

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

PRINTED: 12/19/2007
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 12/06/2007
NAME OF PROVIDER OR SUPPLIER ASH FLAT HEALTHCARE 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 282 SS=D	<p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Physician orders for fluid restriction were followed for 1 (Resident #9) of 2 (Residents #9 and #14) case mix residents with physician orders for fluid restriction due to a diagnosis of Congestive Heart Failure. This failed practice had the potential to affect 3 residents with Physician orders for fluid restriction, according to a list provided by the Administrator on 12/5/07. The findings are:</p> <p>Resident #9 had a diagnosis of Congestive Heart Failure. The Quarterly MDS (Minimum Data Set) dated 9/10/07 documented the resident had independent cognitive skills for daily decision making and had edema and shortness of breath.</p> <p>a. The resident's December 2007 Physician Orders documented, "8/30/07... Fluid restriction, No more than 1500 ml (milliliters)/24 hours **No free water at bedside** **Only allow resident to drink fluids on meal tray and fluids given with medications**"</p> <p>b. The Resident Care Flow Sheet, dated December 2007, used by the Certified Nursing Assistants (CNA) to provide care for the resident, documented: "Feeding... Fluid Restriction... No Water Pitcher at Bedside..." The spaces provided</p>	F 282		
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 282	<p>Continued From page 1</p> <p>beside each item did not have a check mark to identify that these interventions should have been implemented for the resident.</p> <p>A review of the resident's dietary progress notes dated 3/1/07 through 9/3/07 revealed no documentation of fluid restriction for the resident.</p> <p>c. On 12/2/07 at 3:30 p.m., the resident was sitting in an electric scooter and had a water pitcher on her overbed table next to her.</p> <p>d. On 12/2/07 at 12:12 p.m., the resident was served her lunch tray in her room by CNA #8. The CNA asked the resident if she wanted a coke with her lunch and when the resident stated that she did, the CNA took a 12-ounce diet coke from the resident's refrigerator that had already been opened and had a straw in it and gave it to the resident. The resident had an 8-ounce glass of water on her lunch tray.</p> <p>e. On 12/4/07 at 1:05 p.m., the resident was sitting in her electric scooter in her room. The resident had a water pitcher 1/2-full of ice and water on her overbed table, as well as an 8-ounce glass of ice water beside the pitcher. The resident stated that she occasionally drank water from the pitcher.</p> <p>f. On 12/4/07 at 5:30 p.m., the resident received her evening meal in her room served by the Social Service Director (SSD). The resident received approximately 6-ounces of ice water in a glass on her tray; the SSD asked the resident if she wanted a coke with her meal. When the resident stated she wanted a coke, the SSD got a full can of diet coke (12-ounces) from the resident's refrigerator and opened it for the</p>	F 282			

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F 282	Continued From page 2 resident. g. On 12/5/07 at 9:00 a.m., the resident had a water pitcher that was 1/2-full of ice and water and an 8-ounce glass of ice water on her overbed table. h. On 12/5/07 at 9:10 a.m., CNA #6 was working on the resident's hall (600 hall). When asked if any residents on the 600 hall were on fluid restriction, the CNA stated there was one resident, but named another resident on the hall. i. On 12/5/07 at 9:13 a.m., CNA #9 who was assigned to the 600 hall, was asked if any residents on the 600 hall were on fluid restriction. She stated that she could not think of any off the top of her head, but if a resident did not have a mug or something in their room she would know to ask about the resident. j. On 12/5/07 at 9:15 a.m., CNA #5 who was floating between the 100 hall and 600 hall caring for residents on both halls, was asked if any resident on the 600 hall were on fluid restriction; the CNA named a resident on the 600 hall that was on fluid restriction, but it was not Resident #9.	F 282			
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

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F 309	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure a catheter was secured to prevent the potential for trauma to the urinary meatus for 1 (Resident #5) of 2 (Residents #1 and #5) case mix residents with urinary catheters. This failed practice had the potential to affect 2 residents with indwelling catheters, according to the Resident Census and Conditions of Residents form dated 12/2/07. The findings are:</p> <p>1. Resident #5 had diagnoses of Urinary Retention secondary to Renal Failure and Hemiplegia. The Minimum Data Set (MDS) dated 10/8/07 documented the resident had independent cognitive skills for daily decision-making, was incontinent of bowel and had an indwelling catheter.</p> <p>a. The Plan of Care dated 7/10/07 documented, "At risk for complications of indwelling catheter: UTI (Urinary Tract Infection), Injury" and "History of Pressure Ulcer."</p> <p>b. On 12/3/07 at 9:45 a.m., Certified Nursing Assistant (CNA) #1 transferred the resident to his bed and positioned him on his back, with the catheter tubing under the resident's left thigh. The Foley catheter was not secured and was pulled taut against the urinary meatus. The CNA then covered the resident and left the room.</p> <p>c. On 12/3/07 at 11:15 a.m., the Director of Nursing (DON) was asked to check the position of the catheter tubing. The catheter tubing was under the resident's left thigh and was pulled taut against the urinary meatus. The catheter tubing</p>	F 309			

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F 309	Continued From page 4 remained unsecured. The DON stated the catheter was supposed to be secured with a leg strap.	F 309			
F 314 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a catheter was positioned in a manner to decrease the potential for skin breakdown for 1 (Resident #5) of 2 (Residents #1 and #5) case mix residents with urinary catheters. This failed practice had the potential to affect 2 residents with catheters, according to the Resident Census and Conditions of Residents form dated 12/2/07. The findings are: Resident #5 had diagnoses of Urinary Retention secondary to Renal Failure, Hemiplegia and Pressure Sores. The Minimum Data Set (MDS) dated 10/8/07 documented the resident had independent cognitive skills for daily decision-making, was incontinent of bowel, had an indwelling catheter and had two Stage II Pressure Ulcers. a. The Plan of Care dated 7/10/07 documented,	F 314			

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F 314	Continued From page 5 "At risk for complications of indwelling catheter: UTI (Urinary Tract Infection), Injury" and "History of Pressure Ulcer." b. On 12/3/07 at 9:45 a.m., Certified Nursing Assistant (CNA) #1 transferred the resident to his bed and positioned him on his back with the urinary catheter tubing under the resident's left thigh. CNA #2 covered the resident and left the room. c. On 12/3/07 at 11:15 a.m., the Director of Nursing (DON) was asked to check the position of the resident's catheter tubing. The resident's posterior left thigh had a red pressure imprint of the outline of the catheter and tubing connector. The resident stated he was not able to feel pressure on that side of his body. The DON stated the resident had decreased sensation on the left side secondary to a stroke.	F 314		
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES 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, record review and interview, the facility failed to ensure feeding tube flushes were administered as ordered by the physician for 1 (Resident #2) of 3 (Residents #1 through #3) case mix residents with feeding	F 322		

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F 322	<p>Continued From page 6</p> <p>tubes. This failed practice had the potential to affect 6 residents with feeding tubes, per a list provided by the Administrator on 12/06/07. The findings are:</p> <p>Resident #2 had diagnoses of Cerebrovascular Accident and Dysphagia. The Quarterly Minimum Data Set (MDS) dated 10/22/07 documented the resident had swallowing problems, was dependent on staff for feeding and hydration and received 1501 cubic centimeters (cc) to 2000 cc of fluid via feeding tube.</p> <p>a. The resident's plan of care dated 10/22/07 documented, "Potential fluid volume deficit associated with use of diuretic ...Provide fluids thru (through) PEG (percutaneous endogastrostomy) tube.</p> <p>b. The Physician orders dated 8/10/07 and Medication Administration Record (MAR) documented, "Flush PEG tube with 60 cc of water before and after medications." "Flush PEG tube Q (every) shift with 200 cc H2O."</p> <p>c. On 12/4/07 at 8:35 a.m., Licensed Practical Nurse (LPN) #1 was administering the resident's medications via his PEG tube. When asked how much flush she gave before administering the resident's medications, the LPN stated "30 cc." The LPN administered the resident's medications via the PEG tube and then followed with a water flush of 30 cc.</p> <p>The LPN then administered an additional 100 cc of water via the resident's tube; she stated that she would give the other 100 cc at noon, with the resident's other medications. The LPN was shown the MAR and the physician order for 60 cc</p>	F 322			

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F 322	Continued From page 7 of water flush before and after medications; she stated, "Oh, I thought it was 30 cc."	F 322		
F 323 SS=E	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, interview and record review, the facility failed to ensure a restraint was applied correctly to minimize the potential for injury for 1 (Resident #11) of 2 (Residents #4 and #11) case mix residents with restraints, a personal alarm was implemented per manufacturer's guidelines to prevent the recurrence of falls for 1 (Resident #7) of 3 (Residents #4, #7 and #11) case mix residents who required the use of personal alarms and a bed with a broken side rail was not utilized to decrease the potential for injury for 1 (Resident #2) of 8 (Residents #1 through #3, #7, #9, #10, #11 and #14) case mix residents who utilized side rails. These failed practices had the potential to affect 4 residents who required restraints, 8 residents who required personal alarms and 10 residents who utilized side rails, as identified by lists provided by the Administrator on 12/6/07. The findings are: 1. Resident #7 had diagnoses of Alzheimer's Disease and History of Falls. The Minimum Data Set (MDS) dated 10/12/07 documented the	F 323		

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F 323	<p>Continued From page 8</p> <p>resident had moderately impaired cognitive skills for daily decision-making, had short-term memory problems, required limited physical assistance of one person for ambulation, required partial physical support or did not follow directions during tests for balance while sitting and standing, had fallen in the past 30 days, had a fracture in the past 180 days and required placement in an Alzheimer's/Dementia special care unit.</p> <p>a. The Plan of Care dated 10/12/07 documented, "At risk for falls D/T (due to) unsteady gait. Place resident in falls prevention program."</p> <p>b. The Nursing Progress Note dated 11/21/07 documented, "Tab alarm in bed."</p> <p>c. On 12/2/07 at 3:15 p.m., 12/3/07 at 8:50 a.m. and 12/5/07 at 10:30 a.m., the resident was in bed. The tab alarm was clipped to the resident's clothes, but was not attached to the bed.</p> <p>d. The "Instructions for The Attendant, Model PS-4 Fall Prevention Monitoring System" provided by the Administrator on 12/5/07 documented, "The Attendant is designed to sound a beeping signal when a patient either exceeds his or her safe range of movement from a wheelchair, chair or bed, or wishes to call for assistance. The alarm is sounded when the magnet is removed from the monitor...</p> <p>Attach 'The Attendant' to a wheelchair, chair or bed using the belt clip or optional Universal Mounting bracket. Attach alligator clip to patient's garment."</p> <p>2. Resident #11 had a diagnosis of Dementia with Behavior Disturbances. The MDS dated 11/1/07</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>documented the resident had severely impaired cognitive skills for daily decision-making, had periods of altered perception or awareness of surroundings and behavior of wandering.</p> <p>a. The Plan of Care dated 10/11/07 documented the resident required the use of a soft belt restraint due to no safety awareness.</p> <p>b. On 12/2/07 at 3:20 p.m., the resident was seated in a wheelchair with a soft belt restraint across her chest. The straps were laced through the space between the arm rest and the side panel of the wheelchair at the level of the resident's chest.</p> <p>c. On 12/3/07 at 9:00 a.m., the resident was observed seated in a wheelchair with a soft belt restraint across her chest; the top of the restraint was under the resident's armpits. The resident's pelvis was scooted forward in the seat of the chair. The restraint straps were laced through the space between the arm rest and the side panel of the wheelchair, at the level of the resident's chest.</p> <p>d. On 12/5/07 at 9:30 a.m., the resident was seated in a wheelchair with a soft belt restraint across her chest. The straps were laced through the space between the arm rest and the side panel of the wheelchair, at the level of the resident's chest.</p> <p>The facility's Physical Therapy Assistant (PTA) was asked to look at the position of the restraint. The PTA re-applied the resident's restraint by placing it across the resident's lap and securing it between the seat and the side panel of the wheelchair at the level of the resident's hips. The PTA stated that was the correct way to apply the</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>restraint to prevent injury to the resident by chest compression or choking.</p> <p>e. The Application Instruction Sheet for the Posey Soft Belt Restraint documented, "Hips should be held securely against the back of the chair whenever any type of restrictive product is used. The straps should be at 45 degrees over the hips and secured under the seat out of the patient's reach. Make sure straps are secured at a junction of the frame and will not slide in any direction, changing position of the device. Monitor to make sure the patient is not able to slide down or fall off a chair seat. If their body weight becomes suspended off the chair seat, chest compression and suffocation could result.</p> <p>3. Resident #2 had diagnoses of Cerebrovascular Accident with late effect Hemiplegia/Hemiparesis and Muscle Disuse Atrophy. The Quarterly MDS dated 10/22/07 documented the resident had modified independence in cognitive skills for daily decision making, was dependent on the physical assistance of two plus staff for transfers and could not ambulate.</p> <p>a. On 12/2/07 at 5:25 p.m., upon entrance to the resident's room, the resident's bed was on the right side of the room, against the right-hand wall. The resident was lying in bed with his left bed rail was up.</p> <p>b. On 12/3/07 at 8:40 a.m., the resident was in bed with his call light attached to the left rail, close to the head of the bed. The head of the resident's bed was up and the left rail was pulled up at the foot of the bed, but was down at the head of the bed where the resident's call light was attached. The resident was higher than the rail where it was</p>	F 323			

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F 323	Continued From page 11 not pulled up and he could not reach his call light because the rail was down at the head of the bed. The resident was asking for his call light; Certified Nursing Assistant #9 (CNA) came into the resident's room with his roommate and the resident ask her to get his call light for him. The CNA put the light in the resident's reach and left the room to get a clip for the call light. c. On 12/3/07 at 12:00 p.m., the resident was in bed when CNA #1 and CNA #9 were in the resident's room to reposition him. The resident's left bed rail had a plastic toothette stick stuck in it, where the pin was missing, to keep the rail from falling down. When the CNAs were asked why the toothette stick was in the bed rail, CNA #9 stated that the resident's bed rail was broken and she did not want to leave it down. d. On 12/3/07 at 3:00 p.m., the resident was in bed. The resident's left bed rail was still being held up by the small, thin plastic toothette stick. e. On 12/3/07 at 4:25 p.m., Licensed Practical Nurse (LPN) #2 was in the resident's room to give him his medications per his feeding tube. The resident's left bed rail was being held up by the toothette stick. f. On 12/5/07 at 8:35 a.m., the resident was in his bed. The resident's left bed rail had a toothette stick holding it in the up position.	F 323			
F 328 SS=E	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids;	F 328			

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NAME OF PROVIDER OR SUPPLIER ASH FLAT HEALTHCARE 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 328	<p>Continued From page 12</p> <p>Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure oxygen concentrator filters were clean, oxygen tubing, nasal cannulas and/or updraft machine tubing were covered when not in use and oxygen and updraft tubing and cannulas were kept off of the floor for 3 (Residents #10, #13 and #14) of 5 (Resident #2, #8, #10, #13 and #14) case mix residents. This failed practice had the potential to affect 8 residents with physician orders for oxygen as needed or continuous, as identified by the Administrator on 12/6/07. The findings are:</p> <p>1. Resident #10 had a diagnosis of Chronic Pulmonary Heart Disease. The Quarterly Minimum Data Set (MDS) dated 9/12/07 documented the resident had modified independence in cognitive skills for daily decision making, had short-term memory problems and received oxygen therapy.</p> <p>a. The Physician orders for December 2007 documented, "10/29/07... Oxygen @ (at) 2 LPM (liters per minute) prn (as needed) shortness of breath... 11/5/07... Duoneb updraft TID (three times a day) for Bronchitis."</p> <p>b. On 12/2/07 at 3:12 p.m., a oxygen concentrator was on the floor beside the bed. The resident was</p>	F 328			

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F 328	<p>Continued From page 13</p> <p>receiving oxygen at 2 liters per minute by nasal cannula. The concentrator had a black filter that was covered with a white lint-type substance. The resident's updraft machine was on the heat/air unit beside the resident's bed with the tubing and mouth piece attached. The end of the tubing was on the floor, uncovered.</p> <p>2. Resident #13 had diagnoses of Congestive Heart Disease and Shortness of Breath. The Quarterly Minimum Data Set (MDS) dated 11/16/07 documented the resident had modified independence in cognitive skills for daily decision making, had short-term memory problems and received oxygen therapy.</p> <p>a. The Physician order dated 10/22/07 documented, "Oxygen @ at 2 LPM per nasal canula PRN (as needed)."</p> <p>b. On 12/2/07 at 2:40 p.m., an oxygen concentrator was on the floor beside the resident's bed. The concentrator had a black filter that was covered with a white lint type substance. The oxygen concentrator had tubing with a nasal cannula attached dated 11/29/07. The tubing and nasal cannula were not covered or bagged and left open to air.</p> <p>c. On 12/5/07 at 8:50 a.m., the resident's oxygen concentrator was on the floor with a black filter covered with a white lint-type substance. The concentrator had the tubing and nasal cannula attached. The oxygen tubing and both prongs of the nasal cannula were on the floor. The resident stated, "I use that at night; can not breathe."</p> <p>3. Resident #14 had diagnoses of Congestive Heart Disease, Bronchiectasis, Pulmonary</p>	F 328		

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F 328	Continued From page 14 Edema and Shortness of Breath. The Quarterly Minimum Data Set (MDS) dated 11/19/07 documented the resident had modified independence in cognitive skills for daily decision making, had short-term memory problems and received oxygen therapy. a. The Physician order dated 5/15/07 documented, "Oxygen @ at 2 LPM per nasal canula PRN for shortness of breath. Humidifier in room at all times." b. The plan of care dated 11/26/07 documented, "...Requires oxygen for shortness of breath, resident reports that she has had one-half of lung removed. Approaches: Apply oxygen PRN (as needed)." c. On 12/2/07 at 3:28 p.m., the resident was sitting in a recliner receiving oxygen per nasal cannula at 2 liters per minute. The resident's oxygen concentrator was on the floor beside the bed; it had a black filter that was white from a lint-type substance. The oxygen concentrator had tubing dated 11/25/07, with a nasal cannula attached. On the bed side table there was a blue humidifier with the chamber approximately 1/4-full of water. The humidifier had a dirty substance in the chamber that appeared to be mineral deposits; there was no date as to when the water was placed inside.	F 328			
F 445 SS=E	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 445			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 445	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that contaminated linens and/or incontinent briefs were not placed on the floor for 1 (Resident #7) of 5 (Residents #2, #3, #4, #7 and #10) case mix residents who were incontinent and staff did not hold clean linens against their uniforms. This failed practice had the potential to affect 25 residents who were incontinent and all 70 residents in the facility, according to the Resident Census and Conditions of Residents form dated 12/2/07. The findings are:</p> <ol style="list-style-type: none"> 1. Resident #7 had diagnoses of Alzheimer's Disease and Incontinence. The Minimum Data Set (MDS) dated 10/12/07 documented the resident had moderately impaired cognitive skills for daily decision-making and required staff assistance with toileting and personal hygiene. On 12/3/07 at 10:10 a.m., Certified Nursing Assistant (CNA) #2 removed the resident's urine and feces soiled incontinent brief and pants. The CNA stated she did not have a plastic bag and asked asked CNA #3 if she had a plastic bag. CNA #3 stated, "No." CNA #2 placed the urine and feces soiled items on the floor. 2. On 12/3/07 at 10:28 a.m., CNA #4 walked down the 100 hall with clean bed linens in her arms. The linens were being held against her uniform. The CNA took the linens into Resident Room 101 and made the bed. 3. On 12/3/07 at 3:46 p.m., CNA #5 was walking in the 400 hallway, through the fire doors, holding 	F 445			

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F 445	Continued From page 16 clean linens against the chest area of her uniform.	F 445			