

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

PRINTED: 08/15/2007
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 08/03/2007
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 309 SS=E	<p>483.25 QUALITY OF CARE</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure foley catheter tubing was secured to prevent potential trauma to the urinary meatus and failed to ensure foley catheter tubing was positioned to prevent potential back flow of urine for 1 (Resident #2) of 1 case mix resident with a foley catheter. This failed practice had the potential to affect 3 residents with a Physician's Order for a foley catheter according to a list provided by the Director of Nursing (DON) on 8/2/07. The findings are:</p> <p>Resident #2 had a diagnosis of urinary retention. The Quarterly Minimum Data Set (MDS) dated 7/5/07 documented the resident was moderately impaired in cognitive skills for daily decision making, dependent on staff for personal hygiene and had a foley catheter.</p> <p>a. The Plan of Care dated 4/7/07 documented, "...Ensure that catheter tubing is secured, intact and reposition resident carefully to prevent trauma of urinary meatus and dislodging. Use leg band..."</p> <p>b. On 7/30/07 at 5:05 p.m., the foley catheter</p>	F 309		
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 309	Continued From page 1 tubing was not secured with a leg band. Certified Nursing Assistant (CNA) #9 and #10 provided catheter care for the resident. CNA #9 cleaned the catheter tubing by putting the cloth around the tubing at the insertion site and applied pressure while wiping away from the penis. The CNA did not hold the tubing close to the penis to keep the pressure from pulling the catheter tubing as she wiped. The CNA repeated the wipe 4 times with the resident yelling, "That hurts." c. On 7/31/07 at 8:35 a.m., the resident was in bed with both side rails in the upright position. The catheter tubing was hanging over the top of the rail causing the tubing to go up from the resident to the height of the bed rail allowing the the urine in the upper portion of the tubing to backflow into the bladder. d. On 7/31/07 at 8:53 a.m., the foley catheter tubing was not secured with a leg band. e. On 7/31/07 at 8:53 a.m., CNA #7 provided foley catheter care for the resident. The CNA did not hold the tubing close to the penis to keep the pressure from pulling the catheter tubing as it was wiped.	F 309		
F 312 SS=E	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 and record review, the	F 312		

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F 312	Continued From page 2 facility failed to ensure the labia was spread for cleansing and the buttocks were cleansed during incontinent care for 3 (Resident #1, #5 and #8) and failed to ensure the mons pubis, groins and vaginal area were cleansed during incontinent care for 1 (Resident #1) of 8 (Resident #1, #2, #4, #5, #6, #7, #8 and #9) case mix residents that were dependent on staff for incontinent care. This failed practice had the potential to affect 30 residents dependent on staff for incontinent care according to a list provided by the Director of Nursing (DON) on 8/2/07. The findings are: 1. Resident #8 had diagnoses of Diabetes Mellitus, Anemia, Depression, Constipation and Dementia. The Minimum Data Set (MDS) dated 7/9/07 stated the resident was severely impaired in cognitive skills for daily decision making, incontinent of bladder (multiple daily episodes) and bowel (all the time) and was dependent on staff for activities of daily living and hygiene. a. The Plan of Care dated 7/3/07 documented, "Provide incontinent care after each episode, check freq (frequently) and PRN (as needed), Provide good Peri Care and apply skin barrier." b. On 8/1/07 at 11:35 a.m., CNA #2 and #3 provided incontinent care after an episode of bladder incontinence. The labia was not spread for cleansing and the buttocks were not cleansed. 2. Resident # 5 had diagnoses of Alzheimer's Disease and Diabetes Mellitus. The Quarterly MDS dated 5/31/07 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent of bowel/bladder and was totally dependent on staff for toileting and personal hygiene.	F 312			

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F 312	<p>Continued From page 3</p> <p>a. The Plan of Care dated 6/26/06 and updated 3/6/07 documented, "At risk for Urinary Track Infection (UTI) related to incontinence, inability to retrain, severe memory deficits. Approaches: Check frequently and as needed (prn) for incontinence, good peri-care and apply skin barrier."</p> <p>b. On 7/31/07 at 1:38 p.m., CNA #5 provided incontinent care after an episode of bladder and bowel incontinence. The CNA removed the soiled incontinent brief. The resident had a moderate amount of soft brown bowel movement (BM) on the skin and in the brief. The CNA did not spread the labia for cleansing and only washed the lower half of the buttocks. The CNA placed a clean incontinent brief on the resident without applying lotion or barrier cream.</p> <p>3. Resident #1 had a diagnosis of Neurogenic Bladder and a history of Pressure Ulcers. The Quarterly MDS dated 6/06/07 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and required extensive assistance of staff for personal hygiene.</p> <p>a. The Plan of Care dated 10/10/06 (and updated 6/6/07) documented, "Check resident every two hours for incontinence..."</p> <p>b. On 7/31/07 at 12:00 p.m., CNA #6 and #7 assisted the resident to the bathroom and changed the incontinent brief. CNA #6 washed the rectal area and then applied a clean incontinent brief. The mons pubis, groin, buttocks and vaginal area were not cleansed. The labia</p>	F 312			

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F 312	Continued From page 4	F 312		
F 314	was not spread to cleanse the urinary meatus.			
SS=G	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, interview and record review, the facility failed to ensure an accurate skin audit was completed and a pressure ulcer was reported for 1 (Resident #9) and failed to provide incontinent care in a timely manner for 1 (Resident #1) of 11 (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #11 and #12) case mix residents at risk for pressure sores. This failed practice resulted in actual harm to Resident #9 and had the potential to affect 56 residents at risk for the development of pressure sores according to a list provided by the Director of Nursing (DON) on 8/2/07. The findings are: 1. Resident # 9 had diagnoses of Diabetes Mellitus and Severe Peripheral Vascular Disease. The Minimum Data Set (MDS) dated 7/10/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with bed mobility, transfers and locomotion, had one or more foot problems and received preventative or protective foot care.	F 314		

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F 314	Continued From page 5 a. The Pressure Ulcer Risk Assessment dated 7/10/07 documented a score of 12. The form documented that a total score of 8 or greater would indicated the resident should be considered at high risk for skin breakdown and a prevention protocol should be initiated immediately. b. The policy and procedure "Prevention and Treatment of Pressure Ulcers" provided by the DON documented, "Prevention and Treatment of Pressure Ulcers. The purpose of this procedure is to provide guidelines for skin care to assist in preventing the development of pressure ulcers in residents identified to be at risk. Pressure ulcers are a serious skin condition for the resident. Immediately report any signs of a developing pressure ulcer. During daily care and bathing, the CNA (Certified Nursing Assistant) will note the condition of the resident's skin (i.e., the size and location of any new red or tender areas) and forward to the charge nurse/treatment nurse for review and intervention. The charge nurse/treatment nurse will complete a head-to-toe body audit weekly for any resident identified to be at risk for pressure ulcers. The charge nurse/treatment nurse will obtain orders for treatment for any newly identified wound or lesion within the 8 hour shift of discovery of the lesion." c. On 7/31/07 at 8:45 a.m., the resident was lying in bed with her heels in direct contact with the bed surface. CNA #1 attempted to put the resident's shoes on. The resident stated, "Ow, ow, ow, that hurts." The CNA was asked to remove the resident's socks to do a foot audit. There was a blackened area on the right heel that measured approximately 6 centimeters (cm) in	F 314		

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F 314	<p>Continued From page 6</p> <p>diameter that the resident stated was "sore." The CNA stated he hadn't noticed the area before now. The CNA put the resident's socks and shoes on both feet and transferred her to the wheelchair.</p> <p>d. On 7/31/07 at 9 a.m., the treatment nurse, Licensed Practical Nurse (LPN) #1 stated the body audits would be done today on the resident's hall but had not been done yet.</p> <p>e. On 8/1/07 at 8:45 a.m., the weekly body audit sheet dated 7/31/07 for the resident documented, "Heels: clear. Skin w/d (warm, dry) intact." The same documentation was noted for 7/24/07.</p> <p>f. On 8/1/07 at 9:30 a.m., LPN #1 was asked if there had been any new skin concerns reported to him concerning the resident and he stated, "No." He was asked if a body audit had been completed for the resident and he stated, "I did one yesterday, it was all clear." The LPN was asked if the resident's feet had been assessed and stated, "Yes." The LPN was asked to look at the resident's right heel. The LPN stated, "I missed that."</p> <p>g. On 8/1/07 at 9:45 a.m., CNA #1 was asked if he remembered seeing the blackened area on resident's left heel yesterday and the CNA stated "Yes." The CNA was asked if he had reported the area to the charge nurse or the treatment nurse and he stated, "No, I forgot to."</p> <p>h. On 8/1/07 at 10:10 a.m., LPN #1 and the DON evaluated the resident's heel. The black eschar area was measured at 6.3 cm. x 5 cm. The LPN stated the area felt spongy.</p>	F 314			

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F 314	Continued From page 7 i. The Nurse's Note dated 8/1/07 documented, "New unstageable area to R (right) heel noted 7/31/07. Shoes checked - noted to be worn with rough areas both heels." 2. Resident #1 had a diagnosis of Neurogenic Bladder and a history of Pressure Ulcers. The Quarterly MDS dated 6/06/07 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and required extensive assistance of staff for transfers and personal hygiene. a. The Plan of Care dated 10/10/06 (and updated 6/6/07) documented, "...Check resident every two hours for incontinence. Check skin daily for signs of breakdown. Weekly skin audits by nurse and record and provide incontinence care after each episode..." b. The Pressure Ulcer Risk Assessment dated 6/06/07 documented a score of 12. The form documented a total score of 8 or above represented high risk for pressure sores. c. On 7/31/07 at 8:37 a.m., the resident was sitting in a recliner in her room. The room was kept in sight of surveyor until 11:55 a.m. when LPN # 1 came down the hall and asked CNA # 6 if she had checked the resident. The CNA told the LPN that she was not the one who had put the resident in the chair and she thought CNA # 8 had changed the resident before putting her in the chair. d. On 7/31/07 at 12:00 p.m., CNA #6 and #7	F 314		

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F 314	Continued From page 8 assisted the resident to the bathroom and removed the incontinent brief which was saturated with urine. There was a strong urine odor in the bathroom. The wetness indicator line on the incontinent brief had changed color indicating wetness the full length of the line. The resident's slacks were also wet and had to be changed. Before the CNA's were finished changing the resident, a third CNA (CNA #3) came into the bathroom to assist with the resident's care. CNA #3 told CNA # 6 that CNA # 8 had told her she changed the resident that morning before she sat her in her chair. CNA #6 told CNA #3, "we will talk later". The resident was changed after sitting in her recliner for 3 hours and 23 minutes without being checked.	F 314			
F 324 SS=E	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure residents were not transferred by holding their clothing for 2 (Resident #2 and #8) and failed to ensure residents were not transferred by lifting under the axillae area for 3 (Resident #2, #4 and #8) of 13 (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 and #13) case mix residents dependent	F 324			

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F 324	<p>Continued From page 9</p> <p>on staff for transfers. This failed practice had the potential to affect 64 residents that were dependent on staff for transfers according to a list provided by the Director of Nursing (DON) on 8/2/07. The findings are:</p> <p>1. Resident # 8 had diagnoses of Diabetes Mellitus, Anemia, Depression and Dementia. The Minimum Data Set (MDS) dated 7/9/2007 documented the resident was severely impaired in cognitive skills for daily decision making and was totally dependent on staff for transfers.</p> <p>On 8/1/2007 at 11:45 a.m., Certified Nursing Assistant (CNA) #2 and #3 transferred the resident to a wheelchair that was approximately 3 feet away by placing one of their arms underneath the resident's axillae area and held the gait belt with their free hand. The resident was non weight-bearing and the feet were drug across the floor with the knees bent. The gait belt was loose and slid up the resident 's rib cage during the transfer. When that happened, CNA #2 grabbed the back of the pants to complete the transfer.</p> <p>2. Resident #4 had diagnoses of Dementia and Osteoarthritis. The MDS dated 7/25/07 documented the resident was moderately impaired in cognitive skills for daily decision making and required limited assistance of one person for transfers.</p> <p>a. The transfer assessment dated 7/27/07 documented, "OK to bear weight without risk of injury, but give 25-75% of standing effort. 2 person assist stand pivot with gait belt."</p> <p>b. On 8/1/2007 at 12:00 p.m., CNA #2 and CNA # 4 transferred the resident from bed to the wheelchair by placing their arms underneath the</p>	F 324			

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F 324	Continued From page 10 resident's axillae area and held the gait belt with their free hand. The gait belt was loose and slid up the resident's rib cage during the transfer. The resident did not bear weight during the transfer. Both feet drug with the toes barely touching the floor. 3. Resident #2 had a diagnosis of Seizure Disorder. The Quarterly MDS dated 7/05/07 documented the resident was severely impaired in cognitive skills for daily decision making, did not ambulate and was dependent on 2 plus staff for transfers. On 7/31/07 at 8:53 a.m. CNA #7 and #8 transferred the resident from bed to the geri chair by placing their arms underneath the resident's axillae area. One CNA held the gait belt with a free hand and the other CNA held onto the back of the resident's pants. The resident's feet were drawn up during the transfer.	F 324		
F 328 SS=E	483.25(k) SPECIAL NEEDS 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. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the	F 328		

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F 328	Continued From page 11 facility failed to ensure the nasal cannula on oxygen tubing was not left unbagged when not in use for 2 (Resident #10 and #12) and failed to ensure oxygen concentrator filters were not covered with lint for 1 (Resident #10) of 3 (Residents #10, #11 and #12) case mix residents with a Physician's Orders for oxygen. This failed practice had the potential to affect 9 residents who had Physician's Orders for oxygen according to the Director of Nursing (DON) on 8/2/07. The findings are: 1. Resident #12 had diagnoses of Aspiration Pneumonia, Diabetes Mellitus, Cerebrovascular Accident, and Arteriosclerotic Heart Disease. The Minimum Data Set (MDS) dated 7/24/2007 documented the resident was moderately impaired in cognitive skills for daily decision making and received oxygen therapy. a. A Physician's Order dated 7/13/07 documented, "O2 (Oxygen) @ 2L (2 Liters per minute) PRN (as needed) for SOB (shortness of breath) ... " b. On 7/31/07 at 2:40 p.m., the oxygen tubing was uncovered, partially coiled on top of the concentrator with the nasal cannula draped down the side of the concentrator. 2. Resident # 10 had diagnoses of Congested Heart Failure, Chronic Obstructive Pulmonary Disease, Respiratory Distress, and Shortness Of Breath. The Quarterly MDS dated 6/16/07 documented the resident had modified independence in cognitive skills for daily decision making and received oxygen therapy. a. A Physician's Order dated 6/26/07 and for the	F 328			

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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 08/03/2007
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 328	Continued From page 12 month of July 1 through July 31,2007 documented, "Oxygen at 2 LPM (liters per minute) per nasal cannula PRN for SOB or dyspnea." b. The Care Plan dated 3/22/07 documented, "Problem: At risk for complications related to oxygen therapy. Approaches: Oxygen at 2L per nasal cannula as needed for dyspnea. Check filters on the 11-7 shift, change weekly. Check oxygen frequently for infection control." C. On 7/30/07 at 3:30 p.m., the resident's oxygen tubing was on the floor beside the bed with the nasal cannula draped over the top of the concentrator unbagged. The concentrator had a black external filter that was covered with white lint.	F 328		
F 371 SS=E	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 food stored in the freezer was sealed to prevent the potential for cross contamination, failed to ensure employees washed their hands between handling food and picking up objects and failed to maintain freezer temperature at or below 0 degrees. These failed practices had the potential to affect 65 residents who received their meal trays from the kitchen according to the Diet List dated 7/30/07. The	F 371		

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F 371	<p>Continued From page 13 findings are:</p> <ol style="list-style-type: none"> 1. On 8/1/07 at 9:28 a.m., the following observations were made: <ol style="list-style-type: none"> a. A box of sausage on the shelf in the freezer was not sealed. b. A box of broccoli on the shelf in the freezer was not sealed. c. Dietary employee #1 lifted the dish washing machine handle and pulled out clean dish racks. Without washing her hands, she started drying dishes with a towel. 2. On 8/1/07 at 9:30 a.m., Dietary employee #2 lifted up a trash can lid and threw away tissue papers, opened the door to the oven, pulled out a pan that contained butter scotch and laid it on the counter. She placed gloves on both hands and picked up a wash cloth to wipe off the counter. She then used the same wash cloth to hold the pan down, with the wash cloth resting on the butterscotch, while she sliced it. 3. On 8/1/07 at 10:19 a.m., the ice scoop holder on top of the ice machine had a black substance in it. The ice scoop was sitting directly on the black substance. 4. On 8/2/07 at 9:50 a.m., Dietary employee #3 lifted up a trash can lid and threw away tissue paper. Without washing her hands, she picked up bowls and stacked them on the utility cart. Her fingers touched the inside of the bowls. She then started drying dishes with a towel. 5. The 3 door freezer had 2 thermometers, one 	F 371			

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F 371	Continued From page 14 on the left side of the freezer and one on the right side. The following temperatures were noted: 7/30/07 at 3:00 p.m. - Left 42 degrees F(Fahrenheit), Right 38 degrees F 7/30/07 at 6:30 p.m. - Left 42 degrees F, Right 38 degrees F 7/31/07 at 8:30 a.m. - Left 20 degrees F, Right 14 degrees F 8/1/07 at 9:28 a.m. - 14 degrees F	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, interview and record review the facility failed to ensure a yearly chest x-ray was obtained and failed to ensure procedures were in place for a positive PPD (Purified Protein Derivative) for Tuberculosis for 1 (Resident #1) of 1 case mix resident with a positive PPD. The failed practice has the potential to affect all 64 residents as identified by the Resident Census and Conditions of Residents form dated 7/30/07. The findings are:	F 441			

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F 441	<p>Continued From page 15</p> <p>Resident #1 had a diagnosis of history of Tuberculosis (TB) and a positive PPD reaction. The Quarterly Minimum Data Set dated 6/6/07 documented the resident was moderately impaired in cognitive skills for daily decision making.</p> <p>a. On 6/30/04 a chest x-ray documented, "Impression": 1. small right lower lobe infiltrate. 2. With these findings, TB cannot be excluded." A hand written note on the x-ray documented, "Films to be taken to health department by mobile."</p> <p>b. The Plan of Care dated 10/10/06 (and updated 6/6/07) documented: "At risk for development of active TB. Obtain sputum specimens (2) or chest x-ray, at least yearly and document on the resident's chart. Monitor for symptoms of TB, productive cough, diagnosis of pneumonia..."</p> <p>b. A Physician's Progress Note dated January 2007 documented, "course breath sounds." February 2007 documented, "diminished bases." March 2007 documented, "cough non-productive." April 2007 documented, "course bilateral rales upper and cough as usual." May 2007 documented, "course bilateral plus cough." June 2007 documented "Clear to auscultation after coughing."</p> <p>c. On 7/31/07 at 9:53 a.m., the resident was in her room in a recliner. The resident was coughing. The cough sounded productive.</p> <p>d. On 7/31/07 at 12:25 p.m., the resident was at the dining table coughing and the cough sounded productive.</p>	F 441			

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F 441	Continued From page 16 e. On 8/1/07 at 11:20 a.m., the nurse consultant stated they had contacted the hospital and the resident had not had a chest x-ray since 2004. f. On 8/01/07 at 12:13 p.m. the infection control nurse was asked how the facility followed up on a resident who had a positive PPD. The nurse stated the facility never had one test positive and had never had to do a follow up. g. On 8/01/07 at 4:35 p.m., the DON (Director of Nursing) and the Administrator stated they were unsure how to follow up on a previous positive PPD reactor. h. On 8/02/07 at 10:30 a.m., the nurse consultant provided the Arkansas Department of Health guidelines for nursing home follow up of previously documented positive PPD reactors. It documented, "Obtain chest x-ray during anniversary month of admission and any time pulmonary symptoms develop."	F 441			