

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

PRINTED: 05/01/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045259</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>WOODLAND HILLS HEALTHCARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8701 RILEY DRIVE LITTLE ROCK, AR 72205</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 176 SS=E	<p>483.10(n) SELF ADMINISTRATION OF DRUGS</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that a resident was re-evaluated quarterly to determine that it was safe for the resident to continue the administration of the medication, and the resident understands any specific instructions needed for administration of the medication for 1 of 1 (Resident #15) who self administered medications. This failed practice had the potential to affect 1 resident who had been assessed to self administer medications according to a list provided by the Director of Nursing on 4/17/08. The findings are:</p> <p>1. Resident #15 had diagnoses of Poliomyelitis, Glaucoma, and Depression. The annual Minimum Data Set dated 1/28/08 documented the resident was independent in cognitive skills for daily decision making, had no problems with long or short memory problems, and required moderate assistance with Activities of Daily Living.</p> <p>a. The Assessment for Self-Administration of Medications form dated 5/11/04 and reviewed on 8/26/04 documented the resident was safe to self - administer her medications and the ICP team granted approval.</p> <p>b. The Care Plan dated as reviewed on 4/9/08</p>	F 176		
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 176	<p>Continued From page 1</p> <p>documented: Self Administration of Eye Gtts (drops) ... Resident will administer eye gtts accordingly to facility protocol. Keep eye drops easily accessible, and out of reach of other residents for safety. Assess [Resident] for ability to self administer her eye [drops]. Keep medication administration record and document eye drops... May allow [resident] to self administer eye [drops] per protocol of facility.</p> <p>c. The April 2008 Physician order sheet documented, "May allow resident to self administer eye gtts (drops) per protocol of facility."</p> <p>d. The April 2008 Medication Administration Record (MAR) documented the eye drops that were ordered were as follows:</p> <p>Cosopt solution ophthalmic 1 gtt ou (both eyes) Q (every) 12 hours... scheduled times on MAR (Medication Administration Record) was 9:00 a.m., and 9:00 p.m.</p> <p>Pilocarpine solution 1% os (left eye) Q 12 hours... scheduled times on MAR was 9:00 a.m., and 9:00 p.m.</p> <p>Travatar ophthalmic solution 0.004% 1 gtt ou (both eyes) (hour of sleep)... scheduled times on MAR was 9:00 p.m.</p> <p>Pred Forte ophthalmic solution 1% 1 gtt left eye qid (4 times a day)... scheduled times on MAR was 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.</p> <p>Acular ophthalmic solution 1 gtt Lt (left) eye qid... scheduled times on MAR was 9:00 a.m., 1:00</p>	F 176			

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F 176	Continued From page 2 p.m., 5:00 p.m., and 9:00 p.m.  Non-Preservative tears q (every) 2-4 hours prn (as needed) lubrication. (1 gtt both eyes)  d. On 4/16/08 at 10:35 a.m., the resident told the LPN that since she was there she could go ahead and put her eye drops in. The residents eye drops scheduled administration time was 9:00 a.m.  e. On 4/16/08 at 2:40 p.m., the resident was asked to view her bottles of eye drops. The eye drops were all together in a plastic bag in the residents bedside cabinet drawer. None of the bottles of eye drops were dated as to when they had been opened. The resident administered an eye drop, she put the drop directly on her eye instead of the recommended lacrimal sac, and she did not hold light pressure for 1 minute to aid in the absorption of the eye drop. The resident was asked how long she waited before putting in other drops. She stated,"3 minutes." The 2007 Nursing Drug Handbook on page 1140 and 1141 documents recommended time of 5 minutes between drops.  f. As of 4/18/08 at 3 pm, the DON could not provide documentation of self administration of medications assessments that had been completed since 8/26/04.	F 176			
F 221 SS=E	483.13(a) PHYSICAL RESTRAINTS  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221			

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F 221	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that alternative measures were attempted prior to the use of physical restraints, that reduction attempts were made and/or that reassessments for appropriateness of restraint use were conducted and interventions reviewed and updated when appropriate for 4 (Residents # 3, 9, 10, and 12) of 7 (Resident # 3, 4, 5, 7, 9, 10 thru 12) case mix residents who used physical restraints. The failed practice had the potential to effect 23 residents that used physical restraints as documented on the Resident Census and Conditions of Residents form dated 4/18/08. The findings are:</p> <p>1. Resident #10 had diagnoses (dx) of Huntington's Chorea, Anxiety and Depression (Adjustment Reaction) Brief and Alzheimer Dementia. The MDS dated 3/19/08 documented the resident had moderately impaired cognitive skills for daily decision making, required total assistance with Activities of Daily Living and did not have a restraint.</p> <p>a. The Physical Restraint Elimination Assessment form dated 1/16/08 documented "...total score 23..." The form indicated that a score of 21 - 35 made the resident a good candidate for a restraint reduction. [There was no documentation of further evaluation or other interventions put in place for restraint reduction].</p> <p>b. The Physical Restraint Informed Consent form dated 1/19/08 documented, "Self Release Seat Belt while (up) in chair...Specific Target</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>Behaviors: Involuntary body movements, Fall Risk... ..medical symptoms: Huntingtons Chorea..."</p> <p>c. The care plan date reviewed 3/26/08 documented, "Physical Restraint Use ... Self release belt while up in w/c to assist in fall prevention and increase safety d/t (due to) dx of Huntington Chorea. [Check] Q (every) 30 mins and release q 2 hours x 10 mins for exercise."</p> <p>d. A April 2008 Physician's order sheet documented, "Self Release seat belt restraint while up in wc (Wheel chair) [due to] Involuntary Movements r/t Huntington ' s [Disease].</p> <p>e. On 4/15/08 at 12:15 p.m., and 12:15 at 1:15 p.m., the resident was up in a wheelchair and a self release seat belt restraint was in place. The Charge Nurse was asked if the resident could release her self release seat belt restraint. The resident was asked to release the self release seat belt restraint, after three attempts, the resident was not able to release the restraint.</p> <p>f. On 4/16/08 at 2:11 p.m., the DON stated during interview, "We will get Physical Therapy to evaluate her, because we haven't followed up on assessing her for restraint reduction."</p> <p>2. Resident # 3 had diagnoses of Alzheimer Disease and Depression. The Significant Change MDS dated 3/25/08 documented the resident had short term and long term memory deficit, was moderately impaired in cognitive skills for daily decision making, required limited assistance of one person for transfers, ambulation and personal hygiene, and had no devices or restraints.</p>	F 221			

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F 221	Continued From page 5  a. An Incident and Accident report dated 01/8/08 documented: "The resident was in the main dining room in wheelchair, began pushing [wheelchair] away from table then slid out onto floor. ... Additional comments and/or steps taken to prevent recurrence: Wedge cushion to be used in [wheel chair]. PT (Physical Therapy) to eval (evaluate) [resident] for use of restraints - Self release soft belt."  b. A Physician Order dated 1/8/08 documented, "Self Release Seat Belt in w/c (wheelchair), personal alarm on bed due to R (Resident) attempting to ambulates [without assistance] and increased fall risk."  c. An Incident and Accident Report dated 1/14/08 documented "Summoned to pt's (patients) room, pt got up and crawled out of the foot of bed, had wet on floor [and] slipped in it. ... "  d. An Incident and Accident Report dated 3/13/08 documented, "[Resident will undo SRSB (Self Release Seat Belt) to go to BR (bath room) on her own, does not lock w/c [and] sat in floor. ... Interventions not appropriate - family conference "  e. An Incident and Accident Report dated 3/16/08 documented, " Fall to floor without injury. Non - Compliant with allowing safety belt to stay fastened ... SRSB [to] SRSB [with] alarm. ... "  f. An Incident and Accident Report dated 3/23/08 documented that the residents bed alarm was alarming , resident was found laying on the floor of the bathroom. The intervention was Personal Enclosure.	F 221		

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F 221	<p>Continued From page 6</p> <p>g. An Incident and Accident Report dated 3/28/08 documented, " Resident able to undo restraint and stood up and fell on buttocks, the intervention was to discontinue the SRSB (self release set belt)."</p> <p>h. A Physician order dated 3/28/08 documented, "May use soft belt restr (restraint) in w/c due to residents repeated falls and unaware of own safety needs."</p> <p>i. On 4/15/08 at 9:10 a.m., Certified Nursing Assistance (CNA) # 1 stated that the resident was able to go to the bathroom and turns on the emergency light when she needs to go to the bathroom."</p> <p>j. On 4/16/08 at 11:05 a.m., the resident was propelling self in a wheelchair in the hall way and was asking for help to go to bathroom. The resident was taken to the bathroom by CNA #5 and voided in the toilet.</p> <p>k. On 4/16/08 at 3:20 p.m., the Director of Nursing (DON) was asked if the resident had had a Bowel and Bladder assessment, the DON stated, "No, she had not had a bowel and bladder assessment and had not been placed on a bowel and bladder program."</p> <p>l. On 4/18/08 at 8:42 a.m., the Director of Nursing (DON) stated, "The low bed was not implemented because the Son did not want it. " The DON was asked about the use of the wedge cushion that was part of the interventions that had been documented on the incident and accident report dated 1/8/08, the DON stated, " I'm not sure if the wedge cushion was used. " The DON was asked if the facility had any documentation</p>	F 221			

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F 221	<p>Continued From page 7</p> <p>regarding the use of the wedge cushion, As of 4/18/08 at 11:00 a.m., no documentation had been received from the DON that the wedge cushion had been used in the resident ' s wheelchair. The resident had not been assessed and evaluated for a lease restrictive intervention starting with the self release belt on 1/8/08, and interventions that had been put in place had not been implemented.</p> <p>3. Resident # 9 had diagnoses of Dementia, Alzheimer and Depression. The Quarterly MDS dated 1/23/08 documented the resident had short term and long term memory deficit, moderately impaired cognitive skills for daily decision making, required total assistance with transfers and personal hygiene and had a physical trunk restraint.</p> <p>a. A Physician telephone order dated 12/19/07 documented, " 1. D/C (discontinue) soft belt in W/C (wheelchair), 2. Self release seat belt in W/C [due to] impaired cognition and unsteady gait secondary to Dementia. "</p> <p>b. The Physical Restraint Elimination Assessment form dated 1/16/08 documented; "Record total score 30, Candidate status as determined by or elimination program. Plan of care updated yes. Action plan, D/C soft belt; SRSB while in W/C [due to] attempt to transfer [without] assist. " The additional comments, that this is a "Restraint reduction."</p> <p>c. On 4/17/08 the Incident and Accident reports were reviewed for January, February and March of 2008 . There was no documentation of a fall recorded for the resident.</p>	F 221			

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F 221	<p>Continued From page 8</p> <p>d. On 4/17/08 at 4:30 p.m., the resident was sitting in a wheel chair. The resident was asked if she could undo the seat belt, the resident looked at the seat belt and folded her hands, with no attempt to undo the self release seat belt. The resident could not unlatch the self release seat belt, and the self release seat belt was a physical restraint and not a restraint reduction.</p> <p>4. Resident #12 had diagnoses of Alzheimer Disease, Psychosis, and Depression. The Quarterly MDS dated 3/31/08 documented the resident had short term and long term memory deficit, was moderately impaired in cognitive skills for daily decision making, required extensive assistance of one person for transfers, ambulation and personal hygiene, was frequently incontinent of bladder and bowel and had no devices or restraints.</p> <p>a. A Physical Restraint Consent dated 5/21/07 documented: Self Release seat belt in wheelchair... poor safety awareness... unsteady gait... diagnosis Dementia.</p> <p>b. Physical Restraint Elimination Assessment forms dated 3/1/07, 5/13/07 and 9/10/07 documented a score of 17 or 18 for the 3 assessments. The forms documented that a score of 0-20 indicated that the resident was a priority candidate for restraint elimination.</p> <p>c. An Incident and Accident (I&amp;A) Report dated 11/5/2007 documented, found resident sitting in floor, edge of bed, facing wheelchair. SRSE (self release seat belt) undone, personal alarm on w/chair (wheelchair). Nurse's note dated 11/05/07 documented, Resident states she was leaning over to get shoes, resident facing wrong</p>	F 221			

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F 221	Continued From page 9 way ... Resident had SRSB but had undone belt herself. [There were no new interventions documented on the I &A report or in the Clinical record].  d. The care plan dated reviewed 4/1/07 documented, " Devices use; Self release seat belt, ... approach ... Self release seat belt when up in w/c [due to] poor safety awareness. Attempts to transfer without assist [and] unsteady gait secondary to psychosis and weakness. ... "  e. The March 2008 Physician order sheet documented, "Self Release Seat Belt in w/c [due to] poor safety awareness, attempts to transfer without assistance and unsteady gait secondary to psychosis and weakness., chair alarm while in w/c to alert staff when resident attempt to ambulate without assist ... bed alarm to alert staff when resident attempts to transfer without assist ... Low bed [due to] high risk for falls R/T (related to) frequent attempts to ambulate without assistance....  f. On 4/16/08 at 6 p.m. and 4/17/08 at 4:30 p.m. the resident was asked if she could undo the seat belt, the resident looked at the seat belt and she stated "No, I can not take it off" and made no attempt to undo the self release seat belt.  g. On 4/18/08 at 1:40 p.m., the DON was asked for any current consents and documentation regarding Physical restraint elimination and recommendations. The DON was unable to produce any other documentation for consents or current assessments.	F 221			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE  The facility must provide housekeeping and	F 253			

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F 253	Continued From page 10 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure that the facility was maintained in a sanitary and orderly manner as evidenced by feces observed on the floor in the shower room on the Minor Lodge wing and in the drain hole and shower curtain on D hall, dirt and debris on the floor, a build up of rust on the return air vents, feces on the floor, carpet not secured and a brown substance on the floor and walls of a residents room. This failed practice had the potential to affect all 109 residents in the facility as identified on the Residents Census and Conditions of Residents form dated 4/18/08. The findings are:  1. On 4/14/08 at 8:25 p.m. while doing initial rounds the first shower room on the D hall was observed. There was feces in the drain hole and on the shower curtain.  2. On 4/15/08 at 10:16 a.m., during the general tour of the facility, the following was observed.  a. A build-up of dirt and debris was noted on the floor in the area next to laundry room.  b. The grids and overhangs in the ceiling in the therapeutic dining room on the B Hall had build-up of rust on them around return air vents  c. Feces was on the floor in the shower room on the Manor Lodge Wing.  d. The carpet was not fully secured to the floor in	F 253		

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F 253	Continued From page 11 some areas on the C and D Halls.	F 253			
F 282 SS=E	<p>3. On 4/15/08 at 9:15 a.m. and on 4/16/08 at 9:25 a.m., there was a brown substance on the wall, and floor in room G2.</p> <p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure that Physician orders were followed for one case mix resident (Resident # 9) of 19 (Residents 1-12 and 14-20) case mix resident that had physician orders. The failed practice had the potential to affect all 109 residents who had physician orders as identified by the Resident Census and Conditions of Residents form dated 4/18/08. The findings are:</p> <p>1. Resident # 9 had diagnoses of Dementia, Alzheimer and Depression. The quarterly Minimum Data Set dated 1/23/08 documented the resident had moderately impaired cognitive skills for daily decision making.</p> <p>a. The Physician Orders dated 4/15/08 documented: "AFO Boots or equivalent bilateral to be worn [at] all times except bathing R/T [related to] impaired mobility, ankle edema check q (every) 4 hours for redness edema.</p> <p>b. On 4/15/08 at 12:15 p.m., 3:30 p.m., and 4:30</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER  <b>WOODLAND HILLS HEALTHCARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8701 RILEY DRIVE LITTLE ROCK, AR 72205</b>		
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F 282	Continued From page 12 p.m., the resident did not have the AFO boots on.  c. On 4/16/08 at 7:15 a.m., the resident was up in the dining room wearing house shoes. The resident did not have the AFO boots on.  d On 4/17/08 at 9:20 a.m., the resident was in bed the AFO boots were sitting in the floor. At 10:55 a.m. the resident was sitting up in a wheelchair with her house shoes on. The resident was not wearing the AFO boots.	F 282			
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.  This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility to ensure that the head of the bed was elevated at all times per physician orders and that only Licensed staff turned off and disconnected a tube feeding from the PEG (Percutaneous Esophageal Gastrostomy) tube for one case mix resident (Resident # 11) of 5 (Residents # 1, # 11, #12 # 13 and #17) case mix residents who had a PEG tube. This failed practice had the potential to affect a total of 15 residents in the facility who had a PEG tubes according to the Resident Census and Conditions of Residents form dated r 4/18/08. The findings are:	F 322			

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F 322	Continued From page 13 Resident # 11 had diagnoses of Dysphagia. The quarterly Minimum Data Set dated 3/26/08 documented the Resident had severely impaired cognitive skills for daily decision making and had a feeding tube.  a. The care plan dated reviewed 1/17/08 documented: "Keep HOB elevated at all times to prevent aspiration and facilitate digestion."  b. The April 2008 Physician Order sheet documented, "Diabetic AC [at] 54 cc/HR (hour) x 23 hours off one HR/day for ADL'S (activity of daily living) ...keep HOB (head of bed) elevated at all times.  c. On 4/15/08 at 10:15 a.m., CNA (Certified Nursing Assistant) # 3 and # 4 lowered the HOB flat for approximately 5 minutes while the resident was being weighed. The feeding was infusing at 54 cc (cubic centimeters) per hour.  d. On 4/15/08 at 10:42 a.m., CNA # 1 and # 2 were performing incontinent care. CNA # 1 turned off the feeding pump and disconnected the feeding tubing from the resident PEG tube and laid the feeding tubing over the feeding pump. After the care was completed the Charge Nurse replaced all the tubing and reconnected the residents feeding.	F 322			
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION  The facility must ensure that the resident environment remains as free of accident hazards	F 323			

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F 323	<p>Continued From page 14</p> <p>as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure the environment was free of accident hazards as evidenced by the doors to the beauty shop, shower room being left unlocked and the storage rooms in the therapeutic dining room on the Nursing Center Wing containing picture frames with rough edges and a cabinet door with nails extending from it and a med cart on the A Hall was left unlocked and unattended. These failed practices had the potential to affect 56 residents on the A, B, F and G Halls according to the Roster Sample Matrix dated 4/14/08. The findings are:</p> <p>1. On 4/14/08 the following observations were made:</p> <p>a. On 4/14/08 at 8:15 p.m., the door to the beauty shop was unlocked. On the counter there was finger nail polish remover, hair conditioners, gel shampoos, shaving creams and other beauty products with warning labels on them.</p> <p>b. On 4/14/08 at 8:25 p.m., the door to the shower room on the Manor Lodge Wing was left unlocked. Disposable razors, sharp containers, deodorants and body washes were in the shower room.</p> <p>c. On 4/14/08 at 10:16 a.m., in the therapeutic</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>room on the B Hall, the door to the storage room was unlocked. The room contained a accumulation of picture frames with rough edges and a discarded cabinet door with nails protruding from it.</p> <p>2. On 4/14/08 at 10:16 a.m., in the day room located across from the Manor Lodge nurses station, there was an accumulation of cardboard boxes that extended from the floor to the ceiling. There was 4 residents present at the time of the observation and no staff was present.</p> <p>3. On 4/14/08 at 9:30 p.m. the A hall medication cart was parked at the outside of the nursing station facing A hall. The medication cart was unlocked, out of the sight of any staff. There was a resident approximately 4 feet from the medication cart sleeping in a easy chair. At 9:33 p.m. the medication cart was passed by an LPN. At 9:35 p.m. there was no staff in view of the cart until 9:45 p.m. when a CNA passed by the cart. From 9:50 to 10:05 p.m. the cart was not observed by staff. At 9:55 p.m. a family member retrieved a disposable cup from the cart.</p> <p>4. On 4/14/08 at 8:25 p.m. while doing initial rounds the first and second shower was unlocked on the D Hall. There was one resident observed in the hallway in the wheelchair and 1 resident sitting in the wheelchair in the day area near the nurses desk. Inside the first shower room was an open cabinet. There was a red sharps container approximately 1/2 full on the top shelf, 2 bottles McKeesson Body Wash/Shampoo, in a container on the second shelf was a pair of scissors, many disposable razors, 1 bottle hand sanitizer with a small amount in it, 1 speed stick deodorant and 1 secret solid deodorant. The second shower, the</p>	F 323			

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F 323	Continued From page 16 key was observed sticking in the lock on the outside of the door.	F 323			
F 329 SS=E	483.25(l) UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that residents were assessed for reduction and/or discontinuation of sedatives / hypnotics, anti-depressants and proton pump inhibitors for 6 (Resident #2, 3, 9, 8, 12, and 18) of 15 (1- 12 and 14-16 ) case mix residents. This failed practice	F 329			

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F 329	Continued From page 17 had the potential to effect 109 residents that were received medication in the facility according to the Resident Census and Conditions of Residents form dated 4/18/08.  1. Resident #12 had diagnoses of Congestive Heart Failure, Psychosis, Depression, Chronic Obstructive Pulmonary Disease. The Quarterly MDS (Minimum Data Set) dated 3/31/08 documented the resident had moderately impaired cognitive skills for daily decision making,  a. A Physician order dated 12/20/07 documented for Ambien 2.5 mg (milligram) PO (by mouth) Q (every) HS (hour of sleep).  b. The Central Pharmacy Consultation Report form dated 2/22/2008 documented Resident had been receiving Ambien 2.5 mg HS since 12/2007 ... gradual reduction ... Decreasing Ambien 2.5 mg to every other night or discontinuing Ambien while starting Melatonin 3 mg HS. Physician response dated 3/15/08 documented with an X in the box ...I accept the recommendation above, please implement as written. As of 4/15/08 there was no documentation in the clinical record that the physician's response was implemented.  c. On 4/16/08 after review of the MARs (Medication Administration Record) the resident had received Ambien 2.5 mg every night in December beginning on 12/20/07 through 12/31/07 for a total of 11 doses, from 1/1/08 through 1/31/08 for a total of 31 doses, from 2/1/07 through 2/29/08 for a total of 29 doses; from 3/1/08 through 3/31/08 for a total of 31 doses, and from 4/1/08 through 4/16/08 for a total of 16 doses.	F 329		

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F 329	Continued From page 18 2. Resident # 3 had diagnoses of Alzheimer Disease and Depression. The Significant Change MDS dated 3/25/08 documented the resident had moderately impaired cognitive skills for daily decision making, required limited assistance of one person physical assistance for personal hygiene, and was frequently incontinent of bladder and usually incontinent of bowel.  a. A Physician Order dated 12/31/07 documented "Lexapro 5 mg po Q HS."  b. The Drug Regimen Review form dated 3/27/08 documented, "Asking for cc (clinical contraindication) for Lexapro.  c. The Pharmacist Consultation Report for Lexapro dated 3/28/08 documented, Free ted DEP (antidepressant) comment the physician may write a clinical statement indication why tapering of Antidepressant is not feasible. 2008 clinical contraindication letter for continued use of Lexapro at present dosing. Recommend. Resident takes low dose of Lexapro 5 mg HS since 12/07 with DZ (disease) states of Malaise, Fatigue, Alzheimer, Depression, TIA (transient ischemic attack), CAD (coronary artery disease) and Pacemaker, and Depression is ongoing and reducing or tapering the dose would not be in her best interest and Lexapro at present dosing continues to be a valid therapeutic intervention of her and the benefits continued use out weigh any associated risk at this time". The Physicians response "I accept the recommendation(s) above, please implement as written". There were no documentation from the Physician of the resident signs and symptoms of depression or the residents medical condition to continue the Antidepressant medication as required by the	F 329			

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F 329	Continued From page 19 Federal guidelines.  3. Resident # 9 had diagnoses of Dementia, Alzheimer and Depression. The quarterly MDS dated 1/23/08 documented the resident had moderately impaired cognitive skills for daily decision making, required total assistance for transfers and personal hygiene.  a. A Physician order dated 6/5/07 documented, "Abilify 2.5 mg one tab (tablet) PO Q HS." Another order 5/7/07 documented, " Lexapro 10 mg one tab po QD (every day. "  b. The Drug Regimen Review form dated 1/24/08 documented: "eval (evaluation) 2.5 mg HS for GDR (gradual dose reduction) and dated for 2/21/08 documented: " asking for cc (Clinical Contraindication) for Lexapro and 3/27/08 rewriting above" [this was written and dated in same slotted area as the 2/21/08 notation].  c. The Pharmacist Consultation Report recommendation date; 3/28/08, "comment free text DEP (depression) comment the Physician may write a clinical contraindication letter for continued use of Antidepressant at current dosing. 2008 clinical contraindication letter for continued use of Lexapro at current dosing. Recommend Resident has received Lexapro 10 mg per day since 5/07 due to Dx (diagnoses) of Dementia, Depression, Delirium, COPD (congestive obstruction pulmonary disease), Phychosis and Gallbladder Dz and due to multiple Dz states the condition of Depression continues to exist and tapering the Antidepressant would be of no real benefit at this time. Lexapro at current dosing continues to be a valid therapeutic interventions and benefits of continued use	F 329			

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F 329	Continued From page 20 outweigh any associated risk at this time." The Physician response. " I accept the recommendation(s) above, please implement as written" dated 4/7/08. There were no documentation of the resident continued signs and symptoms of depression and there was no risk versus benefit statement from the Physicians for the Antidepressant medication Lexapro as per Federal requirement for Antidepressant medications.  d. The 2007 Lippincott's Nursing Drug Guide, page 141 documented: "indications, Short-term treatment of Schizophrenia, maintaince of stability in patients with Schizophrenia and treatment of acuta manic and mixed episodes associated with Bipolar Disorders, maintenance therapy of patients who have been clinically stable on Abilify for 6 wks[weeks]. The resident does not have diagnoses of Schizophrenia or Bipolar Disorder.  4. Resident # 18 had diagnoses of Depressive Disorder. The Minimum Data Set(MDS) dated for 2/20/08 documented that the resident has short term and long term memory deficits and has overrate impaired cognitive skills for daily decision making. The resident requires extensive assistance with transfers and personal hygiene and the resident received Antidepressant medications over the past 7 days.  a. The Physician Order dated for 11/30/07 documented: "Lexapro 10 mg 1 tab[tab] PO[by mouth] QD[every day]".  b. The Drug Regimen Review documented no request for Lexapro reductions since 12/20/07. The Consultant Pharmacist medication review dated for 3/27/08 review documented " no	F 329			

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F 329	<p>Continued From page 21 problem". There were no documentation regarding dose reduction by the Consultant Pharmacist or a risk versus benefits documentation for the Antidepressant medication Lexapro as per Federal requirement for use of Antidepressant medications.</p> <p>5. Resident # 8 had diagnoses of diagnoses of Psychosis and Schizoaffective Disorder and Bipolar Disorder. The Medicare 14 day assessment documented that the resident had short term and long term memory deficit and moderately impaired cognitive skills for daily decision making. The resident required extensive assistance with transfers and personal hygiene. The resident received Hypnotic medications 7 days over the past 7 days.</p> <p>a. The Physician Orders dated for 3/10/08 documented: "Ambien 5 mg PO [by mouth] [at] bedtime PRN (as needed) Insomnia".</p> <p>b. The Resident Careplan dated for 7/6/07 documented: "Stays up [at] night sleeps in chair [at] nurses station, refuses to sleep in bed. Wanders [at] night in and out of other R[residents] rooms. Will encourage to sleep in bed nightly: Review CPC[compressive plan of care] Approach; Encourage R[resident] to sleep in bed, provide quiet environment to aid in sleep pattern, Meds[medication] as ordered and notify MD[Medical Doctor] Notify MD and family of R's[residents] sleep patterns, redirect R[resident] as needed. The documentation dose not indicate if any interventions were attempted prior to the use of Hyponic medications.</p> <p>c. On 4/18/08 after review of the Residents MAR(medication administration record)</p>	F 329			

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F 329	<p>Continued From page 22</p> <p>documented that the medication Ambien was increased from Ambien 2.5 mg PO at bedtime PRN to Ambien 5 mg po at bedtime PRN. The Ambien 5 mg had been administered 19 times from 3/11/08 through 3/31/08 and had received Ambien daily for the month of April as of 4/17/08.</p> <p>d. The 2007 Lippincott;s Nursing Drug Guide page 1232 documented: "Indications, short term treatment of insomnia. Geriatric patients. Increased chance of confusion, acute brain syndrome. Take this drug exactly as prescribed. Do not exceed prescribed dosage. Long term use is not recommended".</p> <p>e. On 4/18/08 at 3:20 p.m., LPN 4 , stated that " the resident won't take her Ambien from her, she has to wait until her son comes in so that she will take her medication. She does not routinely ask for her Ambien. Review of the resident MAR's the resident received the Ambien daily since 3/11/07 until present.</p> <p>6. Resident # 2 had diagnoses of GERD (Gastroesophageal Reflux Disease). The Medicare 14 day assessment Minimum Data Set(MDS) dated for 1/11/08 documented that the resident had moderately impaired cognitive skills for daily decision making.</p> <p>a. The Physician Orders documented: "Prevacid Solutab 30 mg PT(per tube) QD(daily) 11/16/07.</p> <p>b. The Drug Regimen Review dated for 2/21/08 documented: "Asking for cc for Prevacid" and "3/27/08 waiting reply".</p> <p>c. As of 4/18/08 there was no documentation in the clinical record to indicate the physician had</p>	F 329			

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F 329	Continued From page 23 responded to the drug regimen review.  d. The 2007 Lippincotts Nursing Drug Guide page 676 documented: "Prevacid Proton Pump Inhibitor" "Prevacid, indications, short term treatment(up to 8wk[weeks] ) of GERD: Severe erosive esophagitis, poorly responsive symptomatic GERD"... "An additional; 8 wk course may be helpful for patients who do not heal with 8 wk therapy".  e. The CMS/Center for Medicaid and State Operations/Survey and Certifications Group documentation: "Proton Pump Inhibitors (PPI'S) H2 blocks used for prophylaxis during the acute phase of medical illness should be tapered and possible discontinued after the acute phase of the illness has resolved, unless there is valid clinical indications for prolonged use". Pedric re-evaluation of the medications regiment is necessary to determine whether prolonged or indefinite use of a medications is indicated. The clinical rationale for continued use of a medication(s) may have been demonstrated in the clinical record, or the staff and prescriber may present pertinent clinical reasons for the duration of use."	F 329		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation of the 9:00 a.m. medication pass on 4/17/08 the facility failed to follow physicians orders to ensure that the medication	F 332		

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F 332	<p>Continued From page 24</p> <p>error rate was less than 5%. Physician orders were not followed on 2 case mix residents (Resident #6 and #14) of 7 residents observed during the medication pass. Medication errors were made by 2 LPNs (Licensed Practical Nurses) #1 and #2 of 4 nurses that administered medication according to the DON (Director of Nursing). The medication error rate was 10.87% based on administration of 46 medications and observation of a total of 5 errors. The findings are:</p> <ol style="list-style-type: none"> <li>1. Resident #14 had a physician order dated 10/04/07 for Miralax 17 grams to administer 1/2 dose (8.5 grams) everyday. On 4/17/08 at 8:21 a.m. LPN #1 administered 17 grams.</li> <li>2. Resident #6 had a physician order dated 8/07/07 for ASA (Aspirin) 81 mg everyday per tube, a physician order dated 2/13/08 for Prevacid 30 mg Solutabs everyday, and a physician order dated 3/4/08 for Reglan Syrup to administer 5cc three times a day. <ol style="list-style-type: none"> <li>a. On 4/17/08 at 8:55 a.m., LPN #2 crushed and administered the 81 mg enteric coated ASA.</li> <li>b. On 4/17/08 at 8:55 a.m., LPN #2 crushed and administered the Prevacid Solutabs per tube.</li> <li>c. The Manufacturer documentation states that the Prevacid Solutabs must not be crushed.</li> <li>d. On 4/17/08 at 8:55 a.m., LPN #2 administered 7.5 cc (cubic centimeters) of Reglan syrurp.</li> </ol> </li> <li>6. On 4/17/08 at 8:55 a.m., LPN #2 administered medications per feeding tube without flushing with out at least 30 cc of water prior to the</li> </ol>	F 332		

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F 332	Continued From page 25	F 332			
F 333	administration of the medication.				
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 record review and interview the facility failed to follow physician orders to ensure that residents were free of significant medication errors for 1 case mix resident (Resident #6) observed during the 9:00 a.m., medication pass on 4/17/08. During record review the resident was found to have two significant medications errors. This failed practice had the potential to affect all 109 residents receiving medication in the facility as documented on the Resident Census and Conditions of Residents form dated 4/18/08. The findings are:  1. Resident #6 had a physician order dated 2/13/08 for Prevacid 30 mg. (milligrams) daily.  a. The February, March and April 2008 Medication Administration record documented that the resident received Ambien 5 mg and Prevacid 30 mg from 2/13/08 thru 4/17/08.  c. On 4/18/08 at 11:50 a.m., the resident's physician was asked if he had added the Ambien 5 mg to the resident's orders and he stated that neither him or any of his partners had prescribed the Ambien for the resident.  d. The Resident received a total of approximately 63 unordered doses of Ambien 5mg.	F 333			

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F 333	Continued From page 26 e. This is significant due to the frequency of the error. f. A Physician order dated 2/13/08 documented for Prevacid 30 mg daily. g. The February and March 2008 Medication Administration Record (MAR) documented the medication had been administered Prevacid 30 mg daily from 2/13/08 thru 3/31/08. h. The April 2008 Medication Administration Record documented the resident was administered Prevacid 30 mg twice a day from 4/1/08 thru 4/17/08. i. On 4/17/08 after review of the clinical record and physician order no change in dosage for prevacid was found.	F 333			
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 observation and interview, the facility failed to ensure food stored in the storage area was sealed to prevent the potential for cross contamination, failed to maintained hot food at 140 degrees Fahrenheit ( F ) or above on the steam table and failed to ensure the ice machine were free of debris. The failed practices had the potential to affect 95 residents who received trays from the kitchen as identified on the Diet List	F 371			

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F 371	<p>Continued From page 27 dated 4/15/08. The findings are:</p> <ol style="list-style-type: none"> <li>1. On 4/17 08 at 11:22 a.m., the following observation were made in the facility ' s kitchen:               <ol style="list-style-type: none"> <li>a. The ice machine located in the kitchen had thick accumulation of black substance on the inside back panel hanging down . The inside front panel had accumulations of grayish, brownish and greenish slimy substance with water condensation dripping on the ice. The Dietary Employee #1 stated, " I don't know what the thick substance was. That was yuck."</li> <li>b. The ice scoop holder located on top of the ice machine had water standing with blackish matter floating in it. The ice scoop was resting directly in it.</li> <li>c. A bottle of half used lemon juice dated 2/08 was kept on the shelf above the food preparation counter. The manufacture instruction on the bottle documented, " Refrigerator After Opening."</li> <li>d. A bag of cheese sauce on the shelf above the food preparation counter was not sealed.</li> </ol> </li> <li>2. On 4/17/08 at 4:50 p.m., the temperature of the food items when tested on the steam table by Dietary Employee #3 was as follows: the tartar tots registered 120 degrees Fahrenheit.</li> <li>3. On 4/18/08 at 4:00 p.m., the ice machine by the soda vending machine towards the E-hall where water condensation was dripping down on the ice had an accumulation of slimy blackish and brownish substance on it. Dietary Employee #1 stated, "We clean the ice machine once a month."</li> </ol>	F 371			

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F 371	Continued From page 28 4. On 4/18/08 at 4:22 p.m., Dietary Employee #2 who was cleaning the ice machine stated, " The ice machine was nasty."  5. On 4/18/08 at 1:30 p.m., the documentation received from the Director of Nursing documented, " Ice machine on units are used for filling water pitcher for residents and ice carts."	F 371			
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.  This REQUIREMENT is not met as evidenced by: Based on inspection of the medication rooms and medication carts on 4/17/08, the facility failed to ensure that all products and medications available for administration were in date according to the manufactures dating and that all	F 425			

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F 425	Continued From page 29 medications available for administration were for current residents residing in the facility. This failed practice had the potential to effect all 109 residents that resided in the facility as documented on the Resident Census and Conditions of Residents form dated 4/18/08. The findings are:  1. On 4/18/08 from 10:30 a.m. to 12:45 p.m. and from 2:45 p.m. to 3:15 p.m. the medication rooms and medication carts were reviewed with the following findings:  a. B hall medication room:  7 - 24 gauge IV catheter needles expired 2005 5 - 24 gauge IV catheter needles expired 2006 1 - 24 gauge IV catheter needle expired 2001 1- 24 gauge IV catheter needle expired 2000 6 - 24 gauge IV catheter needle expired 2007 3 - 24 gauge IV catheter needle expired 01/2008 1 - 24 gauge IV catheter needle expired 03/2008  2 - 22 gauge IV catheter needle expired 2001 2 - 22 gauge IV catheter needle expired 2004 1 - 22 gauge IV catheter needle expired 2005 3 - 22 gauge IV catheter needle expired 2006 2 - 22 gauge IV catheter needle expired 03/2008  1 - 20 gauge IV catheter needle expired 1997 2 - 20 gauge IV catheter needle expired 2004 2 - 20 gauge IV catheter needle expired 2006 4 - 20 gauge IV catheter needle expired 04/2007 3 - 20 gauge IV catheter needle expired 02/2008 2 - 20 gauge IV catheter needle expired 01/2008  47 Fibracol Plus Dressing expired 04/2007 28 Carra Smart Foam dressing expired 08/2007	F 425			

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F 425	Continued From page 30 b. B hall medication cart:  1 - Tuberculin PPD vaccine vial not refrigerated and not dated as _____ to when opened. 4 - 25 mg Phenergan suppositories that were not refrigerated. Label documented "Refrigerate."  c. C and D medication cart:  2 - vials of Zyprexa injection 2 mg/2 ml that had been discontinued _____ related to the resident expired November 13, 2007.. 1 - Geodon 20mg/ml vial that had been discontinued _____ related to the _____ resident expired November 13, 2007.  d. A and D medication cart:  1 - multi-dose vial of Fluphenazin 2.5 mg/ml that had been opened on _____ 1/11/08 for Resident #8. 1 - tube Xenaderm ointment that had expired 02/2008 3 - tubes of Accuzyme ointment that had been discontinued on 4/10/08 1- tube of Silvasorb gel that had been discontinued 1- tube of Triamcinolone Acetonide cream that had been _____ discontinued 1 - tube Duoderm ointment that was not labeled 1 - tube of Mupirocin ointment 2% that was not labeled 1 - tube Myoflex ointment that was not labeled 1 - tube Zinc Oxide that was not labeled 1 - tube Glutose 45 that expired 5/2007  e. Treatment cart:  2 - tubes of Accuzyme Ointment that was	F 425		

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F 425	Continued From page 31 discontinued 12/4/2007 related to the resident had been sent to the hospital and expired 1 - tube of Desonid 0.05% cream that expired 03/2008 1 - tube of Fluocinolone 0.025% ointment that expired 02/2008  f. A, C and D halls medication room:  3 - dressing change tray that expired 11/2007 4 - Wound VAC Cannister with Gel that expired 09/2007 5 - VAC Granufoam MED Dressing that expired 10/2007  g. E and F hall medication cart  38 - Lactaid Fast Act tablets that expired 04/2007  2. The facility's Policy and Procedure for Destroying Medications documented the following: Non-unit dose medications not qualifying for return to the issuing pharmacy and drugs left by residents discharged from the facility shall be destroyed.  3. The facility policy and procedure for Labeling of Medication documented as the purpose "The purpose of this procedure is to ensure that all medications maintained in the facility are properly labeled in accordance with current state and federal regulations.	F 425			
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to	F 428			

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F 428	<p>Continued From page 32</p> <p>the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure that the pharmacist reported any irregularities to the attending physician and the Director of Nursing and the reports were acted upon for 2 case mix resident (Resident #6 and 18 ) of 6 (Resident #2, 3, 7, 8, 9, and 18) case mix residents who received antidepressant medication. The failed practice had the potential to affect 44 resident that receive Antidepressant medications according to a list provided by the Director of Nursing dated 4/18/08 at 9:20 a.m. The findings are:</p> <p>1. Resident #6 had a physician order dated 2/13/08 for Prevacid 30 mg. (milligrams) daily.</p> <p>a. The February, March and April 2008 Medication Administration record documented that the resident received Ambien 5 mg and Prevacid 30 mg from 2/13/08 thru 4/17/08.</p> <p>c. On 4/18/08 at 11:50 a.m., the resident's physician was asked if he had added the Ambien 5 mg to the resident's orders and he stated that neither him or any of his partners had prescribed the Ambien for the resident.</p> <p>d. The Resident received a total of approximately 63 unordered doses of Ambien 5mg.</p>	F 428			

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F 428	Continued From page 33 2. On 4/17/08 after review of the Drug Regimen review form dated 9/21/07 thru 3/27/08 the consultant Pharmacist did not identify the above as a drug error during the drug regime review..  3. Resident # 18 had diagnoses of Depressive Disorder. The Minimum Data Set dated 2/20/08 documented the resident had moderately impaired cognitive skills for daily decision making, and had received Antidepressant medications over the past 7 days.  a. The Physician Order dated 11/30/08 documented: "Lexapro 10 mg 1 tab PO (by mouth) QD (every day)."  b. On 4/18/08 after review of the Physician orders and progress notes and clinical record there was no documentation that a failed attempt at a dose reductions for the resident had been attempted and there was not a risk versus benefit statement documented in the clinical record from December 2008 thru March 2008.  c. The Drug Regimen Review form was reviewed on 4/18/08. The form documented a request for Lexapro reductions on 12/20/07. The Consultant Pharmacist medication review form dated for 3/37/08 review documented " no problem."	F 428			
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431			

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F 431	<p>Continued From page 34</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on inspection of the medication rooms and the medication carts on 4/17/08 the facility failed to ensure that all medications that required a physician's order were labeled in accordance with pharmacy regulations and accepted standards of practice. The failed practice had the potential to effect all 109 residents that resided in the facility as documented on the Resident Census and Conditions of Residents form dated 4/17/08. The findings are:</p>	F 431		

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F 431	Continued From page 35 1. On 4/17/08 from 10:30 a.m. to 12:45 p.m., an inspection of the medication rooms and medication carts were done. The following medications were found to be unlabeled:  a. The B hall medication room: 1- 1000cc IV bag of D51/2NS and 2- 30cc vials of 100 unit Hep-lock flush.  b. The C and D hall medication cart: 1-10cc sterile water vial.  c. The A and D hall medication cart: 2-Xenaderm ointment tubes  d. Treatment cart: 1-Accuzyme ointment tube  e. The A, C, and D medication room: 5 - Procrit 20,000/1 ml, 27 - 5cc (cubic centimeter) prefilled Normal Saline flush syringes and 12 - 5cc prefilled Heparin flush syringes.  f. The facility policy and procedure for Labeling of Medication documented as the purpose "The purpose of this procedure is to ensure that all medications maintained in the facility are properly labeled in accordance with current state and federal regulations	F 431		
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	F 441		

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F 441	<p>Continued From page 36</p> <p>resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that the Floor Tech removed the biohazard trash and linen from contact isolation rooms using Standard universal precautions for 1 of 1 case mix resident (Resident #1) who was on contact isolation. This failed practice had the potential to effect all 109 residents in the facility as documented on the Resident Census and Conditions of Residents form dated 4/18/08. The findings are:</p> <ol style="list-style-type: none"> <li>1. Resident #1 had diagnoses of Diabetes Mellitus, and Alzheimer ' s Dementia. A Minimum Data Set dated 3/5/08 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistance with all activities of daily living, was incontinent of bowel, had a foley catheter and a feeding tube. <ol style="list-style-type: none"> <li>a. A Care plan dated as reviewed 3/12/08 had no documentation of the resident for contact isolation.</li> <li>b. On 4/14/08 at 9:43 p.m., LPN #4 stated the resident was on contact isolation. Two red barrels were in the resident's bathroom.</li> <li>c. On 4/16/08 after review of the clinical record there was no documentation of a physician order for Contact Isolation.</li> <li>d. On 4/16/08 at 4:20 p.m. a floor Tech #1 carried an isolation barrel toward the laundry from</li> </ol> </li> </ol>	F 441			

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F 441	<p>Continued From page 37</p> <p>Hall B. He carried the red barrel by one handle on his right side. The Tech was not wearing any protective clothing to prevent cross contamination in the facility. Floor Tech #1 was asked who was responsible for removing the linen and trash from the isolation rooms? The Tech stated that it was the responsibility of the floor techs to check the isolation rooms daily. He stated that they put on gloves and made sure the lids were on tight, took the linen to the laundry and the trash to the biohazard room. There were clean red barrels with red bags in them that were returned to the rooms. The Tech was asked if he had Infection Control training for Standard Universal Precautions.</p> <p>e. 4/17/08 at 11:00 a.m., the Environmental Housekeeper on B hall was asked who was responsible for removing the isolation trash and linen from the residents room that were on isolation. She stated the floor techs.</p> <p>f. On 4/18/08 at 11:30 a.m., floor tech #2 was asked about what precautions were taken when handling the contaminated linen and trash in resident rooms that were on isolation. He stated that it would depend on the type of isolation. He also stated that we wear a gown and gloves when dealing with isolation. If it is respiratory isolation we have to wear a mask too. The surveyor then asked, " How do you know who is on isolation and the type of isolation a resident is on? He stated, " By the sign on the doors. It has instructions on what we are supposed to do and the kind of infection. " The Floor Tech was asked about the contaminated linen and trash in the Resident rooms. Tech stated that " We change out the barrels, and the barrels have rollers so we put on our gloves and gown, make sure the lids</p>	F 441			

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

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F 441	Continued From page 38 are on good, and if there is any linen or trash on the outside of the barrels we wipe them down with sanitizer before removing them from the room. "  g. 4/18/08 at 4:05 p.m., the DON (Director of Nursing) was asked about the isolation barrels and contaminated trash and linen in Isolation room. She stated that the CNAs should inform techs when barrels need to be changed. A memo was out a couple of months for the floor techs to change out the barrels when full; they remove the dirty barrels and bring in 2 clean barrels. Question: Are you aware of the techs spraying the barrels down before removing them from the rooms? DON stated she was not aware of them spraying them down with anything. She stated that the barrels are sprayed down on the outside of the facility.  h. The facilities policy for Standard Infection Precautions received from the DON on 4/18/08 at 10:35 a.m., documented the following under the subtitle Linen. "Handle, transport and process used linen soiled with blood, body fluids, secretions, excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing and avoids transfer of microorganisms to other residents and environments."	F 441		
F 502 SS=E	483.75(j)(1) LABORATORY SERVICES  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by:	F 502		

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F 502	<p>Continued From page 39</p> <p>Based on observation the facility failed to ensure that laboratory supplies that were to be used were not expired. This failed practice had the potential to effect 14 residents on the B Hall as identified on the Resident room listing form received on 4/15/08 11:00 a.m. The findings are:</p> <p>On 4/17/08 from 11:00 a.m. to 11:45 a.m. the following observations were made on the B hall in the medication room:</p> <p>a. 31 - Urine Vacuette sets that expired 2007 and 22 that expired 02/2008 for a total of 53 sets.</p> <p>b. 1 - Bacti Swab that expired 12/15/07.</p>	F 502			