

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

PRINTED: 05/19/2006
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 05/05/2006
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 322 SS=E	<p>483.25(g)(2) NASO-GASTRIC TUBES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure tube feeding formulas were not allowed to hang at room temperature for longer than the manufacturer's maximum recommended hang time for 2 of 2 case mix residents who received continuous tube feedings (Residents #8 and #9). The failed practice had the potential to affect 4 residents who received tube feedings, as documented on the facility's Resident Census and Conditions of Residents form dated 5/2/06. The findings are:</p> <p>The Hazard Analysis Critical Control Point (HACCP) study produced by Abbott (Ross) Laboratories (the company that produces Glucerna), "Preventing Microbial Contamination of Enteral Formulas and Delivery Systems," documented: "...Limiting hangtime to prevent microbes from reaching dangerous levels in tube feedings is an effective and extremely important preventive step. Recommendations for hangtime for decanted, ready-to-use tube feedings are 8 to 12 hours." (Decanted: To pour (a liquid) from one container into another.)</p>	F 322		

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 322	<p>Continued From page 1</p> <p>1. Resident #8 had diagnoses of Febrile Illness, Diabetes Type II and Dysphagia. The Quarterly Minimum Data Set (MDS) dated 3/30/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, totally dependent on staff for activities of daily living and had a feeding tube through which the resident received 76% to 100% of the total daily caloric intake.</p> <p>a. The May 2006 Physician Orders sheet documented a physician order dated 2/21/06 for: "Glucerna per PEG [Percutaneous Endoscopic Gastrostomy] tube running @ [at] 45 cc/hour [cubic centimeters per hour] via pump."</p> <p>b. On 5/1/06 at 9:22 p.m. during the initial tour of the facility, the resident was receiving a tube feeding of Glucerna via a top-fill tube feeding bag connected to a feeding pump set to deliver 40 cc/hour. A handwritten entry on the bag documented: "Glucerna." Although the current date was 5/1/06, the tube feeding bag was dated 5/2/06. The handwritten documentation on the bag did not indicate what time the solution was hung. The label documented the solution was to be administered at 40 cc/hour. The bag contained approximately 950 cc at this time.</p> <p>c. On 5/1/06 at 10:00 p.m., Registered Nurse (RN) #1 was asked what time the resident's tube feeding had been hung. The RN stated her shift (6:00 p.m. to 6:00 a.m.) was responsible for changing the tube feeding bag and tubing every 24 hours. The RN stated, "It was changed at 8:10 p.m. tonight [5/1/06]."</p> <p>d. On 5/2/06 at 11:13 a.m., the same top-fill tube feeding bag of Glucerna dated 5/2/06 was</p>	F 322		

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F 322	<p>Continued From page 2</p> <p>infusing at 40 cc/hour. Approximately 200 cc of Glucerna remained in the bag. An additional entry had been written on the label which documented: "2010 [8:10 p.m.]."</p> <p>e. On 5/2/06 at 2:00 p.m., the same bag of Glucerna was infusing and had approximately 50 cc of Glucerna remaining. At 2:40 p.m., the bag contained approximately 25 cc. Licensed Practical Nurse (LPN) #2 added 2 cans of Glucerna (237 cc each, for a total of 474 cc) to the bag. The LPN was asked if she had added any solution to the bag before 2:40 p.m. The LPN stated, "No, it was hung last night. This is the first time I've added tube feeding." The solution initiated on 5/1/06 at 8:10 p.m. had been hanging for a total 18 hours and 30 minutes at the time the LPN added fresh tube feeding to the formula remaining in the bag.</p> <p>2. Resident #9 had diagnoses of Aspiration Pneumonia, Dysphagia and Gastroenteritis. The Initial Minimum Data Set (MDS) dated 3/28/06 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on two or more persons for activities of daily living and had a feeding tube through which the resident received 76% to 100% of the total daily caloric intake.</p> <p>a. The May 2006 Physician's Order Sheet documented an order dated 3/27/06 for: "PEG Tube: Novasource 2.0 per PEG tube running @ 52 cc/hour via pump."</p> <p>b. On 5/1/06 at 9:37 p.m. during the initial tour of the facility, the resident was receiving a tube feeding via a top-fill feeding bag. Handwritten entries on the bag documented the formula in the</p>	F 322			

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F 322	<p>Continued From page 3</p> <p>bag was Novasource 2.0. Although the current date was 5/1/06, the tube feeding bag was dated 5/2/06. The handwritten documentation on the bag did not indicate what time the solution was hung. The label on the bag documented the solution was to be administered at 52 cc/hour. The bag contained approximately 800 cc of formula at this time.</p> <p>c. On 5/1/06 at 10:00 p.m., RN #1 was asked when the resident's tube feeding had been hung. The RN stated, "It was changed at 7:50 p.m. tonight [5/1/06]."</p> <p>d. On 5/2/06 at 11:32 a.m., the same top-fill tube feeding bag of Novasource 2.0 dated 5/2/06 was infusing at 52 cc/hour. Approximately 550 cc of formula remained. An additional entry had been written on the bag, which documented: "1950 [7:50 p.m.]."</p> <p>e. On 5/2/06 at 12:30 p.m., the same bag of Novasource 2.0 was hanging and contained approximately 500 cc. At 4:30 p.m., the bag contained approximately 250 cc. At 6:00 p.m., LPN #2 was asked if she had added any solution to the bag during her shift (6:00 a.m. to 6:00 p.m.) The LPN stated, "Yes, about 8:00 a.m. I added 480 cc of Novasource 2.0." The LPN was asked if there was any solution remaining in the bag when she added the new solution. The LPN stated, "Yes, about 200 to 300 cc. Closer to 200 cc." The LPN was asked if she had timed and dated the bag when she added the solution. The LPN stated, "I think I did, but I'm not sure. Let's go and look." The Surveyor and LPN #2 went to the resident's room and observed that there was no date, time or amount documented on the tube feeding bag, other than the original hang</p>	F 322			

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F 322	Continued From page 4 date/time. The LPN stated, "I guess I forgot to write it on there, but I usually do." 3. On 5/2/06 at 6:20 p.m., the Administrator and Director of Nursing (DON) were informed that a tube feeding solution for a top-fill tube feeding system using a decanted product should have a hang time of no longer than 8 to 12 hours due to potential microbial contamination. The Director of Nursing stated that it was the facility's policy to change out the tube feeding bag and tubing every 24 hours. 4. On 5/3/06 at 9:00 a.m., the Administrator stated that she had contacted the facility's provider of tube feeding solutions. The provider had contacted the Novartis company (which produces Novasource 2.0) and the standards for hang-time for a decanted product from Novartis was the same as for the Ross products - 8 to 12 hours maximum.	F 322			
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a restraint was used in accordance with the manufacturer's guidelines, to prevent potential accidents/injuries to 1 (Resident #13) of 5 case mix residents with physician orders for physical restraints (Residents #3, #4, #12, #13 and #14). The failed practice had the potential to affect 15 residents with	F 323			

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F 323	Continued From page 5 restraints in use, as documented on the facility's Resident Census and Conditions of Residents form dated 5/2/06. The findings are: Resident #13 had diagnoses of Alzheimer's Dementia with Delusions and Depression, Bipolar I Disorder and Closed Hip Fracture. The Minimum Data Set (MDS) dated 4/11/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, required extensive assistance from staff for transfers and used a trunk restraint daily. a. The May 2006 Physician's Order Sheet documented: "Soft belt when up in recliner and in w/c [wheelchair]." b. On 5/5/06 at 9:00 a.m., the resident was sitting in a recliner in her room with a soft belt restraint applied around her waist. c. On 5/5/06 at 1:30 p.m., Certified Nursing Assistant (CNA) #1 was asked if the resident was supposed to have a restraint applied when she was sitting in the recliner. The CNA stated, "Yes, she uses a belt restraint." d. The manufacturer's guidelines for the soft belt restraint documented: "...Contraindications for Use: Do not use this device for a patient who: Is in a geri-chair or lounge chair. This device is intended for wheelchair and bed use only."	F 323			
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329			

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F 329	<p>Continued From page 6</p> <p>duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure at least 3 hypnotic medication dosage reductions were attempted in a 6-month period before concluding that further dosage reductions were contraindicated for 1 (Resident #6) of 3 case mix residents who received hypnotic medications (see identifiers above). The failed practices had the potential to affect 12 residents who received hypnotic medications, as documented on a list provided by the Director of Nursing (DON) on 5/2/06 at 4:00 p.m. The findings are:</p> <p>Resident #6 had diagnoses of Intractable Insomnia and Medication Overuse. The Quarterly Minimum Data Set (MDS) dated 2/28/06 documented the resident was independent in cognitive skills for daily decision-making, had no problems with short or long-term memory and received a hypnotic medication on 7 of the past 7 days.</p> <p>a. Physician orders dated 9/13/05 documented the resident was to receive Ambien 10 milligrams (mg) every night at bedtime.</p> <p>b. A Consultant Pharmacist Monthly Report dated 12/31/05 documented a written request to</p>	F 329			

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F 329	<p>Continued From page 7</p> <p>the physician for an Ambien dose reduction attempt or justification for continued use. The physician's response dated 1/9/06 was to reduce Ambien to 10 mg every night at bedtime as needed, to administer no more than 5 doses per week. This was not a reduction in the dose of medication that the resident would potentially receive 5 nights per week.</p> <p>c. A physician order dated 2/6/06 documented the Ambien was changed back to 10 mg every night at bedtime.</p> <p>d. A Consultant Pharmacist Monthly Report dated 3/30/06 documented a written request to the physician for an Ambien dose reduction or justification for continued use. The Physician's response documented: "Do not change orders due to... Pt [patient] does not do well!!" No discussion of the specific risks versus benefits of continued Ambien use for this resident was documented.</p> <p>e. On 5/2/06 at 11:10 a.m., 2:05 p.m. and 4:00 p.m., the resident was asleep. On 5/2/06 at 5:20 p.m., the resident was in bed asleep and did not respond to a knock on the door.</p> <p>f. On 5/5/06 at 10:00 a.m., the Director of Nursing (DON) was asked for a risk-versus-benefit statement from the physician for the continued use of Ambien 10 mg. The DON stated, "The physician does not know what to write for a risk-versus-benefit statement." The facility was unable to provide documentation to indicate 3 attempts were made during any 6-month period to reduce the resident's Ambien dosage.</p>	F 329			

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F 329	Continued From page 8 g. The Centers for Medicare and Medicaid Services (CMS) Interpretive Guidelines at F329 documented: "...Drugs used for sleep induction should only be used if: Evidence exists that other possible reasons for insomnia (e.g., depression, pain, noise, light, caffeine) have been ruled out... Daily use of the drug is less than ten continuous days unless an attempt at a gradual dose reduction is unsuccessful... The dose of the drug is equal or less than the following listed doses unless higher doses (as evidenced by the resident response and/or the resident's clinical record) are necessary for maintenance or improvement in the residents functional status... Zolpidem (Ambien) 5 mg... The facility may exceed these doses if it provides evidence to show why it was necessary for the maintenance or improvement in the resident's functional status... For drugs in this category, a gradual dose reduction should be attempted at least three times within six months BEFORE one can conclude that a gradual dose reduction is clinically contraindicated..."	F 329			
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation of the 8:00 a.m. and 12:00 p.m. medication passes on 5/4/06, record review and interview, the facility failed to ensure physician orders were followed to prevent significant medication errors for 1 (Resident #17) of 8 residents observed during the medication passes. A significant medication error was made	F 333			

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F 333	<p>Continued From page 9</p> <p>by 1 Licensed Practical Nurse (LPN #3) of 3 LPN's who administered medications in the facility. The failed practice had the potential to affect 23 residents who resided on the Middle Hall (and received medications from LPN #3), as documented on the Roster/Matrix dated 5/1/06 at 10:25 p.m. The findings are:</p> <p>Resident #17 had diagnoses of Alzheimer's Dementia and Delusions.</p> <p>a. A physician order dated 9/27/05 documented the resident was to receive Razadyne Extended Release (ER) 8 milligrams (mg) every morning with food for Dementia.</p> <p>b. A physician order dated 5/2/06 documented the Razadyne was to be increased to 16 mg every morning. As of 5/4/06, this order had not been transcribed to the May 2006 Medication Administration Record (MAR).</p> <p>c. On 5/4/06 at 8:15 a.m., LPN #3 administered Razadyne 8 mg, instead of 16 mg as ordered by the physician. At 11:45 a.m., LPN #3 was informed of the error and stated, "I didn't know the order had changed. The MAR matched the [medication] card."</p> <p>d. As of 5/4/06 at 11:45 a.m., the medication card of Razadyne capsules contained an 8 milligram capsule in slots #5 through #31. An 8 mg capsule had been removed from slots #1 through #4 (which corresponded to one capsule administered each day from 5/1/06 through 5/4/06). Two 8-mg capsules should have been administered on 5/3/06 and 5/4/06 to provide the 16 mg dose ordered by the physician.</p>	F 333			

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F 333	Continued From page 10 e. This medication error was significant due to the frequency of the error.	F 333		
F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was served at palatable temperatures and not overcooked. The failed practices had the potential to affect 71 residents who received meals from the kitchen, as documented on the facility's Diet List dated 5/2/06. The findings are: 1. On 5/2/06 at 2:00 a.m., 7 of 7 alert and oriented residents who participated in the group interview made (or agreed with) the following comments about the meals served at the facility: a. "...cold at breakfast, lunch and dinner." b. "...meals are cold a lot." c. "...hamburger is overcooked." 2. On 5/2/06 at 8:30 a.m., the pureed scrambled eggs on the steam table had water collected in the bottom of the pan. 3. On 5/2/06 at 8:45 a.m., a breakfast test tray was checked immediately after the last resident	F 364		

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F 364	<p>Continued From page 11</p> <p>was served. The food items on the tray registered the following temperatures:</p> <p>a. Pureed sausage - 115 degrees Fahrenheit.</p> <p>b. Scrambled egg - 118 degrees Fahrenheit.</p> <p>4. On 5/2/06 at 5:50 p.m., a dinner test tray was checked immediately after the last resident was served. The food items on the tray registered the following temperatures:</p> <p>a. Pureed hashbrowns - 116 degrees Fahrenheit.</p> <p>b. Pureed French toast - 118 degrees Fahrenheit.</p> <p>5. On 5/2/06 at 4:21 p.m., one of 2 slices of French toast at the top of a stack on the steam table was burned black on one side and very hard. It had to be broken off in pieces to taste and could not be cut with a knife. The other slice was black on one side and gummy on the other side.</p> <p>6. Resident #10 had diagnoses of Parkinson's Disease and Hypertension. The Minimum Data Set (MDS) dated 2/24/06 documented the resident was independent in cognitive skills for daily decision-making and independent with eating after tray set up.</p> <p>a. A physician order dated 11/13/05 documented the resident was to receive a regular diet.</p> <p>b. On 5/2/06 at 4:50 p.m., the resident was sitting in the main dining room for dinner. The resident was trying to cut his French toast with a knife and fork. After several unsuccessful attempts, he</p>	F 364			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 364	Continued From page 12 threw the utensils down on the table and stated, "I can't!" A Certified Nursing Assistant (CNA) turned the resident's toast over; the toast was burned to a crisp on the underside. 7. Resident #11 had diagnoses of Arthropathy and Hypertension. The MDS dated 4/2/06 documented the resident was moderately impaired in cognitive skills for daily decision-making and required set up only for eating. a. A physician order dated 3/28/06 documented the resident was to receive a regular diet. b. On 5/2/06 at 4:50 p.m., the resident was eating dinner. There was a tough, overcooked piece of sausage on the resident's plate. She attempted unsuccessfully to cut up the sausage then stated, "I can't cut this sausage." A CNA heard the resident's complaint and stated she would get the resident another plate of food.	F 364			
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 food and supplies were properly stored to prevent potential contamination, containers of food were labeled and dated and sanitary techniques were utilized during food preparation to prevent	F 371			

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F 371	<p>Continued From page 13</p> <p>potential food borne illness. The failed practices had the potential to affect 71 residents who received meals from the kitchen, as documented on the facility's Diet List dated 5/2/06. The findings are:</p> <ol style="list-style-type: none"> 1. On 5/1/06 at 9:00 p.m., the following observations were made in the kitchen after the Dietary Staff had gone home for the evening: <ol style="list-style-type: none"> a. One bag of boiled eggs in the first double-door refrigerator was not labeled or dated. b. A ziplock bag of sliced meat in packages was not dated or labeled. c. Four salads in Styrofoam bowls in Refrigerator #2 was not dated or labeled. d. An empty soda can was on top of the milk box. e. Iced cheesecake in the freezer was loosely wrapped and was not dated or labeled. f. One package of 8 chopped steaks in a ziplock bag had no date or label. g. One opened bag of plastic lids and 1 box of paper goods were stored on the floor in a room beside the steam table. These items were being used as a door prop to keep the door open. 2. On 5/2/06 at 7:15 a.m., 2 crockpots, 1 pair of scales and clear plastic cups were stored on the floor in a corner of the storeroom. 3. On 5/2/06 at 11:00 a.m., Dietary Employee #1 was washing dishes. He took a sip of a beverage from a pink pitcher that was sitting amongst the 	F 371			

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F 371	Continued From page 14 dirty dishes on the dish line and continued washing dishes. 4. On 5/2/06 at 11:20 a.m., Cook #2 removed gloves from her hands and placed the used gloves on the counter across from the handwashing sink. The Cook then washed her hands, picked up the same gloves from the counter and donned them, then proceeded to check the temperatures of the food items on the steam table. The Cook also wore the same gloves while placing serving utensils in each food item on the steam table.	F 371		
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. The failed practice had the potential to affect 10 residents who resided in the affected rooms, as documented on the facility's Roster Sample Matrix dated 5/1/06. The findings are: On 5/5/06 at 9:00 a.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	F 458		

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F 458	Continued From page 15 150.4 square feet (or 75.20 square feet per resident) remained.	F 458		
F 502 SS=E	<p>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.</p> <p>483.75(j)(1) LABORATORY SERVICES</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure laboratory supplies were disposed of upon expiration to ensure quality of laboratory services. The failed practice had the potential to affect 52 residents with physician orders for laboratory services, as documented on the facility's Roster/Matrix dated 5/1/06. The findings are:</p> <ol style="list-style-type: none"> On 5/4/06 at 2:30 p.m., the laboratory supplies in the Hall D (400 Hall) medication room were inspected. Forty-eight red/yellow tiger tubes for urinalyses had expired in October 2005 and had not been discarded. On 5/4/06 at 3:05 p.m., the laboratory supplies in the Hall A (100 Hall) medication room were inspected. Eleven red/yellow tiger tubes for urinalyses had expired in October 2005 and had 	F 502		

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F 502	Continued From page 16 not been discarded. 3. On 5/4/06 at 3:05 p.m., Licensed Practical Nurse (LPN) #4 was asked if the facility drew their own lab specimens. The LPN stated, "Yes." 4. Lab Notes - Volume 15, Number 1, 2005 Special Edition Report titled, "Preanalytical Variables in the Chemistry Laboratory," documented: "Preanalytical variables account for 32-75% of laboratory errors, and encompass the time from when the test is ordered by the physician until the sample is ready for analysis... Expired tubes should not be used, as they may have a decreased vacuum, as well as potential changes in any additives in the tubes..."	F 502			