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 ______	09/11/2008

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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 250 SS=E	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the Social Service Director failed to ensure 1 (Resident #2) of 8 (Resident #1-4,7,8,11 and 14) case mix resident who displayed mental and/or psychosocial adjustment difficulty of depression received appropriate treatment and services to correct the assessed problem as evidenced by failure to notify the MD of indicators of depression, failure to have activities or programs that helped to maintain or improve the problem and failed to provide a psychological or psychiatric evaluation to evaluate, diagnose or treatment her condition. These failed practices had the potential to affect 41 residents currently residing in the facility that had a diagnosis of depression according to a list provided by the Nurse Consultant dated 9/11/08 at 3:18 p.m. The finding are: 1. Resident # 2 had diagnoses of Macular Degeneration and Depressive disorder. The Significant Change and 5 day Medicare Minimum Data Set (MDS) dated 5/15/08 documented the resident had short term memory problems and had modified independent cognitive skills for daily decision making in new situation only, had indicators of Depression, Anxiety, sad mood that were exhibited up to five days a week in the following areas:	F 250		

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 250	Continued From page 1 a. Repetitive Verbalizations-e.g. calling out for help. "(God help me)" b. Repetitive Health complaints- e.g. persistently seeks medication attention obsessive concern with body functions. c. Repetitive anxious complaints/concerns (non health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues. d. Insomnia/change in usual sleep pattern e. Sad, pained, worried facial expressions -e.g. furrowed brows f. Crying, tearfulness g. Withdrawal from activities of interest - e.g. no interest in long standing activities of being with family/friends, and received one dose of an Anxiety in the 7 days. a. The resident assessment protocol (RAP) worksheet dated 5/12/08 and signed 5/15/08, documented, " ... Resident continuously states, "Help me, Please. I need help." Resident receives PRN Anxiety when needed. ... Psych Eval available as needed for increased Anxiety and depression." b. The Medicare 14 day MDS and the Medicare 30 day MDS dated 5/20/08, documented the resident had indicators of Depression, Anxiety, sad mood that were exhibited up to daily or almost daily (6, 7 days a week) in the following areas: a. Repetitive Verbalizations-e.g. calling out for help. "(God help me)" b. Repetitive Health complaints- e.g. persistently seeks medication attention obsessive concern	F 250		

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F 250	Continued From page 2 with body functions. c. Repetitive anxious complaints/concerns (non health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues. d. Insomnia/change in usual sleep pattern e. Sad, pained, worried facial expressions -e.g. furrowed brows f. Crying, tearfulness g. Withdrawal from activities of interest - e.g. no interest in long standing activities of being with family/friends c. The Other Medicare required assessment dated 6/26/08 documented the resident had indicators of Depression, Anxiety, sad mood that were exhibited up to daily or almost daily (6, 7 days a week) in the following areas: a. Repetitive questions -e.g. " Where do I go; What do I do?" b. Repetitive Verbalizations-e.g. calling out for help. "(God help me)" c. Expressions of what appear to be unrealistic fears - e.g. fear of being abandoned, left alone, being with others d. Repetitive Health complaints- e.g. persistently seeks medication attention obsessive concern with body functions. e. Repetitive anxious complaints/concerns (non health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues. f. Insomnia/change in usual sleep pattern g. Sad, pained, worried facial expressions -e.g. furrowed brows h. Crying, tearfulness i. Repetitive physical movements - e.g. pacing, hand wringing, restlessness, fidgeting, picking	F 250		

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j. Withdrawal from activities of interest - e.g. no interest in long standing activities of being with family/friends

d. The Quarterly Minimum Data Set dated 8/14/08 documented the resident continued to have indicators of Depression, Anxiety, sad mood that were exhibited up to daily or almost daily (6, 7 days a week) in the following areas:

a. Repetitive questions -e.g. " Where do I go; What do I do?"
b. Repetitive Verbalizations-e.g. calling out for help. "(God help me)"
c. Expressions of what appear to be unrealistic fears - e.g. fear of being abandoned, left alone, being with others
d. Repetitive Health complaints- e.g. persistently seeks medication attention obsessive concern with body functions.
e. Repetitive anxious complaints/concerns (non health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues.
f. Insomnia/change in usual sleep pattern
g. Sad, pained, worried facial expressions -e.g. furrowed brows

e. The plan of care developed 4/9/08 documented the following problems:

Depression r/t (related to) episodes of crying, confusional state and negative statements. The goal for this problem was documented " Will feel more secure, adjusted and happy [with] current situation by NRD (next review date). Approaches were documented as " Administer medication as ordered, encourage resident to attend more out of room activities and less staying in room alone,

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provide comfort/emotional support and reassurance as needed, monitor for adverse side effects of medication and approach in calm, unthreatening manner. ... Alternation in behavior/mood r/t periods of confusion, depression, crying episodes and statements such as " I am useless and helpless, I would kill myself, do you know someone who would kill me?" The goal for this problem was documented as, " Will verbalize feelings and maintain calm demeanor this review period." The approaches were documented as " Administer medications per physician order, encourage resident to participate in group activities, provide consults of appropriate mental health profession if indicated/ordered, monitor closely for deterioration of status and notify M.D. (Medical Doctor) as needed, encourage resident to express feelings/concerns, 1:1 visits to allow resident opportunity to express feelings/emotions, Provide comfort and emotional support when resident is crying/upset, and Encourage participation in all decisions of daily life."

1). As of 9/11/08 at 4:15 p.m., there was no documentation in the plan of care, Nurses Notes, or Social Services notes of new approaches or interventions to indicate the resident received any treatment or services to correct the assessed problems.

f. A Geriatric Depression Scale assessment form dated 4/9/08 documented a score of 13. (The from documented a score greater than 5 indicated probable depression).

g. The Social Services notes from 5/6/08 thru 8/14/08 documented the following:

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F 250	Continued From page 5 1). Social notes dated 5/6/08 documented, "Attending activities of choices, enjoys visit from friends, social with other residents with cont. to monitor and assist as needed." 2). Social notes dated 5/15/08 documented, " No change, will assist with all social needs." 3). Social Notes 5/30/08 documented, " No behaviors will cont. to monitor." 4). Social notes dated 6/30/08 documented, "Will at [times] yell out help, for [no] reason, when asked what she wants res will say "Nothing." Continue to monitor behavior and assist as needed." 5). Social Notes dated 8/14/08 documented, " Yells out " Help" when asked what she needs, res states " Nothing, I just do that." No other behaviors noted will cont to assist with all social needs." h. Activity Notes dated 5/2/08, 5/6/08, 5/15/08, 5/30/08, 6/30/08 and 8/7/08 documented the resident enjoyed coming to Bingo and getting her hair done. 1). On 9/11/08 at 3:30 p.m., the Social Services Director stated that the resident enjoys coming out to bingo, prefers to be alone in the dark and doesn't want her in the room. She was asked if she had referred the resident to a mental health professional and she stated " I thought she was on the list to see Dr. [doctor ' s name]" She was asked, " Do you do 1:1 visits with her?" She stated " Well this morning she yelled at me to get out of her room and I don't visit her every day."	F 250		

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2). As of 9/11/08 there was no documentation in the Social notes or Activity Notes of 1:1 visits as per the plan of care.

i. Nurses notes dated 4/7/08 8:30 a.m., documented " Late entry" "Resident (r) saying " I'm useless [and] helpless" States " I would kill myself, do you know someone who would kill me." Resident very tearful at this time." There was no documentation in this note of any notification to the physician or that a consult with a mental health professional was provided as per the plan of care.

j. Nurses notes dated 4/10/08 9:00 a.m., documented " Late entry for 4/8/08 Resident monitored for 24 hours and behavior monitoring done. had episode of stating, " I would kill myself, do you know someone who would kill me." No negative behavior or other statements made x 24 hrs. Had recent med changes which staff & POA thought was causing increased (arrow up). Md (Medical Doctor) notified, Medication d/c'd 4/7/08. Resident states that she is a Christian and wouldn't kill herself, she was just saying that. Will continue to monitor resident for increased confusion, negative statement or harmful behaviors."

k. On 9/9/08 at 8:50 a.m., the resident was observed in her recliner at the foot of the bed. The room was dark and TV/ Radio was off. The resident stated, "I'm in a lot of trouble?" When asked, " Why?" She stated she refused to have her oxygen because she can breathe better without it and " I know they think I'm a crazy 94 year old woman."

At 2:50 p.m., the resident was again in her

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F 250	Continued From page 7 recliner at the foot of the bed. The room was dark and TV/Radio was off. The resident stated " I can't see to do anything anymore. I do get depressed at times but being 94 years old, what else is there to do." 2. On 9/10/08 at 9:00 a.m., the resident was observed in her recliner at the foot of the bed. The room was dark and TV/Radio was off. She stated that she didn't need to turn the light on because she could see anyway. She also stated that she couldn't watch TV or listen to the radio because " I can't see the TV and I can't keep my thoughts together enough to listen to the radio. " 3. On 9/10/08 at 10:00 a.m., the Director of Nurses was asked if this resident had received any treatment such as a Antidepressant or consult with a mental health professional. She stated that the resident had been on Lexapro in March but she had increased confusion so the medication was discontinued. She stated that she was not sure if the resident had been seen by the Psychiatric that comes to the facility monthly. 4. On 9/10/08 at 10:30 a.m., the Director of Nurses stated that the resident had not seen the psychiatric and that she was going to notify the physician regarding her increased indicators of depression.	F 250		
F 319 SS=E	483.25(f)(1) MENTAL AND PSYCHOSOCIAL FUNCTIONING Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.	F 319		

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This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to ensure appropriate treatment and services were provided to correct the indicators and problems identified for depression for 1 (Resdient #2) of 8 (Resident ' s #1-4,7,8,11 and 14) case mix resident who displayed mental and/or psychosocial adjustment difficulties of depression. The failed practice had the potential to affect 41 residents currently residing in the facility that had a diagnosis of depression according according to a list provided by the Nurse Consultant dated 9/11/08 at 3:18 p.m. The finding are:

1. Resident # 2 had diagnoses of Macular Degeneration and Depressive disorder.
The Significant Change and 5 day Medicare Minimum Data Set (MDS) dated 5/15/08 documented the resident had short term memory problems and had modified independent cognitive skills for daily decision making in new situation only, had indicators of Depression, Anxiety, sad mood that were exhibited up to five days a week in the following areas:

a. Repetitive Verbalizations-e.g. calling out for help. "(God help me)"
b. Repetitive Health complaints- e.g. persistently seeks medication attention obsessive concern with body functions.
c. Repetitive anxious complaints/concerns (non health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues.
d. Insomnia/change in usual sleep pattern
e. Sad, pained, worried facial expressions -e.g.

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furrowed brows
f. Crying, tearfulness
g. Withdrawal from activities of interest - e.g. no interest in long standing activities of being with family/friends,
and received one dose of an Anxiety in the 7 days.

a. The resident assessment protocol (RAP) worksheet dated 5/12/08 and signed 5/15/08, documented, " ... Resident continuously states, "Help me, Please. I need help." Resident receives PRN Anxiety when needed. ... Psych Eval available as needed for increased Anxiety and depression."

b. The Medicare 14 day MDS and the Medicare 30 day MDS dated 5/20/08, documented the resident had indicators of Depression, Anxiety, sad mood that were exhibited up to daily or almost daily (6, 7 days a week) in the following areas:

a. Repetitive Verbalizations-e.g. calling out for help. "(God help me)"
b. Repetitive Health complaints- e.g. persistently seeks medication attention obsessive concern with body functions.
c. Repetitive anxious complaints/concerns (non health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues.
d. Insomnia/change in usual sleep pattern
e. Sad, pained, worried facial expressions -e.g. furrowed brows
f. Crying, tearfulness
g. Withdrawal from activities of interest - e.g. no interest in long standing activities of being with family/friends

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c. The Other Medicare required assessment (coded 8) dated 6/26/08 documented the resident had indicators of Depression, Anxiety, sad mood that were exhibited up to daily or almost daily (6, 7 days a week) in the following areas:

a. Repetitive questions -e.g. " Where do I go; What do I do?"
b. Repetitive Verbalizations-e.g. calling out for help. "(God help me)"
c. Expressions of what appear to be unrealistic fears - e.g. fear of being abandoned, left alone, being with others
d. Repetitive Health complaints- e.g. persistently seeks medication attention obsessive concern with body functions.
e. Repetitive anxious complaints/concerns (non health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues.
f. Insomnia/change in usual sleep pattern
g. Sad, pained, worried facial expressions -e.g. furrowed brows
h. Crying, tearfulness
i. Repetitive physical movements - e.g. pacing, hand wringing, restlessness, fidgeting, picking
j. Withdrawal from activities of interest - e.g. no interest in long standing activities of being with family/friends

d. The Quarterly Minimum Data Set dated 8/14/08 documented the resident continued to have indicators of Depression, Anxiety, sad mood that were exhibited up to daily or almost daily (6, 7 days a week) in the following areas:

a. Repetitive questions -e.g. " Where do I go;

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F 319	Continued From page 11 What do I do?" b. Repetitive Verbalizations-e.g. calling out for help. "(God help me)" c. Expressions of what appear to be unrealistic fears - e.g. fear of being abandoned, left alone, being with others d. Repetitive Health complaints- e.g. persistently seeks medication attention obsessive concern with body functions. e. Repetitive anxious complaints/concerns (non health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues. f. Insomnia/change in usual sleep pattern g. Sad, pained, worried facial expressions -e.g. furrowed brows e. The plan of care developed 4/9/08 documented the following problems: Depression r/t (related to) episodes of crying, confusional state and negative statements. The goal for this problem was documented " Will feel more secure, adjusted and happy [with] current situation by NRD (next review date). Approaches were documented as " Administer medication as ordered, encourage resident to attend more out of room activities and less staying in room alone, provide comfort/emotional support and reassurance as needed, monitor for adverse side effects of medication and approach in calm, unthreatening manner. ... Alternation in behavior/mood r/t periods of confusion, depression, crying episodes and statements such as " I am useless and helpless, I would kill myself, do you know someone who would kill me?" The goal for this problem was documented as, " Will verbalize feelings and maintain calm demeanor this review period." The approaches were	F 319		

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documented as " Administer medications per physician order, encourage resident to participate in group activities, provide consults of appropriate mental health profession if indicated/ordered, monitor closely for deterioration of status and notify M.D. (Medical Doctor) as needed, encourage resident to express feelings/concerns, 1:1 visits to allow resident opportunity to express feelings/emotions, Provide comfort and emotional support when resident is crying/upset, and Encourage participation in all decisions of daily life."

e. As of 9/11/08 at 4:15 p.m., there was no documentation in the plan of care, Nurses Notes, or Social Services notes of new approaches or interventions to indicate the resident received any treatment or services to correct the assessed problems.

f. A Geriatric Depression Scale assessment form dated 4/9/08 documented a score of 13. (The from documented a score greater than 5 indicated probable depression).

g. The Social Services notes from 5/6/08 thru 8/14/08 documented the following:

1). Social notes dated 5/6/08 documented, "Attending activities of choices, enjoys visit from friends, social with other residents with cont. to monitor and assist as needed."

2). Social notes dated 5/15/08 documented, " No change, will assist with all social needs."

3). Social Notes 5/30/08 documented, " No behaviors will cont. to monitor."

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4). Social notes dated 6/30/08 documented, "Will at [times] yell out help, for [no] reason, when asked what she wants res will say "Nothing." Continue to monitor behavior and assist as needed."

5). Social Notes dated 8/14/08 documented, " Yells out " Help" when asked what she needs, res states " Nothing, I just do that." No other behaviors noted will cont to assist with all social needs."

h. Activity Notes dated 5/2/08, 5/6/08, 5/15/08, 5/30/08, 6/30/08 and 8/7/08 documented the resident enjoyed coming to Bingo and getting her hair done.

1). On 9/11/08 at 3:30 p.m., the Social Services Director stated that the resident enjoys coming out to bingo, prefers to be alone in the dark and doesn't want her in the room. She was asked if she had referred the resident to a mental health professional and she stated " I thought she was on the list to see Dr. [doctor ' s name]" She was asked, " Do you do 1:1 visits with her?" She stated " Well this morning she yelled at me to get out of her room and I don't visit her every day."

2). As of 9/11/08 there was no documentation in the Social notes or Activity Notes of 1:1 visits as per the plan of care.

i. Nurses notes dated 4/7/08 8:30 a.m., documented " Late entry" "Resident (r) saying " I'm useless [and] helpless" States " I would kill myself, do you know someone who would kill me." Resident very tearful at this time." There was no documentation in this note of any notification to the physician or that a consult with

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F 319	Continued From page 14 a mental health professional was provided as per the plan of care. j. Nurses notes dated 4/10/08 9:00 a.m., documented " Late entry for 4/8/08 Resident monitored for 24 hours and behavior monitoring done. had episode of stating, " I would kill myself, do you know someone who would kill me." No negative behavior or other statements made x 24 hrs. Had recent med changes which staff & POA thought was causing increased (arrow up). Md (Medical Doctor) notified, Medication d/c'd 4/7/08. Resident states that she is a Christian and wouldn't kill herself, she was just saying that. Will continue to monitor resident for increased confusion, negative statement or harmful behaviors." k. On 9/9/08 at 8:50 a.m., the resident was observed in her recliner at the foot of the bed. The room was dark and TV/ Radio was off. The resident stated, "I'm in a lot of trouble?" When asked, " Why?" She stated she refused to have her oxygen because she can breathe better without it and " I know they think I'm a crazy 94 year old woman." At 2:50 p.m., the resident was again in her recliner at the foot of the bed. The room was dark and TV/Radio was off. The resident stated " I can't see to do anything anymore. I do get depressed at times but being 94 years old, what else is there to do." 2. On 9/10/08 at 9:00 a.m., the resident was observed in her recliner at the foot of the bed. The room was dark and TV/Radio was off. She stated that she didn't need to turn the light on because she could see anyway. She also stated	F 319		

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F 319	Continued From page 15 that she couldn't watch TV or listen to the radio because " I can't see the TV and I can't keep my thoughts together enough to listen to the radio. " 3. On 9/10/08 at 10:00 a.m., the Director of Nurses was asked if this resident had received any treatment such as a Antidepressant or consult with a mental health professional. She stated that the resident had been on Lexapro in March but she had increased confusion so the medication was discontinued. She stated that she was not sure if the resident had been seen by the Psychiatric that comes to the facility monthly. 4. On 9/10/08 at 10:30 a.m., the Director of Nurses stated that the resident had not seen the psychiatric and that she was going to notify the physician regarding her increased indicators of depression.	F 319		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure potentially hazardous material were stored to prevent accessibility to confused/mobile residents. The failed practice had the potential to affect 44 residents who were cognitively impaired and mobile according to Director of Nursing on	F 323		

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F 323	Continued From page 16 9/24/08. The findings are: On 9/9/08 at 12:22 p.m., the door to the personal care (beauty shop) room was found open. The room was unattended. A tall, slender, translucent cylindrical container on the left hand side of a waist-level countertop contained approximately 3 cups of deep blue fluid labeled "Barbicide", "germicide", and "disinfectant". a. On 9/11/08 at 11:25 a.m. the Administrator was asked for the MSDS (Material Safety Data Sheet) sheet for the Barbicide in the personal care area. The Administrator stated, "I think that's just alcohol." b. On 9/11/08 at 2:08 p.m. The facility Bookkeeper provided the MSDS sheet which documented, "Barbicide ... blue liquid with pleasant odor." Toxicological information documents, "This product is corrosive to the eye. Exposure may cause irreversible eye damage. Repeated exposure to the skin may cause ...skin burns." Hazard Identification lists health hazards: "Eye: Direct contact may cause irreversible damage. ... Ingestion: probable mucosal damage. May cause serious injury or death. ... Inhalation: May irritate or damage mucus membrane."	F 323		
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		

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nutritional problem.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure nutritional interventions were implemented to maintain parameters for 1 or 1 case mix resident (Resident #10) who experienced a significant weight loss. The failed practice had the potential to affect 4 other residents who triggered for weight loss according to the Certified Dietary Manager (CDM) on 9/11/08. The findings are:

1. Resident #10 had diagnoses of Dementia, Alzheimer's Disease and Anxiety. The quarterly Minimum Data Set dated 5/7/08 documented the resident had modified independent cognitive skills for daily decision making and had a chewing problem.

a. A physician's order dated 11/20/07 documented for a low cholesterol, puree, no spicy foods diet.

b. The resident experienced a gradual weight loss of 15.4 lbs for a period of 6 months from March 2008 thru September 2008. The facility ' s weight log dated 9/9/08 for each month was as follows:

March 2008 - 156.2 pounds
April 2008 - 153.4 pounds
May 2008 - 150.8 pounds
June 2008 - 149.6 pounds
July 2008 - 146.4 pounds

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F 325	Continued From page 18 August 2008 - 143 pounds September 2008 - 140.8 pounds This was a 9.9% decrease in weight in 6 months. c. On 9/908 at 12:15 p.m., the resident was served pureed greens, pureed chicken with gravy, mashed potatoes, pureed cake, pureed bread, and 1 pat of butter on potatoes. The resident took 1 bite of the greens, 75 percent of the chicken with gravy, 3 bites of the mashed potatoes, 100 per cent of the pureed cake and none of the pureed bread. The resident complained that the chicken was dry and she couldn't eat it. d. On 9/10/08 at 12:00 a.m., the resident was served pureed green beans, dressing, meat with gravy, peaches, and pureed bread. The resident ate 100 per cent of the pureed peaches, 50 per cent of the green beans, 50 per cent of the meat, and 100 per cent of the dressing and no pureed bread. e. On 9/10/08 at 12:26 p.m. after feeding herself the resident took her clothing protector off. When asked if she had finished eating, the resident stated "Yeh." No one encouraged her to eat nor was she offered a substitute for the foods that had not been eaten. 2. The following Dietary Progress Notes were documented by the CDM: a. On 3/9/08, [no time] Dietary progress note documented, "low cholesterol pureed diet ... Snacks available x 3 each day between meals ... weight on 1st at 157.2, will continue to monitor and assess as needed."	F 325		

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F 325	Continued From page 19 b. On 5/21/08 [no time] documented, "Remains on a low cholesterol pureed diet, meals x 3 each day, p.o. intake fair-good. Snacks available x 3 each day between meals. May weight at 150.8. Further assessment to follow as needed." c. On 8/8/08 [no time] documented, "Low cholesterol pureed diet ... snacks are offered x 3 each day, weight on the 1st was 143 pounds. Will continue to monitor and assess as needed." 3. A Nutritional Progress Notes dated 9/8/08 at 2:55 p.m., documented "Weight 141 lbs. 6 % (per cent) loss x 90 days and 10 per cent x 180 days. Resident is receiving a low cholesterol puree. Average po intake 66 per cent - 1482 calories. Needs - calories 1792, protein needs 64 grams...Continue to monitor food intake and continue to offer snacks between meals." The note was signed by the Registered Dietitian (RD) 4. As of 9/11/08 at 2:30 p.m., there was no documentation in the Nurses Notes, or Dietary Progress notes that the physician had been notified of the resident's fair eating consumption of the pureed diet and continued weight loss. 5. On 9/11/08 at 2:05 p.m. the Certified Dietary Manager (CDM) was asked what kinds of snacks were available for the resident. She stated sugar-free pudding, pureed vanilla wafers and pureed fruit. "She gets sugar-free pudding at 10:00 a.m. and 3:00 p.m. and at night she gets fruit. She automatically gets sugar-free skim milk pudding. When asked the reason for sugar-free pudding as the resident had no diagnoses of diabetes and what if the resident's lipids were normal, she stated "We could use skim milk with regular pudding."	F 325		

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F 325	Continued From page 20 The CDM was asked if they had tried the resident on any other diet. She stated, "When she first came in (11/20/07), she was on a low fat, low cholesterol diet. She ate pudding all the time so they decided to try her on a pureed diet. She ate better for 3 days, so the nurses faxed to the doctor to change her to pureed." The CDM was asked if the resident liked pudding, why was she not served pudding with meals as well as in between meals. She stated "Because we send it at snack time because in her mind it was more like pudding. That's all she would eat when we first started to send her a pureed diet with pudding on her tray. She would not eat the vegetables, meat and other stuff."	F 325		
F 329 SS=E	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		

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F 329	Continued From page 21 drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that 1 case mix resident (Resident #3) of 1 case mix resident with a physician order for Ambien, 2 (Residents #10, ad 14) of 4 (Residents #6, 8, 10, and 14) case mix residents with orders for Risperdal and 2 (Residents #10, and #14) of 4 (#7, 8, 10, and 14) case mix residents with orders for Ativan were free of medication used in excessive duration, without adequate indications for use and/or in the absence of a risk versus benefit statement indicating the clinical rationale why a dose reduction would be clinically contraindicated. These failed practices had the potential to affect 3 resident currently receiving Ambien, 7 residents with orders for Ativan and 7 residents currently with orders for Risperdal according to a lists provided by the Medical Record LPN (Licensed Practical Nurse) on 9/11/08 at 11:00 a.m. The findings are: 1. Resident # 3 had a physician's order dated 6/9/08 for Ambien 5 mg (milligram) (1) PO (by mouth) QHS (every hour of sleep) for Insomnia. a. A note to attending Physician/Prescriber dated 7/16/08 from the Consultant Pharmacist Identified Resident #3 as having received "Ambien 5 mg tablet ... Resident is currently receiving regular hypnotic therapy and has not had a gradual dose reduction since initiated or admitted. Please	F 329		

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consider a gradual dose reduction of Ambien 5 mg tablets to ensure resident is on lowest dose possible or change to PRN order. If Resident continues to need Ambien 5 mg tablet please documented clinical rational for current dosage regimen."

b. On 7/17/07 the Physician wrote the following: "Requires 5 mg dose due to chronic anxiety and poor sleep." The physician checked the box that documented, "No changes are to be made at this time."

c. As of 9/10/08 at 5:10 p.m., after review of the clinical record, there were no Nurses Notes indicating the resident had anxiety symptoms or insomia.

d. As of 9/11/08 at 9:00 a.m., the DON could not find documentation that indicated the medical necessity for the use of the medication or justification for not reducing the medication.

2. Resident # 10 had a physician's order dated 4/4/08 for Ativan 0.5 mg at 4:00 p.m. for Anxiety and Risperdal 1.5 mg at 4:00 p.m., dated 4/11/08.

a. The April 2008 til September 2008 Behavior monitoring sheets documented the resident's only behavior was "Crying."

b. Nursing summaries dated from 4/9/08 through 8/30/08 documented the resident had no behaviors and this was normal [no behaviors] for the resident. The summaries did document the resident had episodes of crying.

c. As of 9/10/08 at 5:00 p.m. there was no documentation in the physician notes or nursing

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F 329	Continued From page 23 notes of any behaviors that warranted the use of the Risperdal and/or Ativan. There was also no documentation from the physician of any clinical rationale for the continued use of the Risperdal and/or Ativan. d. As of 9/11/08 at 9:00 a.m., the Director of Nursing (DON) was unable to provide documentation of clinical rationale for the continued use of Risperdal. 3. Resident # 14 was admitted to the facility on 4/1/08 with physician orders for Ativan 0.5 mg (1) PO TID (three times per day) for Anxiety and Risperdal 0.5 mg (1) PO at 1800 (6:00 p.m.) for Dementia with Behavior Disturbances. a. A note to attending Physician/Prescriber dated 7/16/08 from the Consultant Pharmacist identified Resident # 14 as having received "Ativan 0.5 mg TID ... Recommend review resident's current condition and consider a gradual dose reduction of Ativan 0.5 mg TID to evaluate if resident is on the lowest possible dose. Documentation in chart indicates this drug is being used for behavior or psychological effect, the resident has not received a gradual dose reduction previously. If resident continues to need Ativan 0.5 mg BID please document clinical rationale for current dosage regimen." The handwritten response by the physician documented " Pt need to see Psych- If Psych rec (recommends) to decrease (arrow down) the dose - then ok to decrease Ativan." b. On 9/11/08 at 9:30 a.m., the Director of Nurses stated that the resident had not been evaluated by the Psychiatrist as she was unaware of the order.	F 329		

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F 329	Continued From page 24 c. The April 2008 til September 2008 Behavior monitoring sheets documented the resident's only behavior was "Crying." 1). Nursing summaries dated from 4/9/08 through 8/30/08 documented the resident had no behaviors and this was normal for the resident. The summaries did document the resident had episodes of crying. e. As of 9/11/08 at 9:30 p.m., there was no documentation in the physician notes or nursing notes of any behaviors that warrant the continued use of the medication Risperdal and no documentation could be found to indicate a dose reduction had been attempted. There was also no documentation from the physician that documented a risk versus benefit statement for the medication that would indicate why a dose reduction would be clinically contraindicated. f. As of 9/11/08 at 3:30 p.m., the DON was unable to provide documentation of clinical rationale for the continued use of Risperdal.	F 329		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		

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F 371	Continued From page 25 Based on observation, record review, and interview, the facility failed to ensure equipment was maintained in good working order to keep potentially hazardous food at proper temperature to prevent potential for spread of food bourne illness. The failed practice had the potential to affect 11 residents living in the locked "Lighthouse" wing of the facility as documented on the list provided by the Administrator on 9/11/08 at 2:52 p.m.. The findings are: 1. On 9/10/08 at 4:55 p.m., the interior temperature of the dorm-room size fridge in the "Lighthouse" (locked unit) resident dining room was taken and the thermometer registered 47.5º Fahrenheit. The refrigerator had no thermometer of its own inside the unit. 2. On 9/11/08 at 10:45 a.m., CNA(certified nurses assistant) #1 was asked if she monitored the dining room refrigerator temperature. The CNA stated that she did not, but "maybe the next shift does." She indicated second shift might take it. 3. On 9/11/08 at 10:47 a.m., the ADON (Assistant Director of Nurses) stated that she didn't know who tracked the temperature there. 4. On 9/11/08 at 10:48 a.m., the DON (Director of Nurses) stated she thought, "[Name of LPN (Licensed Practical Nurse) #3] does it." 5. On 9/11/08 at 10:50 a.m., LPN #3 was asked who monitored the temperature in the refrigerator in the Lighthouse unit dining room, the LPN stated, "I don't know. The kitchen does the med room and the snack fridge."	F 371		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 371	Continued From page 26 6. On 9/11/08 at 10:52 a.m., the Dietary Manager stated, "The CNAs take the temps on that fridge." 7. On 9/11/08 at 10:54 a.m., the facility's thermometer was borrowed from the kitchen. At 10:57 a.m., the interior temperature of the fridge was 55.0ºF. CNA #1 stated, "I forgot to tell you. The maintenance man is checking every day." [the refrigerator temp] On 9/11/08 at 11:02 a.m., the interior temperature of the refrigerator was 44.6ºF. 8. On 9/11/08 at 11:10, documentation for the temperature checks for the Lighthouse dinning room refrigerator was requested from the Maintenance Supervisor who stated that no log existed, and that he didn't "do the temps there." He then asked, "Do I need to be taking temperatures? Other than the kitchen, Med room, and snack refrigerator, I'm not taking them. Do I need to?" 9. On 9/11/08 at 11:14, vanilla ice cream labeled, "9/11/08 Rothman" was located on the top shelf. The ice cream was soft when pressure was applied to the container. The Maintenance Supervisor stated, "This should be in the freezer." He then opened the freezer to find it full, and stated, "Maybe that's why it's not there." He replaced the container back in the fridge on the shelf beneath the freezing unit. 10. On 9/11/08 at 11:17, the temperature of the fridge taken at the bottom of the refrigerated space was 53.2ºF as taken the maintenance supervisor with the facility thermometer. The Maintenance Supervisor stated, "the fridge is awfully warm. Maybe its going out. Feel the side." The surveyor felt the side of the fridge and	F 371		

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F 371	Continued From page 27 it was hot. The maintenance supervisor stated, "I think it's going out. I turned it down and it clicked on, but its real hot..." 11. On 9/11/08 at 11:21 a.m., the Maintenance Supervisor stated, "Well, I checked that one in the break room" (similar refrigerator), "and the sides are cool. So I guess that one," (in the 500 dining room) "is just going out."	F 371		
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES 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. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure expired medications and supplies were removed from the medication cart and from supply cabinet in medication room. The failed practice had the	F 425		

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F 425	Continued From page 28 potential to affect all 68 residents who resided in the facility according to the Roster Matrix dated 9/8/08. The findings are: 1. On 9/10/08 at 11:45 a.m., the medication cart for the 400, 500, and 600 halls had 5 unopened vials of Haldol 5 mg/ml (milligram per milliliter) that had an expiration date of 8/8/08. 2. On 9/10/08 at 11:45 a.m., the medication cart for the 400, 500, and 600 halls had an opened bottle of B12 tablets that had and expiration date of May 2008. 3. On 9/10/08 at 11:45 a.m., there was a bag of 9 IV start kits that had expiration dates of August 2008. 4. On 9/10/08 at 9:34 a.m. in the medical supply room, four Kendall Fast Cath Female Catheterization kits with expiration dates of August 2008 were mixed in with an additional 3 of the same type of kit with expiration date of March 2009. All of these catheter kits were easily accessible and they were not in "first in first out" arrangement. 5. On 9/10/08 at 9:37 a.m., thirteen packages of Steri-Strips which had expired in August 2008 were in the medical supply room.	F 425		
F 445 SS=F	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 445		

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F 445	Continued From page 29 Based on observation and interview, the facility failed to ensure that a fan was not used from the dirty side of the laundry facility to blow into the clean side of the laundry facility to prevent a positive air flow and increasing the potential for cross contamination in the laundry area. This failed practice had the potential to affect all 68 residents in the facility who have some or all of their laundry washed by the facility. The findings are: 1. On 9/9/08 at 3:04 p.m., there was uncovered soiled linen in the laundry room. A trash can with no lid was holding bedpans in plastic bags. A yellow, Stanley air fan sat on a shelf approximately 5 feet 2 inches from the floor and aimed at a slightly downward angle. The fan was blowing from the dirty linen side to the clean linen side. The entrance to the clean linen side was approximately 11 feet away from the dirty side entrance. There were multiple uncovered dirty linen barrels on the "dirty" side. The flow of air blown by the fan made a line across the tops of several dirty linen barrels and across the washer fronts to the dryers. One of three dryer doors was open, and there was a linen barrel filled with clean linen in front of one of the washers. The line of air conduction passed one clean linen cart which was not fully covered. At the far end of the line of air flow was the linen folding table where stacks of linens and towels were stacked. Air flow from the fan was palpable at the folding table. 2. On 9/9/08 at 3:04 p.m., the Maintenance Supervisor was asked about the fan in the laundry room, the Maintenance Supervisor stated "the fan gets used a lot since the weather has been so hot over the summer. There's only the one AC (air conditioning) unit in the wall behind	F 445		

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F 445	Continued From page 30 the washers, and it gets really hot in here for the girls."	F 445		