STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045155	A. BUILDING ____ B. WING ____	01/12/2007

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ASH FLAT HEALTHCARE AND REHABILITATION CENTER	**66 OSBIRN LANE** **ASH FLAT, AR 72513**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that an assessment was done to determine medical justification and a physician's order was obtained prior to the application of a trunk restraint for 1 (Resident # 3) of 4 (Residents # 2, 3, 5 and 6) case mix residents. This failed practice had the potential to affect 7 residents with restraints (enablers) as identified by a list provided by the Administrator on 1/12/07. The findings are: Resident # 3 had diagnoses of Alzheimer's Disease and Dementia with Behavior Disturbances. The Quarterly Minimum Data Set (MDS) dated 12/14/06 documented the resident had moderately impaired cognitive skills for daily decision-making, required assistance with ADL's (Activities of Daily Living), had an unsteady gait and had fallen in the past 30 days. a. On 1/8/07 at 10:30 a.m., 1:10 p.m., 4:30 p.m. and on 1/9/07 at 8:00 a.m. and 12:00 p.m., the resident was observed seated in a wheelchair with a soft belt restraint. b. On 1/9/07 at 4:00 p.m., the resident's clinical record was reviewed. There was no physician's order for the use of the trunk restraint or documentation to indicate that a pre-restraining assessment had been performed. There was no	F 221		

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 221	Continued From page 1 informed consent in the clinical record. c. On 1/9/07 at 5:00 p.m., the Administrator and MDS nurse were asked if a pre-restraining assessment had been performed and if a physician's order and consent had been obtained. The MDS coordinator presented documentation that indicated a verbal consent had been obtained from the resident's spouse on 12/26/07. She stated she was unable to find documentation that a physician's order had been obtained or a pre-restraining assessment had been performed prior to the application of the restraint.	F 221		
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 daily weights were done and the physician was notified for a weight gain of 5 pounds or greater in 3 days as per the physician's orders for 1 (Resident #4) of 11 (Residents #1 - 11) casemix residents and the facility failed to ensure non-pressure related skin treatment was consistently implemented per physician's orders for 1 (Resident # 7) of 4 (Residents #1, 7, 8, 10) case mix residents. These failed practice had the potential to affect 14 residents receiving non-pressure related skin treatments as identified by a list provided by the MDS Coordinator on 1/12/07 and all 47 residents with physician orders residing in the facility	F 282		

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F 282	Continued From page 2	F 282		

according to the Resident Census and Condition Report provided by the Administrator on 1/9/07. The findings are:

1. Resident # 7 had diagnoses of Alzheimer's Disease and Urinary Tract Infection (UTI). The Admission Minimum Data Set (MDS) dated 12/18/06 documented the resident had severely impaired cognitive skills for daily decision-making and required extensive assistance with toileting and personal hygiene

a. The physician's order dated 1/6/07 documented, "Apply Calmoseptine to buttocks and groin Q (every) shift and PRN (as needed)."

a. The Plan of Care dated 12/13/06 documented, "Problem: At risk for skin breakdown d/t (due to) incont. (incontinent) of bladder & decreased mobility, incont. of bowel. Maintain intact skin".

b. On 1/9/07 at 8:00 a.m., the resident was assisted to the bedside commode by CNA # 4. The resident's groin, penis and scrotum were red and excoriated. CNA # 4 stated, "We used to put ointment on him but now the nurse does it".

c. On 1/9/07, the treatment sheet for January 2007 documented, "12/18/07. Calmoseptine Apply to buttocks and groin q (every) shift and PRN. May keep at BS (bedside)". The treatment was last initialed as having been done on the 7-3 shift on 1/4/07 and the treatment sheet had been folded in half.

d. On 1/9/07 at 10:00 a.m., the Director of Nursing (DON) stated that a folded sheet usually meant that the treatment had been discontinued.

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F 282	Continued From page 3 She stated that she had written an order over the weekend to clarify that the nurses would be doing the treatment and that the Calmoseptine would be kept in the treatment cart instead of at the bedside. A clarification order dated 1/6/07 documented, "Calmoseptine apply to buttocks and groin q shift (3 times a day) and prn". The DON was asked if a new treatment sheet had been filled out and she stated, "No". The DON was asked if the treatment had been done on 1/8/07 and she stated, "No". 2. Resident #4 had diagnoses of End Stage Congestive Heart failure and Pulmonary Hypertension. The MDS (Minimum Data Set) dated 12/05/06 documented the resident had independent cognitive skills for daily decision making. a. A Physician order dated 10/13/06 documented, "Daily wt (weight) call MD (medical doctor) for gain above 5 pounds in 3 days". b. According to the resident's October 2006 MAR (Medication Administration Record) and weight sheet the resident was weighed daily from her admit date of 10/13/06 through 10/26/06 and then was changed to weekly weights. c. ON 1/10/07 at 10:05 a.m., L.P.N. (Licensed Practical Nurse) # 1 was asked where to find daily weights for this resident. She stated she thought the resident had been refusing daily weights and the order was just for three days anyway. d. The last week of December 2006 the weekly weight record documented the resident weighed 156 pounds. On January 5, 2007 the resident weighed 179 pounds with a weight gain of 23	F 282		

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F 282	Continued From page 4 pounds in one week. There was no documentation available for review that the physician was notified of the resident's weight gain. e. On 1/10/07 at 11:39 am, the Nurse Consultant stated that she had thought the residents increase in weight might have been due to being weighed on a new scale and she had not notified the physician. She stated that when they received the new scale they weighed all the residents to have a base weight for the new scale. When asked if any other resident had a large weight discrepancy from the old scale to the new she stated, "NO". f. On 1/10/07 at 11:53 a.m., the Director of Nursing (DON), stated that she had filled out a request for lab to be drawn for the resident on Sunday night, 1/07/07, because the resident's face was "puffy". The DON also stated that the lab was drawn on Tuesday morning 1/09/07 and when the facility received the lab results she faxed it to the physician. The DON was asked if the physician had been informed of the DON's clinical assessment of the resident which prompted the DON to request the lab work or that the resident had a 23 pound weight gain in one week. The DON stated, "No, I didn't, it was his patient, I thought he'd know why". When the DON was asked if any other resident had a large discrepancy in their weight from the old scale to the new scale she stated, "No there wasn't". g. On 1/10/07 at 12:38 p.m., the resident was asked if the physician wanted her weighed daily if she had a problem with that and she stated, "no". She was then asked, if the staff comes in and asked you to leave your room and go weigh every	F 282		

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F 282	Continued From page 5 day would you have a problem with that? She stated, "I would not have a problem with that". h. On 1/10/07 at approximately 1:30 p.m., in a phone conversation with the resident's physician, the physician stated he had ordered the daily weights and to be notified of above 5 pound weight gain in three days on 10/13/06 because of the resident's Congestive Heart Failure and Pulmonary Hypertension so he could monitor the resident for fluid overload. He stated he had not ordered the resident to be changed to weekly weights but he had been told by the facility that the resident was refusing to be weighed. He also stated he was not aware until today that the resident had gained 23 pounds.	F 282		
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, interview and record review, the facility failed to ensure all areas of the perineum and buttocks were cleansed and the same area of the washcloth was not used for 4 (Resident #1, 2, 3, and #7) of 4 case mix residents that required assistance with personal hygiene. These failed practices had the potential to affect 17 incontinent residents that required assistance with personal hygiene according to a list provided by the Administrator on 1/12/07. The findings are:	F 312		

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F 312	Continued From page 6	F 312		

1. Resident # 7 had diagnoses of Alzheimer's Disease and Urinary Tract Infection (UTI). The Admission Minimum Data Set (MDS) dated 12/18/06 documented the resident had severely impaired cognitive skills for daily decision-making, required extensive assistance with toileting and personal hygiene and had a Urinary Tract Infection in the past 30 days.

a. The Plan of Care dated 12/13/06 documented, "Problem: At risk for skin breakdown d/t (due to) incont. (incontinent) of bladder and decreased mobility, incont. of bowel. Maintain intact skin. ... Problem: Requires 1 - 2 assist c (with) all ADL's (Activities of Daily Living). Ensure resident maintains odor free, clean and well groomed. ... Problem: Risk for UTI d/t hx. (history) of UTI".

b. On 1/9/07 at 8:00 a.m., the resident was assisted to the bedside commode by CNA # 4. The resident's incontinent brief had several dark smears in the seat. The CNA was asked if resident had soiled the brief and CNA stated, "No, that's blood stains from his hemorrhoids". The CNA went into the bathroom and put soap and water on 2 washcloths. The resident's groin, penis and scrotum were red and excoriated. CNA # 4 wiped the left groin one time, then wiped the right groin one time then wiped the anal area one time using the same portion of the same wash cloth. The foreskin was not retracted and the penis was not cleansed. The groin and anal areas were not rinsed or dried. There was no barrier cream used on the excoriated areas. The blood stained brief was not changed.

2. Resident # 2 had diagnoses of Parkinson Disease, Urinary Frequency, and Urinary Tract

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F 312	Continued From page 7 Infection. The Minimum Data Set (MDS) dated 11/21/06 documented the resident had severely impaired cognitive skills for daily decision making and was incontinent of bowel and bladder. a. The Physician Orders dated 12/06 documented "Macrobid Caps MCR 100 Mg. (1) PT QD for chronic UTI. Cranberry Juice 4 OZ. PT QD at 8 p.m. D/T chronic UTI's" b. On 1/9/07 at 11:35 a.m., incontinent care was provided for the resident by CNA #1 and 2. CNA's #1 and #2 removed the resident's sweat pants and disposable brief, then turned the resident to the left side. CNA #1 cleansed the resident's right buttock and rectal area front to back with a disposable wipe and peri wash. The CNA's then turned the resident to the right side and cleansed the resident's left buttock and rectal area from front to back with a disposable wipe and peri wash. The CNA's put a clean brief on the resident and redressed the resident in the sweat pants. The resident's pubic area, groin, labia, or ureteral areas were not cleansed. The CNA's were asked if the brief they removed from the resident was wet with urine and they both stated, "yes". 3. Resident # 3 had diagnoses of Alzheimer's Disease and Dementia with Behavior Disturbances. The Quarterly Minimum Data Set (MDS) dated 12/14/06 documented the resident had moderately impaired cognitive skills for daily decision-making, required assistance with ADL's (Activities of Daily Living), was incontinent of bowel and bladder and had a Stage 2 pressure ulcer. a. On 1/8/07 at 4:30 p.m., CNA # 6 entered the	F 312		

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F 312	Continued From page 8 resident's room and stated she was going to get the resident up for supper. The resident was in bed. CNA # 6 pulled back the covers. The resident was clothed only in a t-shirt. The incontinent pad was urine soaked. The bottom half of the t-shirt was wet. The CNA donned gloves and sprayed periwash on a rag. Using the same surface of the rag, the CNA wiped the anterior thighs and suprapubic area using a back and forth motion. The penis, scrotum and the groin area was not cleansed. 4. Resident #1 had a diagnoses of Diabetic Neuropathy and Right Above the Knee Amputation. The resident's MDS (Minimum Data Set) dated 12/05/06 documented the resident was independent in cognitive skills for daily decision making, had a stage 2 pressure ulcer and was frequently incontinent of bowel and bladder. a. On 1/09/06 at 11:18 a.m., CNA #3 went into the resident's room to get him out of bed for lunch. The resident did not have a heel protector on his left heel. The CNA was doing incontinent care and cleansed the resident's front peri area. The CNA did not clean any part of the resident's buttocks or coccyx before applying a clean brief.	F 312		
F 314 SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

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F 314	Continued From page 9	F 314		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that residents perineal/buttocks areas were cleansed and dried to prevent the development of pressure sores for 2 (Residents # 1, # 3) case mix residents, failed to report changes in skin condition for 1 (Resident # 3) case mix resident and failed to put on heel protector when the resident was in bed and apply ointment to reddened areas of the buttocks,as per physician orders to for 1 (Resident # 1) of 6 (Residents # 1 - 4, 7, 9) case mix residents who are at risk for pressure ulcers. These failed practices had the potential to affect 15 residents at risk for pressure sores as identified by a list provided by the Administrator on 1/12/07. The findings are:

1. Resident # 3 had diagnoses of Alzheimer's Disease and Dementia with Behavior Disturbances. The Quarterly Minimum Data Set (MDS) dated 12/14/06 documented the resident had moderately impaired cognitive skills for daily decision-making, required assistance with ADL's (Activities of Daily Living), was incontinent of bowel and bladder and had a Stage 2 pressure ulcer.

a. The Plan of Care dated 12/14/06 documented, "Potential for skin breakdown d/t (due to) decreased mobility and resident will not lie down during day time for very long period of time and is up in w/c (wheelchair) majority of day and is incontinent".

b. The Physician's order dated 12/28/06 documented, "DC (discontinue) Xenaderm to

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F 314	Continued From page 10 coccyx and R (right) of coccyx. Healed". c. On 1/8/07 at 4:30 p.m., CNA # 6 entered the resident's room and stated she was going to get the resident up for supper. The resident was in bed. CNA # 6 pulled back the covers. The resident was clothed only in a t-shirt. The incontinent pad was urine soaked. The bottom half of the t-shirt was wet. The CNA donned gloves and sprayed periwash on a rag. Using the same surface of the rag, the CNA wiped the anterior thighs and suprapubic area using a back and forth motion. The penis, scrotum and the groin area was not cleansed. The CNA turned the resident onto his left side on the urine soaked pad. The sacral - coccyx area was dark red over the entire surface. There was an area to the right lower buttocks that measured approximately 0.5 cm in diameter that had a bloody wound base. CNA # 6 stated, "That's a sore". The CNA did not wash the buttocks or the right side. The CNA put a pull up incontinent brief and pants partially up on the resident with the resident lying on his left side. She then folded. the incontinent pad under the resident and rolled him back onto his back on the bare mattress. The resident reached down and held his penis in both hands and urinated. The urine streamed over the resident's hands and down both sides of his pelvis onto the mattress and the incontinent pad that was still partially under him.. CNA # 6 stated, "He's wetting again". The CNA did not do any additional incontinent care. d. On 1/9/07 at 9:00 a.m., the DON stated that there had been no skin issues reported for this resident yesterday or today. 2. Resident #1 had a diagnoses of Diabetic	F 314		

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Neuropathy and Right Above the Knee Amputation. The resident's MDS (Minimum Data Set) dated 12/05/06 documented the resident was independent in cognitive skills for daily decision making, had a stage 2 pressure ulcer and was frequently incontinent of bowel and bladder.

a. The resident's December 2006/ January 2007 physician orders documented, "Heel protector on LT (left) heel at all times while in bed". Physician orders dated 10/26/06 documented, " ... Clean LT (left) buttock with NS (normal saline) apply Xenaderm Q (every) shift ... " an order written 1/04/07 documented, " ... change TX (treatment) to buttock to PRN (as needed) for redness".

b. On 1/09/07 at 8:17 a.m., CNA (Certified Nursing assistant) #3 transferred the resident to the bed using a mechanical lift. The CNA did not put heel protector on the resident's left heel before leaving his room.

c. On 1/09/07 at 10:29 a.m., the DON (Director of Nursing) went into the resident's room to do his treatments. The resident was in bed when the DON entered the room and did not have a heel protector on his left heel. The DON stated that the residents buttocks and coccyx area were red but had no open areas. The DON did not apply Xenaderm to buttocks.

d. On 1/09/06 at 11:18 a.m., CNA #3 went into the resident's room to get him out of bed for lunch. The resident did not have a heel protector on his left heel. The CNA was doing incontinent care and cleansed the resident's front peri area. The CNA did not clean any part of the resident's buttocks or coccyx before applying a clean brief.

F 322	483.25(g)(2) NASO-GASTRIC TUBES	F 322		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322 SS=D	Continued From page 12 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure that PEG (Percutaneous Endoscopic Gastrostomy) tube was flushed prior to the administration of medications as ordered by the physician for 1 (Resident #1) of 2 (Residents # 1, 2) case mix residents. This failed practice had the potential to affect 3 residents with PEG tubes as identified by a list provided by the Administrator on 1/12/07. The findings are: Resident #1 had a diagnosis of Dysphagia. The resident's MDS (Minimum Data Set) dated 12/05/06 documented the resident was independent in cognitive daily decision making skills and had a feeding tube. a. The December 2006/January 2007 physician orders documented: "flush peg tube with 30cc (Cubic Centimeters) of H2O (water) before and after meds (or until water flows clear). b. On 1/09/07 at 8:53 a.m., L.P.N. (Licensed Practical Nurse)#2 mixed the dry crushed medications with water and administered the medications into the gastrostomy tube. The nurse did not flush the tube with 30cc of H2O	F 322		

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F 322	Continued From page 13 before administering the medication as ordered per the physician.	F 322		
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that restraints were applied per manufacturer's guidelines to prevent injuries for 2 (Resident # 3, # 7) of 4 (Residents #2, 3, 5, 6) case mix residents with restraints. This failed practice had the potential to affect 7 residents with restraints as identified by a list provided by the Administrator on 1/11/07. The findings are: 1. The Manufacturer's Guidelines for the Application of the Soft Wheelchair Belt provided by the Administrator on 1/10/07 documented, "Note Caution regarding the following conditions: Patients who slide forward or down or who attempt to slide under their belts by pulling them up over their chest. They could slide far enough under the strap to become suspended in the restraint, resulting in chest compression, restriction or suffocation. Make sure straps are secured at chair frame and will not slide in any direction, changing position of the device". 2. Resident # 3 had diagnoses of Alzheimer's Disease and Dementia with Behavior Disturbances. The Quarterly Minimum Data Set (MDS) dated 12/14/06 documented the resident had moderately impaired cognitive skills for daily	F 323		

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F 323	Continued From page 14 decision-making, required assistance with ADL's (Activities of Daily Living), had an unsteady gait and had fallen in the past 30 days. a. On 1/8/07 at 10:30 a.m., 1:10 p.m., 4:30 p.m. and on 1/9/07 at 8:00 a.m. and 12:00 p.m., the resident was seated in a wheelchair with a soft belt restraint. The restraint was positioned over the resident's abdomen and around the seat back. The straps were not secured to a junction of the frame to prevent the restraint from sliding up. 3. Resident # 7 had diagnosis of Alzheimer's Disease. The Admission Minimum Data Set (MDS) dated 12/18/06 documented the resident had severely impaired cognitive skills for daily decision-making, required extensive assistance with ADL's, had an unsteady gait and had fallen in the past 30 days. a. The physician's order dated 12/26/06 documented, "Soft seat belt while in w/c (wheelchair) r/t (related to) no safety awareness, no impulse control secondary to dementia". b. On 1/8/07 at 11:15 a.m. and 4:20 p.m. and on 1/9/07 at 8:00 a.m. and 12:00 p.m., the soft belt restraint was positioned across the resident's abdomen and around the seat back. The straps were not secured to a junction of the frame to prevent the restraint from sliding up.	F 323		
F 324 SS=E	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.	F 324		

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F 324	Continued From page 15	F 324		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that interventions for the tab alarms to prevent falls were consistently implemented for 3 (Residents #3, #7 and #4) and correctly implemented for 1 (Resident # 5) of 5 (Residents #3, 4, 5, 6 and 7) case mix residents requiring the use of a tab alarm and failed to ensure that interventions were implemented for a lap buddy when the resident was in a wheelchair to prevent falls for 1 (Resident # 4) of 1 case mix residents with physician orders for a lap buddy. This failed practice had the potential to affect 16 residents requiring the intervention of a tab alarm according to the list from the Administrator on 1/12/06 and 1 residents identified to have physician orders for a lap buddy according to the the Administrator on 1/25/07 at 2:00 p.m.. The findings are:

1. Resident # 3 had diagnoses of Alzheimer's Disease and Dementia with Behavior Disturbances. The Quarterly Minimum Data Set (MDS) dated 12/14/06 documented the resident had moderately impaired cognitive skills for daily decision-making, required assistance with ADL's (Activities of Daily Living), had an unsteady gait and had fallen in the past 30 days.

a. The physician's order dated 9/16/06 documented, "Tab alarm while in w/c (wheelchair) and bed d/t (due to) no safety awareness and no impulse control".

b. The Plan of Care dated 12/14/06 documented, "At risk for falls d/t unsteady gait secondary to hypotension and potential for s/e (side effects) of meds used for CAD (Coronary

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Artery Disease). Tab alarm on while in bed and w/c."

c. On 1/8/07 at 10:30 a.m., 1:10 p.m., 4:30 p.m. and on 1/9/07 at 8:00 a.m. and 12:00 p.m., the resident was observed seated in a wheelchair. The tab alarm was not present.

2. Resident # 7 had a diagnosis of Alzheimer's Disease. The Admission Minimum Data Set (MDS) dated 12/18/06 documented the resident had severely impaired cognitive skills for daily decision-making, had an unsteady gait and had fallen in the past 30 days.

a. The Physician's Order dated 12/13/06 documented, "Tab alarm in bed & w/c".

b. On 1/8/07 at 4:20 p.m., 1/9/07 at 8:00 a.m. and 12:00 p.m., the resident was in the wheelchair. The tab alarm was not present.

3. Resident #4 had a diagnosis of End Stage Congestive Heart Failure. The MDS (Minimum Data Set) dated 10/26-06 documented the resident was independent in cognitive skills for daily decision making and required one person physical assist for transfers.

a. The physician orders dated December 2006/January 2007 documented: "Tab alarm while in bed D/T (due to) no safety awareness and no impulse control. Lap buddy in w/c (wheelchair) D/T (due to) no safety awareness and no impulse control".

b. On 1/08/07 at 1:03 p.m., the resident was in her bed and there was no tab alarm present on her bed.

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F 324	Continued From page 17 c. On 1/08/07 at 3:04 p.m., the resident was coming down the hall in an electric wheelchair with no lap buddy on. d. On 1/08/07 at 4:46 p.m., the resident was sitting on the edge of the bed. There was no alarm present on the bed. The resident stated that she did not have a bed alarm. e. On 1/09/07 at 9:37 a.m., resident was in the electric wheelchair in the smoke room. There was no lap buddy on. 4. Resident #5 had diagnoses of Alzheimer's Disease, Anxiety State and Muscle Disuse Atrophy. The Minimum Data Set (MDS) dated 12/14/06 documented the resident was moderately impaired in cognitive skills for daily decision making and needed extensive assistance of one person physical assistance for transfers. a. A physician order dated 1/8/06 documented, "DC (discontinue) soft belt and apply tab alarm in w/c (wheel chair) and bed". b. The care plan dated 9/28/06 documented, "Problem Onset: ... At risk for falls DT (due to) Hx (history) of falls ... antianxiety use, narcotic pain med use, no safety awareness and no impulse control ... ". c. On 1/9/07 at 9:00 a.m., the resident was in a wheelchair with a chair alarm attached to the left arm of the chair and the clip at the end of the string, attached to the back of her shirt. The resident stood up and the alarm did not sound.	F 324		
F 425	483.60 PHARMACY SERVICES	F 425		

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The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

This REQUIREMENT is not met as evidenced by:
Based on observation, the facility failed to ensure expired medication were removed from the medication carts. This failed practice had the potential to affect all 47 residents in the facility as identified by the Administrator on 1/08/07 at 10:15 a.m.. The findings are:

1. On 1/11/07 at 9:15 a.m., the following pharmacy items was expired in the Hall 1, 2, 3, 4, and the right side of 5 medication cart.

a. One bottle of Vitamin C 500 milligrams (mg) had an expiration date of 10/06.

b. One bubble medication card contain 10 tablet of Lorazepam 0.5 mg had an expiration date of 10/06.

1. The medication had been used on these dates: (See if can verify were this information was obtained from)
 11/18/06
 11/21/06
 12/02/06
 12/08/06
 12/09/06 (2 times)

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F 425	Continued From page 19 12/13/06 (2 times) 12/27/06 01/07/06 (2 times) 2. On 1/11/07 at 9:30 a.m., the following pharmacy items was expired in the Hall 6 and the left side of 5 medication cart. a. One bottle of 355 ml of Kaopectate, had an expiration date of 9/06. b. One bottle of 100 Zinc Gluconate 50 mg, had an expiration date of 9/06.	F 425		
F 431 SS=F	483.60(d) LABELING OF DRUGS AND BIOLOGICALS Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This REQUIREMENT is not met as evidenced by: Based on inspection and interview of the medication room and medication carts on 1/11/07, the facility failed to ensure that items which require a physician's prescription were labeled in accordance with state law and accepted principles of pharmacy labeling. This failed practice had the potential to affect all 47 residents according to the Administrator on 1/8/07 at 10:15 a.m. The findings are: 1. On 1/11/07 at 9:15 a.m., the following prescription only items were stored in the Hall 1, 2, 3, 4, and the right side of 5 medication carts	F 431		

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F 431	Continued From page 20 with no prescription label: a. Nine vials of Albuterol 2.5 milligrams (mg)/ 3 ml. b. Seven vials of Atrovent 0.5 mg/3 ml. c. A plastic bag labeled with name and Lasix 40 mg on the a plastic bag. The bag contained 7 whole tablets, 3 half tablets, and 1/4 tablet. d. Licensed Practical Nurse (LPN) #1 was asked, "What are these tablets?" The LPN #1 stated, "The whole tablets are Lasix 40 mg and the half tablets are 80 mg broke in half". 2. On 1/11/07 at 9:30 a.m., the following prescription only item was stored in the Hall 6 and the left side of 5 medication cart with no prescription label: a. One bottle of 100 of Potassium Chloride 10 Millievequalent (mEq). b. One bottle of 5 ml of Patanol 0.1%. c. Eleven vials of Albuterol 2.5 mg/3 ml.	F 431		
F 441 SS=E	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	F 441		

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F 441	Continued From page 21 corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure a safe, sanitary environment was maintained to prevent the development and transmission of disease and infection for 2 (Residents # 2 and 3) of 11 (Residents #1-11) case mix residents. These failed practices had the potential to affect 3 residents with PEG tubes and 47 residents currently residing in the facility according to the Residents Census and Conditions of Residents form dated 1/8/07. The findings are: 1. Resident # 3 had diagnoses of Alzheimer's Disease and Dementia with Behavior Disturbances. The Quarterly Minimum Data Set (MDS) dated 12/14/06 documented the resident had moderately impaired cognitive skills for daily decision-making, required assistance with ADL's (Activities of Daily Living), was incontinent of bowel and bladder and had a Stage 2 pressure ulcer. a. On 1/8/07 at 4:30 p.m., CNA # 6 entered the resident's room and stated she was going to get the resident up for supper. The resident was in bed. CNA # 6 pulled back the covers. The resident was clothed only in a t-shirt. The incontinent pad was urine soaked. The bottom half of the t-shirt was wet. The CNA donned gloves and sprayed periwash on a rag. Using the same surface of the rag, the CNA wiped the anterior thighs and suprapubic area using a back and forth motion. The penis, scrotum and the groin area was not cleansed. The CNA did not wash the buttocks. The CNA put a pull up	F 441		

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F 441	Continued From page 22 incontinent brief and pants on the resident and pulled them up the thighs with the resident lying on his left side. She then folded. the incontinent pad under the resident and rolled him back onto his back on the bare mattress. The resident reached down and held his penis in both hands and urinated. The urine streamed over the resident's hands and down both sides of his pelvis onto the mattress and the incontinent pad that was still partially under him.. CNA # 6 stated, "He's wetting again". The CNA did not do any additional incontinent care. CNA attempted to sit the resident up but was unable to and stated, "I'm going to get some help." CNA # 6 put the call light on and CNA # 5 entered the room. CNA # 6 removed her gloves and CNA's # 5 and # 6 assisted the resident to stand up, pulled up the incontinent brief and the pants and transferred him to the wheelchair. CNA # 6 removed the resident's wet t-shirt by grabbing the wet tail of the shirt with her bare hands and pulling it off over the resident's head, picked out a new t-shirt from the drawer and assisted the resident into it, picked the resident's cap up from the nightstand and placed it on his head and then opened the door to the corridor without washing her hands. CNA # 5 sat down on the wet mattress and attached the resident's restraint to the wheelchair. The resident was rubbing his urine soaked hands together and lacing his fingers as if washing his hands while he was being transported by CNA #6 to the dining room. The CNA did not was her hands after completing incontinent care or prior to transporting the resident to the dining room. The resident was placed at the table. A glass of water was sitting on the table. The resident rubbed his hand around the rim of the glass and then picked it up to drink. Surveyor intervened and instructed staff that resident needed to have hands washed	F 441		

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F 441	Continued From page 23 and glass replaced with a fresh one. 2. Resident # 2 had diagnoses of Parkinson Disease, Urinary Frequency, Urinary Tract Infection, Dysphagia, and Gastrostomy Status. The Minimum Data Set (MDS) dated 11/21/06 documented the resident had severely impaired cognitive skills for daily decision making, had a feeding tube and was incontinent of bowel and bladder. a. On 1/9/07 at 11:35 a.m., CNA #1 and 2 provided incontinent care for the resident. CNA's #1 and #2 removed the resident's sweat pants and disposable brief. CNA #1 cleansed the resident's right buttock and rectal area from the front to back with a disposable wipe and peri wash. CNA #1 noted that the feeding tube was disconnected from the gastrostomy tube and reconnected the two ends, touching the ends that connect with her dirty gloves. The CNA's turned the resident to the right side and cleansed the resident's left buttock and rectal area front to back with a disposable wipe and peri wash. The CNA's turned the resident on her back and CNA # 1 noted the feeding tube became disconnected from the gastrostomy tube again and reconnected it with the same dirty gloves a second time. The CNA's put a clean disposable brief and sweat pants on the resident wearing the same dirty gloves. The resident's pubic area, groin, labia, or ureteral areas were not cleansed. The CNA's were asked if the brief they removed from the resident was wet with urine and they both stated, "yes".	F 441		