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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045203	A. BUILDING ______ B. WING ______	C 03/30/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATESVILLE HEALTHCARE CENTER	**1975 WHITE DRIVE** **BATESVILLE, AR 72501**

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F 000	INITIAL COMMENTS Complaint #12433, unsubstantiated.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure the privacy curtain was pulled during incontinent care for 1 (Resident #2)	F 164		

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 164	Continued From page 1 of 10 case mix residents (Residents #1 through 8, 14 and 15) who required assistance with incontinent care. This failed practice had the potential to affect 27 residents who required incontinent care according to the Resident Census and Conditions of Residents form dated 3/27/07. The findings are: Resident #2 had diagnoses of Renal Failure, Reactive Confusion and Dementia with Behaviors. The Annual Minimum Data Set dated 2/9/07 documented the resident was severely impaired in cognitive skills for daily decision making, incontinent of bladder and had an ostomy. a. On 3/28/07 at 9:58 a.m., the resident was in bed. Certified Nursing Assistant (CNA) #1 and 2 turned the resident onto the left side facing the door to the hall and removed the wet disposable incontinent brief. The privacy curtain between the resident and the hallway door was not pulled.	F 164		
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the urethral area, scrotum and inner thighs were not cleaned during incontinent care for 1 (Resident #5) of 10 case mix residents (Residents #1 through 8, 14 and 15) who required assistance with incontinent	F 312		

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F 312	Continued From page 2 care. The facility failed to ensure facial hair was removed for 1 (Resident #7) of 5 case mix residents (Residents #1, 5, 7, 8, and 14) who required assistance with shaving facial hair. The facility failed to ensure fingernails and toenails were trimmed for 1 (Resident #4) of 15 case mix residents (Residents #1 through 15) who required assistance with nail care. This failed practice had the potential to affect 27 residents who were incontinent, all 89 residents (for nail care) according to the Resident Census and Conditions of Residents form dated 3/27/07 and 37 residents who required assistance with shaving facial hair according to a list provided by the Administrator on 3/30/07 at 9:49 a.m. The findings are: 1. Resident #5 had diagnoses of Chronic Obstructive Pulmonary Disease, End Stage Peripheral Vascular Disease, Congestive Heart Failure and Cerebrovascular Accident. The Significant Change Minimum Data Set (MDS) dated 3/28/07 documented the resident was moderately impaired in cognitive skills for daily decision making and incontinent of bowel and bladder. a. On 3/28/07 at 10:30 a.m., Certified Nursing Assistant (CNA) #3 and 4 performed incontinent care. The resident had on a wet incontinent brief. After removing the soiled incontinent brief, CNA #3 used Derma Cen Perineal Wash on an Adult Wipe and cleansed the resident's buttocks and rectal area with one swipe for each Adult Wipe used. CNA #3 then used one Adult Wipe and swiped the penis one time. A circular motion was not used on the urethral area, the scrotum and inner thighs were not cleansed. b. The facility's policy for Perineal Care received	F 312		

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F 312	Continued From page 3	F 312		

from the Director of Nursing on 3/29/07 at 9:55 a.m. documented, "For a male resident: Wash perineal area starting with urethra and working outward. Wash and rinse urethral area using a circular motion. Continue to wash the perineal area including the penis, scrotum and inner thighs."

2. Resident #5 had diagnoses of Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Congestive Heart Failure and Muscle Weakness. The Quarterly MDS dated 2/16/07 documented the resident was moderately impaired in cognitive skills for daily decision making and required extensive assistance of one person for personal hygiene.

a. On 3/26/07 at 7:25 p.m., the resident was in bed watching TV and his face was unshaven.

b. On 3/28/07 at 10:46 a.m., the resident's beard was approximately 1/4 inches in length. The Surveyor asked the resident if he was growing a beard and he stated, "No."

c. On 3/29/07 at 11:02 a.m., CNA #5 stated she started to shave the resident today. "I shave him about every other day. I wasn't over here yesterday. I was here Monday (3/26/07). I didn't shave him on Monday. The resident still had his chin unshaved.

3. Resident #4 had diagnosis of Quadriplegia, Upper Respiratory Disease, History of Pneumonia, Convulsions, and Decubitus Ulcers. The Medicare 5 day MDS dated 3/18/07 documented the resident was severely impaired in cognitive skills for daily decision making and was totally dependent on staff for personal

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F 312	Continued From page 4 hygiene. a. The Plan of Care dated 2/26/07 documented the resident required, "total care in all adls (Activities of Daily Living), unable to make needs known to staff..." b. On 3/26/07 at 7:40 p.m.; 3/27/07 at 10:48 a.m., 5:26 p.m. and 3/28/07 at 8:40 a.m., the resident had long, blunt at the top, fingernails with sharp edges. c. On 3/27/07 at 10:55 a.m., the resident was in bed and the toenails extended beyond the toes.	F 312		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a restraint was used in accordance with manufacturer's instructions for 1 (Resident #3) of 2 case mix Residents (Resident #3 and 6) who used a restraint. This failed practice had the potential to affect 9 residents who used a restraint according to a list provided by the DON (Director of Nursing) on 3/30/07 at 9:50 a.m. The findings are: 1. On 3/27/07 at 6:07 p.m., the Application Instruction Sheet (for the) Posey Soft Belt was received from the DON. It documented, "Discontinue use immediately if the patient is able to slide forward or down underneath the device. They could slide far enough under the device to	F 323		

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F 323	Continued From page 5	F 323		

become suspended resulting in chest compression and suffocation." Page 2 documented, "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. Restraints with pelvic pieces may be necessary to reduce sliding down or pulling the restraint over their head." It also documented, "Do not use Posey products... on any type of furniture which does not allow application as directed in the product application sheet."

2. Resident #3 had diagnoses of Huntington's Chorea, Anxiety State Abnormal Involuntary Movement, Speech Disturbance and Dysphagia. The Annual Minimum Data Set (MDS) dated 12/20/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, had problems with sitting and standing balance, repetitive movements, experienced a fall in the past 31 to 180 days and received an antipsychotic and antidepressant medications.

a. The Plan of Care dated 12/26/07 documented, "Potential for functional decline related to use of restraint while up for safety. Seat belt on at all times..." Interventions included, "Evaluate effectiveness of less restrictive restraint if possible. Position comfortably using correct body alignment, and functional positioning."

b. A physician clarification order dated 2/7/07 documented, "Soft belt restraint at all times d/t (due to) gait abnormality, safety awareness and poor posture d/t diagnosis of Huntington's Chorea."

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F 323	Continued From page 6 c. On 3/26/07 at 7:28 p.m., the resident was in his room seated in a large recliner. His legs were drawn up, especially on the right. and his extremities were in constant motion. The resident had slid down in the recliner and had a large pillow in his lap. d. On 3/27/07 at 11:05 a.m., the resident was awake in the large (electric) recliner. The foot rest was folded down and not in use. The resident had slid down in the recliner but his buttocks were still on the seat. He had a soft belt restraint in place and it was above his waist, about the nipple line, and the resident had slid down in the recliner. e. On 3/27/07 at 4:50 p.m., the resident was up in the recliner with the soft belt restraint. The resident had slid far down in the recliner. f. On 3/27/07 at 6:30 p.m., the DON said she was not aware of a problem with the restraint but the resident, "does slide down in the chair."	F 323		
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure pressure was not applied to the shoulder joints while moving a resident up in bed for 1 (Resident #2) of 8 case mix residents (Residents #2, 4 through 7, 10, 14 and 15) who required extensive to total assistance with bed-mobility and transferring. This failed practice	F 324		

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F 324	Continued From page 7	F 324		

had the potential to affect 25 residents who were totally dependent on staff for transfers according to the Resident Census and Conditions of Residents form dated 3/27/07. The findings are:

Resident #2 had diagnoses of Renal Failure, Reactive Confusion and Dementia with Behaviors. The Annual Minimum Data Set dated 2/9/07 documented the resident was severely impaired in cognitive skills for daily decision making and was totally dependent on staff for bed mobility.

a. On 3/28/07 at 9:58 a.m., the resident was in bed. Certified Nursing Assistant (CNA) #1 and 2 completed incontinent care on the resident and moved her up in bed. The CNA's stood on each side of the bed, locked their arms under the resident's shoulder joints and drug the resident's body up to the head of the bed. They did not use the resident's pad which they had just placed under the resident.

b. The facility's Moving a Resident Up in Bed policy provided by the Director of Nursing on 3/29/07 at 3:22 p.m. documented, "If the resident is unable to assist you: One person stands on each side of the bed. Position a lift sheet abd (abdominal)/or pad from under the resident's thigh to above the shoulders. (Note: A draw sheet may be used in lieu of a lift sheet.) Roll both sides of the lift sheet toward the resident's body. Stand straight and turn slightly toward the head of the bed. Keep your feet flat on the floor approximately 12 inches apart. The foot nearest the head of the bed should be turned in that direction. Grasp the rolled lift sheet on both sides of the resident at the thighs and shoulders. On the count of '1,2,3,go,' lift the resident toward the

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F 324	Continued From page 8 head of the bed. (Note: Flex your knees and shift the weight to the front foot.)"	F 324		
F 328 SS=D	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; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure oxygen was provided at the rate of flow ordered by the physician for 1 (Resident # 4) of 3 case mix residents (Resident #4, 5 and 12) who received oxygen therapy. This failed practice had the potential to affect 6 residents in who received oxygen according to the list provided by the DON (Director of Nursing) on 3/30/07 at 9:00 a.m. The findings are: Resident #4 had diagnosis of Quadriplegia, Upper Respiratory Disease, History of Pneumonia, Convulsions, and Decubitus Ulcers. The Medicare 5 day Minimum Data Set dated 3/18/07 documented the resident was severely impaired in cognitive skills for daily decision making, had Pneumonia and Respiratory infection, was unable to lie flat due to shortness of breath, had recurrent lung aspirations in the last 90 days and	F 328		

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F 328	Continued From page 9 received Oxygen therapy. a. A physician orders dated 3/14/07 documented Oxygen at 3 liters per minute via nasal canula b. On 3/26/07 at 2:37 p.m., 3/26/07 at 7:40 p.m., 3/27/07 at 7:40 a.m. and 5:27 p.m. and 3/28/07 at 8:40 a.m., the resident received oxygen at 2 liters per minute by nasal canula. c. The March 2007 Medication Administration Record (MAR) documented Oxygen was to be administered at 3 liters per minute via nasal canula. The MAR had a space for nurse documentation of flow rate documentation once each shift, or 3 times each day. The boxes were initialed for each shift from the first through the 28th of March. d. On 3/29/07 at 8:45 a. m., LPN (Licensed Practical Nurse) #1 was asked if she documented the Oxygen flow rate when she passed medications. She stated, "Yes, [Resident #4]. hers is 3 liters a minute."	F 328		