

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

PRINTED: 02/25/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045203	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/08/2008
NAME OF PROVIDER OR SUPPLIER BATESVILLE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1975 WHITE DRIVE BATESVILLE, AR 72501	
(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 248 SS=E	<p>483.15(f)(1) ACTIVITIES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a variety of weekend activities were provided to appeal to the residents' interests and enhance quality of life. The failed practice had the potential to affect 83 residents who could participate in some type of weekend activity, as documented on a list provided by the Administrator on 2/8/08. The findings are:</p> <ol style="list-style-type: none"> 1. On 2/5/08 at 10:45 a.m., five alert and oriented residents participated in a group interview. The residents were asked about their scheduled weekend activities. Their comments were as follows: <ul style="list-style-type: none"> a. "The weekend activities are boring." b. "The activities are boring, especially on weekends." c. "Yeah! Very boring." d. "Weekend activities could be better." <p>When asked if they were allowed to have any input into the types of activities the facility offered, the residents stated they did not know.</p> <ol style="list-style-type: none"> 2. On 2/4/08 at 2:19 p.m. during the initial tour of 	F 248		

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 248	Continued From page 1 the facility, the Assistant Director of Nursing (ADON) stated Resident #17 was alert, oriented times three and interviewable. On 2/7/08 at 3:46 p.m., this resident was asked about weekend activities. The resident stated, "On weekends, they have church and singing sometimes. They probably could do more, but there are usually a lot of visitors. But, they could have a movie in the TV room that would last about 2 hours. Probably not many would come, but they could do that. I'd come." 3. The January and February 2008 Activity Calendars documented a 10:00 a.m. board game activity and 3:00 p.m. movie activity were the only activities offered on Saturdays. The Sunday activities consisted of church/religious activities and board games only. 4. On 2/7/08 at 5:28 p.m., the Activity Director stated, "Some of the residents told me after the group meeting that weekend activities were boring. There's no documentation for weekend activities, or maybe very little. I verbally check on Mondays. A CNA [Certified Nursing Assistant] is supposed to play games with them on Sunday. No one is designated." 5. On 2/7/08 at 6:05 p.m., the Activity Director stated, "We have nothing current as far as documentation for weekend activities. Nothing this year."	F 248			
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282			

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F 282	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the physician's plan of care for supplemental feedings was implemented for 2 (Residents #12 and #13) of 2 case mix residents with physician orders for supplemental feedings. The facility also failed to ensure thickened liquids were served in accordance with the physician's plan of care for 1 (Resident #12) of 1 case mix resident with a physician order for thickened liquids. The failed practices had had the potential to affect 27 residents with physician orders for supplemental feedings and 2 residents with physician orders for thickened liquids, as documented on the Diet List dated 1/7/08. The findings are: 1. Resident #12 had diagnoses of Dysphagia and Presenile Dementia. The Quarterly Minimum Data Set (MDS) dated 11/28/07 documented the resident was severely impaired in cognitive skills for daily decision making, required limited assistance with eating and had chewing and swallowing problems. a. A physician order dated 3/22/07 documented the resident was to receive a pureed diet with honey consistency liquids and fortified foods. b. On 2/4/08 at 5:36 p.m., the resident was served chocolate cake moistened with regular milk instead of thickened milk. c. On 2/5/08 at 8:15 a.m., the resident was served pureed eggs, bread and pureed oatmeal that was a thin consistency, instead of honey	F 282			

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F 282	<p>Continued From page 3</p> <p>consistency. The resident consumed only 2 bites of the oatmeal. The Certified Nursing Assistant who was assisting the resident stated, "The cereal was too thin."</p> <p>d. On 2/5/08 at 12:23 p.m., the resident was served pureed turkey, mixed vegetables, bread, noodles, a carton of chocolate Magic Cup and pound cake with approximately 1 tablespoon of regular, unthickened milk settling at the bottom of the bowl. No fortified food items were served to the resident.</p> <p>2. Resident #13 had diagnoses of Diabetes Mellitus, Depressive Disorder and Reflux Esophagitis. The Quarterly MDS dated 12/12/07 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for eating and had a chewing problem.</p> <p>a. A physician order dated 9/20/07 documented the resident was to receive a mechanical soft consistency diet and fortified foods.</p> <p>b. On 2/4/08 at 5:28 p.m., the resident was served a bowl of stew, a carton of chocolate ice cream, a carton of whole milk, stewed tomatoes and chocolate cake. No fortified foods were served to the resident.</p> <p>c. On 2/5/08 at 12:25 p.m., the resident was served noodles, a roll, ground turkey, mixed vegetables and pound cake. No fortified foods were provided.</p> <p>3. On 2/6/08 at 8:30 a.m., Dietary Employee #2 stated, "We give cheesy eggs or super cereal at breakfast, then at lunch and supper we give extra</p>	F 282			

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F 282	Continued From page 4	F 282			
F 309	margarine, extra gravy and ice cream."				
SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure necessary care and services to prevent potential Urinary Tract Infections (UTI's) and restore bladder function were provided to 1 (Resident #11) of 2 case mix residents with indwelling urinary catheters in use (Residents #10 and #11), as evidenced by failure to remove the indwelling catheter when there was no longer a medical justification for its use. The facility also failed to ensure urinary catheter tubing was secured to prevent potential catheter displacement or trauma to the urinary meatus, failed to ensure the catheter drainage bag was kept off of the floor and failed to ensure personal hygiene was provided in a manner to prevent potential Urinary Tract Infection (UTI) for 1 (Resident #9) of 3 case mix residents with indwelling urinary catheters (Residents #9, #10 and #11). The failed practices had the potential to affect 4 residents with indwelling urinary catheters, as documented on the Resident Census and Conditions of Residents form dated 2/4/08. The findings are: 1. Resident #11 was admitted to the facility on	F 309			

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F 309	<p>Continued From page 5</p> <p>12/19/07 with diagnoses of Cirrhosis, Septic Right Knee and Leg and Scrotal Swelling. The Initial Minimum Data Set (MDS) dated 12/26/07 documented the resident was independent in cognitive skills for daily decision making, totally dependent on staff for activities of daily living, had two Stage II pressure sores and had an indwelling catheter.</p> <p>a. Physician Orders dated 12/19/07 documented: "Flush Foley Catheter every day with 100 cc's [cubic centimeters] normal saline. Change Foley every month and prn [as needed]. Maintain heplock and Foley."</p> <p>b. The Resident Plan of Care dated 12/28/07 documented: "Potential for complications related to presence of indwelling catheter. Resident was admitted with this. Is incontinent of bowels, pad and briefs in use. Was admitted with pressure ulcers... has had right knee surgery, has a brace and is non weight bearing to right leg. Potential for complications due to was admitted with 2 stage 2 pressure ulcer to coccyx. 12/19/07 - Resident has developed a Stage II pressure ulcer to right lateral leg from brace rolling. 1/16/08 - Resident has continued with 1 stage II pressure ulcer to leg and has 4 fluid filled blisters to lower extremities due to excess edema. 2/6/08 - Resident has 1 Stage II pressure sore to right lateral leg."</p> <p>c. On 2/4/08 at 3:05 p.m., the Assistant Director of Nursing (ADON) stated, "The residents go to the hospital and get Foley catheters, then we take them out when they come back."</p> <p>d. On 2/5/08 at 9:00 a.m., the resident was asked why he had a urinary catheter. He pointed</p>	F 309			

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F 309	<p>Continued From page 6</p> <p>to his right knee. When asked if he still had a pressure sore on his coccyx, the resident stated, "No, the only sore I have is on my leg from a brace rubbing it."</p> <p>e. On 2/7/08 at 1:00 p.m., Licensed Practical Nurse (LPN) #2 was asked if the resident still had a pressure sore to his coccyx. The LPN stated, "No, the only treatment he gets now is on his leg." When asked if she was aware of why the resident still had a urinary catheter in place, the LPN stated, "No, he was admitted with it is all I know."</p> <p>2. Resident #9 had diagnoses of Dementia and Urinary Tract Infection.</p> <p>a. The Hospital Admission Record dated 10/6/07 documented the resident had a UTI.</p> <p>b. The November 2007 Medication Administration Record (MAR) documented a physician order dated 11/19/07 for: "Sulfa DS 1 po [by mouth] BID [twice daily] for 5 days."</p> <p>c. The December 2007 MAR documented a physician order dated 12/29/07 for: "Cipro 500 mg [milligrams] 1 po BID."</p> <p>d. The Significant Change Minimum Data Set (MDS) dated 1/5/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, required extensive assistance with personal hygiene and had a UTI in the last 30 days.</p> <p>e. A Final Microbiology Urine Culture Report dated 1/22/08 documented the resident's urine specimen grew cultures of Vancomycin Resistant Enterococcus (VRE) faecium.</p>	F 309			

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F 309	Continued From page 7 f. Nurses' Notes dated 2/2/08 at 4:15 p.m. documented: "CNA [Certified Nursing Assistant] reported while transferring resident to bathroom 18 fr [French] catheter was pulled out with bulb intact." g. On 2/5/08 at 8:25 a.m., the resident was sitting in her recliner. The urinary catheter drainage bag, which was not in a privacy bag, was attached to the recliner at a level which allowed the bag to rest on the floor. h. On 2/6/08 at 8:25 a.m., Certified Nursing Assistant (CNA) #1 placed the resident's urinary catheter drainage bag directly on the bathroom floor in front of the commode. i. On 2/6/08 at 10:05 a.m., CNA #1 assisted the resident to the shower room. There was no leg strap or other means of securing the catheter in place to prevent potential dislodgement of the catheter as the CNA undressed and showered the resident. The CNA placed the urinary catheter drainage bag directly on the shower room floor twice during the resident's shower. During the shower, the resident had an incontinent bowel movement. The CNA cleansed the feces from the anal area using a front-to-back and back-to-front repetitive motion. j. The facility's Catheter Care, Urinary Policy and Procedure was provided by the Administrator on 2/8/08 at 11:20 a.m. and documented: "Purpose: The purpose of this procedure is to prevent infection of the resident's urinary tract... General Guidelines: ...Be sure the catheter tubing and drainage bag are kept off the floor... Ensure that the catheter remains secured with a leg strap to	F 309			

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F 309	Continued From page 8 reduce friction and movement at the insertion site... Steps in the Procedure: ...Secure catheter utilizing a leg band." k. The facility's Perineal Care Policy and Procedure was provided by the Administrator on 2/8/08 at 11:10 a.m. and documented: "...The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition... Steps in the procedure: ...Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks."	F 309		
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, record review and interview, the facility failed to ensure transfer assistance was provided in a manner to prevent potential injury to 1 (Resident #4) of 3 case mix residents who were totally dependent on staff for transfers (Residents #4, #10 and #11). The failed practice had the potential to affect 20 residents who required 2-person or mechanical lift transfers, as documented on a list provided by the Administrator on 2/8/08. The facility also failed to ensure supervision and monitoring were provided for 2 (Residents #2 and #20) of 2 case mix	F 323		

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F 323	Continued From page 9 residents with a history of behavior symptoms. The failed practice had the potential to affect 16 residents who were cognitively impaired and resided on the facility's 500 Hall secured unit, as documented on a list provided by the Administrator on 2/8/08 at 11:10 a.m. The findings are: 1. Resident #4 had diagnoses of Femur Fracture and Congestive Heart Failure. The Quarterly Minimum Data Set (MDS) dated 12/21/07 documented the resident was severely impaired in cognitive skills for daily decision making and totally dependent on 2 or more persons' assistance for transfers. a. The Daily Care Guide (Nursing Assistant Care Plan which was not dated) documented: "...Transfer Assistance: A [assistance]." There was no documentation to inform the reader as to the number of persons or transfer method required to safely transfer the resident. b. The Plan of Care dated 12/21/07 documented: "Potential for complications due to resident requires total care in ADLs [activities of daily living], bed mobility, transfers... resident is unable to make needs known to staff... Provide one or two person physical assistance for ADL support." There was no documentation noted regarding how the resident should be transferred. c. Nurse's Notes dated 2/6/08 at 7:10 a.m. documented, "...Res [resident] is nonweight bearing..." d. On 2/6/08 10:22 a.m., Certified Nursing Assistants (CNA's) #2 and #3 and Nursing Assistant (NA) #1 were in the resident's room to	F 323		

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F 323	<p>Continued From page 10</p> <p>transfer the resident from the wheelchair to the bed. The resident was wearing an immobilizer on her left lower leg. CNA #2 and NA #1 each placed an arm under one of the resident's arms at the axillary area and lifted the resident out of the wheelchair and into bed. The resident did not bear weight on her lower extremities at any time during the transfer. CNA's #2 and #3 stated the resident was weight-bearing. CNA #3 stated the CNA's knew if a resident was not weight-bearing, "by their chart." NA #1 agreed.</p> <p>e. A Rehabilitation Screen Rehab [rehabilitation] Care Note dated 2/6/08 (not timed) documented: "...Patient is non-ambulatory and is total A [assistance] for transfers... PT [Physical Therapy] recommends Hoyer lift for transfers for patient + [and] staff safety..."</p> <p>f. On 2/7/08 at 3:34 p.m., the Assistant Director of Nursing (ADON) stated, "The CNAs have a Kardex that lists special needs for residents, in the front of the ADL Book."</p> <p>g. On 2/7/08 at 3:40 p.m., the ADON stated, as she was reviewing the CNA Daily Care Guide for this resident, "She [resident] needs assist with transfers."</p> <p>h. A list provided by the Administrator on 2/8/08 documented Resident #4 required a mechanical lift transfer.</p> <p>2. Resident #2 had diagnoses of Dementia with Behavior Disturbances, Insomnia and Impulse Control Disorder. The Initial Minimum Data Set (MDS) dated 11/26/07 documented the resident was ambulatory, moderately impaired in cognitive skills for daily decision making, had long and</p>	F 323		

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F 323	<p>Continued From page 11</p> <p>short term memory problems, exhibited behavioral symptoms such as wandering, verbally and physically abusive behaviors, socially inappropriate/disruptive behaviors and resistance to care and had varying mental functioning over the course of the day.</p> <p>a. An Incident/Accident Report dated 1/27/08 at 5:00 p.m. documented: "Resident [Resident #2] was observed fondling another female resident [Resident #20]." Nurses' Notes dated 1/27/08 at 5:00 p.m. documented: Resident found in another resident's room involved in sexually inappropriate behavior. Resident redirected to own room. Hands washed thoroughly. Family and Doctor notified."</p> <p>b. A Verification of Investigation Report dated 1/28/08 at 6:00 a.m. for the above incident documented: "Immediate Resident Protection Initiated: Resident removed from other resident's room. Resident assisted in thorough handwashing. Behavior redirected. Talked with other resident and questioned her about incident and she stated she, "Don't know what your [you're] talking about."</p> <p>c. The Plan of Care dated 11/23/07 included an update dated 1/28/08 which documented the resident was sexually inappropriate toward another female resident by fondling her. Interventions included: Remove resident from other resident's room, assist in thorough handwashing and redirect behavior."</p> <p>d. The January and February 2008 Monthly Behavior Monitoring Flowsheets had no documentation of monitoring this resident for inappropriate sexual behaviors.</p>	F 323			

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F 323	Continued From page 12 e. As of 2/7/08, there were Nurses Notes' documenting monitoring of the resident's behaviors from 1/27/08 through 2/2/08 but no documentation of the resident's behaviors after 2/2/08. 3. Resident #20 had a diagnosis of Dementia with Behavior Disturbances. The Annual Minimum Data Set dated 1/4/08 documented the resident was non-ambulatory, severely impaired in cognitive skills for daily decision making, had long and short term memory problems, exhibited behavioral symptoms such as wandering and resistance to care and had varying mental functioning over the course of the day. a. An Incident/Accident Report dated 1/27/08 at 5:00 p.m. documented: "Resident [#20] was observed being fondled by another female resident [#2]." Nurses' Notes dated 1/27/08 at 5:00 p.m. documented: "Resident found involved in sexually inappropriate behavior in room. Residents separated and redirected. Family and Doctor notified." There was no further documentation of monitoring for inappropriate sexual behaviors. b. A Verification of Investigation Report dated 1/28/08 at 6:00 a.m. documented: "Immediate Resident Protection Initiated: Residents separated. Complete Physical exam. Redirect behavior. Resident is unable to verbalize or remember what happened due to advanced dementia." c. The Plan of Care dated 1/2/08 included an update dated 1/28/08 which documented the resident exhibited sexually inappropriate behavior	F 323			

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F 323	Continued From page 13 with another female resident when she was fondled by the other resident. Interventions included: "Separate residents, complete physical exam, monitor for vaginal irritation, and redirect behavior." d. The Behavior Monitoring Book located at the Nurses' Station had no Monthly Behavior Monitoring Flowsheet for this resident. e. Social Service Progress Notes dated 1/27/08 through 1/30/08 documented monitoring of the resident's behaviors, but there was no documentation of the resident's behaviors after 1/30/08.	F 323		
F 329 SS=E	483.25(I) 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 drugs.	F 329		

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F 329	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure cough, cold and allergy medications were monitored for effectiveness and continued need, in order to prevent the continued use of these medications in excess of the manufacturer's recommended duration for 2 of 3 (Residents #3, #9 and #10) case mix residents with physician orders for cough, cold or allergy medications. The failed practice had the potential to affect 13 residents with physician orders for Claritin and 2 residents with physician orders for guaifenesin, as documented on a list provided by the Administrator on 2/8/08 at 11:10 a.m. The findings are: 1. Resident #9 had diagnoses of Cerebrovascular Accident, Hypertension and Allergies. The Significant Change Minimum Data Set dated 1/5/08 documented the resident was moderately impaired in cognitive skills for daily decision making and received more than 9 medications daily. a. A Change in Condition Report dated 4/6/07 documented: "Res c/o runny nose and requesting an antihistamine." The physician's response documented: "Loratadine [Claritin] 10 mg daily." b. On 2/8/08 at 10:40 a.m., Medication Administration Records (MAR's) were reviewed from October 2007 through the present. The MAR's documented the Claritin 10 mg was administered daily from 10/1/07 through 2/8/08.	F 329			

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F 329	Continued From page 15 2. Resident #10 had diagnoses of Cough and Respiratory Abnormality. The MDS dated 1/11/08 documented the resident was moderately impaired in cognitive skills for daily decision making and received 15 different medications in the last 7 days. a. A physician order dated 3/20/06 documented: "Robitussin syr [syrup], 100 mg [milligrams]/5 mL [milliliters], give 2 tsp. [teaspoons] PO [by mouth] PC [after meals] & [and] HS [hour of sleep]." b. The Care Plan dated 1/3/08 documented: "Resident receives 9 or more medications per day... Interventions... Drug review by Pharmacist monthly with referrals to MD [Medical Doctor]... Letter to MD for review about reduction or change in medications." c. The Consultant Pharmacist Communication Report dated 1/30/08 documented: "This resident currently is receiving 9 or more medications on a routine basis and some may be unnecessary duplications. Please review this resident's chart to determine if any medications might be reduced or discontinued and document this in your progress notes and/or in the space provided..." The physician's response dated 1/31/08 documented: "No changes." d. On 2/7/08 at 3:23 p.m., the Director of Nursing (DON) stated she did not realize the resident had been receiving Robitussin since 3/20/06. When asked if a resident was only supposed to receive this medication on a short-term basis, such as 2 weeks, the DON stated, "Uh huh [yes]." The DON stated the 1/30/08 letter to the physician was the only letter that had been sent regarding	F 329			

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F 329	Continued From page 16 this resident's medication regimen. e. On 2/8/08, the facility received a physician order which documented: "Robitussin DC [discontinue] routine schedule." f. The Geriatric Dosage Handbook 12th edition, copyright 2007, by Lexicom documented: "Guaifenesin... Robitussin... Warnings/Precautions: Should not be used for persistent or chronic coughs... Patient information... if cough persists for more than 1 week... physician should be consulted... Additional information: Should not be used for persistent or chronic cough such as that occurring with smoking, asthma, chronic bronchitis, or emphysema or for cough associated with excessive phlegm; there is lack of convincing studies to document the efficacy of guaifenesin..." 3. The Centers for Medicare and Medicaid Services (CMS) Medication Issues of Particular Relevance Table 1 documented: "All cough, cold, allergy medications: Indications/Duration: should be used only for a limited duration (less than 14 days) unless there is evidence of enduring symptoms that cannot otherwise be alleviated and for which a cause cannot be identified and corrected."	F 329			
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure physician	F 333			

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F 333	<p>Continued From page 17</p> <p>orders were followed to prevent significant medication errors for 1 (Resident #3) of 3 case mix residents with physician orders for cough, cold or allergy medications (Residents #3, #9 and #10). The failed practice had the potential to affect 13 residents with physician orders for Claritin, as documented on a list provided by the Administrator on 2/8/08. The findings are:</p> <p>Resident #3 had diagnoses of Senile Delirium, Hypertension and Allergic Rhinitis. The Quarterly Minimum Data Set (MDS) dated 12/12/07 documented the resident was moderately impaired in cognitive skills for daily decision making, had long and short term memory problems and was administered 9 or more medications daily.</p> <p>a. A physician order dated 12/6/07 documented: "Claritin 10 mg [milligrams] tablet give one po [by mouth] QHS [every night at bedtime]."</p> <p>b. A Change in Condition Report dated 12/14/07 documented: "Res. [resident] c/o [complained of] sore throat, right ear pain and difficulty hearing... throat is red, [no] pustules noted to area... any orders? Please advise." The physician's response documented: "Claritin D 1 po in am [morning] prn [as needed] watch BP [blood pressure] while taking." The facility's response to this order documented: "Res. already receives Loratadine [Claritin] 10 mg 1 po Q [every] day... do you wish to continue Claritin D prn?" The physician's response documented: "Use instead not in addition."</p> <p>A handwritten entry dated 12/18/07 on the Physician Orders sheet documented: "Use Claritin D 1 po Q am instead of Loratadine."</p>	F 333			

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F 333	Continued From page 18 c. The December 2007 Medication Administration Record (MAR) documented the Claritin 10 mg 1 po QHS and the Claritin D Q am were both administered every day from 12/19/07 through 12/31/07 (a total of 13 days). The Claritin D (which was originally ordered as an as-needed medication) was administered daily from 1/1/08 through 1/31/08. The Claritin D and Claritin were both administered on 2/1/08 and the Claritin D continued to be administered as a scheduled daily medication through 2/7/08. d. On 2/7/08 at 5:30 p.m., the Director of Nursing (DON) was asked to interpret the physician order as to whether the Claritin D was to be a scheduled or an as-needed medication. The DON stated she was not sure. e. The Geriatric Dosage Handbook Including Clinical Recommendations and Monitoring Guidelines by Lexi-Com, copyright 2007, documented: "...Use: relief of nasal and non-nasal symptoms of seasonal allergic rhinitis... Dosage: geriatrics and adults: oral 10mg/day [milligrams per day]."	F 333			
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced	F 371			

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F 371	Continued From page 19 by: Based on observation and interview, the facility failed to ensure food was stored in the storage room and freezer in a manner to prevent potential cross contamination and freezer burn, failed to ensure the ice scoop holder was free of debris and failed to ensure Dietary Employees washed their hands between dirty and clean tasks. The failed practices had the potential to affect 86 residents who received meal trays from the kitchen, as documented on the Diet List dated 1/7/08. The findings are: On 2/4/08 at 2:05 p.m., during a tour of the kitchen, the following observations were made: a. An opened bag of sugar on the shelf in the storage room was not sealed. b. An opened box of raisins on the shelf in the storeroom was not sealed. c. An opened box of chicken patties was stored on a shelf in the freezer with the contents uncovered. d. A box of beef fritters, a box of squash and a box of okra were all stored open on a shelf in the freezer with the contents uncovered. e. An opened bottle of lemon juice, half-full and dated 12/18/07, was stored on a rack in the kitchen. The manufacturer's label on the lemon juice documented: "Refrigerate after opening." f. The ice scoop on the right side of the ice machine had water standing it and greyish debris floating in the water. The ice scoop was in contact with the dirty water in the scoop holder.	F 371		

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F 371	Continued From page 20 g. On 2/5/08 at 9:16 a.m., Dietary Employee #1 lifted the trash can lid and threw away a plastic bag, opened the milk refrigerator, removed cartons of milk, shakes and thickened beverages and placed them on the counter. Without washing her hands, the employee picked up drinking glasses with her fingers touching the inside rims of the glasses and placed the glasses on the counter. She then poured beverages into the glasses to be served to the residents during the 10:00 a.m. snack pass and the lunch meal. h. On 2/5/08 at 9:32 a.m., Dietary Employee #1 used a paper towel to wipe off orange juice that spilled on her blouse. She then wiped around the sink and lifted the trash can lid and threw away the paper towel. She picked up a wash cloth from a bucket of sanitizer and used it to clean spilled orange juice from the counter. Without washing her hands, she picked up a glass by its rim and poured orange juice into it. She then placed the glass in the refrigerator to be given to a resident during the lunch meal.	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.	F 425			

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F 425	Continued From page 21 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, record review and interview, the facility failed to ensure medications were administered within 1 hour of the scheduled administration time, in accordance with facility policy and acceptable standards of nursing practice for 1 (Resident #6) of 7 case mix residents who resided on the 600 Hall (Residents #3, #4, #6, #7, #10, #17 and #18). The failed practice had the potential to affect 30 residents who resided on the 600 Hall, as documented on a list provided by the Administrator on 2/8/08. The findings are: Resident #6 had diagnoses of Acute Peptic Ulcer, Diabetes Mellitus, Hyperlipidemia, Hypertension, Heart Disease, Muscle Weakness, Depressive Disorder and Osteoarthritis. The Quarterly Minimum Data Set (MDS) dated 12/7/07 documented the resident was moderately impaired in cognitive skills for daily decision making and had long term and short term memory problems. a. A physician order dated 5/26/05 documented: "Zantac tabs [tablets] 150 mg [milligrams] one po [orally] BID [two times a day]." 1.) The February 2008 Medication Administration	F 425		

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F 425	<p>Continued From page 22</p> <p>Record (MAR) documented the Zantac was to be administered at 8:00 a.m. and 8:00 p.m. daily.</p> <p>2.) On 2/6/08 at 10:45 a.m., Licensed Practical Nurse (LPN) #1 administered the Zantac 150 mg to the resident, 2 hours and 45 minutes past the scheduled administration time. The LPN then initialed the MAR to indicate the medication was administered at 8:00 a.m. as scheduled.</p> <p>b. A physician order dated 2/14/07 documented: "Glucotrol tabs 10 mg give 1 tab po BID... Glucophage tabs 1000 mg give 1 tab po BID."</p> <p>1.) The February 2008 MAR documented the Glucotrol and Glucophage tablets were to be administered at 8:00 a.m. and 8:00 p.m. daily.</p> <p>2.) On 2/6/08 at 10:45 a.m., LPN #1 administered Glucotrol 10 mg and Glucophage 1000 mg, 2 hours and 45 minutes past the scheduled administration time.</p> <p>c. A physician order dated 7/11/05 documented: "Calcium 500 mg with D give 1 tab po BID."</p> <p>1.) The February 2008 MAR documented the Calcium with D tablets were to be administered at 8:00 a.m. and 8:00 p.m. daily.</p> <p>2.) On 2/6/08 at 10:45 a.m., LPN #1 administered the Calcium 500 mg, 2 hours and 45 minutes past the scheduled administration time.</p> <p>d. A physician order dated 5/1/05 documented: "Zocor tabs 40 mg 1 tab po Q [every] day."</p> <p>1.) The February 2008 MAR documented the</p>	F 425			

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F 425	Continued From page 23 Zocor tablets were to be administered at 8:00 a.m. daily. 2.) On 2/6/08 at 10:45 a.m., LPN #1 administered the Zocor 40 mg to the resident, 2 hours and 45 minutes past the scheduled administration time. e. A physician order dated 9/12/05 documented: "Diltiazem HCL [hydrochloride] ER [extended release] caps [capsules] 180 mg 1 cap po daily - Do not crush." 1.) The February 2008 MAR documented the Diltiazem capsules were to be administered at 8:00 a.m. daily. 2.) On 2/6/08 at 10:45 a.m., LPN #1 administered the Diltiazem HCL ER 180 mg to the resident, 2 hours and 45 minutes past the scheduled administration time. f. A physician order dated 2/14/05 documented: "Actos tabs 15 mg give 1 po QD [every day]." 1.) The February 2008 MAR documented the Actos tablets were to be administered at 8:00 a.m. daily. 2.) On 2/6/08 at 10:45 a.m., LPN #1 administered the Actos 15 mg to the resident, 2 hours and 45 minutes past the scheduled administration time. g. A physician order dated 2/14/05 documented: "Aspirin tabs 81 mg give 1 tab po QD." 1.) The February 2008 MAR documented the aspirin tablets were to be administered at 8:00	F 425			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045203	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/08/2008
NAME OF PROVIDER OR SUPPLIER BATESVILLE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1975 WHITE DRIVE BATESVILLE, AR 72501		
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F 425	Continued From page 24 a.m. daily. 2.) On 2/6/08 at 10:45 a.m., LPN #1 administered the aspirin 81 mg to the resident, 2 hours and 45 minutes past the scheduled administration time. h. A physician order dated 2/14/05 documented: "Imdur tabs CR [controlled release] 120 mg give 1 tab po QD - Do not crush." 1.) The February 2008 MAR documented the Imdur tablets were to be administered at 8:00 a.m. daily. 2.) On 2/6/08 at 10:45 a.m., LPN #1 administered the Imdur CR 120 mg to the resident, 2 hours and 45 minutes past the scheduled administration time. i. A physician order dated 8/20/07 documented: "Niferex capsule give one po Q day." 1.) The February 2008 MAR documented the Niferex capsules were to be administered at 8:00 a.m. daily. 2.) On 2/6/08 at 10:45 a.m., LPN #1 administered the Niferex capsule to the resident, 2 hours and 45 minutes past the scheduled administration time. j. A physician order dated 5/30/07 documented: "Lexapro 20 mg tablet give one po q day." 1.) The February 2008 MAR documented the Lexapro tablets were to be administered at 8:00 a.m. daily.	F 425			

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F 425	<p>Continued From page 25</p> <p>2.) On 2/6/08 at 10:45 a.m., LPN #1 administered the Lexapro 20 mg to the resident, 2 hours and 45 minutes past the scheduled administration time.</p> <p>k. A physician order dated 2/14/05 documented: "Naproxen tabs EC [enteric coated] 500 mg give 1 tab po BID with food."</p> <p>1.) The February 2008 MAR documented the Naproxen tablets were to be administered at 8:00 a.m. and 5:00 p.m. daily.</p> <p>2.) On 2/6/08 at 10:45 a.m., LPN #1 administered the Naproxen EC 500 mg to the resident, 2 hours and 45 minutes past the scheduled administration time.</p> <p>l. A physician order dated 2/14/05 documented: "Tylenol tabs 325 mg give 2 tabs po QAM [every morning]."</p> <p>1.) The February 2008 MAR documented the Tylenol tablets were to be administered at 8:00 a.m. daily.</p> <p>2.) On 2/6/08 at 10:45 a.m., LPN #1 administered 2 of the Tylenol 325 mg tablets to the resident, 2 hours and 45 minutes past the scheduled administration time.</p> <p>m. On 2/6/08 at 10:45 a.m., LPN #1 was asked why the resident's medications were being administered 2 hours and 45 minutes past their scheduled administration times. The LPN stated, "I am just behind today."</p> <p>n. The facility's policy and procedure titled, "Administering Oral Medications" was provided by</p>	F 425			

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F 425	Continued From page 26 the Administrator on 2/8/08 and documented: "...Always verify the 5 rights before administering medications - the right medication; the right dose; the right resident; the right route; and the right time... Administer medications within one (1) hour before or after their scheduled time."	F 425			
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure mechanical lifts used for resident transfers were stored in a clean and sanitary manner to prevent the potential spread of infection. The failed practice had the potential to affect 7 residents who required a mechanical lift for transfers, as documented on a list provided by the Administrator on 2/8/08 at 11:10 a.m. The findings are: On 2/6/08 at 4:10 p.m. during the environmental tour of the facility, a Sara 2000 mechanical lift and a Marisa mechanical lift were stored in the 500 Hall hopper room. The fabric sling of the Sara 2000 lift was touching the rim of the hopper sink. The hopper had dried, white spills and splatters	F 441			

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F 441	Continued From page 27 all over the rim, bottom and all sides of the double compartment hopper sink and had 2 areas of a dried brown substance approximately 2 inches in diameter in the bottom of one side of the sink. The Marisa lift was positioned over the hopper with the bar approximately 3 inches from the hopper rim.	F 441			