

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

PRINTED: 05/02/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045371</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/18/2005</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESTWOOD HEALTH AND REHAB INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>802 S WEST END STREET</b> <b>SPRINGDALE, AR 72764</b>	
(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 241 SS=B	<p>483.15(a) DIGNITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and observation the facility failed to ensure residents dependent on staff for eating were fed in a manner to provide dignity for 3 (Residents #8, #10, #13) of 6 case mix residents(Resident #1, #4, #7, #8, #13, #17)who were dependent on staff for eating. The failed practice had the potential to affect 25 residents who were dependent on staff dependent on staff for eating as documented on the Resident Census and Condition of Residents form dated 8/17/05. The findings are:</p> <p>1. Resident # 10 had a diagnosis of Dementia. The Quarterly Minimum Data Set dated 05/02/05 documented the resident required extensive staff assistance for eating.</p> <p>On 8/16/05 at 1:00 p.m., LPN (License Practical Nurse) #1 was observed standing over the resident and feeding the resident lunch.</p> <p>2. Resident #8 had a diagnosis of Osteoarthritis. The Minimum Data Set dated 6/14/05</p>	F 241		9/15/05

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 241	Continued From page 1 documented the resident was totally dependent on staff for eating.  a. On 8/16/05 at 12:58 p.m., the resident was feeding self finger foods in the dining room. The meal tray also contained green beans and mashed potato salad. LPN #1 was standing up and feeding a resident at the same table. LPN #1 would periodically step in front of Resident #8, putting some of the green beans on a spoon and hand it to this resident who took the spoon and fed self.	F 241			
F 282 SS=D	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, interview and record review, the facility failed to ensure a physician order was obtained prior to applying a restraint for	F 282		9/15/05	

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F 282	<p>Continued From page 2</p> <p>1 (Resident #13) of 2 case mix residents (Residents #8, #13) who had restraints. The failed practice had the potential to affect 8 residents who had restraint use as documented on a Restraint list dated 8/15/05. The findings are:</p> <p>1. Resident #13 had diagnoses of Arterial Sclerotic Heart Disease, Chronic Obstructed Heart Disease, Degenerative Joint Disease, Chronic Pain and Renal Failure.</p> <p>a. The Admission Orders dated 8/11/05 documented: ". . . Restraints - if yes, type/frequency/reason. Side rails - if yes, type/frequency/reason." These areas were blank.</p> <p>b. On 8/15/05 at 1:52 p.m. and on 8/16/05 at 5:45 p.m., and at 6:02 p.m., the resident was lying in bed with full side rails up times 2.</p> <p>c. On 8/16/05 at 5:30 p.m., the resident stated, "I guess they have my siderails up because they had them up in the hospital because I had an IV (intravenous fluids), a catheter and Oxygen."</p> <p>d. On 8/17/05 at 1:35 p.m., the Nurse Consultant stated, "All resident's should be assessed, careplanned, order received and get a consent signed before any type of restraints are applied on admission."</p> <p>2. The Policy and Procedure for physical restraint use provided by the Nurse Consultant on 8/17/05 documented, "General Guidelines for the Use of Physical Restraints. . . General Guidelines . . . 2. Practices that meet the definition of a restraint include, but are not limited to: a. Using side rails to keep a resident from voluntarily getting out of</p>	F 282			

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F 282	Continued From page 3 bed as opposed to enhancing mobility while in bed."	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 observations, interview and record review, the facility failed to ensure that a resident admitted to the facility with a catheter had a physician order for the Foley catheter for 1 resident (#13) and failed to ensure the catheter tubing was secured to prevent the potential for injury to the meatus for 1 (Resident #6) of 6 case mix residents (Residents #4, #6, #7, #11, #12, #13, #14) who had Foley Catheters. The failed practices had the potential to affect 7 residents who had catheters as documented on the Resident Census and Condition of Residents form dated 8/17/05. The findings are:  1. Resident #6 had a diagnosis of Urinary Retention. The Quarterly Minimum Data Set (MDS) dated 4/27/05 documented the resident required a Foley catheter.  a. The Care Plan dated 5/9/05 documented: ". . . AT RISK FOR SKIN BREAKDOWN . . . 16 [French 5cc] build indwelling [catheter]." The Care Plan did not document that the resident didn't want a leg band."	F 309		9/15/05	

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F 309	Continued From page 4  b. The August 2005 Physician order sheet documented: "7/18/05- FOLEY CATHETER: 16 [French] WITH BULB SIZE OF 5cc DUE TO URINARY RETENTION."  c. On 8/16/05 at 9:55 a.m., CNA (Certified Nursing Assistant) #3 was performing incontinent care and a body audit for the resident. The CNA removed the residents slacks and it was noted the catheter tubing had no leg strap or any other device to secure the tubing. The catheter tubing was pulled taught and wiggled from side to side. The catheter tubing was not secured by a leg band.  d. On 8/17/05 the Policy and Procedure for Foley Catheter Care provided by the Nurse Consultant on 8/17/05 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.) . . . Report unsecured catheters to the supervisor. . ."  2. Resident #13 had a diagnosis of Renal Failure. The Siloam Springs Hospital History and Physical dated 8/1/05 documented, ". . . Neurological - Alert and oriented x's 3." On 8/16/05 the Care Plan Coordinator at the facility stated, "The Admission Minimum Data Set (MS) is in progress."  a. The Admission Nursing Assessment dated 8/11/05 documented the resident had catheter. The Admission Orders dated 8/11/05 did not have physician orders for a catheter.  b. On 8/15/05 at 3:55 p.m., at 8/16/05 at 5:45	F 309			

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F 309	Continued From page 5 p.m., at 6:02 p.m., the resident had a Foley Catheter.  c. On 8/16/05 at 4:00 p.m., the Nurse Consultant stated, "I am unable to locate in the resident Medical Records an order for the Foley Catheter. He was just admitted last Thursday and ya'll came Monday. We haven't checked his admission records yet."	F 309			
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:  Based on observation, record review and interview the facility failed to conduct weekly skin audits for residents who were high at risk for pressure sores per the facility policy, failed to ensure treatment was obtained for the pressure sores for 1 resident #6) of 4 case mix residents (Residents #6, #7, #13, #14) who had pressure sores. These failed practices had the potential to affect 43 residents who were incontinent or frequently of bowel, 9 residents occasionally or frequently incontinent of bladder as documented on the Resident Census and Condition of Residents form dated 8/17/05. The findings are:	F 314		9/15/05	

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F 314	<p>Continued From page 6</p> <p>1. Resident #6 had diagnoses of Emphysema, Chronic Obstructed Pulmonary Disease, Cerebral Vascular Accident, Anemia and Urinary Retention. The Quarterly Minimum Data Set (MDS) dated 4/27/05 documented the resident required extensive staff assistance with all activities of daily living, was incontinent of bowel, had a foley catheter, skin desensitized to pain or pressure, and had no pressure sores.</p> <p>a. The Care Plan dated, 1/26/05 documented: "Problem . . . At risk for skin breakdown, related to immobility, (occasionally) incontinent, (History of) breakdown. . .Approaches-provide skin care. . .monitor skin and report any change of condition promptly."</p> <p>b. The Pressure Ulcer Risk Assessment dated 7/6/05 documented a total score of 11, with a total score of 8 or higher representing residents at high risk for pressure sores.</p> <p>c. A Body Audit form conducted on 7/16/05 documented: "Duoderm to buttock. . . . Duoderm to coccyx/buttock [every] 3rd day and [as needed]."</p> <p>d. The body audit dated 7/23/05 documented, "Slightly red, . . . TREATMENTS: Barrier Cream to Buttock [as needed]."</p> <p>e. On 8/16/05 at 9:55 a.m., incontinent care and a body audit was performed for the resident by CNA (Certified Nursing Assistant) #3. There were 2 open areas identified on the resident's left coccyx that measured approximately 0.5 cm (Centimeters) by 1.0 and 1.0 cm. by 0.2 cm. The Nurse Consultant stated, "They are stage II's. One looks new and the other looks older."</p>	F 314			

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F 314	Continued From page 7  f. On 8/16/05 at 10:00 a.m., the resident stated, "The sores have been there about 2 weeks. They were healing, but last night they were pulling up my pants and scrapped them and it hurt. I told the nurse. I had to have something for pain."  g. On 8/16/05 at 10:15 a.m., CNA #3 stated, "When we see a new area on a resident we are supposed to tell the Nurse immediately."  h. On 8/16/05 at 10:17 a.m., CNA #2 stated, "I think she got the areas from setting on the bedside commode."  i. On 8/16/05 at 10:28 a.m., the Nurse Consultant asked the Treatment Nurse if the resident was on her current treatment list and the Treatment Nurse stated, "No."  j. On 8/16/05 at 10:40 a.m., the Nurse Consultant and the Treatment Nurse were unable to locate documentation of a body audit completed within the past 2 weeks. The Treatment Nurse stated, "I don't have it." The last body audit report located was dated, 7/29/05 and documented, "old scab on [left] elbow." No pressure sore(s) was identified.  2. An inservice form entitled "Inservice Education Report" dated 8/5/05 provided by the Nurse Consultant documented, "Weekly skin audits on all resident who are high/at risk."  3. The facility Policy and Procedure for Prevention and Treatment of Pressure Ulcers documented: ". . Risk Factor-.Preventive Actions: Assess the at risk resident's skin condition weekly per facility skin and wound care program."	F 314			

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F 332 F 332 SS=E	Continued From page 8 483.25(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 and record review, and interview of the 8:00 a.m. medication pass on 8/18/05, the facility failed to ensure the medication error rate was less than 5%. Physician orders were not followed for 1 (Resident #7,) out 5 residents observed during medication passes, which resulted in medication errors. Medication errors were made by 2 LPNs (Licensed Practical Nurses)#2 and LPN #3 of 6 Licensed Nurses who administered medications in a 24 hour period. The failed practice had the potential to affect all 67 residents in the facility, as identified by the Director of Nursing (DON) on 8/18/05 at 1:52 p.m. The medication error rate was 10.52%, based on the administration of 56 medications and 1 medications ordered but not administered with a total of 6 errors noted. The finding are:  1. Resident #7 had a physician orders dated 8/10/05 for FML eye drops both eyes 1 drop two times a day.  a. On 8/18/05 at 8:03 a.m. during the 8:00 a.m. medication pass LPN #2 did not shake the FML eye drops.  b. The Medication Administration Record (MAR) documented the eye medication to be a	F 332 F 332		9/15/05	

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F 332	<p>Continued From page 9 suspension.</p> <p>2. Resident #7 had physician order dated 8/1/05 for Acidophilus one tablet by mouth (po) three times a day with meals.</p> <p>On 8/18/05 at 8:03 a.m. during the 8:00 a.m. medication pass LPN #2 administered Acidophilus with Pectin. The resident was administered the wrong medication.</p> <p>3. Resident # 7 had a physician order dated 6/17/05 that documented for Docusate 240 milligram (mg) 1 capsule po every day.</p> <p>a. On 8/18/05 at 8:03 a.m. during the 8:00 a.m. medication pass LPN #2 could not find Docusate 240 mg. LPN #2 stated she would just use Docusate 100 mg and give 2 capsules and write a clarification order later.</p> <p>b. On 8/18/05 LPN #2 wrote an order to change that documented: "Docusate 240 mg is changed to Docusate 200 mg 1 po every day."</p> <p>c. According to Handbook of Commonly Prescribed Drugs 15 th edition, there are two Docusate strengths- Docusate Sodium 100 mg and Docusate Calcium 240 mg. These are two different drugs.</p> <p>4. Resident #7 had a physician order dated 8/9/05 for Nitrofurantoin 50 mg four times a day for 10 days.</p> <p>On 8/18/05 at 8:03 a.m. during the 8:00 a.m. medication pass LPN #2 administered all 8:00 a.m. medications except Nitrofurantoin 50 mg. to the resident.</p>	F 332			

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F 333 F 333 SS=E	Continued From page 10 483.25(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:  Complaint # 10494 was substantiated (all or in part) in these findings.  Based on observation, record review, and interview of the 8:00 a.m. medication pass on 8/18/05 the facility failed to follow physician orders to ensure that residents were free of significant medication errors. Two (Residents #7, #1) of 5 residents observed during the medication passes had significant medication errors. A significant medication error was made by 1 (LPN #2) of 2 Licensed Practical Nurses who administered medications. The failed practices had the potential to affect 32 residents who received medications from this Nurse as identified by the Director of Nursing (DON) from the Resident Room Bed Report dated 8/18/05 at 1:52 p.m.. The findings are:  1. Resident #7 had a physician order dated 8/9/05 for Nitrofurantoin 50 mg (milligram) four times a day for 10 days.  a. On 8/18/05 at 8:03 a.m., during the 8:00 a.m. medication pass LPN #2 administered all of the residents 8:00 a.m. medications except Nitrofurantoin 50 mg.  b. On 8/18/05 at 12:15 p.m., during the medication reconciliation the following was noted:	F 333 F 333		9/15/05	

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F 333	<p>Continued From page 11</p> <p>According to facility records on 8/9/05 the Nitrofurantion 50 mg was ordered from the Pharmacy and the facility received 40 capsules.</p> <p>c. There were 33 signatures on the Medication Administration Record (MAR) for the month of 8/05. There should have been 7 capsules left. The bottle contained 20 capsules.</p> <p>d. Due to the frequency of the error and the residents condition this was a significant error.</p> <p>2. Resident #1 had diagnoses of Atrial Fibrillation, Congestive Heart Failure, Coronary Heart Disease.</p> <p>a. A physician order dated 8/02/05 documented: "Coreg 6.25 milligrams (mg.) BID [twice a day].</p> <p>b. During the medication pass on 8/18/05 at 11:45 a.m., the resident's family inquired of the Licensed Practical Nurse (LPN) #2, what medication the resident was receiving, and was she receiving heart medications. A facility investigation was done and Resident #1 missed 16 doses of Coreg 6.25 mg.</p> <p>c. The August 2005 Mediation Administration Record (MAR) had no documentation regarding the Coreg 6.25 mg or any information regarding when the resident was admitted back from the hospital and readmitted to the facility.</p> <p>d. On 08/16/05 at 11:00 a.m., the Director of Nursing stated, "We will have to check our orders from the hospital better and not look at the faxed copy sent before admission."</p> <p>e. This was significant due to the frequency of the</p>	F 333			

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F 333	Continued From page 12 error.	F 333		
F 371 SS=F	<p>483.35(h)(2) SANITARY CONDITIONS - FOOD PREP &amp; SERVICE</p> <p>The facility must store, prepare, distribute, and serve food under sanitary conditions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure the ice machine was free of mildew/mold failed to ensure dishes, utensils and posts and pans were sterilized to prevent the potential for food borne illness. These deficient practices had the potential to affect 66 residents who received their meals from the Dietary Department as documented on the Diet Roster dated 8/15/05. The findings are:</p> <p>1. On 8/15/05 at 10:38 a.m., the ice machine had a blackish, mildew/mold substance on the inside right side of the machine.</p> <p>a. On 8/16/05 at 8:27 a.m. the Dietary Manager stated the ice machine was to be cleaned once a week. Record review of the cleaning schedule documented that the machine had not been cleaned weekly.</p> <p>2. On 8/16/05 at 12:50 p.m., Dietary Employee #1 was storing the clean dishes at the noon meal. 1/3 of the dishes had been washed and stored at this time (cups, plates, bowls, glasses, trays). The wash water temperature registered 170 degrees Fahrenheit (F.) and the rinse water registered 170 degrees F. The litmus sheet test strip revealed 0 ppm (parts per million). This identified that there</p>	F 371		9/15/05

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F 371	<p>Continued From page 13</p> <p>was no sterilizing agent being dispensed on the dishes or into the machine as evidenced by the lack of color change on the litmus test strips. Dietary Employee #1 stated, "Let me check the container." She pulled out a container and said, "It's empty." The empty container was the detergent. The sanitizer was full but was not dispensing into the machine. At this time no sanitizer or detergent was dispensing into the machine.</p> <p>a. At 1:00 p.m. the rinse temperature was 173 degrees F.</p> <p>b. At 1:05 the Clinical Records Employee stated the facility keeps the temperature hot plus has the sanitizer for the machine so that if one doesn't work the other one will. At 170 and 173 degrees F the machine would not sanitize the dishes and the sanitizer was not dispensing in the machine.</p> <p>c. CMS (Centers for Medicare/Medicaid Services) guidelines document the hot water wash cycle for dish washing should be maintained at 140 degrees F or higher and the rinse cycle should be maintained at 180 degrees F. or higher to effectively sanitize dishes.</p> <p>d. The industrial dish machine had manufacturer instructions posted that documented: "Low temperature chemical sanitizing: Wash temperature 120 degrees F., Rinse temperature 120 degrees F." The label on the chemical sanitizer attached to the dish machine documented, "USES: A concentrated liquid chlorine solution for use in general laundry applications where the extra destaining power of active chlorine is desired. It may be used as a soil removal aid or as a destaining removal aid or</p>	F 371			

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F 371	Continued From page 14 as a destaining presoak for blood an other difficult protein stains. Do not use on natural silk, wool or nylon fibers. Do not pour directly on clothes."  3. On 8/16/05 at 1:15 p.m., Dietary Employee #2 was manually washing pots and pans. She used the 1st sink to wash the pots and the 2nd sink to rinse the pots. She did not use the third sink. The sanitizing solution was positioned to dispense into the third sink.  a. The litmus test strip revealed 0 ppm (parts per million) of the sanitizer as evidenced by lack of color change on the litmus sheets checked on the clean pots and pans air-drying and in the water in the second sink where the pots and pans were rinsed.  b. CMS guidelines document the manual dishwashing is to be done in a 3 compartment sink (wash, rinse and sanitize): Sanitizing solution used according to manufacturer's instruction.  c. The manufactures's Sanitizer Test Procedures documented, "Chlorine minimum limit 50 ppm, maximum limit 100 ppm.	F 371			
F 431 SS=E	483.60(d) LABELING OF DRUGS AND BIOLOGICALS  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  This REQUIREMENT is not met as evidenced	F 431		9/15/05	

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F 431	Continued From page 15 by: Based on inspection of the medication room on 8/17/05, the facility failed to ensure that items that require a physician's prescription were labeled in accordance with state law and accepted principles of pharmacy labeling. This failed practice had the potential to affect all 67 residents according to the Administrator on 8/15/05 at 1:30 a.m. who receive medications. The findings are:  On 8/17/05 at 1:45 p.m., the following prescription only items were stored in the medication room with no prescription labels:  a. Two 1000 milliliters (ml) bottles of Sterile Water for irrigation.  b. Three Haldol 5 mg (milligram) /ml (milliliter) 1 ml vial.  c. Two Humalog 100 units/ml 10 ml vials.  d. Two Lantus 100 units/ml 10 ml vials.  e. Fifteen Procrit 2000 units/ml 1 ml vials.	F 431			
F 432 SS=E	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 432		9/15/05	

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F 432	Continued From page 16 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by:  Based on observation of the Medication Room on 8/17/05 the facility failed to ensure that medications were properly stored at the proper temperature. The failed practice had the potential to affect 5 residents who received medication stored in this medication room according to the Director of Nursing 8/18/05 at 1:52 p.m.. The findings are:  The Medication Room refrigerator that was 40 degrees F. (Fahrenheit) was observed on 8/17/05 at 1:45 p.m., and the following medications were stored at improper temperatures:  a. Four Promethazine 25 mg/ml (milligrams/milliliters). The proper storage is 68 to 77 degrees F according to Physician's Desk Reference (PDR).  b. Three B 12 1000 micrograms (mcg)/ml 1 ml vial. According to the storage label on the vial, "store at room temperature 59 to 86 degrees."  c. Three Haldol 5 mg/ml 1 ml vial. The proper storage temperature is 59 to 86 degrees F. according to the PDR.	F 432			
F 502 SS=E	483.75(j)(1) LABORATORY SERVICES  The facility must provide or obtain laboratory	F 502		9/15/05	

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F 502	<p>Continued From page 17</p> <p>services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to follow the manufacturer's recommendations and maintain daily glucometer calibrations on 2 of 2 glucometers in the facility to ensure accurate fingerstick blood sugar readings. The failed practice had the potential to affect 2 residents who required blood glucose monitoring as identified by the Director of Nursing on 8/18/05 at 1:52 p.m. The findings are:</p> <ol style="list-style-type: none"> <li>1. The Glucometer Log for the North Hall was reviewed on 8/17/05 at 2:12 p.m., and there was no documentation the glucometer had been calibrated on 6/08/05, 6/9/05, 6/16/05, 6/19/05, 7/20/05, 7/21/05, 7/22/05, 7/23/05, 7/24/05, 7/25/05.</li> <li>2. The Glucometer Log for the South Hall was reviewed on 8/17/03 at 2:12 p.m., and there was no documentation the glucometer had been calibrated on 6/9/05, 6/16/05, 6/19/05, 7/3/05, 7/13/05, 7/20/05, 7/21/05, 7/21/05, 7/22/05, 7/23/05, 7/24/05, 7/25/05.</li> <li>3. On 8/17/05 the Nurse Consultant stated that one of the glucometers had been broken, but did not remember when.</li> <li>4. The Manufacturer's Guidelines recommended the accuracy of the meter be checked daily.</li> </ol>	F 502			