

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

PRINTED: 08/10/2006
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 C 07/27/2006
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 000	INITIAL COMMENTS	F 000			
F 156 SS=C	<p>Complaints #11779 and #11793 were unsubstantiated.</p> <p>Complaint #11490 was substantiated (all or in part) with deficiencies cited at F312 and F314.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during</p>	F 156			
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 156	<p>Continued From page 1</p> <p>the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and</p>	F 156			

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F 156	<p>Continued From page 2</p> <p>procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure Medicaid and Medicare contact information was posted in the facility. The failed practice had the potential to affect all 65 residents, as identified by the Administrator on 7/24/06. The findings are:</p> <ol style="list-style-type: none"> 1. On 7/25/06 at 10:30 a.m. during the environmental tour, no Medicare/Medicaid contact information was posted in the facility. 2. On 7/25/06 at 11:25 a.m., the Administrator's assistant stated, "Well, they were posted here. I'll 	F 156			

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F 156	Continued From page 3 get a poster and put it back up."	F 156			
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure privacy was provided during perineal care for 1 (Resident #8)	F 164			

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F 164	Continued From page 4 of 10 case mix residents who were dependent on staff for perineal care (Residents #1, #4, #5, #6, #7, #8, #13, #14, #15 and #16), as evidenced by failure to close the privacy curtain when the resident's perineal area was exposed. The failed practice had the potential to affect 49 residents who were occasionally or frequently incontinent of urine, as documented on a list provided by the Director of Nursing (DON) on 7/27/06 at 8:45 a.m. The findings are: Resident #8 had a diagnosis of End Stage Renal Disease. The Minimum Data Set (MDS) dated 4/21/06 documented the resident was moderately impaired in cognitive skills for daily decision-making and required extensive assistance from staff for personal hygiene. a. On 7/25/06 at 9:28 a.m., Certified Nursing Assistants (CNA's) #1 and #3 provided perineal care and urinary catheter care to the resident. The CNA's did not close the privacy curtain. The resident was in the "A" Bed, directly in front of the door. During the procedure, five persons entered the room of the resident and on four of these occasions, the resident was uncovered and the buttocks and perineal area were exposed. b. On 7/27/06 at 8:22 a.m., Licensed Practical Nurse (LPN) #3 (the CNA Training Coordinator) stated, "If the resident was next to the door, we would definitely pull the privacy curtains."	F 164			
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of	F 167			

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F 167	Continued From page 5 correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the long-term care survey results were posted in a location that would be accessible to residents in wheelchairs and were clearly marked. The failed practices had the potential to affect all 65 residents, as documented on the facility's Resident Census and Conditions of Residents form dated 7/24/06. The findings are: On 7/25/06 at 10:30 a.m. during the environmental tour with the facility's Maintenance Supervisor, the results of the most recent long-term care survey were in an unmarked container attached to the wall of the 400 Hall. The container was 67 inches from the floor and was not accessible to residents in wheelchairs. When the Surveyor commented on the location of the survey results, the Maintenance Supervisor stated, "I see what you mean; I'll fix that right now."	F 167			
F 253 SS=C	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253			

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F 253	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure personal care equipment was properly stored and maintained in clean condition and failed to ensure baseboards and air vents were maintained in clean condition. The failed practices had the potential to affect all 65 residents, as identified by the Administrator on 7/24/06. The findings are: 1. On 7/24/06 during the initial tour of the facility, the following observations were made: a. At 4:45 a.m., a bedside commode with dried, brown stains and a fecal odor was in Resident Room 110. b. At 5:12 a.m., a bedside commode in Room 112 had urine (approximately 2 inches deep) in the bottom of the bowl. There was a strong smell of urine in the room. 2. On 7/25/06 during the environmental tour, the following observations were made: a. At 8:05 a.m., 2 cardboard boxes and 2 plastic storage containers were found on the floor of the storage closet on Hall 100. b. At 8:06 a.m., 2 bathpans were in the floor under the sink of Room 101. The air return vent in this room was covered with a thick, fuzzy substance. c. At 8:08 a.m., the air return vent in Room 111 was coated with a fuzzy, brown substance.	F 253			

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F 253	Continued From page 7 d. At 8:09 a.m., there was a build-up of a yellowish substance on the threshold of the 100 Hall whirlpool room. The baseboards that extended the full length of the 100 Hall had a thick build-up of the yellow substance as well. e. At 8:10 a.m., the storage closet of the tub room had 4 empty cardboard boxes on the floor. f. At 8:13 a.m., the 100 Hall bed pan room had 3 boxes on the floor under the sink. g. At 8:14 a.m., an uncovered, unlabeled bedpan was in the floor beside the toilet in Room 111. h. At 8:15 a.m., 7 unlabeled denture cups were on the lavatory and an uncovered bathpan was on the floor in the bathroom of Room 108. i. At 9:32 a.m., a bathpan was on the floor in the bathroom of Room 204. The privacy curtain was 6 inches too short to provide full visual privacy. j. At 9:46 a.m., an unlabeled denture cup was on the bathroom lavatory in Room 401. k. At 9:49 a.m., an unlabeled, uncovered bathpan was on the back of the toilet and 2 unlabeled, uncovered bathpans were on the floor under the sink in Room 408. l. At 9:58 a.m., an unlabeled, uncovered specimen cap was hanging on the towel bar and an unlabeled emesis basin was on the back of the lavatory in the bathroom of Room 305. m. At 10:13 a.m., the baseboards in the main dining room had a build-up of a thick, yellow substance.	F 253			

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F 253	Continued From page 8 n. At 10:14 a.m., 2 lap buddies, a 4-foot length of foam padding and 3 pads were found in the floor of the storage closet next to the main dining room. o. At 10:23 a.m., the North Hall weight room (where residents were weighed) had 4 cardboard boxes on the floor. There were 6 soft drink cans and paper trash on the floor around the trash can. p. At 10:25 a.m., in Room 124, the air return vent was coated with a brown fuzzy substance. The toilet extender in the bathroom had numerous brown stains and a fecal odor was present in the room. q. At 10:27 a.m., the nurse's supply closet on the North Hall had 4 boxes of supplies and 2 bags of oxygen tubing on the floor.	F 253			
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: Based on observation, record review and interview, the facility failed to ensure urinary catheter care was provided in a manner to prevent potential Urinary Tract Infections (UTI's) for 1 (Resident #8) of 4 case mix residents with	F 309			

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F 309	<p>Continued From page 9</p> <p>indwelling urinary catheters (Residents #1, #2, #4 and #8). The failed practice had the potential to affect 6 residents with indwelling urinary catheters, as documented on the facility's Resident Census and Conditions of Residents form dated 7/24/06. The findings are:</p> <p>Resident #8 had diagnoses of End-Stage Renal Disease. The Minimum Data Set dated 6/16/06 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for personal hygiene, incontinent of bowel and bladder and did not have an indwelling urinary catheter.</p> <p>a. On 7/24/06 at 4:28 a.m. during the initial tour of the facility, Licensed Practical Nurse (LPN) #5 stated the resident received dialysis 3 times weekly and had a urinary catheter.</p> <p>b. On 7/25/06 at 9:28 a.m., Certified Nursing Assistants (CNA's) #1 and #3 provided urinary catheter care and perineal care to the resident. CNA #1 used a moistened washcloth and Derma Cens Perineal Foam to cleanse the anterior perineal area appropriately from front to back. The resident was turned to the left side and the buttocks were cleansed from the top of the buttocks down to the vaginal area. There was a large amount of dark brown stool on the washcloth that was used to wipe toward the vagina. The resident was turned to her back. Without opening the resident's legs, the CNA cleansed the urinary catheter from the labia downward. At no time during the cleaning of the urinary catheter, was the labia separated to expose the urethral meatus for cleansing.</p> <p>c. The facility's policy and procedure for Perineal</p>	F 309			

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F 309	Continued From page 10 Care was provided by the Director of Nursing (DON) on 7/26/06 at 4:45 p.m. and documented: "...Separate labia and wash downward from front to back. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches)... wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks."	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: Complaint #11490 was substantiated (all or in part) with these findings. Based on observation, record review and interview, the facility failed to ensure incontinent care was provided for 1 (Resident # 6) of 5 (Residents #7, #14, #15, #16 and #6) case mix residents who were incontinent of urine. The failed practice had the potential to affect 49 residents who were occasionally or frequently incontinent of urine, as documented on a list provided by the Director of Nursing (DON) on 7/27/06 at 8:45 a.m. The findings are: Resident #6 had diagnoses of End-Stage Multiple Sclerosis and Seizures. The Quarterly Minimum Data Set dated 4/27/06 documented the resident had modified independence in cognitive skills for	F 312			

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F 312	<p>Continued From page 11</p> <p>daily decision making, was totally dependent on staff for activities of daily living and was incontinent of urine with multiple daily episodes of incontinence.</p> <p>a. On 7/25/06 at 7:32 a.m. and 9:30 a.m., the resident was sitting in a geri-chair in her room. At 10:45 a.m., the resident was sitting in a geri-chair in activities listening to music and at 12:15 p.m., the resident was back in her room, still sitting in the geri-chair.</p> <p>b. On 7/25/06 at 2:30 p.m., Certified Nursing Assistants (CNA's) #1 and #2 transferred the resident from the geri-chair to bed for incontinent care. When the resident was lifted out of the geri-chair, the incontinent pad underneath the resident was soaked with urine, with brown rings extending from the middle to the outer edges of the incontinent pad. Urine dripped onto the floor from the resident's incontinent brief during the transfer and a strong odor of urine emanated from the resident. The wet brief was removed and the resident's inner and outer labial folds were a bright, deep red. The resident winced each time the washcloth touched her skin during incontinent care. The resident was asked by the Surveyor if the incontinent care was painful. She stated, "Not too much." The resident was asked if her incontinent brief had been changed since she was placed in her geri-chair this morning. She stated, "No, night shift [11:00 p.m. to 7:00 a.m. shift] got me up." CNA's #1 and #2 were asked, "Who was responsible for checking and changing the resident today?" CNA #1 stated she and CNA's #2 and #3 were responsible for the resident's care. When asked if they had changed the resident's incontinent brief, CNA's #1 and #2 both stated, "No."</p>	F 312			

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NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHAB INC			STREET ADDRESS, CITY, STATE, ZIP CODE 802 S WEST END STREET SPRINGDALE, AR 72764		
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F 312	Continued From page 12 c. On 7/25/06 at 2:37 p.m., the Director of Nursing (DON) entered the room to examine the resident's perineal area. The DON was asked if the resident's perineal area was excoriated. The DON stated, "Yes, both sides." d. On 7/25/06 at 2:42 p.m., CNA #3 was asked by the Surveyor if she had checked and changed the resident's incontinent brief that day. CNA #3 stated, "I checked her. She wasn't wet. No, I haven't changed her today."	F 312			
F 314 SS=D	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: Complaint #11490 was substantiated (all or in part) with these findings. Based on observation, record review and interview, the facility failed to ensure incontinent care was provided for 1 (Resident # 6) of 5 (Residents #7, #14, #15, #16 and #6) case mix residents who were incontinent of urine. The failed practice had the potential to affect 49 residents who were occasionally or frequently incontinent of urine, as documented on a list	F 314			

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F 314	<p>Continued From page 13 provided by the Director of Nursing (DON) on 7/27/06 at 8:45 a.m. The findings are:</p> <p>Resident #6 had diagnoses of End-Stage Multiple Sclerosis and Seizures. The Quarterly Minimum Data Set dated 4/27/06 documented the resident had modified independence in cognitive skills for daily decision making, was totally dependent on staff for bed mobility, transfers, toilet use and personal hygiene, was incontinent of bowel and bladder, had no pressure ulcers, had skin that was desensitized to pain or pressure, was on a turning/repositioning program and received preventative or protective skin care.</p> <p>a. The Plan of Care dated as reviewed/revised by the facility on 5/24/06 documented: "...Totally dependent for all ADL's [activities of daily living] d/t [due to] End Stage MS [Multiple Sclerosis] with paralysis/contractures... Uses R [right] arm only... Provide incontinent care x 2 [by 2 staff members] after each episode. Keep [resident] clean, dry and odor free... Do good peri care with skin barrier... Uses geri-chair, needs total assist [assistance] with geri-chair mobility..."</p> <p>b. On 7/25/06 at 7:32 a.m. and 9:30 a.m., the resident was sitting in a geri-chair in her room. At 10:45 a.m., the resident was sitting in a geri-chair in activities listening to music and at 12:15 p.m., the resident was back in her room, still sitting in the geri-chair</p> <p>c. On 7/25/06 at 2:30 p.m., Certified Nursing Assistants (CNA's) #1 and #2 transferred the resident from the geri-chair to bed for incontinent care. When the resident was lifted out of the geri-chair, the incontinent pad underneath the resident was soaked with urine, with brown rings</p>	F 314			

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F 314	Continued From page 14 extending from the middle to the outer edges of the incontinent pad. Urine dripped onto the floor from the resident's incontinent brief during the transfer and a strong odor of urine emanated from the resident. The wet brief was removed and the resident's inner and outer labial folds were a bright, deep red. The resident winced each time the washcloth touched her skin during incontinent care. The resident was asked by the Surveyor if the incontinent care was painful. She stated, "Not too much." The resident was asked if her incontinent brief had been changed since she was placed in her geri-chair this morning. She stated, "No, night shift [11:00 p.m. to 7:00 a.m. shift] got me up." CNA's #1 and #2 were asked, "Who was responsible for checking and changing the resident today?" CNA #1 stated she and CNA's #2 and #3 were responsible for the resident's care. When asked if they had changed the resident's incontinent brief, CNA's #1 and #2 both stated, "No." d. On 7/25/06 at 2:37 p.m., the Director of Nursing (DON) entered the room to examine the resident's perineal area. The DON was asked if the resident's perineal area was excoriated. The DON stated, "Yes, both sides." e. On 7/25/06 at 2:42 p.m., CNA #3 was asked by the Surveyor if she had changed the resident's incontinent brief that day. CNA #3 stated, "No, I haven't changed her today."	F 314			
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible.	F 323			

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F 323	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the environment was free of potential hazards, as evidenced by failure to remove a trash can with sharp, broken edges from the room of 1 (Resident #7) of 17 case mix residents whose rooms were observed (Residents #1 through #16 and #19). The failed practice had the potential to affect 2 residents who resided in Room 117, as observed on 7/25/06 at 10:18 a.m. The findings are: Resident #7 had diagnoses of Alzheimer's Disease and Osteoarthritis. The Minimum Data Set (MDS) dated 7/11/06 documented the resident was severely impaired in cognitive skills for daily decision-making, had periods of restlessness, exhibited wandering behaviors on 1 to 3 of the last 7 days, required limited assistance from staff to walk in the room or corridor, had an unsteady gait and fell in the last 31 to 180 days. a. On 7/24/06 at 4:40 a.m. during the initial tour of the facility, Certified Nursing Assistant (CNA) #4 stated the resident was confused, combative, used a wheelchair for mobility and had a vision problem. b. On 7/25/06 at 10:18 a.m., a trash can in the resident's room was badly chipped, with sharp, broken edges, which represented a potential skin tear risk to the resident.	F 323			
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance	F 324			

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F 324	<p>Continued From page 16 devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure transfer assistance was provided in a manner to prevent potential injury for 1 (Resident #6) of 12 case mix residents who required two-person assistance for transfers (Residents #1 through #8 and #13 through #16). The failed practice had the potential to affect 44 residents who required two-person transfers, as identified by the Director of Nursing (DON) on 7/27/06 at 9:02 a.m. The findings are:</p> <p>Resident #6 had diagnoses of End-Stage Multiple Sclerosis and Seizures. The Quarterly Minimum Data Set dated 4/27/06 documented the resident had modified independence in cognitive skills for daily decision-making, totally dependent on the assistance of 2 staff members for transfers and had full loss of voluntary movement in both arms, hands, legs and feet.</p> <p>a. The Plan of Care dated as reviewed/revised by the facility on 5/24/06 documented: "...Totally dependent for all ADL's [activities of daily living] d/t [due to] End Stage MS [Multiple Sclerosis] with paralysis/contractures, Seizure d/o [disorder] and Arthritis... Uses R [right] arm only... Total assist [assistance] of two or more with all transfers..."</p> <p>b. On 7/25/06 at 2:30 p.m., Certified Nursing Assistants (CNA's) #1 and #2 transferred the resident from the geri-chair to the bed for incontinent care. The CNA's placed a rolled</p>	F 324			

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F 324	Continued From page 17 towel under both knees and one arm under each of the residents axillae and transferred the resident to the bed. This transfer technique placed the resident's full weight upon the shoulder and knee joints.	F 324			
F 328 SS=E	<p>c. On 7/26/06 at 5:00 p.m., the DON was informed of the transfer technique demonstrated by CNA's #1 and #2. The DON stated, "I've never heard of such."</p> <p>483.25(k) SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and record review, the facility failed to ensure oxygen and respiratory equipment was maintained in clean and sanitary condition and properly stored to prevent potential contamination for 5 (Residents #1, #8, #9, #15 and #16) of 6 case mix residents who received respiratory therapy (Residents #1, #2, #8, #9, #15 and #16). The failed practice had the potential to affect 11 residents who received respiratory therapy, as identified by the Director of Nursing on 7/27/06 at 8:45 a.m. The findings are:</p>	F 328			

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F 328	Continued From page 18 1. Resident #1 had a diagnosis of Congestive Heart Failure. The Significant Change Minimum Data Set dated 6/09/06 documented the resident was severely impaired in cognitive skills for daily decision making and totally dependent on staff for all activities of daily living. a. Physician orders dated 6/14/06 documented: "O2 [oxygen] @ [at] 2L/min [2 liters per minute] per NC [nasal cannula] for comfort. Check every shift... Change oxygen tubing, cannulas, humidifier bottle and water, and clean concentrator filter weekly." b. On 7/24/06 at 4:30 a.m., the resident was receiving oxygen at 2 liters per minute via nasal cannula. The oxygen concentrator filter had a thick, dust-like substance coating the entire surface. The humidifier bottle and tubing were not dated. An oxygen face mask and tubing were lying uncovered and unlabeled on the resident's nightstand. c. On 7/24/06 at 8:06 and 10:00 a.m., the resident was receiving oxygen via nasal cannula. The humidifier bottle and tubing were not dated and the concentrator filter had a thick coating of a light-brown substance. d. On 7/24/06 at 11:40 a.m., the oxygen concentrator was off. The resident's nasal cannula and tubing were draped, uncovered across the top of the concentrator. The filter remained coated with a thick light brown substance. e. On 7/25/06 at 7:35 a.m., 11:37 a.m. and 2:00 p.m. and 7/26/06 at 8:49 a.m., the humidifier	F 328			

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F 328	<p>Continued From page 19</p> <p>bottle was not dated. The nasal cannula and tubing were looped across the top of the concentrator. The tubing was not bagged and the filter had a thick coating of a light brown substance.</p> <p>2. Resident #9 had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). The Annual Minimum Data Set dated 5/3/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, required limited assistance with activities of daily living and received oxygen therapy.</p> <p>a. Physician orders dated 5/16/05 documented: "O2 @ 2L/min per NC PRN [as needed] SOB [shortness of breath] for COPD... Change and date oxygen humidifier/NC [nasal cannula]/tubing every Tuesday on 11/7 [11:00 p.m. to 7:00 a.m.] shift. Cleanse filter Tuesday 11/7 shift."</p> <p>b. On 7/24/06 at 4:48 a.m., 7:58 a.m., 9:58 a.m. and 11:30 a.m. and 1:30 p.m., the resident was receiving oxygen at 2 liters per minute via nasal cannula. The oxygen concentrator filter had a thick, light-brown substance coating the entire surface.</p> <p>3. Resident #15 had diagnoses of Chronic Obstructive Pulmonary Disease and Pneumothorax. The Quarterly Minimum Data Set dated 4/28/06 documented the resident was moderately impaired in cognitive skills for daily decision-making and required total assistance with activities of daily living.</p> <p>a. Physician orders dated 3/17/06 documented: "Change oxygen tubing, cannulas, humidifier</p>	F 328			

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F 328	<p>Continued From page 20</p> <p>bottle and water and clean concentrator filter weekly."</p> <p>b. On 7/24/06 at 4:08 a.m., the resident's concentrator filter had a thick coating of a light-brown substance over the entire surface. The oxygen tubing and nasal cannula were draped over the top of the concentrator uncovered and not dated.</p> <p>4. Resident #19 had diagnoses of Chronic Obstructive Pulmonary Disease, History of Tuberculosis and Acute Respiratory Failure. The Quarterly Minimum Data Set dated 7/17/06 documented the resident had modified independence in cognitive skills for daily decision making and required limited assistance with activities of daily living.</p> <p>a. Physician orders dated 12/12/04 documented: "O2 via NC @ 2 LPM [liters per minute] PRN to maintain O2 Sat [saturation]... Change oxygen tubing, cannulas, humidifier bottle and water and clean concentrator filter weekly on 11/7."</p> <p>b. On 7/24/06 at 4:01 a.m., the resident was receiving oxygen at 2 liters per minute via nasal cannula. The concentrator filter had a heavy coating of a brown substance.</p> <p>5. Resident #8 had diagnoses of Cardiovascular Disease and Hypertension. The 5-day Medicare Minimum Data Set dated 4/21/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, required extensive assistance of staff for transfers and ambulation and experienced shortness of breath and inability to lie flat due to shortness of breath in the 7 days preceding the assessment date.</p>	F 328			

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F 328	Continued From page 21 a. A physician order dated 7/21/06 documented: "O2 @ 2L [2 liters] per NC PRN to maintain PO2 [partial pressure, oxygen] > [greater than] 90%... Check sats [oxygen saturation] q [every] shift." b. On 7/24/06 at 4:28 a.m., the resident's oxygen tubing/nasal cannulae were draped across the side rails without a bag or other type of covering. c. On 7/24/06 at 7:55 a.m. and 8:40 a.m., the resident was receiving oxygen at 2 liters per minute via nasal cannula. At 9:50 a.m. and 1:00 p.m., the oxygen tubing/cannulae were draped across the bedside table 6. The facility's Policy and Procedure for Respiratory Therapy Equipment documented: "...Change oxygen cannulae and tubing every week on Wednesday during the night shift and as necessary... Keep oxygen cannulae and tubing used PRN [as necessary] in a plastic bag when not in use... Wash filters from oxygen concentrators in soapy water every week on Wednesday during the night shift... mark bottle (humidifier bottle) with date and initials upon opening..."	F 328			
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the 8:00 a.m. medication pass on 7/25/06 and record review, the facility	F 332			

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F 332	<p>Continued From page 22</p> <p>failed to follow physician orders to ensure the medication error rate was less than 5%. Physician orders were not followed for 3 (Residents #10, #11 and #12) of 6 residents observed during the medication passes. Medication errors were made by 2 of 2 Licensed Practical Nurses (LPNs) who administered medication (LPN's #1 and #2). The failed practice had the potential to affect all 65 residents (who received medications from these nurses) as documented on the facility's Resident Census and Conditions of Residents form dated 7/24/06. The medication error rate was 10.53%, based on observation of 52 medications administered plus 5 medications ordered but not administered and a total of 6 errors detected. The findings are:</p> <p>1. Resident #10 had a physician order dated 7/26/04 for Refresh eye drops, one drop in each eye twice a day.</p> <p>a. On 7/25/06 at 7:48 a.m., LPN #1 administered Artificial Tears to the resident instead of Refresh eye drops.</p> <p>b. Refresh eye drops contain Carboxymethylcellulose and Artificial Tears contain Polyvinyl Alcohol.</p> <p>2. Resident #12 had a physician order dated 6/2/06 for Vitamin D 400 units to be administered, 2 tablets daily.</p> <p>a. The facility's Medication Schedule, provided by the Administrator on 7/24/06 at 8:20 a.m., documented medications ordered for daily administration would be administered at 8:00 a.m. daily.</p>	F 332			

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F 332	Continued From page 23 b. On 7/25/06 at 8:10 a.m., during the 8:00 a.m. medication pass, LPN #2 administered Resident #12's 8:00 a.m. medications, but did not administer the Vitamin D 400 units to the resident as ordered. 3. Resident #11 had physician orders dated 7/1/06 for Duoneb Updraft 4 times daily, Pepcid 20 milligrams (mg.) daily, Advair 100/50 inhaler twice daily and Artificial Tears twice daily. On 7/25/06 at 8:01 a.m., LPN #1 administered the resident's medications, but did not administer the Duoneb Updraft, Pepcid 20 mg, Advair inhaler and Artificial Tears. This resulted in 4 errors. 4. On 7/25/06 at 8:01 a.m., LPN #1 administered Protonix 40 mg to Resident #11, with no physician order to do so. 5. Resident #11 had a physician order dated 7/1/06 for Senokot, one tablet twice a day. On 7/25/06 at 8:01 a.m., LPN #1 administered Senokot S to the resident, instead of Senokot as ordered by the physician. The Senokot website at www.Senokot.com documented Senokot S contains a stool softener in addition to the senna laxative contained in regular Senokot tablets.	F 332			
F 333 SS=E	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation of the 8:00 a.m. medication	F 333			

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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 C 07/27/2006
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 333	<p>Continued From page 24</p> <p>pass on 7/25/06 and record review, the facility failed to ensure physician orders were followed in order to prevent significant medication errors for 2 (Residents #11 and #12) of 6 residents observed during the medication pass. Significant medication errors were made by 2 of 2 Licensed Practical Nurses who administered medications (LPN's #1 and #2). The failed practice had the potential to affect all 65 residents (who received medication from these nurses), as documented on the facility's Resident Census and Conditions of Residents form dated 7/24/06. The findings are:</p> <p>1. Resident #12 had a diagnosis of Health Maintenance and a physician order dated 6/2/06 for Vitamin D 400 units, 2 tablets every day. The facility's Medication Schedule, provided by the Administrator on 7/24/06 at 8:20 a.m., documented medications ordered for daily administration would be administered at 8:00 a.m. daily.</p> <p>a. During the 8:00 a.m. medication pass on 7/25/06 at 8:19 a.m., LPN #2 administered the resident's 8:00 a.m. medications, but did not administer the Vitamin D as ordered.</p> <p>b. The June and July 2006 Medication Administration Records (MAR's) had no documentation of the Vitamin D being ordered or administered at any time since the original 6/2/06 physician order. This was a total of approximately 53 doses missed.</p> <p>c. On 7/25/06 when the facility checked the computerized orders, the physician order for Vitamin D was not found and the medication was not available for administration to the resident.</p>	F 333			

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F 333	Continued From page 25 e. This medication error was significant due to the frequency of the error. 2. Resident #11 had a diagnosis of Gastroesophageal Reflux Disease (GERD) and a physician order dated 6/22/05 for Protonix 40 milligrams (mg) every day. a. A physician order dated 7/1/06 documented the Protonix order was changed to Pepcid 20 mg daily. b. The July 2006 MAR documented the Pepcid was administered only once in July, on 7/4/06. The MAR also documented on 7/10/06, the order was changed back to Protonix 40 mg. On 7/25/06 at 8:01 a.m., LPN #1 administered Protonix 40 mg. to the resident. c. As of 7/25/06 at 8:15 a.m., there was no physician order to change back to Protonix 40 mg. d. The resident received only one Pepcid 20 mg from 7/1/06 through 8:01 a.m. on 7/25/06 and received Protonix 40 mg from 7/10/06 through 8:01 a.m. on 7/25/06 with no physician order to do so. e. This medication error was significant due to the frequency of the error.	F 333			
F 365 SS=D	483.35(d)(3) FOOD Each resident receives and the facility provides food prepared in a form designed to meet individual needs.	F 365			

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F 365	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure food was served in a consistency to meet the needs of 1 (Resident #7) of 6 case mix residents with physician orders for modified consistency diets (Residents #1, #2, #3, #4, #6 and #7). This failed practice had the potential to affect 31 residents in the facility with physician orders for modified consistency diets, according to the facility Diet Roster dated 7/24/06. The findings are: Resident #7 had diagnoses of Alzheimer's Dementia, Depression with Anxiety and Renal Insufficiency. The Quarterly Minimum Data Set (MDS) dated 6/30/06 documented the resident was severely impaired in cognitive skills for daily decision-making and required set-up only assistance for eating. a. The Nurses' Notes dated 5/14/06 at 1:40 p.m. documented: "Resident fell from merrywalker and hit floor breaking dentures and bruising nose. Resident had blood from mouth on floor and nose bleeding. 911 called." b. The Nurses' Notes dated 5/14/06 on the 3:00 p.m. to 11:00 p.m. shift documented: "Resident face swollen, eyes has black swollen rings, eyes partly swollen shut... blood dripping slowly from face and nose." c. The Resident Diet and Status Report documented: "5/15/06 - Change Regular Diet to pureed until condition improves."	F 365			

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F 365	<p>Continued From page 27</p> <p>d. A physician order dated 5/15/06 documented: "Diet: Regular Pureed, NAS [No Added Salt]."</p> <p>e. The Diet Roster dated 7/24/06 documented, "NAS, Pureed."</p> <p>f. The Consumption Report for July 2006 documented the resident's average daily intake was 65.6%.</p> <p>g. On 7/24/06 at 8:15 a.m., the pureed diet menu documented: "Pureed cream of wheat, pureed egg, pureed sausage, pureed waffles." The resident was served ground sausage instead of pureed sausage, scrambled eggs instead of pureed eggs and 2 servings of cream of wheat. The resident consumed 100% of the cream of wheat but did not consume the sausage and eggs.</p> <p>h. On 7/24/06 at 12:10 p.m., the pureed diet menu documented: Pureed chicken, pureed green beans, mashed potatoes and gravy, pureed slurry bread, pureed cake." The resident, who ate in the feeder dining room, was served ground chicken breast instead of pureed chicken breast, green beans instead of pureed green beans, 1 slice of white bread instead of pureed slurry bread and a piece of white cake, instead of pureed cake. The diet card documented: "Mechanical Soft NAS Diet."</p> <p>i. On 7/25/06 at 8:00 a.m., the pureed menu documented pureed egg, pureed sausage and pureed bread. In the dining room, the resident was served ground sausage instead of pureed sausage and scrambled eggs instead of pureed eggs. The eggs and the sausage were not eaten.</p>	F 365			

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F 371 F 371 SS=C	Continued From page 28 483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the kitchen staff kept the kitchen free of employee personal items, closed the kitchen door and windows to secure the preparation area from possible pest and contaminates from outside of the building, covered the ice machine scoop when not in use to protect it from potential contamination, stored food items in properly sealed containers in the store room, stored items in the refrigerator in a manner to preserve quality and cleaned and sanitized the kitchen and dining areas. The failed practices had the potential to affect 65 residents who received a tray from the Dietary Department, as documented on the Facility Census Sheet dated 7/24/06 at 9:18 a.m. The findings are: 1. On 7/24/06 at 4:40 a.m. during the initial tour of the kitchen, the following observations were made: In the kitchen: a. A 3/4 cup of coffee was on the handwashing sink and a 3/4 smoked cigarette was on the ledge above the handwashing sink.	F 371 F 371			

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F 371	<p>Continued From page 29</p> <p>b. The window above the sink was open about 4 inches and a box fan was blowing on high on 24 sausage patties on an open tray.</p> <p>c. The back door was ajar about 1 inch, which opened the kitchen to the outside back of the building.</p> <p>d. The ice scoop storage container was open. The container was sitting on the lid. In the bottom of the container, there was a hair and a brown substance that the scoop was resting in.</p> <p>e. An employee's purse was on top of the ice machine.</p> <p>f. The kitchen floor from the door to the bathroom and in front of the juice machine was dirty and sticky.</p> <p>In the storeroom:</p> <p>a. A bag of corn chips and 1 package of coconut were in unsealed packages.</p> <p>b. The bulk dry milk cannister, bulk flour cannister, large box of disposable forks, large box of disposable spoons and paper plates were open and not covered.</p> <p>In the reach-in refrigerator:</p> <p>a. The butter pats in a white bucket were not covered.</p> <p>b. The pimiento cheese was not dated.</p> <p>In the dining room:</p>	F 371			

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F 371	Continued From page 30 a. An 8-ounce glass of brown liquid was at room temperature on the feeder table, which had not been cleaned from the last meal. The table surface was sticky with crumbs, spills and beverage rings. b. In the coffee area, the disposable spoons stored on the counter for use, had brown spots over them. c. A denture cup was on the counter next to the sink. 2. On 7/24/06 at 11:45 a.m., the Dietary Manager stated the janitor closet door was locked and that was where the mop was located and the dietary employee assigned could not mop the floor. When questioned about the availability of other mops, she stated it was the only one available to the Dietary Department.	F 371			
F 441 SS=D	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 by: Based on observation, record review and	F 441			

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F 441	<p>Continued From page 31</p> <p>interview, the facility failed to ensure universal precautions were observed during and after incontinent care, as evidenced by failure to sanitize a bottle of peri-wash designated for multi-resident use after using and handling the peri-wash bottle during incontinent care for 1 (Resident #8) of 10 case mix residents who were dependent on staff for perineal care (Residents #1, #4, #5, #6, #7, #8, #13, #14, #15 and #16). The failed practice had the potential to affect 11 residents who resided on the 400 Hall, as identified by the Director of Nursing (DON) on 7/27/06 at 8:45 a.m. The findings are:</p> <p>Resident #8 had diagnoses of End Stage Renal Disease and Cellulitis. The Minimum Data Set dated 6/19/06 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for personal hygiene and incontinent of bowel and bladder.</p> <p>a. On 7/25/06 at 9:28 a.m., Certified Nursing Assistants (CNA's) #1 and #3 provided perineal and foley catheter care. Derma Cens Perineal foam was brought into the room by CNA #1. The foam was located in the CNA's right uniform jacket pocket. The perineal foam was removed from the pocket with gloved hands while cleaning the resident. The foam was applied to a washcloth and returned to the CNA's pocket. During the perineal care, the bottle of Derma Cens Perineal Foam fell out of the the CNA's pocket and onto the floor. The bottle of foam was picked up from the floor and placed on the resident's bed. The bottle was used 2 more times and placed back on the bed, with the CNA wearing the same gloves that had been worn while cleansing urine and feces from the</p>	F 441			

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F 441	Continued From page 32 resident's skin. After the care was completed, the CNA placed the bottle of Derma Cens Perineal foam on the clean linen cart without cleansing and sanitizing the bottle. b. On 7/25/06 at 10:10 a.m., Licensed Practical Nurse (LPN) #3 (the Nurses Aide Training Coordinator) stated, "The only thing we use on multiple residents is the periwash." c. The Perineal Care and Catheter Care policies provided by the DON on 7/26/06 at 4:45 p.m. documented: "...Place the equipment on the bedside stand or overbed table. Arrange the supplies so they can be easily reached... maintain clean technique..."	F 441			
F 460 SS=B	483.70(d)(1)(iv)-(v) RESIDENT ROOMS Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure a means of providing full visual privacy was available in 9 resident rooms. The failed practice had the potential to affect 14 residents who resided in these rooms, as documented on the facility's Roster/Sample Matrix dated 7/24/06. The findings are:	F 460			

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F 460	<p>Continued From page 33</p> <p>On 7/25/06 during the environmental tour of the facility, the following room did not have a means of providing full visual privacy around (or between) individual beds:</p> <p>a. At 8:14 a.m., the privacy curtain in Room 111, between Beds A and B had a 19-inch gap because the curtain was not wide enough to completely close between the beds. (The facility's Roster/Sample Matrix dated 7/24/06 documented only one resident resided in this room at the time of the survey.)</p> <p>b. At 8:15 a.m., in Room 108, the privacy curtain was 9 inches too short to provide full visual privacy around the bed. (The facility's Roster/Sample Matrix dated 7/24/06 documented 2 residents resided in this room at the time of the survey.)</p> <p>c. At 8:17 a.m., the privacy curtain in Room 106 was 9 inches too short to provide full visual privacy. (The facility's Roster/Sample Matrix dated 7/24/06 documented 2 residents resided in this room at the time of the survey.)</p> <p>d. At 9:35 a.m., the privacy curtain in Room 202 was 12 inches too short to provide full visual privacy. (The facility's Roster/Sample Matrix dated 7/24/06 documented 2 residents resided in this room at the time of the survey.)</p> <p>e. At 9:46 a.m., the privacy curtain in Room 401 was 24 inches too short to provide full visual privacy. (The facility's Roster/Sample Matrix dated 7/24/06 documented only one resident resided in this room at the time of the survey.)</p> <p>f. At 9:49 a.m., the privacy curtain was 8 inches</p>	F 460			

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F 460	Continued From page 34 too short to provide full visual privacy in Room 408. (The facility's Roster/Sample Matrix dated 7/24/06 documented only one resident resided in this room at the time of the survey.) g. At 9:50 a.m., the privacy curtain in Room 407 was 8 inches too short to provide full visual privacy. (The facility's Roster/Sample Matrix dated 7/24/06 documented 2 residents resided in this room at the time of the survey.) h. At 10:18 a.m., the privacy curtain in Room 117 was 12 inches too short to provide full visual privacy. (The facility's Roster/Sample Matrix dated 7/24/06 documented only one resident resided in this room at the time of the survey.) i. At 10:25 a.m., in Room 124, the privacy curtain was 12 inches too short to provide full visual coverage. (The facility's Roster/Sample Matrix dated 7/24/06 documented 2 residents resided in this room at the time of the survey.)	F 460			