	<p>Continued From page 13</p> <p>resident repeated his request, "I am thirsty". The ADON stated, "I'll get you something."</p> <p>1) On 5/16/07 at 8:02 a.m., CNA #6 and 8 handed the resident a 4 ounce carton of thickened juice and left the room.</p> <p>2) On 5/16/07 at 8:15 a.m., the resident was in bed. The carton of juice was not visible. The resident's gown was red stained on the left shoulder area. The resident used the board to state, "I am thirsty". The surveyor informed the ADON of the resident's request. The ADON stated, "he also refused thickened milk. He wanted water and of course, I can't give him that."</p> <p>3) On 5/16/07 at 8:20 a.m. and 8:35 a.m., the resident continued to state on the board, "I am thirsty." There were no staff in the room.</p> <p>i. On 5/16/07 at 8:40 a.m., CNA #6 was asked what types of liquids the resident can have. CNA #6 stated, "He can have ice chips and thickened liquids." The surveyor asked CNA #6 about thickened water. CNA #6 stated, "He can have thickened water. We ask the nurse when he says he's thirsty."</p> <p>j. On 5/16/07 at 8:50 a.m., the ADON was asked why can't he have water. The ADON stated, "He can't even have ice and no water. Not even thickened cause ST said no."</p> <p>k. On 5/16/07 at 4:50 p.m., the ST was asked how she communicated with the staff for the resident's oral intake. The ST stated, "I'm here every day. I tell the charge nurse and they read my notes." The ST was asked about the red sign over the bed. The ST stated, "That's an old sign</p>	F 282			

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F 282	Continued From page 14 that must have been over looked." The ST also stated, "We follow the Frazier Water Protocol. The DON can give it to you."	F 282			
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a treatment order was obtained for 1 (Resident #4) of 12 (Resident #1 - 10, 17 and 20) who received preventive skin care. The facility failed to ensure re-admission medications were verified by the physician and bowel elimination was monitored for 1 of 1 case mix resident (Resident #4) who required a bowel evacuation program. The facility failed to ensure there was leg strap in place to secure the Foley catheter tubing to prevent potential trauma to the urinary meatus for 1 (Resident #6) of 4 case mix residents (Resident #4, 6, 8 and 9) who had a Foley catheter. These failed practices had the potential to affect 112 residents who received preventive skin care and 6 residents who had a Foley catheter according to	F 309			

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F 309	<p>Continued From page 15</p> <p>the Resident Census and Conditions of Residents form dated 5/15/07 and only 1 resident who required a bowel evacuation program as per a list provided on 5/18/07. The findings are"</p> <p>1. Resident #4 had a diagnosis of Multiple Sclerosis. The Quarterly Minimum Data Set dated 5/3/07 documented the resident was moderately impaired in cognitive skills for daily decision making, dependent on staff for all activities of daily living and was incontinent of bowel.</p> <p>a. The plan of care developed 5/14/07 documented a problem of " At risk for skin breakdown related to: incontinence with inability to retrain and impaired bed mobility" with interventions that included " Provide padding for pressure points and bony prominences, including bed and chair."</p> <p>1) On 5/14/07 at 3:08 p.m., the resident was in bed. The resident stated "My toe hurts." The top sheet was lifted to view the resident's feet. The right great toe was black around the nail, with some purple coloring and there was dried blood on the medial aspect of the great toe. The resident stated she did not know what happened.</p> <p>2) A admission nursing assessment report dated 5/8/07 documented the right great toe red with open area to the nail bed.</p> <p>3) A weekly skin assessment dated 5/14/07 documented, "G-tube site clean, no open skin areas noted. Skin dry & flaky to face and scalp."</p> <p>4) As of 5/14/07 at 3:30 p.m., there was no documentation in the nurses notes, physician orders or treatment records of this area to the</p>	F 309			

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F 309	Continued From page 16 great toe. 5) On 5/14/07 at 5:15 p.m., the resident had a dressing to the right great toe that was dated 5/14/07. b. The plan of care dated 3/5/07 identified a problem as of 7/28/05 of "Potential for constipation as related to decreased peristalsis r/t (related to) Multiple Sclerosis" with interventions that included "Monitor frequency & consistency of bowel movements, do digital bowel check if no bowel movement within 3 days." 1) A physician order dated 8/30/06 documented, "Bisacodyl Suppositories (Dulcolax supp) 1 supp rectally every other day at bedtime." The April 2007 Medication Administration Record (MAR) documented the resident received this medication as ordered. 2) The Hospital Admission Medication List and History was dated 5/3/07 and documented the resident was admitted to the hospital with a diagnosis of Dehydration. The hospital admission medication list documented, "Biscolax supp PR (per rectum) every other day @ HS (bedtime)." 3) Nurses notes dated 5/8/07 documented the resident was readmitted to the nursing home. 4) The Physician Order for 5/8/07 through 5/31/07 did not document an order for the Bisacodyl suppositories. 5) The Significant Change Minimum Data Set (MDS) dated 5/14/07 documented the resident was moderately impaired in cognitive skills for daily decision making, dependent on staff for all	F 309			

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F 309	<p>Continued From page 17</p> <p>Activities of Daily Living, and incontinent of bowel with bowel elimination pattern regular-at least one movement every three days.</p> <p>6) On 5/16/07 at 10:30 a.m., the bowel elimination record from 5/8/07 through 5/31/07 documented the only bowel movement was a large one on 5/10/07.</p> <p>7) On 5/16/07 at 10:35 a.m., LPN (Licensed Practical Nurse) #4 was asked "How do you monitor bowel movements?" She stated, "The CNA's (Certified Nursing Assistants) will tell us, we look at the BM (bowel movement) book or sometimes the resident can tell us." She was then asked "How often do you check the BM book?" She stated, "Once a week, if they haven't had a BM in 3 days, then I give them something."</p> <p>8) On 5/16/07 at 2:05 p.m., LPN #3 was asked "How do you monitor bowel elimination?" She asked "For [Resident #4] or everyone else?" This surveyor stated "Both." She stated the CNA's would tell her if a resident didn't have a bowel movement and/or she would look at the bowel movement record. She stated that this resident received a suppository every other night and that she gave her a fleets enema this morning with good results. She was asked for the medication record that documented the every other night suppository. She looked at the Medication Record and stated "Well, she used to get them."</p> <p>9) On 5/16/07 at 2:20 p.m., the Director of Nurses was asked about the transfer sheet documentation to resume previous nursing orders and the suppository not being carried forward. The DON stated that the hospital sent them a medication continuation form that has the</p>	F 309			

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F 309	Continued From page 18 medications checked if they are to be continued. Once the facility received the form, the ADON on the floor faxes it to the physician for verification. She further stated that a resident would receive a laxative every 3 days if no bowel movement. 10) On 5/16/07 at 2:30 p.m., the ADON (Assistant Director of Nursing) stated that she had 2-3 re-admissions that day and did not fax it to the physician for verification. 11) The facility policy and procedure for Bowel Maintenance Protocol obtained from the facility on 5/18/07 documented, "The charge nurse must monitor for normal B.M. at least every 3rd day."	F 309			
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312			

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F 312	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a the hair was dried after a shower was completed for 1 (Resident #4) of 16 (Resident #2-11 and 16-21) case mix residents who were dependent for bathing. This failed practice had the potential to affect 68 residents who were dependent for bathing as per the Resident Census and Conditions of Residents report dated 5/15/07. The findings are: Resident #4 had a diagnosis of Multiple Sclerosis. The Significant Change Minimum Data Set (MDS) 5/14/07 documented the resident was moderately impaired in cognitive skills for daily decision making and was dependent on staff for personal hygiene and bathing. a. The plan of care developed 5/14/07 documented a problem of "Totally dependent for ADL's (activities of daily living), related to Multiple Sclerosis" with interventions that included "Provide shower 3 X's (times) weekly." b. On 5/14/07 at 5:15 p.m., the resident stated she was just back from a shower and her hair was wet. No staff offered to dry the residents hair.	F 312			
F 314 SS=G	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	F 314			

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F 314	<p>Continued From page 20</p> <p>they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a treatment order was obtained in a timely manner, a turning and repositioning program was implemented and incontinent care was provided in manner to prevent shearing for 1 (Resident #10) of 7 case mix residents (Resident #2, 3, and 6-10) who had pressure sores. These failed practices caused actual harm to Resident #10 whose pressure sore deteriorated and had the potential to cause more than minimal harm to 14 residents who had pressure sores as per the Resident Census and Conditions of Residents report dated 5/15/07. The findings are:</p> <p>1. Resident #10 had diagnoses of Alzheimer and Decubitus. The 90 day Medicare Minimum Data Set dated 3/28/07 documented the resident was severely impaired in cognitive skills for daily decision making, had a Stage IV pressure sore and was on a turning/repositioning program.</p> <p>a. The plan of care developed 1/3/07 identified a problem of "Pressure ulcer on coccyx is Stage 4" with interventions that included "Assist to turn and reposition q (every) 2 hours and Monitor size, stage depth, color, odor, drainage. Record QD. (daily) and Report any significant change to physician."</p> <p>b. The wound/skin healing record dated 5/11/07</p>	F 314			

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F 314	<p>Continued From page 21</p> <p>documented the resident had a Stage 4 pressure ulcer that measured 4.0 cm (centimeter) x 2.8 cm x < (less than) 0.3 cm, with serous exudate, the wound bed had granulation tissue, the surrounding skin color was normal for skin and the surrounding tissue/wound edges was normal for skin.</p> <p>c. On 5/15/07 at 9:00 a.m., the resident was in the wheelchair at the bedside. The position was marked with a bright pink piece of paper under the right lower thigh.</p> <p>d. On 5/15/07 at 10:15 a.m., 10:40 a.m., 11:15 a.m. and 11:40 a.m., the resident was in the wheelchair at the bedside in the same marked position.</p> <p>e. On 5/15/07 at 12:05 p.m., the treatment nurse and CNA (Certified Nursing Assistant) #1 pulled the resident up in the wheelchair but did not change her position. While leaving the room, CNA #1 stated to the treatment nurse "We will put her to bed after lunch so you can do her treatment."</p> <p>f. On 5/15/07 at 12:15 p.m., RN (Registered Nurse) #1 was advised that the resident had been in the same marked position for 3 hours and 15 minutes and a body audit was requested.</p> <p>g. On 5/15/07 at 12:17 p.m., CNA #1 and 2, transferred the resident to bed. The resident had a dressing on the coccyx dated 5/14/07.</p> <p>h. On 5/15/07 at 12:30 p.m., the treatment nurse measured the wound as 4.5 cm x 2.5 cm x 0.4 cm. The treatment nurse measured the depth by placing a Q-tip into the wound, pulling the Q-tip</p>	F 314			

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F 314	<p>Continued From page 22</p> <p>out and measured the depth of the drainage on the Q-tip instead of sliding her fingers down the Q-tip to the top of the skin. After measuring the depth in the correct manner, the depth was 12 cm. There was a brown necrotic area in the left upper corner of the wound that measured 1.5 cm x 0.8 cm. The treatment nurse stated that this area was new and that she first observed this area on 5/14/07. There was also another brown necrotic area in the left lower corner of the wound that measured 0.2 cm x 2 cm. The Treatment nurse stated that this area was not there when she did the treatment on 5/14/07. The surrounding tissue was white and macerated approximately 1 cm. The treatment nurse stated that she documented this as normal for the skin because it was normal for this resident. The treatment nurse also stated that the nurse, who did the treatment on the weekend, told her there was a couple of bad spots in the wound.</p> <p>i. On 5/16/07 at 8:10 a.m., there was no documentation on the physician orders, treatment notes, or nurses notes that the physician was consulted about the change in the wound.</p> <p>j. On 5/16/07 at 9:10 a.m., LPN (Licensed Practical Nurse) #1, who did the treatment over the weekend was interviewed. She was asked to describe the wound. She stated that she saw some bruising around the wound, some dark cherry colored areas with slough on it. She stated that she did not see any brown. She was then asked, "Did you notified the physician of the change in the wound?" She stated, "No, I reported it to the treatment nurse." She was also asked "Did the resident get up over the weekend?" She stated, " No."</p>	F 314			

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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 314	Continued From page 23 k. On 5/16/07 at 9:20 a.m., the DON (Director of Nursing) and CNA #2 turned the resident to the left side. The dressing to the coccyx was saturated with a green, serosanguinous drainage. The DON stated, "I didn't expect to have to take the dressing completely off." The dressing was removed. The wound had the brown areas and maceration around the the surrounding tissue. The resident voided when she was turned over. CNA #2 performed peri care by putting cleansing foam on a dry wash cloth and dry towel instead of wetting the washcloth to prevent friction.	F 314			
F 315 SS=D	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: Based on observation, record review and interview, the facility failed to ensure a toileting program was provided for 1 (Resident #12) of 1 case mix resident who was continent of bowel and bladder. This failed practice had the potential to affect 13 residents who were continent of bowel and bladder as documented on a list provided by the Director of Nursing on 5/18/07. The findings are: Resident #12 had a diagnosis of Bilateral Below	F 315			

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F 315	<p>Continued From page 24</p> <p>the Knee Amputation. The Quarterly Minimum Data Set (MDS) dated 4/26/07 documented the resident had modified independence in cognitive skills for daily decision making and no short/long term memory problems, required limited assistance of staff for activities of daily living and extensive assist of staff to transfers, was usually continent of bowel and occasionally incontinent of bladder and did not require a scheduled toileting program.</p> <p>a. The Plan of Care dated 8/3/07 documented, "Problem: Limited assist to totally dependent for most ADL's, related to: Generalized weakness and cognitive decline." with an approach of "Provide incontinent care following each episode, keeping [Resident #12] clean and dry and odor free. Maintaining dignity.</p> <p>b. On 5/15/07 at 9:55 a.m., CNA (Certified Nursing Assistant) #6 and 7) transferred the resident to and from the shower. The resident was not toileted.</p> <p>c. On 5/15/07 at 10:10 a.m., CNA #6 was asked about toileting the resident. CNA #6 stated, "Don't do no good to toilet her. She uses briefs."</p> <p>d. On 5/16/07 at 1:45 p.m., the resident was asked if they took her to the bathroom would she use it. The resident stated, "Sure, I have control of my bowels and my bladder but they use diapers on me and when I have to, I let it out. They don't take me to toilet and I gave up asking them because I couldn't hold it 'til they came. I wouldn't have to wear this diaper if I went to the bathroom but it's hard for them to get me out of this chair or the bed."</p>	F 315			

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F 315	Continued From page 25 e. On 5/17/07 at 1:55 p.m., CNA #6 was asked if there were any residents of the 2nd floor on a toileting schedule. CNA #6 stated, "No one on a routine toileting." f. On 5/17/07 at 1:57 p.m., LPN (Licensed Practical Nurse) #3 was asked, "Do you have a toileting program." LPN #3 stated, "They don't per say, have a program." The LPN was asked if the residents were assessed for a bowel/bladder (B/B) training program. LPN #3 stated, "No". The LPN was asked why not toilet this resident. LPN #3 stated, "She will use a bed pan. She is continent of B/B. She just won't get up and go."	F 315			
F 318 SS=E	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure hand positioning devices were in place to prevent further contractures for 3 (Resident #4, 9 and 10) of 6 (Resident #3, 4, 8-10 and 16) case mix residents who had hand contractures. This failed practice had the potential to affect 16 residents who had hand contractures as per a list provided by the Director of Nursing on 5/18/07. The findings are: 1. Resident #4 had a diagnosis of Multiple	F 318			

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F 318	<p>Continued From page 26</p> <p>Sclerosis. The Significant Change Minimum Data Set (MDS) 5/14/07 documented the resident was moderately impaired in cognitive skills for daily decision making, dependent on staff for all Activities of Daily Living and had full loss in range of motion affecting both arms, hands, legs and feet.</p> <p>a. The plan of care developed 5/14/07 did not document the resident's loss of range of motion.</p> <p>b. On 5/15/07 at 8:00 a.m., 9:20 a.m., and 3:00 p.m., the resident was in bed. The left hand was contracted and there was no positioning device in place.</p> <p>2. Resident #10 had diagnoses of Alzheimer and Decubitus. The 90 day Medicare Minimum Data Set dated 3/28/07 documented the resident had short/long term memory problems, was severely impaired in cognitive skills for daily decision making, dependent on staff for transfers and had partial loss of range of motion affecting both hands.</p> <p>a. The plan of care developed on 1/3/07 and updated on 4/23/07 did not document the resident's limited range of motion.</p> <p>b. The May 2007 Physician Order sheet documented, "Splint to (L) [left] hand and Restorative PROM (Passive range of motion) to LUE (left upper extremity) before applying splint 5 x/wk (times a week)."</p> <p>c. On 5/15/07 at 8:25 a.m., the resident was in bed and both hands were clenched in a fist. There was no splint or positioning device in either hand.</p>	F 318			

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F 318	Continued From page 27 d. On 5/15/07 at 9:00 a.m. and 10:40 a.m., the resident had a splint on the left hand. The right hand was in a fist and there was no positioning device in place to prevent contractures. e. On 5/16/07 at 10:20 a.m., the resident's hands were clenched into a fist. The ADON (Assistant Director of Nursing) was asked to open the resident's hands. The right hand could be opened wide enough for a hand roll and the left hand could not be opened as wide. When the ADON opened the left hand there was an immediate sour odor present. The ADON was asked to wipe the palm of the left hand with a Q-tip. She retrieved a Q-tip, wiped the palm of the hand and stated, "It smells musty." The resident's splint and handroll were on the bedside table. 3. Resident #9 had diagnoses of Cerebral Vascular Accident and Dementia. The Quarterly MDS dated 3/1/07 documented the resident was severely impaired in cognitive skills for daily decision making, had short/long term memory problems, required total care for all ADL's, and had functional limitation in range of motion on both arms and hands. a. The May 2007 Physician Order sheet documented, "Splint left hand on for 8 hours as tolerated." b. On 5/14/07 at 2:40 p.m., 5/15/07 at 8:25 a.m. and 3:05 p.m., and 5/16/07 at 7:45 a.m., the resident's left hand was clenched and contracted. There was no positioning device or splint in place.	F 318			
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a	F 322			

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F 322	<p>Continued From page 28</p> <p>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 and record review, the facility failed to ensure the head of the bed remained elevated while the tube feeding was infusing for 1 (Resident #4) of 6 (Resident #2, 4, 5, and 8-10) case mix residents who had a feeding tube. This failed practice had the potential to affect 22 residents who had a feeding tube as per the Resident Census and Conditions of Residents report dated 5/15/07. The findings are:</p> <p>Resident #4 had a diagnosis of Multiple Sclerosis. The Significant Change Minimum Data Set 5/14/07 documented the resident was moderately impaired in cognitive skills for daily decision making, dependent on staff for all Activities of Daily Living and had a feeding tube.</p> <p>a. The Physician Order sheet dated 5/8/07 - 5/31/07 documented tube feeding 2 Cal HN at 30 cc (cubic centimeters) per hours via pump. The physician orders did not document to keep the head of the bed elevated.</p> <p>b. The plan of care developed 5/14/07 did not document a problem of being at risk for aspiration due to receiving nutrition through a feeding tube or to keep the head of the bed elevated.</p>	F 322			

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F 322	Continued From page 29	F 322			
F 323 SS=E	<p>c. On 5/14/07 at 3:10 p.m., CNA (Certified Nursing Assistant) #3 rolled the head of the bed flat with the tube feeding infusing while she turned the resident. At 3:15 p.m., the CNA rolled the head of the bed up.</p> <p>483.25(h)(1) ACCIDENTS</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the failed to ensure protective door covers did not have sharp edges, screws did not extend from the walls and chairs and electrical plugs were secured in the electrical outlet. The facility failed to ensure side rails were not loose and did not have gaps between the mattress and the side rails for 1 (Resident #12) of 8 (# 4,8,9,12,16,18-20) case mix residents who required side rails. These failed practices had the potential to affect all 115 residents. The findings are:</p> <p>1. On 5/15/07 at 10:35 a.m., the following observations were made:</p> <p>a. The protective shield on the center section of the entrance door into the dining room on the 4th floor had sharp edges.</p> <p>b. There was 1 chair in the dining room on the 4th floor with a screw in the armrest of the chair that extended at least 1 inch from outward.</p>	F 323			

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F 323	Continued From page 30 2. On 5/15/07 at 9:40 a.m., on 300 Hall in the Day Room/ Dining Room the Air conditioner/ Heater unit the electrical plug was half way out with part of the metal exposed and the prongs were bent to the side. On 5/15/07 at 10:15 a.m., the Maintenance man stated that happens all the time. Those plugs get hit by wheelchairs and it bends them. 3. Resident #12 had a diagnosis of Bilateral Below the Knee Amputation. The Quarterly Minimum Data Set (MDS) dated 4/26/07 documented the resident had modified independence in cognitive skills for daily decision making, required limited assistance of staff for activities of daily living and extensive assist of staff to transfers and bed rails were used for bed mobility and transfers. On 5/16/07 at 7:30 a.m., the resident was in bed and there were full side rails up on each side of the bed. The side rails were loose on both sides of the bed and there was an approximate 3 to 4 inch gap between the bed and the side rails.	F 323			
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that	F 325			

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F 325	<p>Continued From page 31</p> <p>acceptable parameters of nutrition was maintained for 1 case mix resident (resident #15) who had experienced weight loss as evidenced by failure to implement interventions. This failed practice had the potential to affect 4 residents who had an unplanned weight loss as documented on the Resident Census and Condition of Residents dated 5/14/07. The findings are:</p> <p>Resident #15 was admitted to the facility on 2/22/07 and had diagnoses of Malnutrition, Dementia, Hypothyroidism and Senile with Delusional Features. The Initial 5 day Medicare Minimum Data Set dated 2/27/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required limited assistance of person with eating, had edema, weight 180 pounds, had a weight loss of 5% in the past 30 days or 10 % in the past 180 days, received a dietary supplement.</p> <p>a. The Initial Nutritional History/Assessment Data Collection Form dated 2/25/07 documented the resident weighed 180 pounds on 2/22/07.</p> <p>b. The plan of care dated 2/27/07 documented a problem of "Altered nutrition" with approaches of "Monitor for weight loss. Report any significant weight loss and gain promptly to physician. Diet as ordered by physician. Give resident adequate time to consume food."</p> <p>c. The May 2007 Physician Order sheet documented a regular diet.</p> <p>d. The Annual Weight Report documented the resident weighed 175 pounds in March 2007, 167 pounds in April 2007 and 166 pounds in May</p>	F 325			

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F 325	Continued From page 32 2007. This was a 7.7% weight loss in 3 months. e. A dietary progress note completed by the Registered Dietitian dated 4/20/07 documented, "Poor intake @ times resident current weight 167 lbs. (pounds) Wt. down 8 lbs, past 30 days. Order ProMod 2 scoops BID. Monitor labs, skin, intake and wt (weight) c poc." f. A dietary progress note completed by the Registered Dietitian dated 5/11/07 documented, "Current weight 166 lbs. Wt down. 9 lbs past 60 days. Monitor wt, labs skin and intake." g. On 5/15/07 at 1:58 p.m., the Food Service Manager stated he was not aware of the resident's weight loss and stated, "He's on a regular diet." h. On 5/15/07 at 1:01 p.m., the resident was served barbecued chicken, baked beans, potatoes salad, a slice of wheat bread, iced tea, 4 ounces of orange juice, and a bowl of pineapples with a cherry. The resident used his hands and the fork to feed himself. j. On 5/15/07 at 5:30 p.m., the resident was served spaghetti and meat sauce, garlic bread, salad, orange juice, ice tea, water. The resident ate the food using his hands and a fork. k. As of 5/18/07, there was no documentation in the clinical record the physician was notified of the severe weight loss and new interventions were implemented to prevent further weight decline.	F 325			
F 333 SS=E	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of	F 333			

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F 333	Continued From page 33 any significant medication errors. This REQUIREMENT is not met as evidenced by: Based observation and record review, the facility failed to ensure medications were administered as ordered for 2 (Resident #2 and 22) of 22 case mix residents (Resident 1-22) who received medications. This failed practice had the potential to affect all 115 residents. The findings are: 1. Resident #22 had a diagnosis of Hypertension. a. A physician order dated 4/30/07 documented Lisinopril 5 mg (milligrams) daily. b. The hospital Medication Continuation Orders initiated when the resident was discharged on 5/8/07 documented Lisinopril 5 mg 1 tablet daily. c. On 5/17/07 at 8:40 a.m., LPN #1 did not administer the Lisinopril. d. The MAR dated 5/8/07 through 5/31/07 did not document Lisinopril. e. This was a significant medication error due to the resident's condition and frequency of the error. 2. Resident #2 had diagnoses of Acute Renal Failure and Senile Dementia with Delusional Features. The Significant Change of Condition Minimum Data Set (MDS) dated 4/5/07, documented the resident was severely impaired in cognitive skills for daily decision-making, had a swallowing problem, feeding tube, and an unstable weight.	F 333			

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F 333	Continued From page 34 a. A physician order dated 1/12/07 documented Zyprexa 5 mg (milligrams) po (by mouth)/pt (per tube) every QHS (at bedtime), Zyprexa 2.5 mg 30 minutes prior to bathing, and Zyprexa 5 mg every 12 hours PRN (as needed) for agitation. b. The May 2007 Medication Administration Record (MAR) documented Zyprexa 2.5 mg was administered on 5/1/07 on the 3:00 p.m. - 11:00 p.m. shift prior to bathing and Zyprexa 5 mg was administered at bedtime from 5/1/07 - 5/15/07. c. On 5/17/07 at 10:20 a.m., Licensed Practical Nurse (LPN) #5 was asked to get the Zyprexa out of the medication cart. The only medication card for the resident was Zyprexa 2.5 mg. d. The Refill Order Sheet dated 3/2/07, 3/29/07, 4/12/07, and 5/3/07 documented the facility received Zyprexa 2.5 mg 30 tablets on each date. The facility received a total of 120 tablets of Zyprexa 2.5 mg from 3/2/07 through 5/3/07. e. The medication card dated 5/3/07 documented Zyprexa 2.5 mg 1 tablet at bedtime and 9 doses were dispensed. Based on the number of Zyprexa 2.5 mg received from 3/2/07 through 5/3/07 the resident was administered 99 doses of Zyprexa 2.5 mg. This was only half of the recommended ordered dose of 5 mg. f. This was a significant medication error based on the frequency of the error.	F 333			
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371			

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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 371	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure eggs that were not cooked completely were pasturized eggs, expired and molded food was removed from use to prevent the potential for food borne illness. This failed practice had the potential to affect 94 residents who received food from the kitchen according to the Diet list dated 5/18/07. The findings are. 1. On 5/14/07 at 2:20 p.m. the following observations were made in the storage room: a. There were 3 boxes of English muffins with an expiration date of 3/27/07. b. There was 1 open bag of hamburger buns on the bread rack that were molded. c. There was one 3 pound can of tuna with an expiration date of 5/11/07. 2. On 5/16/07 during the breakfast meal, Resident #12 was served a fried egg with a runny yolk. At 10:34 a.m., the Dietary Manager was asked if they had pasturized eggs in the facility and he stated, "We only have grade A eggs for the residents." 3. On 5/17/07 at 9:30 a. m., 11:10 a.m., 11:40 a.m., and 3:30 p.m. and on 5/18/07 at 8:30 a.m., there were 2 trash cans that did not have lids on them.	F 371			
F 441	483.65(a) INFECTION CONTROL	F 441			

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F 441 SS=E	<p>Continued From page 36</p> <p>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure scissors were disinfected between wound treatment procedures and nursing staff did not handle medications with their bare hands. These failed practices had the potential to affect all 115 residents. The findings are:</p> <p>1. Resident #8 had diagnoses of Cerebral Vascular Accident with left side weakness and Aphasia. The Significant Change Minimum Data Set (MDS) dated 4/30/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required total care by staff for all activities of daily living (ADL's) and had pressure ulcers.</p> <p>On 5/15/07 at 2:45 p.m., the treatment nurse provided wound care. The treatment nurse stated, "He has stage II pressure sores on both heels." The treatment nurse entered the resident's room with the treatment cart. A pair of scissors was on the top of the cart. The treatment</p>	F 441			

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F 441	<p>Continued From page 37</p> <p>nurse used the scissors to cut the soiled dressings from the right and the left foot. The scissors were placed back on top of the treatment cart during the wound care procedure. The treatment nurse completed the wound care and placed the scissors into her pocket as she left the room. The treatment nurse stated, "I'm going to [Resident #9] (resident's name) next". The treatment nurse did not cleanse the scissors after this wound care procedure.</p> <p>2. Resident #9 had diagnoses of Cerebral Vascular Accident and Dementia. The Quarterly MDS dated 3/1/07 documented the resident was severely impaired in cognitive skills for daily decision making, required total care for all ADL's and had Pressure Ulcers.</p> <p>On 5/15/07 ay 3:05 p.m., the treatment nurse entered the resident's room to provide wound treatment. The treatment nurse stated, "She has stage 4 pressure sores on both ankles." The treatment nurse set up supplies for the wound care and removed the scissors from her pocket. The treatment nurse placed the scissors on the top of the treatment cart. During the procedure, the treatment nurse used the scissors to cut the soiled dressing from the right and the left foot. The right foot Kerlix gauze was soaked through the dressing with a red/brown substance. The treatment nurse cut through the red/brown stained dressing to remove the Kerlix wrap. The treatment nurse left the room with the scissors on the top of the treatment cart. The treatment nurse did not cleanse the scissors before entering this room after wound care was provided to Resident #8.</p> <p>3. On 5/15/07 at 3:35 p.m., the surveyor asked</p>	F 441			

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F 441	Continued From page 38 the treatment nurse when she had cleansed the scissors. The treatment nurse stated, "I do treatments for the house, starting on the 4th floor. I haven't cleaned the scissors from floor to floor or resident to resident." 4. Resident #12 had diagnoses of Bilateral below the knee amputation. The Quarterly MDS dated 4/26/07 documented the resident had modified independence in cognitive skills for daily decision making and had no short/long term memory problems. On 5/16/07 at 8:30 a.m., the resident was in her bed covered with the bed spread. There was a red pill on the bed spread. LPN (Licensed Practical Nurse) #3 was informed. LPN #3 entered the room and stated, "Oh, that's her Lopressor (Blood pressure pill). LPN #3 picked up the pill with her bare hands from the bed spread and administered it to the resident.	F 441			
F 468 SS=D	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, the failed to ensure hand rails were securely mounted to the wall. These failed practices had the potential to affect all 19 residents who resided on the 4th floor according the facility's Roster Matrix dated 5/14/07. The findings are: On 5/15/07 at 10:35 a.m., the handrail located between the elevator doors on the 4th floor was	F 468			

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F 468	Continued From page 39 not secured to the wall.	F 468			