

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

PRINTED: 10/15/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2008
NAME OF PROVIDER OR SUPPLIER LITTLE ROCK HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 5720 WEST MARKHAM LITTLE ROCK, AR 72205		
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F 000	INITIAL COMMENTS	F 000			
F 157 SS=E	<p>Complaint #13956, substantiated, all or in part, with deficiencies cited at F157, F323, and F505.</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:</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>Complaint #13956, substantiated, all or in part, in these findings.</p> <p>Based on record review, and interview, the facility failed to ensure the physician was consulted about lab work that was not completed for 1 (Resident #2) of 5 (Residents #1-5) case mix residents who had orders for laboratory tests. This failed practice had the potential to affect all 117 residents who had orders for laboratory tests according to the census provided by the Administrator on 10/6/08. The findings are:</p> <p>Resident #2 had diagnoses of UTI (urinary tract infection), Dehydration, and Weight Loss. The Annual Minimum Data Set dated 7/11/08 documented the resident was severely impaired in cognitive skills in daily decision making, incontinent of bowel and bladder, and had a feeding tube.</p> <p>a. A "Patient Transfer Form" documented a physician order dated 6/25/08 for "BMP (basic metabolic panel) and CBC (complete blood count) monthly starting 6/30/08."</p> <p>b. The October 2008 Physician Order sheet documented, "Lab orders: CBC, BMP Q (every) month."</p> <p>c. The lab section in the clinical record documented a BMP and Hematology Profile was done on 6/30/08 and 10/3/08. There was no documentation in the clinical record of the lab results for July, August, or September 2008.</p> <p>d. As of 10/7/08, there was no documentation in the nurses' notes that the lab specimens were obtained and sent to the laboratory for processing</p>	F 157			

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F 157	Continued From page 2 for July, August and September 2008. e. As of 10/7/08, there was no documentation on the "Patient Draw Log" for June 2008 to October 2008 requesting the CBC and BMP. f. On 10/7/08 at 10:15 a.m., LPN (Licensed Practical Nurse) #1 was asked for the results of the July, August and September 2008 labs that were ordered monthly for this resident. LPN #1 said, "I think that might be one of them that got missed because of the computer." g. On 10/7/08 at 2:44 p.m. the DON was asked who was responsible for monitoring lab orders, requisitions, and that the labs were done for Resident #2. The DON said, "Actually on Ms. name (Resident #2), it was my fault. I failed to assure the monthly order for lab was carried over so it would be done monthly. I filled out so the first one was done, but I failed to carry it over." She said the original order came from the hospital at re-admit. She said she had done an audit last month, caught that the labs were not being done, made out the proper requisition, but 3 months were missed before I audited. She said LPN #1 will now be monitoring all labs. h. On 10/7/08 at 3:35 p.m. the DON was asked for a copy of where the physician was notified of the labs not being done for July, August and September. The DON stated, "I probably didn't, I probably didn't let him know."	F 157			
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323			

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F 323	Continued From page 3 prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #13956 was substantiated, all or in part, in these findings. Based on observation, record review, and interview, the facility failed to ensure the wheelchair did not tip over when in the locked position, a physical therapy evaluation was completed related to falls and the call light was in reach when in the wheelchair for 1 (Resident #1) of 4 (Residents #1, #2, #3, and #5) case mix residents who were identified as being at risk for falls. These failed practices had the potential to affect 57 residents who were identified as being at risk for falls according to a list provided by the Director of Nursing on 10/8/08. The findings are: Resident #1 had diagnoses of History of Falls, Parkinson's Disease, and Degenerative Joint Disease Involving Multiple Joints. The Annual Minimum Data Set dated 9/1/08 documented the resident was moderately impaired in cognitive skills for daily decision making, had limitation of range of motion of one leg and foot with partial loss of voluntary movement on one leg, had an unsteady gait, and had fallen in the past 30 days. a. An Event Reporting Form dated 8/31/08 at 11:20 a.m. documented the resident was found in the floor, and that the resident stated, "wheelchair wheels don't lock properly." The intervention documented was, "Maintenance to check wheelchair." The Nurse's Note dated 8/31/08 at	F 323			

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F 323	<p>Continued From page 4</p> <p>11:25 a.m. documented, "Staff heard pt. [patient] yelling, 'Help, Help' Upon entering room, staff observed pt. lying flat on back with w/c (wheelchair) at head. Resident stated, 'I fell. The wheels are locked and I still fell...'"</p> <p>b. A Resident Concern or Grievance Form dated 9/3/08 filed by the resident's son documented, "wheels on wheelchair wore out and need to be replaced." Actions taken were documented as, "ordered wheels for chair 9/3/08, " with a note at the bottom of the form documenting, "had to reorder from [name of supplier] on 9-11-08."</p> <p>c. A Physician's Order dated 9/19/08 documented, "PT [Physical Therapy] consult for brand new w/c."</p> <p>d. The Nurse's Note dated 9/20/08 at 2:40 p.m. documented, "Pt's (Patient's) son called wanting to know why her w/c had not been fixed. Attempted to explain to him that the parts for her w/c had been ordered and that we had replaced it with another w/c..."</p> <p>e. A Service Log dated 9/23/08 documented, "Problems [with] chair: good." A handwritten note to the side documented, "Brakes loosening." A summary letter from the supplier for the 9/23/08 visit (sent to the facility on 10/7/08) documented, "Our technicians were in your facility September 23, 2008 in response to the tires that were ordered and would not go on the wheelchair. They were not able to replace the tires. The manufacturer does not have replacement tires that will fit the wheelchair. When inspecting the chair they determined there was not anything structurally wrong with the tires that were on the chair. Any wheelchair with solid rubber tires will</p>	F 323			

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F 323	Continued From page 5 slide on a hard surface if the resident does not use proper sitting technique." f. The Resident Care Plan dated 9/30/08 documented, "Problem:... At risk for falls. Approach:... 7. Keep call light in reach." g. On 10/7/08 at 11:30 a.m., the Physical Therapist (PT) and the Occupational Therapist (OT) were in the resident's room. OT was asked, "Is this the resident's wheelchair?" OT stated, "I've just worked here about a week." Surveyor observed a white identification bracelet affixed to the wheelchair frame on the back of the chair with the resident's name. The wheelchair wheels were slick, and the wheel brakes were in the locked position. The surveyor took 2 fingers of the right hand and pushed on the left handle of the wheelchair. The chair slid forward easily for approximately 10 inches. OT was asked, "Is this chair supposed to do that?" OT stated, "You should lock the wheels." OT was asked, "The wheels are locked. Should the chair do that?" OT stated, "Maybe if there is weight in the chair it won't do that." OT sat in the chair, and the surveyor pushed on the left handle of the wheelchair. The chair moved forward approximately 8 inches. OT was asked, "How much do you weigh?" OT stated, "About 185 pounds." PT stated, "Perhaps if she got into the chair like this," and backed up to the wheelchair, held the arms of the chair and pushed down as PT began to sit down in the wheelchair, the wheelchair tipped forward as it slid backward slightly. PT stated, "Yes, it tipped." OT stated, "Nobody told me about any problem with the wheelchair." No anti-tipping devices were on the wheelchair.	F 323			

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F 323	Continued From page 6 h. On 10/7/08 at 12:49 p.m., the resident was sitting in the wheelchair in the middle of the room. The call light was tied to the side rail against the wall tied in a knot onto the rail, approximately 7 feet away, out of reach of the resident. No staff were present with the resident. i. On 10/7/08 at 2:32 p.m., the Maintenance Director was asked, "Do you keep a log of maintenance requests?" The Maintenance Director stated, "No, a lot of times I'll be on the floor working on an air conditioner and someone will tell me that some brakes need tightening. I just go ahead and do it. I don't write it down." The Maintenance Director was asked, "Is the wheelchair for [the resident] her's or does it belong to the facility?" The Maintenance Director stated, "I don't know." j. On 10/7/08 at 2:35 p.m., the resident's daughter was asked, "Is this wheelchair the resident's property?" The daughter stated, "No, it belongs to the nursing home." k. On 10/8/08 at 10:25 a.m., PT was asked, "Have you received a a referral to evaluate [Resident #1] for a wheelchair?" The order for the PT consult dated 9/19/08 was shown to the physical therapist. The PT stated, "No. I never saw that before. We didn't get an order to do therapy until the resident got out of the hospital." l. On 10/8/08 at 11:50 a.m., Licensed Practical Nurse (LPN) #4 stated, "We have to keep the call light tied to that bedrail because [Resident #1] is afraid that the light will fall to the floor. LPN #4 was asked, "Is the call light in reach when she is sitting in the wheelchair?" LPN #4 stated, "No."	F 323			
F 505	483.75(j)(2)(ii) LABORATORY SERVICES	F 505			

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F 505 SS=D	Continued From page 7 The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Complaint #13956, was substantiated, all or in part, in these finding: Based on record review and interview, the facility failed to ensure laboratory results were promptly communicated to the physician to allow appropriate interventions and treatment in a timely manner for 1 (Resident #1) of 5 (Residents #1-5) case mix residents who had orders for laboratory tests. This failed practice had the potential to affect all 117 residents who had orders for laboratory tests according to the census provided by the Administrator on 10/6/08. The findings are: Resident #1 had diagnosis of Urinary Tract Infection. The Annual Minimum Data Sets dated 9/1/08 documented the resident was moderately impaired in cognitive skills for daily decision making, and was incontinent of urine one time a week or less. a. The Nurses' Progress Note dated 7/15/08 documented, "11-7 (11:00 p.m.-7:00 a.m.). Resident awake @ (at) freq. (frequent) intervals... C/O (complains of) discomfort on urination. Up to BR (bathroom) with assist X (times) 4. Urine cloudy with slight foul odor. P.O. (oral) fluids encouraged. UA (urinalysis) specimen collected for AM lab." b. The Urinalysis dated 7/16/08 documented the	F 505			

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F 505	<p>Continued From page 8</p> <p>resident's urine had 3 + Bacteria (normal range documented as negative) and 50-75 White Blood Cells (normal range documented as none seen). The lab sheet had a hand written note that documented, "Faxed 7/17/08. Refaxed 7/25/08". There was no order in the medical record for this urinalysis.</p> <p>c. The Physician's progress note dated 7/17/08 documented, "...Plan: Follow: No lab this week..."</p> <p>d. The Nurse's Progress note dated 7/22/08 for the time period 7/16/08 through 7/22/08 documented, "... Medication Changes: No med change in last 7 days... Abnormal Lab Results: None..."</p> <p>e. A Physician's Order dated 7/25/08 documented, "U/A + C&S (Culture and Sensitivity)." The Urinalysis dated 7/25/08 documented the resident's urine had 4 + bacteria (normal range documented as negative) and TNTC (too numerous to count) White Blood Cells (normal range documented as 0-5). The lab sheet had a hand written note that documented, "Faxed 7/30/08." The fax stamp at the top of the laboratory form documented that the urinalysis was faxed to the facility on 7/26/08. The physician was not faxed the urinalysis results for 4 days. There was no culture and sensitivity report in the medical record for this specimen.</p> <p>f. The Nurse's Progress Note dated 7/29/08 for the time period 7/23/08 through 7/29/08 documented, "...Medication Changes: No med change in last 7 days... Abnormal Lab Results: None..."</p> <p>g. The Nurse's Progress Note dated 8/5/08 for</p>	F 505			

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F 505	<p>Continued From page 9</p> <p>the time period 7/30/08 through 8/5/08 documented, "...Medication Changes: No med change in last 7 days... Abnormal Lab Results: None..."</p> <p>h. The Nurse's Notes dated 8/7/08 documented, "...[Physician] [was] notified of resident's daughter concern about lab work. [Physician] ordered UA C&S in AM..." The Physician's Telephone Orders dated 8/7/08 documented, "UA with C&S in am [morning]."</p> <p>i. The Urine Culture report from the sample collected 8/8/08 and reported on 8/10/08 documented that the resident's urine contained Escherichia Coli with a colony count greater than 100,000. The hand written note on the bottom of the report documented, "Faxed 8/11/08."</p> <p>j. The Physician's Telephone Orders dated 8/12/08 documented, "Cipro 250 mg 1 tab (tablet) po (by mouth) x 10 days." Antibiotic therapy was started 29 days after the onset of symptoms on 7/15/08.</p> <p>k. On 10/8/08 at 9:43 a.m., the Director of Nursing (DON) was asked, "The urinalysis you received on 7/26/08 was not faxed until 7/30/08. Why did the facility wait 4 days before faxing that abnormal result to the physician?" The DON stated, "I look at the labs and then take them to the nurse. They fax it to the doctor. I don't know why the 4 days."</p> <p>l. On 10/8/08 at 10:20 a.m., the resident's physician was asked, "Does the facility follow up faxes with a phone call?" The physician stated, "Sometimes the charge nurse or [DON] will. I make a decision on whether the resident has</p>	F 505			

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F 505	<p>Continued From page 10</p> <p>symptoms or not before I treat it." The physician was asked, "Even with 4+ bacteria?" The physician stated, "I would normally treat that... I would wait for the culture and sensitivity report before I would treat it... Anytime I order a urinalysis it comes with a culture and sensitivity. There's no use getting a urinalysis without a culture and sensitivity."</p> <p>m. On 10/8/08 at 11:15 a.m., the DON was asked, "The lab ordered on 7/25/08 was for a urinalysis with a culture and sensitivity. Was a culture and sensitivity done on that sample?" The DON stated, "Yes, there was." The DON was asked, "Is there a copy of that on the chart." The DON stated, "I'll call the lab and see where it is." The DON produced a copy of the culture and sensitivity from the sample on 7/25/08 that documented that the resident had greater than 100,000 colony forming units of Escherichia Coli in the urine. The DON was asked, "Was this report communicated to the physician?" The DON stated, "I don't know."</p> <p>n. On 10/8/08 at 11:50 a.m., Licensed Practical Nurse (LPN) #4 was asked, "When you have a lab that you fax, how do you make sure it went through OK?" LPN #4 stated, "The fax will give a message that it was sent." LPN #4 was asked, "If there is no action or orders from the physician, what do you do?" LPN #4 stated, "Most of the time we call the doctor's office. We may be waiting on the culture and sensitivity to come through, and it may be that I forgot it. Like [Resident #1's] [lab]. We may have been waiting for the culture and sensitivity and by the time they notice that there hasn't been a report, the lab may have thrown out the specimen." LPN #4 was asked, "Do you have a system to make sure the</p>	F 505			

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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		
(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 505	Continued From page 11 lab is reported to the doctor?" LPN #4 stated, "I don't believe we need a system. We're just supposed to know. I sometimes leave lab out on my desk and ask the next day if they got any orders." o. The policy "Test Results" provided by the DON on 10/8/08 at 12:00 p.m. documented, "Policy statement: The resident's attending physician will be notified of the results of diagnostic tests. Policy Interpretation and Implementation:... 2. Should the test results be provided to the facility, the attending physician shall be promptly notified of the results. 3. The director of nursing services, or charge nurse receiving the test results, shall be responsible for notifying the physician of such test results..."	F 505			