

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

PRINTED: 08/17/2007
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 08/03/2007
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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 000	INITIAL COMMENTS	F 000		
F 176 SS=D	<p>Complaint #12770, substantiated (all or in part) with deficiencies cited at F176, F309 and F324.</p> <p>483.10(n) SELF ADMINISTRATION OF DRUGS</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #12770, substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure self administration of an updraft treatment was not allowed for 1 (Resident #6) of 1 case mix resident who received updraft treatments and was assessed as not being a candidate for self administration of medications. This failed practice had the potential to affect 7 residents who received respiratory treatments according to the Resident Census and Conditions of Residents form dated 8/1/07. The findings are:</p> <p>Resident #6 had diagnoses of Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Disease (CHF). The Admission Minimum Data Set (MDS) dated 6/11/07 documented the resident was moderately impaired in cognitive skills for daily decision making, received oxygen therapy and had shortness of breath in the past 7 days.</p> <p>a. A physician order dated 5/23/07 documented, "A/A (Albuterol/Atrovent) updrafts TID (three</p>	F 176		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 176	Continued From page 1 times a day) PRN (as necessary) SOB (short of breath)." b. The "Assessment for Resident Self Administration of Meds (Medications)" dated 5/23/07 documented, "1). Is the resident cognitively impaired? Yes. 2). Does the resident have a visual deficit? Yes. 4). Can the resident name his/her medication dosage, frequency and reason for use? No... Based on the entire assessment and answers to #1, #2, and #4, the resident will not be able to self administer medications... Based on the entire assessment and answers to #1, #2, and #4, the resident would not be considered safe to self administer medications." c. On 8/1/07 at 8:10 a.m., the resident was sitting on the side of the bed with an updraft machine running. The resident was talking to himself and the updraft mouth piece was not in his mouth most of the treatment. The resident was asked where he got the medicine in his updraft machine. He stated, "I got it up at the desk." He was asked if he had anymore in his room. The resident pointed to his drawer. The drawer contained 2 vials of Atrovent 0.02% and 1 vial of Albuterol 0.083%. There was no nurse present while the resident was self administering the updraft treatment. The resident was asked where he got the Albuterol and Atrovent from. The resident stated, "From a nurse, but I don't know her name." The resident was asked how do you use it and the resident stated, "I use a big one (Atrovent). But if I don't have one, I use 2 little ones (Albuterol)."	F 176		
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must	F 309		

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F 309	<p>Continued From page 2</p> <p>provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #12770, substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure an assessment was completed and interventions were developed and implemented to reduce the need for frequent changing of a Foley catheter and catheter care was provided to decrease the risk of urinary tract infections for 1 (Resident #5) of 2 case mix residents (Resident #3 and #5) who had a Foley catheter. These failed practices had the potential to affect 3 residents who had a Foley catheter according to the ADON (Assistant Director of Nursing) on 8/3/07 at 9:10 a.m. The findings are:</p> <p>Resident #5 had diagnoses of Urinary Retention and Cerebral vascular Accident (CVA). The Quarterly Minimum Data Set (MDS) dated 6/1/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive to total assistance with activities of daily living (ADLs), had an indwelling catheter and Urinary Tract Infections (UTIs) in the last 30 days.</p> <p>a. The July 2007 Physician Orders documented a physician order with a start date of 4/20/06,</p>	F 309		

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F 309	<p>Continued From page 3</p> <p>"F/C care with soap and H2O QD (every day)."</p> <p>b. On 8/2/07, during record review, the nurse's notes documented from September 2006 through February 2007, the resident f/c had been changed monthly (last change recorded 2/28/07) per physician's orders until March 10, 2007.</p> <p>Nurses notes dated 3/10/07 at 10:45 a.m. (late entry), documented, "Foley catheter pulled out during transfer back to bed after bath. Reinserted 16 Fr F/C using sterile tech. clear urine noted in bag."</p> <p>c. Nurses Notes dated 3/15/07, 3/20/07, and 3/26/07 documented the catheter was leaking and was changed.</p> <p>d. Nurses notes dated 3/31/07 at 5:00 p.m. documented, "Resident's Foley cath has been noted to be leaking today. Has had small output via drainage bag but diapers have been very wet." At 5:30 p.m., "Doctor notified of the above new orders received. 1) D/C 16 Fr Foley 2) Insert 18 Fr Foley 5 cc bulb, change every month and PRN." At 6:45 p.m., "16 Fr Foley Dc'd, inserted 18 Fr 5 cc Foley without problems..."</p> <p>e. Nurses notes dated 4/5/07 at 5:30 p.m. documented, "cath. leaking changed cath with 18 Fr 5 cc F/C using sterile tech without problems..."</p> <p>f. Nurses notes dated 4/12/07 at 2:30 p.m. documented, "cath leaking, [changed] with 18 fr 5 cc F/C using sterile tech without problems noted 350 cc dark yellow urine with some sediments noted. Placed call to Doctor with N.O.(new order) UA (urinalysis) C&S (culture and sensitivity).</p>	F 309			

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F 309	<p>Continued From page 4</p> <p>1) The urinalysis report received on 4/17/07 documented 3 plus bacteria and morganelia morganii. The report also documented the physician was notified and an order was given for Bactrim DS BID (twice a day) for 10 days.</p> <p>2) Nurses notes dated 4/17/07 at 8:00 p.m. documented, "antibiotic started ...Res. found with Foley cath out, new cath reinserted under sterile tech without difficulty..."</p> <p>g. Nurses notes dated 5/8/07 at 6:30 a.m. documented, "cath changed D/T (due to) not draining using sterile tech. 1600 cc amber return with much sediment specimen collected and sent to lab."</p> <p>The lab report dated 5/10/07 documented bacteria 2 plus and proteus mirabilis. The report also documented the physician was notified on 5/14/07 and gave a new order for Ampicillin 250/500 (10 cc) QID (four times a day) times 10 days.</p> <p>h. Nurses notes dated 5/16/07 at 12:00 a.m. documented, "...F/C changed D/T not draining..."</p> <p>i. Nurses notes dated 5/23/07 documented, "Res cont antibiotic... urine specimen sent to lab. displays no sign or symptoms of discomfort..."</p> <p>Nurses notes dated 5/24/07 at 5:30 p.m. documented the antibiotic was completed.</p> <p>j. A urinalysis completed on 5/25/07 documented pseudomonas aeruginosa.</p> <p>1) Nurses notes dated 5/25/07 at 4:30 p.m. documented, "Doctor called with N.O. order Cipro</p>	F 309		

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F 309	<p>Continued From page 5</p> <p>500 mg Pgt (per gastrostomy tube) BID times 7 days..."</p> <p>2) Nurses notes dated 5/25/07 at 8:00 p.m. documented, "...[changed] F/C 18 Fr 5 cc using sterile technique..."</p> <p>k. Nurses notes dated 5/26/07 at 11:10 a.m. documented, "...CNA (Certified Nursing Assistant) reports while res was in shower she noticed F/C was out. no bleeding noted. F/C 18 Fr 10 cc reinserted using sterile technique..."</p> <p>l. The care plan updated 5/31/07 documented, "Problem onset: 3/19/07 - Urinary: Resident has f/c and is at risk for UTI" with Approaches: "**Change #16fr/5cc f/c q (every) month *F/C care qd with soap and H2O (water) *Observe during routine care for s/s (signs/symptoms) of UTI: abnormal color, odor, amount, and consistency of urine, abnormal labs *Fluids pgt [per gastrostomy tube]." The care plan did not address the frequent leaking around the catheter resulting in frequent removal and insertions of Foley catheter with increase risk of infections or the chronic UTIs.</p> <p>m. The June 2007 Medication Administration Record (MAR) documented the Foley catheter was changed on 6/5/07 and 6/12/07. There was no documentation on the MAR or the nurses notes as to why the catheter was changed.</p> <p>n. Nurses Notes dated 6/9/07 and 6/23/07 documented the F/C was changed either due to leaking or not draining. Nurses Notes dated 6/29/07 documented the F/C was changed, no reason given.</p>	F 309			

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F 309	<p>Continued From page 6</p> <p>o. Nurses notes dated 7/7/07 documented the F/C was changed either due to leaking. Nurses notes dated 7/12/07 and 7/19/07 documented the F/C was changed, no reason given .</p> <p>p. The July 2007 Medication Administration Record (MAR) documented the Foley catheter was changed on 7/27/07. There was no documentation on the MAR or the nurses notes as to why the catheter was changed.</p> <p>q. On 8/1/07 at 3:35 p.m., NA (Nursing Aide) #7 provided incontinent care. LPN #5 was present in the room to help reposition the resident. The resident was on her back. NA #7 untaped the incontinent brief and rolled the incontinent brief down between the resident's legs. A F/C leg band was present on her left thigh. The NA took the wipes and touched the labia close to the F/C tubing. NA #7 did not spread the labia and wipe. She did not clean the catheter tubing. The NA and LPN rolled the resident onto her left side and feces was present. NA #7 used the wipes and removed the feces wiping front to back and then put on a clean incontinent brief. NA #7 was asked who did the catheter care in the facility. She stated, "The nurses clean the catheters, the only thing I do is empty it."</p> <p>r. On 8/1/07 at 3:55 p.m., LPN #3, the Charge Nurse, was asked who did catheter care in the facility. She stated, "I think the CNAs are supposed to do it when they do incontinent care, but I do my own."</p> <p>On 8/1/07 at 4:00 p.m., LPN #5 was asked who did catheter care in the facility. She stated, "The nurses. It's done everyday. But the CNAs are supposed to know how."</p>	F 309			

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F 309	Continued From page 7	F 309		
F 324 SS=D	<p>On 8/2/07 at 11:30 a.m., the ADON was asked if CNAs were supposed to do F/C care. She stated, "Yes." She was asked when are the CNAs supposed to do F/C care. She stated, they should do it after each incontinent episode and prn. Even if the BM (bowel movement) is not touching the Foley, the area is contaminated."</p> <p>s. On 8/3/07 at 9:00 a.m., the ADON was asked if she was aware the Foley catheter was changed 22 times in the past 4 months and she stated no.</p> <p>483.25(h)(2) ACCIDENTS</p> <p>The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #12770, substantiated (all or in part) in these findings.</p> <p>Based on observation, record and interview, the facility failed to ensure the correct sized sling was used during a transfer using the Viking mechanical lift for 1 (Resident #10) of 4 case mix residents (Resident #3, 4, 5 and 10) who required the use of the mechanical lift for transfers. This failed practice had the potential to affect 40 residents who required the use of the mechanical lift according to the observations made on 8/1/07 of the resident's name plates. The findings are:</p> <p>Resident #10 had a diagnosis of Trans Ischemic Attacks (TIAs). The Medicare 5-day Minimum Data Set (MDS) dated 7/25/07 documented the resident was independent in cognitive skills for</p>	F 324		

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F 324	<p>Continued From page 8</p> <p>daily decision making, required total assistance with transfers, was lifted mechanically in the last 7 days and weighed 102 pounds.</p> <p>a. The "Tender Lift and Care Lift/Transfer Assessment Form (Functional Ability)" dated 7/12/07 documented, "Assessment completed by [LPN (Licensed Practical Nurse) #4] Lift Required: Viking." The sling size was documented as small, however someone marked a line through it and documented a medium size sling.</p> <p>b. The Care plan dated 7/20/07 documented, "Total care for bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. *Transfer per 2 staff with Viking lift..." The care plan did not address the type or size of sling (lift pad) the resident required during transfers.</p> <p>c. On 8/1/07 at 7:41 a.m., there was a red dot labeled V/M (2) located outside the resident's door, next to the resident's name plate. LPN (Licensed Practical Nurse) #4 stated the red dot meant the resident required the use of the Viking lift and a medium size sling (lift pad) with the assistance of 2 staff members.</p> <p>d. The July 2007 and August 2007 Resident Care Flow sheet, used by the Certified Nursing Assistants (CNAs), documented under "Activity/Out of Bed" section documented, "transfer: Lift Type," and it was blank. The flow sheet did not indicate what type or size of sling the resident required or how much assistance was required.</p> <p>e. On 8/2/07 at 10:05 a.m., the resident was in her room with CNA #1. The resident was sitting in a large shower chair next to her bed. CNA #1</p>	F 324			

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F 324	Continued From page 9 stood next to the resident. CNA #1 stated she was waiting for CNA #2 to come help her put the resident back to bed. While the resident was sitting in the chair, she began to fidget, leaning forward slightly and moved about in the chair. The resident was asked what was wrong. She stated, "I'm hurting." She was asked where are you hurting. She stated, "My butt." CNA #1 stated to the resident, "She will be here in a few minutes and we will put you to bed." Approximately 10 minutes later, CNA #1 left the room and came back with CNA #2 who stated as she entered the room, "I forgot about you." The sling (lift pad) was already present under the resident. The staff placed the straps in a crisscross position between her legs then connected the straps to the Viking lift and proceeded to lift the resident into the air. As the CNAs started toward the resident's bed, the resident's buttocks started to slowly slide out of the bottom of the sling. The resident slid into a jack-knife position while in the sling and her hips were protruding out below the bottom opening of the sling. The bottom seam of the sling was positioned at the middle section of the resident's back. CNA #2 was asked if the resident's hips were suppose to be positioned in the sling like that. She stated, "No, her hips are suppose to be up inside the sling." After the transfer, the sling (lift pad) was checked and the inside tag of the sling (lift pad) was yellow, the label on the the lift indicated the sling was a size medium, and was labeled an amputee sling. The resident had both her legs. f. On 8/2/07 at 11:15 a.m., CNA #1 was asked how did she know what lift to use and what sling size to use for each resident. She stated, "I just ask one of the other aides."	F 324			

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F 324	<p>Continued From page 10</p> <p>g. On 8/2/07 at 2:00 p.m., during a telephone interview with the representative of the manufacturer of the slings, it was explained to him how the resident had been positioned in the sling during the transfer. He stated, "...I talked with the consultant of the nursing home and told her an amputee sling is OK to use on other residents, however I recommend when you use it, make sure the proper size is used." He stated, "Here it sounds like the improper size was used. ...If you have the buttocks coming out of the sling it's not correct," He stated it sounded like "there was a problem with the individual operator... Clearly a case where the tailbone was not positioned correctly on the sling when they started. The person's tailbone should be placed at the opening bottom seam of the sling. They had her too far down in the sling." He also stated, "...the sling was too generous for her... I think she would be best suited for a small high back sling..."</p> <p>h. On 8/2/07 at 1:35 p.m., on the wall outside of Resident #12's room, there was a red dot that documented, "V/L (2)". CNA #4 was asked what did the red dot mean on the outside of the door next to the resident's name plate. She stated, "Viking lift." The CNA was specifically asked what was the meaning of each abbreviation on the red dot. She indicated the 'V' meant for Viking lift and the 'L' meant to use a large lift pad (sling). She was asked what did the number 2 mean. She stated, "I have know idea, it may mean 2 people assist, but I thought 2 people always did it anyway."</p> <p>i. On 8/2/07 at 1:36 p.m., on the wall outside of Resident #11's room, there was a red dot that documented, "S/M (1)". CNA #3 was asked what did the red dot mean on the outside of the door</p>	F 324			

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F 324	Continued From page 11 next to the resident's name plate. She indicated the 'S' meant sit to stand lift and medium size sling. She was asked what did the number 1 mean. She stated, "I'm going to tell you the truth, I'm not sure."	F 324			
F 329 SS=E	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329			

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F 329	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure eye drops were not administered on a continuous basis unless medically indicated for 1 (Resident #2) of 2 case mix residents (Resident #2 and 3) who received eye drops This failed practice had the potential to affect 109 residents according to the Administrator on 8/1/07 at 7:17 a.m. The findings are:</p> <p>Resident #2 had diagnoses of Headache and Convulsions. The Quarterly Minimum Data Set (MDS) dated 6/7/07 documented the resident had modified independence in cognitive skills for daily decision-making and no infections.</p> <p>a. A Nurse's Note dated 5/14/07 at 4:20 p.m. documented, "Eyes are running and matted..."</p> <p>b. A Physician Order dated 5/14/07 documented, "Tobradex 1 or 2 drops both eyes QID (four times daily) until clear."</p> <p>c. The May, June, July and August 2007 Medication Administration Record (MAR) documented the resident received the Tobradex eye drops 4 times a day from 5/15/07 through 7/31/07, and 2 times on 8/1/07.</p> <p>d. As of 8/1/07 at 12:00 p.m., there was no documentation in the clinical record through 8/1/07 to indicate the resident was experiencing eye problems.</p> <p>e. On 8/1/07 at 12:55 p.m., the resident's eyes were were not red and there was no drainage.</p>	F 329			

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F 329	<p>Continued From page 13</p> <p>The resident was asked if she had noticed any recent problems with her eyes. She stated she had been having trouble keeping her eyes open and that she would occasionally see black spots, and they would occasionally itch.</p> <p>f. On 8/1/07 at 2:10 p.m., Licensed Practical Nurse (LPN) #1 was asked if she had noticed any problems, such as redness or drainage, with the resident's eyes. She stated no and that the last time that was observed was a couple of months ago. At 2:12 p.m., the Tobradex bottle documented a refill date of 7/25/07.</p> <p>g. On 8/1/07 at 2:23 p.m., the physician's office was contacted. The physician's nurse stated the normal duration of treatment for Tobradex was a week to 10 days. The nurse also stated that if the resident's eyes did or didn't clear up by the end of that time frame, the physician should be contacted for further guidance.</p> <p>h. The 2006 Physician's Desk Reference page 558 documented, "Tobradex (tobramycin and dexamethasone ophthalmic suspension) is a sterile multiple dose antibiotic and steroid combination for topical ophthalmic use... Dexamethasone is a potent corticoid... Warnings: Prolonged use of steroids may result in glaucoma, with damage to the optic nerve, defects in visual acuity and fields of vision, and posterior subcapsular cataract formation... Prolonged use may suppress the host response and thus increase the hazard of secondary ocular infections... The most frequent adverse reactions to topical ocular tobramycin are hypersensitivity and localized ocular toxicity, including lid itching and swelling... Dosage and Administration: Not more than 20 ml (milliliters) should be prescribed</p>	F 329			

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F 329	Continued From page 14 initially and the prescription should not be refilled without further evaluation... "	F 329		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the 8:00 a.m., 12:00 p.m. and 5:00 p.m. medication passes on 8/1/07 and record review, the facility failed to follow physician orders to ensure that the medication error rate was less than 5%. Physician orders were not followed on 3 (Residents #3, #8 and #9) of 14 residents observed during the medication passes. Medication errors were made by 3 (LPNs [Licensed Practical Nurse] #1, 2, and 3) of 6 nurses observed administering medications. The medication error rate was 7.41% based on administration of 53 medications plus 1 medication ordered but not administered, with a total of 4 errors. This failed practice had the potential to affect 94 residents who received medications from these nurses according to the Director of Nursing on 8/1/07 at 5:00 p.m. The findings are: 1. Resident #3 had a physician order dated 6/22/07 for Refresh Tears to use 2 drops in each eye twice a day. On 8/1/07 at 8:37 a.m., LPN #1 did not administer the Refresh Tears. 2. On 8/1/07 at 8:37 a.m., LPN #1 administered Lopressor 25 mg (milligrams) to Resident #3.	F 332		

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F 332	Continued From page 15 a. As of 8/1/07, there was no documentation in the clinical record of a physician order for the Lopressor 25 mg. b. The August 2007 Medication Administration Record documented Lopressor 25 mg twice a day. 3. Resident #8 had a physician order dated 9/28/05 for Naprosyn 500 mg twice a day with breakfast and supper. On 8/1/07 at 3:55 p.m., the resident was administered Naprosyn 500 mg, 1 hour before supper. 4. Resident #9 had a physician order dated 7/22/07 for a Combivent Inhaler to use 2 puffs with a spacer 4 times a day. a. On 8/1/07 at 4:23 p.m., LPN #3 did not shake the inhaler before administering the first puff. b. The Centers for Medicare and Medicaid Services guidelines documented to shake the inhaler before administering the medication.	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, record review and interview, the facility failed to ensure medications were given as ordered and medications not ordered were not given for 1 (Resident #3) of of	F 333			

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F 333	<p>Continued From page 16</p> <p>14 residents case mix residents (Resident #1 - 14) who received medications. These failed practices had the potential to affect all 109 residents. The findings are:</p> <p>Resident #3 had a physician order dated 6/22/07 for Refresh Tears to use 2 drops in both eyes twice a day but no documented diagnosis for use.</p> <p>a. On 8/1/07 at 8:37 a.m., the Refresh Tears were not administered by LPN (Licensed Practical Nurse) #1.</p> <p>b. The June, July and August 2007 Medication Administration Record (MAR) documented the Refresh Tears were discontinued on 6/22/07.</p> <p>c. On 8/1/07 at 12:02 p.m., LPN #1 contacted the physician. The LPN stated the physician told her that the resident should've received the Refresh Tears and to start giving them. The resident did not receive the Refresh Tears from 6/22/07 through 8:37 a.m. on 8/1/07.</p> <p>d. This medication error was significant due to the frequency of the error.</p> <p>e. On 8/1/07 at 8:37 a.m., LPN #1 gave the resident Lopressor 25 mg (milligrams).</p> <p>f. As of 8/1/07, there was no documentation in the clinical record of a physician order for the Lopressor.</p> <p>g. The June, July and August 2007 MAR documented the resident received the medication twice a day since 6/22/07.</p> <p>h. On 8/1/07 at 12:02 p.m., LPN #1 contacted the</p>	F 333			

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F 333	Continued From page 17 physician. The LPN stated the physician told her that the Lopressor should not be administered and to stop giving it.	F 333			
F 441 SS=D	<p>i. This medication error was significant due to the frequency of the error.</p> <p>483.65(a) INFECTION CONTROL</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that under the infection control program causative factors for frequent changes in Foley catheters along with frequent Urinary Tract infections were investigated in order to develop and implement interventions to decrease the risk of UTIs and monitoring of staff to ensure catheter care was provided to decrease the risk of infections for 1 (Resident #5) of 2 case mix residents (Resident #3 and #5) who had a Foley catheter; that nursing staff maintained clean technique to prevent the spread of infections during bed baths and that nursing staff washed their hands after providing bathing/incontinent care and before changing linen, handling personal care items or applying</p>	F 441			

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F 441	<p>Continued From page 18</p> <p>lotion to the body to prevent the spread of infections for 1 (Resident #7) of 5 (Residents #1, 3, 5, 7 and 10) case mix residents who were dependent on staff for bathing. This failed practice had the potential to affect 3 residents who had a Foley catheter according to the ADON (Assistant Director of Nursing) on 8/3/07 at 9:10 a.m. and to affect 20 residents who were dependent on staff for bathing according to the Resident Census and Conditions of Residents form dated 8/1/07. The findings are:</p> <p>1. Resident #5 had diagnoses of Urinary Retention and Cerebral vascular Accident (CVA). The Quarterly Minimum Data Set (MDS) dated 6/1/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive to total assistance with activities of daily living (ADLs), had an indwelling catheter and Urinary Tract Infections (UTIs) in the last 30 days.</p> <p>a. The July 2007 Physician Orders documented a physician order with a start date of 4/20/06: "F/C care with soap and H2O QD [every day]."</p> <p>b. On 8/2/07, during record review, the nurse's notes documented from September 2006 through February 2007, the resident f/c had been changed monthly (last change recorded 2/28/07) per physician's orders until March 10, 2007.</p> <p>Nurses notes dated 3/10/07 at 10:45 a.m. (late entry), documented, "Foley catheter pulled out during transfer back to bed after bath. Reinserted 16 Fr F/C using sterile tech. clear urine noted in bag."</p> <p>c. Nurses Notes dated 3/15/07, 3/20/07, and</p>	F 441			

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F 441	<p>Continued From page 19</p> <p>3/26/07 documented the catheter was leaking and was changed.</p> <p>d. Nurses notes dated 3/31/07 at 5:00 p.m. documented, "Resident's Foley cath has been noted to be leaking today. Has had small output via drainage bag but diapers have been very wet." At 5:30 p.m., "Doctor notified of the above new orders received. 1) D/C 16 Fr Foley 2) Insert 18 Fr Foley 5 cc bulb, change every month and PRN." At 6:45 p.m., "16 Fr Foley Dc'd, inserted 18 Fr 5 cc Foley without problems..."</p> <p>e. Nurses notes dated 4/5/07 at 5:30 p.m. documented, "cath. leaking changed cath with 18 Fr 5 cc F/C using sterile tech without problems..."</p> <p>f. Nurses notes dated 4/12/07 at 2:30 p.m. documented, "cath leaking, [changed] with 18 fr 5 cc F/C using sterile tech without problems noted 350 cc dark yellow urine with some sediments noted. Placed call to Doctor with N.O.(new order) UA (urinalysis) C&S (culture and sensitivity).</p> <p>1) The urinalysis report received on 4/17/07 documented 3 plus bacteria and morganelia morganii. The report also documented the physician was notified and an order was given for Bactrim DS BID (twice a day) for 10 days.</p> <p>2) Nurses notes dated 4/17/07 at 8:00 p.m. documented, "antibiotic started ...Res. found with Foley cath out, new cath reinserted under sterile tech without difficulty..."</p> <p>g. Nurses notes dated 5/8/07 at 6:30 a.m. documented, "cath changed D/T (due to) not draining using sterile tech. 1600 cc amber return with much sediment specimen collected and sent</p>	F 441			

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F 441	<p>Continued From page 20 to lab."</p> <p>The lab report dated 5/10/07 documented bacteria 2 plus and proteus mirabilis. The report also documented the physician was notified on 5/14/07 and gave a new order for Ampicillin 250/500 (10 cc) QID (four times a day) times 10 days.</p> <p>h. Nurses notes dated 5/16/07 at 12:00 a.m. documented, "...F/C changed D/T not draining..."</p> <p>i. Nurses notes dated 5/23/07 documented, "Res cont antibiotic... urine specimen sent to lab. displays no sign or symptoms of discomfort..."</p> <p>Nurses notes dated 5/24/07 at 5:30 p.m. documented the antibiotic was completed.</p> <p>j. A urinalysis completed on 5/25/07 documented pseudomonas aeruginosa.</p> <p>1) Nurses notes dated 5/25/07 at 4:30 p.m. documented, "Doctor called with N.O. order Cipro 500 mg Pgt (per gastrostomy tube) BID times 7 days..."</p> <p>2) Nurses notes dated 5/25/07 at 8:00 p.m. documented, "...[changed] F/C 18 Fr 5 cc using sterile technique..."</p> <p>k. Nurses notes dated 5/26/07 at 11:10 a.m. documented, "...CNA (Certified Nursing Assistant) reports while res was in shower she noticed F/C was out. no bleeding noted. F/C 18 Fr 10 cc reinserted using sterile technique..."</p> <p>l. The care plan updated 5/31/07 documented, "Problem onset: 3/19/07 - Urinary: Resident has</p>	F 441		

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F 441	<p>Continued From page 21</p> <p>f/c and is at risk for UTI" with Approaches: **Change #16fr/5cc f/c q (every) month *F/C care qd with soap and H2O (water) *Observe during routine care for s/s (signs/symptoms) of UTI: abnormal color, odor, amount, and consistency of urine, abnormal labs *Fluids pgt (per gastrostomy tube)." The care plan did not address the frequent leaking around the catheter resulting in frequent removal and insertions of Foley catheter with increase risk of infections or the chronic UTIs.</p> <p>m. The June 2007 Medication Administration Record (MAR) documented the Foley catheter was changed on 6/5/07 and 6/12/07. There was no documentation on the MAR or the nurses notes as to why the catheter was changed.</p> <p>n. Nurses Notes dated 6/9/07 and 6/23/07 documented the F/C was changed either due to leaking or not draining. Nurses Notes dated 6/29/07 documented the F/C was changed, no reason given.</p> <p>o. Nurses notes dated 7/7/07 documented the F/C was changed either due to leaking. Nurses notes dated 7/12/07 and 7/19/07 documented the F/C was changed, no reason given .</p> <p>p. The July 2007 Medication Administration Record (MAR) documented the Foley catheter was changed on 7/27/07. There was no documentation on the MAR or the nurses notes as to why the catheter was changed.</p> <p>q. On 8/1/07 at 3:35 p.m., NA (Nursing Aide) #7 provided incontinent care. LPN #5 was present in the room to help reposition the resident. The resident was on her back. NA #7 untaped the</p>	F 441			

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 08/03/2007
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F 441	<p>Continued From page 22</p> <p>incontinent brief and rolled the incontinent brief down between the resident's legs. A F/C leg band was present on her left thigh. The NA took the wipes and touched the labia close to the F/C tubing. NA #7 did not spread the labia and wipe. She did not clean the catheter tubing. The NA and LPN rolled the resident onto her left side and feces was present. NA #7 used the wipes and removed the feces wiping front to back and then put on a clean incontinent brief. NA #7 was asked who did the catheter care in the facility. She stated, "The nurses clean the catheters, the only thing I do is empty it."</p> <p>r. On 8/3/07 the Infection Control Log was reviewed. The facility included the resident's UTIs, however there was no documentation to indicate the facility had intervened and investigated why the resident's F/C had been changes so many times or developed interventions to decrease the need to change the F/C so frequently in order to decrease the risk of UTIs. When this was discussed with the ADON, she commented, "...I see what your saying."</p> <p>s. On 8/1/07 at 3:55 p.m., LPN #3, the Charge Nurse, was asked who did catheter care in the facility. She stated, "I think the CNAs are supposed to do it when they do incontinent care, but I do my own."</p> <p>On 8/1/07 at 4:00 p.m., LPN #5 was asked who did catheter care in the facility. She stated, "The nurses. It's done everyday. But the CNAs are supposed to know how."</p> <p>On 8/2/07 at 11:30 a.m., the ADON was asked if CNAs were supposed to do F/C care. She stated, "Yes." She was asked when are the</p>	F 441			

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

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F 441	<p>Continued From page 23</p> <p>CNAs supposed to do F/C care. She stated, they should do it after each incontinent episode and prn. Even if the BM (bowel movement) is not touching the Foley, the area is contaminated."</p> <p>2. Resident #7 had diagnoses of Cardiomyopathy and Pneumonia. The Admission Nursing Assessment dated 7/27/07 documented the resident was incontinent and dependent on staff for bathing.</p> <p>On 8/1/07 at 2:30 p.m., Certified Nursing Assistant (CNA) #6 gave the resident a bed bath and provided incontinent care. The CNA donned gloves, filled a basin with body wash and water, then washed the resident's face, neck, chest, abdomen and arms with a washcloth dipped in the basin of soap and water. The CNA then washed the resident's groin area and penis. The same washcloth was dipped back into the basin of water and used to wash the resident's legs and back. The resident was rolled onto the left side and there was a large amount of soft feces. The CNA used wipes to remove most of the feces from the resident's scrotum and buttocks area. A small amount of feces remained on the resident's left buttock. Wearing the same gloves used to give the resident a bath and provide incontinent care, the CNA picked up the resident's oxygen tubing and moved it off of the bed. CNA #6 then proceeded to make the bed with clean linens wearing the same gloves. The CNA changed gloves, got a clean wash cloth and water to clean feces off of the left buttock, and with the same gloves on, applied lotion to the resident's arms, hands, chest and legs.</p>	F 441			