

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

PRINTED: 04/20/2007
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 04/06/2007
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 157 SS=D	<p>483.10(b)(11) NOTIFICATION OF CHANGES</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that the physician was consulted when a new Stage 2 Pressure ulcer was identified for 1 (Resident #</p>	F 157		

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 157	Continued From page 1 10) of 9 case mix residents (Resident #2, 3, 6, 7, 8, 9, 10, 11, and #12) with or at risk for pressure ulcers. This failed practice had the potential to affect 48 residents who had or were at risk for pressure ulcers as identified by the Administrator on 4/6/07 at 1:55 p.m. The findings are: 1. Resident #10 had diagnoses Bullous Dermatoses, Impetigo, Pemphigoid, and Dementia. The Significant Change Minimum Data Set (MDS) dated 2/6/07 documented the resident had modified independent cognitive skills for daily decision making, required extensive assist with transfers, bed mobility, total assist with toilet use, hygiene and had 4 stage 2 pressure ulcers. a. On 4/3/07 at 10:08 a.m. CNA (Certified Nursing Assistant) #1 pointed to an open area to the resident's right buttock beside a dressing to the sacral area and stated, "She's got an open area here." The CNA then stated that she would go tell the nurse and that the spot on her back was leaking. Upon completion of the care provided by the CNAs, CNA #1 spoke with LPN #3 (Licensed Practical Nurse #3), telling the LPN of the open area on the residents sacral area. b. On 4/3/07 at 10:43 a.m., LPN #3 did the treatment to the wound in the upper back. LPN #3 pointed to the newly opened area to the right buttock, no treatment was provided at that time and the area was left open to air. c. On 4/3/07 at 11:35 a.m., the April 2007 Treatment Administration Record (TAR) documented physician order, " 4/3/07, Clean area R (right) lower leg [with] N/S (normal saline) - Apply Vaseline gauze - wrap [with] kling qd	F 157			

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F 157	Continued From page 2 (every day) May wrap legs [with] kling qd for protection - very fragile ... order date 4/4/07 Clean area on (L) [left] knee [with] N/S Apply Vaseline gauze - cover [with] kling qd " No order written for treatment of the newly opened area to the right buttock. d. On 4/4/07 at 12:25 p.m. the Physician Orders were copied. There was no order written for treatment of the newly opened area to the right buttock. e. On 4/4/07 at 3:15 p.m., after review of the clinical record, there was no documentation indicating that the physician had been notified of the new open area on the right buttock.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. 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. 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. 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.	F 164		

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F 164	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that the privacy curtain was completely closed, the window treatments were closed and the door leading to the hallway was closed prior to and during personal care and that the staff knocked prior to entering a residents room for 1 (Resident # 7) of 8 case mix residents (Resident #3, 4, 5, 6, 7, 8, 9, and #12) who required assistance with incontinent care. This failed practice had the potential to affect 70 residents who were identified as being incontinent of bowel and/or bladder and dependent on staff for incontinent care as identified by the administrator on 4/4/07 at 1:55 p.m. The findings are: 1. Resident # 7 had diagnoses of Intercranial Hemorrhage, Dementia and Dysphagia. The Significant Change Minimum Data Set (MDS) dated 1/20/07 documented the resident had severely impaired cognitive skills for daily decision making, was totally dependent on staff for toilet use, personal hygiene, bathing, and was incontinent of bowel and bladder. a. On 4/3/07 at 4:42 p.m., CNA # 5 (Certified Nursing Assistance #5) provided incontinent care for the resident. The CNA removed the top sheet	F 164		

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F 164	Continued From page 4 and the brief without the privacy curtain closed around the residents bed. The Resident's roommate was sitting upright in his bed watching. The CNA also did not close the window curtains or blinds on the window. The resident's window faced the front of the facility. b. On 4/3/07 at 4:43 a.m., CNA #6 entered the room and the residents genitalia was exposed. c. On 4/3/07 at 4:51 a.m., CNA # 5 left the room, opened the door into the hallway and left it open, the privacy curtain was open approximately 4-5 feet fully exposing the resident's uncovered body from the waist down to anyone passing in the hallway.	F 164		
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT- WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that a comprehensive	F 274		

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F 274	Continued From page 5 assessment was completed within 14 days after a significant change in physical condition for 1 (Resident #12) of 1 casemix residents who had a decline in 2 or more areas. This failed practice had the potential to affect all (100) residents as documented on the Resident Census and Conditions of Residents form dated 4/4/07. The findings are: 1. Resident # 12 had diagnoses of Cellulitis, Anxiety State, Depression and Dementia with behaviors. The Medicare 14 Day Minimum Data Set (MDS) dated 1/1/07 documented that the resident moderately impaired cognitive skills for daily decision making, required extensive assistance of one staff member for transfers, was independent with eating, was continent of bowel and rarely incontinent of bladder, was able to feed self unassisted and was able to move about on and off the unit with limited assistance of one person. a. The Care Plan dated 12/28/2006 documented, " Problem Onset: Impaired mobility ... Assist resident with all transfer and reinforce safety measures ... " b. On 4/2/07 at 4:53 p.m., Registered Nurse #1 stated that resident was alert and oriented times 2, required total assistance with care, was incontinent of bowel and bladder, required the use of a wheel chair and staff for locomotion and was a feeder. c. On 4/3/07 at 12:30 p.m., the resident was sitting up in a high back wheel chair with side head support and foot rests with anti tip bars. The resident with sitting at the feeder dining room waiting to be assisted with the noon meal.	F 274			

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F 274	Continued From page 6 d. On 4/4/07 at 11:45 a.m., Certified Nursing Assistant (CNA) #9 performed a one person transfer for the resident from the bed to a wheelchair without use of a gait belt. The CNA put both of his arms around the residents upper chest and back underneath the residents armpits. The CNA lifted the resident to the wheelchair. The resident was unable to bear weight, her right foot dug the floor and her shoulders were raised by the CNA's arms being underneath them. e. On 4/4/07 at 11:45 a.m., CNA #9 was asked if he normally transferred the resident alone. He stated, "Yeah, she doesn't weight much, she's easy." The CNA was asked if gait belts were used in the facility, CNA #9 stated, "Yeah." The CNA was asked when gait belts were to be used, the CNA stated, "We use them when they (residents) resist us or need to be guided." The CNA then wheeled the resident to the dining room for lunch.	F 274		
F 279 SS=D	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	F 279		

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F 279	Continued From page 7 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 observation, record review and interview the facility failed to ensure that the care plan addressed interventions and developed measurable goals for all problems identified for 2 (Resident #9 and #11) of 17 (Resident #1 thru 12 and # 17 thru 21) casemix residents who had a care plan. This failed practice had the potential to affect all 100 residents residing in the facility as documented on the Resident Census and Conditions of Residents form dated 4/4/07. The findings are: 1. Resident # 9 had diagnoses of Alzheimer's Dementia UTI, Rocky Mountain Spotted Fever, GERD, Anemia, Weight Loss and Peripheral Vascular Disease. The Medicare 14 Day Minimum Data Set (MDS) dated 3/20/07 documented that the resident had severely impaired cognitive skills for daily decision making, required limited assistance of one staff person for transfers and ambulation, required extensive assistance of 1 staff member for dressing, toilet use, personal hygiene, required partial physical support or did not follow directions for test while in a sitting-position and/or trunk control, had an unsteady gait, had moderate pain less than daily, fell in the past 30 days and used a trunk restraint daily.	F 279		

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F 279	Continued From page 8 a. The Temporary Problem List dated 3/8/06 and 3/16/07 and copied 4/4/07 at 5:00 p.m., did not address the residents Lap belt restraint or personal safety alarm. b. Physician order dated 3/9/07 documented "PSA (Personal Safety Alarm) while in bed or [up] in w/c (wheelchair). c. Admission Physician orders dated 3/8/07 documented orders for Lap belt restraint, personal safety alarm, health shakes between meals, an antibiotic for UTI, and Megace for poor appetite. d. On 4/3/07 at 8:35 a.m., 12:30 p.m., 1:30 p.m., and 4:25 p.m., the resident's soft belt lap restraint was in place e. On 4/2/07 at 3:35 p.m., and on 4/4/07 at 12:45 p.m., 2:00 p.m., and 4:30 p.m., the resident's side rails were up on both sides of the bed. A sign above the bed documented, "Do not put side rails up (safety hazard)." 1. On 4/5/07 at 5:50 p.m., the DON stated, "When the rails were up she climbed over them. The family wanted them left down. After that, got her a personal alarm for bed and wheelchair and then when we got the soft belt, just used the alarm on the bed." f. The resident's "Temporary Problem List" (Care Plan) dated 3/8/07 with a addition on 3/16/07, documented a problem of falls, there were no approaches/interventions documented for this problem. On 3/16/07, there was a problem added of Actual fall without injury with approaches	F 279		

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F 279	<p>Continued From page 9</p> <p>documented was keep living area as clutter free as possible, personal safety alarm in place as ordered, remind resident not to ambulate without assistance, and physical therapy to continue treatment as ordered.</p> <p>The MDS information dated 3/20/07 documented that the resident had severely impaired cognitive skills, and required assistance with all ADL,s according to the Medicare 14 day assessment.</p> <p>g. On 4/4/07 at 5:00 p.m., after complete review of the clinical record, there was no problems and/or approaches for soft belt restraint, bed side rail safety or resident activities of daily living needs documented in the Temporary Problem List. There was no other care plan in the clinical record.</p> <p>h. The Temporary Problem List documented on the top of the form "For permanent documentation of temporary problems (those with anticipated duration of 14 days or less)."</p> <p>2. Resident # 11 had diagnoses of Acute Renal Failure, Reactive Psychoses, Depression, and Affective Psychosis. The Admission Minimum Data Set dated 1/8/07 documented the resident had Modified Independent cognitive skills for daily decision making, was totally dependent for transfers, toilet use for bowel movement, had a Supra pubic catheter and required extensive assistance for dressing and bed mobility.</p> <p>a. A Resident Assessment Protocol Summary dated 1/8/07 triggered problem areas of Cognitive loss, ADL (Activities of Daily Living) function, Urinary incontinence and indwelling catheter, falls, nutritional status, dehydration/fluid maintenance, pressure ulcers, and psychotropic</p>	F 279			

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F 279	Continued From page 10 drug use. b. A Temporary Problem List dated 12/26/06 and revised 1/18/07 had no documentation that addressed the Resident's Suprapubic catheter, Cognitive loss, nutritional status, or dehydration/fluid maintenance. c. There was no care plan developed after the initial Temporary Problem List" was developed 12/26/06 and revised 1/18/07. 3. On 4/3/07 at 11:45 a.m., the Director of Nurses was asked if the resident had any other care plan besides the Temporary Problem List. At 11:50 a.m., the DON (Director of Nursing) stated, No, that was the only one done.	F 279		
F 309 SS=E	483.25 QUALITY OF CARE 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that a foley catheter was secured to prevent trauma to the urinary meatus for 2 (Resident #10, #11) of 3 (Resident #6, 8, 10, and 11) case mix residents with Foley catheters. This failed practice had the potential to affect 7 residents who were identified as having a Foley/Suprapubic catheter as documented on the Resident Census and	F 309		

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F 309	Continued From page 11 Conditions of residents dated 4/4/07. The findings are: 1. Resident #10 had diagnoses: Bullous Dermatoses, Impetigo, Pemphigoid, and Dementia. The Significant Change of Condition Minimum Data Set (MDS) dated 2/6/07 documented the resident had modified independent cognitive skills for daily decision making, required extensive assist with transfers, bed mobility, and dressing, required total assist with hygiene, and had a Foley Catheter. a. On 4/2/07 at 2:15 p.m., 4/3/07 at 10:43 p.m., 4/3/07 at 2:11 p.m., and on 4/4/07 at 10:40 a.m. the resident had a Foley catheter in place draining to a bedside drainage bag. The foley catheter tubing was not secured. 2. Resident # 11 had diagnoses of Acute Renal Failure, Reactive Psychoses, Depression, and Affective Psychosis. The Admission Minimum Data Set dated 1/8/07 documented the resident had modified independent cognitive skills for daily decision making, was totally dependent for transfers and toilet use, required extensive assistance for mobility and dressing. and had a Suprapubic catheter. a. On 4/3/07 at 9:45 a.m., and 4/4/07 at 2:15 p.m., the resident had a suprapubic catheter in place. The catheter tubing was not secured to prevent trauma to the supra pubic insertion site.	F 309		
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.	F 312		

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F 312	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that the penis, groin, scrotum, and thigh (that showed evidence of urine) areas were cleansed after toileting for 4 (Resident # 3, 6, 7, and 12) of 6 casemix (Residents # 3, 4, 6, 7, 8, and 12) who were dependent on staff for incontinent care. This failed practice had the potential to affect 70 residents that required assistance with incontinent care as identified by a list provided by the Administrator on 4/6/07 at 1:55 p.m. The findings are: 1. Resident #3 had diagnoses of Cerebrovascular Accident (CVA), Convulsions, Brain Injury, Aphasia, Right Hemiparesis, Blind in Left Eye, and Dementia. A Quarterly Minimum Data Set dated 12/20/06 documented the resident had moderately impaired cognitive skills for daily decision making, was frequently incontinent of bowel and bladder, required extensive assistance of one person for transfers, dressing and personal hygiene, was totally dependent for toilet use, had full loss of arm and hand on one side and partial loss of leg and foot on one side. a. The resident's Plan of Care dated 9/20/06 documented a problem as"Inability to sense need to urinate" with approaches as....."Give perineal care when resident is incontinent." b. On 4/4/07 at 2:15 p.m., Certified Nursing Assistant (CNA) #4 was assisting Resident #3 with toileting. The resident was seated on the	F 312		

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F 312	<p>Continued From page 13</p> <p>commode and after he finished the CNA used a disposable wipe and wiped front to back to cleanse the gluteal fold but did not cleanse the penis, groin, thigh or scrotum areas. As a brief was being applied with the resident standing, drops of urine were noted on the resident's right inside thigh. The resident was dressed and assisted to the wheelchair without having been completely cleaned.</p> <p>2. Resident # 7 had diagnoses of Urinary Tract Infection (UTI), Intracranial Hemorrhage, Dementia, and Dysphagia. The Significant Change of Condition Minimum Data Set (MDS) dated 1/29/07 documented the resident had modified independent cognitive skills for daily decision making, required extensive assist with transfers, bed mobility, and dressing, required total assist with toilet use and personal hygiene and had Peg Tube Feedings.</p> <p>a. On 4/3/07 at 4:42 a.m. during incontinent care, CNA # 5 did not cleanse the resident's penis or testes. The resident had been incontinent of urine and feces in the brief. A clean brief was applied without cleansing of the penis or testes.</p> <p>3. Resident # 6 had diagnoses of Hypertension, Chronic Ischemic Heart Disease and Dementia. The Medicare 14 day Minimum Data Set (MDS) dated 2/8/07 documented the resident had moderately impaired cognitive skill for daily decision making and required extensive assistance of one staff member for personal hygiene and bathing.</p> <p>a. On 4/5/07 at 9:45 a.m., CNA # 8 failed to cleanse the resident's mons pubis or labia while the resident during a shower.</p>	F 312		

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F 312	Continued From page 14	F 312			
F 314 SS=E	<p>4. Resident # 12 had diagnoses of Anxiety State, Depression, and Dementia with Behaviors. The Medicare 14 Day MDS dated 1/1/07 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance for hygiene needs, and was incontinent of bowel and bladder.</p> <p>a. On 4/4/07 at 9:45 a.m., CNA # 9 did not cleanse all feces from the resident's right buttock before applying a clean brief, when the resident had been incontinent of stool.</p> <p>483.25(c) PRESSURE SORES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that necessary treatment was provided for 1 (Resident #10) who had a new opened area on the buttock and repositioned to prevent the potential or skin breakdown for 1 (Resident # 7) of 9 case mix residents (Resident #2, 3, 6, 7, 8, 9, 10, 11, and #12) who had a pressure sore or was at risk for pressure sores. This failed practice had the potential to affect 48 residents who were identified as being at risk for developing pressure</p>	F 314			

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F 314	<p>Continued From page 15</p> <p>sores or who had pressure sores as identified by the Administrator on 4/6/07. The findings are:</p> <p>1. Resident # 7 had diagnoses of Urinary Tract Infection (UTI), Intracranial Hemorrhage, Dementia, and Dysphagia. The Significant Change of Condition Minimum Data Set (MDS) dated 1/29/07 documented the resident had modified independent cognitive skills for daily decision making, required extensive assistance with transfers, bed mobility and dressing and required total assistance with toilet use, hygiene and Peg Tube Feedings.</p> <p>a. A Resident Assessment Protocol Worksheet dated 1/29/07 documented the resident was at risk for breakdown related to impaired mobility, incontinence, and altered nutrition.</p> <p>b. On 4/3/07 at 4:42 a.m., during incontinent care, CNA (Certified Nursing Assistant) # 5 did not cleanse the resident" penis or testes. The resident had been incontinent of urine and feces in the brief. A clean brief was applied without cleansing of the penis or scrotum.</p> <p>c. On 4/3/07 2:10 p.m., the resident's position was marked at the outer aspect of the right shoulder with a blue ink pen.</p> <p>d. On 4/3/07 at 3:45 p.m. the resident's position remained unchanged with the pen marking in the place at right shoulder.</p> <p>e. On 4/3/07 at 4:42 p.m. the resident was turned to the left side by CNAs # 5 and #6 to clean the anal area of feces. The residents position was unchanged from the 2:10 p.m., position that had been marked. The resident remained in the</p>	F 314			

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F 314	<p>Continued From page 16</p> <p>same position for 2 hours and 42 minutes without being repositioned/turned.</p> <p>2. Resident #10 had diagnoses Bullous Dermatoses, Impetigo, Pemphigoid, and Dementia. The Significant Change of Condition Minimum Data Set (MDS) dated 2/6/07 documented the resident had modified independent cognitive skills for daily decision making, required extensive assist with transfers, toilet use and hygiene and had 4, stage 2 pressure ulcers.</p> <p>a. On 4/3/07 at 10:08 a.m., CNA #1 pointed to an open area on the resident's right buttock beside a dressing on the sacral area. The CNA stated, "She's got an open area here. " The CNA stated that she would go tell the nurse and that the spot on her back "is leaking." Upon completion of the care provided by the CNAs, CNA #1 went and spoke with LPN #3 (Licensed Practical Nurse #3).</p> <p>b. On 4/3/07 at 10:43 a.m., LPN #3 did the treatment to the wound on the upper back. LPN #3 pointed to the newly opened area to the right buttock, no treatment was provided at that time and the area was left open to air.</p> <p>c. On 4/3/07 at 11:35 a.m., the April 2007 Treatment Administration Record (TAR) was reviewed and there was no order for the open area to the right buttock to be treated.</p> <p>d. On 4/4/07 at 12:25 p.m., the Physician Orders were reviewed. There were no Physician orders for treatment of the newly opened area to the right buttock.</p> <p>e. On 4/4/07 at 3:15 p.m., the Clinical Record</p>	F 314			

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F 314	Continued From page 17	F 314		
F 322 SS=D	<p>was reviewed. There was no documentation to verify that the resident ' s physician had been notified of the open area identified on 4/03/07.</p> <p>483.25(g)(2) NASO-GASTRIC TUBES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that only Licensed qualified staff turned on or off a residents tube feeding for 1 (Resident #7) of 1 case mix resident who had physician orders for a tube feeding. This failed practice had the potential to affect 1 resident who received total nutrition via a continuous Tube Feeding as documented on the Residents Census and Conditions of Residents dated 4/4/07. The findings are:</p> <p>1. Resident # 7 had diagnoses of Urinary Tract Infection (UTI), Intracranial Hemorrhage, Dementia, and Dysphagia. The Significant Change of Condition Minimum Data Set (MDS) dated 1/29/07 documented the resident had modified independent cognitive skills for daily decision making, required extensive assistance with transfers, bed mobility and dressing and required total assistance with toilet use, hygiene and Peg Tube Feedings.</p>	F 322		

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F 322	Continued From page 18 a. The Care Plan dated 2/6/07 documented, " Problem Onset: 11/11/2005 At risk for aspiration [related to] Peg Tube secondary to swallowing problem ... approaches ... Elevate HOB (head of bed) to 45 degrees at all times to prevent aspiration ... " b. The Physician orders documented, " ... Jevity 1.2 cal (calorie) 75 cc (cubic centimeters) per hour via G (gastrostomy) tube ... Head of bed elevated 30 - 45 degrees at all times ... " c. On 4/3/07 4:40 p.m., CNA (Certified Nursing Assistant) #5 lowered the resident's head of the bed with the feeding pump infusing formula at a rate of 75 milliliters (ml) an hour via a Peg Tube. The tubing was caught underneath the side railing, on the back side of the bed, putting a great tension on the tubing, which caused the pump to start beeping after approximately 4-5 minutes with the head of the bed in the flat position and the feeding pump infusing the formula. CNA # 6 entered the room and stated to CNA #5. "You can't put the head of the bed down while the pump is running, you have to put it on hold while the head of the bed is down." CNA #5 stated, "It's okay for just a short time to do the care." CNA #6 put the pump on hold. After care was completed CNA #6 restarted the pump. d. On 4/3/07 5:10 p.m., CNA #6 was asked about his training with residents receiving tube feedings. He stated that he had worked here since September of 2006 and that he had been instructed by the nurses here on how to put the pump on hold to do the care, then to restart the pump and never put the head of the bed down with the pump on.	F 322		

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F 322	Continued From page 19 e. On 4/3/07 at 5:15 p.m. The Director of Nursing stated, "The facility's policy is for only nurses to turn the pumps on/off or put on hold, CNAs are to never work the pumps. The CNAs have been instructed to come and get the nurse to put the pump on hold for care." f. On 4/3/07 at 5:15 p.m., The Registered Nurse #1 stated, "CNAs are never to work the pumps, only nurses turn the pumps on/off, and put on hold. " g. On 4/3/07 at 5:30 p.m., Licensed Practical Nurse (LPN) # 3 stated, " They (nurses) instruct CNAs to have a nurse turn the pump on or off, or put the pump on hold with lowering the bed during care. " h. On 4/3/07 at 5:30 p.m., LPN # 4 was asked what instruction CNAs had been given for residents with tube feedings and providing care. He stated, "The CNAs know they are not to touch the feeding tube pumps at all. They know they are to come get a nurse to put it on hold during care."	F 322		
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 environment was free of splintered, sharp jagged areas on the wood paneling and resident doors, and that the floor did not have sunken	F 323		

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F 323	Continued From page 20 areas and medication is stored appropriately. This failed practice had the potential to affect 22 cognitive impaired independently mobile residents as identified by the Director of Nursing on 4/4/07. The facility also failed to ensure that soft belt restraints were applied per manufacturer's instructions for 5 (resident # 3, # 9, # 16, # 21, and #25) of 5 Case mix residents with physician orders for a soft belt restraints. This failed practice had the potential to affect 9 residents in the facility that had orders for soft belt restraints as identified by the Director of Nursing on 4/4/07. The findings are: 1. On 4/2/03 the following observations were made: a. At 3:32 p.m., in room 101A the water container lid had a broken area along the edge that had a piece of plastic missing and the edges were jagged and sharp. b. At 10:15 a.m. the wood paneling on the wall that surrounded the television room on the front side was an area approximately 1inch in length that was splintered and sharp and on the right side of the wall was a second area approximately the same length that was splintered and sharp. Both areas were approximately 3 to 4 inches above the floor. c. On the 300 hall, at the end of the wall with wood paneling the floor had a sunken area that was 3 to 4" wide and 10 to 12" long and 1/2" deep. d. On 300 hall, the door to room 308 on the outer edge had an area that was sharp and jagged. Room 306 had a chip 1 to 1 1/2" long out of the	F 323			

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F 323	Continued From page 21 outer edge of the door. e. At 5:05 p.m. in room 103A there was a packet of Lanaseptic Therapeutic Cream laid on the bedside table. The packet documented on the label, "Warnings For External Use Only Avoid contact with eyes ... If swallowed, get medical help or contact a Poison Control Center right away ..." 2. On 4/3/07 at 4:05 p.m., the manufacturer's Application Instruction Sheet for the Lap Belt documented, "3) Go around the back post and cross the straps behind the patient. Secure the loops on the wheelchair tilt levers. The belt should be over the patient's hip at a 45 degree angle holding at the hips against the back of the chair. ... 8) Make sure straps are secured at a juncture of the frame and will not slide in any direction, changing position of the device ... If dislodged, patient injury could occur." 3. Resident # 9 had diagnoses of Alzheimer's Dementia and Peripheral Vascular Disease. The Medicare 14 Day Minimum Data Set (MDS) dated 3/20/07 documented that the resident had severely impaired cognitive skills for daily decision making, required partial physical support while sitting-position and/or trunk control, had a fall in the past 30 days and used a trunk restraint daily. a. On 4/3/07 at 8:35 a.m., 12: 30 p.m., 1:30 p.m., and 4:25 p.m., the resident's soft belt lap restraint incorrectly applied according to the manufacturer's instructions while the resident was in the wheelchair. One strap was passed through the opening between the armrest and the metal skirt plate and the other strap was passed	F 323			

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F 323	<p>Continued From page 22</p> <p>through the opening between the back support and the chair seat instead of around the side bars on each observation.</p> <p>b. On 4/2/07 at 3:35 p.m., 4/4/07 at 12:45 p.m., 2:00 p.m., and 4:30 p.m., the resident's side rails were up on both sides of the bed. A sign above the bed documented, "Do not put side rails up (safety hazard)."</p> <p>c. On 4/5/07 at 5:50 p.m., the DON stated, "When the rails were up and she climbed over them. The family wanted them left down. After that, got her a personal alarm for the bed and wheelchair and then when we got the soft belt and just used the alarm on the bed."</p> <p>d. On 4/6/07 at 11:25 a.m., the resident was up in the wheelchair in her room by her bed. The resident's soft belt restraint was not connected to the wheelchair tip bar, it was lying in the floor. The resident had both hands on the arm rests and started to rise form the seat of the wheelchair without assistance. The MDS nurse was near the room and was informed of the restraint not being in place for the resident and the residents attempt to get out of the chair unassisted.</p> <p>4. Resident # 25 had diagnoses of Cerebral Vascular Accident, Osteoarthritis, Dementia, and Depression. A Quarterly MDS dated 11/18/06 documented the resident had modified independent conative skills for daily decision making, required limited assistance with transfers, had a fall in the past 31 to 180 days, and used a trunk restraint daily.</p> <p>a. On 4/3//07 at 4:20 p.m., the resident's soft belt lap restraint was incorrectly applied according to</p>	F 323			

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F 323	<p>Continued From page 23</p> <p>the manufacturer's instruction while the resident was in the wheelchair. One of the straps was passed between the armrest and skirt plate and the other strap was passed between the back support and the seat of the chair instead of around the side bars.</p> <p>5. Resident # 21 had diagnoses of Fractured Lumbar Vertebra, and Bipolar Affect. A Significant change MDS dated 2/12/07 documented the resident had independent cognitive skills for daily decision making, required extensive assistance for transfers and ambulation, and used a trunk restraint daily.</p> <p>a. On 4/3/07 at 4:38 p.m., the resident's soft belt lap restraint was incorrectly applied according to the manufacturer's instructions while the resident was in the wheelchair. Both straps were passed through the opening between the back support and the seat of the wheel chair instead of around the side bars.</p> <p>6. Resident #3 had diagnoses of Cerebrovascular Accident (CVA), Convulsions, Brain Injury, Aphasia, Right Hemiparesis, Blind in Left Eye, and Dementia. A Quarterly Minimum Data Set dated 12/20/06 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance of one person for transfers, dressing and personal hygiene, was totally dependent for toilet use, had full loss of arm and hand on one side and partial loss of leg and foot on one side, and required the use of a trunk restraint.</p> <p>a. The resident's Plan of Care dated 12/20/06 documented, " Problem ... "Potential for falls and or injury related to visual and physical impairment</p>	F 323			

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F 323	<p>Continued From page 24</p> <p>with restraint use related to CVA with right (R) sided hemiparesis (HEM) and blind in left eye ... approaches Soft belt restraint when up in wheelchair (w/c). Monitor frequently to ensure safety is maintained ..."</p> <p>a. A physician's order dated 6/7/06 documented, "Soft belt restraint to assist resident in positioning due to CVA-R HEM."</p> <p>b. On 4/3/07 at 4:30 p.m., the resident #3's soft belt lap restraint was incorrectly applied according to the manufacturer's instructions while the resident was in a wheelchair (w/c). The straps were both passed between the opening between the back support and the seat, instead of around side bars.</p> <p>c. On 4/3/07 at 4:10 p.m., the resident was sitting the Dining Room in a w/c with a soft belt restraint in place. The straps were slipped through the seat and the back of the w/c behind the resident and then crisscrossed and attached to the tip bars.</p> <p>d. On 4/4/07 at 9:57 a.m. the resident was sitting in a w/c in front of the water fountain with the soft belt restraint in place. The restraint straps were placed between the back and the seat of the w/c and attached to the tip bars.</p> <p>7. On 4/4/07 at 9:57 a.m., the DON was informed of the incorrect application of the soft belt restraint. She was asked if the Certified Nursing Assistants (CNA) had been inserviced about the correct restraint application and she stated, "The Physical Therapist told them they could be tied either way."</p>	F 323			

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F 323	Continued From page 25 8. Resident #16 had diagnoses of Depressive Disorder, Dementia, Seizure Disorder, and Anxiety. The Quarterly Minimum Data Set dated 12/20/06 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance of staff for transfers, ambulation and used a trunk restraint daily. a. On 4/3/07 at 4:05 p.m. the resident was in the dining room with a soft belt restraint in place. The left tie strap of the restraint was over the metal side of the wheel chair and the right tie strap was between the back rest of the wheelchair and the seat. b. On 4/3/07 at 4:25 p.m., the resident ' s soft belt restraint was incorrectly applied according to the manufacturer's instructions while the resident was in the wheelchair. The straps on each side of the belt were passed between the back support and the seat of the chair instead of around the side bars. c. On 4/5/07 at 10:35 a.m., the resident was in the day room in a wheelchair with a soft belt restraint in place. The right tie strap was between the seat of the wheelchair and the back rest then attached to the tip bar. 9. On 4/4/07 at 10:10 a.m., Physical Therapist #1 stated, "I showed them (staff) last week the way I learned in PT (Physical Therapy) school was a universal way for wheelchair restraints. That's my fault ... I focused on safety points of contact and not tying too tight or the resident would get agitated or put the belt up too high and they would scoot down."	F 323		
F 324	483.25(h)(2) ACCIDENTS	F 324		

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F 324 SS=D	Continued From page 26 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 that residents were transferred by staff that had been trained for 1 (Resident#2) and the axilla was not used to support the residents weight during a transfer for 1 (Resident #12) of 9 (Resident #2, 3, 5, 6, 7, 8, 9, 11,and 12) case mix residents that required assistance with transfers and that a personal alarm functioned properly for 1 (Resident #17) of 1 casemix residents with personal alarms. This failed practice had the potential to affect 63 residents that required assistance with transfers as identified by the Administrator on 4/6/07 and 1 residents that had personal alarms according to the list provided by the Director of Nursing on 4/4/07 at 9:10 a.m. The findings are: 1. Resident # 12 had diagnoses of Cellulitis, Anxiety State, Depression and Dementia. The Medicare 14 Day Minimum Data Set (MDS) dated 1/1/07 documented that the resident had moderately impaired cognitive skills for daily decision making and required limited assistance of one staff member for transfers. a. On 4/4/07 at 11:45 a.m., Certified Nursing Assistant (CNA) # 9 performed a one person transfer for the resident from the bed to a wheelchair. The CNA put both of his arms around the upper chest and back underneath the armpits of the resident and lifted the resident to	F 324			

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F 324	<p>Continued From page 27</p> <p>the wheelchair. The resident was unable to bear weight, her right foot drug the floor and her shoulders were raised by the CNA's arms underneath them.</p> <p>b. On 4/4/07 at 11:45 a.m., CNA #9 was asked if he normally transferred the resident alone, the CNA stated, "Yeah, she doesn't weight much, she's easy."</p> <p>2. Resident #2 had a diagnosis of Paralysis Agitans, Cerebral Vascular Accident, and Dementia. A significant change MDS dated 2/8/07 documented the resident had moderately impaired cognitive skills for daily decision making, and was totally dependent on staff for transfers.</p> <p>a. On 4/4/07 at 11:55 a.m., the facility beautician transferred the resident from the wheelchair to the beauty shop chair. The beautician put her arms around the resident, lifted the resident from the wheelchair holding the residents pants and placed the resident in the beauty shop chair. At 12:05 p.m., the Administrator was asked if the beautician was trained in transferring residents. He stated, the beautician said when the building first opened she had been trained, but there is nothing documented.</p> <p>3. Resident #17 had diagnoses of Alzheimer, Osteoarthritis, and Dementia. The Quarterly Minimum Data Set (MDS) dated 11/10/06 documented the resident had moderately impaired cognitive skills for daily decision making, required limited assistance with transfers and ambulation, had an unsteady gait and had a fall in the past 31-180 days. The MDS did not document restraint use.</p>	F 324		

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F 324	Continued From page 28	F 324		
F 332 SS=E	<p>483.25(m)(1) MEDICATION ERRORS</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation of the 4:00 p.m., medication pass on 4/2/07 and the 8:00 a.m., medication pass on 4/3/07 the facility failed to follow physician orders to ensure that the medication error rate was less than 5%. Physician orders were not followed on 4 (Resident #1, 13, 14, and 15) of 13 residents observed during the medication passes. Medication errors were made by 2 (Licensed Practical Nurse (LPN) #1 and #2) of 6 nurses that administer medication according to the Director of Nursing. This failed practice had the potential to affect 61 residents receiving medication from these nurses as identified by the List provided by the Administrator on 4/3/07 at 11:35 a.m.. The medication error rate was 8.51% based on administration of 46 medications plus 1 medication ordered but not administered and observation of a total of 4 errors. The findings are:</p>	F 332		

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F 332	Continued From page 29 1. Resident #1 had a physician order dated 2/28/07 for Carafate 1 gm (gram) four times a day. a. On 4/2/07 at 7:55 a.m., the medication was not administered on by LPN #1. 2. Resident #14 had a physician order dated 1/12/07 Novolin N insulin to be administer 18 units every day. a. On 4/2/07 at 4:22 p.m., LPN #2 drew up the insulin without rolling the bottle to remix the insulin which is a suspension. b. The Physician Desk Reference 2001 edition documented page 2238, " Novolin N ... The insulin substance (the cloudy material) settles at the bottom of the vial, therefore, the vial must be gently agitated or rotated so that the contents are uniformly mixed before a dose is withdrawn. " 3. Resident #1 had a physician order dated 2/19/07 for Antivert 12.5 mg (milligrams) three times a day, but Antivert 25 mg was administered at 7:55 a.m., on 4/3/07 by LPN #2. 4. Resident #15 had a physician order dated 2/19/07 for vitamin B-12 500 mcg to administer 1/2 tablet everyday but B-Complex with B-12 was administered at 8:05 a.m., on 4/3/07 by LPN #2 which contained other B vitamins and only 5 mcg of B-12.	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.	F 333		

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F 333	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation of the 4:00 p.m., medication pass on 4/2/07, the 8:00 a.m. medication pass on 4/3/07 and record review, the facility failed to follow physician orders to ensure that residents were free of significant medication errors for 2 (Resident #1 and 6) of 13 residents observed during the medication pass. A significant medication error was made by 2 (Licensed Practical Nurse [LPN] # 2 and 5) of 6 nurses that administered medications according to Registered Nurse #1. This failed practice had the potential to affect 39 residents receiving medication from these nurses as identified by the list provided by the Administrator on 4/3/07 at 11:35 a.m.. The findings are: 1. Resident #1 had diagnoses of Dizziness and giddiness and a physicians order dated 2/19/07 for Antivert 12.5 mg three times a day. a. During the medication pass on 4/3/07 at 7:55 a.m., Antivert 25 mg was administered by LPN #2. b. Three medication cards dispensed from the pharmacy on 3/13/07 contained a total of 90 tablets when dispensed. c. On 4/3/07 at 7:56 a.m., the cards contained 46 tablets indicating 44 tablets of Antivert 25 mg had been administered to Resident #1. d. On 4/3/07 at 10:30 a.m. the dispensing pharmacy stated that Antivert 25 mg was all they had dispensed for resident #1.	F 333			

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F 333	Continued From page 31 e. The Physicians Desk Reference 2001 edition page 2469 documented, " Antivert ... For the control of Vertigo associated with diseases affecting the vestibular system, the recommended dose is 25 to 100 mg (milligrams) daily, in divided dosage ... " This was significant due to the condition of the resident and frequency of the error. 2. Resident #6 had a diagnoses of Hypertension and Renal Disease. The Medicare 14 day Minimum Data Set (MDS) documented that the resident had moderately impaired cognitive skills for daily decision making. a. The physician order dated 1/26/07 documented, "Clonidine HCL 0.2 mg (milligram) patch once a week on Tues (Tuesday)." b. On 4/5/07 at 9:45 a.m., a circular patch was (at shower time)on the resident's left chest just below the clavicle (collarbone) with date of 3/27/07, 7 - 3, and [initials] written in center of patch. c. On 4/5/07 at 10:20 a.m., the April 2007 Medication Administration Record (MAR) documented no signature or initial in the space for the Tuesday, April 3 administration of the Clonidine HCL patch. d. On 4/5/07 at 10:50 a.m., the Director of Nursing (DON) was informed and observed the resident's patch. The resident pointed to the patch and stated, "That needs to be changed." The LPN #5 was instructed by the DON to change the patch.	F 333		
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES	F 425		

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F 425	<p>Continued From page 32</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that medications available for administration were in date and had not expired, that feeding tube formulas were in date, not expired and the containers were not severely dented. These failed practices had the potential to affect all 100 residents as identified on the Resident Census and Conditions of Residents form dated 4/4/07. The findings are:</p> <p>a. On 4/02/07 at 430 p.m., the following observations were made on the medication carts and the medication room</p> <p>1. Clonidine HCL 0.1 mg - 28 pills in package</p>	F 425		

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F 425	Continued From page 33 that expired 6/2006 2. Clonidine HCL 0.1 mg - 28 pills in package that expired 9/2006. 3. Ibuprofen 400 mg - 20 pills in package that expired 11/25/06. 4. Bisacodyl 5 mg - 30 pills in package that expired 10/14/06 5. Trimethobenzamide 300 mg - 14 pills in package that expired 10/30/06. 6. Hydroxyzine 25 mg - 13 pills in package that expired 1/4/07. 7. Mirtazepine 15 mg - 25 pills in package that expired 1/31/07. 8. Hydroxyzine 25 mg - 28 tablets in package that expired 3/16/07. 9. Hydroxyzine Pamoate 25 mg - 25 tablets in package that expired 3/21/07. 10. Amiodarone 200 mg - 30 tablets in package that expired 3/31/07. 11. Colace 50 mg/15cc - 40 cc left in bottle that expired 2/07. 12 Naproxen Sodium 220 mg - 35 pills in package that expired 11/06. 13. Ferrous Sulfate 325 mg - 500 pills in the package that expired 3/07.	F 425		

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F 425	Continued From page 34	F 425		
F 441 SS=D	<p>14. On 4/3/07 at the following observations were made:</p> <p>b. At 10:43 a.m., on the 300 hall, in the Nourishment room there were 14, 8-ounce cans of Jevity 1.2 that had an expiration date of February 2007.</p> <p>1. At 11:22 a.m., on the 100 hall in the Central supply room there was 2 cases that contained 8 (1000 ml) ready to hang bottles of Jevity 1.2 that had an expiration date of April 1, 2007, and 5, 8-ounce cans of Jevity 1.2 that were severely dented along the sealed edges of the cans. The dented cans were in a case of 24 cans.</p> <p>483.65(a) INFECTION CONTROL</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that staff provided care in a manner to prevent the spread of infection for 1 of 1 casemix resident (Resident #10). This failed practice had the potential to affect all 100 residents in the facility as</p>	F 441		

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F 441	<p>Continued From page 35</p> <p>documented on the Resident Census and Conditions of Residents form dated 4/4/07. The findings are:</p> <p>1. Resident #10 had diagnoses Bullous Dermatoses, Impetigo, Pemphigoid, and Dementia. The Significant Change of Condition Minimum Data Set (MDS) dated 2/6/07 documented the resident had modified independent cognitive skills for daily decision making, extensive assistance with transfers, bed mobility, and dressing, required total assist with toilet use and hygiene and had Antibiotic resistant infection.</p> <p>a. The Temporary Problem Listet dated 1/30/07 documented, " Problem Open wounds ... Approaches ... Isolation (contact) per policy ... "</p> <p>b. On 4/3/07 at 9:28 a.m. CNA # 3 went into the resident's room to take vital signs. The digital thermometer and blood pressure equipment were taken into the resident's room and set on the overbed table. The CNA did not wash her hands upon entering the resident's room and did not use gloves. Vital signs were taken using the equipment taken into the room. The equipment was not cleansed/sanitized after coming in contact with the resident's body. The CNA left the room without washing her hands, and was observed going into another resident's room (next door) with the same equipment. She did not wash her hands in that room prior to taking that resident's vital signs with the equipment that was used on Resident #10.</p> <p>c. On 4/5/07 at 9:05 a.m. CNA #7 was asked about the use of thermometers and blood pressure cuff and other equipment for use when</p>	F 441			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 04/06/2007
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 441	<p>Continued From page 36</p> <p>taking residents vital signs. The CNA stated that they used the same equipment for all residents unless the resident was on an isolation. Then they try to leave the "stuff" in the room.</p> <p>d. On 4/5/07 at 9:10 a.m., LPN #5 was asked if CNA's use the same equipment on other residents and she stated, "The equipment is used for other residents." Asked how do you handle it if the resident is on isolation, she stated, "There should be a thermometer and blood pressure cuff left in the room, if not then it's okay to use them with probe covers as long as it is cleansed after use before bringing out."</p> <p>e. The Policy and Procedure for "Isolation for Communicable Diseases - Contact Precautions" given by the Administrator on 4/5/07 at 9:30 a.m. documented, " ... Patient Care Equipment:</p> <ol style="list-style-type: none"> 1. Dedicated patient-care equipment should be considered for the resident. 2. If use of common equipment items is unavoidable, the items should be adequately cleaned and/or disinfected before use for another patient." 	F 441		