

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

PRINTED: 01/28/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045207</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/11/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUACHITA NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 COUNTRY CLUB ROAD CAMDEN, AR 71701</b>		
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F 000	INITIAL COMMENTS	F 000			
F 157 SS=E	<p>Complaint #13225 was substantiated (all or in part) with deficiencies cited at F157 and F314.</p> <p>483.10(b)(11) NOTIFICATION OF CHANGES</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 157			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>Complaint #13225 was substantiated (all or in part) in these findings:</p> <p>Based on record review and interview, the facility failed to ensure the responsible party and/or the physician was notified of changes in condition and/or treatment for 3 (Residents #16, #21 and #23) of 11 (Residents #14 through #24) case-mix residents who were reviewed for physician and family notification. This failed practice had the potential to affect all 110 residents in the facility, according to the Resident Census and Conditions of Residents form dated 1/7/08. The findings are:</p> <p>1. Resident #16 had diagnoses of Alzheimer's Disease, Anxiety State, Conduct Disturbances and Chronic Ischemic Heart Disease. The Quarterly Minimum Data Set (MDS) dated 12/14/07 documented the resident had severely impaired cognitive skills for daily decision making and had a unstable status that was fluctuating, precarious or deteriorating.</p> <p>a. The Nurse's Notes dated 11/13/07 at 1:00 p.m. documented, "resident crying in D/R (dining room) with c/o (complaint of) stomach pain. Taken to room &amp; (and) laid down. Stomach hard on palpation. ...Call placed to M.D. (medical doctor) awaiting returned call..."</p> <p>When the physician returned the call, on 11/13/07 at 6:00 p.m., he ordered the facility to check for an impaction, use dulcolax and send U.A. (urine) in a.m. (morning). There was no documentation that the resident's responsible party had been notified of the resident's condition or the treatment ordered by the physician.</p> <p>b. The Nurse's Noted dated 11/15/07 at 10:45</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>a.m. documented, "Cath (catheter) inserted using sterile tech (technique) urine specimen obtain &amp; sent to lab..." There was no documentation the resident's responsible party had been notified that the resident had been catheterized and a urine specimen had been sent to the lab.</p> <p>c. The Nurse's Notes dated 11/19/07 at 10:00 a.m. documented, "ABT (antibiotic) started- Amoxil 250 mg (milligrams) T.I.D. (3 times a day) X (times) 7 days..."</p> <p>There was no documentation that the resident's responsible party was notified that the resident had developed an infection (Urinary Tract Infection) or that the resident had been started on an antibiotic. There was no documentation in the Nurse's Notes that the resident's responsible party had been contacted at anytime during the seven days the resident received antibiotics.</p> <p>d. The Nurse's Notes dated 12/12/07 at 12:45 p.m. documented, "Summoned to feeding assist table d/t (due to) resident with head down slumped to left, eyes closed, not responding to verbal or tactile stimuli... Taken to room via w/c (wheelchair). 12:55 [p.m.] In room with continued unresponsive, tactile stimuli performed with some arousal noted. With continued stimulation res. (resident) began to lift head and start to smile. Assisted X 2 to bed with HOB (head of bed) up..."</p> <p>There was no documentation that the physician was consulted or that the resident's responsible party had been notified of the change in the resident's condition.</p> <p>e. On 1/11/08 at 11:35 a.m., when asked if she could provide any documentation that the</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>resident's responsible party had been notified of the resident's condition on 11/13/07, 11/15/07, 11/19/07 or 12/12/07 or any documentation the physician had been notified of the resident's condition on 12/12/07, the Director of Nurses (DON) responded, "No."</p> <p>2. Resident #21 had diagnoses of Alzheimer's Disease and Senile Delusion. The Quarterly MDS dated 10/10/07 documented the resident had moderately impaired cognitive skills for daily decision making and was totally dependent on staff for activities of daily living.</p> <p>a. The Nurse's Notes dated 10/3/07 at 4:00 p.m. documented, "Resident's hands swollen and red rash present on both arms. Both hands also have a blister present with clear fluid in blisters. There is no edema anywhere on body except hands. Dr. [name of physician] notified. See new orders." There was no documentation that the resident's responsible party had been called or otherwise notified of the resident's condition.</p> <p>b. The Nurse's Notes dated 11/23/07 at 10:30 a.m. documented, "Call placed to Dr. [name of physician] office d/t (due to) resident being very lethargic. Resident not eating @ (at) meal times. Awaiting return call... 11:10 a.m. Dr [name of physician] nurse returned call with N.O. (new order). Decrease Ativan to 0.5 mg @ H.S. (bedtime)." There was no documentation that the resident's responsible party had been notified of the resident's change of condition.</p> <p>c. The Nurse's Notes dated 11/24/07 at 1:45 p.m. documented, "Placed call to Dr. [name of physician] office d/t resident being very lethargic to see if he wants to change Ativan to PRN (as</p>	F 157			

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F 157	<p>Continued From page 4 needed) &amp; hold Thorazine to see if resident becomes alert. Waiting return call."</p> <p>d. The Nurse's Notes dated 11/24/07 [no time given] documented, "Consumed approx (approximately) 25% of breakfast &amp; 50% of lunch. Continues to be very lethargic. Very little verbal response. All meals have to be spoonfed."</p> <p>e. The Nurse's Notes dated 11/24/07 at 2:30 p.m. documented, "N.O. D/C (discontinue) Thorazine 10 mg; change Thorazine 0.5 mg po (by mouth) TID (three times a day) to PRN; Change Ativan 0.5 mg @ H.S. (bedtime) to PRN."</p> <p>f. The Nurse's Notes dated 11/24/07 at 5:30 p.m. documented, "Res (resident) continues to be very lethargic. Unable to eat food she placed in mouth... Placed call to Dr. [name of physician] gave report N.O. Send to ER (Emergency Room) for evaluation if family agrees. Spoke to [name], resident's son, agrees that if that is what he needs to send. Taken to [name of hospital] via NH (nursing home) transportation."</p> <p>This was the first documentation that the resident's son had been contacted, since the resident's condition changed 31 hours earlier, on 11/23/07 at 10:30 a.m.</p> <p>g. On 1/11/08 at 11:40 a.m., when asked if there was any documentation that the family had been notified when the resident had a change of condition on 10/3/07 and 11/23/07, the DON responded, "No."</p> <p>3. Resident #23 had diagnoses of Alzheimer's Disease, Dementia with Behaviors, Depressive Disorder and Anxiety Disorder. The Quarterly</p>	F 157			

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F 157	Continued From page 5 MDS dated 12/5/07 documented the resident had moderately impaired cognitive skills for daily decision making and required extensive to total dependence for activities of daily living.  a. The Nurse's Notes dated 1/3/08 at 9:00 a.m., documented, "CNA (Certified Nursing Assistant) reported to this LPN (Licensed Practical Nurse) that the resident had skin breakdown on buttocks. This LPN noted red area approx. (approximately) 4 in (inches) x (by) 2 in on coccyx... Called [name of doctor] to alert him of skin breakdown..."  b. On 1/14/08 at 9:00 a.m., the DON stated, "I can find no documentation that the family was notified of the reddened area across the resident's coccyx."  4. The facility Policy and Procedure for Notification of Change provided by the Nurse Consultant on 1/11/08 at 4:20 p.m. documented, "...Purpose: To ensure that a resident and their legal representative or family member are informed of changes in their medical condition and/or treatment... Policy Statement: The resident, resident's physician, and resident's legal representative or family member will be notified when a life-threatening condition or clinical complications, or need to significantly alter treatment or accident occurs..."	F 157			
F 221 SS=D	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.  This REQUIREMENT is not met as evidenced	F 221			

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F 221	Continued From page 6 by: Based on observation, record review and interview, the facility failed to ensure double restraints were not applied for 1 (Resident #15) of 6 (Residents #10, #12, #13, #15, #16 and #17) case mix residents with restraints. This failed practice had the potential to affect 14 residents who had physician orders for restraints, according to documentation received from the Director of Nursing (DON) on 1/10/08 at 9:48 a.m. The findings are:  1. The facility Policy and Procedure titled, "Restraints - Physical" was received from the DON on 1/10/08 at 9:48 a.m. and documented: "...Essential Points - A physical restraint is defined as any article, device or garment that is used primarily to modify resident behavior by interfering with free movement. These can include cloth vests, soft ties, lab [lap] buddies, soft mittens, seat belts, geri-chairs and/or other devices including side rails that restrict resident movements."  2. Resident #15 had diagnoses of Alzheimer's Disease, Dementia with Behavior Disturbance, Mental Disorder and Memory Loss. The Minimum Data Set (MDS) dated 10/4/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with ambulation in the room and had a trunk restraint.  a. The care plan dated 7/17/07 documented: "Problem/Need... Pelvic restraint while up in w/c (wheelchair) d/t (due to) slides down, poor body control secondary to Alzheimer's and old CVA (cerebrovascular accident), enables resident to maintain proper sitting posture and prevents	F 221			

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F 221	Continued From page 7 sliding down in w/c. Goal... Decreased complications r/t (related to) use of restraint as evidenced by tolerating least restrictive, effective method... Approaches... Apply appropriate restraint/enabler per M.D. (medical doctor) orders..."  b. The "Interdisciplinary Resident Data Collection Form" dated 9/22/07 documented: "Reason for screen: I&A (Incident and Accident) Resident referral for PT screen [secondary to] I&A occurring on 9/14/07. Nsg (Nursing) Notes... resident was found to have turned his w/c over in his room... Recommend resident either receive a new high seat w/c (wheelchair) or possibly a geri-chair with leg rest down, to allow pt (patient) ability to propel self ad lib (as desires)."  c. The Physician order dated 1/8/07 documented: "May use soft belt in geri-chair to prevent unassisted amb (ambulation) r/t (related to) Alzheimer's..."  d. On 1/10/07 at 8:55 a.m., the resident was in the dining room in a Geri-chair, in the reclined position, with a soft belt restraint applied.  e. On 1/10/07 at 9:45 a.m., the resident was in his room in a Geri-chair, in a reclined position, with a soft belt restraint applied.	F 221			
F 309 SS=D	483.25 QUALITY OF CARE  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

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F 309	Continued From page 8  This REQUIREMENT is not met as evidenced by: Complaint #13225 was substantiated (all or in part) in these findings:  Based on observation, record review and interview, the facility failed to ensure physician orders for the treatment of wounds were followed to promote healing and decrease the potential for contamination for 1 (Resident #4) of 4 (Residents #4, #13, #23 and #24) case-mix residents with open wounds. This failed practice had the potential to affect 11 residents with pressure ulcers, stasis ulcers or surgical incisions, according to a list provided by the Director of Nurses on 1/11/08 at 10:25 a.m. The findings are:  1. Resident #4 had diagnoses of Multiple Ischemic Ulcers and Dry Gangrene. The Medicare 14-Day Minimum Data Set dated 12/24/07 documented the resident had two Stage I Stasis Ulcers, one Stage II Stasis Ulcer and three Stage IV Stasis Ulcers, had Foot Problems and Care and received application of dressings, with or without topical medications.  a. The Physician order dated 1/8/08 documented: "...Clean Lt (left) inner ankle [with] Saf Clens - apply Panafil ointment and cover [with] dry drsg (dressing) QOD (every other day)... Clean R) (right) inner ankle [with] Safe Clens - apply Panafil ointment and cover [with] dry drsg QOD... Clean R) outer ankle [with] Saf Clens - apply Panafil ointment and cover [with] dry drsg QOD."  b. On 1/8/08 at 8:13 a.m., 8:59 a.m., 9:30 a.m., 10:15 a.m., 10:36 a.m. and 11:18 a.m., the	F 309			

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F 309	<p>Continued From page 9</p> <p>resident was sitting in a recliner with her legs elevated. There were numerous open ulcers on both of the residents feet and ankles; no dressings were present on either of the resident's feet or ankles. There were open areas (ulcers) on the resident's outer left foot, inner left ankle and left heel.</p> <p>The resident's left heel, with the open area, was lying directly on the plastic covered foot rest of the recliner, creating a potential for contamination of the resident's wound. The other open areas on the left foot were being touched by the lap cover that was covering the residents feet and legs. There were open areas (ulcers) present on the bilateral ankles, right foot and on the inner side of the right foot. The small toe on the right foot was necrotic (completely black) and was odorous. All open areas of the right foot and ankles were being touched by the lap cover that was lying on the resident's feet and legs, creating a potential for contamination of the resident's wound.</p> <p>c. On 1/8/08 at 11:22 a.m., the Director of Nurses (DON) accompanied the surveyor to the resident's room; the surveyor pointed out to the DON that the resident's feet and ankles had no dressings in place and the open area of the resident's left heel was directly lying on the plastic covering of the recliner foot rest. The DON was shown that the other open wounds on both of the resident's feet were being touched by the lap cover.</p> <p>When asked if dressings should have been put on the resident's feet, the DON responded, "The dressings were taken off of the resident's feet for her shower this morning. The CNAs (Certified Nursing Assistant) must had failed to tell the</p>	F 309			

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F 309	Continued From page 10 Treatment Nurse the resident's feet needed to be dressed. The Treatment Nurse starts doing her dressings about 10:00 a.m..."  d. The Doctor's Progress Notes dated 1/8/08 documented, " R (right) foot- multiple ischemic ulcers. Dry Gangrene. No infection. L (left) foot- Medial Malleolus- Stage II- slight drainage. Lateral mid foot- Stage III - Moderate drainage- Heel- minimal drainage..."	F 309			
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all areas of the perineum were cleansed during incontinent care for 1 (Resident #11) of 11 (Residents #1 through #5, #7, #8 and #10 through #13) case mix residents who were incontinent. This failed practice had the potential to affect 42 residents in the facility who were incontinent, as identified by documentation provided by the Director of Nursing on 1/10/08 at 9:48 a.m. The findings are:  Resident #11 had diagnoses of Hypertension and Diabetes Mellitus. The Minimum Data Set dated 9/20/07 documented the resident had modified independence in cognitive skills for daily decision making, required extensive physical assistance of 2 persons with hygiene and was incontinent of bladder.	F 312			

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NAME OF PROVIDER OR SUPPLIER  <b>OUACHITA NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 COUNTRY CLUB ROAD</b> <b>CAMDEN, AR 71701</b>		
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F 312	Continued From page 11  a. The Care Plan dated 12/17/07 documented, "Problem: Potential for Pressure Ulcers: resident is obese, unable to walk, dx (diagnosis) DM (diabetes mellitus) is incontinent of urine, requires assist with transfer and bed mobility, refuses pressure relief cushion in w/c (wheelchair) Goal: Decreased complication r/t (related to) skin as evidenced by resident will have no s/s (signs and symptoms) of skin breakdown next 90 days Approach: ...incontinent care after each episode..."  b. On 1/9/08 at 8:55 a.m., the resident had been incontinent of urine. After removing the resident's urine soiled incontinent brief, Certified Nursing Assistant (CNA) #1 provided incontinent care. The CNA did not separate and cleanse the labia or cleanse the resident's buttocks, before placing a clean brief on her. The resident had duoderm on the coccyx and the bottom edge of it was loose.  c. On 1/10/08 at 10:55 a.m., the Director of Nursing (DON) provided a documented titled, "Incontinent and Catheter Care Observation Checklist." The DON stated the document was used for training of Certified Nursing Assistants. The form documented, "...Female: Wipe one side of labia and then the other? Wipe urinary meatus front to back. Wipe all skin folds of perineal area including abdomen and thighs, changing area on cloth for each wiping stroke, wiping front to back... Wipe the rectal area and buttocks thoroughly, wiping from the base of the labia towards and extending over the buttocks... Changing area of wipe with each stroke..."	F 312			
F 314 SS=D	483.25(c) PRESSURE SORES	F 314			

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F 314	<p>Continued From page 12</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13225 was substantiated (all or in part) in these findings:</p> <p>Based on observation, record review and interview, the facility failed to ensure pressure relieving devices were utilized for the lower extremities to decrease the potential for skin breakdown for 1 (Resident #4) of 20 (Residents #1 through #19 and #24) case-mix residents. This failed practice had the potential to affect all 110 residents in the facility receiving preventive skin care, according to the Resident Census and Conditions of Residents form dated 1/7/08. The findings are:</p> <p>1. Resident #4 had diagnoses of Multiple Ischemic Ulcers and Dry Gangrene. The Medicare 14-Day Minimum Data Set dated 12/24/07 documented the resident had two Stage I Stasis Ulcers, one Stage II Stasis Ulcer and three Stage IV Stasis Ulcers, received application of dressings to the feet, with or without topical medications and received preventive or protective foot care.</p> <p>a. On 1/8/08 at 8:13 a.m., 8:59 a.m., 9:30 a.m.,</p>	F 314			

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F 314	Continued From page 13 10:15 a.m., 10:36 a.m. and 11:18 a.m., the resident was sitting in a recliner with her legs elevated. Both of the resident's feet were lying directly on the plastic covered foot rest of the recliner, creating pressure and the potential for skin breakdown.  b. On 1/8/08 at 11:22 a.m., the Director of Nurses (DON) accompanied the surveyor to the resident's room; the surveyor pointed out to the DON that the resident's feet and ankles had no dressings in place and the open area of the resident's left heel was directly lying on the plastic covering of the recliner foot rest.  When asked if dressings should have been put on the resident's feet, the DON responded, "The dressings were taken off of the resident's feet for her shower this morning. The CNAs (Certified Nursing Assistant) must had failed to tell the Treatment Nurse the resident's feet needed to be dressed. The Treatment Nurse starts doing her dressings about 10:00 a.m. The CNAs should have put heel protectors on the resident's feet until the Treatment Nurse dressed the feet."  c. The facility's policy and procedure titled "Pressure Sores" was received from the DON on 1/10/08 at 9:48 a.m. and documented, "Purpose - To ensure resident who enters the facility without pressure sores does not develop pressure sores..."	F 314			
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323			

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F 323	Continued From page 14  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure restraints were applied according to manufacturer's directions for 2 (Resident #13 and #15) of 6 (Residents #10, #12, #13, #15, #16 and #17) case mix residents with restraints, hot water used by residents was kept at a safe temperature to decrease the potential for burns, bathing rooms were kept locked when not in use and hazardous chemicals were not accessible to residents. This failed practice had the potential to affect 22 confused and independent residents on the 100, 200, 300, 400 and 500 Halls, 73 residents who used the shower on the 200 Hall and 14 residents who had physician orders for restraints, according to documentation received from the Director of Nursing (DON) on 1/10/08 at 9:48 a.m. The findings are:  1. On 1/9/08, hot water temperatures were taken and the following temperatures were recorded:  a. 8:35 a.m. - Resident Room 508, 140 degrees Farenheit.  b. 8:55 a.m. - Resident Room 501, 138.2 degrees Farenheit and Resident Room 104, 134.4 degrees Farenheit.  c. 8:57 a.m. - Resident Room 107, 136 degrees Farenheit.  d. 9:00 a.m. - Resident Room 208, 134 degrees	F 323			

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F 323	<p>Continued From page 15</p> <p>Fahrenheit and Resident Room 503, 138.1 degrees Fahrenheit.</p> <p>e. 9:03 a.m. - Resident Room 305, 132 degrees Fahrenheit.</p> <p>f. 9:06 a.m. - Resident Room 407, 132 degrees Fahrenheit.</p> <p>g. On 1/9/08 at 10:25 a.m., the Maintenance Director provided documentation of water temperatures that had been taken in the facility. There were no temperatures documented after 12/31/07. On 12/31/07 the only temperatures recorded were for the 700 hall and were documented at 109 to 110 degrees.</p> <p>The Maintenance Director was asked how often the water temperatures were taken weekly; he stated that he had not done them for this week [January 7-11, 2008]. There was no documentation, available for review, of the hot water temperatures from 12/31/07 through 1/11/08..</p> <p>2. On 1/9/08 at 9:30 a.m., during the environmental tour conducted with the maintenance staff, the 200 Hall shower door was unlocked and a spray bottle of "General Purpose non-Acid Disinfectant Cleaner" was in the second shower stall, hanging on the rail.</p> <p>The bottle label read: "FIRST AID: If inhaled: ...Call a poison control center or doctor for further treatment advice. If on skin or clothing: ...Call a poison control center or doctor for further treatment advice. If in eyes: ...Call a poison control center or doctor for further treatment advice."</p>	F 323			

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F 323	Continued From page 16  3. Resident #15 had diagnoses of Alzheimer's Disease, Dementia with Behavior Disturbance, Mental Disorder and Memory Loss. The Minimum Data Set (MDS) dated 10/4/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with ambulation in the room and had a trunk restraint.  a. The care plan dated 7/17/07 documented: "Problem/Need... Pelvic restraint while up in w/c (wheelchair) d/t (due to) slides down, poor body control secondary to Alzheimer's and old CVA (cerebrovascular accident), enables resident to maintain proper sitting posture and prevents sliding down in w/c. Goal... Decreased complications r/t (related to) use of restraint as evidenced by tolerating least restrictive, effective method... Approaches... Apply appropriate restraint/enabler per M.D. (medical doctor) orders. Check restraint q (every) 30 min (minutes) and release q 2 hrs (hours) when in use..."  b. The "Interdisciplinary Resident Data Collection Form" dated 9/22/07 documented: "Reason for screen: I&A (Incident and Accident) Resident referral for PT screen [secondary to] I&A occurring on 9/14/07. Nsg (Nursing) Notes... resident was found to have turned his w/c over in his room... Recommend resident either receive a new high seat w/c (wheelchair) or possibly a geri-chair with leg rest down, to allow pt (patient) ability to propel self ad lib (as desires)."  c. The Physician order dated 1/8/07 documented: "May use soft belt in geri-chair to prevent unassisted amb (ambulation) r/t (related to) Alzheimer's. Check q (every) 30 minutes and	F 323			

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F 323	Continued From page 17 release q 2 hours."  d. On 1/10/07 at 8:55 a.m., the resident was in the dining room in a Geri-chair, in the reclined position, with a soft belt restraint applied; the soft belt was tied in a knot at the back of the chair.  4. Resident #13 had diagnoses of Depressive Disorder, Macular Degeneration and Nonpsychotic Brain Syndrome. The Quarterly MDS dated 11/28/07 documented the resident had moderately impaired cognitive skills for daily decision making, had extensive to total dependence on staff for bed mobility, transfers, locomotion on and off the unit and activities of daily living.  a. The Resident's care plan, dated 09/25/07, documented, "...Fall/Physical Restraints: Resident was admitted following pelvic fx (fracture) after a fall, at risk for additional falls d/t (due to) impaired mobility and confusion... soft belt restraints used to prevent..."  b. The physician's order dated 1/3/08 documented, "May have soft belt restraint in w/c (wheelchair) to prevent unassisted ambulation D/T (due to) confusion and unsteady gait. Check Q (every) 30 min. (minutes) and release Q 2H (Hours).  c. On 1/8/08 at 5:25 p.m., the resident was in the dining room at the feeding assist table. The resident was in the wheelchair with a seat belt restraint in place. The seat belt restraint was around the resident and tied in a knot across the back of the wheelchair.  5. On 1/10/08 at 9:20 a.m., the "Soft Wheelchair	F 323			

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F 323	Continued From page 18 Belt 6564" manufacturer instructions were reviewed and documented, "...Application Instructions: 1. Wrap the belt around the patient's waist with the soft foam pad toward the patient over the abdomen. The patient's hips should be against the back of the chair. 2. Secure the buckle behind the patient so the patient can breath easily and sit comfortably..."  6. On 1/10/07 at 9:48 a.m., the "Restraints - Physical" was received from the Director of Nurses and documented, "...All nursing staff members must be trained in the safe and proper application of each type of restraint..."	F 323			