

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

PRINTED: 02/05/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/25/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 157 SS=G	<p>Complaint #13253 was substantiated (all or in part) with deficiencies cited at F157 and F309.</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 #13253 was substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Physician was immediately consulted regarding the presence of audible, abnormal lung sounds for 1 of 1 (Resident #21) case mix resident which resulted in harm for Resident #21 who was hospitalized with Congestive Heart Failure and required diuresis. The facility also failed to ensure the physician was consulted and the family notified of a significant temperature elevation for 1 of 1 (Resident #5) case mix resident. This failed practice had the potential to affect 6 residents with conditions/diseases that made the resident's condition unstable, as documented on a list provided by the Administrator on 1/28/08. The findings are:</p> <p>1. Resident #21 was admitted to the facility on 10/5/07 with diagnoses of Alzheimer's Disease, Right Sided Stroke, Cancer of Prostate, Skin Cancer and Expressive Aphasia, Atrial Fibrillation and Acute Coronary Syndrome. An Admission Minimum Data Set dated 10/25/07 documented the resident was moderately impaired in cognitive skills for daily decision making, had wandering behaviors, resisted care, required limited assistance for transfers, needed assistance with ambulation and required extensive assistance with dressing.</p> <p>a. A Nurse's Note dated 11/19/07 documented the resident was re-admitted to the facility from the hospital at "1030" (10:30 a.m.). A Nurse's Note dated 11/19/07 at 11:00 p.m. documented, "Resting [with] eyes closed - Restless, picking at clothes - non-verbal- hasn't opened eyes tonight..."</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>Res (Resident) refused to open mouth for pm meds (medications). Oral care given - Incontinent care [every] 2 hours and [as needed] - turned - repositioned for comfort - will monitor."</p> <p>b. A Nurse's Note dated 11/21/07 documented, "Sig (significant) change noted."</p> <p>c. The next Nurse's Note was dated 11/23/07 at 9:15 a.m. and documented, "Res alert [with] confusion. Resp (respirations) even and unlabored. Audible wet lung sounds upon entering room. (Resident's Head of Bed up 45 degrees, no complaint or signs and symptoms of pain/discomfort). Incont (incontinent) of [bowel and bladder]. Peri-care given [after] each episode. Wears briefs. Res unclothing self all day, redress res each time entering room. Res refused lunch. Family aware. 1800 (6:00 p.m.) Family called [and] very upset wanting MD (Medical Doctor) called and res to be sent to ER (emergency room) for eval (evaluation). [6:10 p.m.] MD paged [6:15 p.m. New order] Send to ER for eval."</p> <p>d. There was no documentation the physician was notified of the resident's "wet lung sounds" from 9:15 a.m. until 6:10 p.m., when the resident's family requested the physician be notified.</p> <p>e. A Patient Transfer Form dated 11/22/07 [11/23/07] documented "[decreased] cognitive status. Audible wet lungs (possible aspiration)... Ate 25% of one meal in last 3 or 4 days."</p> <p>f. An Emergency Room History and Physical dated 11/23/07 documented "...presents to the emergency room from nursing home with history</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>of increasing shortness of breath and rattling in his chest. They sent him to the emergency room tonight for evaluation and treatment... Lungs: Rales bilaterally... Radiology: Chest x-ray reveals congestive heart failure... Emergency Department Course: He was given 60 [milligrams] of Lasix [Intravenously]..."</p> <p>2. Resident #5 had diagnoses of Spastic Quadriplegia, Postictal Coma, Organic Brain Syndrome, and Psychotic Disorder. The quarterly Minimum Data Set (MDS) dated 11/21/07 documented the resident had moderately impaired cognitive skills for daily decision making and was totally dependent on two or more staff members for bed mobility, dressing, toilet use, and personal hygiene.</p> <p>a. The Nurse's Notes dated 1/8/08 documented, "0430 (4:30 a.m.) temp (temperature) 101.7 ax. (Axillary) gave Apap ES (extra strength) ii (2) po (by mouth)..." There was no documentation in the clinical record that the physician or the family was notified of the significant increase in the resident 's temperature.</p> <p>b. The Nurse's Notes dated 1/8/08 documented, "(1000) [10:00 a.m.] temp 98.8 ax..." There were no other documented temperature assessments after 1/8/08 at 10:00 a.m.</p> <p>c. On 1/9/08 at 9:20 a.m., Licensed Practical Nurse (LPN) #8 was asked if vital signs were taken or temp checked after 10:00 a.m. on 1/8/08 and she stated, "No." The LPN was asked, what was the procedure when a resident ran high temp; the LPN stated, "We give them something if it's on their orders and call the physician." When asked if she could tell if the physician was</p>	F 157			

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F 157	Continued From page 4 called from looking at the notes, the LPN looked at the Nurse's Notes and the 24-hour report and stated, "There is no documentation that the physician was notified of this high temp." The surveyor and LPN went to the resident ' s room and looked at the urine in the resident's catheter tubing. When asked, what she would say that urine looked like, the LPN stated, "Cloudy, very cloudy. I'm going to let the doctor know about this." d. The Nurse's Notes dated 1/9/08 at 9:40 a.m. documented, "Call into [Physician] this a.m. (morning) [with] report of [elevated] temp and urine sediment. Received T.O. (telephone order) for UA (urinalysis) [with] C+S (culture and sensitivity)..." e. The Urinalysis Report dated 1/10/08 from urine collected 1/9/08 at 10:00 a.m. documented, "...Blood/Hemoglobin: 3 +... Bacteria: 4 +... RBC's (Red Blood Cells): Too numerous to count. WBC's (White Blood Cells) 20-40..." f. The Physician Order dated 1/10/08 at 13:00 (1:00 p.m.) documented, "Bactrim DS 1 P.O. (by mouth) BID (twice a day) x (times) 7 days r/t (related to) UTI (Urinary Tract Infection)..."	F 157			
F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 176			

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F 176	Continued From page 5 interview, the facility failed to ensure that before residents were allowed to self-administer medications, an interdisciplinary team assessment was conducted to ensure the practice was safe for 1 of 1 (Resident #2) case mix resident who self-administered updraft treatments. The facility also failed to ensure that a care plan was developed to address the self-administration of updraft treatments, including a documented plan of where the updraft medications would be stored and who would be responsible for documenting the administration of the physician-ordered medications. The failed practices had the potential to affect 4 residents who self-administered medications, as identified by the Administrator on 1/10/08. The findings are: 1. Resident #2 had diagnoses of Chronic Obstructive Pulmonary Disease, Emphysema and Macular Degeneration. The Significant Change Minimum Data Set (MDS) dated 12/27/07 documented the resident had modified independence in cognitive skills for daily decision-making. a. A January 2008 Physician Order Sheet documented the resident was to receive Albuterol updraft treatment TID (three times a day) and "may self administer after set up." b. As of 1/9/08 at 12:45 p.m., the clinical record contained no assessment of the resident's ability to safely and correctly self-administer her own medications. The clinical record did not document the Interdisciplinary Team's evaluation or approval of the self-administration of updraft treatments. There was no documentation on the Plan of Care dated 12/27/07 to address where the updraft medications would be stored, who would	F 176			

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F 176	<p>Continued From page 6</p> <p>be responsible for documenting the administration of the updraft treatments or that the resident's ability to safely and correctly self-administer the updraft treatments was assessed or care planned.</p> <p>c. On 1/9/08 at 12:45 p.m., during an interview, Licensed Practical Nurse (LPN) #1, the Charge Nurse caring for the resident, stated that the resident was able to hold and self-administer the updraft treatments after it was set up for her and that the resident did self-administer her own updraft treatments.</p> <p>d. On 1/9/08 at 2:00 p.m., LPN #1 stated, "We do not have an assessment for the resident to self-administer her updraft treatments. I filled one out after you asked where the assessment could be found."</p> <p>The LPN handed this surveyor an assessment for self-administration of medications with the resident's name and room number documented at the bottom of the form; the form was dated 1/9/08 and signed by the LPN.</p> <p>e. On 1/10/08 at 9:00 a.m., LPN #2 placed medication in the chamber connected to the mouth piece for an updraft treatment, then handed it to the resident, turned the machine on and left the room. The LPN stated the resident was supposed to administer her updraft treatment after set up.</p> <p>f. On 1/10/08 at 9:10 a.m., the resident was observed sitting in the wheelchair alone in the room self-administering her updraft treatment.</p> <p>g. On 1/10/08 at 9:17 a.m., LPN #2 entered the</p>	F 176			

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F 176	Continued From page 7 resident's room, removed the mouth piece with tubing attached, turned off the machine and left the room. h. The facility's Policy and Procedure for Self-Administration of Drugs documented, "A resident may not... be permitted to self-administer or retain any medication in his/her room unless so ordered, in writing, by the attending Physician... After being assessed by the Interdisciplinary care plan team as appropriate for self-administration of medication. The nurse supervisor must record in the resident's medical record that self administration has been authorized and shall identify the name, strength, and quality of each medication retained at the bed side. The Interdisciplinary team will re-assess the resident quarterly and as needed to determine ability to continue self-administration of medication."	F 176			
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure meals were served in a prompt manner, trays were delivered and served concurrently to residents at the same table and in the same dining area and desserts were served on dishes to promote dignity and respect. This failed practice had the potential to affect 77 residents in the facility that received meals from the kitchen, according to the diet list dated 1/8/08. The findings are:	F 241			

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F 241	Continued From page 8 1. On 1/8/08 at 11:30 a.m., Resident #9, who had moderately impaired cognitive skills for daily decision-making as documented by the Minimum Data Set (MDS) dated 11/19/07, was gotten up; CNA #12 stated, "It's time for lunch." The resident asked, "Is it on the table yet?" The CNA stated, "It will be soon." The resident stated, "It'll be hours." The resident was taken to the dining room at 11:40 a.m. a. At 12:00 p.m., there were 21 residents in the dining room; staff was feeding 2 residents, 3 residents were feeding themselves and 1 resident was sitting with a family member eating a burger and fries that had been brought in. b. At 12:27 p.m., Resident #9 was served a lunch tray. 2. On 1/9/08 at 11:50 a.m., the tray cart arrived at the activities dining room with 8 trays on it. There were 15 residents in the dining room. a. At 12:00 p.m., only 5 of the 15 residents in the dining room had trays and were eating. b. At 12:15 p.m., there were 4 residents seated at the square table near the piano. Three of the 4 residents were served their trays and were eating, while one resident was not served and sat and watched the other residents eat. c. At 12:20 p.m., 4 residents remained un-served. A Certified Nursing Assistant (CNA), who was in charge of the dining room, removed an empty tray from a table and a resident who was seated against the wall said, "Bring me some of that." The CNA informed her that her tray was	F 241		

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F 241	Continued From page 9 on the way. When asked if she could feed herself, the resident said, "Yes." When the resident was asked how long she had been in the dining room she stated, "About an hour." The resident then stated, "I'm hungry." d. The other three residents seated along the wall of the activities dining room were asked if they could feed themselves and they stated, "Yes." The resident's trays were served at 12:25 p.m. e. At 12:28 p.m., a resident's lunch tray was placed on a dirty table with three other trays. The CNA removed one of the trays from the table and pushed the resident's wheelchair up to the table and fed the resident while the remaining two dirty meal trays were on the table. f. On 1/9/08 at 1:00 p.m., the Dietary Manager was asked why the residents were not served consecutively in each dining room; she stated, "We serve some residents in each dining and some down each hall at different times. And that's just the way we do it." 3. On 1/9/08 at 10:35 a.m., all servings of desserts were on Styrofoam plates. When asked why Styrofoam plates were used, the Dietary Manager stated the facility did not have any desserts plates and used the Styrofoam plates when they served pies and cookies.	F 241			
F 309 SS=G	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	F 309			

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F 309	Continued From page 10 and plan of care. This REQUIREMENT is not met as evidenced by: Complaint #13253 was substantiated (all or in part) in these findings. A. Based on observation, record review and interview, the facility failed to ensure 1 of 1 (Resident #21) case mix residents with an acute medical condition was assessed and monitored for respiratory distress for a period of 8 hours and 45 minutes after symptoms were identified; the facility failed to ensure prompt assessment of resident condition, immediate consultation with the physician, and monitoring of vital signs/resident condition resulting in a delay in treatment for 1 of 1 (Resident #5) case mix resident with a significant body temperature elevation and cloudy urine following the insertion of an indwelling urinary catheter; and the facility failed to ensure all injuries were reported by Certified Nursing Assistants to charge nurses for assessment and monitoring for 1 of 1 (Resident #10) case-mix resident who sustained an injury to her toe. The failed practices resulted in actual harm to Resident #21 who was admitted to the hospital with Congestive Heart Failure and had the potential to cause more than minimal harm to 6 residents in the facility with conditions/diseases that made their conditions unstable, as documented on a list provided by the Administrator on 1/28/08. The findings are: 1. Resident #21 was admitted to the facility on 10/5/07 with diagnoses of Alzheimer's Disease, Right Sided Stroke, Cancer of Prostate, Skin	F 309			

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F 309	<p>Continued From page 11</p> <p>Cancer and Expressive Aphasia. From 11/9/07 through 11/19/07, the resident was hospitalized and upon discharge received additional diagnoses of Atrial Fibrillation and Acute Coronary Syndrome. An Admission Minimum Data Set (MDS) dated 10/25/07 documented the resident was moderately impaired in cognitive skills for daily decision making, had wandering behaviors, resisted care, required limited assistance for transfer, needed assistance with ambulation and required extensive assistance with dressing.</p> <p>a. A Nurse's Note dated 11/9/07 at 11:30 a.m. documented the resident was confused and forgetful, transferred and ambulated "ad lib" (at will), was very unsteady and wandered. "New orders received to go to [Gero-psychiatric hospital] for eval (evaluation)."</p> <p>b. A Nurse's note dated 11/19/07 documented the resident was re-admitted to the facility from the hospital at "1030" (10:30 a.m.). A Nurse's Note dated 11/19/07 at 11:00 p.m. documented, "Resting [with] eyes closed - Restless, picking at clothes - non-verbal- hasn't opened eyes tonight...Res (Resident) refused to open mouth for pm meds (medications). Oral care given - Incontinent care [every] 2 hours and [as needed] - turned- repositioned for comfort - will monitor."</p> <p>c. A Nurse's Note dated 11/21/07 documented, "Sig (significant) change noted."</p> <p>d. The next Nurses Note was dated 11/23/07 at 9:15 a.m. and documented "Res alert [with] confusion. Resp (respirations) even and unlabored. Audible wet lung sounds upon entering room. (Resident's Head of Bed up 45</p>	F 309			

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F 309	<p>Continued From page 12</p> <p>degrees, no complaint or signs and symptoms of pain/discomfort). Incont (incontinent) of [bowel and bladder]. Peri-care given [after] each episode. Wears briefs. Res unclothing self all day, redress res each time entering room. Res refused lunch. Family aware. 1800 (6:00 p.m.) Family called [and] very upset wanting MD (Medical Doctor) called and res to be sent to ER (emergency room) for eval (evaluation). [6:10 p.m.] MD paged [6:15 p.m. New order] Send to ER for eval."</p> <p>1) There was no documentation the residents lungs were auscultated or any assessment of the resident's condition was conducted. The physician was not consulted until 6:15 p.m.</p> <p>2) There was no documentation the resident's condition was monitored throughout the day on 11/23/07 until 6:00 p.m., when the Nurse's Notes documented, "Family called [and] very upset wanting MD called and res to be sent to ER for eval. [6:10 p.m.] MD paged [6:15 p.m. New order] Send to ER for evaluation."</p> <p>e. A Patient Transfer Form dated 11/22/07 [11/23/07] documented "[decreased] cognitive status. Audible wet lungs (possible aspiration)... Ate 25% of one meal in last 3 or 4 days."</p> <p>f. An Emergency Room History and Physical dated 11/23/07 documented "...presents to the emergency room from nursing home with history of increasing shortness of breath and rattling in his chest. They sent him to the emergency room tonight for evaluation and treatment... Lungs: Rales bilaterally... Radiology: Chest x-ray reveals congestive heart failure... Emergency Department Course: He was given 60 [milligrams] of Lasix</p>	F 309			

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F 309	<p>Continued From page 13</p> <p>[Intravenously]... Plan: Admit the patient to the hospital for diuresis and further evaluation and treatment."</p> <p>g. A hospital History and Physical dated 11/23/07 documented, "Lungs: Crackles in bilateral bases. The patient does have audible congestive upper airway sounds. Respirations are shallow and even with occasional agonal respirations... Assessment: 1. Congestive heart failure systolic, decompensated. 2. Volume contraction secondary to dehydration. 3. Worsening Alzheimer's dementia. 4. Swallowing difficulty with possible aspiration. Plan: 1. The patient was placed on D5W (Dextrose 5% in water) at a rate of 60. 2. He will be given small doses of IV (intravenous) Lasix. 3. He was started on Zosyn for possible aspiration pneumonia. 4. Frequent suctioning."</p> <p>2. Resident #5 had diagnoses of Spastic Quadriplegia, Postictal Coma, Organic Brain Syndrome, and Psychotic Disorder. The quarterly Minimum Data Set (MDS) dated 11/21/07 documented the resident had moderately impaired cognitive skills for daily decision making and was totally dependent on two or more staff members for bed mobility, dressing, toilet use and personal hygiene.</p> <p>a. The physician order dated 1/4/08 documented, "1. May In & (and) Out cath (catheterize) D/T (due to) no output in 7 hr (hours). May anchor 16 fr (French)/30 cc (cubic centimeter) balloon if > (greater than) 300 [cc] out. (output)..."</p> <p>b. The Nurse's Notes dated 1/4/08 at 01:40 (1:40 a.m.) documented, "In & Out cath procedure, 625 cc out. anchored 16 fr 30 cc balloon. ...dark</p>	F 309			

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F 309	<p>Continued From page 14</p> <p>yellow urine noted in cath bag." There was no documentation in the nurse's notes for 1/5/08, 1/6/08, or 1/7/08.</p> <p>c. The Nurse's Notes dated 1/8/08 documented, "0430 (4:30 a.m.) temp 101.7 ax. (axillary) gave Apap ES (extra strength) ii (2) po (by mouth)..." There was no documentation in the clinical record that the physician or the family was notified of the significant increase in the resident's temperature.</p> <p>d. The Nurses Notes dated 1/8/08 documented, "(1000) [10:00 a.m.] temp 98.8 ax..." There were no other documented temperature assessments after 1/8/08 at 10:00 a.m.</p> <p>e. On 1/9/08 at 9:20 a.m., Licensed Practical Nurse (LPN) #8 was asked if vital signs were taken or temp (temperature) checked after 10:00 a.m. on 1/8/08 and she stated, "No." The LPN was asked, what the procedure was when a resident ran high temp and the LPN stated, "We give them something if it's on their orders and call the physician." When asked if she could tell if the physician was called from looking at the notes, the LPN looked at the Nurse's Notes and the 24-hour report and stated, "There is no documentation that the physician was notified of this high temp."</p> <p>The surveyor and the LPN went to the resident's room and looked at the urine in the catheter tubing. When asked what she would say that urine looked like, she stated, "Cloudy, very cloudy. I'm going to let the doctor know about this."</p> <p>f. The Nurse's Notes dated 1/9/08 at 9:40 a.m. documented, "Call into [Physician] this a.m.</p>	F 309		

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F 309	<p>Continued From page 15</p> <p>(morning) [with] report of [elevated] temp and urine sediment. Received T.O. (telephone order) for UA (urinalysis) [with] C+S (culture and sensitivity)..."</p> <p>g. The Urinalysis Report dated 1/10/08 from urine collected 1/9/08 at 10:00 a.m. documented, "...Blood/Hemoglobin: 3 +... Bacteria: 4 +... RBC's (Red Blood Cells): Too numerous to count. WBC's (White Blood Cells) 20-40..."</p> <p>h. The Physician Order dated 1/10/08 at 13:00 (1:00 p.m.) documented, "Bactrim DS 1 P.O. (by mouth) BID (twice a day) x (times) 7 days R/T (related to) UTI (Urinary Tract Infection)..."</p> <p>3. Resident #10 had diagnoses of Dementia, Parkinson's Disease, Osteoporosis, Peripheral Neuropathy and Cerebral Vascular Accident with Left Sided Mild Hemiparesis. The Quarterly MDS dated 10/26/07 documented the resident had moderately impaired cognitive skills for daily decision making and required extensive assistance of 2 or more persons with transfers.</p> <p>a. The Plan of Care dated 10/26/07 documented: "...Problem: Bone Loss - Risk of Fractures and Injury due to Osteoporosis... Approach: ...Instruct Staff on careful turning and transfer due to fragile bones and risk of fracture..."</p> <p>b. On 1/8/08 at 11:45 a.m., Certified Nursing Assistant (CNA) #10 moved the Vanderlift toward the resident's chair and bumped the resident's foot with the leg of the Vanderlift. The resident cried out in pain. The resident was transferred from the chair to the bed by CNA #10 and CNA #2. The resident's right second toe, first joint, had a 0.5 cm (centimeter) red mark. CNA #2 was</p>	F 309			

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F 309	<p>Continued From page 16</p> <p>asked what the red mark was and the CNA stated, "I don't know, this is the first time I've seen it." CNA #10 was asked why the resident cried out when she moved and the CNA stated, "I didn't step on her foot if that's what you mean." CNA #10 was asked, if she bumped [the resident's] foot with the leg of the lift and the CNA stated, "I probably did." CNA #10 was asked, if the red mark on the resident's toe was from that and the stated, "Probably."</p> <p>c. On 1/9/08 at 9:05 a.m., the resident's clinical record did not contain any documentation of the red mark to the resident's toe or of the toe bump incident on 1/8/08.</p> <p>d. On 1/9/08 at 9:15 a.m., LPN #8 was asked, if she saw any documentation about the injury to this resident's toe yesterday and the LPN stated, "No." The LPN was asked if she knew anything about an injury and the LPN stated, "No." CNA #10 was asked if she reported the injury to the resident's toe, that occurred yesterday, to the nurse and the CNA stated, "No, I just forgot."</p> <p>B. Based on observation and record review, the facility failed to ensure Foley catheter tubing was stabilized during cleansing to prevent the potential for injury to the bladder or urinary meatus for 1 (Resident #4) and failed to ensure Foley catheter tubing was cleansed during catheter care for 1 (Resident #5) of 2 (Residents #4 and #5) case mix residents with Foley catheters. This failed practice had the potential to affect 4 residents with Foley catheters, according to a list provided by the Administrator on 1/10/08. The findings are:</p> <p>1. Resident #4 had a diagnosis of Urinary Tract</p>	F 309			

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F 309	Continued From page 17 Infection. The Significant Change Minimum Data Set (MDS) dated 1/4/08 documented the resident had severely impaired cognitive skills for daily decision-making, had an indwelling catheter, was dependent on staff for personal hygiene and had a urinary tract infection in the last 30 days. a. The resident's January 2008 MAR (Medication Administration Record) documented: Catheter care every shift. b. On 1/08/08 at 10:08 a.m., Certified Nursing Assistant (CNA) #5 provided incontinent care for the resident. The CNA washed down the catheter tubing, away from the resident, pulling on the catheter tubing. The CNA did not hold the catheter tubing or stabilize the tubing to keep the tubing from pulling on the resident's bladder and urinary meatus, which risked injury to the resident and possible dislodging of the catheter from the resident's bladder. c. On 1/8/08 at 11:15 a.m., LPN #1 provided catheter care for the resident. The LPN wiped up the catheter tubing, pulling the catheter tubing away from the resident without stabilizing the tubing or holding on to the tubing to prevent the tubing from being pulled away from the resident, with the risk of dislodging the catheter or causing injury to the resident's urinary tract. d. On 1/8/08 at 12:50 p.m., CNA #5 provided incontinent care for the resident. The CNA used a wet wipe to clean the resident's Foley catheter tubing by encircling the tube with a wet wipe and pulling on the catheter tubing, away from the resident. The CNA did not hold on to the tubing to stabilize it before wiping it to prevent tension on the resident's bladder and urinary meatus or	F 309			

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F 309	Continued From page 18 dislodging the catheter from the bladder. e. Best Practices - A Guide to Excellence in Nursing Care, copyright 2003 by Lippincott Williams & Wilkins, page 440 documented, "Alert. Don't pull on the catheter while you're cleaning it. This can injure the urethra and the bladder wall. It can also expose a section of the catheter that was inside the urethra, so that when you release the catheter, the newly contaminated section will reenter the urethra, introducing potentially infectious organisms." 2. Resident #5 had diagnoses of Spastic Quadriplegia, Postictal Coma, Organic Brain Syndrome, and Psychotic Disorder. The Quarterly Minimum Data Set (MDS) dated 11/21/07 documented the resident had moderately impaired cognitive skills for daily decision making and was totally dependent on 2 or more staff members for bed mobility, dressing, toilet use, and personal hygiene. a. The facility policy for Urinary Catheter Care documented, "...16. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward..." b. The physician order dated 1/4/08 documented, "...Foley cath (catheter) care q (every) shift & (and) prn (as needed)..." c. On 1/9/08 at 9:35 a.m., CNA #10 and CNA #11 performed Foley catheter care for the resident. CNA #11 cleansed the meatus of the penis, but did not wash the Foley catheter tubing. d. On 1/9/08 at 9:40 a.m., CNA #11 was asked	F 309			

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F 309	Continued From page 19 how she would say the urine in the catheter tube looked and the CNA stated, "Cloudy." The CNA was asked how she was taught to do catheter care and the CNA stated, "To clean the tubing from the penis out." When asked if she had cleaned the tubing, the CNA stated, "No, I forgot."	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 and record review, the facility failed to ensure all soiled areas were cleansed after incontinent episodes for 1 (Resident #3) of 9 (Residents #3, #4, #5, #7 through #10, #14 and #15) case mix residents with bowel or bladder incontinence. This failed practice had the potential to affect 51 incontinent residents dependent on staff for personal hygiene, according to a list provided by the Administrator on 1/10/08. The findings are: Resident #3 had diagnoses of Acute UTI (Urinary Tract Infection) and Dementia. The Significant Change MDS (Minimum Data Set) dated 1/3/08 documented the resident was incontinent of bowel and bladder, required extensive assistance from staff for personal hygiene and had a UTI in the last 30 days. a. On 1/8/08 at 1:06 p.m., the resident requested to go to the bathroom. Certified Nursing Assistant (CNA) #7 and CNA #6 went into the resident's	F 312		

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F 312	Continued From page 20 room to assist her to use a bed pan. CNA #7 stated the resident's brief was wet when she removed it. The resident had a bowel movement while on the bed pan; CNA #7 cleaned the resident's vaginal area and down the crease of each groin, but did not clean the resident's pubic area that had been in contact with the wet brief. b. On 1/8/08 at 3:08 p.m., the resident was in bed; CNA #5 stated the resident's brief was wet. After removing the resident's brief, the CNA took wet wipes and cleansed the resident's vaginal and groin areas, but did not clean the resident's pubic area though it had been in contact with the wet brief.	F 312			
F 314 SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure pressure relieving devices were utilized for the lower extremities to minimize the risk for skin breakdown for 2 (Residents #1 and #9) of 4 (Residents #1, #4, #9 and #10) case mix residents who required the use of pressure-relieving devices for their lower extremities. This failed practice had the potential	F 314			

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F 314	<p>Continued From page 21</p> <p>to affect 7 residents in the facility that required pressure-relieving devices to their lower extremities, as identified by a list provided by the Administrator on 1/10/08. The findings are:</p> <p>Resident #9 had diagnoses of Alzheimer's Dementia and History of Pressure Sores. The Minimum Data Set (MDS) dated 11/19/07 documented the resident had moderately impaired cognitive skills for daily decision-making, required extensive assistance for bed mobility and required pressure-relief devices for chair and bed.</p> <p>a. The Pressure Ulcer Risk Assessment form dated 11/7/07 documented, "If the total score is 8 or greater, the resident should be considered at high risk for skin breakdown and a prevention protocol should be initiated immediately." The form documented the resident scored "14."</p> <p>b. The Plan of Care dated 11/14/07 documented, "Blue padded booties on feet to [reduce] pressure."</p> <p>c. On 1/7/08 at 7:25 p.m. and on 1/8/08 at 10:25 a.m., 11:15 a.m. and 5:30 p.m., the resident was lying in bed with regular non-skid socks on his feet, not pressure relieving booties.</p> <p>2. Resident #1 had diagnoses of Congestive Heart Failure, Joint Disorder, Osteoporosis, Affective Mental Disorder with Depression, Seborrhic Keratosis, and Seborrhic Dermatitis. The Significant Change Minimum Data Set (MDS) dated 11/8/07 documented the resident had moderately impaired cognitive skills for daily decision-making, required limited assistance of one person for bathing and hygiene, and had one</p>	F 314			

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F 314	Continued From page 22 Stage II pressure ulcer. a. The Braden Scale assessment dated 12/17/07 documented, "...Score: 18. ...Score of 12 or less = (equals) High Risk..." b. The Plan of Care dated 11/8/07 documented, "Identify date: 08/09/07 Skin impairment: Stage II to Right Outer Ankle. ...Approach: ...Provide padding for pressure points and bony prominences, including bed/chair..." c. The Physician Order dated 12/27/07 documented, "Treatment: Right ankle - clean [with] sterile H2O (water). Apply Silvasorb & (and) cover dressing qd (every day) til (until) healed." d. On 1/8/08 at 10:00 a.m., the resident was lying in bed positioned on the right side with the right outer ankle pressing on the bed, without a pressure relieving device or pad. e. On 1/8/08 at 10:45 a.m., the resident was lying in bed positioned on the right side with the right outer ankle pressing on the bed, without a pressure relieving device or padding on the right ankle. f. On 1/8/08 at 11:20 a.m., the resident was lying in bed positioned on the right side with the right outer ankle pressing on the bed, without a pressure relieving device or padding on the right ankle. The left leg rested on top of the right leg, which added additional pressure to the bony prominence of the right ankle. g. On 1/9/08 at 10:00 a.m., the resident was lying in bed positioned on the right side with the right	F 314			

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F 314	Continued From page 23 outer ankle pressing on the bed, without a pressure relieving device or padding on the right ankle. h. On 1/9/08 at 11:00 a.m., Licensed Practical Nurse (LPN) #7 was asked how long the resident had that decubitus; the LPN stated, "Quite some time." The LPN was asked, how did the resident get the pressure sore and she stated, "She [resident] lies in bed with her ankle against the bed. She's non-compliant. We've tried to get her to get some new diabetic shoes but she won't." When asked what kind of pressure relieving devices were in use for the resident, the LPN stated, "There aren't any bridges or splints here. She won't let us use them." The LPN was told that the Care Plan called for padding for pressure points and bony prominences. The LPN was asked if padding or pressure relief devices were being used and the LPN stated, "There are no pressure relieving devices being used. She is non-compliant with all of them." When asked if she could show the surveyor where the non-compliance was documented in the medical record, the LPN stated, "It's not documented."	F 314			
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:	F 322			

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F 322	<p>Continued From page 24</p> <p>Based on observation, record review and interview, the facility failed to ensure the feeding tube was flushed after being shut off for 1 hour for 1 (Resident #4) of 2 (Residents #4 and #10) case mix residents with feeding tubes. This failed practice had the potential to affect 3 residents with PEG (Percutaneous Endoscopic Gastrostomy) tubes, per a list provided by the Administrator on 1/10/08. The findings are:</p> <p>Resident #4 had diagnoses of Cerebrovascular Accident and Dysphagia. The Significant Change Minimum Data Set dated 1/4/08 documented the resident had a feeding tube and was dependent on staff for feeding.</p> <p>a. The January 2008 Physician Order Sheet documented, "Tube feeding intake turn pump off for 1 hour during 6a-6p (6:00 a.m. to 6:00 p.m.) and 1 hour 6p-6a (6:00 p.m. to 6:00 a.m.) @ (at) 1200 (12:00 p.m.) and 2400 12:00 a.m.). Diabetisource AC 38 cc (cubic centimeters) per hour via pump."</p> <p>b. On 1/8/08 at 1:10 p.m., Licensed Practical Nurse (LPN) #1 was in the resident's room to hook the resident back up to her feeding pump, after the scheduled hour of being shut off. The LPN did not flush the feeding tube to prevent the tube from clogging before reattaching the tube to the resident's PEG tube site.</p> <p>c. The facility policy and procedure for Flushing and Patency of Feeding Tube, found behind the resident's MAR (Medication Administration Record), documented under #6 a: "Thoroughly flush enteral feeding devices every 4-6 hours during continuous feeding; #6 b: whenever feedings are on hold..."</p>	F 322			

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F 323 SS=E	<p>483.25(h) ACCIDENTS AND SUPERVISION</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure personal alarms, devices utilized to minimize the potential for falls, were correctly or consistently attached for 4 (Residents # 3, # 8, # 9, and # 14) of 6 (Residents #3, #6 through #9 and #14) case mix residents with personal alarms and failed to implement physician's orders to ensure a Wander Guard bracelet was utilized to minimize the potential for elopement from the facility for 1 (Resident # 8) of 3 (Residents # 8, 9, and 14) case mix residents who required the use of a wander guard bracelet. The facility also failed to ensure transfers were performed in a manner to minimize the potential for injury for 2 (Resident # 3 and # 7) of 3 (Resident # 3, 7, and 9) case mix residents who required 2 person assistance for transfers. The facility failed to ensure hazardous materials were stored in a manner to prevent access by mobile, confused residents on the middle "L" hall and failed to ensure dryer filters did not pose a fire hazard due to excessive accumulation of lint. These failed practices had the potential to affect 21 residents who required the use of personal alarms, 18 residents who required the use of a Wander Guard bracelet, 18 residents requiring 2 person assist with transfers</p>	F 323			

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F 323	<p>Continued From page 26</p> <p>and 12 independently mobile and confused residents on the middle "L" halls, as identified by lists provided by the Administrator on 1/10/08 and 28 residents on the 100-Hall, according to a list provided by the Administrator on 1/7/08. The findings are:</p> <p>1. Resident #8 had diagnoses of Alzheimer Dementia with Delusions, Confusion and Osteoporosis. The Minimum Data Set (MDS) dated 11/19/07 documented the resident had moderately impaired cognitive skills for daily decision-making, required limited assistance with locomotion on and off the unit, had an unsteady gait and had skin tears or cuts present.</p> <p>a. The Physician's order dated 5/2/06 documented, "Wander guard Bracelet to wrist. Check for placement and proper functioning q (every) shift."</p> <p>1) The Elopement Risk Assessment dated 11/7/07 documented, "Resident cognitively impaired with poor decision-making skills, able to ambulate independently, verbally expresses the desire to go home, wandering/seeking to find spouse and/or family - states she's waiting for family to come and take her home."</p> <p>2) On 1/7/08 at 7:32 p.m. and on 1/8/08 at 10:30 a.m., 11:20 a.m., 1:00 p.m. and 5:30 p.m., the resident did not have a Wander Guard bracelet on.</p> <p>3) On 1/8/08 at 5:30 p.m., the MDS Coordinator was asked to check for placement of a Wander guard bracelet. She checked the resident's wrists and ankles and stated, "She doesn't have one on. We have a list of everyone that is supposed to</p>	F 323			

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F 323	Continued From page 27 have one." The MDS Coordinator checked the list and stated, "She's on it." b. The Fall Risk Assessment dated 11/7/07 documented: "If the total score is 10 or greater, the resident should be considered at high risk for potential falls." The form documented the resident scored "18." 1) The Plan of Care dated 11/19/07 documented, "At risk for falls related to history of same, unsteady gait. Risk of fractures and injury due to osteoporosis." 2) On 1/7/08 at 7:32 p.m., the resident was lying in bed. The personal alarm (Attendant, Model PS-4) was clipped to resident's clothing but the alarm box was lying on top of the mattress and was not attached/secured to the bed. 2. Resident #9 had diagnoses of Alzheimer's Dementia and Organic Brain Syndrome. The MDS dated 11/19/07 documented the resident had moderately impaired cognitive skills for daily decision-making, had mental function that varied over the course of the day, required extensive assistance for ambulation, had an unsteady gait and had fallen in the past 31-180 days. a. The Plan of Care dated 8/23/07 documented, "At risk for falls due to history of same and weakened condition; closed head injury. Non-compliant with calling for help before getting up. Alarm in bed and in chair." b. On 1/7/08 at 7:25 p.m. and on 1/8/08 at 10:25 a.m. and 5:30 p.m., the resident was lying in bed. The personal alarm was clipped to resident's clothing but the alarm box was lying on top of the	F 323			

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F 323	Continued From page 28 mattress and was not attached/secured to the bed. 3. Resident #14 had diagnoses of Parkinson's Disease, Dementia and History of Falls. The MDS dated 12/10/07 documented the resident had moderately impaired cognitive skills for daily decision-making, had repetitive physical movements, required assistance with transfers and ambulation and had fallen in the past 30 days and in the past 31 to 180 days. a. The Plan of Care dated 12/10/07 documented, "At risk for falls related to history of same, unsteady gait, weakness, non-compliant with calling for help before getting up; crawls around on floor. Resident turned off and broke alarms." b. On 1/8/08 at 4:05 p.m., the resident was sitting in her wheelchair in the activity room. The personal alarm box was attached to the wheelchair but the clip was not fastened to the resident. The resident was beside a bookcase and was bent forward at the waist, re-arranging items on the bottom shelf. Ce3rtified Nursing Assistant (CNA) #1 entered the room and stated, "You better straighten up, you're going to fall on your face." The CNA assisted the resident to sit back up in the wheelchair, but did not attach the resident's alarm. The CNA left the room. The resident immediately bent back forward at the waist and continued to re-arrange books on the shelf. At 4:15 p.m., CNA #2 entered the room, assisted the resident to sit back up in the chair and attached the alarm. She told the resident, "You need to sit up." The resident stood up with the alarm attached and took a step forward. The string was long and the alarm did not disconnect	F 323			

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F 323	<p>Continued From page 29</p> <p>and/or sound. CNA #1 stated, "The string is too long."</p> <p>c. The Instructions for the Attendant, Model PS-4 Fall Prevention Monitoring System alarm provided by the Administrator on 1/11/08 documented, "To use The Attendant, Attach The Attendant to a wheelchair, chair, or bed using the belt clip or optional Universal Mounting Bracket. The length of the cord should be adjusted according to the placement of The Attendant on the wheelchair, chair, or bed. This is done with the cord length adjuster. Test the cord length by asking the patient to lean forward a comfortable distance. Adjust the string, allowing the patient to move naturally before the alarm is activated. If the patient moves beyond the safe limit, the magnet detaches from the face of the unit from any angle, producing an audible tone to remind the patient to sit back down, and alerts the staff that a patient is at risk of falling."</p> <p>4. Resident #3 had diagnoses of Anemia, Dementia and Hip Fracture. The Quarterly MDS dated 12/20/07 documented the resident was moderately impaired in cognitive skills for daily decision making, had short term memory problems, required extensive assistance from staff for transfers, had not been ambulating in her room or the corridor, and had fallen in the last 30 days.</p> <p>a. On 1/8/08 at 11:40 a.m., the resident was in bed and the box of her personal alarm was laying on the bed behind her pillow. The alarm box was not attached to the bed but was laying on the bed, unstabilized.</p> <p>b. On 1/8/08 at 12:15 p.m. and at 1:06 p.m., CNA</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>#7 and CNA #6 were in the resident's room to assist her to use the bedpan her personal alarm box was laying on the bed not attached to the bed.</p> <p>c. On 1/8/08 at 2:35 p.m., Licensed Practical Nurse (LPN) #3 was in the resident's room to provide an updraft treatment. The resident's personal alarm box was laying on the bed, not attached to the bed.</p> <p>d. On 1/8/08 at 3:08 p.m., CNA #3 and CNA #5 were in the resident's room to transfer her from her bed to her chair. Her personal alarm box was still laying on the bed by the resident and not attached to the bed.</p> <p>The CNAs transferred the resident from her bed to her wheelchair. CNA #3 applied a gait belt to the resident as she sat on the edge of her bed but the CNAs did not hold to the gait belt to help the resident stand up from her bed. Each CNA placed an arm under one of the resident's arms and pulled her to standing position by the bed putting her weight on her arms and shoulders.</p> <p>5. Resident #7 had diagnoses of Cerebrovascular Accident with left sided Hemiparesis, Lymphoma, and Congestive Heart Failure. The Admission MDS (Minimum Data Set) dated 12/22/07 documented the resident needed extensive assistance of two or more persons for transfers, had limitation of functional abilities, one side of her body had full loss of voluntary movement, including leg and foot and was unable to ambulate.</p> <p>On 1/8/08 at 11:30 a.m., CNA #4 wheeled the resident from the dining room to her bathroom</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>and placed the wheel chair by the toilet. The resident was sitting in the wheel chair. CNA #3 and CNA #4 each placed one arm under the resident's armpit and placed other hand on the side of the gait belt and manually lifted the resident from the wheelchair. The resident's feet were dragging across the floor; she did not bear weight while the CNAs placed her on the toilet. The CNAs placed one hand under the resident's armpits and lifted, dragged her feet across the floor and placed the resident back into the wheel chair. The gait belt was not used.</p> <p>6. Accessible Hazardous Items:</p> <p>a. On 1/7/08 at 7:27 p.m., an opened bottle of Aloe Vesta Skin Protectant was in the unlocked vanity in the unlocked bathroom beside room 11 on the middle hall. The bottle warning documented, "...For external Use Only: If swallowed get medical help or consult a Poison Control Center..." The Material Safety Data Sheet provided by the Environmental Manager documented, "...First Aid Measures. Ingestion: Seek medical attention immediately. Vomiting may be induced if person is conscious and not experiencing convulsions..."</p> <p>b. On 1/11/08 at 9:40 a.m., the Housekeeping Supply Room located on the middle "L" hall was unlocked and contained the following:</p> <p>1) Three (3) one gallon containers of Oasis Pro Finished Floor Low Odor Stripper. The Material Safety Data Sheet (MSDS) supplied by the Housekeeping Supervisor documented, "Liquid. Colorless. Aromatic. Danger! Causes respiratory tract, eye and skin burns. Harmful if swallowed. Do not ingest. Do not get in eyes, on</p>	F 323			

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F 323	Continued From page 32 skin or on clothing. Do not breathe vapor or mist. 2) One case of Oasis Pro floor Finish Normal Frequency Maintenance floor care product. The Material Safety Data Sheet (MSDS) supplied by the Housekeeping Supervisor documented, "Liquid. Caution! Repeated or prolonged contact with irritants may cause dermatitis. May cause eye irritation. Avoid contact with eyes. Wash thoroughly after handling". 7. On 1/8/08, during environmental rounds which began at 9:30 a.m., 2 of 3 functional dryers in the laundry room had an accumulation of lint that was approximately 1/2 inch thick and came off in a solid sheet when the filters were tapped with a finger.	F 323		
F 325 SS=E	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure interventions were developed and consistently implemented to prevent severe weight loss for 1 (Resident #3) of 3 (Residents #3, #15 and #16) case mix residents with weight loss. This failed practice had the potential to affect 12 residents with weight loss, per a list provided by the Administrator on 1/10/08. The findings are:	F 325		

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F 325	<p>Continued From page 33</p> <p>Resident #3 had diagnoses of Acute Renal Failure and End Stage Chronic Obstructive Pulmonary Disease. The significant change Minimum Data Set(MDS) dated 1/3/08 documented the resident was moderately impaired in cognitive skills for daily decision making, had short-term memory problems, had a significant weight loss with no edema and was independent in eating with set up help only required for meals.</p> <p>a. The resident's plan of care documented as of 1/3/08 weight loss interventions were: Encourage resident to be up for meals, supplement 1 can at bed time, ST (Speech Therapy) to eval (evaluate) and treat as indicated and assist with meals as needed.</p> <p>b. The January 2008 Physician orders documented, "Diet: Regular."</p> <p>c. According to the Individual Weight Variance Monitoring Sheet, the resident was admitted to the facility, from the hospital, on 9/17/07 weighing 175 pounds.</p> <p>d. According to the facility's 9/24/07 weight record, the resident had lost down to 166 pounds.</p> <p>e. A weight meeting was held on 9/26/07 and documentation written to put the resident in restorative dining. The 10/3/07 weight meeting minutes listed the resident under restorative feeding.</p> <p>f. The dietary progress note dated 9/27/07 documented the resident weighed 165 pounds, a loss of 10 pounds since admission. The note documented the weight loss was possibly due to</p>	F 325			

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F 325	Continued From page 34 edema when the resident first came in to the facility. g. The weight record dated 10/2/07 documented the resident weighed 162 pounds. h. The dietary progress note dated 10/3/07 and written by the dietary manager documented the resident's meal intake the last 3 days had averaged 50% and possibly a supplement to boost weight gain would be recommended. No documentation was found in the clinical record that a supplement was started. i. Licensed Practical Nurse (LPN) #4, who was in charge of monitoring residents with weight loss, was interviewed on 1/10/08 at 10:00 a.m., stated that on 10/3/07 the resident was placed on the restorative dining program. However, the LPN stated the resident's restorative dining program was discontinued on 10/10/07 due to the resident refusing to be fed by restorative staff. No new intervention was documented when the restorative program was discontinued. j. The facility's weight record dated 10/8/07 the resident weighed 161 pounds. An unsigned dietary progress note dated 10/8/07 documented, "weight down 1 pound Dr (doctor has) been advised of weight loss. Will continue to monitor." k. The weight record dated 10/15/07 documented the resident weighed 163 pounds. A dietary progress note dated 10/17/07 and written by the dietary manager documented, weight up 2 pounds will continue and ask again about a supplement. There was no documentation in the clinical record that a supplement was given to the resident.	F 325			

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F 325	Continued From page 35 l. The dietary progress note dated 10/18/07 and written by the registered dietician documented, staff felt the weight loss was due to desirable fluid loss. Keep family and doctor advised of weight fluctuations. According to LPN #4, during an interview on 1/10/08 at 10:00 a.m., the resident had diarrhea 10/18/07 through 10/20/07 and was placed on a BRAT diet of bananas, rice, applesauce and toast from 10/22/07 until 10/24/07 for the diarrhea. m. The weight record dated 10/22/07 documented the resident weighed 154 pounds. A dietary progress note dated 10/22/07 and written by the dietary manager documented the resident weighed 154 pounds and would be on the BRAT diet until further notice. Resident not eating well will continue to monitor. n. The weight record dated 10/29/07 documented the resident weighed 152 pounds. A dietary progress note, written by the dietary manager on 10/31/07, documented that the resident's weight was down 2 pounds from the last weight, continue to monitor. No interventions were documented for the resident. o. The weight record dated 11/5/07 documented the resident weighed 154 pounds. The dietary progress note dated 11/5/07 documented the resident's weight was up 2 pounds, will continue to monitor weight and intake. p. The weight record dated 11/12/07 documented the resident weighed 156 pounds. q. The weight record dated 11/19/07 documented	F 325			

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F 325	<p>Continued From page 36</p> <p>a weight of 155 pounds for the resident.</p> <p>r. The weight record dated 11/26/07 documented the resident weighed 154 pounds. A progress note by the dietary manager documented that the resident refused snacks and the family brought in food frequently and urged her to eat and that the family fed the resident frequently. "Intake is very poor. Discontinue pimientto cheese sandwiches secondary to refusal. Continue to keep doctor and family advised of weight fluctuation."</p> <p>s. A progress note dated 11/26/07, written by the Registered Dietician(RD), documented the resident was down 21 pounds and the staff noted the resident was confused. "Resident appears confused told RD "I choke a lot-on liquids. Resident gets supplement Oyster Shell Calcium and Centrovite. Resident is on a regular diet and gets yogurt. Resident referred to Speech therapy for an eval regarding choking. Keep doctor and family advised of resident's weight loss."</p> <p>t. The Speech Therapist evaluated the resident on 11/26/07 and did not find a choking problem and did not continue to treat the resident.</p> <p>u. the weight record dated 12/5/07 documented the resident weighed 155 pounds. During and interview with LPN #4, on 1/10/07 at 10:00 a.m., she stated that weekly weights were not done on the resident in December [2007] because he did not trigger for weight loss because of the fluctuations in his weight.</p> <p>v. According to a communication sheet sent to the physician on 12/19/07, the family requested the resident get Ensure at bed time. The Ensure was started on 12/21/07 according to the</p>	F 325			

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F 325	<p>Continued From page 37</p> <p>physicians order sheet.</p> <p>w. According to a hospital history and physical, on 12/23/07 the resident was admitted due to Bronchitis and COPD (Chronic Obstructive Pulmonary Disease) and remained at the hospital until returning to the facility on 12/29/07.</p> <p>x. On 1/10/07, review of the resident's weight records documented that the resident weighed 163 pounds on 10/15/07 (3 months prior). The weight records documented that the resident weighed 149 pounds on 1/4/08, a significant weight loss of 8.5% for 3 months.</p> <p>On 1/10/07 at 9:35 a.m., the resident was weighed by Certified Nursing Assistant (CNA) #8 and CNA #9; the resident weighed 147.3 pounds. This was an additional weight loss of 1.7 pounds in the six days between 1/4/08 and 1/10/07. From 10/15/07 until 1/10/08, the resident lost 15.7 pounds; a 3 month significant weight loss of 9.6%.</p> <p>y. On 1/10/07 at 10:20 a.m., when the RD was asked what had been done about the resident's weight loss, she asked LPN #4 who was present at the interview if the resident had lost more weight and the LPN told her, "Yes."</p> <p>The RD then stated that she had written a note to stop the pimiento cheese sandwiches because the resident would not eat them, but as of 11/12/07 the resident was getting yogurt with her evening meal. When the RD was asked why the yogurt was given to the resident she stated, "We give a lot of our residents yogurt because they like it."</p>	F 325			

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F 325	Continued From page 38 z. On 1/10/07 at 2:38 p.m., the Director of Nurses (DON) was interviewed concerning the resident's weight loss. When asked what interventions had been put in place to prevent the resident's weight loss from continuing, aside from the speech evaluation, restorative dining and Ensure that had been requested by the family, the DON stated, "We notified the doctor and he did not order anything. We follow the doctor's orders and if he doesn't order anything we don't do anything. Besides in October she was gaining some. We give snacks 3 times a day to all of our residents." aa. On 1/10/07, a review of 15 weeks of weight meeting minutes revealed the resident's weight loss was discussed only four out of 15 weeks. On 9/26/07 and 10/03/07, the resident was placed on the minutes under restorative feeding recommendation. On 10/17/07 the weight meeting minutes list the resident under the significant weight loss list, but no recommendations were documented. On the 10/24/07 meeting minutes, the resident was listed under significant weight loss, down 9 pounds, with no recommendation documented. The other 11 weeks of weekly weight meetings did not mention the resident in the minutes. A review of the resident's meal consumption records, from admission to the facility through 1/09/07, revealed the resident generally averaged approximately 50% - 75% of meals most of the time, with occasional 25% or 100% consumption.	F 325			
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.	F 332			

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F 332	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observation of the 8:00 p.m. medication pass on 1/7/08 and the 8:00 a.m. medication pass on 1/8/08 and record review, the facility failed to ensure that the medication error rate was less than 5%. Physician orders were not followed for 3 (Residents #11, #12 and #13) of 12 residents observed during the medication passes resulting in medication errors. Medication errors were made by 2 Licensed Practical Nurses (LPN) (LPN #1 and #2) of 6 licensed nurses observed administering medications in the facility. This failed practice had the potential to affect 28 residents in the facility on the L-Hall, according to the Roster/Matrix dated 1/7/08. The medication error rate was 6.25% based on administration of 48 medications with 3 medication errors observed. The findings are: 1. Resident #11 had a physician order dated 1/31/07 for Colace 100 milligrams (mg) 2 by mouth (po) every bedtime (hs). On 1/7/08 at 7:58 p.m., during the 8:00 p.m. medication pass, LPN #1 administered Colace 100 mg 1 (one) to the resident. 2. Resident #12 had a physician order dated 12/21/07 for Miralax 1 capful 17 grams po every hs Give with 8 ounces (oz) of water. a. The water cups on the facility's medication carts had a 5 oz capacity. b. LPN #1 measured the Miralax 17 grams and poured it into 2.5 oz of water.	F 332			

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F 332	Continued From page 40 c. On 1/7/08 at 8:09 p.m., during the 8:00 p.m. medication pass, the LPN administered the Miralax 17 grams in 2.5 oz. of water. The cup still contained undissolved Miralax. The LPN poured the undissolved Miralax into 3 oz of water, for a total amount of 5.5 ounces, and the resident drank it. 3. Resident #13 had a physician order dated 12/6/06 for Miralax 17 grams po every daily. Give with 6 - 8 oz of water. a. The facility's water cups on the medication carts had a 5 oz capacity. b. On 1/8/08 at 7:52 a.m., during the 8:00 a.m. medication pass, LPN #2 administered the Miralax 17 grams in a 5 oz cup of water.	F 332			
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure menus and recipes were followed to ensure nutritional adequacy for 21 residents on mechanical soft diets, 1 of 1 (Resident #20) case mix resident on a 2 gram sodium diet and 19 residents on pureed diets. This failed practice had the potential to affect 21 residents on mechanical soft diets, 19	F 363			

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F 363	<p>Continued From page 41</p> <p>residents on pureed diets and 1 resident on 2 gram sodium diet, according to the diet list dated 1/8/08. The findings are:</p> <p>1. On 1/9/08, the lunch menu for the pureed diet documented 3 oz (ounces) pureed hamburger steak and 1/2 cup pureed peas and carrots.</p> <p>a. On 1/9/08 at approximately 10:05 a.m., Cook #1 placed an undetermined amount of peas and carrots into the blender along with a large undetermined amount of liquid. The peas were of a soup-like consistency after the liquid was added. The cook then added large amounts of food thickener to the soup-like peas and carrots. The amount of thickener used was not measured. Due to the large amount of liquid added and the unmeasured amount of peas and carrots placed into the container, the 1/2 cup portions as documented on the menu could not be determined.</p> <p>The cook was asked how she could determine if she had enough pureed peas and carrots. She said, "When it reaches this level." She then pointed to a point on the pan.</p> <p>b. On 1/9/08 at 10:15 a.m., Cook #1 prepared green beans as an alternate for the pureed diet. She poured green beans into the blender, added an undetermined amount of liquid to liquify the green beans and then added an undetermined amount of food thickener to thicken the soup-like mixture. Vegetables are considered to be 95% water, therefore this increased the volume and decreased the nutritional value.</p> <p>c. On 1/9/08 at 10:30 a.m., Cook #1 placed 16 hamburger steaks in a blender and blended them</p>	F 363			

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F 363	<p>Continued From page 42</p> <p>for 21 servings. She added a large undetermined amount of liquid to puree the meat which increased the volume, but decreased the nutritional value. When completed it was of a soup-like consistency.</p> <p>During this time, the Dietary Manager informed the cook the meat was "not pureed long enough, it's grainy." Cook #1 then extended the process, added more liquid and food thickener.</p> <p>2. Resident #20 had diagnoses of Hypertension, Arteriosclerotic Heart Disease, Aortic Stenosis and Cardiovascular Disease.</p> <p>a. The Physician order dated 1/3/08 documented the resident was to receive a 2 gram sodium diet.</p> <p>b. On 1/9/08, for the noon meal, the menu documented low salt hamburger steak, mashed potatoes, low salt peas and carrots. There was no low sodium food prepared for the noon meal. The resident was served a regular diet.</p> <p>c. On 1/9/08, for the supper meal, the menu documented the following Low salt items: Turkey Divan with Broccoli and Rice Pilaf. There was no low sodium food prepared for the supper meal. The resident was served Turkey from the regular Turkey and regular Rice Pilaf.</p> <p>3. On 1/9/08 the menu for the supper meal documented 6 oz. Turkey Divan with Broccoli.</p> <p>a. Recipe #42 Turkey Divan with Broccoli documented the following ingredients: frozen broccoli spears, baked turkey breasts, margarine solids, salt, pepper, grated parmesan cheese.</p>	F 363			

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F 363	<p>Continued From page 43</p> <p>1) Instructions were to melt margarine and pour over broccoli, and sprinkle with salt, pepper and grated parmesan cheese. Arrange turkey slices over broccoli.</p> <p>2) Ingredients for the sauce documented, melted margarine, flour, milk, liquid scrambled eggs, salt and pepper. Stir until until blended and pour over turkey and broccoli. Bake at 350 for 15 minutes.</p> <p>b. On 1/9/08 at 3:10 p.m., Cook #2 pureed Broccoli and Cauliflower separately from the Turkey.</p> <p>When asked why she pureed the broccoli separate from the turkey she said, "That's how I was taught. It doesn't look like they have enough on their tray if it's all together."</p> <p>4. On 1/9/08, the menu for the mechanical soft diet for the supper meal documented, ground Turkey Divan with Broccoli. No ground Turkey was prepared for any residents on a mechanical soft diet.</p> <p>a. On 1/9/08 at 4:40 p.m., Cook #2 informed the Dietary Manager (DM) she had not remembered to grind turkey for the mechanical soft diets. The DM replied, "Turkey is really tender. I think it will be Okay."</p> <p>The DM turned to the surveyor and asked, "Don't you think it's tender enough?" The surveyor did not comment.</p> <p>b. On 1/9/08, the supper trays for residents on mechanical soft diets left the kitchen with solid slices of turkey on them.</p>	F 363			

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F 363	Continued From page 44 c. On 1/9/08, during observation of the supper meal, the Administrator and the Consulting Dietician observed meal service in the activities dining room. One resident, whose tray identification card documented mechanical soft ,was observed attempting to eat a whole piece of turkey with a fork. When she pierced it with the fork and was unable to eat it, she put it back on her plate and tried to cut it. The Administrator observed that the resident was unable to cut the meat; she walked out to the nurses' station and requested assistance for that resident.	F 363			
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure dietary employees followed proper handwashing procedures to prevent the potential for contamination. This failed practice had the potential to affect 81 residents in the facility who were served meals from the kitchen, according to the diet list dated 1/8/08. The findings are. 1. On 1/9/07 at 11:10 a.m., Dietary Aide #1 entered the kitchen with a plastic bag containing onions and gave the onions and some change to the Dietary Manager. The Dietary Aide proceeded to handle silverware and bowls, without washing her hands. The Dietary Manager (DM) placed the money in	F 371			

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F 371	Continued From page 45 her pocket did not wash her hands after receiving the change from the Dietary Aide. Then, without washing her hands, the DM handled clean bowls and utensils and dished up potatoes to be served. 2. On 1/9/07 at 11/35 a.m., while wearing rubber gloves Cook #1 cleaned off the cook preparation table with a wet dish towel and afterwards went to the stove and picked up hamburger steak from a pan on the stove. While still wearing the gloves, she placed the hamburger steaks in the blender. The cook did not remove the gloves or wash her hands during this process. 3. On 1/9/07 at 4:25 p.m., while wearing rubber gloves, the p.m. Dish Washer took a garbage can outside. After returning from the outside, the p.m. Dish Washer placed a garbage liner in the can while standing in the hallway. She pushed the garbage can back into the kitchen with both gloved hands touching the inside rim of the garbage can. She then returned to the dish machine and washed the steam table pans and placed them on the steam table, without washing her hands.	F 371		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 46 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the bed pan was cleansed and disinfected in a manner to prevent possible cross contamination for 1 (Resident #3) of 6 (Residents #2, #3, #4, #6, #7 and #16) case mix residents on the 100-Hall. This failed practice had the potential to affect 28 residents residing on the 100 hall, according to a list provided by the Administrator on 1/7/08. The findings are: Resident #3 had a diagnosis Acute Urinary Tract Infection. The Significant Change Minimum Data Set dated 1/3/08 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive physical assistance of two-plus persons for toileting and had a urinary tract infection in the last 30 days. a. On 1/8/8 at 1:06 p.m., the resident had a bowel movement on a bed pan. Certified Nursing Assistant (CNA) #7 took the resident's bed pan to the bathroom that the resident shared with her roommate and dumped the feces into the commode. The CNA then held the bedpan over the sink to place water in it and then held it up under the hand soap dispenser to place soap in the bed pan. The bed pan had feces stuck to the sides and bottom that did not come off when the pan was emptied into the commode, so the CNA took toilet tissue and washed the bed pan with the toilet tissue. The bed pan was not disinfected before being placed in a bag and put on a shelf in the resident's closet. b. On 1/10/08 at 12:00 p.m., the facility provided	F 441		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/25/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143		
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F 441	Continued From page 47 the policy and procedure for Disinfection of Bedpans. Documented under equipment and supplies necessary to perform the procedure was: soap and water, disinfectant solution, paper towels and personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Documented under infection control protocol was: wear appropriate personal protective equipment (e.g., gloves, gown, mask, eyewear, etc., as necessary) to prevent exposure to spills or splashes of blood or other potentially infectious materials. Documented under steps in the procedure was: #7 wash surface of bedpan or urinal with disinfectant solution, #8 rinse with hot running water, #9 Pour small amount of disinfectant solution (enough to thoroughly wet surfaces) on and into bedpan or urinal or spray liberally to thoroughly wet the surfaces, #10 rotate bedpan or urinal to allow solution to cover entire inner surface and #11 place article on paper towel to allow to air dry or dry article with paper towel. c. On 1/10/08 at 12:07 p.m., CNA #9 stated that the disinfectant for bedpans was kept in the utility room.	F 441			
F 458 SS=B	483.70(d)(1)(ii) RESIDENT ROOMS Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure multiple-bed resident rooms provided at least 80 square feet of usable living space per resident. This failed practice had the potential to affect 9 residents who resided in the affected rooms, as	F 458			

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F 458	Continued From page 48 identified by the Roster Matrix provided by the Administrator on 1/7/08. The findings are: On 1/7/08 at 7:15 p.m., the following observations were made: a. Semi-private Resident Rooms #5, #6, #7 and #9 measured 161-square feet each. The rooms contained a portable closet which measured 10.6-square feet. When the space consumed by the closet was subtracted from the room size, only 150.4-square feet (or 75.20-square feet per resident) remained. b. Semi-private Resident Room #8 measured 161-square feet. The room contained 1 portable closet that measured 6.3-square feet. When the space consumed by the closet was subtracted from the room size, only 154.7-square feet (or 77.35-square feet per resident) remained.	F 458			