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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465152 | A. BUILDING ______ B. WING ______ | 05/25/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| KOLOB CARE & REHABILITATION | 178 SOUTH 1200 EAST ST GEORGE, UT 84790 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 |
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| F 241 SS=E | 483.15(a) DIGNITY | F 241 | **F241 - Dignity** | |

**F 241 — 483.15(a) DIGNITY**

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based upon interviews with residents, it was determined that the facility did not 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. Specifically, residents stated during individual interviews and a confidential group interview, that call lights were not answered in a timely manner . A review of Resident Council minutes indicated that the staff did not answer call lights in a timely manner. Resident identifiers 1, 7, 16.

Findings include:

1. During an interview with resident 16 on May 24, 2006, at 8:50 A.M., she stated that there are two Certified Nurses Aides (CNA's) that do not do tasks that she needs done for her. She stated that when she has a request to have help in tasks, the two CNA's often "walk off without doing what I ask". She further stated that because "there are only two aides for the three halls at night", call bells are often not answered in a timely manner. She stated that she herself has had to go and see what other residents need when their call bells have been on for an extended time. Then, because she can ambulate well, she goes and finds a CNA or a Nurse to inform them of other resident needs.

6/21/06 POC acceptable completion date 6/29/06

**F241 - Dignity**

**How corrective action will be accomplished for those residents found to have been affected by the deficient practice:**

a. Residents 1 and 16 were visited by the Social Worker and encouraged to report slow call light response times to the Social Worker or DON immediately. The two C.N.A.'s identified by Resident 16 have been in-serviced. — June 26, 2006

b. Resident 7 has been discharged from the facility.

**How the Facility will identify other residents having the potential to be affected by the same deficient practice:**

a. The Administrator or his designee will attend Resident Council and encourage the residents to report slow call light response times to the Social Worker or DON immediately. — June 29, 2006

**Measures and plan put into place to ensure that the deficient practice does not recur:**

a. Facility staff will be educated to answer call lights in a timely manner and provide appropriate assistance to residents. — June 28, 2006

**How the Facility will monitor its performance to make sure that the solutions are sustained.**

a. DON or designee will randomly monitor call light response times. Formal monitoring will be documented at least weekly. As call light response times show consistent improvement, formal documentation of monitoring will take place no less often than monthly. If call light response times become worse or do not show improvement, documented formal monitoring will be increased. Results will always be reported to the QA team on a monthly basis. Feedback will also be obtained from the Resident Council. Noncompliance will also be reported to the Administrator. — Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 6/21/2006

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 241 | Continued From page 1<br><br>2. During a review of Resident Council Minutes, it was discovered that call bells not being answered in a timely manner was identified as in issue in April, 2006.<br><br>3. During an interview with resident 1, on 5/22/06 at 10:50 AM, the resident said that it takes staff 20 to 30 minutes to answer the call light, and the day shift is the worst.<br><br>4. During an interview with resident 7, on 5/22/06 at 10:30 AM, the resident said that it takes staff 30 minutes to answer the call light and then they tell the resident they are short staffed and will be right back and the resident said it is another 30 minutes before they return. Resident 7 said that the delay in answering the call light has resulted in the resident soiling themself on occasion. | F 241 | | |
| F 309<br>SS=G | 483.25 QUALITY OF CARE<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based upon interviews and record reviews, it was determined that the facility did not provide the necessary care and services to attain or maintain the highest practicable physical, mental, and | F 309 | **F309 – Quality of Care**<br>**How corrective action will be accomplished for those residents found to have been affected by the deficient practice:**<br>a. For Residents 6 and 3 follow up has since been completed and corrections have been made.<br>b. Resident 19 has been discharged from the facility.<br>**How the Facility will identify other residents having the potential to be affected by the same deficient practice:**<br>a. The facility will complete an audit to see if there are other residents waiting unnecessarily to seen a physician.<br>b. The facility will complete an audit to see if there is any follow up to be completed on lab results.<br>c. The facility will complete an audit to see if there are any MD orders for physician consults that need follow up. | June 26, 2006<br><br>June 26, 2006 |

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| F 309 | Continued From page 2<br><br>psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 3 of 19 sample residents. Specifically, the facility did not provide one resident with timely evaluation for a possible fracture by a physician, or provide pain medication, for another resident the facility did not follow up on lab results for a low dilantin level. Resident identifier 6, 3, 19.<br><br>Findings include:<br><br>1. Resident 6 was admitted to the facility on May 1, 2004. The resident was admitted with a diagnoses that include chronic airway obstruction, hypercholesteremia, depression, hypertension, and bowel and bladder incontinence.<br><br>In an Interview with resident 6, on 5/24/06 at 1:50 PM, resident stated she remembers falling in her bathroom and breaking her arm. When asked if the fracture was painful, she stated that it was painful, and that her arm immediately hurt after her fall. Further, she stated that it was a "constant pain". When asked if she informed the staff of the pain, she stated that she asked for pain medicine and that she was sure they knew she was in pain. She explained that her doctor was "on vacation", so it took days for her to receive her pain medication and that it "took about a week before I could see the doctor".<br><br>Resident 6's medical record reveals the resident fell to the floor on<br>4/5/06 at 4:15 PM. The documentation indicates resident 6 was in pain after the fall to the floor. On 4/5/06 at 4:35 PM, Licensed Practical Nurse (LPN) 1 noted in the Nurses Notes, "R fore arm | F 309 | **F309 – Quality of Care; Continued**<br>**Measures and plan put into place to ensure that the deficient practice does not recur:**<br>a. Staff will be in-serviced to follow facility policy for the following: quickly contacting a physician when needed, follow up on orders for labs, and ensuring that MD orders for consults are followed in a timely manner.<br>b. DON or designee will provide daily monitoring and supervision of lab orders, lab results, MD follow through, scheduling for MD appointments, and accident follow up. DON or designee will ensure timely notification and follow up with attending MD, on-call MD, or Medical Director as appropriate.<br>**How the Facility will monitor its performance to make sure that the solutions are sustained.**<br>a. DON or designee will monitor on a daily basis for the following: quick follow up with a doctor when needed, timely follow up on MD orders for labs, and timely physician consults when ordered by a doctor. Results will be reported to the QA Committee on a monthly basis. This Plan of Correction will be integrated into the facility QA program by June 28, 2006. | June 28, 2006<br><br>Ongoing |

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| F 309 | Continued From page 3 | F 309 | | |

(forearm) pain ... fell reaching for bathroom doorknob ... ACTIONS: continue to observe".

On 4/5/06, at 10:00 PM, resident 6's primary care physician's office was faxed with the message, "...would like order for x-ray to R (right) elbow d/t (due to) fall large elevation. Also order for pain medication for comfort. "

The documentation illustrates that the resident had abnormal assessment results. On 4/6/06, at 12:52 AM, LPN 2 stated in Nurses Notes, "Assessed resident observed large knot on right elbow, ice applied. Clld (called) Md's (Medical Doctor's) office on-call msg (message) svc (service) x5 (five times). No call back. Faxed Md office requesting xray (x-ray) to right elbow and pain medication ..."

It should be noted that the facility's "Unusual Occurrence Record" Policy states, "Point of Emphasis: In the event that family and/or physician notifications are made involving the use of answering machines or answering service, staff must follow up by making actual voice contact to provide assurance the appropriate notifications were in fact received." (p. 3)

Again, the documentation indicates the resident was experiencing pain. On 4/6/06, at 4:50 PM, LPN 1 noted in the Nurses Notes, "Resident's right elbow is swollen and bruised. Pain. Doctor was faxed last night regarding symptoms." The nurses notes documented that a on call physician okayed x-ray for the resident's primary care physician late in the afternoon. The nurses notes state "resident will be taken tomorrow. Awaiting okay on pain meds. Ice pack has been applied to

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| F 309 | Continued From page 4<br>area off/on. "<br><br>On 4/6/06, at 4:50 PM the facility received a physician's telephone order for an x-ray for the eight elbow, and an order for Darvocet N 100 milligrams, to be given every six hours in the event of pain.<br><br>On 4/6/06, at 7:00 PM, resident was given pain medication (Darvocet N-100).<br>On 4/7/06, at 12:59 AM, resident was given pain medication.<br><br>On 4/7/06, at 11:01 PM, the Nurses Notes reflect that resident arrived back from Emergency Room. No notation regarding time leaving to Emergency Room is found in the Record. Accompanying Discharge Orders received upon her return state, "You have a fracture ..." Nurses Note at 11:01 PM states, "Splint to right arm with ace wrap and sling. LN (Licensed Nurse) gave Darvocet for pain ..."<br><br>On 4/8/06, at 4:39 AM, the resident received her pain medication.<br><br>On 4/9/06, at 0530, Resident was transported to hospital for surgery to her right arm fracture. She arrived back to the facility on April 10, 2006, at 1:00 P.M.<br><br>On April 10, 2006, a late entry by LPN 1, in the Nurses Notes appears, stating, "Since we had no response to fax submitted on 4/5 for x-ray and pain med (medication) request, called (physician's) office afternoon of 4/6. Message on phone stated (primary physician) was out of office and to contact other doctor. Called back and | F 309 | | |



06/21/2006 WED 12:47 [TX/RX NO 6152] 006

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| F 309 | Continued From page 5<br><br>asked front receptionist to put me through to someone who could okay x-ray. Given to (on call physician's) medical assistant. Gave her my cell phone number so she could contact me with orders. Did not get x-ray okay until late afternoon and pain med okay until after 5 PM. Faxed pharmacy and notified (facility's transport service). Not able to take until next day. Resident had minor pain and was ambulating well with walker to meals."<br><br>During an interview with Registered Nurse (RN) 1, on 5/24/06, she stated that the resident fell on 4/5/06, went to the hospital for an x-ray on 5/7/06, and came back to the facility with her arm in a sling. She stated the resident went to the hospital for surgery on 4/9/06.<br><br>RN 1 was asked about the 4/6/06 Nurses Notes entry on 12:52 AM. Specifically, she was asked if the fact that the doctor's office was called five times and faxed once with a request for an x-ray and pain medication, and ice applied to the site, could indicate that the resident was in pain. She stated the request for pain medication was only "prophylactic". RN 1 stated that the "late entry" of 4/10/06 notes that the resident was "ambulating well" with a walker. However, RN 1 stated that she directed LPN 1 to make the late entry on 4/10/06.<br><br>When RN 1 was asked who the Medical Director was, she was able to name facility's Medical Director. When asked if the facility has a policy directing that the Medical Director be informed if care is needed and the attending physician cannot be located, she stated that the facility only calls the Medical Director in "life threatening | F 309 | | |

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| F 309 | Continued From page 6<br>instances".<br><br>Resident 19 was admitted to the facility on 1/7/06 with diagnoses that included seizure disorder, subarachnoid hemorrhage, hemiplegia, hypertension and cerebral vascular accident.<br><br>Resident 19's closed medical record was reviewed on 5/24/06.<br><br>Resident 19's medication administration record for 1/06 documented the resident received "Dilantin Cap 100 mg (milligram) po (by mouth) every eight hours at 1400 (2:00 PM), 2200 (10:00 PM), and 0600 (6:00 AM)."<br><br>Resident 19 had a physician's order for Lab test to be drawn on 1/9/06, the tests requested were, CBC with Differential/Platelet (complete blood cell count), and Dilantin level (seizure medication). There was a copy of a fax, dated 5/23/06, that was sent to resident 19's primary care physician that said, "This lab was not called to us -though- dilantin level is very subtherapeutic. Drawn on 1-9-06 and we got results today. As you know, [resident] had a gran mal seizure today, went to ER (emergency room) and was transported back to Las Vegas."<br><br>The blood work that was drawn on 1/9/06 document that resident 19's Dilantin level was 2.7 mcg (microgram)/ml (milliliters). The ER records document that blood work was drawn on 1/23/06, | F 309 | | |

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| F 309 | Continued From page 7 | F 309 | | |

and resident 19's Dilantin level was 1.7 mcg/ml.

Reference : Laboratory and Diagnostic Test with Nursing Implications, seventh edition, Joyce LeFever Kee, MSN, RN, 2005, pg. 334 and 335. Therapeutic Range: Adult: As an anticonvulsant, 10-20 mcg/ml. Nursing Implications With Rationale: Check serum phenytoin (Dilantin) result and immediately report nontherapeutic levels to the health care provider.

There was no documentation in resident 19's closed medical record that a follow up on the lab results had been done. From 1/9/06 to 1/23/06 was a period of 14 days before the facility requested resident 19's lab results.

Resident 3 was admitted on 1/04/06 with diagnoses which included; failure to thrive, dementia, atherosclerosis, atrial fibrillation, hemorrhage of gastrointestinal tract, and incontinence

Resident 3's medical record was reviewed on 5/23/06.

On 3/5/06, at 9:30 PM, a physician telephone order was written. Send pt (patient) to ER (emergency room) of rectal bleeding worsens. HCT (hematocrit) lab in AM. Arrange for GI (gastro intestinal) consult. It was signed by resident 3 ' s physician.

No GI consult could be found in resident 3 ' s



06/21/2006 WED 12:47 [TX/RX NO 6152] 009

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| F 309 | Continued From page 8<br>medical record.<br><br>No other documentation could be found in the nurses' notes regarding the GI consult. | F 309 | | |
| F 323<br>SS=E | 483.25(h)(1) ACCIDENTS<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview with the maintenance manager, it was determined that the facility did not ensure that resident environment remained as free from accident hazards as possible.<br><br>Findings include:<br><br>On 5/23/06 between 10:00 AM and 11:00 AM the water temperature was tested in 27 resident rooms, using 3 different temperature measuring gauges.<br><br>Room 332 had a bathroom sink water temperature of 128.5 degrees Fahrenheit.<br>Room 109 had a bathroom sink water temperature of 125.0 degrees Fahrenheit.<br>Room 113 had a bathroom sink water temperature of 125.0 degrees Fahrenheit.<br>Room 114 had a bathroom sink water temperature of 128.1 degrees Fahrenheit.<br>Room 116 had a bathroom sink water temperature of 124.3 degrees Fahrenheit. | F 323 | **F323 – Accidents**<br>**How corrective action will be accomplished for those residents found to have been affected by the deficient practice:**<br>a. No residents were found to be affected by the practice.<br>**How the Facility will identify other residents having the potential to be affected by the same deficient practice:**<br>a. This element of the Plan of Correction will be addressed in items 3 and 4.<br>**Measures and plan put into place to ensure that the deficient practice does not recur:**<br>a. The Facility will ensure that the facility water temps remain in the range of 110 to 120 degrees Fahrenheit<br>**How the Facility will monitor its performance to make sure that the solutions are sustained.**<br>a. The Manager of Plant Operations or designee will monitor water temperatures on a weekly basis. He will check the temps at approximately 10 different places each week. When necessary, corrections will immediately be made. Results will always be reported to the QA team on a monthly basis. | June 28, 2006<br><br>Ongoing |



06/21/2006 WED 12:47 [TX/RX NO 6152] 010

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| F 323 | Continued From page 9<br><br>On 5/24/06 at 9:30 AM the maintenance man accompanied the surveyors to several rooms in the facility and the water temperatures were tested. All temperatures were within normal range. The maintenance person stated that after being made aware of the temperatures in the rooms on 5/23/06 he spent several hours during the evening checking the water heating systems. | F 323 | | |
| F 467 SS=B | 483.70(h)(2) OTHER ENVIRONMENTAL CONDITIONS - VENTILATION<br><br>The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined that the facility failed to ensure outside ventilation ( by mechanical means) was available in all bathrooms. This failure was found in 14 rooms in the facility and created the potential for unpleasant odors and stale air to remain in the area.<br><br>Findings Include:<br><br>Automatic exhaust fans in 14 rooms failed to provide adequate movement of air to cause a piece of toilet tissue to adhere to the vents. Rooms 327, 333, 335, and all resident rooms in the #100 hallway (Rooms 105, 107, 108, 109, 110, 111, 112, 113, 114, 115, and 116.)<br>There was no air movement in the bathrooms of | F 467 | **F467 – Other Environmental conditions - Ventilation**<br>**How corrective action will be accomplished for those residents found to have been affected by the deficient practice:**<br>a. No residents were found to be affected by the practice.<br>**How the Facility will identify other residents having the potential to be affected by the same deficient practice:**<br>a. This element of the Plan of Correction will be addressed in items 3 and 4.<br>**Measures and plan put into place to ensure that the deficient practice does not recur:**<br>a. All faulty automatic exhaust fans have been identified and repaired or replaced.<br>**How the Facility will monitor its performance to make sure that the solutions are sustained.**<br>a. The Director of Plant Operations or designee will monitor the exhaust fans in the resident bathrooms on a monthly basis. Corrections will be made and results will be reported to the QA team on a monthly basis. | June 28, 2006<br><br>Ongoing |

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| F 467 | Continued From page 10<br>the #100 hallway with the bathroom doors shut. The bathrooms became uncomfortably warm with stagnate air within 2 minutes.<br><br>On 5/23/06 urine odors were noticed lingering in resident rooms #327, #335 and #113. The odors in the bathrooms of rooms #327, #335, and #133 had very strong urine odors.<br><br>On 5/23/06 at 9:30AM, the maintenance man was interviewed regarding the venting failure in the #100 rooms. The ventilation system is automated and is facility wide. Due to current construction in the facility it was thought that there may have been some damage done that they were unaware of. | F 467 | | |
| F 502 SS=E | 483.75(j)(1) LABORATORY SERVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and interview with the facility staff, it was determined that the facility did not provide laboratory services in a timely manner. Specifically, the facility did not provide laboratory results to the resident's physician within timeframe normal for appropriate interventions for 4 of 19 sampled residents. Resident identifiers 4, 9, 13, 19.<br><br>Findings include: | F 502 | **F502 Laboratory Services**<br>**How corrective action will be accomplished for those residents found to have been affected by the deficient practice:**<br>a. Resident 19 has been discharged from the facility.<br>b. Follow up has been completed for residents 4, 9, and 13.<br>**How the Facility will identify other residents having the potential to be affected by the same deficient practice:**<br>a. An audit will be conducted to ensure there are no other labs without proper follow up.<br>**Measures and plan put into place to ensure that the deficient practice does not recur:**<br>a. Nursing staff will be in-serviced to ensure proper follow up of MD orders for labs.<br>**How the Facility will monitor its performance to make sure that the solutions are sustained.**<br>4. DON or designee will monitor daily for adequate follow up on MD orders for labs. Results will be reported to the QA team on a monthly basis. | June 26, 2006<br><br>June 26, 2006<br><br>Ongoing |



06/21/2006 WED 12:47 [TX/RX NO 6152] 012

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| | 465152 | A. BUILDING ______ B. WING ______ | 05/25/2006 |

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| F 502 | Continued From page 11<br><br>Resident 13 was admitted to the facility on 02/13/06 with diagnoses including diabetes, hypertension, cardiovascular disease, and Alzheimer.<br><br>On 5/11/06 the facility received physician orders for the following labs; "HgbA1c (Glycosylated Hemoglobin, a test for monitoring blood glucose control over a period of weeks), CMP( Comprehensive Metabolic Panel, a test for a group of 14 specific tests used to evaluate organ function and check for conditions). Lipid panel ( a test ordered to determine coronary heart disease). The order further stated "am shift lab date: 05/12/06 CALL DR. WITH RESULTS."<br><br>Review of resident 13's medical record on 5/23/06 at 2:15 PM, revealed no copy of the lab results.<br><br>Review of the facility lab book on 5/24/06 at 0930 AM, revealed no copy of the labs being drawn.<br><br>Review of the facility nursing notes on 5/23/06 at 2:00 PM, revealed no documentation of labs being drawn on 05/12/06.<br><br>On 5/24/06 at 09:30 AM, in an interview with facility staff 1, confirmed that laboratory results are obtained from the laboratory, dated and faxed to the physician, and a copy placed in the residents medical record.<br><br>On 5/24/06 at 0:955 AM, in an interview with LPN (licensed practical nurse) 3, confirmed that the lab results had been obtained from the laboratory on 5/23/06 and faxed to the resident's primary | F 502 | | |

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| F 502 | Continued From page 12<br>care physician at 5:55 PM and was now in the chart.<br><br>Resident 9 was admitted to the facility with diagnoses which included cardiac dysrhythmia, hypertension, pneumonia, dementia, depressive disorder, rhinitis, constipation, urinary tract infection, arthropathy, and spinal stenosis.<br><br>On 5/4/06, at 7:00 AM, the facility received a physician ' s order from the primary care physician to draw a blood Potassium Level. On 5/8/06, at 7:45 AM, the Laboratory test was performed. The Potassium Level was 3.3 millimoles per liter. The normal Potassium range is 3.5-5.5 millimoles per liter. The results were subsequently received by the facility and faxed to physician' s office on 5/9/06, at 3:00 AM.<br><br>There is no further documentation in the medical record regarding the Potassium Level until a fax dated 5/22/06 at 3:00 PM, that states, "What would you like us to do for her potassium levels. The original lab results were faxed on 5-9-06, this is another copy." At 4.50 PM, the physician sent an order to add Potassium Chloride 10 milligrams every day to the resident 9"s medication regime and to draw a Basic Metabolic Panel after two weeks.<br><br>Resident 19 was admitted to the facility on 1/7/06 with diagnoses that included seizure disorder, subarachnoid hemorrhage, hemiplegia, hypertension and cerebral vascular accident. | F 502 | | |

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| F 502 | Continued From page 13<br><br>Resident 19's closed medical record was reviewed on 5/24/06.<br><br>Resident 19 had a physician's order for Laboratory test to be drawn on 1/9/06, the tests was a for a CBC with Differential/Platelet (complete blood cell count), and Dilantin level (seizure medication). The blood work that was drawn on 1/9/06 document that resident 19's Dilantin level was 2.7 mcg (microgram)/ml (milliliters). Therapeutic Range: Adult: As an anticonvulsant, 10-20 mcg/ml.<br><br>There was no documentation in resident 19's closed medical record that a follow up on the lab results had been done. From 1/9/06 to 1/23/06 was a period of 14 days before the facility requested resident 19's lab results.<br><br>Resident 19's closed medical record documented that on 1/23/06 the resident was sent to the emergency room with a gran mal seizure. A Dilantin level drawn at the hospital was 1.7 mcg/ml<br><br>Resident 4 was admitted to the facility on 7/11/05 with diagnoses which included; migraine headaches, hypertension, gastro esophageal reflux disease, neurogenic bladder, type I diabetes, cerebral vascular accident, and hemiplegia.<br><br>A review of resident 4 ' s medical record was completed on 5/23/06, that revealed a physician order dated 7/20/05 for a CMP (comprehensive metabolic panel) Q (every) 6 months, January and July. | F 502 | | |

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| F 502 | Continued From page 14<br><br>Resident 4 ' s medical records were reviewed for laboratory results. No documentation could be found that this test was performed for July 2005 and January 2006. Furthermore, laboratory results were found for BMP (basic metabolic panel) on 1/20/06, but no physician order could be found. | F 502 | | |