

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

PRINTED: 01/11/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/06/2006
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF BENTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 ALCOA ROAD BENTON, AR 72015	
(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 000	INITIAL COMMENTS Complaint #11325, substantiated (all or in part) with a deficiency cited at F282.	F 000		
F 282 SS=D	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. This REQUIREMENT is not met as evidenced by: Complaint #11325, substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure a physician order for restorative evaluation and treatment were implemented for 1 (Resident #1) of 4 (Residents #1 through #4) case mix residents who were at risk for falls. This failed practice had the potential to affect 16 residents who were at risk for falls according to the Registered Nurse supervisor on 1/7/06 at 11:35 a.m. The findings are: Resident #1 had diagnoses of Brain Cancer and Seizure Disorder. The Admission Minimum Data Set (MDS) dated 10/4/05 documented the resident was moderately impaired in cognitive skills for daily decision-making and had an unsteady gait. a. The Care Plan dated 9/28/05 documented in the Problem section, "At risk for falls related to	F 282		

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 282	Continued From page 1 unsteady gait. b. A Nurse's Note dated 12/20/05 at 6:10 a.m. documented, "Resident up in room and fell backwards hitting back of head on chair in room, c/o (complained of) pain in area but no bump detected at this time, neuro checks started..." c. A Nurse's Note dated 12/20/05 at 9:30 a.m. documented, "[Physician] here, evaluated, orders received for soft belt up in W/C (wheelchair) for safety, RNA (Restorative Nursing Aide) to eval (evaluate) and treat." d. On 1/5/06 at 1:00 p.m., the Assistant Director of Nursing stated, "I would need to get clarification because our RNA can't evaluate and treat. But there was a mix up somewhere because I never got the order." e. On 1/5/06 at 1:05 p.m., the Director of Nursing stated, "We review the orders every morning. I never saw that order." f. As of 1/6/06 at 9:00 a.m., there was no documentation in the clinical record the resident was evaluated and treated by restorative services.	F 282			