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| F 000 | INITIAL COMMENTS<br><br>Complaint #12227 was unsubstantiated<br><br>Complaint #12246 was unsubstantiated<br><br>Complaint #12253 was substantiated (all or in part) with deficiencies cited at F309 and F327.<br><br>Complaint #12255 was unsubstantiated | F 000 | | |
| F 282 SS=D | 483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure a dietary recommendation was implemented for 1 of 1 (Resident #1) case mix resident who had been identified by the Dietary Manager as having a low albumin level. This failed practice had the potential to affect 7 other residents in the facility that had dietary recommendations in the past 30 days, according to the Administrator on 1/9/07 at 2:57 p.m. The findings are:<br><br>Resident #1 was admitted to the facility on 12/26/06 and had diagnoses of Congestive Heart Failure and Cardiomyopathy. An Admission 5-Day Medicare Minimum Data Set dated 1/2/07 documented the resident was independent in cognitive skills for daily decision making and required limited to extensive assistance for all activities of daily living. | 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<br><br>a. Lab values dated 12/27/06 documented the resident's albumin level was 2.9, with the normal albumin level range of 3.5 - 4.8.<br><br>b. The resident's Dietary Progress Notes dated 12/27/06 documented, "...Add 1 scoop Beneprotein TID [three times a day] with medication pass r/t [related to] low albumin per R.D. [Registered Dietician] recommendation..."<br><br>c. On 1/7/07 at 10:00 a.m., during a record review of the resident's December 2006 and January 2007 Medication Administration Records, there was no documentation that indicated the resident received the Beneprotein.<br><br>d. On 1/8/07 at 2:15 p.m., the Director of Nursing stated the dietary recommendations given to her, did not include the Beneprotein for the resident. | F 282 | | |
| F 309 SS=D | 483.25 QUALITY OF CARE<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Complaint #12253 was substantiated (all or in part) in these findings.<br><br>Based on record review and interview, the facility failed to ensure a Physician order was obtained prior to checking for an impaction and removing | F 309 | | |

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feces for 1 (Resident #3) of 7 (Residents #1, #3 thru #8) case mix residents who required assistance with Activities of Daily Living (ADLS). This failed practice had the potential to affect 96 residents in the facility that required assistance with ADLs, according to the Administrator on 1/9/07 at 2:57 p.m. The findings are:

Resident #3 had diagnoses of Congestive Heart Failure and Constipation. A Quarterly Minimum Data Set (MDS) dated 11/8/06 documented the resident had moderately impaired cognitive skills for daily decision making and experienced constipation in the 14 days prior to the assessment.

a. On 1/6/07 at 1:00 a.m., the resident's roommate stated, "She was really impacted last week. They rolled her over and tried to clean her up. Her rectum was like this (demonstrated the size of a softball). It was open like that. They got it out."

b. As of 1/6/07 at 2:00 p.m., the facility's BM (Bowel Movement) Elimination Record for December 2006 and January 2007 documented the resident had not had a bowel movement since December 20, 2006 (17 days). Of those 17 days, 12 days were left blank.

c. On 1/7/07 at 11:24 a.m., Certified Nursing Assistant (CNA) #4 was asked if the resident had been impacted. She stated, "Oh man. Yes she was. I noticed she wasn't acting the same. She was real weak and had saliva coming out of her mouth. I asked her what was wrong and she said I don't know. I laid her down and turned her over to clean her and I saw it. It was just stuck there. I told [CNA #5] to go get [Licensed Practical Nurse

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(LPN) #1] right then, because she needed an enema or something. It was so bad. She wasn't eating... " She was asked approximately how much feces was removed. She stated, "It was like 2 baseballs. She was bleeding a little and couldn't push because it hurt. I felt so sorry for her. [LPN #1] dug her out and said 'That's all I'm doing.' Then I stayed with her until she felt comfortable." CNA #4 was asked when this happened. She stated, "It's been a couple of weeks ago."

d. On 1/8/07 at 11:10 a.m., LPN #1 stated, "I can't pinpoint a time...seems like it's been a couple of months ago. CNAs called me to the room saying they thought [Resident #3]) was impacted. She looked full (rectum). I checked her; everything was soft so I said everything was OK. I left the room. I didn't feel like anything needed to be done except give her more time." LPN was asked if she had noticed any bleeding. She stated, "No." She was asked if the resident was in any pain. She stated, "She was grunting a little bit but she was on her side which is not real comfortable for her." She was asked if any feces came out of the rectum when she removed her finger. She stated, "Some came out when I checked her. It was very soft; maybe a cup full." LPN #1 was asked if she felt the resident was impacted. She stated, "No." She was then asked if she had thought about calling the doctor to see if he possibly would want to start her on any medications or increase her fluids. She stated, "No because I didn't see anything to make me think she was having any problems." LPN #1 was asked if she had documented a nurse's note or an assessment on the situation. She stated, "Probably not."

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| F 309 | Continued From page 4<br>e. On 1/8/07 at 12:55 p.m., CNA #5 stated, "We had noticed she'd stopped eating and she was drooling, so we decided to lay her down. Her stomach was hard. So I went and got [LPN #1]. First she came in and looked at her and said 'Yes she's impacted', so she put some gloves on and dug some out. [LPN #1] acted like 'Shhhhh, don't tell anyone' because I guess a nurse isn't supposed to do that without an order. And [Resident #3] was trying to push her bottom together because it was hurting her... She used her forefinger and middle finger and went in twice and pulled out balls of feces. It was like a ball of play dough. There was bleeding."<br><br>f. On 1/9/07 at 3:00 p.m., the Director of Nursing was asked if it was facility practice to have a Physician order to digitally remove feces from a resident or to check for an impaction. She stated, "Yes, you have to have an order for that."<br><br>g. As of 1/9/07 at 3:00 p.m., there was no documentation in the clinical record to indicate the Physician had been notified of the resident's difficulty with having a bowel movement or of rectal bleeding. | F 309 | | |
| F 323 SS=B | 483.25(h)(1) ACCIDENTS<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure the environment was free from hazards as evidenced by failure to lock unattended medication carts. This failed practice | F 323 | | |

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| F 323 | Continued From page 5 had the potential to affect 48 residents that were independently mobile in the facility, according to the Administrator on 1/9/07 at 2:57 p.m. The findings are:<br><br>On 1/6/07 at 12:30 a.m., a medication cart was beside the nurse's station. The bottom drawer of the cart was open exposing several cards containing different medications. Two Certified Nursing Assistants were sitting at the nurse's station and were asked where the nurse was. They pointed down one of the halls. At that time, another medication cart was by the medication room, unlocked and unattended. At 12:34 a.m., the Registered Nurse (RN) on duty walked to the nurse's station and stated he had gone to get snacks and thought the other nurse was watching the medication carts. One resident in a wheelchair was approximately 12-feet away from the first medication cart. | F 323 | | |
| F 327 SS=D | 483.25(j) HYDRATION<br><br>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.<br><br>This REQUIREMENT is not met as evidenced by:<br>Complaint #12253 was substantiated (all or in part) in these findings.<br><br>Based on observation, record review and interview, the facility failed to ensure sufficient fluids were administered for 1 (Resident #7) of 4 (Residents #3, #4, #6 and #7) case mix residents who had been assessed as being at risk for dehydration. This failed practice had the potential to affect 45 residents in the facility who had been | F 327 | | |

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assessed by the facility has being at risk for dehydration, according to the Administrator on 1/8/07 at 3:10 p.m. The findings are:

Resident #7 was admitted to the facility on 12/20/06 and had diagnoses of Alzheimer's Dementia and Osteoporosis. An Admission Minimum Data Set (MDS) dated 1/3/07 documented the resident had a severely impaired cognitive skills for daily decision making and required total assistance with eating; Section K (Oral/Nutritional Status) of the MDS was not completed.

a. A Complete Blood Count (CBC) for the resident dated 12/21/06 documented, "Red Blood Cells [CBC] 3.38 - L, Hemacrit [HCT] 31.2 - L [Low], Hemoglobin [HGB] 0.6 - L, BUN [Blood Urea Nitrogen] 27 - H [High], Creatinine 1.30 - H and BUN [Blood Urea Nitrogen]/Creatinine Ratio 21 - H. These values were the most recent available for review.

b. An Assessment of Risk for Dehydration dated 12/20/06 documented a score of 11 for the resident. A score of 9 - 20 indicated a resident was at High Risk for Dehydration. The assessment also indicated the resident consumed 50% or less offered of fluids consumed including supplements.

c. A Malnutrition Risk Assessment dated 12/20/06 documented a score of 14 for the resident; a total score of 10 or above represented the resident as being at High Risk. The assessment also indicated the resident fluid intake was less than 500 ml [milliliters] and the resident's feeding ability was "fed by staff ..."

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| F 327 | Continued From page 7<br>d. The resident's Bowel Movement (BM) Record dated January 2007 was blank.<br><br>e. On 1/7/07 at 3:55 p.m., the MDS coordinator was asked if the resident had a care plan; she stated the resident's care plan had not been generated due to admission on 12/20/06. She was asked then if there was a temporary care plan initiated; the temporary care plan provided did not address hydration concerns.<br><br>f. A Resident Status and Care Plan (CNA [Certified Nursing Assistant] care plan) had no date given when initiated and did not address the resident's fluid requirements. This section was left blank. On 1/7/07 at 12:00 noon, the Administrator was asked when the form was initiated for the resident. He stated the form was included in the admission packet and was completed on admission.<br><br>g. On 1/7/07 at 11:00 a.m., the "Nutritional History" completed by the Dietary Manager, for the resident was dated 12/21/06 and was not completed for the resident's fluid requirements. The estimated fluid need was left blank.<br><br>h. On 1/7/07 at 9:00 a.m., the resident was sitting in a reclined Geri-chair located in the facility's TV room. At this time, the Sound of Music was on the TV. At 10:10 a.m., the resident was still in same area. The Assistant Director of Nursing and the Activity Assistant placed a pillow under the resident's lower extremities. The resident remained there until 11:30 a.m. and was not offered any fluids.<br><br>i. On 1/7/07 at 11:30 a.m., the Activity Assistant offered rolls (bread) to the residents in the TV | F 327 | | |

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room; Resident #7 was not offered.

CNA #2 pulled the resident (in the Geri-chair) from one side of the TV room to the other side of the TV room (relocated the Geri-chair). The resident was not repositioned, nor offered any fluids.

j. On 1/7/07 at 11:32 a.m., CNA #1 came into the TV room pushed the resident out of the TV room and down to her room. CNA #1 exited the resident's room and proceeded down the hall to assist CNA #3 with another resident. The resident's water pitcher was behind the resident, on her bedside table, and did not have a straw. The resident was not offered fluids.

At 11:39 a.m., the Activity Assistant was in the TV room passing out white 8-ounce Styrofoam cups of water to residents. The resident remained in her room until 11:45 a.m. and was not offered fluids.

k. On 1/7/07 at 11:45 a.m., CNA #1 and CNA #3 came down Hall 3, from helping another resident, and stopped at Resident #7's room. CNA #3 pushed Resident #7 back down to the TV room and placed her in the same area and reclined the Geri-chair.

l. On 1/7/07 at 12:30 p.m., Resident #7 was sitting in the feeding assistance room of the dining room.

At 12:45 p.m., the Assistant Director of Nursing (ADON) brought the resident's lunch tray and set up in front of her. CNA #1 left her feeding assistance table and went over to Resident #7 and tried to arouse the resident and attempted to

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feed her. The resident was lethargic and unaware of her surroundings. The resident received one 240 cc (cubic centimeter) cup of tea, one whole roll, mechanical soft meat with gravy, cubed carrots and potatoes and strawberry cobbler dessert. CNA #1 was heard stating to other CNAs in the room, "She will eat when her daughter feeds her."

At 1:05 p.m., the resident remained lethargic. At 1:06 p.m., CNA #1 stated, "I don't think it's the right texture of food for her." At 1:15 p.m., CNA #1 used a straw to get the resident to consume her tea. The resident consumed one small sip of tea. At 1:20 p.m., the CNA stated, "I think pureed would be better for her." At his time, the Dietary Manager intervened and provided one carton of Strawberry Ice Cream and one small bowl of mashed sweet potatoes. The resident consumed 100% of ice cream and approximately 1/3 of the mashed sweet potatoes.

The resident's meal consumption dated 1/7/07 documented for lunch that she tolerated 10% of the meal and consumed 120 cc of the fluids.

m. The resident's vital sign and weight flow sheet documented the resident's weights since admission as, "12/20/06 - 90 lbs [pounds], 12/26/06 - 87 lbs., 1/1/07 - 88 lbs., and 1/7/07 - 88 lbs."

n. On 1//7/07 at 2:30 p.m., the resident's daughter stated they came in to visit the resident around 1:30 p.m. -1:40 p.m. They observed the staff pushing the resident out of the dining room and to her room. They placed the resident in the room and left and had not been back. The daughter stated she had only fed her mother at the facility

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one time since admission, 12/20/06. The family stated the resident had tolerated (2) 8-ounce glasses of juice since brought back to her room.

o. Based on observation, Resident #7 did not receive fluids and was not offered fluids from 9:00 a.m. - 12:45 p.m. (approximately 3 hours and 45 minutes).

p. On 1/7/07 at 4:30 p.m., the Dietary Manager was asked why the resident's estimated fluid needs had not been calculated on the nutritional assessment. She stated she was waiting for the resident's height in order to calculate the estimated caloric needs and had not finished the assessment.

The resident's lethargy at lunch was discussed with the Dietary Manager; she stated the facility had not tried anything else to get the resident to eat, other than the ice cream and mashed sweet potatoes. During the interview, she also stated the Nursing Department did not provide her a list of residents who were at risk for dehydration.

q. On 1/8/07 at 2:35 p.m., the Dietary Manager (DM) provided a completed Nutritional Assessment, as was requested on 1/7/07. The Assessment, provided on 1/8/07, calculated the resident was to receive 1230cc of fluids per 24 hour period.

r. The resident's "Meal Consumption" log dated January 2007 documented the resident consumed fluids during the meal service only. The log did not document fluids had been received between meals:

1/1/07 - 840cc

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| F 327 | Continued From page 11<br>1/2/07 - 775cc<br>1/3/07 - 840cc<br>1/4/07 - 840cc<br>1/5/07 - 480cc (refused lunch fluids)<br>1/6/07 - 840cc<br><br>s. The facility was unable to provide documentation that since the resident had been admitted on 12/20/06 she had been receiving the estimated fluid requirements (1230cc/24 hour period), as calculated by the Dietary Manager on 1/7/07.<br><br>t. On 1/7/07 at 3:52 p.m., the family requested following observation was made. CNA #6 and CNA #7 were changing the resident's incontinent brief. The brief strip was blue, which indicated the resident was wet. The resident's brief had a strong odor and was wet with dark colored urine. When the brief was picked up to check for heaviness, it was very light, barely wet.<br><br>u. A Physician's order dated 1/7/07 at 5:17 p.m. documented, "CBC and CMP stat."<br><br>v. The resident's CBC values dated 1/7/07 documented, "RBC 3.56 - L, HGB 11.2 - L, HCT 32.8 - L, BUN 27 - H, Creatinine 1.2 - WNL [within normal limits], Albumin 3.1 - L, and Bilirubin total only 0.17 - L." | F 327 | | |
| F 333 SS=D | 483.25(m)(2) MEDICATION ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and | F 333 | | |

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|---|---|---|---|
| | 045408 | A. BUILDING ______<br>B. WING ______ | C<br>01/09/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GRACE HEALTHCARE OF BENTON | 3300 ALCOA ROAD<br>BENTON, AR 72015 |

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| F 333 | Continued From page 12<br>interview, the facility failed to ensure that updraft treatments were administered as ordered by the Physician for 1 of 1 (Resident #8) case mix resident who had a Physician ordered updraft treatment, resulting in a significant medication error. This failed practice had the potential to affect 12 residents in the facility that had Physician ordered updraft treatments, according to the Administrator on 1/9/07 at 2:57 p.m. The findings are:<br><br>Resident #8 had diagnoses of Bronchitis and Chronic Obstructive Pulmonary Disease (COPD). A Significant Change Minimum Data Set (MDS) dated 12/12/06 documented the resident had modified independence in cognitive skills for daily decision-making, no short/long-term memory problems and had exhibited shortness of breath in the prior 7 days.<br><br>a. A hospital history and physical dated 12/4/06 documented, "...presents with a 2 week history of shortness of breath. She states that she was pretty much ignored until she started producing yellowish and greenish sputum and then she was sent to the emergency room for evaluation...Impression: Bronchitis with bronchospasm. Plan: The patient is admitted to the hospital for aggressive bronchopulmonary toilet including updrafts, mucolytics and antibiotics."<br><br>b. A hospital discharge summary dated 12/8/06 documented, "Final Diagnoses: COPD exacerbation, Bronchitis... Discharge Instructions: DuoNeb updraft treatments every 6 hours and prn."<br><br>c. A Physician Order dated 12/8/06 documented, | F 333 | | |

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| F 333 | Continued From page 13<br>"DuoNeb updraft Q [every] 6 hours and prn [as needed]." According to the resident's December 2006 and January 2007 Medication Administration Records (MAR), the updraft treatment was to be administered at 6:00 a.m., 12:00 p.m., 6:00 p.m. and 12:00 a.m.<br><br>d. On 1/6/07 at 11:57 a.m., the resident stated that her updrafts really helped her when she could get them. The resident was asked when she had gotten her last updraft treatment. She stated, "Yesterday morning. I asked for one this morning before I got out of bed around 8:00 a.m. but haven't gotten it yet."<br><br>e. On 1/6/07 at 12:08 p.m., the medication cart contained 2 boxes of DuoNeb for the resident. One box contained one dose, the other box contained 27 doses. From December 8, 2006 through January 6, 2007, 112 doses should have been administered. Reconciliation of the medication available for administration revealed that a total of only 60 doses had been delivered from the provider pharmacy. Of these 60 delivered doses, 28 were still un-administered; only 32 of the ordered 112 doses had been given.<br><br>f. On 1/8/07 at 8:12 a.m., a representative from the provider pharmacy stated that only 2 boxes of DuoNeb (60 doses) had been delivered to the facility for this resident.<br><br>g. This was a significant medication error due to the condition of the resident (Chronic Obstructive Pulmonary Disease) and the frequency of the error. | F 333 | | |
| F 514 SS=E | 483.75(l)(1) CLINICAL RECORDS<br><br>The facility must maintain clinical records on each | F 514 | | |

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| F 514 | Continued From page 14<br>resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure accurate and complete clinical records were maintained for 3 (Residents #3, #7 and #8) of 8 (Residents #1 thru #8) case mix residents. This failed practice had the potential to affect 101 residents in the facility, according to the Administrator on 1/9/07 at 2:57 p.m. The findings are:<br><br>1. Resident #8 had diagnoses of Bronchitis and Chronic Obstructive Pulmonary Disease (COPD). A Significant Change Minimum Data Set (MDS) dated 12/12/06 documented the resident had modified independence in cognitive skills for daily decision-making, no short/long-term memory problems and had exhibited shortness of breath in the prior 7 days.<br><br>a. A Physician Order dated 12/8/06 documented, "DuoNeb updraft Q [every] 6 hours and prn [as needed]." According to the resident's December 2006 and January 2007 Medication Administration Records (MAR), the updraft treatment was to be administered at 6:00 a.m., | F 514 | | |

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| F 514 | Continued From page 15 | F 514 | | |

12:00 p.m., 6:00 p.m. and 12:00 a.m.

b. On 1/6/07 at 11:57 a.m., the resident stated that her updrafts really helped her when she could get them. The resident was asked when she had gotten her last updraft treatment. She stated, "Yesterday morning. I asked for one this morning before I got out of bed around 8:00 a.m. but haven't gotten it yet."

c. On 1/6/07 at 12:08 p.m., the medication cart contained 2 boxes of DuoNeb for the resident. One box contained one dose; the other box contained 27 doses. The facility documented that 73 doses of the DuoNeb was administered from December 8, 2006 through January 6, 2007, when only 60 doses were available for administration.

d. On 1/8/07 at 8:12 a.m., a representative from the provider pharmacy stated only 2 boxes of DuoNeb (60 doses) had been delivered to the facility for this resident.

2. Resident #3 had diagnoses of Congestive Heart Failure (CHF) and Constipation. A Quarterly MDS dated 11/8/06 documented the resident had experienced constipation in the 14 days prior to the assessment.

As of 1/6/07 at 2:00 p.m., the facility's BM (Bowel Movement) Elimination Records for December 2006 and January 2007 documented the resident had not had a bowel movement since December 20, 2006 (17 days). Of those 17 days, 12 days were left blank.

3. Resident #7 had diagnoses of Alzheimer's Dementia and Osteoporosis. An Admission MDS

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| F 514 | Continued From page 16<br>dated 1/3/07 documented the resident had severely impaired cognitive skills for daily decision making and required total assistance with activities of daily living.<br><br>a. An Assessment of Risk for Dehydration dated 12/20/06 documented a score of 11 for the resident. A score of 9 - 20 indicated the resident was at High Risk for Dehydration. The assessment also documented the resident consumed 50% or less offered of fluids consumed including supplements.<br><br>b. The resident's Bowel Movement (BM) Record dated January 2007 was blank.<br><br>c. On 1/7/07 at 5:45 p.m., the resident's blank BM Elimination Record was shown to the Director of Nursing (DON). There was no comment. | F 514 | | |