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BATESVILLE HEALTHCARE CENTER	**1975 WHITE DRIVE** **BATESVILLE, AR 72501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #11476 was unsubstantiated.	F 000		
F 151 SS=B	483.10(a)(1)&(2) EXERCISE OF RIGHTS The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on interview the facility failed to ensure 5 (Residents #7, #11, #12, #13 and #20) of 8 (Residents #4, #7, #9, #11, #12, #13, #15 and #20) case mix residents who wanted to vote were allowed to exercise their rights as a citizen of the United States. This failed practice had the potential to affect 18 residents in the facility who were capable of voting, according to the Medicare Manager on 5/26/06 at 8:15 a.m. The findings are: 1. On 5/25/06 at 10:00 a.m., during the group interview, the residents stated that no one had voted and that absentee ballots had not been mentioned to them for the May 23, 2006 election. 2. On 5/25/06 at 7:40 a.m., the Administrator was asked if the residents had voted in the election on Tuesday, May 23, 2006. The Administrator stated that she did not know but would contact the Social Director who was out following surgery. 3. On 5/25/06 at 10:42 a.m., the Administrator	F 151		

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 151	Continued From page 1 stated that she had contacted the Social Director on the telephone and asked about the resident voting. The Administrator stated that the facility did not get the absentee ballots for voting in the primary election. The Administrator stated "They always vote in the regular election, we just missed this one."	F 151		
F 176 SS=B	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a resident was assessed prior to allowing the resident to self administer updrafts for 1 (Resident #12) of 6 case mix residents (Residents #4, #6, #9, #12, #13 and #14) who receive updrafts. This failed practice had the potential to affect 17 residents who receive updrafts, according to the Nurse Consultant on 5/26/06 at 11:40 a.m. The findings are: 1. The facility's policy entitled "Self-Administration of Medication" documented: "General Guidelines: 1. A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician. 2. ... d. The nurse supervisor must record in the resident's medical record that self-administration has been authorized ..." 2. Resident #12 had a diagnosis of Chronic	F 176		

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F 176	Continued From page 2 Airway Obstruction. The Admission Minimum Data Set dated 4/5/06 documented that the resident had modified independence in cognitive skills for daily decision. a. A Physician order dated 3/28/06 documented: "Xopenex Sol (solution) 0.63 mg (milligrams) per 3 ml (milliliters) administered updraft QID (four times a day) prn (as needed)." b. On 5/23/06 at 10:20 a.m., the resident was in bed on the right side with the updraft mouthpiece in his mouth. There was no nurse present in the resident's room during the administration of the updraft. c. On 5/25/06 at 11:00 a.m., the resident was asked if the nurses stay with him during the administration of his updraft treatments; the resident stated, "No."	F 176		
F 248 SS=B	483.15(f)(1) ACTIVITIES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure individualized activities were provided for 3 (Residents #3, #6 and #9) of 5 (Residents #3, #4, #5, #9 and #13) case mix residents on an individualized activity program. This failed practice had the potential to affect 10 residents on the individualized activity	F 248		

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F 248	Continued From page 3 program, as identified by the Activity Director on 5/26/06. The findings are: 1. The Individual Programming activity logs for Residents #3, #6 and #9, provided by the Activity Director, were copied on 5/24/06 at 11:00 a.m. 2. Resident #3 had diagnosis of Dysphagia, Difficulty in Walking, Depression Psychosis, Anxiety State, Cerebral Palsy and Depressive Disorder. The Quarterly Minimum Data Set (MDS) dated 5/10/06 documented the resident had short/long-term memory problems, moderately impaired cognitive skills for daily decision making, socially inappropriate behavior, required extensive assistance for activities of daily living (ADL) and spent an average time involved in activities of from 1/3 to 2/3 of the time. a. The Individual Programming form, completed by the Activity Director, documented for the month of May 2006: "5/11/06 10 min (minutes) current event, R(resident) enjoyed staff reading. 5/19/06, 45 min, Dance, R attended dance, seemed to enjoy, smiled a lot." The resident was invited to attend one group activity on 5/5/06 and declined. b. There were no other activities documented as having been offered for the month of May 2006. 3. Resident #6 had diagnoses of Psychosis, Chronic Ischemic Heart Disease, Insomnia and Anxiety State. The Quarterly MDS dated 4/21/06 documented the resident had short/long-term	F 248		

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memory problems, moderately impaired cognitive skills for daily decision making, was totally dependent for ADLs and spent an average time involved in activities of from 1/3 to 2/3 of the time.

a. The Individual Programming form completed by the Activity Director documented for the month of May 2006:

"5/4/06 10 min (minutes) check up, R (Resident) confused this day."

"5/15/06 10 min check up, talked about R daughter. R enjoyed the company.

5/19/06, 45 min, Dance, R joined other in DR (dining room) for live music & a dance R seemed to enjoy."

b. The resident's Individual Programming form documented, for May 2006, no other activities the resident had been invited to or any other individual activities the resident had been offered.

4. Resident #9 had diagnoses of Difficulty in Walking, Malaise and Fatigue, Paranoid State, Anxiety Disorder, Dementia, Insomnia, Presenile Depression and Transient Organic Mental Disorder. The Quarterly MDS dated 4/28/06 documented the resident had short/long-term memory problems, modified independence in cognitive skills for daily decision making, required total dependence for ADLs and spent an average time involved in activities of from 1/3 to 2/3 of the time.

a. The Individual Programming form completed by the Activity Director documented for the month of May 2006:

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F 248	Continued From page 5 "5/9/06 10 min (minutes) current event, R(resident) enjoyed staff reading." b. The resident was invited to two group activities which were declined. The resident did not receive any other individual activities. 5. On 5/25/06 at 11:45 a.m., the Activity Director stated her activity log book was current and up to date. 6. Activities were not offered two times per week as the Activity Director stated they should have been, according to the Individual Programming activity logs provided by the Activity Director.	F 248		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure linoleum was secured to the floor and met the base of the wall in the beauty shop and 300 Hall hopper room, the floor tile was in good repair in the sitting area, floors in resident rooms were free of stains, wax and dirt buildup around the walls, doors were free of gouges, over bed table frames were clean and free of debris and ceiling tiles were in good repair. This failed practice had the potential to affect 86 residents in the facility, according to the Resident Census and Conditions of Residents form dated 5/22/06. The findings are:	F 253		

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1. During an environmental tour with the Maintenance Director and the Environmental Supervisor on 5/23/06 at 3:15 p.m., the following observations were made:

a. The linoleum in the beauty shop and the 300-Hall hopper room was coming away from the wall along the edge approximately 1 to 1 and 1/2 inches; the edge of the linoleum was turning up around the entire perimeter of the room.

b. In the sitting area next to the Nurses' work station, one floor tile measuring approximately 2 by 4-inches was missing from under the table holding the television.

c. At the head of Bed "B" in Resident Room #519 there was a yellow stain measuring approximately 1-foot by 4-inches along the wall.

d. In Resident Room #618 a ceiling tile was dislodged, leaving a gap of approximately 1-inch on two sides of the tracking.

2. On 5/23/06 at 12:05 p.m., there was a build-up of dirt and wax along the base boards in Resident Room #514.

3. On 5/23/06 at 12:15 p.m., the entry door to Resident Room #604 had multiple gouges and chips ranging from 1-centimeter (cm) to 0.25 cm in size on the edge of the door, next to the hinges.

4. On 5/24/06 at 1:45 p.m., in Resident Room #307:

a. The entry door into the room had 14 gouges on

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F 253	Continued From page 7 the edge of the door closest to the door hinges. The gouges ranged from 1 to 0.5 cm in size. b. The over bed table had dried white/yellow/tan substances on the frame. 5. On 5/25/06 at 7:35 a.m., in Resident Room #607, the base board along the bathroom wall, with the commode, had a build up of dirt and wax.	F 253		
F 279 SS=B	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to accurately assess Hospice care on the	F 279		

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F 279	Continued From page 8 Minimum Data Set and include Hospice care in the resident's plan of care for 1 of 1 (Resident #6) case mix resident. This failed practice had the potential to affect one resident receiving Hospice care. The findings are: Resident #6 had diagnoses of Chronic Aortic Stenosis, Dementia and Hypertension. The Quarterly Minimum Data Set dated 4/21/06 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive to total dependence for activities of daily living and monitoring of an acute medical condition. a. The Physician Orders dated May 2006 documented: "11/22/05 Hospice Pt (patient) -- Continue all medications." b. The Quarterly Minimum Data Set dated 4/21/06 did not have Hospice care marked in the section of "Special Treatments, Procedures, and Programs." c. The resident's plan of care revised on 5/1/06 did not address Hospice care. d. There was no documentation of the Hospice programs plan of care for the resident in the medical record. e. On 5/24/06 at 2:12 p.m. the Director of Nursing Services stated "They [Hospice] come every day and the RN [Registered Nurse] comes one time a week and we can call them anytime." She then reviewed the resident's medical record and stated "We missed it, it is not on there. It [Hospice on the MDS and the plan of care] must have slipped through the crack."	F 279		

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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 personal hygiene was provided for 6 (Residents #1, #2, #4, #6, #8 and #9) of 8 case mix residents who were incontinent and required assistance with Activities of Daily Living (ADL) (Residents #1 thru 6, #8, and #9). This failed practice had the potential to affect 42 residents who were incontinent and required assistance with ADLs, according to the listing provided by the Director of Nursing on 5/25/06 at 4:35 p.m. The findings are: 1. The facility's entitled "Perineal Care" documented: "Infection Control Protocol and Safety: 3. Maintain clean technique ... Steps in the Procedure: ...9. For a female resident: ... b. Wash perineal area, wiping from front to back (1) separate labia and wash area downward from front to back. ... (2) Continue to wash the perineum moving from inside outward to and including thighs, ... e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. ... 10. For a male resident: ... b. Wash perineal area starting with urethra and working outward ... (1) Retract foreskin of the uncircumcised male. (2). Wash and rinse urethral area using a circular	F 312		

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motion. (3) Continue to wash the perineal area including the penis, scrotum and inner thighs. ... h. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus and buttocks."

2. Resident #1 had diagnoses of Paranoid Schizophrenia and Debility. The Annual Minimum Data Set (MDS) dated 4/7/06 documented that the resident had severely impaired cognitive skills for daily decision making, was totally dependent on 2 + persons for toilet use and was incontinent of bowel and bladder.

a. The Care Plan documented: "Problem/Need: Potential for complications due to is incontinent of b/b (bowel/bladder), pad and brief in use daily, resident is unable to make needs known to staff, requires total care in all adl's (Activities of Daily Living) ... Approaches: Cna's (Certified Nurses Assistants) to check q (every) 2 hr (hour) clean and dry turning and repositioning resident. Monitor skin integrity for redness rash excoriation..."

b. On 5/24/06 at 11:30 a.m., Certified Nurses Assistant (CNA) #3 and CNA #4 provided incontinent care for the resident; when the CNAs removed the resident's covers, the resident was on the left side and was wearing a brief. There was urine on the residents sheet and the resident was wet from the left lower abdomen to the left upper thigh area. The CNAs provided incontinent care, but did not clean the urine from the resident's left side, hip or upper thigh.

c. On 5/24/06 at 12:00 p.m., CNA #3 and CNA #4 were asked if they had cleaned the urine from the resident's left side, hip or upper thigh; the CNAs

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stated "No." When asked if they should have cleaned the urine off the resident, the CNAs stated "Yes."

3. Resident #2 had diagnoses of Paranoid Schizophrenia, Hallucinations and Dementia. The Quarterly MDS dated 5/5/06 documented the resident had moderately impaired cognitive skills for daily decision making, was totally dependent for toilet use and incontinent of bladder.

a. The Care Plan, reviewed on 5/5/06, documented: "Problem/Need: Potential for complications due to the resident is incontinent of bladder, unable to control self, has confusion at times, requires supervision with most adl's ... Approaches: Cna's to check q 3 hr, clean and dry as needed..."

b. On 5/24/06 at 7:55 a.m., CNA #6 and CNA #7 provided incontinent care; the resident was on her back and the incontinent pad was wet with urine. CNA #6 cleaned the resident's left groin, right groin and mid-labia area from the front to half way to the back; the resident's sheets were changed and an adult brief was applied.

The CNAs did not clean the lower half of the labia and the groin areas, nor did they clean the urine from the resident's buttocks, rectal area, inner or posterior thighs.

c. On 5/24/06 at 8:30 a.m., CNA #6 was asked why she only cleaned part way down the resident's groin areas and mid labia; the CNA stated, "I thought we were going to roll [resident] over and I'd clean it from the back."

When asked why didn't you wash the urine from

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the buttocks, rectum, posterior or inner thighs, CNA #6 stated "I thought we'd turn [resident] over and I'd do that then."

4. Resident #8 had diagnoses of Hallucinations and Schizophrenia. The Annual MDS dated 4/14/06 documented that the resident had moderately impaired cognitive skills for daily decision making, was incontinent of bowel and bladder and required extensive assistance for toilet use.

a. The Care Plan documented: "Problem/Need: Potential for complication due to requires total care with bed mobility, dressing, toilet us... Approaches: Cna's to check q 2 hr, clean and dry..."

b. On 5/24/06 at 1:55 p.m., CNA #8 and CNA #9 provided incontinent care; the resident had been incontinent of bowel and bladder and was returned to bed and the resident's brief was removed. The CNAs both cleaned the resident's rectal and buttocks, as the resident was turned from side the side.

When CNA #9 was asked why the resident was not cleaned through the groin and labia, the CNA stated "[Resident] usually doesn't let us, so I didn't try."

5. Resident #6 had diagnoses of Urinary Tract Disorder, Debility and Psychosis. The Quarterly MDS dated 4/21/06 documented the resident had moderately impaired cognitive skills for daily decision making and required extensive assistance for activities of daily living.

a. On 5/24/06 at 9:03 a.m., CNA #5 and CNA #6

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BATESVILLE HEALTHCARE CENTER	**1975 WHITE DRIVE BATESVILLE, AR 72501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 13 assisted the resident to the bedside commode. The CNAs removed the resident's brief, which was wet according to CNA #5. The resident urinated in the bedside commode; CNA #5 then wiped the resident from the mid labia to the rectum using toilet paper. A clean brief was applied and the resident was assisted back to bed. The CNAs did not provide incontinent care. b. On 5/24/06 at 9:20 a.m., CNA #5 and CNA #6 were asked if the resident had been incontinent and if the brief that was removed was wet; CNA #5 stated "Yes." When asked if they had cleaned the urine off of the resident, the CNAs stated "No, we forgot." 6. Resident #4 had diagnosis of Cerebrovascular Accident and Urinary Incontinence. An MDS dated 4/21/06 documented the resident had moderately impaired cognitive skills for daily decision making. (Any toileting, hygiene and incontinent info on MDS???) a. The resident's plan of care revised on 4/19/06 documented: "Problem/need: Potential for complications due to resident is incontinent of bowels/bladder requires total care in most adl's (activities of daily living)." The plan of care documented as an approach: "cna's (Certified Nursing Assistants) to check q 2hr (every two hours) clean and dry." b. On 5/24/06 at 10:15 a.m., CNA #1 sprayed a wet wash cloth with peri-wash and spread the resident's legs; the CNA wiped down the left groin one swipe and changed to a new cloth, then wiped down the right groin in one swipe. The resident was then turned for peri-care to buttocks. The scrotum was not cleaned.	F 312		

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F 312	Continued From page 14 5. Resident #9 had diagnoses of Muscle Disuse Atrophy and Osteoarthritis. An MDS dated 4/28/06 documented the resident had modified independence in cognitive skills for daily decision makings. a. The resident's plan of care revised on 4/28/06 documented: "Problem/need: resident is at risk for the development of pressure ulcers due to has a history of skin break down requires total care." b. The plan of care documented: "target goal: the resident will be kept clean and dry." An approach on the plan of care was: "cnas to check q 2 hrs clean." c. On 5/24/06 at 9:55 a.m., during the provision of incontinent care by CNA #1, the resident's labia was not spread for cleansing, nor were the resident's buttocks washed. When asked how he was taught to do peri care, the CNA stated that he had been taught to wipe down each side, then down the middle in the front using different cloths for each wipe, then turn resident over and wipe down the middle with different cloths and pat dry. He then stated that with men it is the same except you clean the foreskin.	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	F 323		

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F 323	Continued From page 15 by: Based on observation the facility failed to ensure the 500 Hall shower room had ceramic tiles that were free of sharp edges. This failed practice had the potential to affect 32 residents who used the 500 Hall shower room, as identified by the Administrator on 5/25/06. The findings are: On 5/23/06 at 3:15 p.m., during environmental rounds with the Maintenance Director and the Environmental Supervisor, the 500 Hall shower had two broken 2-inch ceramic tiles on the seat area to the left of the entry, ceramic corner tiles broken and missing in an area approximately 2-inches in a triangular shape, 1 ceramic tile on the corner (two tiles up from the floor) that had approximately 1-inch broken and missing and on the left shower stall wall on the right corner at the entry, an area approximately 2-inches in width was broken out of the tile located 2 tiles up from the floor. All of the broken tiles had sharp jagged edges.	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, record review and interview the facility failed to ensure a soft belt restraint was tied in manner to enable rapid release for 1 (Resident #5) of 3 (Residents #3, #5 and #10) case mix residents who required a soft belt belt restraint. This failed practice had the	F 324		

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F 324	Continued From page 16 potential to affect 6 residents with soft belt restraints, according to the listing provided by the Director of Nursing on 5/26/06 at 10:00 a.m. The findings are: 1. The manufacturers directions on the application of a soft belt restraint documented: "Put the belt over the patient's lap, soft foam down. Bring the straps over the hips, down and under the chair at a 45 degree angle, attach around the back post, and secure them at a juncture of the frame which will not allow the straps to slide ... Secure them out of the patient's reach with a quick release tie or buckle." 2. Resident # 5 had diagnoses of Alzheimer's Dementia, Psychosis, and Schizoaffective Disorder Bipolar Type. The Quarterly Minimum Data Set dated 4/28/06 documented that the resident had severely impaired cognitive skills for daily decision making and used a trunk restraint daily. On 5/23/06 at 11:10 a.m., the resident was up in the wheelchair with a soft belt restraint on. The ties of the restraint went between the back of the wheelchair and the seat and were then crossed multiple times behind the chair, in the center, resulting in a braid-like appearance. The ties were then tied in a slip knot to the lower chair frame.	F 324		
F 328 SS=B	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;	F 328		

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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 administered at the Physician ordered flow rate for 3 (Residents #3, #4 and #13) and the oxygen concentrator filter was free of debris for 1 (Resident #13) of 5 (Residents #3, #4, #6, #9 and #13) case mix residents. This failed practice had the potential to affect 13 residents who had Physician orders for oxygen therapy, as identified by the Director of Nurses (DON) on 5/25/06. The findings are:

1. The Manufacturer's instructions for setting flow meters on concentrators documented: "Bisect the ball with the line on the flowmeter with the line on the Remote Flowmeter when setting the prescribed flowrate. This will ensure an accurate flowrate."

2. Resident #13 had diagnoses of Chronic Airway Obstruction and Congestive Heart Failure. An Annual MDS dated 2/24/06 documented that the resident had modified independence in cognitive skills for daily decision making and received oxygen therapy.

a. A Physician order dated 3/3/05 documented: "O2 @ 1 liter/minute via nasal cannula."

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F 328	Continued From page 18 b. On 5/22/06 at 12:57 p.m., the resident was sitting up in a chair in his room, eating lunch; he was receiving oxygen via nasal cannula at 1 and 1/2 liters per minute. Both oxygen concentrator filters were covered with a light covering of dust/lint/dirt that flew into the air when the filters were scrapped with a finger nail. c. On 5/23/06 at 6:10 p.m., the resident was propelling himself in a wheelchair; the resident's nasal cannula was in place and the tubing was connected to a portable oxygen E-tank affixed to the wheelchair. The setting on the tank of oxygen was just over the very beginning of the zero on the gauge. d. On 5/26/06 at 8:30 a.m., the DON stated the setting on a portable oxygen tank for 1 liter per minute was just past the zero. When asked if when the needle was just at the beginning of the zero, was it at 1 liter, the DON stated "No." 3. Resident #4 had diagnoses of Chronic Airway Obstruction and Congestive Heart Failure. A Quarterly Minimum Data Set (MDS) dated 4/21/06 documented the resident had moderately impaired cognitive skills for daily decision making and received oxygen therapy. a. A Physician order dated 10/26/05 documented: "O2 (oxygen) at 2L/M (2 liters per minute) PRN (as needed)." b. On 5/22/06 at 4:35 p.m., the resident was in bed with his oxygen on. The resident's oxygen concentrator flow rate was set with the regulator ball in the space between the 1 and 1/2 and 2 liter lines, instead of bisecting the 2 liter line to deliver the ordered 2 liters of oxygen needed by the	F 328		

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F 328		F 328		

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resident.

c. On 5/23/06 at 8:34 a.m., the resident was in bed with oxygen on. The resident's oxygen concentrator flow rate was set with the regulator ball in the space between the 1 and 1/2 and 2 liter lines, instead of bisecting the 2 liter line to deliver the ordered 2 liters of oxygen needed by the resident.

d. On 5/24/05 at 8:20 a.m., the resident was in bed with oxygen on. The resident's oxygen concentrator flow rate was set with the regulator ball in the space between the 1 and 1/2 and 2 liter lines, instead of bisecting the 2 liter line to deliver the ordered 2 liters of oxygen needed by the resident.

e. On 5/24/06 at 10:15 a.m., the resident was in bed with oxygen on. The resident's oxygen concentrator flow rate was set with the regulator ball in the space between the 1 and 1/2 and 2 liter lines, instead of bisecting the 2 liter line to deliver the ordered 2 liters of oxygen needed by the resident.

4 . Resident #3 had a diagnosis of Acute Respiratory Failure. A Quarterly MDS dated 5/10/06 documented the resident had moderately impaired cognitive skills for daily decision making and received oxygen therapy.

a. The resident's May 2006 Physician orders documented: "O2 @ 2L/Minute (O2 at 2 liters per minute) via nasal cannula PRN (as needed)."

b. On 5/23/06 at 5:20 p.m., the resident was in his room sitting in his recliner with his oxygen on; the oxygen concentrator flow rate was set in the

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F 328	Continued From page 20 space between 2 and 2 - 1/2 liters.	F 328		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the 8:00 a.m. medication pass on 5/25/06, record review and interview the facility failed to ensure that the medication error rate was less than 5%. Physician orders were not followed for 3 residents (Residents #19, #20 and #21) of 5 residents observed during medication passes, resulting in medication errors. Medication errors were made by 2 Licensed Practical Nurses (LPN) (LPN #1 and LPN #2) of 3 nurses administering medications in the facility. This failed practice had the potential to affect 36 residents in the facility, according to the Roster/Matrix on 5/22/06 at 2:45 p.m. The medication error rate was 7.54% based on administration of 51 medications and the omittance of 2 medications with 4 medication errors observed. The findings are: 1. Resident #19 had a Physician order dated 1/29/04 for Lactaid Caplets give 1 caplet po (by mouth) tid (three times a day) ac (before meals). a. On 5/25/06 at 8:10 a.m., LPN #1 administered Lactaid to the resident. b. When asked if they had breakfast this morning, the resident stated, "Yes."	F 332		

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F 332	Continued From page 21 c. When asked if the resident had eaten, the LPN stated, "In the dining room around 7:00 a.m." 2. Resident #20 had a Physician telephone order dated 5/24/06 for Garamycin ophthalmic drops 2 drops in both eyes tid. a. On 5/25/06 at 8:52 a.m., LPN #2 administered Gentamicin 2 drops in each eye immediately, without anytime between drops. b. On 5/25/06 at 8:52 a.m., the LPN stated, "I do not have to wait between drops, because it is the same medication." c. The CMS guideline: Medication Errors to Failure to Follow Manufacturers Specifications or Accepted Professional Standards. "Medication Instilled into the Eye: The administration of eye drops without achieving the following critical objectives: Eye Contact: The eye drop, but not the dropper, must make full contact with conjunctival sac and then be washed over the eye when the resident closes the eyelid; and Sufficient Contact Time: The eye drop must contact the eye for a sufficient period of time before the next drop is instilled. The time for optimal eye drop absorption is approximately 3 to 5 minutes." 3. Resident #20 had a Physician order dated 4/11/06 for Vitamin C 500 mg (milligram) bid (twice a day). On 5/25/06 at 8:52 a.m., all of the resident's 8:00 a.m. medications were administered, except the Vitamin C 500 mg. 4. Resident #21 had a Physician order dated 3/17/06 for Celexa 40 mg daily.	F 332		

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F 332	Continued From page 22 On 5/25/06 at 8:58 a.m., all of the resident's 8:00 a.m. medications were administered, except the Celexa 40 mg.	F 332		
F 333 SS=E	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 of the 8:00 a.m. medication pass on 5/25/06, record review and interview the facility failed to ensure Physician orders were followed to ensure that residents were free of significant medication errors. 1 resident (Resident #20) of 5 residents observed during the medication pass was found to have a significant medication error. A significant medication error was made by 1 (LPN #2) of 3 Licensed Nurses that administered medications. This failed practice had the potential to affect 29 residents receiving medications, as identified by the facility on the Roster/Matrix on 5/25/06 at 2:45 p.m. The findings are: a. Resident #20 had a diagnoses of Decubitus Ulcer (bottom of right foot), Alcohol Abuse, Tobacco Use Disorder, Rheumatoid Arthritis and Dermatitis. A Physician order dated 4/11/06 for Vit (Vitamin) C 500 mg (milligram) bid (twice a day); the order was handwritten on a "Physician's Orders" sheet and signed by the Physician. b. On 5/25/06 at 8:52 a.m., during the 8:00 a.m. medication pass, LPN #2 administered all of the resident's 8:00 a.m. medications, except the	F 333		

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F 333	Continued From page 23 Vitamin C 500 mg. c. On 5/25/06, in clinical record review, the resident's May 2006 "Physician's Orders" did not document the Physician order dated 4/11/06 for Vitamin C 500 mg bid and the resident's May 2006 Medication Administration Record (MAR) did not reflect an order for Vitamin C 500 mg bid. According to the May 2006 MAR, the resident did not receive the Vitamin C 500 mg on days 5/1/06 thru 5/25/06, as ordered. d. This was significant due to the frequency of the error and the condition of the resident.	F 333		
F 441 SS=C	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, interview and record review the facility failed to ensure the ice machine located between the 100 and 200 halls was clean and all communicable diseases were investigated and tracked. These failed practices had the potential to affect all 86 residents, according to Resident Census and Condition of Residents	F 441		

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form dated 5/23/06. The findings are:

1. On 5/23/06 at 3:15 p.m., during environmental rounds, the ice machine in the alcove between the 100 and 200 Halls had a pink-reddish slime build-up on the plastic front of the diverter inside the machine.

2. The facility's policy entitled "Infection Control Monitoring" documented "Monitoring Functions: Review all acquired and nosocomial infections monthly and quarterly..."

a. On 5/24/06 at 4:00 p.m., the Infection Control Log was reviewed. The Infection Control Log documented infections for which antibiotics were ordered.

b. On 5/25/06 at 3:30 p.m. the Assistant Director of Nursing (ADON) was asked if the facility tracked any infections or communicable diseases other than those requiring antibiotics. The ADON stated "No."

3. Resident #4 had diagnosis of Methicillin-Resistant Staphylococcus Aureus of the toe. A Quarterly MDS dated 4/21/06 documented the resident had moderately impaired cognitive skills for daily decision making.

a. The resident's plan of care revised on 4/19/06 documented: "Problem/strengths: Potential for complications due to isolation. Goal: Resident will have no complications due to isolation in the next 90 days. Intervention: Use universal precautions when giving care."

b. On 5/24/06 at 10:15 a.m., CNA #1 and CNA #2 were observed during the process of incontinent

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F 441	Continued From page 25 care. CNA #2 took the soiled linen from the resident's bed with gloved hands to a biohazard container in the room. The foot pedal that opened the barrel did not work; the CNA used the linen to push the lid of the container up. She placed the linen in the container; without changing gloves the CNA assisted to make the resident's bed with clean linen. The CNA then took the resident's soiled gown to the container, opened the container with her gloved hand, pushed the gown down into the container and went back to the resident to finish assisting with care. The CNA did not change her gloves throughout the process. c. On 5/24/06 at 2:25 p.m., CNA #1 used a paper towel to lift the linen container lid and gloves to lift the lid of the trash container. When asked why he did not use the foot pedals, he stated "They don't work well and I can't get them open far enough." d. On 5/24/ 06 at 4:30 p.m., the Director of Nursing (DON) was accompanied to the residents room to check the hazardous waste containers. When the lid did not open on the linen container, and the trash container opened some of the time to approximately 3-4 inches with the foot pedals, the DON stated "They need to get them fixed."	F 441		
F 445 SS=D	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	F 445		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 445	Continued From page 26 by: Based on observation, interview and record review the facility failed to ensure washcloths were handled in a manner to prevent possible infections during incontinent care for 1 (Resident #1) of 8 (Residents #1 thru #6, #8 and #9) case mix residents who were incontinent. This failed practice had the potential to affect 43 residents who were incotinent, according to a listing provided by the Director of Nursing on 5/25/06 at 4:35 p.m. The findings are: 1. Resident #1 had diagnoses of Paranoid Schizophrenia and Debility. The Annual Minimum Data Set (MDS) dated 4/7/06 documented that the resident had severely impaired cognitive skills for daily decision making, was totally dependent on 2 + persons for toilet use and was incontinent of bowel and bladder. a. The Care Plan (Page 11 of 15) documented: "Problem/Need: Potential for complications due to is incontinent of b/b (bowel/bladder), pad and brief in use daily, resident is unable to make needs known to staff, requires total care in all adl's (Activities of Daily Living) ... Approaches: Cna's (Certified Nurses Assistants) to check q (every) 2 hr (hour) clean and dry turning and repositioning resident." b. On 5/24/06 at 11:30 a.m., Certified Nurses Assistant (CNA) #3 and CNA #4 provided incontinent care for the resident. CNA #4 wet four washcloths and handed them to CNA #3. CNA #3 placed the wet washcloths across the foot board. CNA #3 set up two plastic bags for trash and linens at the foot of the resident's bed and used all of the washcloths when cleaning the resident's	F 445		

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 05/26/2006

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F 445	Continued From page 27 groin and mid labia. CNA #4 wet three more washcloths and handed them to CNA #3, who hung the wet washcloths across the foot board. CNA #4 used all of the washcloths when cleaning the residents buttocks and rectal area. When the resident was turned to the left side, CNA #3 wet four more washcloths and hung them on the right side rail. CNA #3 then used two of the washcloths when cleaning the resident's right buttocks and rectum. c. On 5/25/06 at 3:30 p.m., when was asked if wet washcloths should be hung on the foot board or side rails before using the washcloths for incontinent care, the Assistant Director of Nursing (ADON) stated, "No."	F 445		
F 468 SS=B	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure handrails were secured to the wall in resident areas. This failed practice had the potential to affect 5 residents on 300 Hall that were independently ambulatory or wheelchair mobile, as identified by the Director of Nurses on 5/25/06. The findings are: 1. The following observations were made during a tour with the Maintenance Director and the	F 468		

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 05/26/2006

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F 468	Continued From page 28 Environmental Supervisor conducted on 5/23/06 at 3:15 p.m.: a. Approximately 4-feet of handrail, located to the right of the entry door to Resident Room #311 was loose and not secured to the wall. b. Approximately 4-feet of handrail, located between Resident Room #307 and the exit door leading to the resident smoking area was loose and not secured to the wall.	F 468		