

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

PRINTED: 05/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045371	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/09/2008
NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHAB, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 802 S WEST END STREET SPRINGDALE, AR 72764	
(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 157	<p>483.10(b)(11) NOTIFICATION OF CHANGES</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the physician was consulted regarding pressure ulcers, ostomy care and pain management during treatments for</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>1 (Resident #3) of 2 (#3 and #7) case mix residents who required pressure ulcer and ostomy care. This failed practice had the potential to affect 29 residents in the facility who required wound care, according to a list provided by the Administrator on 5/8/08. The findings are:</p> <p>Resident #3 had diagnoses of Quadriplegia, Feeding Jejunostomy (J) - Tube and Brain Damage. An admission Minimum Data Set (MDS) dated 3/28/08 documented the resident had severely impaired cognitive skills for daily decision making, required total assistance by staff for activities of daily living, had moderate pain less than daily related to joints and soft tissue (lesion/muscle), had 1 stage II and 2 stage IV pressure ulcers and required ostomy care.</p> <p>1. Admission Physician orders dated 3/11/08 documented "Cleanse J-tube site and Colostomy with WC [wound cleanser]. Apply Drainage sponge. Secure with tape. Change Q [every] day and PRN [as needed]."</p> <p>a. The Treatment Administration Record (TAR) from 3/11/08 through 4/5/08 documented the treatment was provided daily. On 4/6/08 an "H" was documented on the TAR indicating the resident was hospitalized.</p> <p>b. A Nurses Note dated 4/21/08 documented the resident was re-admitted to the facility. "Skin is pale, moist, warm [with] non-healing PU's [pressure ulcers] noted to coccyx [and] right lateral ankle - also has duoderm to bilat[eral] hips [with] intact skin underneath - Res[ident] has... jejunostomy tube..." There were no physician's orders for ostomy care or treatment to the right hip and right ankle pressure ulcer.</p>	F 157			

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F 157	Continued From page 2 c. As of 5/6/07, there was no documentation the Physician was consulted regarding treatment orders for the J-tube/G-tube site or sites on the right hip and right ankle. There were no treatments documented for these sites on the Treatment Administration Record (TAR). 2. A physicians's order dated 3/11/08 documented Oxycodone 20 mg/ml- [milligrams/milli-liters] give 0.5 ml per tube every 4 hours-pain. The last documentation the medication was administered was dated 4/5/08. a. A readmission Nurses Note dated 4/21/08 documented, "Family states res[ident] is in pain daily, and requires routine pain med[ication]." The Oxycodone was not on the readmission orders dated 4/21/08. b. On 5/7/08 at 10:45 a.m., the treatment nurse conducted a body audit in the presence of the Director of Nurses (DON) and Assistant DON. The resident moaned as he was turned and repositioned during the body audit. Tears were running down the right cheek. The ADON asked the resident as she rolled him toward her "Are you hurting?" and said "I'm sorry." The surveyor asked the ADON if she thought he felt pain. The ADON stated, "Yes." The surveyor asked what was done for the pain. The ADON stated, "He gets scheduled pain medication." c. As of 5/7/08, there was no documentation the physician was consulted regarding the resident's pain management regimen.	F 157			
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any	F 221			

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F 221	<p>Continued From page 3</p> <p>physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure restraints were evaluated and assessed for reduction or elimination for 1 (Resident # 9) of 3 case mix residents (Resident # 1, 5, and 9) who were restrained. This failed practice had the potential to affect 9 residents with physicians orders for restraints, according to list provided by the facility on 5/9/08. The findings are:</p> <p>Resident #9 had diagnoses of Cerebrovascular Accident, Parkinson's Disease and Depression. A Quarterly Minimum Data Set dated 4/24/08 documented the resident had long and short term memory problems, was moderately impaired in cognitive skills for daily decision making, required total assistance for transfer and locomotion, did not walk, had sustained a fall in the past 31 - 180 days and had used a limb restraint daily for the past 7 days. No other type of restraint was checked.</p> <p>a. A physician order dated 12/22/06 documented, "1. PT [physical therapy] screen for positioning device [secondary to] frequent falls and for lack of safety awareness [due to] dementia. 2. Apply Lap Buddy when [up] in wc [wheelchair]."</p> <p>b. A "Pre-Restraining Assessment" dated 12/22/06 documented, "Medical Symptoms warranting use of restraint: Poor safety awareness R/T [related to] Dementia." The</p>	F 221			

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F 221	Continued From page 4 section of the form titled "Referral to physical or occupational therapy was checked "Yes... Recommendations: Screen d/t [due to] poor safety awareness frequent falls." There was no documentation any other interventions were attempted prior to the use of restraints. c. A "Physical Restraint Consent and Acknowledgment" form dated 12/22/06 documented "lap buddy." The section "Understanding Restraint Use" documented, "Physical restraints are any manual method, material equipment attached or adjacent to the resident body that the individual cannot remove easily and that restricts freedom of movement or normal access to the resident's body." In answer to a question on the form "How will the use of this device improve the resident's ability to function?" The answer was documented as, "improve safety awareness." d. The facility's "Physical Restraint Reduction Assessment" documented, "Assess resident response to use of restraint monthly for the first 90 days following initiation of restraint device. Thereafter reassess the continuing need for restraint on admission, readmission, and at least quarterly or with change of condition. Document Interdisciplinary Team [IDT] conclusion regarding the need for a change in restrain device or the initiation of restraint reduction or elimination in the appropriate section on the back of this form." e. A "Physical Restraint Reduction Assessment" dated 4/17/07 documented the resident was non-ambulatory, wheelchair mobile with assist, had normal sitting balance, was combative/severely agitated without provocation and currently took antidepressants. In the section	F 221			

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F 221	<p>Continued From page 5</p> <p>titled, "Unusual occurrences" none were checked. "Candidate for restraint reduction or elimination: No... If 'No' indicate specific reason: IDT Assessment Indicates: Current interventions successful. No falls past 3 mos [months]." There was no documentation any attempts at reduction or elimination had been planned or attempted.</p> <p>f. A "Physical Restraint Reduction Assessment" completed on 9/15/07 documented the resident was non-ambulatory, wheelchair mobile with assist, leaned to side, forward or backward, exhibited/expressed fears or anxieties and currently took antidepressants. In the section titled "Unusual occurrences none were checked. The form documented "IDT Assessment Indicates: Candidate for restraint reduction or elimination: No." The form documented, "If 'No' indicate specific reason: The IDT team deems this restraint necessary for safety unable to reduce at this time." There was no documentation an attempt at reduction or elimination had been attempted or planned.</p> <p>g. The resident's Plan of Care dated 4/7/07 and reviewed/revised by the facility on 7/5/07, 10/08/07 and 3/05/08 documented, "Resident is a risk for loss of dignity due to use of physical restraints. Approaches: Continue to evaluate to make certain the least restrictive restraint is used, Restraint: Lap buddy when in w/c [wheelchair] due to increase falls and poor safety awareness." No plan for a gradual reduction or elimination of the lap buddy had been developed.</p> <p>h. The facility's policy and procedure "General Guidelines for the Use of Physical Restraints" documented, "Purpose: The purpose of these physical restraint guidelines is to ensure each</p>	F 221			

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F 221	Continued From page 6 resident attains and maintains his/her highest practicable well being in an environment... General Guidelines: ...Restraint use is temporary... The need for restraints will be reevaluated on admission, readmission and with a change of condition as well as at least quarterly to determine if continued restraint use is necessary to treat the medical symptoms." i. On 5/06/08 at 8:30 a.m., 12:10 p.m. and 5:15 p.m., the resident was sitting in her wheelchair in the dining room with lap buddy in place. On 5/07/08 at 8:32 a.m. the resident was in her room sitting in the wheelchair with a lap buddy on. j. On 5/08/08 at 3:20 p.m., the Director of Nursing was asked the reason the resident had a lap buddy since 12/06. She looked in the chart and stated the consultant said she thought it was more an enabler due to the resident leans in the chair. k. On 5/08/08 at 3:20 p.m., the facility was asked if there had been any reduction or elimination attempts. As of 5/8/08 none were provided.	F 221			
F 282 SS=B	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 of the 4:00 p.m. medication pass on 5/5/08 and the 8:00 a.m. medication pass on 5/6/08 and record review, the facility	F 282			

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F 282	Continued From page 7 failed to ensure the physician's plan of care was implemented for 1 of 1 case mix resident (Resident #10) who received an inhaler. The findings are: Resident #10 had a physician order dated 12/27/07 for Advair 250/50 1 puff twice a day (bid) "rinse mouth after administration". a. On 5/5/08 at 3:54 p.m. LPN #1 had the resident inhale from the Advair 250/50 and stated, "Take a big drink." She did not instruct the resident to spit the water out. b. The manufacturer's package insert on "How to Use Your Advair Diskus" documented "Rinse your mouth with water after breathing-in the medicine. Spit the water out. Do not swallow".	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 assess and obtain physicians orders for treatment of a Jejunostomy tube (J-tube) site and a Gastrostomy tube (G-tube) site for 1 (Resident #3) of 2 (#3 and #7) case mix residents who required tube feedings. The facility failed to assess pain and provide pain management during treatment procedures for 1	F 309		

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F 309	<p>Continued From page 8</p> <p>(Resident #3) of 2 (#3 and #8) case mix residents who exhibited signs of pain. The facility failed to ensure Foley catheter tubing was secured to prevent trauma to the urinary meatus or dislodgement for 1 (Resident # 8) of 3 case mix residents (Resident # 3, 7 and 8) who had indwelling catheters. These failed practices had the potential to affect 3 facility residents who required tube feedings, 8 residents on pain management programs and 5 residents with catheters, as documented on the Resident Census and Conditions of Residents report dated 5/5/08. The findings are:</p> <p>Resident #3 had diagnoses of Dysphagia, Feeding Tube and Brain Damage. The admission Minimum Data Set (MDS) dated 3/28/08 documented the resident had severely impaired cognitive skills for daily decision making, short/long term memory problems, required total care by staff for all activities of daily living, had moderate pain less than daily related to joints and soft tissue (lesion/muscle), had 1 stage II and 2 stage 4 pressure ulcers and had a feeding tube.</p> <p>1. The admission Physician's orders dated 3/11/08 documented "Cleanse J-tube site, Colostomy with WC [wound cleanser]. Apply Drainage sponge. Secure with tape. Change Q [every] day and PRN [as needed]."</p> <p>a. The Treatment record dated April 2008 documented "Treatment: Cleanse J-tube site and Colostomy with WC apply Drainage sponge. Secure with tape. Change Q day and PRN." This was initialed as provided daily from 4/1/08 through 4/5/08. On 4/6/08 an "H" was entered indicating the resident was hospitalized.</p>	F 309		

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F 309	<p>Continued From page 9</p> <p>b. A Discharge Summary from the hospital and dated 4/21/08 documented a diagnosis of Methicillin Resistant Staphylococcus Aureus Sepsis. The summary documented the resident had a Percutaneous Endoscopic Gastrostomy (PEG) tube placed on a previous admission. At a later date he was sent to a hospital in Little Rock and a Jejunostomy tube (J-tube) was placed... The discharge summary documented, "He does have frequent stools associated with this. Infectious disease [department] entertained the thought of doing a diverting colostomy to help prevent further contamination of wound. This may be considered at a later date."</p> <p>c. According to the discharge summary, the resident had a Jejunostomy feeding tube and a gastrostomy stoma site. The resident did not have a colostomy. There were no re-admission orders for care of the J-tube and G-tube sites.</p> <p>d. On 5/7/08 at 11:11 a.m., the J-tube site had a saturated brown/red drainage on the 4x4 sponge. The surveyor asked when the dressing was changed. The treatment nurse stated, "I can't tell you. There is no date." The surveyor asked the treatment nurse to describe the site. The treatment nurse stated, "There is an odor, brown, wet and a little blood." The G-tube site was covered with a 4x4 sponge dressing with no date. The 4x4 had bloody, serosanguinous drainage and dried formula. The surveyor asked how often this should be changed. The treatment nurse stated, "Every shift and PRN." The surveyor asked when was the last time it was changed. The treatment nurse stated, "I don't know."</p> <p>e. As of 5/6/07 there was no documentation the facility had obtained physician's orders for care</p>	F 309			

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F 309	<p>Continued From page 10 and treatment of the J-tube or G-tube sites. There were no treatments documented on the Treatment Administration Record.</p> <p>2. A physicians's order dated 3/11/08 documented Oxycodone 20 mg/ml- [milligrams/milli-liters] give 0.5 ml per tube every 4 hours-pain. The last documentation the medication was administered was dated 4/5/08.</p> <p>a. A readmission Nurses Note for Resident #3 dated 4/21/08 documented "Family states res[ident] is in pain daily, and requires routine pain med[ication]". The Oxycodone was not on the readmission orders dated 4/21/08.</p> <p>b. A physician's order dated 4/21/08 documented "Tylenol 500 mg per J-tube PRN every 4 hours for pain." As of 5/7/08 at 11:15 am the Medication Administration Record documented the last dose of Tylenol was initialed as given at 8:00 am on 4/28/08.</p> <p>c. On 5/7/08 at 10:45 a.m., the treatment nurse conducted a body audit in the presence of the Director of Nurses (DON) and Assistant DON. The resident moaned as he was turned and repositioned during the body audit. Tears were running down the right cheek. The ADON asked the resident as she rolled him toward her "Are you hurting?" and said "I'm sorry." The surveyor asked the ADON if she thought he felt pain. The ADON stated, "Yes". The surveyor asked what was done for the pain. The ADON stated, "He gets scheduled pain medication."</p> <p>d. As of 5/7/08 there was no documentation the physician was consulted regarding the resident's pain management regimen.</p>	F 309			

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F 309	Continued From page 11 3. On 5/8/08 at 8:10 a.m., the DON was interviewed as follows: a. The DON was asked who supervised and monitored wound treatments and pain management. The DON stated, "The treatment nurse and me". The DON was asked who should consult the physician for pain management and wound care. The DON stated "The treatment nurse". b. On 5/8/08 at 8:10 a.m., the DON was asked why she was not aware there were no orders/treatments for wound care or pain management for this resident. The DON stated, "He [the treatment nurse] was using standing protocol orders. He was not documenting and he was not calling the physician so we wouldn't know it. I can't answer why he didn't know better". c. On 5/8/08 at 8:10 a.m., the DON was asked who supervised and monitored treatments to ensure they were done. The DON stated, "The treatment nurse and me". d. On 5/8/08 at 8:10 a.m., the DON was asked why she was not aware there were no orders/treatments for the stoma sites on this resident. The DON stated, "He [the treatment nurse] was using standing protocol orders and not calling the physician so we wouldn't know it.. I can't answer why he didn't know better." 4. Resident #8 had diagnoses of Hypotension, Decubitus Ulcers, Gastroesophageal Reflux Disease (GERD), Failure to Thrive and Quadriplegia. A Quarterly Minimum Data Set dated 5/4/08 documented the resident had modified independence in cognitive skills for daily	F 309			

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F 309	Continued From page 12 decision making, required total assistance with all ADL's (activities of daily living) and had an indwelling catheter. a. A physician's order dated 9/07/08 documented, "Foley Catheter: Supra Pubic Foley Monitor Q [every] shift..." b. The resident's Plan of Care documented "ADL Standard Care Plan: Resident requires assist with ADLs because of Quadriplegia, Toileting: Foley Care PRN [as needed]." c. On 5/7/08 at 12:00 p.m., the resident's catheter was not secured with a leg strap or by any other means to prevent potential dislodgement and trauma to the site. At the tubing insertion site was reddish/brown drainage. d. The facility's policy and procedure, "Foley Catheter Care..." documented, "Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh)."	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 that all soiled areas of skin were cleansed and free of feces	F 312			

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F 312	<p>Continued From page 13</p> <p>during incontinent care for 1 (Resident #5) of 6 (Residents #2, #3, #5, #6, #7 and #9) case mix residents who were incontinent of bowel and bladder and dependent on staff for incontinent care. The failed practice had the potential to affect 45 residents who were dependent on staff for incontinent care, as documented on the Resident Census and Conditions of Residents form dated 5/5/08. The findings are:</p> <p>Resident #5 had a diagnosis of Urinary Retention. The Quarterly Minimum Data Set (MDS) dated 3/6/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance for toilet use and was incontinent of bowel and bladder.</p> <p>a. On 5/6/08 at 9:10 a.m. during incontinent care, the resident was rolled to the right side. Certified Nursing Assistant (CNA) #5 cleansed the resident's groin area. The CNA did not separate and cleanse between the labia. The CNA cleaned feces from the anal area and turned the resident to the left side, leaving feces on the right lateral side of the resident's thigh and buttock, where the feces had smeared from the brief under the resident. The CNA did not roll the resident back to the right to see if she was clean. The CNA placed a clean brief on the resident and stated she was finished.</p> <p>b. The facility's Policy and Procedure for Perineal Care documented: "Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent skin infections and/or irritation, and to observe the resident's skin condition... For a female resident: ...1) Separate labia and wash area downward from front to back... 2) Continue to wash the perineum moving</p>	F 312			

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F 312	Continued From page 14 from inside outward to and including thighs, alternating from side to side... 4) gently dry perineum..."	F 312		
F 314 SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to assess, monitor, obtain physician orders for treatment and failed to provide a protein/calorie supplement to promote healing of identified pressure ulcers as recommended by the Registered Dietitian for 1 (Resident #3) of of 3 (#1, #3 and #8) case mix residents with pressure ulcers. The facility also failed to conduct treatments as ordered for 1 (Resident #8) of of 3 (#1, #3 and #8) case mix residents who had pressure ulcers. These failed practices had the potential to affect 11 residents in the facility who had pressure ulcers, according to the Administrator on 5/8/08. The findings are: 1. Resident #3 had diagnoses of Decubitus Ulcer, Quadriplegia and Brain Damage. An admission Minimum Data Set (MDS) dated 3/28/08 documented the resident had severely impaired cognitive skills for daily decision making, was totally dependent on staff for all activities of	F 314		

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F 314	<p>Continued From page 15</p> <p>daily living, had a feeding tube and one stage II and two stage 4 pressure ulcers.</p> <p>a. A hospital discharge summary dated 4/21/08 documented the resident was admitted to the hospital on 4/6/08 and was discharged on 4/21/08.</p> <p>b. Nurses notes dated 4/21/08 at 1:00 p.m. documented the resident was readmitted to the facility from the hospital where he was treated for Pneumonia, Sepsis and Methicillin Resistant Staphylococcus Aureus in a pressure ulcer. The nurses note documented the resident had a non-healing pressure ulcer to the coccyx and the right lateral ankle and "duoderm to right and left hips with the skin intact underneath".</p> <p>c. A statement received from the treatment nurse on 5/8/08 documented "On 4/21/08 I performed a body audit on [the resident]. I found a pressure ulcer to resident's coccyx [with] wound vac in place [and] functioning. I found a pressure ulcer to resident's left hip that was healed. I found a pressure ulcer to residents [right] hip with dressing in place. Pressure ulcer to [right] ankle [with] dressing intact. Healed pressure ulcer noted to [right] lateral foot. ... [no] other skin issues noted at this time."</p> <p>d. An Admission Nursing Assessment dated 4/21/08 documented PU [pressure ulcer] indicating the coccyx and right ankle on a diagram. There were no measurements or descriptions of the lesions. The section titled "Comments" documented "please see TAR (Treatment Administration record] for full body assessment". There were no treatment orders for the pressure sores on the right ankle or hip.</p>	F 314			

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F 314	<p>Continued From page 16</p> <p>There was no documentation of an assessment or treatment orders for the right hip or right ankle on the April 2008 TAR.</p> <p>e. Readmission Physician orders dated 4/21/08 documented a treatment to the coccyx. There were no treatment orders for the pressure sores on the right hip or right ankle.</p> <p>f. The weekly Skin Audit records dated 4/21/08, 4/22/08, 4/23/08, 4/24/08 and 4/29/08 signed by the treatment nurse documented Pressure Ulcers on the right hip, the right ankle and the coccyx. As of 5/7/08 there were no descriptions, staging or measurements of the lesions for the right hip or the right ankle.</p> <p>g. A statement dated 5/7/08 and signed by the Assistant Director of Nursing (ADON) documented "On 5/5/08 a body audit was done on res[ident]. Upon doing the audit a dressing was noted on [right] foot, this was not removed [at] this time. There was another dressing to [right] hip that was intact, this was also not removed".</p> <p>h. On 5/7/08 at 8:00 a.m. Certified Nursing Assistants (CNA) #3 and #4 were providing care. A CombiDERM dressing to the right hip had no date and the gauze bandage to the right ankle was dated 4/30/08.</p> <p>i. On 5/7/08 at 9:45 a.m., the treatment nurse was asked about the undated dressing to the right hip. The treatment nurse stated, "I think that is changed 3 times a week. He was asked about the dressing to the right ankle dated 4/30/08. The treatment nurse stated "I didn't see the date. It's a stage II and also changed 3 times a week".</p>	F 314			

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F 314	Continued From page 17 j. On 5/7/08 at 9:45 a.m., the treatment nurse was asked to check his Medication Administration Record and Treatment Administration Record (MAR/TAR). The treatment nurse looked and stated "It's not on my treatment record for the right hip or the right ankle". He stated, "I use the standing order protocol for these treatments." k. As of 5/7/08 at 9:45 a.m., there were no treatment orders for the pressure sores to the right hip or right ankle. l. On 5/7/08 at 10:50 a.m., the treatment nurse removed the CombiDERM dressing on the right hip. When the the gauze bandage on the right ankle was removed there was an undated CombiDERM dressing beneath. The dressings were saturated with exudate from the wounds. The Treatment Nurse crumpled and opened the dressings repeatedly as he described the drainage. Wearing the same gloves he patted both sides of his uniform looking for a measuring device. He contaminated each wound by using the same transparent measurement guide to measure each wound. He did not change his soiled gloves between touching and measuring each wound. After measuring each lesion he documented his findings on a Body Audit Sheet. He did not change gloves between treatments to 3 open pressure ulcers and 2 stoma sites. 1). A reddened area on the right hip measured 3 centimeters (cm) by 2.4 cm with an excoriated center measuring 1 cm by 1 cm. The treatment nurse stated it was a stage II. 2). A gauze dressing saturated with brown drainage and dated 4/30/08 was removed form	F 314		

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F 314	<p>Continued From page 18</p> <p>the right ankle. The pressure sore measured 2.1 cm by 2 cm pink wound bed serosanguinous drainage. The treatment nurse stated it was a stage II.</p> <p>m. On 5/8/08 at 8:10 a.m., the DON was asked who supervised and monitored pressure ulcers and wound treatments. The DON stated, "The treatment nurse and me". The DON stated, "The treatment nurse is supposed to give us a weekly skin report and I get it for daily stand up". She was asked why she was not aware there were no physicians orders for treatments. She stated, "He was using standing protocol orders and not calling the physician so we wouldn't know it... I can't answer why he didn't know better".</p> <p>o. A Registered Dietician's (RD) progress note dated 4/24/08 documented "Has been in hospital. Continues multiple pressures ulcers. Recommend adding Arginaide and Glutamine for wound healing.. This will also add approx[imately] 200 K-calories and 34 grams of protein. Monitor as necessary".</p> <p>1). As of 5/7/08, the RD recommendations were not documented on the April or May 2008 MAR.</p> <p>2). On 5/7/08 at 1:10 p.m., Licensed Practical Nurse (LPN) #7 was asked if she gave the Arginaide and Glutamine. She looked at her MAR and stated, "It's not written on my MAR and I have not given it."</p> <p>3). On 5/7/08 at 1:12 p.m., the DON stated, "The RD and I go over her recommendations. I never saw it. This was missed".</p> <p>2. Resident # 8 had a diagnosis of Multiple Decubitus Ulcers, Failure to Thrive and</p>	F 314			

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F 314	<p>Continued From page 19</p> <p>Quadriplegia. A Quarterly Minimum Data Set dated 5/4/08 documented the resident had modified independence in cognitive skills for daily decision making, required total assistance with all activities of daily living and had two stage IV pressure sores.</p> <p>a. A physician's order dated 5/5/08 documented, "Clean #1 wound to R [right] buttock [with] w/c [wound cleaner] and pat dry. Apply premoistened Aquacel and cover [with] CombiDERM drsg [dressing] QD [every day] and PRN [as needed]." The same order was written for wound # 2, 3, 4, 5, and left lateral ankle.</p> <p>b. The facility's Weekly Pressure Ulcer Records dated 5/5/08 documented wound #1 was a stage III pressure ulcer to the right buttock; #2 was a stage III pressure ulcer to the left buttock; #3 was a stage III pressure ulcer to the left buttock; #4 was a stage III pressure ulcer on the left buttock; #5 was a stage IV pressure ulcer on the right buttock and a stage III pressure ulcer on the left lateral ankle.</p> <p>c. On 5/07/08 at 12:00 p.m., all the dressings on pressure ulcers # 1 through 5 and the left lateral ankle were initialed and dated 5/5/08.</p> <p>d. On 5/07/08 at 12:10 p.m., the treatment nurse was asked when the resident's dressings were supposed to be changed. He stated. "We change dressing three times a week, Monday, Wednesday and Friday. The nurse was asked whose initials were on the dressing and he stated "I think the initials are [the DON's]."</p> <p>e. On 5/07/08 at 12:30 p.m., the Director of Nursing stated she had done a body audit,</p>	F 314			

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F 314	Continued From page 20 measured all the wounds and applied new the dressings on Monday (5/5/08). She confirmed the initials were hers.	F 314		
F 322 SS=E	f. As of 5/7/08 at 12:00 p.m., the treatments to the 6 pressure ulcers had not been done since 5/5/08. The treatments were ordered daily. 483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure tube feedings were administered continuously as prescribed by the physician for 2 of 2 case mix residents (Resident # 3 and 7) who had feeding tubes. The facility failed to ensure the head of the bed (HOB) remained elevated while feeding was infusing to prevent the potential for aspiration for 1 (Resident # 3) and failed to ensure flushes were performed as prescribed by the physician before and after administration of medication for 2 (Resident # 3 and #7) of 2 case mix residents (Resident # 3 and 7) who received formula and medications via a feeding tube. This failed practice had the potential to affect 3 residents in the facility who had feeding tubes, as documented on the Resident Census and Conditions of Residents form provided by the Director of Nursing on	F 322		

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F 322	Continued From page 21 5/5/08 at 4:00 p.m. The findings are: 1. Resident #7 had a diagnosis of Cerebral Vascular Accident (CVA). A Physician's order dated 4/2/08 documented: "Speech Therapy to treat 5 times a week for 5 weeks to address speech/language and swallowing dysfunction." The Minimum Data Set (MDS) dated 4/29/08 documented the resident had a problem with short term memory, was moderately impaired in cognitive skills for daily decision making, had a feeding tube and received 76%-100% calories through tube feedings. a. The May 2008 Physician Orders documented, "Glucerna 75cc [cubic centimeters] Q [every] hour per peg [percutaneous endoscopic gastrostomy] tube to be administered via pump to provide 1800 Cal [calories]/1800cc [cubic centimeters] Q [every] day." b. On 5/5/08 at 4:39 p.m. during the 5:00 p.m. medication pass, the feeding tube had been disconnected. Certified Nurse Aide (CNA) #6 stated the resident and his wife told him to disconnect the tube feeding and CNA # 6 disconnected it. c. On 5/8/08 at 2:37 p.m. during an interview, the Director of Nursing [DON] was asked if CNA's were trained to disconnect tube feedings. The DON stated, "No." d. On 5/8/08 at 3:00 p.m., CNA # 6 was asked if he was trained by the facility to disconnect Tube Feedings. He stated, "No I haven't - the resident and his wife wanted me to disconnect it, so I did." e. The resident had a physician's order dated	F 322			

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F 322	<p>Continued From page 22</p> <p>5/5/08 to flush peg tube with 90 milliliters (ml) of water before and after medications.</p> <p>1) On 5/5/08 at 5:03 p.m., Licensed Practical Nurse (LPN) #2 stated as she looked at the Medication Administration Record (MAR), "The resident is to receive 90 ml before and after meds and 250 ml flush."</p> <p>2) On 5/5/08 at 5:07 p.m. during the 5:00 p.m. medication pass, LPN #2 administered two 60 ml syringes for a total of 120 ml before meds and four 60 ml syringe for a total of 240 ml of water after meds.</p> <p>2. Resident #3 had diagnoses of Feeding J-tube (Jejunostomy tube) and Brain Damage. The Admission Minimum Data Set (MDS) dated 3/28/08 documented the resident had severely impaired cognitive skills for daily decision making, had short/long term memory problems, required total care by staff for all activities of daily living and required a feeding tube.</p> <p>a. Physician orders dated 4/21/08 documented: "Flush with 60cc of H2O [water] before and after meds [medication]."</p> <p>b. On 5/6/08 at 11:45 am, LPN #1 during medication administration used an Asepto syringe to draw up 60 cc's of H2O and flushed the tube, then drew up another 30 cc's of H2O and flushed the tube. LPN #1 stated, "[I'm] going to flush with 90 cc's of H2O before and after his medications. LPN #1 administered the resident's medication and repeated this process for a 90 cc flush after the medications.</p>	F 322		

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F 322	<p>Continued From page 23</p> <p>c. On 5/6/08 at 12:15 pm, the surveyor asked LPN #1 to look at her MAR. LPN #1 looked at the MAR and stated, "Oh, I flushed with 90 cc's instead of 60 cc's of H2O. How bad of an error is that?"</p> <p>d. On 5/5/08 at 2:57 p.m., the resident was in bed. Osmolyte tube feeding at 70 cc's an hour was on via pump.</p> <p>e. On 5/5/08 at 2:57 p.m., 2 CNA's (#1 and #2) were observed raising up the head of the bed (HOB). CNA's #1 and #2 stated, "We just turned him." The surveyor asked the steps they used to turn the resident. CNA #1 stated, "We lowered the head of the bed to turn and reposition him."</p> <p>f. On 5/8/08 at 10:00 a.m., during an interview, CNA #3 was asked what she was taught about care with residents who had tube feedings by pump. CNA #3 stated, "Head of the bed up at all times if the pump is on. I know to turn it off if I lower the head of the bed."</p> <p>g. Physician orders dated 4/21/08 documented the following: "Osmolyte 1.5 Cal at 70 cc/HR [cubic centimeters per hour] per J-tube to be administered via pump."</p> <p>1) On 5/6/08 at 10:40 a.m. and at 11:40 a.m., the resident was observed in bed. The tube feeding pump was turned off.</p> <p>2) On 5/6/08 at 11:45 a.m., LPN #1 entered the room. LPN #1 was asked about the pump in the off position. LPN #1 turned the pump on and stated, "Someone must have turned it off."</p> <p>3) On 5/6/08 at 12:30 p.m. during further</p>	F 322			

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F 322	Continued From page 24 interview, LPN #1 stated, "I remember now, I did turn the pump off and forgot to turn it back on."	F 322			
F 329 SS=D	483.25(I) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure a Histamine (H2) Antagonist was not administered for longer than 12 weeks without documentation of a clinical rationale for 1 of 1 (Resident # 8) case mix resident with a physician's order for Pepcid. This failed practice had the potential to affect 14 facility residents who	F 329			

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F 329	Continued From page 25 received an H2 Antagonist, as identified by the facility on 5/8/08. The findings are: Resident # 8 had a diagnosis of Gastroesophageal Reflux Disease (GERD). a. A physician's order dated 9/18/07 documented, "Pepcid (Famotidine) 20 mg [milligrams] PO [by mouth] BID [twice a day]." b. The Medication Administration Records through May 8, 2008 documented the Pepcid was administered twice daily as ordered. c. As of 5/08/08, there was no documentation in the clinical record of a rationale or medical symptom that warranted the continued use of Pepcid, an H2 Antagonist. d. The Lexi-Comp's Drug Information Handbook for Nursing, 8th edition copyright 2007 documented on pages 498 - 499, "Famotidine, U.S. brand name Pepcid... Pharmacologic Category... Histamine H2 Antagonist... Dosing - Adults and Elderly: GERD: Oral: 20 mg twice daily for 6 weeks."	F 329		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the 4:00 p.m. medication pass on 5/5/08 and the 8:00 a.m. medication pass on 5/6/08, record review and interview, the facility failed to ensure that the medication error	F 332		

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F 332	<p>Continued From page 26</p> <p>rate was less than 5%. Physicians orders were not followed for 2 residents (Residents #7, and #11) of 9 residents observed during the medication passes, which resulted in medication errors. Medication errors were made by 3 Licensed Practical Nurses (LPN's #1, #2, and #3) of 3 licensed nurses observed administering medications in the facility. This practice has the potential to affect 73 residents in the facility according to the Administrator on 5/5/08. The medication error rate was 13.043% based on observation of 45 medications administered, 1 medication ordered but not administered and a total of 6 medication errors detected. The findings are:</p> <ol style="list-style-type: none"> 1. Resident #7 had a physician order dated 5/4/08 for Lactobacillus 2 capsules (caps) via percutaneous endoscopic gastrostomy (peg) tube twice daily (bid). <ol style="list-style-type: none"> a. On 5/5/08 at 4:58 p.m., LPN #2 stated as the medications were set up for the resident, "I don't know why it says 2 caps, so I'll pour out 2 capfuls." The LPN poured from a bottle labeled Lactulose 10 grams/15 milliliter (ml). b. LPN #2 administered Lactulose 10 grams/15 ml 2 capfuls (7.5 ml) instead of the Lactobacillus 2 capsules. c. This resulted in 2 errors. 2. Resident #11 had a physician order dated 9/13/07 for Artificial Tears 2 drops both eyes every shift. <ol style="list-style-type: none"> a. On 5/5/08 at 5:33 p.m. during the 5:00 p.m. medication pass LPN #2 administered Refresh 	F 332			

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F 332	Continued From page 27 Tears 1 drop in both eyes. b. According to the facility's stock bottles Artificial Tears contained Polyethylene Glycol and Polyvinyl Alcohol. The Refresh Tears contained Carbomethylcellulose Sodium. c. This resulted in 2 errors. 3. Resident #11 had a physician order dated 9/13/07 for Artificial Tears 2 drops both eyes every shift. a. On 5/6/08 at 8:43 a.m. during the 8:00 a.m. medication pass, LPN #3 administered Refresh Tears 2 drops in both eyes without waiting any time between drops. b. According to the facility's stock bottles Artificial Tears contained Polyethylene Glycol and Polyvinyl Alcohol. The Refresh Tears contained Carbomethylcellulose Sodium. c. On 5/6/08 at 11:20 a.m., the surveyor asked LPN #3, "Did you give 1 or 2 drops to the resident?" LPN #3 stated, "Two drops." The surveyor asked, "Did you wait any time between drops?" LPN #3 stated, "I didn't think you had to, with the same kind." d. According to the Centers for Medicare and Medicaid Services (CMS) Interpretive Guidelines: "Medications instilled into the eye, the drop must contact the eye for a sufficient period of time before the next eye drop is instilled. The time for optimal eye drop absorption is approximately 3 to 5 minutes. (It should be encouraged that when the procedures are possible, systemic effects of eye medication can be reduced by	F 332			

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F 332	Continued From page 28 pressing the tear duct for approximately three minutes after the administration)."	F 332			
F 428 SS=D	e. This resulted in 2 errors. 483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure the Pharmacist Consultant identified extended use of greater than 12 weeks for the drug Pepcid for 1 (Resident #8) of 1 case mix resident with a physician order for Pepcid. This failed practice had the potential to affect 14 residents who received an H2 (Histamine) Antagonists, as identified by the facility on 5/8/08. The findings are: Resident #8 had a diagnosis of Hypotension, Gastroesophageal Reflux Disease (GERD), Failure to Thrive and Quadriplegia. The Quarterly Minimum Data Set dated 5/4/08 documented the resident had modified independence in cognitive skills for daily decision making and required total assistance with all activities of daily living. a. A physician's order dated 9/18/07	F 428			

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F 428	Continued From page 29 documented, "Pepcid (Famotidine) 20 mg [milligrams] PO [by mouth] BID [twice a day]." b. The Lexi-Comp's Drug Information Handbook for Nursing, 8 th edition copyright 2007 documented on pages 498 - 499, Famotidine, U. S. brand name Pepcid, in the section for Pharmacologic Category " Histamine H2 Antagonist" and "Dosing - Adults and Elderly: GERD: Oral: 20 mg twice daily for 6 weeks." c. As of 5/8/08, the Medication Administration Records documented the Pepcid was administered as twice a day as ordered. d. As of 5/08/08, there was no documentation in the clinical record of a diagnosis or medical symptoms for the continued use of Pepcid, an H2 Antagonist. e. As of 5/8/08 the "Consultant Pharmacy Monthly Chart Review had not addressed the continued use of the Pepcid.	F 428			
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced	F 441			

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F 441	<p>Continued From page 30</p> <p>by:</p> <p>Based on observation, record review and interview, the facility failed to ensure treatments were conducted in a manner to prevent cross contamination or spread of infection for 2 (Resident #3 and 8) of 2 (#3 and #8) case mix residents who required treatments. This failed practice had the potential to affect 11 residents in the facility who required treatments, according to the Administrator on 5/8/08. The findings are:</p> <p>1. Resident #3 had diagnoses of Feeding J-tube and Brain Damage. An admission Minimum Data Set (MDS) dated 3/28/08 documented the resident had severely impaired cognitive skills for daily decision making, had short/long term memory problems, required total care by staff for all activities of daily living, had 1 stage II and 2 stage 4 pressure ulcers, had a feeding tube and required ostomy care.</p> <p>a. Nurses notes dated 4/21/08 at 1:00 p.m. documented the resident was readmitted to the facility from the hospital where he was treated for Pneumonia, Sepsis and Methicillin Resistant Staphylococcus Aureus in a pressure ulcer. The nurses note documented the resident had a non-healing pressure ulcer to the coccyx and the right lateral ankle and "duoderm to right and left hips with the skin intact underneath".</p> <p>The Admission physician orders dated 4/21/08 documented diagnoses of MRSA and Sepsis of Decubitus ulcers.</p> <p>b. On 5/7/08 at 10:50 am, a body audit was conducted by the treatment nurse. The DON and ADON were present. The resident had 3 pressure sores and a stoma site. After he</p>	F 441			

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F 441	<p>Continued From page 31</p> <p>removed the dressings on the right hip and right ankle, the dressings were saturated with exudate from the wounds. The Treatment Nurse crumpled and opened the dressings repeatedly as he described the drainage. After removing the dressing from the residents right ankle and he looked at it, he then laid the soiled dressing on top of the incontinent pad. The LPN Treatment Nurse patted both sides of his uniform with his soiled gloves looking for a measuring device. He contaminated each wound by using the same transparent measurement Guide to measure each wound. He did not change his soiled gloved between touching and measuring each wound. He documented on a Body Audit Sheet after each measurement with the same soiled gloves. He then removed the 4x4 sponge dressings from around the resident's stoma sites and palpated the sites with the same soiled gloves.</p> <p>c. As of 5/7/08, there was no documentation in the clinical record that the resident was free of MRSA since he was readmitted from the hospital. There was no documentation the facility had consulted with the physician regarding the need for infection control precautions.</p> <p>d. The facility Policy and Procedure for MRSA documented the following: "When a resident is diagnosed with an antibiotic resistant organism..., Standard and contact Isolation Precautions must be implemented. The infection control coordinator must be notified when a resident is diagnosed with an antibiotic resistant organism to ensure that appropriate and current Centers for Disease Control guidelines are implemented".</p> <p>e. The resident was not on any isolation precautions during the survey. On 5/7/08 the</p>	F 441			

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F 441	<p>Continued From page 32</p> <p>facility was asked for documentation the resident did not need isolation precautions. On 5/8/08 at 9:30 a.m. the facility obtained a faxed copy of the hospital discharge summary dated 4/22/08 that documented "Discharge Diagnoses 1. Methicillin-resistant Staphylococcus Aureus (MRSA) sepsis." Handwritten on the side of the Summary was documented, "Colonized, known. . . 5/8/08."</p> <p>f. On 5/8/08 at 10:35 a.m. the Administrator was asked, "How did you determine the resident did not need to be in isolation for the MRSA?" She stated, "I think he came here with a history of MRSA." The DON stated, "No, this hospital stay he was in the hospital and had antibiotics for MRSA." The Administrator was asked, "Had you asked the doctor if the resident was colonized before yesterday?" she stated, "No."</p> <p>2. Resident #8 had a diagnosis of Hypotension, Decubitus Ulcers, Gastroesophageal Reflux Disease (GERD), Failure to Thrive and Quadriplegia. The Quarterly Minimum Data Set dated 5/4/08 documented the resident had modified independence for cognitive skills for daily decision making, required total assistants with all ADL (activities of daily living) had an indwelling Catheter, and had decubitus ulcers.</p> <p>a. On 5/07/08 at 12:00 p.m., the treatment nurse began doing a body audit on Resident #8. He washed his hands and applied gloves. He turned the resident onto his left side. He pulled the dressing back with one side still attached to the wrist. He used a transparent measurement sheet and measured the skin tears on the wrist. He then placed the dressing back over the skin tears. He then turned and picked up his ink pen and wrote the measurement down on a piece of</p>	F 441			

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F 441	Continued From page 33 paper. The dressing on the right ankle was done the same way as the wrist. b. The treatment nurse then pulled the right hip dressing back. The dressing was saturated with brown drainage and has soaked through the dressing on to the draw sheet. The wound had a packing which was saturated with brown drainage, he pulled the packing out and held it in his left hand while he measured the wound. After he measured the wound he placed the dressing back over the wound and tried to smooth the dressing down with his hand to secure the tape. He picked up his pen and documented the measurements on the paper. c. The nurse wore the same soiled gloves and used the same transparent measuring sheet for the next 4 pressure sore treatments. Each time he measured he documented his measurements without changing gloves.	F 441			
F 502 SS=D	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: Based on record review and interview, the facility failed to ensure a potassium level was obtained as ordered by the physician for 1 (Resident # 8) of 9 (Residents #1 through #9) case mix residents. This failed practice had the potential to affect all 73 facility residents, according to the Resident Census and Condition of Residents dated 5/5/08. The findings are:	F 502			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045371	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/09/2008
NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHAB, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 802 S WEST END STREET SPRINGDALE, AR 72764		
(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 502	Continued From page 34 Resident #8 had diagnoses of Hypotension, Decubitus Ulcers and Hyperkalemia. 1. A physician order date 2/26/08 documented, "Decrease K CL [potassium chloride] to 10 meq [milliequivalents] PO [by mouth] BID [twice a day], check K+ [potassium] in 2 weeks." 2. On 5/8/08 at 2:25 p.m., the Administrator was asked for the potassium laboratory results but could not provide the results and stated, "We can do a stat one (potassium level) now."	F 502			