

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

PRINTED: 08/20/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>08/07/2008</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW REHABILITATION &amp; HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 BARROW ROAD LITTLE ROCK, AR 72204</b>
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{F 000}	INITIAL COMMENTS	{F 000}		
{F 157} SS=D	<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: REWRITTEN DEFICIENCY</p>	{F 157}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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>Based on record review and interview, the facility failed to ensure the physician was immediately consulted and the family immediately notified regarding a change in condition for 1 (Resident #3) of 12 case mix residents (Residents #1 through #12). The failed practice had the potential to affect all 96 residents, as documented on the Resident Census and Conditions of Residents form dated 8/7/08. The findings are:</p> <p>Resident #3 had diagnoses of Alzheimer's Disease and Cerebrovascular Accident. The Significant Change Minimum Data Set (MDS) dated 7/24/08 documented the resident was moderately impaired in cognitive skills for daily decision making, totally dependent on staff for activities of daily living, had an indwelling catheter, was monitored for an acute medical condition and received oxygen therapy.</p> <p>a. The Care Plan dated 6/6/08 documented: "Cognitive impairment... Goal - Will have no decrease in level of consciousness or functional level... Approaches - ...assess change in level of consciousness... Note changes and notify MD [Medical Doctor] as needed."</p> <p>b. Nurses' Notes dated 7/21/08 at 6:37 p.m. documented: "Wound infection first dose [antibiotic] given will monitor for sign of adverse reaction."</p> <p>c. Nurses' Notes dated 7/22/08 at 2:52 a.m. documented: "Patient lethargic this shift. Had difficulty taking medications. Difficult to arouse. V/S [vital signs] monitored fluids encouraged will continue to monitor. BP [blood pressure] 99/72, pulse 90, respirations 18, temperature 96.9 [degrees Fahrenheit]." There was no</p>	{F 157}			

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{F 157}	Continued From page 2  documentation the physician was consulted at this time regarding the resident's lethargy and difficulty swallowing medications. There was no documentation the resident's family was notified of the change in condition.  d. Nurses' Notes dated 7/22/08 at 2:54 a.m. documented: "Resident had difficulty swallowing meds [medications]. Lethargic throughout shift. Difficult to arouse. Will continue to monitor." There was no documentation the physician was consulted at this time regarding the resident's continued lethargy and difficulty swallowing medications. There was no documentation the resident's family was notified.  e. Nurses' Notes dated 7/22/08 at 5:39 a.m. documented: "Refused - Levothyroxine Sod [sodium] 100 mcg [microgram] tab [tablet] unable to wake resident to take medication." There was no documentation the physician was consulted at this time regarding the inability to wake the resident for medication administration.  f. Nurses' Notes dated 7/22/08 at 10:56 a.m. documented: "Held Lomotil tab 2.5 mg [milligrams] d/t [due to] lethargic continue to observe physician called. On antibiotic for wound infection. Adverse reaction none noted at this time just started last night. Continue to monitor fluids encouraged." This was a period of approximately 8 hours after Nursing staff identified and documented the resident's lethargy and difficulty taking medications.  g. Nurses' Notes dated 7/23/08 at 2:40 p.m. documented the physician ordered a hospice consultation.	{F 157}			
{F 282}	483.20(k)(3)(ii) COMPREHENSIVE CARE	{F 282}			

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{F 282} SS=E	Continued From page 3 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: REWRITTEN DEFICIENCY  Based on observation, record review and interview, the facility failed to ensure the physician's plan of care was implemented for the following: One (Resident #5) of 6 case mix residents with physician orders for blood glucose testing (Residents #1, #4, #5, #6, #8 and #10). One (Resident #12) of 1 case mix resident with physician orders for pulse checks prior to medication administration. One (Resident #1) of 1 case mix resident with a physician orders for positioning devices. The failed practices had the potential to affect 36 residents with physician orders for blood glucose testing, 14 residents with physician orders pulse checks prior to medication administration and 57 residents with physician orders for positioning devices, as documented by the Director of Nursing on 8/12/08. The findings are:  1. Resident #5 had a diagnosis of Diabetes Mellitus. The Annual Minimum Data Set (MDS) dated 7/4/08 documented the resident had modified independence in cognitive skills for daily decision making and had Diabetes Mellitus.  a. A physician order dated 2/5/08 documented:	{F 282}			

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{F 282}	<p>Continued From page 4</p> <p>"Accu-checks [blood glucose testing] Monday &amp; [and] Thursday 0730 [7:30 a.m.] diabetes... [for results less than] 60 or [greater than] 300 call MD [Medical Doctor]..."</p> <p>b. Nurses' Notes dated 7/31/08 at 5:49 p.m. documented: "Chemstrip result: 359." There was no documentation the physician was notified of the blood glucose result greater than 300, as ordered by the physician.</p> <p>c. On 8/7/08 at 8:30 a.m., the Administrator stated there was no documentation the physician was notified of the blood glucose result on 7/31/08.</p> <p>2. Resident #12 had diagnoses of Hypertension, Chest Pain and Coronary Artery Disease. The MDS dated 6/30/08 documented the resident had modified independence in cognitive skills for daily decision making, shortness of breath, edema and fell in the past 30 days and in the past 31 to 180 days.</p> <p>a. The August 2008 Medication Administration Record (MAR) documented an order dated 3/5/08 for Lopressor 75 milligram (mg) tablet by mouth (PO) every 12 hours and, "hold if systolic BP [blood pressure] less than 100 or pulse less than 60 a.m. and p.m. [morning and evening]." As of 8/7/08, there was no documentation of the pulse checks prior to Lopressor administration on the August 2008 MAR.</p> <p>b. On 8/7/08 at 11:00 a.m., Licensed Practical Nurse (LPN) #2 was asked about the order to check the resident's pulse prior to Lopressor administration. She stated, "It wasn't done."</p>	{F 282}			

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{F 282}	Continued From page 5 3. Resident #1 had diagnoses of Cerebrovascular Disease and Flaccid Hemiplegia. The Quarterly MDS dated 6/2/08 documented the resident required total assistance with transfers, did not ambulate and had impaired sitting and standing balance.  a. A physician order dated 5/24/08 documented: "Supportive Device: Tray table on W/C [wheelchair] for positioning R/T [related to] sliding down and leaning to side to increase mobility D/T [due to] left side hemiplegia."  b. A Restraint/Positioning Needs Assessment dated 3/31/08 documented: "Restraint/Positioning Equip[equipment] Usage: Lap tray... Reassessed 7/25/08."  c. On 8/4/08 at 4:48 p.m., 8/5/08 at 8:35 a.m., 9:50 a.m., 10:15 a.m. and 12:40 p.m. and 8/6/08 at 10:45 a.m., the resident was sitting in a wheelchair with no lap tray in place.	{F 282}			
{F 309} SS=D	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: REWRITTEN DEFICIENCY  Based on observation and record review, the facility failed to ensure an indwelling catheter was	{F 309}			

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{F 309}	Continued From page 6 properly secured and handled to prevent pulling and potential trauma to the urinary meatus for 1 (Resident #11) of 2 (Residents #4 and #11) case mix residents with indwelling catheters. The failed practice had the potential to affect 3 residents with indwelling catheters, as documented on the Resident Census and Conditions of Residents form dated 8/7/08. The findings are:  Resident #11 had a diagnosis of Senile Dementia. The Quarterly Minimum Data Set dated 7/10/08 documented the resident required extensive assistance with all activities of daily living and had an indwelling catheter.  a. A physician order dated 3/11/08 documented: "...indwelling catheter 16 fr [French]/10 cc [cubic centimeter bulb]..."  b. On 8/5/08 at 9:25 a.m., the resident was transferred from a wheelchair to bed by Certified Nursing Assistants (CNA's) #2 and #3. There was a leg band on the resident's left thigh under which the catheter was positioned. The Y-port at the proximal end of the catheter was positioned below the catheter strap, therefore the catheter was able to slide up and down beneath the leg strap as the resident was moved. The catheter bag contained approximately 500 cc of dark brownish urine. As CNA #2 was releasing the sling from the hooks of the hydraulic lift, CNA #3 was attempting to place the catheter bag into a privacy bag under the bed frame near the foot of the bed, causing the catheter to stretch and become taut and elongated. When the Surveyor informed the CNA that the catheter tubing was being pulled, the CNA moved the privacy bag to the bed rail in the middle of the bed and placed	{F 309}			

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{F 309}	Continued From page 7	{F 309}			
{F 323}	the catheter bag into it.				
SS=E	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 prevent accidents.  This REQUIREMENT is not met as evidenced by: REWRITTEN DEFICIENCY  Based on observation, record review and interview, the facility failed to ensure potentially hazardous prescription medications were not left in accessible areas of resident rooms for 2 (Residents #6 and #13) of 13 case mix residents (Residents #1 through #13). The facility also failed to ensure fall prevention interventions were evaluated and revised when found to be ineffective for 1 (Resident #10) of 4 case mix residents with physical restraints in use (Residents #6, #7, #9 and #10). The failed practices had the potential to affect 14 residents who resided on the 300 and 400 Halls and were confused and independently mobile, as identified by the Administrator on 8/7/08 and 9 residents with physical restraints in use, as documented on the Resident Census and Conditions of Residents form dated 8/7/08. The findings are:  1. Resident #6 had diagnoses of Dementia with Behaviors. The Minimum Data Set (MDS) dated 5/29/08 documented the resident was moderately impaired in cognitive skills for daily decision	{F 323}			

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{F 323}	Continued From page 8 making and had short and long term memory problems.  a. A physician order dated 7/2/08 documented the resident was to receive Restasis 0.05% Ophthalmic emulsion 1 drop to each eye twice daily (bid).  b. The 2005 Physician's Desk Reference (PDR) documented potential adverse reactions to Restasis included ocular burning, conjunctival hyperemia, discharge, epiphora, eye pain, foreign body sensation, pruritus, stinging and visual disturbance.  c. On 8/6/08 at 10:15 a.m., the resident was sitting in a wheelchair in his room with the overbed table positioned over his lap. An open, full vial of Restasis ophthalmic solution was sitting on the left side of the resident's overbed table. Licensed Practical Nurse (LPN) #1 was informed. At 10:25 a.m., LPN #1 entered the resident's room and stated, "It was from the night nurse. He gets it at 6:00 a.m. and 21:00 [9:00 p.m]."  2. Resident #13 had a diagnosis of Delusional Disorder. The Quarterly Minimum Data Set (MDS) dated 6/6/08 documented the resident was moderately impaired in cognitive skills for daily decision making, had short and long term memory problems and required supervision with transfers.  a. The Plan of Care dated 6/28/08 documented: "Cognitive impairment... constantly moving about the room... she looks for things..."  b. On 8/4/08 at 4:46 p.m., the resident was sitting on the side of the bed. A 1000 cubic centimeter	{F 323}			

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{F 323}	<p>Continued From page 9</p> <p>(cc) bottle of approximately 300 cc of clear fluid sat on an overbed table on the opposite side of the room. The pharmacy label on the bottle documented, "Clorpactin 2 gm [gram] vial, refrigerate, discard after 8/5/08." There were no staff members in the room or in the hallway near the room. Two residents were in the hall self-propelling their wheelchairs and one resident was ambulating in the hallway near the resident's door.</p> <p>c. On 8/4/08 at 4:49 p.m., Licensed Practical Nurse (LPN) #1 was asked to come into the room, then was asked about the bottle of Clorpactin solution. LPN #1 stated, "She was doing treatments and left it in here." LPN #1 removed the bottle.</p> <p>d. On 8/5/08 at 9:10 a.m., LPN #1 stated, "The solution [from Resident #13's room] was discarded yesterday as it had not been refrigerated. The treatment had been done at 3:00 p.m."</p> <p>e. The Material Safety Data Sheet provided by a local pharmacy on 8/6/08 documented: "Clorpactin... First Aid Measures: Inhalation: Remove to fresh air, seek medical attention if irritation develops. Skin: Wash affected areas with copious amounts of water, seek medical attention if irritation develops. Eyes: Flush eyes with water for 15 minutes. Seek medical attention if irritation persists. Intake: Seek medical attention..."</p> <p>3. Resident #10 had diagnoses of Senile Dementia and Organic Brain Syndrome. The Quarterly Minimum Data Set dated 6/10/08 documented the resident was severely impaired</p>	{F 323}			

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{F 323}	<p>Continued From page 10</p> <p>in cognitive skills for daily decision making, required extensive assistance with transfers, was non-ambulatory and had a chair that prevented rising in use daily.</p> <p>a. A physician order dated 1/7/08 documented: "Supportive Device: Lap buddy when in w/c [wheelchair] D/T [due to] inability to ambulate alone due to unsteadiness due to dementia."</p> <p>b. A Physical Restraint Consent Form dated 2/6/08 documented: "Lap buddy D/T increase confusion and unsteady gait."</p> <p>c. The Plan of Care dated 3/4/08 documented: "Noncompliance related to dementia/poor cognition. Noncompliance with physicians orders/care. Removal of Lap Buddy... Approaches - Notify family of noncompliance. Continue to remind resident of need to be compliant with care/orders... Potential for falls/injury... decline in cognitive status, unsteady gait, forgetfulness... Observe, record and report all unsafe conditions and situations... Monitor closely..."</p> <p>d. A Physical Restraint Reduction Assessment form dated 6/25/08 documented the resident was not a candidate for reduction or elimination due to, "Client has had two incidents of 'found on floor' in last 30 days audit - cont[continue] to have lap buddy r/t [related to] poor judgement/dementia."</p> <p>e. On 8/5/08 at 10:30 a.m., the resident was sitting in a wheelchair in his room. The Velcro on the left side of the lap buddy was unfastened from the wheelchair arm and the left side of the lap buddy was pulled up and out of the chair. There was no staff in the room. LPN #3 entered and</p>	{F 323}			

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{F 323}	<p>Continued From page 11</p> <p>re-attached the lap buddy to the chair then wheeled the resident toward the Nurses' Station and told another nurse the resident was removing his lap buddy. They discussed applying a chair alarm.</p> <p>f. On 8/5/08 at 10:45 a.m., LPN #3 stated the physician's nurse had been notified regarding the resident removing his lap buddy. A Physician's Telephone Order dated 8/5/08 at 11:55 a.m. documented: "Therapy to screen R/T taking off Lap tray."</p> <p>g. On 8/5/08 at 12:45 p.m. and 1:00 p.m., the resident was sitting in the wheelchair with a lap buddy in place. There were no other safety devices attached to the wheelchair.</p> <p>h. An Occupational Therapy (OT) Screen dated 8/6/08 and signed by the Occupational Therapist documented: "Nursing stated pt [patient] been unsafe in w/c [wheelchair], frequently attempting to go take off lap buddy. Skilled OT to assess for w/c safety."</p> <p>i. On 8/6/08 at 9:10 a.m., the resident was sitting in a wheelchair with the lap buddy on. No other safety devices/alarms were attached to the wheelchair.</p> <p>j. On 8/7/08 at 8:35 a.m., the resident was sitting in a wheelchair with the lap buddy in place. The resident was pulling at the Velcro. There were no other safety devices attached to the resident's wheelchair.</p> <p>k. On 8/7/08 at 11:20 a.m., the Occupational Therapist stated she had, "Screened him yesterday and will evaluate him today and put an</p>	{F 323}			

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

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{F 323}	Continued From page 12 alarm in his chair."  I. On 8/7/08 at 3:10 a.m., the Occupational Therapist showed the Surveyors a new evaluation which documented: "Pt [patient] attempts to take off lap buddy. Care plan nurse and hall nurse personally informed about change to self releasable seatbelt chair alarm with sensor pad today." The facility continued to utilize the lap buddy for a period of approximately 5 months after the problem regarding the resident's removal of the lap buddy was documented on the Care Plan and a period of 2 days after LPN #3 observed the resident removing the lap buddy.	{F 323}			
F 363	483.35(c) MENUS AND NUTRITIONAL ADEQUACY  Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the planned, written menu was followed to ensure nutritional needs were met for 2 (Residents #6 and #7) of 12 case mix residents who received meals from the kitchen (Residents #1 through #12). The failed practice had the potential to affect 90 residents who received meals from the facility kitchen, as documented on a list provided by the Administrator on 8/7/08 at 2:45 p.m. The findings are:	F 363			

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F 363	<p>Continued From page 13</p> <p>1. Resident #7 had diagnoses of Diabetes Mellitus and Dementia. The Annual Minimum Data Set (MDS) dated 7/3/08 documented the resident was moderately impaired in cognitive skills for daily decision making, had short and long-term memory problems, required limited assistance with eating and received a mechanically altered diet.</p> <p>a. A physician order dated 7/26/07 documented: "Diet: Regular - pureed."</p> <p>b. The Plan of Care dated 2/4/08 documented: "...Provide ordered diet... hx [history] of weight loss..."</p> <p>c. The written menu for the 8/5/08 regular, pureed lunch meal documented: "Barbecued chicken, baked beans, potato salad, bread, margarine, frosted brownie..."</p> <p>d. On 8/5/08 at 12:35 p.m., the resident was served pureed barbecue chicken, pureed baked beans, pureed bread and one margarine. Certified Nursing Assistant (CNA) #1 sat by the resident for the meal and stated, "He got no dessert."</p> <p>e. On 8/5/08 at 12:45 p.m., a 4-ounce cup of wild berry Magic Cup was placed on the resident's table. The resident did not receive the pureed potato salad or a pureed brownie on his tray, even after the missing items were brought to the attention of the facility staff.</p> <p>2. Resident #6 had diagnoses of Diabetes Mellitus and Dementia with Behaviors. The MDS dated 5/29/08 documented the resident was moderately impaired in cognitive skills for daily</p>	F 363			

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F 363	Continued From page 14 decision making and required extensive assistance with eating.  a. A physician order dated 7/2/08 documented the resident was to receive a low concentrated sweets with ground meat diet.  b. The written menu for the 8/5/08 low concentrated sweets dinner meal documented: "Tomato soup, Grilled Cheese Sandwich, Saltine Crackers, Baked Apples, Coffee or Tea and Milk."  c. On 8/5/08 at 5:22 p.m., the resident did not receive baked apples on his meal tray. CNA #4 was asked about the resident's dessert and stated, "He didn't get it."	F 363			
{F 502} SS=E	483.75(j)(1) LABORATORY SERVICES  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by: REWRITTEN DEFICIENCY  Based on record review and interview, the facility failed to ensure laboratory services were provided in accordance with the physician's order for 2 (Residents #1 and #5) of 12 case mix residents with physician orders for laboratory services (Residents #1 through #12). The failed practice had the potential to affect all 96 residents with physician orders for laboratory services, as identified by the facility on 8/7/08. The findings are:	{F 502}			

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{F 502}	<p>Continued From page 15</p> <p>1. Resident #5 had a diagnosis of Congestive Heart Failure. The Minimum Data Set (MDS) dated 7/4/08 documented the resident had modified independence in cognitive skills for daily decision making.</p> <p>a. A physician order dated 6/3/08 documented: "Digoxin 0.125 mg [milligrams] tab [tablet] Lanoxin PO [by mouth] QD [every day]."</p> <p>b. A physician order dated 6/11/08 documented: "Digoxin level q [every] 30 days."</p> <p>c. On 8/7/08 at 9:35 a.m., Licensed Practical Nurse (LPN) #1 was asked for the July 2008 Digoxin level. The results were not documented anywhere in the clinical record. LPN #1 telephoned the laboratory then stated, "It was not done for July."</p> <p>3. Resident #1 had diagnoses of Anemia and Cardiovascular Disease.</p> <p>a. A Physician's Telephone Order dated 7/14/08 documented: "Guaiac stool X [times] 2 for occult blood... Anemia."</p> <p>b. On 8/5/08 at 11:40 a.m., LPN #1 stated there were no results for the stool specimens. She stated, "We were not sending them out at that time and they were not done in the facility." She stated she would call the doctor to have the order discontinued.</p> <p>c. As of 8/6/08, there was no documentation that the stool specimens ordered by the physician had been collected or Guaiac tested for occult blood.</p>	{F 502}			