

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

PRINTED: 06/02/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/19/2006
NAME OF PROVIDER OR SUPPLIER OJACHITA NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1411 COUNTRY CLUB ROAD CAMDEN, AR 71701		
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F 000	INITIAL COMMENTS	F 000			
F 164 SS=E	<p>Complaint #11452 was unsubstantiated.</p> <p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility</p>	F 164			

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 164	<p>Continued From page 1</p> <p>failed to ensure that room doors and privacy curtains were closed during flushing of a feeding tube by staff for 2 (Residents #5 and #11) of 4 (Residents #1, #5, #9 and #11) case mix residents who received tube feedings. This failed practice had the potential to affect 15 residents who had a Physician order for tube feedings, as documented on the Residents Census and Conditions of Residents form dated 5/15/06. The findings are:</p> <p>1. Resident #5 had a diagnosis of Depression. The Quarterly Minimum Data Set (MDS) dated 4/26/06 documented the resident had modified independence in cognitive skills for daily decision making and required total staff performance for tube feedings.</p> <p>a. On 5/16/06 at 7:37 a.m., Licensed Practical Nurse (LPN) #2 did not close the resident's privacy curtain or the resident's hallway door during flushing of the resident's feeding tube; this allowed full view of the procedure for any staff, visitors or other residents in the hallway.</p> <p>b. On 5/18/06 at 9:05 a.m., the resident stated, "When I am being tube fed, I want the door closed and the privacy curtain pulled. It bothers me to be exposed."</p> <p>2. Resident #11 had a diagnosis of Cognitive Impairment. The Quarterly MDS dated 4/22/06 documented the resident had severely impaired cognitive skills for daily decision making and required total staff performance for all activities of daily living.</p> <p>a. On 5/16/06 at 11:49 a.m., LPN #2 raised the resident's gown, which exposed the resident's</p>	F 164			

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F 164	Continued From page 2 abdomen, during flushing of the resident's feeding tube. During the procedure the LPN did not close the resident's privacy curtain or hallway door; a visitor passed by the resident's doorway and looked into the room.	F 164		
F 241 SS=B	<p>b. On 5/17/06 at 10:23 a.m., LPN #2 stated "I forgot to pull the curtain or close the door. I know to close the door, but I forgot."</p> <p>483.15(a) DIGNITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure that the abdomen and tube feeding site was covered for 1 (Resident #9) of 4 (Residents #1, #5, #9 and #11) case mix residents who received tube feedings and that transport in a shower chair was in a forward motion for 1 (Resident #22) of 20 (Residents #1 thru #4, #6 thru #18, #22, #26 and #27) case mix residents that required assistance with bathing. This failed practice had the potential 15 residents who had a Physician order for tube feedings and 103 residents that required assistance with bathing, according to the Residents Census and Conditions of Residents form dated 5/15/06. The findings are:</p> <p>1. Resident #9 had a diagnosis of Brain Injury. The Quarterly MDS dated 2/1/06 documented the resident had moderately impaired cognitive skills</p>	F 241		

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F 241	Continued From page 3 for daily decision making, required total staff performance for all activities of daily living and had a Gastrostomy tube for supplemental feedings. On 5/15/06 at 5:39 p.m., the resident's upper left side of her abdomen and her feeding tube were hanging out and over her pelvic vest in full view of the staff, residents and visitors that were in the Dining Room. 2. Resident #22 had a diagnosis of Senile Dementia. The Quarterly Minimum Data Set (MDS) dated 1/11/06 documented the resident had moderately impaired cognitive skills for daily decision making and required total staff performance for locomotion. On 5/17/06 at 2:03 p.m., Certified Nursing Assistant #4 pulled the resident backwards in a shower chair, down the hallway.	F 241			
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure fortified foods were served for 1 of 1 (Resident #16) case mix resident who had Physician orders for fortified foods. This failed practice had the potential to effect 3 residents who had Physician orders for	F 282			

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F 282	Continued From page 4 fortified foods, according to the Diet List dated 5/15/06. The findings are: Resident #16 had diagnoses of Diabetes Mellitus and Hypertension. The Quarterly Minimum Data Set dated 2/27/06 documented the resident had moderately impaired cognitive skills for daily decision making and required setup for eating. a. A Physician order dated 4/17/06 documented Fortified foods with meals three times a day. b. On 5/15/05 at 5:05 p.m., the resident was served Barbecue Pork on a bun, Tator Tots, Mixed Vegetables, a carton of whole Milk, Apple Sauce, Water and Coffee. There was no fortified food/milk served to the resident. c. On 5/16/06 at 7:40 a.m., the resident was served 2 slices of toast, a bowl of Corn Flakes, 1 scrambled egg, 1 slice of bacon, 4 oz of orange juice, 1 carton of whole milk, water and coffee. There was no fortified food/milk served to the resident. d. On 5/17/06 at 7:34 a.m., the resident was served 2 slices of toast, a bowl of Corn Flakes, 1 scrambled egg, 1 slice of bacon, 4 oz of juice, 1 carton of whole milk, water and coffee. There was no fortified food/milk served to the resident. e. On 5/18/06 at 2:22 p.m., Dietary Employee #1 stated, "We forgot to send fortified foods to the resident."	F 282			
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain	F 309			

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F 309	<p>Continued From page 5</p> <p>or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and record review, the facility failed to ensure Foley catheter care was provided using clean areas of a cloth to wipe away from the urinary meatus for 1 (Resident #12) of 3 (Residents #1, #6 and #12) case mix residents with Foley catheters. This failed practice had the potential to affect 6 residents who had indwelling Foley Catheters, according to the Resident Census and Conditions of Residents form dated 5/15/06. The findings are:</p> <p>Resident #12 had a diagnosis of Urinary Retention. An Annual Minimum Data Set (MDS) dated 5/3/06 documented the resident had moderately impaired cognitive skills for daily decision making, required total staff performance for toileting and extensive assistance of staff for hygiene.</p> <p>a. The facility's Policy and Procedure for Male Catheter Care documented: "Purpose - To minimize the risk of catheter associated urinary tract infection and its related problems... Maintain cleanliness. Procedure - 7. ...wipe around catheter at insertion site using circular movements... Turn wash cloth and gently wipe down catheter away from penis head. 8. Wash penis and peri area with wash cloth. 10. Drop wash cloth into the water."</p>	F 309			

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F 309	Continued From page 6 b. On 5/16/06 at 9:24 a.m., Certified Nursing Assistant (CNA) #1 wiped the resident's Foley catheter tubing from the Meatus, downward four (4) times, without turning to a clean area of the cloth. The CNA then cleansed feces from the resident's rectum and wiped the resident's left buttock upward three (3) times, without turning to a clean area of the cloth. The CNA used one washcloth to cleanse all areas and one washcloth to rinse all areas, during the provision of Foley and incontinent care. The CNA placed the soiled cloths on the resident's bedside table after each use.	F 309		
F 312 SS=E	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 that the scrotum, rectal area and buttocks were cleansed during incontinent care for 1 (Resident #4) of 9 (Residents #1 thru #4, #7, #9, #11,#13 and #14) who required assistance with incontinent care and that finger nails were clean and trimmed for 2 (Residents #11 and #13) of 11 (Residents #1 thru #4, #6, #7, #9, #11, #13, #14 and #16) case mix	F 312		

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F 312	<p>Continued From page 7</p> <p>residents who were dependent on staff for nail care. This failed practice had the potential to affect 103 residents that required assistance with activities of daily living, according to the Resident Census and Conditions of Residents form dated 5/15/06. The findings are:</p> <p>1. Resident #4 had a diagnosis of Alzheimer's Disease. A Medicare 90-Day Minimum Data Set (MDS) dated 5/8/06 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance of staff for toileting and hygiene and was incontinent of bowel and bladder.</p> <p>a. On 5/17/06 at 9:41 a.m., the resident received incontinence care after being incontinent of urine. During the provision of care, Certified Nursing Assistant (CNA) #2 did not cleanse the resident's Scrotum, Buttocks or Rectal area.</p> <p>b. The facility Policy and Procedure for Perineal Care documented: "Purpose: to ensure adequate skin care to control odor and prevent skin damage...Procedure .7 Using clean technique, clean resident from front to back."</p> <p>2. Resident #11 had a diagnosis of Cognitive Impairment. A Quarterly MDS dated 4/22/06 documented the resident had severely impaired cognitive skills for daily decision making and required total staff performance for all activities of daily living.</p> <p>a. On 5/15/06 at 5:17 p.m., the resident's nails were long and discolored.</p> <p>b. On 5/16/06 at 9:32 a.m., 11:49 a.m., 2:03 p.m. and 3:52 p.m., the resident's nails were long and</p>	F 312			

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F 312	Continued From page 8 discolored and the resident's left palm was covered with a yellow/brown crusty material. c. On 5/17/06 at 7:40 a.m., the resident's nails were long and discolored, and the resident's left palm was covered with a yellow/brown crusty material. d. On 5/17/06 at 10:20 a.m., the yellow/brown crusty material remained and the resident's hands were shown to the treatment nurse. The resident's right palm and fingers were covered with a dried, white flaky substance. 3. Resident #13 had a diagnosis of Episodic Mood Disorder. A Quarterly MDS dated 4/11/06 documented the resident required limited assistance of one person for bathing and hygiene. a. The Plan of Care, updated on 4/16/06, documented: "Staff to assist with personal hygiene---(oral care, brush hair, nail care and peri-care)." b. On 5/15/06 at 5:55 p.m. and on 5/16/06 at 8:16 a.m., 12:45 p.m. and 3:55 p.m., the resident had long finger nails with a dark substance under all ten finger nails.	F 312			
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315			

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F 315	<p>Continued From page 9</p> <p>infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and record review the facility failed to ensure incontinent care was provided in a manner to prevent the potential for urinary tract infections for 1 (Resident #11) of 9 (Residents #1 thru #4, #7, #9, #11, #13 and #14) case-mix residents. This failed practice had the potential to affect 70 residents frequently incontinent of bowel and bladder, according to the Resident Census and and Conditions of Residents form dated 5/15/06. The findings are:</p> <p>Resident #11 had diagnoses of Hypertension, Diabetes Mellitus and Hemiplegia. A Quarterly Minimum Data Set dated 4/22/06 documented the resident had severely impaired cognitive skills for daily decision making and was totally dependent on staff for all activities of daily living.</p> <p>1. On 5/17/06 at 10:10 a.m., with the resident was on his right side, Certified Nursing Assistant (CNA) #2 and CNA #3 wiped the resident's anal area and removed bowel movement. CNA #2 then took a wipe and wiped the resident from front to back and from back to front with the same wipe.</p> <p>The CNAs then turned the resident on his back and wiped the penis off in a circular motion, starting at the base of the penis and moving to the tip, once. CNA #2 took another wipe and wiped back to front and front to back on either side of the penis.</p>	F 315			

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F 315	Continued From page 10 The CNAs did not touch the pubic area; they then placed a clean brief on the resident. 2. The Perineal Care Policy documented: "Spray perineum with peri/wash solution. Wet washcloth. Using clean technique, clean resident from front to back. Dry residents perineum from front to back." 3. The Incontinent Policy stated to Expose the buttock area. Remove the fecal material from the resident's buttocks area using toilet tissue. Always work from "front to back."	F 315			
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure positioning devices were applied to prevent further contractures of the hands for 1 of 1 (Resident #5) case mix resident who had contractures of both hands. This failed practice had the potential to affect 3 residents in the facility that required the use of hand positioning devices, according to the Director of Nursing (DON) on 5/18/06. The findings are: Resident #9 had a diagnosis of Brain Injury. The	F 318			

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F 318	Continued From page 11 Quarterly Minimum Data Set dated 2/1/06 documented the resident had moderately impaired cognitive skills for daily decision making, required total staff performance for all activities of daily living and had contractures of both hands. a. The resident's Nursing Restorative Care Program dated 5/06 documented: "3. Apply hand roll to right hand after ROM [Range of Motion], while up in W/C [wheelchair], 5x/wk [five times a week], ongoing." b. On 5/15/06 at 5:39 p.m., on 5/16/06 at 7:26 a.m., 11:25 a.m., 12:34 p.m., 2:08 p.m., 3:37 p.m. and on 5/17/06 at 7:50 a.m., the resident had her left Thumb across the Palm of her left hand and a rolled washcloth resting on top of it, with the fingers curled on top of the washcloth. There was no hand roll in the resident's right hand. c. On 5/17/06 at 7:50 a.m., the resident had her left Thumb across the Palm of her left hand and a rolled washcloth resting on top of it, with the fingers curled on top of the washcloth. There was no hand roll in the resident's right hand. d. On 5/17/06 at 10:31 a.m., when the resident's right hand was checked by a Certified Nursing Assistant (CNA), there was an indentation between the resident's right Thumb and the first Finger. e. On 5:18 06 at 9:00 a.m., when the resident's left hand was checked by the Restorative CNA, the area that could be seen had a red indentation on the base of the little finger, where the resident's left Thumb had been resting.	F 318		
F 323	483.25(h)(1) ACCIDENTS	F 323		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/19/2006
NAME OF PROVIDER OR SUPPLIER OUACHITA NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1411 COUNTRY CLUB ROAD CAMDEN, AR 71701		
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F 323 SS=D	Continued From page 12 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 that topical over-the-counter medication was not left accessible at the bedside for 1 (Resident #15) of 18 (Residents #1 thru #18) case mix residents. This failed practice has the potential to affect 12 independently ambulatory residents in the facility, according to the Resident Census and Conditions of Residents form dated 5/15/06. The findings are: 1. Resident #15 had a diagnosis of Depression. The Quarterly Minimum Data Set dated 2/16/06 documented the resident had independent cognitive skills for daily decision making. a. A bottle of Absorbine Jr. was on the resident's over bed table, next to her bed, on 5/15/06 at 1:40 p.m. and on 5/16/06 at 8:25 p.m., 10:27 a.m., 12:07 p.m. and 2:17 p.m. The Absorbine Jr. label documented: "Warning: For external use only. Use only as directed... Avoid contact with eyes. Do not apply to wounds or damaged skin...Extremely flammable. Keep away from fire, sparks and heated surfaces." b. On 5/17/06 at 2:42 p.m., the Director of Nurses stated the Absorbine Jr. should not have been at the resident's bedside.	F 323			

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F 332 F 332 SS=E	Continued From page 13 483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the 5:00 p.m. medication pass on 5/17/06 and the 8:00 a.m. medication pass on 5/18/06, the facility failed to ensure Physician orders were followed to ensure that the medication error rate was less than 5%. Physician orders were not followed for 3 (Resident #23, #24 and #25) of 10 residents observed during the medication passes. Medication errors were made by 2 (Licensed Practical Nurse [LPN] # 1 and LPN #2) of 4 Nurses that administered medications. This failed practice had the potential to affect 72 residents receiving medication from these nurses, according to the Director of Nurses. The medication error rate was 5.08% based on administration of 58 medications, plus 1 medication ordered but not administered, and observation of a total of 3 errors. The findings are: 1. Resident #23 had a Physician order dated 12/12/03 for Novolog 70/30 insulin 30 units every morning; 30 units of Humulin 70/30 administered at 7:47 a.m. on 5/18/06 by LPN #1. 2. Resident #24 had a Physician order dated 4/20/06 for Plavix 75 mg every day with food; the Plavix 75 mg was not administered to the resident at 9:13 a.m. on 5/18/06 by LPN #1, when the LPN administered the residents other medications.	F 332 F 332			

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F 332	Continued From page 14 3. Resident #25 had a Physician order dated 5/12/06 for Caltrate + D to administer one tablet every day; however, Calcium Carbonate 500 mg + D was administered at 9:36 a.m. on 5/18/06 by LPN #2. The 2005 Physician Desk Reference for Nonprescription Drugs and Dietary Supplements entry for Caltrate +D documented: "Calcium 600 mg."	F 332			
F 333 SS=E	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation of the 5:00 p.m. medication pass on 5/17/06 and the 8:00 a.m. medication pass on 5/18/06 and record review, the facility failed to ensure Physician orders were followed to ensure that residents were free of significant medication errors. 2 (Residents #23 and #24) of 10 residents observed during the medication pass were found to have a significant medication error. Significant medication errors were made by 1 (LPN #1) of 4 nurses that administered medication daily. This failed practice had the potential to affect 40 residents receiving medications from this nurse. The findings are: 1. Resident #23 had a diagnosis of Diabetes Mellitus and a Physician order dated 12/12/03 for NovoLog 70/30 insulin 30 units every morning. a. During the medication pass on 5/18/06 at 7:47	F 333			

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F 333	<p>Continued From page 15</p> <p>a.m., 30 units of Humulin 70/30 administered by LPN #1, instead of the ordered NovoLog 70/30.</p> <p>b. The U.S. Food and Drug Administration (FDA) Consumer magazine January-February 2002 documented: "Humulin 70/30 and Novolog Mix 70/30 - The onset, peak, and duration of action of these mixtures would reflect a composite of the intermediate and short- or rapid-acting components, with one peak of action." 1) "Type of Insulin - Rapid-acting: NovoLog - Onset of Action: 15 minutes, Peak of Action: 40-50 minutes and Duration of action: 3-5 hours." 2) "Type of Insulin - Short-acting: Humulin - Onset of Action: 30-60 minutes, Peak of Action: 50-120 minutes and Duration of action: 5-8 hours."</p> <p>c. This was significant due to the class of the drug, which is anti-diabetic.</p> <p>2. Resident # 24 had a diagnosis of Diastolic Heart Failure and Hypertension and a Physician order dated 4/20/06 for Plavix 75 mg every day with food.</p> <p>a. During the medication pass on 5/18/06 at 9:13 a.m., the resident's Plavix 75 mg was not administered by LPN #1.</p> <p>b. The April 2006 Medication Administration Record (MAR) documented that the Plavix was administered from 4/21/06 thru 4/30/06.</p> <p>c. The Plavix 75 mg was not listed on the May 2006 MAR and contained no documentation that the medication had been given.</p> <p>d. On 5/18/06 at 10:20 a.m., LPN #1 stated that</p>	F 333			

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F 333	Continued From page 16 there was no card of Plavix for the resident. e. On 5/18/06 at 12:58 p.m., the provider pharmacy stated that prior to today, the last time Plavix was dispensed for the resident was on 4/20/06 for 10 tablets. f. Plavix 75 mg was was not administered to the resident from 5/1/06 thru 9:13 a.m. on 5/18/06. g. This was significant due to the frequency of the error.	F 333		
F 365 SS=D	483.35(d)(3) FOOD Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure thickened liquid were served according to Physician orders for 1 (Resident #9) of 2 (Residents #9 and #16) case mix residents who received thickened liquids. This failed practice had the potential to affect 6 residents who received thickened liquids, according to the Diet List dated 5/15/06. The findings are: Resident #9 had diagnoses of Brain Injury and Reflux Esophagitis. The A Quarterly Minimum Data Set dated 2/1/06 documented the resident was moderately impaired in cognitive skills for daily decision making, required one person assist for eating and had chewing and swallowing problems.	F 365		

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F 365	Continued From page 17 a. A Physician order dated 2/23/05 documented, "Low concentrated sweets with honey thick liquids." b. On 5/17/06 at 7:50 a.m., the resident received a cup of ice water. The CNA gave the resident two sips of water with a teaspoon from the cup. The resident started coughing after drinking the water.	F 365		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was stored in a manner to prevent potential freezer burn and cross contamination and the ice machine was free of debris. These failed practices had the potential to affect 99 residents who received their meal trays in the kitchen, according to the Resident Census and Conditions of Residents form dated 5/15/06. The findings are: 1. On 5/15/06 at 12:33 p.m., the following observations made were: a. The ice machine, located in a room on 400 hall, had a slimy yellowish substance on the panel where ice shoots down into the ice collector.	F 371		

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F 371	Continued From page 18 b. An ice scoop holder, located on the utility cart in the room on 400 hall, had water standing in it with sediment floating on it. The bottom of holder had a wet, red/yellowish, slimy-looking substance sitting in it. c. An ice scoop in an open zip lock bag, located on the utility cart ice chest kept in the kitchen, had black substance on the scoop. d. A box of beef patties in the walk-in freezer was not covered, exposing the contents to freezer burn. e. A zip-lock bag stored in the refrigerator contained cheese slices; it was not closed, exposing the contents to cross-contamination. f. A bag of french toast, stored on the shelf in the freezer, was not closed, exposing the contents to freezer burn.	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. This REQUIREMENT is not met as evidenced by:	F 441			

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F 441	<p>Continued From page 19</p> <p>Based on observation, the facility failed to ensure staff washed their hands and changed gloves after providing Foley catheter and incontinent care to prevent the potential for transmission of infection for 1 (Resident #12) of 3 (Residents #1, #6 and #12) case mix residents who required Foley catheter care and assistance with hygiene. This failed practice had the potential to affect 6 residents who required Foley catheter care, as documented on the Resident Census and Conditions of Residents form dated 5/15/06. The findings are:</p> <p>1. Resident #12 had a diagnosis of Urinary Retention. The Annual Minimum Data Set dated 5/3/06 documented the resident had moderately impaired cognitive skills for daily decision making, required total staff performance for toileting and extensive assistance of staff for hygiene.</p> <p>a. The facility's Policy and Procedure for Male Catheter Care documented: "Purpose (to) Minimize the risk of catheter associated urinary tract infection and its related problems, Maintain cleanliness," "Procedure 13. Remove gloves, 14. Wash hands"</p> <p>b. On 5/16/06 at 9:24 a.m., Certified Nursing Assistant (CNA) #1 applied gloves, took the resident's wash basin out of the resident's room, to the shower room, where the CNA filled the basin with water for the resident's catheter care. The resident had been incontinent of feces; the CNA performed catheter care and cleaned feces from the resident, without changing gloves.</p> <p>After the care was given the CNA left the resident's room, wearing the same soiled gloves, and looked in the clean linen cart for a plastic bag</p>	F 441			

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F 441	Continued From page 20 to place the soiled linens in. The CNA then took a roll of plastic bags from the Housekeeping cart, tore off plastic bags and then replaced the roll of bags onto the Housekeeping cart. The CNA did not take off the soiled gloves until she placed the soiled linens into the plastic bag.	F 441			