STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045063	A. BUILDING ____ B. WING ____	09/16/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE ROCK HEALTHCARE & REHAB	**5720 WEST MARKHAM** **LITTLE ROCK, AR 72205**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by:	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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Based on observation, record review and interview, the facility failed to ensure the physician was consulted regarding a change of condition requiring treatment for 1 (Resident #9) of 10 case mix residents who resided on the second floor nursing unit (Residents #6 through #9, #11, #13, #17, #22, #23 and #25). The failed practice had the potential to affect 50 residents who resided on the second floor nursing unit, as documented on the Roster Matrix provided by the Administrator on 9/12/05. The findings are:

Resident #9 had diagnoses of Ulcerative Colitis, Depressive Disorder and Anemia. The Quarterly Minimum Data Set dated 7/24/05 documented the resident was independent in cognitive skills for daily decision-making, had no long or short-term memory problems and was easily understood.

a. On 9/12/05 at 1:15 p.m., the resident pointed to a half-dollar sized, reddened area on the left side of her face and stated, "I've had this infection over a week and nobody will do anything. It's made me sick all over."

b. On 9/12/05 at 4:00 p.m., the resident complained of a "burning pain" and stated the area on her cheek felt "hot to touch." The resident also stated, "I told the nurse again today and she said she remembered me telling her about it last week. She says she's going to get me something for it."

c. On 9/13/05 at 9:20 a.m., the resident stated, "They finally brought me some cream for my face last night." The resident showed the surveyor an envelope of 10 packages of triple antibiotic cream and stated, "I've been putting this stuff on it, and it's feeling a little better."

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F 157	Continued From page 2 d. As of 9/13/05 at 10:00 a.m., there was no documentation in the Nurses' Notes that the area on the resident's cheek had been assessed, no documentation that the physician had been consulted and no documentation of a physician order for the use of triple antibiotic cream. e. On 9/13/05 at 10:15 a.m., the unit Assistant Director of Nursing (ADON) stated she was not aware that the resident was receiving triple antibiotic cream. She also stated there was no Treatment Sheet for this resident and, "I'll go down and look at her and call the doctor." f. A physician order was obtained on 9/13/05 which documented: "Clobetasol 0.05% Cream" for "rash on face."	F 157		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure showers were maintained in clean condition, doors, door frames and furniture were in good repair, ceiling tiles were free of stains, floors were free of lint and dirt build-up, linen cart covers were free of tears, floor tiles were free of discolorations, stains and cracks, laminate door panels were intact and free of black and grey streaking, equipment was maintained in clean condition and outside screens were in good	F 253		

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repair. The failed practice had the potential to cause more than minimal harm to 62 residents who resided on the third and fourth floors of the facility, as documented on the Roster Matrix provided by the Administrator on 9/12/05 (and no more than minimal harm to the remaining 47 residents). The findings are:

1. On 9/13/05 at 8:30 a.m. during the environmental tour with the Housekeeping and Maintenance Supervisors, the following observations were made on the fourth floor:

a. In the shower room, the grout under the shower head was stained with a black and brown substance approximately 1.5 feet from the floor. Three ceiling tiles directly in front of the entry door had a dark stained area which measured approximately 15 inches in diameter.

b. The door frame of the janitor closet had a casing that was coming loose from the left side, approximately 8 inches from the bottom of the door. The laminate on the outside of the door was loose on the top right side of the panel.

c. The ceiling tile next to the sprinkler head in front of the elevators had a stain which measured approximately 15 inches in diameter. The ceiling tile next to the light fixture to the left of the elevators had a stain which measured approximately 6 inches in diameter.

d. The Nurses' Station entryway next to the elevators was missing the rubber threshold cover, which left the metal exposed. The floor outside the Nurses' Station had a buildup of dirt and lint in the corners. The entry to the Nurses Station next to the kitchen also had the threshold cover

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F 253	Continued From page 4 missing. e. There was a build-up of dirt and lint behind both fire doors and along the baseboard between the fire door and Resident Room #409. f. The entrances to Resident Rooms #410 and #406 had the casings separated from the door frame approximately 6 inches from the bottom of the frame. g. In the hallway in front of the entrance to Resident Room #402, the ceiling tile had a stain which measured approximately 4 by 6 inches in diameter. h. The baseboard along the entire hall had a buildup of dirt at the edge. i. The exterior laminate door panels on 18 resident rooms, the Dirty Utility Room, the Central Supply Room, the Janitor Closet, the Resident Smoking Room, 2 Medication Rooms and the kitchen had grey and black discolored streaks on the surface of the lower half of the doors. j. In the Resident's Smoking Room, all three walls had peeling paint and areas where the paint surface was rough. The bottom right corner of the door to the restroom had a hole which measured approximately 2 inches in diameter. k. The Resident's Day Room had areas of peeling, chipped paint along the walls by the table and at the back of the couch. The areas measured approximately 1 foot in width. 2. On 9/13/05 at 10:25 a.m. during the environmental tour with the Housekeeping and	F 253		

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Maintenance Supervisors, the following observations were made on the facility's third floor:

a. In the Shower Room, there was a black substance along the grout lines on the bottom three wall tiles of all three walls and extending six tiles upward below the shower head. The entry door to the shower had a gash missing out of the bottom which measured approximately 4 inches. The laminate panel on the exterior of the door had separated from the door and was chipped along the edge. Two shower chairs in the dry side of the shower room had a yellow and brown substance on all four casters, hair and lint on the seat of the chairs and a brown, smeared substance on the underside of the seat of one of the chairs. Eight floor tiles in front of the shower room had a grey, cloudy stain on the surface.

b. The door frame casing was separated from the door frame below the room number of Resident Room #324.

c. There was a build-up of dirt and lint behind the fire doors near Room #322 and the fire doors near the kitchen. The laminate panel on the right fire door near the kitchen had separated from the door.

d. Next to Resident Rooms #322 and #323, the threshold had four floor tiles with approximately one-inch holes and four floor tiles that were cracked and broken.

e. The linen cart cover had tears approximately 2 inches up from the bottom of the material along the front and on the back of both sides.

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f. The entry to the Nurses' Station next to the Clean Utility Room and the entry next to the elevators had the rubber threshold cover missing, which left the metal exposed. The baseboard next to the Medication Room was separated from the wall.

g. The exterior laminate door panels of 31 resident rooms, the Clean Utility Room, the Dirty Utility Room, the Central Supply Room, the Janitor Closet, the Resident Day Room, the 2 Medication Rooms and the Shower Room had grey and black discolored streaks on the surfaces of the lower half of the doors.

h. The Resident's Day Room had 3 chairs with loose seats.

i. Between the Shower Room doors, the wallpaper was missing in an area measuring approximately 1 foot by 6 inches above the handrail.

j. To the left of the door to Room #309, the wallpaper was torn away from the wall in a triangular area measuring approximately 2 inches.

k. The ice machine in the third floor kitchen area had a build-up of a brown slimy substance on the inside of the lid at the front.

3. On 9/13/05 at 3:00 p.m. during the environmental tour with the Housekeeping and Maintenance Supervisors, the following observations were made on the second floor:

a. The Shower Room floor had an area approximately 2 feet long under the grab bar that

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F 253	Continued From page 7 had a black substance in the grout lines. The laminate on the exterior of the entry door had partially separated from the door and the casing had partially separated from the door frame. The ceiling tile directly in front of the entry door had a hole which measured approximately 2 inches in diameter. The ceiling tile in the corner in front of the entry door had a hole which measured approximately 2 inches in diameter. The ceiling tile beside the light fixture had a stain which measured approximately 1 foot in diameter. b. There was a build-up of dirt and lint behind both fire doors and a hole in the ceiling tile near the left fire door. c. At the entry to Resident Room #222, one ceiling tile had a 1/4-inch gap where the tile did not meet the track. d. To the left of the elevators, there were 2 floor tiles with holes measuring approximately 1/2 inch to 2 inches in diameter. e. The Resident's Day Room had an indented area in the wall which measured approximately 1 foot by 4 inches. The right corner of the room had a 1-inch chunk missing from the plaster. f. There was a build-up of dirt and lint behind both fire doors to the left of the elevators. g. The cover for the linen cart had an area of frayed material which measured approximately 6 inches wide on the front. h. Resident Room #205 door frame casing was partially separated from the door frame at the bottom.	F 253		

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i. The exterior laminate door panels on 30 resident rooms, both sets of fire doors, the Dirty Utility Room, the Central Supply Room, the Janitor Closet, the Resident Day Room, the kitchen, the Nurses Storage Closet and the Shower Room had grey and black discolored streaks on the surfaces of the lower half of the doors.

j. Resident Room #228 had a 1.5 foot tear in the bottom of the window screen.

k. In the center of the wall between Resident Room #226 and #228, there was a square area of missing wallpaper which measured approximately 1.5 by 2 feet.

l. The wallpaper was torn and peeling in an area which measured approximately 2.5 feet on the wall to the right of Resident Room #222.

4. On 9/13/05 at 3:25 p.m. during the environmental tour with the Housekeeping and Maintenance Supervisors, the following observations were made on the first floor:

a. Above the Activity Calendar in the front entrance, a ceiling tile had an approximately 2 by 2 foot stain.

b. The entry door to the main dining room had holes in the plastic door frame cover. Next to the right corner window, a ceiling tile had an approximately 2 foot by 4 inch stain. The ceiling tile to the right side of the window divider was bulging and not meeting the track on one side. On the left side of the window divider, one ceiling tile was cracked and had an approximately 1 by 2

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F 253	Continued From page 9 foot stain. Above the piano, there were 6 ceiling tiles with stains. In the center of the dining room, 2 ceiling tiles had stains measuring approximately 6 inches to 2 feet in diameter. c. The corner of the dietary entrance had a build-up of dirt. The Dish room door had an area approximately 10 inches up from the floor where the door frame casing had separated from the frame. d. The Elevator Equipment door had an area approximately 8 inches up from the floor where the door frame casing had separated from the frame. e. Inside the entry to the Handicapped Restroom, the corner trim was missing. f. The exterior laminate door panels to the Main Dining Room, the Laundry, 3 restrooms, the Telephone Room, the beauty shop, the Activities/Social Room, the Accounting Office, the Human Resources Office the Receptionist's Office had grey and black discolored streaks on the surfaces of the lower half of the doors. g. In the Main Dining Room, the wallpaper was peeling away from the wall in an approximately 3-inch area above the electrical outlet next to the television. h. At the dietary entrance, the wallpaper in the corner next to the doorframe had a hole measuring approximately 1 inch in diameter. i. The return air vent in the dining room was covered by an approximately 1/8-inch thick layer of gray dust.	F 253		

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j. In the sitting area next to the time clock, the wallpaper was peeling away from the wall in the corner and on the left wall below the clock.

k. To the left of the dish room entry door, the wallpaper was tacked to the wall with push pins. The entire area of wallpaper measuring approximately 3.5 by 2.5 feet had separated from the wall.

l. In the dining room, the wallpaper was missing around the thermostat next to the activity calendar.

m. Four dining room chairs had the vinyl coming loose from the back of the seat area of the chairs.

n. The hallway at the laundry entrance had wallpaper peeling away from the wall in an area which measured approximately 2 feet from the ceiling and along the bottom approximately 2 feet up from the floor. Across from the Rehabilitation Room, the wallpaper had a 1-inch triangular area which was torn. Under the bulletin board and between the elevators and the handicapped restroom, the wallpaper had peeled away from the wall. Under the reception window, the wallpaper had six areas that were torn in 2-inch strips. Under the accounting window, the wallpaper had two 1-inch tears. To the right of the handicapped restroom, the wallpaper was peeling away from the wall in a 2-inch area. Behind the water fountain, the wallpaper had a 2-inch area that had peeled away from the wall.

5. On 9/12/05 at 3:35 p.m., Resident #3's room had a tube feeding bag hanging on a pole which had a heavy build-up of a mud-colored substance

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F 253	Continued From page 11 at the base of the pole were the support legs attached. 6. On 9/12/05 at 3:53 p.m., Resident Room #320 had a tube feeding pump with a tan substance caked on the surface of the pump. 7. On 9/13/05 at 8:35 a.m., the ice cart on the third floor had a dried brown substance around the edges and brown water in the bottom shelf of the cart. 8. On 9/13/05 at 9:17 a.m., Resident Room #310 had dark-brown stains on the privacy curtain between the beds. The side rail padding for Bed B had brown smears on the surface. 9. On 9/13/05 at 10:40 a.m., the curtain over the closet area in Resident Room #220 was smeared with a brown substance. 10. On 9/13/05 at 11:50 a.m. and 3:00 p.m., Resident Room #314A had a tube feeding pump with a dried, tan substance on the top surface of the pump. 11. On 9/14/05 at 9:45 a.m., the fourth floor Resident Smoke Room window and the Resident Day Room windows did not have screens. 12. On 9/14/05 at 10:15 a.m., Resident #4's bedside table was missing a drawer pull. The wall opposite the bed had multiple scuffed areas from the door to the window. The laminate panel on the bathroom door had multiple dark scuffed areas. The curtain for the closet area was soiled with dark smudges. 13. On 9/14/05 at 10:30 a.m., Resident #10's	F 253		

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F 253	Continued From page 12 bedside table was missing a drawer pull. The wall opposite the bed had multiple scuffed areas from the door to the window. The baseboard on the wall opposite the bed had multiple dark areas. The laminate panel on the bathroom door had multiple dark scuffed areas. The curtain for the closet area was soiled with dark smudges.	F 253		
F 282 SS=D	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 the physician's plan of care was implemented for 1 (Resident #23) of 10 case mix residents who resided on the 200 Hall and had physician orders for medications (Residents #6 through #9, #11, #13, #17, #22, #23 and #25). The failed practice had the potential to affect 50 residents who resided on the 200 Hall, as documented on the Roster Matrix provided by the Administrator on 9/12/05. The findings are: Resident #23 had diagnoses of Cerebrovascular Accident, Hypertension and Atherosclerotic Heart Disease. The Quarterly Minimum Data Set dated 6/19/05 documented the resident had modified independence in cognitive skills for daily decision-making and required limited assistance	F 282		

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F 282	Continued From page 13 with activities of daily living. a. A physician order dated 1/20/05 documented: "Lopressor 50 mg [milligrams] 1 tab [tablet] by mouth twice daily. Check pulse, if < [less than] 60 or > [greater than] 100 chart and call MD [Medical Doctor]." b. On 9/14/05 during the 9:00 a.m. medication pass, LPN #1 administered the Lopressor to the resident without first checking the resident's pulse.	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 the frequency of bowel movements was monitored and failed to ensure interventions were implemented to facilitate normal bowel function in accordance with the Plan of Care and the facility's Bowel Maintenance Protocol for 1 (Resident #14) of 2 case mix residents who had a diagnosis of Constipation (Residents #2 and #14). The failed practice had the potential to affect 15 residents who resided on the third floor of the facility and were diagnosed with Constipation, as identified by	F 309		

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the Director of Nursing (DON) on 9/15/05. The facility also failed to ensure a newly identified area of skin excoriation was reported to the physician to obtain treatment orders in a timely manner and failed to ensure incontinent care was provided in a manner to prevent further skin breakdown and promote healing for 1 (Resident #8) of 8 case mix residents who were incontinent (Residents #6 through #9, #11, #13, #17 and #23). This failed practice had the potential to affect 79 residents who were incontinent, as documented on the facility's Resident Census and Conditions of Residents form dated 9/15/05. The findings are:

1. Resident #14 had diagnoses of Vascular Dementia with Delusions and Behavior Disturbance and Constipation. The Medicare 5-Day Minimum Data Set dated 6/27/05 documented the resident had short and long-term memory problems, was severely impaired in cognitive skills for daily decision-making, dependent on staff for toileting and personal hygiene and incontinent of bowel and bladder.

a. The Plan of Care dated as revised on 6/22/05 and 7/8/05 documented: "Problem - Constipation... Interventions - Encourage Fluids... Monitor Stool Consistency, color and amount..."

b. A physician order dated 12/16/04 documented the resident was to receive Neurontin 200 milligrams (mg) three times daily and a physician order dated 6/27/05 documented the resident was also to receive Seroquel 50 mg three times daily.

c. The 2004 Lippincott's Nursing Drug Guide documented the potential adverse effects of Neurontin and Seroquel included Constipation.

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d. The June 2005 Bowel Elimination Record documented no bowel movements from 6/3/05 through 6/14/05 and from 6/23/05 through 6/30/05.

e. The July 2005 Bowel Elimination Record documented no bowel movements from 7/12/05 through 7/15/05 and from 7/17/05 through 7/31/05.

f. The September 2005 Bowel Elimination Record documented no bowel movements from 9/8/04 though 9/13/05.

g. On 8/13/05 at 8:44 a.m., the resident was sitting in a wheelchair at the bedside with a belt restraint in place. At 9:17 a.m., Certified Nursing Assistants (CNAs) #1 and #2 transferred the resident from the wheelchair to the bed. No fluids were offered to the resident. There was a pitcher of water at the bedside with no glass or straw. The water level in the pitcher was marked by the Surveyor at this time.

h. On 8/13/05 at 10:05 a.m., the resident remained in bed. The water level in the pitcher remained at the same marked position.

i. On 8/13/05 at 11:55 a.m., the resident was sitting in a wheelchair at the bedside. The water level in the pitcher remained at the same marked position.

j. On 8/13/05 at 12:30 p.m., the resident was served a pureed diet. The tray included 120 cubic centimeters (cc) of water, 120 cc of tea and 120 cc of apple juice. The resident was offered and consumed all of the apple juice. No other

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F 309	Continued From page 16 fluids were offered and at 1:05 p.m., the resident was removed from the dining room. k. On 8/13/05 at 3:00 p.m., the resident was in bed. The water level in the pitcher at the bedside remained in the same marked position. l. On 8/13/05 at 3:20 p.m., a staff member removed the water pitcher from the room and took it to the Dietary Department for cleaning. No fluids were left at the bedside. m. On 8/13/05 at 5:05 p.m., CNA #3 dressed the resident and transferred her into the wheelchair. No fluids were offered to the resident at this time. n. On 8/13/05 at 5:25 p.m., the resident was served a pureed diet which included 120 cc of apple juice. No other fluids were on the tray. At 6:10 p.m., the resident had consumed all of the apple juice. The Surveyor asked CNA #4 to offer the resident water. The resident consumed approximately 75% of a 240 cc glass of water. o. On 9/14/05 at 1:00 p.m., the Assistant Director of Nursing (ADON) was asked how residents with Constipation were monitored to ensure they were assisted with having bowel movements if needed. The ADON stated, "The nurses are supposed to monitor the bowel movements by the Bowel Elimination Record, and if the resident has not had a bowel movement in 3 days, they are to give them a laxative." p. As of 9/14/05, there was no documentation in the Nurses' Notes, the Medication Administration Records or elsewhere in the clinical record to indicate the resident was ever checked for fecal impactions or received a laxative to assist her	F 309		

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with having a bowel movement.

q. The facility's Resident Bowel Maintenance Inservice documentation was provided by the Director of Nursing on 9/14/05 at 2:55 p.m. and documented: "To prevent constipation et [and] possible fecal impactions the charge nurse must monitor for normal BM [bowel movement] at least q [every] 3 days. If no BM in 3 days perform digital exam to check for presence of mass in rectum (excess soft = constipation), (Hard large bulk = impaction.) If constipation is found, administer PRN [as needed] laxative. Monitor and document results amt [amount], color, consistency)..."

r. The facility's Bowel Maintenance Protocol documented the following:

1.) Encourage and Ensure resident consumes adequate fluids.

2.) Serve warm prune juice q [every] day and as tolerated.

3.) Administer stool softener daily as ordered.

4.) If no BM q [every] 3 days, Administer laxative as ordered allow 3-6 [3 to 6] hours for results, monitor document results, amt., color, and consistency.

5.) If no results notify M.D. [Medical Doctor].

2. Resident #8 had diagnoses of Below-Knee Amputation due to Peripheral Vascular Disease, Myocardial Infarction and Chronic Obstructive Pulmonary Disease. The Admission Minimum Data Set dated 7/1/05 documented the resident

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was independent in cognitive skills for daily decision-making, required limited assistance of 1 person for bed mobility, was totally dependent on staff for transfers, personal hygiene and bathing, was incontinent of bowel and bladder and had a Urinary Tract Infection in the past 30 days.

a. The Weekly Skin Assessment dated 9/9/05 documented: "No open skin areas noted."

b. The Weekly Skin Assessment dated 9/12/05 documented: "Periarea excoriated, skin surrounding rectum extremely red & [and] irritated, some slight bleeding noted..." There was no documentation the physician was notified of the skin breakdown at this time.

c. On 9/13/05 at 10:45 a.m., Certified Nursing Assistant (CNA) #6 provided incontinent care to the resident. The CNA cleansed urine and feces from the resident's skin using apricot body wash and water, then dried the resident without first rinsing the soap from the resident's skin. The resident's buttocks and perianal area were very red. The inner left buttock was excoriated and bleeding. The resident complained of pain and refused to get up in the chair because of pain in the perianal area and buttocks. The CNA stated, "I reported this over the weekend, but the nurse didn't do anything about it. I asked the nurse if I could put some Lantiseptic on it and she said yes." The resident stated, "It has been hurting me for about a week." The CNA agreed that the area had been open for approximately one week. Licensed Practical Nurse (LPN) #1 entered the resident's room during this interview and CNA #6 showed her the area of excoriation and redness. The LPN stated she would notify the physician and get a treatment order. The LPN left the

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F 309	Continued From page 19 room, returned several minutes later and stated she had obtained a physician order for Lantiseptic to be applied to the excoriated/reddened area every shift.	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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure bathing services were provided in a manner to maintain good hygiene for 1 (Resident #6) of 7 case mix residents who were dependent on staff for activities of daily living (Residents #6, #7, #8, #11, #13, #17 and #23). The failed practice had the potential to affect 36 residents who resided on the 200 Hall and were dependent on staff for activities of daily living, as identified by the Assistant Director of Nursing on 9/15/05 at 8:30 a.m. The findings are: Resident #6 had diagnoses of End-Stage Multiple Sclerosis, Paranoid Schizophrenia and Chronic Urinary Tract Infection. The Quarterly Minimum Data Set (MDS) dated 7/23/05 documented the resident had modified independence in cognitive skills for daily decision-making, was totally dependent on staff for bed mobility, transfers, personal hygiene and bathing and was totally incontinent of bowel and bladder.	F 312		

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On 9/13/05 at 9:25 a.m., Certified Nursing Assistant (CNA) #5 provided a bed bath to the resident. The CNA brought a wash basin of water to the bedside and added Apricot Shampoo and Body Wash to the water. The Directions for Use on the label of this product documented: "For hands and body, apply to wet washcloth, wash body gently, then rinse." The following observations were made during the bath:

1.) CNA #5 washed the resident's hands, arms, axillae and chest area with the soapy water in the wash basin, then dried these areas without rinsing off the soap.

2.) The CNA then washed the resident's feet and up her legs toward the groin area with the soapy water. She then dried these areas without rinsing the soap from the resident's skin.

3.) The CNA sprayed peri-wash onto the same soapy washcloth that had been used to cleanse the resident's feet and legs and used this cloth to wash the resident's groin area. She then took a clean washcloth, dipped it into the soapy water and cleansed the resident's inner labia and perineal area. The CNA then dipped the same washcloth into the basin of soapy water and used it to cleanse the labia and perineal area again. The CNA then dried the areas without rinsing the soap from the resident's skin.

4.) The CNA turned the resident to her left side and washed her upper and lower back, using the same washcloth and dried the resident's back without rinsing. She then washed the resident's buttocks and rectal area and dried without rinsing. The CNA stated, "The peri-wash is supposed to be pH balanced, so we don't have to rinse."

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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: Based on observation, record review and interview, the facility failed to ensure personal hygiene services/incontinent care were provided in a manner to prevent potential Urinary Tract Infections (UTI's) for 2 (Residents #6 and #8) of 8 incontinent case mix residents (Residents #6, #7, #8, #9, #11, #13, #17 and #23). The failed practice had the potential to affect 39 incontinent residents who resided on the 200 Hall where Certified Nursing Assistants (CNAs) #5 and #6 were assigned to work, as reported by the Assistant Director of Nursing on 9/15/05 at 8:30 a.m. The findings are: 1. Resident #6 had diagnoses of End-Stage Multiple Sclerosis, Paranoid Schizophrenia and Chronic Urinary Tract Infection. The Quarterly	F 315		

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Minimum Data Set (MDS) dated 7/23/05 documented the resident had modified independence in cognitive skills for daily decision-making, totally dependent on staff for bed mobility, transfers, personal hygiene and bathing and was incontinent of bowel and bladder.

On 9/13/05 at 9:25 a.m., Certified Nursing Assistant (CNA) #5 provided a bed bath to the resident. The CNA brought a wash basin with water to the bedside and added Apricot Shampoo and Body Wash to the water. The Directions for Use on the label of this product documented: "For hands and body, apply to wet washcloth, wash body gently, then rinse." The CNA dipped a washcloth in the soapy water and used it to cleanse the resident's feet and legs. The CNA then sprayed peri-wash onto the same washcloth and used it to cleanse the resident's groin areas. The CNA then changed washcloths, washed the inner labia and perineal area, dipped the same soiled washcloth back into the soapy water and cleansed the labia and perineal area again. The CNA then dried this area without rinsing the soap from the resident's skin.

2. Resident #8 had diagnoses of Below-Knee Amputation due to Peripheral Vascular Disease, Myocardial Infarction and Chronic Obstructive Pulmonary Disease. The Admission Minimum Data Set (MDS) dated 7/1/05 documented the resident was independent in cognitive skills for daily decision-making, required limited assistance of staff for bed mobility, was totally dependent on staff for personal hygiene and bathing, incontinent of bowel and bladder and had a history of Urinary Tract Infection in the past 30 days.

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F 315	Continued From page 23 On 9/13/05 at 10:45 a.m., CNA #6 provided incontinent care to the resident. Fecal material was smeared on the resident's perianal area, buttocks, groin and perineal area. The CNA brought a wash basin filled with water to the bedside and added Apricot Shampoo and Body Wash to the water. The CNA washed the resident's vaginal and perineal areas with a washcloth dipped into the soapy water, wiping back and forth over the vaginal area and smearing feces from the perianal area toward the vaginal area. She then dipped the same washcloth into the soapy water and washed the vaginal area again. The CNA then dried the area without rinsing off the soap.	F 315		
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the environment was as free of accident hazards as possible, as evidenced by failure to maintain furniture and doors in safe condition, failure to secure potentially hazardous items in the shower rooms, failure to ensure tiles in a shower room were free of rough, broken edges and failure to ensure baseboards were intact. The failed practice had the potential to cause more than minimal harm to 62 residents who resided on the third and fourth floors of the facility, as documented on the Roster Matrix provided by the	F 323		

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Administrator on 9/12/05 (and no more than minimal harm to the remaining 47 residents). The findings are:

1. On 9/13/05 at 8:30 a.m. during the environmental tour with the Housekeeping and Maintenance Supervisors, the following observations were made on the fourth floor:

a. The entrance to the Resident Shower Room was unlocked and unattended. Inside the room, an unlocked cabinet contained a 13.5 ounce bottle of Dandruff Shampoo approximately one-fourth full. The label on the bottle documented: "If swallowed, get medical help or contact a poison control center." The unlocked cabinet also contained a 4-ounce tube of Vitamin A/Vitamin D ointment. The label on the tube documented: "If swallowed, get medical help or contact a poison control center."

b. The Resident Smoking Room had 4 chairs with chipped, gouged, rough and splintered legs, which posed a potential skin tear risk.

c. The Day Room had a couch along the entry wall with multiple tears in the plastic covering on the back, front and arms. The seat had a tear in the upholstery which measured approximately 3 by 3 inches. The edges of the tears were sharp to touch. The front legs of the couch were gouged and splintered along the entire front up to the upholstery. Five chairs in the room had scratched, gouged and splintered legs. The entry door to the room had a laminate panel that had separated from the door on the right, upper corner. The hinged side of the door had a broken, chipped area with a sharp edge that measured approximately 5 inches in length.

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d. The laminate panel on the left fire door had a chipped, broken and wrinkled area with sharp edges next to the bottom hinge. The laminate panel on the right fire door had pulled away from the door and had a sharp edge approximately 4 inches in length.

2. On 9/13/05 at 8:45 a.m. during the environmental tour with the Housekeeping and Maintenance Supervisors, the following observations were made on the third floor:

a. The Shower Room contained the following items in an unlocked cabinet to the left of the linen shelves:

1.) One 0.5 ounce tube of Lantiseptic Skin Protectant with a warning label which documented: "If swallowed get medical help or contact a poison control center."

2.) One 2.47 ounce tube of Protective Ointment with a warning label which documented: "In case of accidental ingestion, seek professional assistance or contact a poison control center."

3.) Five disposable razors.

b. The Shower Room also had 8 broken tiles with sharp edges on the divider wall between the shower and the dry area and one lounge chair with sharp, splintered areas on both front legs.

c. Rooms #301, #312, #316, #318, #323, #324, #329, #336 and #337 had sharp, gouged areas on the laminate door panels, which posed a potential skin tear risk.

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d. The Day Room entry door had a loose laminate panel with exposed sharp edges approximately 6 inches up from the bottom of the door and sharp, chipped areas in the laminate panel on the right side of the door. The baseboard around the air conditioner had cracked and sharp chipped corners.

e. The left fire door next to the kitchen had an approximately 4-inch chunk missing from the corner of the door. The wood was sharp and splintered in this area, which was approximately one foot up from the floor.

f. The Nurses Station entry next to the Clean Utility Room had approximately 2 inches of baseboard missing, which left sharp edges exposed. The Nurses Station entry next to the Central Supply Closet had a hole in the baseboard which left a sharp edge exposed.

3. On 9/13/05 at 3:00 p.m. during the environmental tour with the Housekeeping and Maintenance Supervisors, the following observations were made on the second floor:

a. Resident Rooms #204, #206, #207, #208, #210, #211, #212, #213, #224, #225, #232, #234 and #236 had chipped, gouged laminate door panels with sharp edges exposed.

b. The left fire door had a 1/2-inch torn area in the laminate door panel with a sharp, pointed edge exposed, approximately 6 inches up from the floor.

c. The Janitor Closet entry door had an cracked, broken areas in the laminate door panels on the interior and exterior surfaces of the door. Sharp

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edges were exposed on both sides of the door.

d. The Resident Day Room had an outlet cover missing from the wall by the corner next to the window.

4. On 9/13/05 at 3:25 p.m. during the environmental tour with the Housekeeping and Maintenance Supervisors, the following observations were made on the first floor:

a. The laminate panel on the right entry door to the main dining room was loose at the bottom corner, which left an approximately 6-inch sharp edge exposed.

b. The dietary entry door had an approximately 3-inch chunk missing from the corner of the door at the latch area. This left a sharp, splintered edge exposed.

c. The Telephone Room entry door had an approximately 3-inch chunk missing from the corner of the door at the latch area, which left a sharp, splintered edge exposed. Inside the Telephone Room, the bottom of the left door facing had a loose casing, which left a sharp, pointed edge exposed.

F 326 SS=E — 483.25(i)(2) NUTRITION — F 326

Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:

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Based on observation, record review and interview, the facility failed to ensure therapeutic diets were served as ordered by the physician to 3 of 3 case mix residents with physician orders for pureed diets (Residents #11, #14 and #15) and for 2 of 2 case mix residents with physician orders for supplements with meals (Residents #11 and #14). The failed practices had the potential to affect 16 residents with physician orders for pureed diets and 14 residents with physician orders for supplements with meals, as documented on the Diet Order Report provided by the facility on 9/12/05. The findings are:

1. Resident #14 had diagnoses of Vascular Dementia with Delusions, Behavior Disturbance and Major Depression. The Medicare 5-Day Minimum Data Set dated 6/27/05 documented the resident had short and long-term memory problems, was severely impaired in cognitive skills for daily decision-making and was dependent on staff for eating.

a. The August/September 2005 Physician Orders sheets documented the resident was to receive a pureed diet with enhancers and a house supplement three times daily with meals.

b. On 9/13/05 at 12:30 p.m., the resident was served a pureed diet, 120 cubic centimeters (cc) water, 120 cc tea, 120 cc of apple juice. No house supplement was served with the resident's meal, as ordered by the physician.

c. On 9/13/05, the facility's menu for the evening meal documented the residents on pureed diets were to receive pureed pears for dessert. At 5:25 p.m., the resident was served a pureed diet with regular Mandarin oranges instead of pureed

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pears. The tray also included 120 cc of regular apple juice. There was no high-calorie juice and no house supplement on the tray. Certified Nursing Assistant (CNA) #4 was asked by the Surveyor not to serve the Mandarin oranges. The evening meal tray card documented the resident was to receive a pureed diet with no dairy products and, "Weight loss... Ice Tea, HCJ [high calorie juice] and Resource J."

d. On 9/13/05 at 5:55 p.m., the Evening Cook was asked what food item was being served as dessert for the residents on pureed diets. The Cook stated regular Mandarin oranges were served to the residents on pureed diets. The Cook was then asked what foods had been fortified or enhanced for the residents who required fortified foods. The Cook stated, "The only thing fortified was the fortified milk."

e. On 9/13/05 at 6:00 p.m., the Administrator was informed by the Surveyor of the Cook's use of regular Mandarin oranges for the residents on pureed diets. The Administrator immediately pulled the Mandarin oranges off of the tray line and notified the floor staff that the oranges should not be served.

2. Resident #11 had diagnoses of Mental Retardation, Renal Insufficiency and Gastritis. The Quarterly Minimum Data Set dated 7/16/05 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for eating and had a chewing problem.

a. The Care Plan dated 8/16/05 documented: "Diet - Pureed NCS [no concentrated sweets] c [with] Resource Diabeta."

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F 326	Continued From page 30 b. On 9/13/05 at 12:30 p.m., no Diabetic Resource was served with the resident's lunch tray. c. On 9/13/05 at 6:00 p.m., no Diabetic Resource was served with the resident's supper tray. Whole Mandarin orange slices were served as the dessert for this meal, instead of pureed pears as documented on the facility's menu. 3. Resident #2 had diagnoses of Malnutrition, Anemia, Diverticulitis and Hypokalemia. The Quarterly Minimum Data Set (MDS) dated 5/30/05 documented the resident was moderately impaired in cognitive skills for daily decision-making, required limited assistance of one person for eating and weighed 103 pounds. a. The Care Plan dated 6/10/05 and reviewed/revised 8/20/05 documented: "Problem: Malnutrition Diagnosis... Interventions: Assist with all meals; Offer alternatives for foods refused; Monitor food acceptance record; FORTIFIED MILK WITH EACH MEAL; Megestrol 30 cc [cubic centimeters] p.o. [by mouth] QD [every day]; HEALTHSHAKES TID [3 times daily] WITH MEALS; Weight loss alert c/ [with] enhancers... 9/13/05 Eldertonic 15 cc p.o. tid..." b. The August/September 2005 Physician Orders sheets documented orders signed by the physician on 8/25/05 as follows: 1.) "6 oz. [ounces] fortified milk w/ [with] each meal." 2.) "Health Shake with meals."	F 326		

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F 326	Continued From page 31 c. A Nutrition Assessment dated 8/21/05 documented: "Supplemental foods... HPM [high protein milk] and HS [Healthshake]... R [Resident] weight loss has stopped, back up 1 1/2 lbs [pounds], still only 73% IBW [ideal body weight] with enhancers and appetite stimulant." d. On 9/13/05 at 12:32 p.m., the resident received a lunch tray in the third floor dining room. The beverages included on the resident's tray were a Health Shake, apple juice, buttermilk and water. No fortified milk was served. e. On 9/13/05 at 5:35 p.m., the resident was served a supper tray in the third floor dining room. The beverages included on the tray were fortified milk and orange juice. No Health Shake was served. The resident consumed 100% of the orange juice and none of the fortified milk. The resident was not assisted or encouraged to drink the fortified milk and was not offered more orange juice before being assisted to leave the table.	F 326		
F 327 SS=E	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure sufficient fluid intake to maintain proper hydration was provided, assessments were conducted to determine hydration needs, reassessments were conducted upon readmission to the facility and care plans were developed to include specific	F 327		

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interventions to meet hydration needs for 1 (Resident #14) of 7 case mix residents who resided on the third floor and were at risk for Dehydration (Residents #2 through #5, #10, #14 and #18). The failed practices had the potential to affect 22 residents who resided on the third floor and were at risk for Dehydration, as documented on a list provided by the Director of Nursing on 9/15/05. The findings are:

1. The Centers for Medicare and Medicaid Services (CMS) interpretive guidelines at F327 - Hydration document: "Sufficient fluid means the amount of fluid needed to prevent dehydration... and maintain health. The amount needed is specific for each resident, and fluctuates as the resident's condition fluctuates... A general guideline for determining baseline daily fluid needs is to multiply the resident's body weight in kg [kilograms] times 30cc [cubic centimeters]... signs and symptoms of dehydration... abnormal laboratory values... elevated hemoglobin and hematocrit, potassium, chloride, sodium, albumin, transferrin, blood urea nitrogen (BUN), or urine specific gravity..."

2. The Handbook of Geriatric Nursing Care, Second Edition, Lippincott, Williams & Wilkins, page 409 documented: "Preventing Dehydration: Monitor Intake and Output. Ensure an intake of at least 1500 ml [milliliters] of oral fluids and output of 1,000 ml per 24 hours. Less than 1,000 ml per day may lead to more concentrated urine which predisposes the patient to urinary tract infections..."

3. Resident #14 had diagnoses of Vascular Dementia with Delusions, Behavior Disturbance and Major Depression. The Medicare 5-Day

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Minimum Data Set dated 6/27/05 documented the resident had short and long-term memory problems, was severely impaired in cognitive skills for daily decision-making and was dependent on staff for eating.

a. The Plan of Care dated 6/2/05 and reviewed/revised 6/22/05 documented: "Problem - Potential for Dehydration and Fluid/Electrolyte Imbalance due to M-W-F [Monday, Wednesday and Friday] Furosemide use... Interventions - Encourage Fluids, Monitor for S/S [signs and symptoms] of Dehydration and Monitor Labs for Abnormals..."

b. Nurses' Notes dated 5/27/05 at 9:00 a.m. documented: "At 0930 [9:30 a.m.]... slow to respond. Resident returned to bed, B/P [blood pressure] 70/palpated, HR [heart rate] 92, R [respirations] 22, T [temperature] 98.8, Pulse ox [oximeter] @ [at] 99% with 2 liters oxygen." The notes documented the resident was transferred to the hospital at 9:45 a.m.

c. The Hospital History and Physical dated 5/27/05 documented the resident was transferred to the Emergency Department with a decreased level of consciousness. She was found to be hypotensive, had leukocytosis and renal insufficiency and was felt to be in need of admission to the hospital for probable Urinary Tract Infection (UTI) with Sepsis and decreased level of consciousness. The Assessment and Plan for this hospital stay was documented as: "Sepsis, Renal insufficiency, dehydration, hypotension, possible Urinary Tract Infection." The physical examination documented: "Oropharynx mucous membranes are dry."

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d. The hospital Laboratory Results dated 5/27/05 documented the following:

1.) Urinalysis - 1+ Leukocytes.

2.) BUN - 84 H [high] (normal 7-18).

3.) Sodium - 153 H (normal 135-145).

4.) Potassium - 5.6 H (normal 3.5-5.1).

5.) Chloride - 123 H (normal 98-107).

6.) Creatinine - 4.2 H (normal .6-1.3).

e. The Admission Nursing Assessment dated 6/2/05 documented the resident was admitted back to the facility on 6/2/05 at 2:30 p.m.

f. Physician Progress Notes dated 6/16/05 documented: "Problem: [Decreased] LOC [level of consciousness] & [and] muscle twitches, Resident has had decreased level of consciousness today, upper & lower extremity jerking, vomiting x [times] 2 past 2 days, increased sedation, decreased B/P, not eating today. Send to ER [Emergency Room] for eval [evaluation]."

g. The hospital History and Physical dated 6/16/05 documented the resident was admitted to the hospital with diagnoses of Acute Renal Failure, Sepsis, Dehydration and UTI."

h. The Laboratory Data section of the hospital History and Physical dated 6/16/05 documented the following results:

1.) White Blood Cell Count - 14.4 H (normal

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range 5-10).

2. BUN - 65H (normal 7-18).

3. Sodium - 148 H (normal 135-145).

4. Chloride - 123 H (normal 98-107).

5. Creatinine - 4.1 H (normal .6-1.3).

6. Urinalysis Positive, CNS [Culture and Sensitivity] Pending.

i. The Admission Nursing Assessment dated 6/22/05 documented the resident was readmitted to the facility on 6/22/05 at 6:35 p.m.

j. The General Chemistry Report dated 6/24/05 (2 days after the resident's return from the hospital) documented the following:

1.) BUN - 8 (within normal limits).

2.) Sodium - 144 (within normal limits).

3.) Creatinine - 1.0 (within normal limits).

k. The General Chemistry Report dated 6/28/05 (6 days after the resident's return from the hospital) documented the following:

1.) BUN - 13 (within normal limits).

2.) Sodium - 141 (within normal limits).

3.) Creatinine - 1.2 (within normal limits).

4.) Potassium - 3.7 (within normal limits).

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l. The General Chemistry Report dated 7/5/05 documented the BUN was elevated to 27 and the Chloride was elevated to 119.

m. The General Chemistry Report dated 7/12/05 documented the BUN was further elevated to 39, Chloride was 115 and Calcium was 10.4.

n. The Nutritional Progress Notes dated 7/29/05 and signed by the Registered Dietitian (RD) documented the resident had been hospitalized in May and June 2005 with Acute Renal Failure, possible Sepsis, Dehydration, intravenous fluids antibiotic treatment. There was no documentation in this note that the resident's fluid needs were calculated. The recommendation documented: "May D/C [discontinue] HS [house shake] TID [three times daily]."

o. As of 9/14/05, there was no documentation on the Plan of Care, Dietary Notes, Nurses' Notes or elsewhere in the clinical record to indicate the facility assessed the resident's fluid needs and planned specific interventions provide for these needs to prevent the recurrence of Dehydration.

p. On 8/13/05 at 8:44 a.m., the resident was sitting in a wheelchair at the bedside with a belt restraint in place. At 9:17 a.m., Certified Nursing Assistants (CNAs) #1 and #2 transferred the resident from the wheelchair to the bed. No fluids were offered to the resident. There was a pitcher of water at the bedside with no glass or straw. The water level in the pitcher was marked by the Surveyor at this time.

q. On 8/13/05 at 10:05 a.m., the resident remained in bed. The water level in the pitcher remained at the same marked position.

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r. On 8/13/05 at 11:55 a.m., the resident was sitting in a wheelchair at the bedside. The water level in the pitcher remained at the same marked position.

s. On 8/13/05 at 12:30 p.m., the resident was served a pureed diet. The tray included 120 cubic centimeters (cc) of water, 120 cc of tea and 120 cc of apple juice. The resident was offered and consumed all of the apple juice. No other fluids were offered and at 1:05 p.m., the resident was removed from the dining room.

t. On 8/13/05 at 3:00 p.m., the resident was in bed. The water level in the pitcher at the bedside remained in the same marked position.

u. On 8/13/05 at 3:20 p.m., a staff member removed the water pitcher from the room and took it to the Dietary Department for cleaning. No fluids were left at the bedside.

v. On 8/13/05 at 5:05 p.m., CNA #3 dressed the resident and transferred her into the wheelchair. No fluids were offered to the resident at this time.

w. On 8/13/05 at 5:25 p.m., the resident was served a pureed diet which included 120 cc of apple juice. No other fluids were on the tray. At 6:10 p.m., the resident had consumed all of the apple juice. The Surveyor asked CNA #4 to offer the resident water. The resident consumed approximately 75% of a 240 cc glass of water.

x. The facility's Hydration Protocol was provided by the Director of Nursing on 9/14/05 at 2:55 p.m. and documented the following:

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F 327	Continued From page 38 1.) All resident fluid needs will be assessed per dietary consultation and nursing assessments to ensure all resident hydration needs are met. 2.) Nursing staff to include CNA's will encourage resident to consume adequate amounts of fluid. To this end, staff will offer water on each round and upon resident's request. 3.) Adequate amounts of fluids will be served at each meal time. During this time, residents will be encouraged to consume fruits and vegetable served. y. On 9/15/05 at 8:45 a.m., the Assistant Director of Nursing (ADON) for the third floor was asked to locate any documentation of an assessment of the resident's fluid needs or specific interventions to prevent the recurrence of Dehydration. The ADON stated there was no assessment of the resident's fluids needs and no documentation of interventions to prevent the recurrence of Dehydration for this resident.	F 327		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the 8:00 a.m. medication pass on 9/14/05, record review and interview, the facility failed to ensure the medication error rate was less than 5%. Physician orders were not followed for 2 (Residents #24 and #3) of 9 residents observed during the medication pass,	F 332		

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which resulted in medication errors. Medication errors were made by 1 Licensed Practical Nurse (LPN) of 5 LPNs observed administering medications in the facility. The failed practice had the potential to affect 25 residents who received medications from this LPN, as documented on a list provided by the Director of Nursing (DON) on 9/15/05 at 2:45 p.m. The medication error rate was 14.28% based on administration of 56 medications and a total of 8 errors detected. The findings are:

1. Resident #24 had physician orders dated 1/31/05 for: "Clozaril 25 mg [milligrams] 2 tablets (50 mg) by mouth morning (Give W/ [with] 100 mg tab [tablet])... Clozaril 100 mg tablet 1 tab by mouth every morning." These orders indicated the resident should receive a total of 150 mg of Clozaril each morning.

On 9/14/05 at 8:30 a.m. during the 8:00 a.m. medication pass, LPN #3 punched two 100 mg tablets of Clozaril from the medication card into a medication cup to administer to the resident, for a total of 200 mg instead of 150 mg as ordered by the physician. The Surveyor stopped the LPN from administering the medication and asked her to recheck the order/strength of the Clozaril tablets. The LPN then administered 1.5 of the Clozaril 100 mg tablets for a total of 150 mg.

2. Resident #3 had physician orders for Aspirin 325 mg 1 tablet per tube every day (2/8/05), Ferrous Sulfate 325 mg 1 tablet per tube daily (2/8/05), Lisinopril 10 mg 1 tablet per tube daily (2/8/05), Multivitamin 1 tablet per tube daily (2/8/05), Prevacid 30 mg 1 capsule by mouth daily (6/13/05), Vitamin C 500 mg 1 tablet per tube daily (2/8/05) and Zinc 50 mg 1 tablet per

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F 332	Continued From page 40 tube daily (2/8/05). On 9/14/05 at 8:43 a.m. during the 8:00 a.m. medication pass, LPN #3 crushed all of the above medications and mixed them in water. When the LPN attempted to administer the medication and water mixture through the resident's feeding tube, the tube became clogged. The LPN emptied the remainder of medication/water mixture into a plastic cup and set it aside while attempting to unclog the tube. After the LPN unclogged the tube, she flushed the tube with water and began to leave the room. The Surveyor asked the LPN if the resident's medications were going to be administered. The LPN stated, "I had forgotten about them." The LPN then administered the remainder of the resident's medications through the feeding tube. Since the medications were all mixed together in one medication cup, this resulted in seven errors.	F 332		
F 371 SS=F	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure dietary employees washed their hands between dirty and clean tasks, failed to ensure the ice machine was maintained in clean condition and failed to ensure food was handled in a manner to prevent cross-contamination and potential foodborne illness. The failed practices had the potential to affect 90 residents who received meals from the kitchen, as documented	F 371		

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F 371	Continued From page 41 on the facility's Resident Census and Conditions of Residents form dated 9/12/05. The findings are: 1. On 9/12/05 at 1:06 p.m. during the intal tour of the kitchen, the following observations were made: a. The ice machine in the kitchen had a red and black moldy substance on the panel where the ice shoots down to the reservoir. Dietary Employee #1 stated, "We clean the machine once a month." b. A blue container was hanging in front of the ice machine. The ice scoop was stored in this container. The container had water standing in the bottom, with a black and grey, furry substance with the appearance of mold growing on the surface of the water. c. On 9/12/05 at 1:34 p.m., Dietary Employee #2 was in the dish machine room washing dishes in a pan of soapy water. The employee emptied leftover food from the plates into the trash can, placed a rack of dirty dishes into the dish machine, picked up a water hose from the floor and used it to add more water to the pan of soapy water. She rinsed and transferred more dishes into the dish racks, then pushed the racks into the dish machine. Without washing her hands, she began to stack clean dishes and clean utensils, with her fingers touching the insides of the plates and the tips of the utensils. d. On 9/12/05 at 4:15 p.m., Dietary Employee #3 was wearing gloves on both hands. The employee picked up a pan from a rack and placed it on the counter by the stove. She picked up a knife from the middle compartment of the	F 371		

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F 371	Continued From page 42 three-compartment sink, which had wet, loose food particles on the bottom surface. She used the knife to open a box of beef patties. Without changing gloves, she removed beef patties from the box and placed them in a pan to be cooked for the lunch meal. e. On 9/12/05 at 4:45 p.m., Dietary Employee #3 used a spatula to separate raw meat then used the same spatula to scrape cooked food into pans to be placed on the steam table for the evening meal. When the employee was informed by the Surveyor, the employee stated, "I took the wrong spatula."	F 371		
F 426 SS=D	483.60(a) PHARMACY SERVICES - PROCEDURES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure medications were available to be administered as ordered and failed to ensure physician orders were accurately transcribed to subsequent months' physician order sheets and Medication Administration Records for 1 (Resident #8) of 10 case mix residents who resided on the 200 Hall and had physician orders for medications (Residents #6 through #9, #11, #13, #17, #22, #23 and #25). The failed practice had the potential to affect 50	F 426		

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residents who resided on the 200 Hall, as documented on the Roster Matrix provided by the Administrator on 9/12/05. The findings are:

Resident #8 had diagnoses of Myocardial Infarction and Chronic Obstructive Pulmonary Disease. The Admission Minimum Data Set (MDS) dated 7/1/05 documented the resident was independent in cognitive skills for daily decision-making and had a feeding tube.

a. A physician order dated 6/27/05 documented: "Nitroglycerin 0.4 mg/1HR [milligrams per hour]... Patch (...Transderm-Nitro (10mg/24HR). Apply 1 Patch Every 24 Hours."

1.) The September 2005 Medication Administration Records (MARs) documented that Licensed Practical Nurse (LPN) #1 applied a Nitroglycerin Patch on 9/12/05. The August and September 2005 MARs did not document what time the patches were applied from 8/16/05 through 9/12/05, to ensure the patches were applied every 24 hours as ordered. The administration time for the patches documented: "7-3 [7:00 a.m. to 3:00 p.m. shift]."

2.) On 9/13/05 at 10:45 a.m., the resident was observed during a bed bath. There was a Nitroglycerin Patch on the left side of the resident's chest. The patch was dated 9/11/05. LPN #1 was asked about the discrepancy between the MAR and the date on the patch at this time. The LPN stated, "I am waiting for the patch to come in from the pharmacy. I applied it yesterday and used the last one, then reordered it... I guess I just dated it wrong."

3.) The facility's second floor pharmacy order

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form documented the Nitroglycerin patches were ordered from the pharmacy on 9/13/05.

4.) Nurses' Notes dated 9/13/05 (not timed) documented: "Pt [patient] out of Nitroglycerin patches today, ordered per pharmacy, not delivered yet. [Physician] notified, orders to apply when patch arrives and change the time for application to that time..."

b. The handwritten admission physician orders dated 6/27/05 documented: "Sucralfate (Carafate) Suspension 1 GM [gram] PT [per tube] Q [every] 6 Hours."

1.) The physician order for Carafate was incorrectly transcribed to the July, August and September Physician Orders sheets and Medication Administration Records (MARs) as: "Carafate 1G/10ML [1 gram per 10 milliliters] Liquid 1 CC [cubic centimeter] (1GM) Per Tube Every 6 Hours." Administering only 1 cc of the medication would result in the resident only receiving 10% of the dose ordered by the physician. This incorrectly transcribed order was initialed on the August/September 2005 MAR as administered 4 times daily from 8/16/05 through 9/14/05.

2.) The Pharmacy Label on the resident's bottle of Carafate documented: "Give 1CC Every 6 Hours." The Manufacturer's Label on the bottle of Carafate documented: "1Gm/10ML."

3.) On 9/14/05 at 11:00 a.m., LPN #1 was asked how many cc's of Carafate she administered when passing medications to this resident. The LPN stated, "I give 1 cc of Carafate."

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F 498	Continued From page 45	F 498		
F 498 SS=E	483.75(f) PROFICIENCY OF NURSE AIDES	F 498		

The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and interview, the facility failed to ensure transfers were completed in a manner to prevent potential injury for 1 (Resident #7) of 8 case mix residents who required weight-bearing support during transfers (Residents #6 through #8, #11, #13, #17, #22 and #25). The failed practice had the potential to affect 30 residents who required weight-bearing support during transfers, as identified by the Director of Nursing on 9/15/05. The findings are:

Resident #7 had diagnoses of Hypertension, Diabetes Mellitus and Acute Renal Failure. The Quarterly Minimum Data Set dated 7/11/05 documented the resident was severely impaired in cognitive skills for daily decision-making and totally dependent on the physical assistance of 2 or more persons for transfers.

a. On 9/13/05 at 8:40 a.m., Certified Nursing Assistants (CNA's) #7 and #8 sat the resident up on the side of the bed and positioned themselves on each side of the resident. The CNA's lifted the resident by the axillae and carried the resident from the bed to the chair. They did not support the resident's lower body during the transfer. The resident's full weight was supported by the upper arms and shoulder joints.

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F 498	Continued From page 46 b. On 9/13/05 at 11:10 a.m., CNA's #5 and #6 transferred the resident from the chair to the bed. The CNA's stood on either side of the resident, lifted the resident by the axillae and did not provide any support to the resident's lower body. The resident's full weight was supported only by the upper arms and shoulder joints. c. As of 9/14/05, the Plan of Care dated as reviewed on 8/31/05 did not address the resident's need for assistance with transfers, nor the method of transfer to be utilized to prevent potential injury to the resident.	F 498		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514		

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Based on observation, record review and interview, the facility failed to ensure documentation of the provision of activities and the residents' participation in those activities was completed for 4 (Residents #7, #9, #11 and #22) of 22 case mix residents who resided in the facility at the time of the survey (Residents #1 through #18 and #22 through #25). The failed practice had the potential to affect 109 residents, as documented on the facility's Resident Census and Conditions of Residents form dated 9/15/05. The findings are:

1. On 9/14/05 at 9:00 a.m., the Social Services Director (who was also the acting Activity Director) was asked for activity participation sheets for Residents #1, #2, #3, #4, #6, #8, #10 and #12.

a. On 9/14/05 at 1:50 p.m., the Social Services Director (who is also the acting Activity Director) provided individual activity participation sheets for July, August and September 2005 for the above residents.

b. On 9/14/05 at 3:00 p.m., the Activity Assistant was asked for a list of residents who required in-room activities. The Activity Assistant provided the list as requested and was then asked for activity participation sheets for the residents on the in-room activity list. The Activity Assistant stated the in-room activities were documented by the Social Services Director (SSD).

c. On 9/14/05 at 3:10 p.m., the SSD was asked for activity participation sheets for the residents who required in-room activities, excluding the 8 residents whose documentation had been provided earlier that day. The SSD stated she

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had them all in a book and would go get them. The surveyor accompanied the SSD to her office. The SSD searched for the book, but was unable to locate it. The surveyor then accompanied the SSD to several offices to search for the book, which was never located.

d. On 9/14/05 at 3:45 p.m., the SSD and the surveyor entered an office that had stacks of individual activity participation sheets on the desk. The sheets were all labeled with residents' names, but did not have any activities documented. The SSD looked through all the sheets on the desk and stated, "I thought these were filled out, but I guess they're not." The SSD was asked if the activity sheets for the 8 residents requested earlier were the only residents whose in-room activities had been documented. She stated, "Yes."

2. Resident #7 had diagnoses of Parkinson's Disease and Alzheimer's Dementia. The Quarterly Minimum Data Set dated 7/11/05 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for locomotion and spent no time attending activities.

a. The Plan of Care dated as revised on 8/31/05 documented: "Activities Because of limited time out of bed and mobility limitations, does not routinely attend activity functions... [Goal]: Bedside Program... Offer 1:1 room visits."

b. As of 9/14/05, the facility's Room Visit Schedule did not include this resident's name and the August and September 2005 Group Activity Participation sheets did not document attendance by this resident to any group activities.

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c. On 9/14/05, the SSD was unable to provide an activity participation record for this resident.

3. Resident #9 had diagnoses of Depressive Disorder and Arthritis. The Quarterly Minimum Data Set (MDS) dated 7/24/05 documented the resident was independent in cognitive skills for daily decision-making, spent 1/3 to 2/3 of awake time involved in activities and was totally dependent on staff for locomotion. The Annual MDS dated 1/22/05 documented the resident's activity preferences as cards/other games, music, spiritual/religious activities, watching TV and talking or conversing.

a. As of 9/14/05, the facility's Room Visit Schedule did not include this resident's name and the August and September 2005 Group Activity Participation sheets did not document attendance by this resident to any group activities.

b. On 9/14/05, the SSD was unable to provide an activity participation record for this resident.

4. Resident #11 had diagnoses of Mental Retardation and Seizure Disorder. The Quarterly MDS dated 7/16/05 documented the resident was severely impaired in cognitive skills for daily decision-making, spent no time involved in activities and was totally dependent on staff for locomotion off the unit. The Annual MDS dated 4/15/05 documented the resident's preferred activity settings as the day/activity room and preferred activities included music and watching TV.

a. The facility's Room Visit Schedule listed this resident to receive 1-to-1 (1:1) visits on Tuesdays

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F 514	Continued From page 50 and Thursdays. b. As of 9/14/05, the August and September 2005 Group Participation sheets did not document attendance of any group activities by this resident. c. On 9/14/05, the SSD was unable to provide an activity participation record for this resident. 5. Resident #22 had diagnoses of Depressive Disorder and Diabetes Mellitus. The Admission MDS dated 8/1/05 documented the resident spent more than 2/3 of the time involved in activities and was totally dependent on staff for locomotion off the unit. a. As of 9/14/05, the facility's Room Visit Schedule did not include this resident's name. The August and September 2005 Group Participation sheets documented the resident participated in only 1 activity, "floor visits" on 8/19/05 at 2:00 p.m. b. On 9/14/05, the SSD was unable to provide an activity participation record for this resident.	F 514		