

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

PRINTED: 11/02/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2005
NAME OF PROVIDER OR SUPPLIER ASH FLAT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	INITIAL COMMENTS Complaint # 9718 was unsubstantiated. Complaint #9723 was substantiated (all or in part) with a deficiency cited at F253.	F 000		
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure survey results of the the most recent Statement of Deficiencies (CMS-2567) were posted with the accommodation of magnification or large print to ensure readability for anyone with vision problems wishing to review the survey results. This failed practice had the potential to affect all 49 residents of the facility identified on the Resident Census and Conditions of Residents form dated 1/24/05. The findings are: a. On 1/25/05 at 2:50 p.m., the results of the last annual survey was posted in a binder in the Front Lobby Day Room. There were no means of magnification or large print readily available to residents or visitors who had vision difficulties and	F 167		2/26/05

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.

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

PRINTED: 11/02/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/27/2005
NAME OF PROVIDER OR SUPPLIER ASH FLAT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 167	Continued From page 1 wanted to review the survey results. b. On 1/25/05 at 4:10 p.m., the Administrator stated there used to be a magnification sheet with the book but someone must have taken the magnification sheet out of the binder.	F 167			
F 253 SS=E	483.15(h)(2) ENVIRONMENT The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Complaint #9723 was substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure bedside commodes, elevated commode seats and privacy curtains were clean. These failed practices had the potential to affect all 49 residents in the facility identified by the Administrator on 1/24/05. The findings are: 1. On 1/23/05 between 10:27 p.m. and 10:53 p.m., the elevated commode seats in Rooms #207, #108 and #100 had a dried brown substance down the inside of the seats. 2. On 1/24/05 at 2:45 p.m.; on 1/25/05 at 8:30 a.m., 10:40 a.m., 11:20 a.m., 12:25 p.m. and 2:35 p.m.; and on 1/26/05 at 9:45 p.m., a half dollar size yellow, brown dried substance was on the privacy curtain in Room #201. 3. On 1/25/05 at 8:30 a.m., 10:40 a.m., 11:20	F 253		2/26/05	

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

PRINTED: 11/02/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/27/2005
NAME OF PROVIDER OR SUPPLIER ASH FLAT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 253	Continued From page 2 a.m., 12:25 p.m. and 2:35 p.m.; and on 1/26/05 at 9:45 a.m., a dried brown splattered substance was around the inside of the elevated commode seat in Room #201. 4. On 1/26/05 at 10:30 a.m. and 3:00 p.m., the bedside commode in Room #402 had a dried, dark brown substance smeared onto the back portion of the seat.	F 253			
F 312 SS=D	483.25(a)(3) QUALITY OF CARE A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure incontinent care was provided to 1 case mix resident (Resident #7) of 9 case mix residents (Residents #1, #3, #6, #7, #8, #10, #11, #15 and #16) who required incontinent care. This failed practice had the potential to affect 19 residents who were identified as incontinent on the Roster Sample Matrix dated 1/24/05. The findings are: Resident #7 had diagnoses of Parkinson's Disease, Dementia with Behaviors, and Diabetes Mellitus. The Quarterly Minimum Data Set dated 11/4/04 documented the resident had moderately impaired cognitive skills in daily decision making, had short-term and long-term memory problems, and required assistance of staff with personal hygiene.	F 312		2/26/05	

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

PRINTED: 11/02/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2005
NAME OF PROVIDER OR SUPPLIER ASH FLAT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 312	Continued From page 3 a. The plan of care dated 8/5/04 documented: "Resident is incontinent of bladder & bowel...Routine skin assessment & peri-care with incontinent episodes." b. The Resident Care Flow Sheet dated 1/05 documented: "Incontinent care with soap and water, rinse, dry & apply lotion prn [as needed] after inc.[incontinent] episodes." c. On 1/24/05 at 12:38 p.m., Certified Nurse Assistant (CNA) #3 removed an adult incontinence brief from the resident and stated it was wet. CNA #4 cleaned the resident's rectal area with a peri-wash wet cloth from front to back twice, using the same surface each time. The same area was rinsed and dried. The penis, scrotum and frontal area of the resident were not cleaned in any manner before a clean adult incontinence brief was applied.	F 312		
F 316 SS=D	483.25(d)(2) QUALITY OF CARE A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure incontinent care was provided in a manner to prevent infection for 2 case mix residents (Residents #3 and #6) of 9 case mix residents (#1, #3, #6, #7, #8, #10, #11, #15, #16) who required pericare. This failed practice had the potential to affect 19 residents in the facility who were identified as incontinent on	F 316		2/26/05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2005
NAME OF PROVIDER OR SUPPLIER ASH FLAT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 316	Continued From page 4 the Roster Sample Matrix dated 1/24/05. The findings are: 1. Resident #6 had diagnoses of Alzheimer's Disease, Psychosis, and Urinary Tract Infection. The Minimum Data Set (MDS) dated 11/5/04 documented the resident had moderately impaired cognitive skills for daily decision making, had a short-term memory problem, and required assistance from staff for personal hygiene. a. The plan of care dated 11/5/04 documented the resident had potential for skin breakdown due to "frequent bladder incontinence" and to give "preventive skin care per facility protocol." b. The Resident Care Flow Sheet dated 1/05 documented: "Incontinent care with soap and water, rinse, dry & apply lotion prn after inc. episodes." c. On 1/25/05 at 11:12 a.m., Certified Nursing Assistant (CNA) #2 used a periwash wet cloth to clean the vulva and used the same surface to clean the rectal area after the resident urinated. The areas were rinsed with the same surface of the wet washcloth then dried with another washcloth. 2. Resident #3 had diagnoses of Urinary Frequency, Irritable Bladder and Dementia. The MDS dated 12/04/04 documented the resident had moderately impaired cognitive skills for daily decision making, had short-term and long-term memory problems, required assistance of staff with personal hygiene and toileting, and had a Urinary Tract Infection in the last 30 days. a. The History and Physical dated 10/29/04	F 316		

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

PRINTED: 11/02/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/27/2005
NAME OF PROVIDER OR SUPPLIER ASH FLAT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 316	Continued From page 5 documented a history of blood, white blood cells and bacteria in the urine. b. The Plan of Care dated 12/4/04 documented the resident had incontinent episodes and required assistance of one person for toileting and to cleanse skin with soap and water after each episode using clean technique. c. On 01/24/05 at 11:20 a.m., CNA #2 assisted the resident to the bathroom and provided incontinent care. The resident was rinsed back to front 3 times and the rectal area was then rinsed with the same area of the cloth. 3. The Incontinent Peri-care policy provided by the Administrator 1/26/05 at 12:17 p.m. documented: "wet cloth with peri-wash and/or spray peri-wash on perineal area. Using clean technique, clean from front to back."	F 316			
F 323 SS=E	483.25(h)(1) QUALITY OF CARE 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, the facility failed to ensure that keys were available to all areas of the facility, furniture used by the residents was maintained in good repair, exit doors were not blocked, and an electrical outlet was secured and without sharp edges. This failed practice had the potential to affect all 49 residents in the facility identified by the Resident Census and Conditions of Residents	F 323		2/26/05	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/27/2005
NAME OF PROVIDER OR SUPPLIER ASH FLAT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 6</p> <p>form provided by the Administrator and dated 1/24/05. The findings are:</p> <p>1. On 1/23/05 at 10:15 p.m., Licensed Practical Nurse (LPN) #1 stated there were no keys to the kitchen and the Administrator would have to be called to provide keys to the area for an inspection.</p> <p>On 1/23/05 at 10:35 p.m., the Administrator arrived at the facility and stated, "We have a new Dietary Manager and we have just had to change out the locks in the kitchen. That is why nursing didn't have a key to the kitchen."</p> <p>2. On 1/25/05, the following was observed:</p> <p>a. At 2:50 p.m., a maroon colored sofa in the Lobby had a sharp nail protruding approximately 1 inch from the left armrest.</p> <p>b. At 2:52 p.m., a second maroon colored sofa in the Lobby had a sharp nail protruding approximately 1 inch from the left armrest.</p> <p>c. At 2:53 p.m., a beige arm chair in the Lobby had a sharp nail protruding approximately 1/2 inch from the left armrest.</p> <p>d. At 2:55 p.m., two bulletin boards in the 100 Hallway had a nail protruding approximately 1/2 inch from each of them.</p> <p>e. At 3:10 p.m., a metal picnic table near the front entrance to the facility had a sharp edge on the table top that had been welded to the table rim.</p> <p>f. At 3:15 p.m., there was a pipe approximately 1 inch in diameter and 21 feet in length was on the</p>	F 323			

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

PRINTED: 11/02/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2005
NAME OF PROVIDER OR SUPPLIER ASH FLAT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	Continued From page 7 ground near the egress door of the 500 Hallway. The pipe extended the total length of the porch to the doorway. The pipe was approximately 2 inches above the surface of the porch and created a hazard to those needing to exit the building in the case of an emergent situation. The pipe had been embedded in concrete on one end. The Maintenance Director stated he did not know the purpose of the pipe, but the pipe had been blown over and out of the ground during a recent high wind. g. At 3:27 p.m., two bulletin boards in the 300 Hallway had a nail protruding approximately 1/2 inch from each of them. h. At 4:00 p.m., an electrical outlet on a support pole in the Dining Room was loose. The outlet cover was made of metal and appeared to have previously had a face plate cover that had been removed. The hinges of the face plate cover remained intact and protruded approximately 1/2 inch from the right edge of the face plate.	F 323		
F 332 SS=D	483.25(m)(1) QUALITY OF CARE 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 12:00 p.m. medication pass on 1/25/05, the facility failed to ensure physician orders were followed for 3 of 24 residents (Resident #9, #14, #15) observed during the medication pass. Medication errors were made by 1 of 3 Licensed Practical Nurses (LPN's) who administered medications daily. The	F 332		2/26/05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2005
NAME OF PROVIDER OR SUPPLIER ASH FLAT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 332	Continued From page 8 medication error rate was 6.38% based on administration of 45 medications plus 2 medications ordered but not administered, with a total of 3 errors. This failed practice had the potential to affect 38 residents in the facility who received medications from this nurse according to LPN #4 on 1/26/05. The findings are: 1. Resident #14 had a physician order dated 1/18/05 for Carbidopa w/Levodopa tabs 25-100mg (2= 50-200mg) po (orally) tid (three times a day). This was not administered by LPN #2 on 1/25/05 at 12:46 p.m. 2. Resident #9 had a physician order dated 11/06/04 for Lactaid (1) po tid with meals which was not administered by LPN #2 on 1/25/05 at 12:53 p.m. 3. Resident #15 had a physician order dated 11/04/04 for Regular Insulin 10 units subcutaneous 15 minutes ac (before meals) which was not administered due to the accucheck blood sugar was 94. On 1/25/05 at 2:42 p.m., the accucheck blood sugar was 146 and LPN#2 gave Resident #15 10 units of Regular Insulin without notifying the physician.	F 332		
F 441 SS=E	483.65(a)(1)-(3) INFECTION CONTROL The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced	F 441		2/26/05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/27/2005
NAME OF PROVIDER OR SUPPLIER ASH FLAT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 9</p> <p>by:</p> <p>Based on observation and record review, the facility failed to ensure their infection control policy for hand washing was implemented for 4 case mix residents (Resident #6, #3, #16 and #14) of 15 case mix residents. These failed practices had the potential to affect all 49 residents identified by the Administrator on 1/24/05. The findings are:</p> <p>1. Resident #16 had diagnoses of Alzheimer's Disease and Hypertension. The MDS dated 11/20/05 documented the resident was comatose and was totally dependent on staff for feeding.</p> <p>On 1/24/05 at 12:25 p.m., CNA #2 picked up the resident's napkin from the table, cleaned the CNA's name tag with the napkin and replaced the napkin beside the resident's plate on the table</p> <p>2. Resident #6 had diagnoses of Alzheimer's Disease, Psychosis and Urinary Tract Infection. The Minimum Data Set (MDS) dated 11/5/04 documented the resident had moderately impaired cognitive skills for daily decision making, had a short-term memory problem, and required assistance from staff for personal hygiene.</p> <p>On 1/25/05 at 11:12 a.m., Certified Nurse Assistant (CNA) #2's name tag, hanging on a lanyard, contacted the buttocks of Resident #6 during pericare. The CNA left the room without cleaning the name tag.</p> <p>4. Resident #14 had diagnoses of Parkinsonism and Convulsions. The MDS dated 1/21/05 documented the resident had modified independent cognitive skills for daily decision making and required limited assistance in eating</p>	F 441			

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

PRINTED: 11/02/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/27/2005
NAME OF PROVIDER OR SUPPLIER ASH FLAT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 10 and mobility needs.</p> <p>On 1/24/05 at 12:30 p.m., CNA #1 pulled on the resident's wheelchair arms to place the resident up to the table. Without washing her hands, the CNA pulled the skin off a piece of chicken and separated the meat with her bare hands on to the resident's tray. When finished with this task, CNA #1 did not wash her hands and proceeded to assist 4 other non-case mix residents sitting at the table with their tray set up.</p> <p>5. The Handwashing and Hand Hygiene policy provided by the Administrator 1/26/05 at 11:15 a.m. documented: "...hand hygiene is indicated after touching a source that is likely to be contaminated."</p> <p>3. Resident #3 had diagnoses of Leukocytosis, Urinary Frequency, Irritable Bladder and Dementia. The MDS dated 12/04/04 documented the resident had moderately impaired cognitive skills for daily decision making; had short term and long term memory problems; required assistance of staff with personal hygiene and toileting; and had a Urinary Tract infection (UTI) in the last 30 days</p> <p>On 1/25/05 at 11:39 a.m., CNA #2 entered the resident's bathroom and washed her hands and gloved. CNA #2 picked up and handled the soiled name tag (which had touched Resident #6's buttocks) with the gloved hands before picking up clean wash cloths and assisting Resident #3 to the bathroom and with pericare.</p>	F 441			