STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045304	A. BUILDING ______ B. WING ______	R-C 03/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEBE RETIREMENT CENTER, INC.	**709 MCAFEE LANE BEEBE, AR 72012**

(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 324} SS=E	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: Rewritten Deficiency Based on observation, interview and record review, the facility failed to ensure that interventions to prevent the recurrence of falls were consistently implemented for 5 (Residents # 3, 5, 6, 7 and 8) of 8 (Residents #1, 2, 3, 4, 5, 6, 7 and 8) case mix residents at risk for falls. These failed practices had the potential to affect 68 residents at risk for falls as identified by a list provided by the Administrator on 3/7/07. The findings are: 1. Resident # 5 had diagnoses of Alzheimer's Dementia with behaviors and Seizures. The Minimum Data Set (MDS) dated 1/15/07 documented the resident had moderately impaired cognitive skills for daily decision-making, had a seizure disorder, an unsteady gait and had fallen in the past 30 days. a. The Plan of Care dated 1/5/07 and last updated 2/21/07 documented, " ... Potential for falls related to history of falls. ..." On 1/5/07 the Plan of care documented, " ... Alert staff/resident [and] family to risk for falls. Re-educated 1/5/07 (hand written in margin) Educate resident [and] family about Fall Risk Plan. Place call light in reach if able to use. Assure basic care needs are met: glasses, hearing aide, footwear, cane/walker available, personal items in reach. Assess foot	{F 324}		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045304	A. BUILDING ______ B. WING ______	R-C 03/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEBE RETIREMENT CENTER, INC.	**709 MCAFEE LANE BEEBE, AR 72012**

(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 324}	Continued From page 1	{F 324}		

wear for sticking to the floor/remind to wear shoes." On 1/7/07 the Care Plan documented, "... Refer to OT (occupational Therapy)/PT (Physical Therapy) for screening. Self - release belt ... " On 1/8/07 the Care Plan documented, "Assess for least restrictive device by OT ..." On 1/23/07 the Care Plan documented, "... Use bed alarm." On 1/24/07 the Care Plan documented, "Use chair alarm" ... On 2/21/07 the Care Plan documented, "Use low bed [and] fall pad when resident in bed ..." Under the section for Dates of actual falls, documented: "... 2/21/07 - Fd (Found)/ floor - Anti roll backs ..."

b. The Unusual Occurrence Report dated 1/4/07 and time of occurrence 0140 (1:40 a.m.) documented, "Res (resident) lying on L (left) side on floor beside bed." The box indicating Side rails use, the box indicating the side rails were up was checked.

c. The Unusual Occurrence report dated 1/7/07 and time of occurrence 0245 (2:45 a.m.)documented, "Resident found sitting in floor in room, bed SR (side rails) are (arrow up) up. CNA (Certified Nursing Assistant) states alarm was attached to resident, that resident removed alarm." Written at the bottom of form dated 1/8/07 documented, " ... Self release belt applied".

d. The Unusual Occurrence report dated 1/23/07 and time of occurrence 11:00 p.m., documented, "... Found in floor on knees. Bed alarm pad on bed did not alarm. Checked for function [and] working now. Bed alarm on bed."

e. The Unusual Occurrence report dated 1/24/07 and time of occurrence 8:00 p.m., documented, "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045304	A. BUILDING ______ B. WING ______	R-C 03/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEBE RETIREMENT CENTER, INC.	**709 MCAFEE LANE** **BEEBE, AR 72012**

(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 324}	Continued From page 2 ... Found on floor. Had self release belt on chair & chair alarm, had released. ... Use chair alarm in seat." f. The Unusual Occurrence report dated 2/21/07 and time of occurrence 1:10 a.m. documented, "Observed res (resident) lying on R (right) side on the floor, alarm sounding off, Side rails up. Care plan intervention for res to have low bed, res has attempted to crawl over side rails prior on 2/13/07." The witness statement documented, "He somehow got in the floor with side rails still up, on his side, and a piece broken off the side rail on the other side of the room ..." g. The Unusual Occurrence report dated 2/21/07 at 1330 (1:30 p.m.) documented, "Found lying on floor behind door in room. Intervention - Anti Roll Backs". h. On 3/5/07 at 1:40 p.m., and on 3/6/07 at 3:25 p.m., the resident was observed sitting in a wheelchair with the clip of a personal alarm dangling and not hooked to the resident. i. On 3/5/07 at 1:40 p.m., 3:10 p.m., 6:50 p.m. and 7:35 p.m. and on 3/6/07 at 12:15 p.m., 3:25 p.m. and 4:00 p.m., the resident was observed in a wheelchair that was not equipped with an anti roll back device. j. On 3/7/07 at 8:45 a.m., the Physical Therapist verified there was not an anti roll back device present on the wheelchair that the resident was in. 2. Resident # 6 had diagnoses of Vascular Dementia with Depression, Muscle Wasting and Difficulty Walking. The MDS dated 1/31/07	{F 324}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045304	A. BUILDING ______ B. WING ______	R-C 03/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEBE RETIREMENT CENTER, INC.	**709 MCAFEE LANE BEEBE, AR 72012**

(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 324}	Continued From page 3	{F 324}		

documented the resident had moderately impaired cognitive skills for daily decision-making, did not ambulate, was dependent on staff for transfers, had fell in the past 30 days and had fell in the past 31 - 180 days.

a. The Plan of Care dated 2/11/07 documented, "Potential for falls related to history of falls. Use chair pad."

b. The Physician's Order Sheet for March 2007 documented, "Chair alarm on when up in chair".

c. The Unusual Occurrence Report dated 1/28/07 documented, "Resident removed her personal alarm & transferred self unassisted. Resident found on floor of hallway in front of w/c (wheelchair). Intervention: Chair alarm to be placed on resident's chair."

d. On 3/5/07 at 1:30 p.m., the resident was observed propelling herself in hallway in a wheelchair. A personal alarm, not a chair alarm, was on the wheelchair but was not attached to resident.

3. Resident # 7 had diagnoses of Alzheimer's Dementia, Arthritis and Low Back Pain. The MDS dated 2/23/07 documented the resident had moderately impaired cognitive skills for daily decision-making, required extensive assistance with transfers, did not ambulate and had fallen in the past 31-180 days.

a. The Physician's Order Sheet for March 2007 documented, "Chair Alarm on when up in chair. Check placement and working q (every) shift".

b. The Plan of Care dated 2/28/07 documented,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045304	A. BUILDING ____ B. WING ____	R-C 03/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEBE RETIREMENT CENTER, INC.	**709 MCAFEE LANE** **BEEBE, AR 72012**

(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 324}	Continued From page 4 "Potential for falls related to history of falls. Use chair alarm". c. On 3/6/07 at 6:50 a.m., 7:30 a.m. and 8:30 a.m., 11:35 a.m. and 12:40 a.m., the resident was sitting in a wheelchair with the clip of the personal alarm dangling and not attached to the resident. At 1:00 p.m., the Director of Nursing was informed of the alarm being unhooked and fastened it onto the resident. d. On 3/6/07 at 3:25 p.m., the resident was sitting in the wheelchair. The personal alarm was not attached to the resident. 4. Resident # 8 had diagnoses of Alzheimer's Dementia and Anemia. The MDS dated 12/11/06 documented the resident had severely impaired cognitive skills for daily decision-making, required extensive assistance with transfers and ambulation, had an unsteady gait and no falls in past 30 days nor any falls in the past 31 - 180 days. a. The Plan of Care dated 10/4/06 documented, "Potential for falls related to history of falls. Use chair alarm". b. On 3/6/07 at 6:50 a.m., the resident was sitting in a wheelchair on a pillow. The clip to the personal alarm was attached to the edge of the pillowcase. c. On 3/6/07 at 8:10 a.m., CNA's # 1 and # 2 assisted the resident to stand up and transfer to the bedside commode. The alarm clip was still attached to the edge of the pillowcase and the alarm did not sound.	{F 324}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045304	A. BUILDING ______ B. WING ______	R-C 03/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEBE RETIREMENT CENTER, INC.	**709 MCAFEE LANE** **BEEBE, AR 72012**

(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 324}	Continued From page 5	{F 324}		

Surveyor: Worsham, Charlene

5. Resident #3 had a diagnosis of Vertebral Fracture. The quarterly MDS dated 12/15/06 documented the resident had moderately impaired cognitive skills for daily decision making skills, required extensive assistance of staff for transfers, fell in the past 31 - 180 days and other fracture in last 180 days.

a. The resident's plan of care documented: self-releasing belt to be on when up in w/c (wheelchair) or chair secondary to falls.-poor safety awareness-attempts to transfer unassisted. Use bed and chair alarm.

b. The resident's physician order documented: " *Bed Alarm on in bed to help prevent falls".

c. An "Unusual Occurrence Report" dated 1/29/07 documented that the resident was found in the floor laying on her back. The section of the "Unusual Occurrence Report" where staff document whether the resident's bed/chair alarm was in use had "No" checked indicating that the alarm was not in use when the resident fell.

d. On 3/5/07 at 3:07 a.m. the resident was in bed in her room with the surveyor standing in the doorway when CNA (Certified Nursing Assistant # 3) entered the resident's room and checked the resident's bed alarm. The CNA turned the alarm on and stated that the alarm was off when asked by the surveyor if the alarm was off.

e. On 3/6/07 at 3:37 p.m. the resident was in her bed and her bed alarm green light was not flashing that indicated the alarm was turned on. The DON (Director of Nurses) was asked to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045304	A. BUILDING ____ B. WING ____	R-C **03/08/2007**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEBE RETIREMENT CENTER, INC.	**709 MCAFEE LANE** **BEEBE, AR 72012**

(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 324}	Continued From page 6 check the resident's alarm. When the DON checked the bed alarm the on/off switch was in the off position. The Don moved the alarm switch to the on position and stated that the alarm had been off.	{F 324}		