

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

PRINTED: 05/11/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2007
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 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 164 SS=D	<p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure full visual privacy was provided for 1 (Resident #8) of 6 (Resident #3-6,8, and 9) case mix residents dependent on staff for incontinent care. This failed practice had the potential to affect the 43 residents in the facility who were dependent on</p>	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.

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

PRINTED: 05/11/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2007
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 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 164	Continued From page 1 staff for incontinent care as per list provided by the Assistant Director of Nursing on 4/27/07. The findings are: Resident #8 had diagnoses of Alzheimer's dementia with Behavior Disturbance, Hypertension, Osteoarthritis, Depression and Left Hip Fracture. The Minimum Data Set dated 4/03/07 documented the resident had severely impaired cognitive skills for daily decision making, and was dependent on staff for activities of daily living. a. On 4/23/07 at 3:30 p.m. Certified Nursing Assistant #1 and #2 were putting a gown on the resident. The door was open approximately 2-3 inches, no curtains were drawn around the resident. The resident's nude body was exposed to passersby in the hallway. The Assistant Director of Nursing and surveyor was outside in hallway.	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 toenails were trimmed on one (Resident #8) of 15 (Residents #1-14 and 18) case mix residents and fingernails were clean for 2 (Residents #12 and 18) of 15 (Residents #1-14 and 18) case mix resident's dependent for nail care. The facility also failed to	F 312		

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

PRINTED: 05/11/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2007
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 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 312	Continued From page 2 ensure incontinent care was provided completed for 3 (Residents #3, 5 and 8) of 6 (Residents #3-6,8, and 9) case mix resident's dependent on staff for incontinent care. This failed practice had the potential affect the 43 residents who were dependent on staff for incontinent care and 82 resident's who were dependent on staff for nail care as per the list provided by the ADON (Assistant Director of Nursing) on 4/27/07. The findings are: 1. Resident #8 had diagnoses of Alzheimer's dementia with Behavior Disturbance, Hypertension, Osteoarthritis, Depression, Left Hip Fracture, The Minimum Data Set dated 4/03/07 documented the resident had severely impaired for cognitive skills for daily decision making, and was dependent on staff for activities of daily living. a. On 4/25/07 at 11:07 incontinent care was provided by CNA (Certified Nursing Assistant) #3 and 4. The resident was laying on a wet incontinent pad and the bottom sheet was also wet. Incontinent care was provided to the buttocks and rectal area, the soiled incontinent pad was removed, the resident was left on the wet sheet, turned, and incontinent care continued on the front. The CNA's failed to wash the Mons pubis and did not separate the labia. The resident's left foot which had a dressing covering a pressure sore was also laying on the part of the sheet wet with urine. b. The resident's right great toenail was observed to be long and jagged, and right toenails 3,4, and 5 were growing over the tips of the resident's toes. Toenails on toes 2 and 3 of the left foot were growing over the tips of the toes.	F 312		

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

PRINTED: 05/11/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2007
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 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 312	Continued From page 3 2. Resident #3 had diagnoses of CVA and chronic obstructive Lung Disease. The Minimum Data Set dated 3/16/07 documented the resident had severely impaired cognitive skills for daily decision making, was incontinent of bowel and bladder and dependent on staff for hygiene. a. On 4/25/07 at 10:35 a.m., CNA" #5 and 6 provided incontinent care for the resident. The CNA failed to separated the labia and did not wash the buttocks. 3. Resident #5 had diagnoses of Alzheimer's dementia and Aggressive behavior. The minimum data set dated 3/13/07 documented the resident had severely impaired cognitive skills for daily decision making, was incontinent of bowel and bladder, and was totally dependent on staff for hygiene. a. On 4/25/07 at 10:53 a.m. CNA's #5 and 6 provided incontinent care for the resident. The CNA failed to separate and cleanse the labia. 4. Resident #18 had diagnoses of Atrial fibrillation, Alzheimers, Hypothyroidism, Pain, and Hip fracture. On initial rounds the ADON stated the resident was confused, required total care for activities of daily living and resident fell at home. Resident admitted 4/7/07 MDS assessment not completed. a. On 4/26/07 at 10:04 a.m. and 12:35 p.m. the resident had a black substance under fingernails and cuticles of the right hand. 5. Resident # 12 had diagnoses of Alzheimer's dementia and status post left hip trochanter	F 312		

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

PRINTED: 05/11/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2007
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 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 312	Continued From page 4 nailing. The MDS dated 3/16/07 documented the resident had moderately impaired cognitive skills for daily decision making and was dependent on staff for hygiene. a. On 4/24/07 at 9:25 a.m. the resident had a dark dirt like build up under the fingernails of all 10 fingers and around the cuticles on the left hand. The resident was rubbing her face with her hands. b. On 4/26/07 at 10:04 and 11:05 the resident had a dark dirt like build up underneath her her left index, middle and ring finger. c. On 4/26/07 at 1:50 p.m. and 3:40 p.m. the resident had a dark dirt like build up under all the fingernails of her left hand.	F 312		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure pressure relieving devices were used and/or heels were off loaded to prevent pressure for 1 (Resident #8) of 5 (Residents #1, 3, 4, and 8) case mix residents with pressure sores. This failed practice had the	F 314		

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

PRINTED: 05/11/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/27/2007
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 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 314	<p>Continued From page 5</p> <p>potential to affect the 68 residents in the facility with or at risk for pressure sores as identified on a list provided by the Assistant Director of Nursing on 4/27/07 at 8:45 a.m.. The findings are:</p> <p>Resident #8 had diagnoses of Alzheimer's dementia with Behavior Disturbance, Hypertension, Osteoarthritis, Depression, Left Hip Fracture, Blepharitis, Nutritional Deficiency, Weight Loss, and Dry Eye Syndrome. The Minimum Data Set dated 4/09/07 documented the resident had severely impaired cognitive skills for daily decision making, was dependent on staff for bed mobility, was frequently incontinent of bowel and bladder and had no pressure ulcer.</p> <p>a. The Weekly Pressure Ulcer Record documented Date of onset 4/18/07; Site/Location: (L) (left) inner foot; Stage IV; size in CM (Length x Width): 1.5 x 1.5; Wound Bed: Black; Surrounding skin color: Pink; Surrounding tissue/wound edges: intact; Preventative Measures/Progress: Turned q (every) 2 hours; Pressure Relieving interventions: pressure relieving mattress.</p> <p>b. The Standard Care Plan for Skin Integrity with a review date of 4/9/07 documented: Skin Risk Assessment Score 11 (high Risk); Potential for skin breakdown related to: [decreased] mobility, bedfast most of x (time) and bowel incontinence. Approaches: At Risk skin care: ... Turn and reposition every 2 hours, no extra incontinent pads in use, wedge cushion for positioning, heel protectors, elbow protectors.</p> <p>c. On 4/23/07 at 11:12 a.m., the resident was in bed turned to her right side with a dressing to her</p>	F 314			

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

PRINTED: 05/11/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2007
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 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 314	Continued From page 6 inner left foot laying on a folded blanket. d. On 4/24/07 at 9:10 a.m., the resident was repositioned by Certified Nursing Assistant #4 and 7, shifting her body to the left. Her feet and heels were left laying on the bed without any off loading. e. On 4/24/07 at 11:02 a.m., the resident was laying on her right side, the left inner foot was laying on an incontinent pad with the area with the dressing was on laying directly on the incontinent pad. f. On 4/25/07 at 7:20 a.m., the resident was turned to the left side. The resident was positioned with her feet laying on an incontinent pad on the bed. g. The facility's Policy for "prevention and Treatment of Pressure Ulcers provided by the Director of Nurses on 4/27/07 documents: " ... Preventative actions: For a resident in bed: ... Make every attempt to "float heels" (keeping heels off of the bed) by placing a pillow from knee to ankle or use of other devices as recommended by therapy and prescribed by the physician."	F 314		
F 323 SS=E	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 the facility failed to ensure the doors were free of gouges and splinters and the electrical outlets were free of cracks and	F 323		

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

PRINTED: 05/11/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/27/2007
NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	Continued From page 7 broken areas. This failed practice had the potential to affect 8 residents who were mobile on 100 Hall, 9 mobile residents on 200 Hall, 8 mobile residents on 400 Hall, 5 mobile residents on 500 Hall, 8 mobile residents on 600 Hall and 41 residents who use the front lobby as identified by the Director of Nursing on 4/26/07. The findings are: On 4/25/07 at 1:55 p.m., the following items were identified: 1. Resident room #105 had gouges on the entry door, exposing splinters, on the hinged side of the door approximately 1 foot up from the floor. 2. 200 Hall Shower Room entry door had a metal trim on the back of the door that was detached from the door approximately 1 1/2 inch exposing sharp metal edges. 3. The left fire door on 400 Hall had a gouge approximately 2 inches in length on the hinged side of the door approximately 1 1/2 feet up from the floor. 4. Resident room #602 had gouges on the entry door, exposing splinters, on the hinged side of the door approximately 2 feet up from the floor. 5. There was an electrical outlet cover in the lobby beside the bird aviary that was broken and missing an area approximately 1 inch in length.	F 323			