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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045408	A. BUILDING ______ B. WING ______	C 10/13/2008

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

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F 000	INITIAL COMMENTS Complaint #13970, substantiated, all or in part, with deficiencies cited at F309 and F323. Complaint #13969, substantiated, all or in part, with deficiencies cited at F225, F226 and F282.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225		

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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incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Complaint #13969, substantiated, all or in part, in these findings.

Based on record review and interview, the facility failed to ensure an investigation was completed and reported to the Office of Long Term Care (OLTC) and other State agencies in accordance with State law for an injury of unknown origin for 1 of 1 (Resident #8) case mix residents who had an injury of unknown injury. This failed practice had the potential to affect 74 cognitively impaired residents according to a list dated 10/22/08. The findings are:

Resident #8 had a diagnosis of Alzheimer's Disease. The Quarterly Minimum Data Set dated 8/18/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required limited assistance with bed mobility, extensive assistance of one person for transfers and limited assistance of one person for toilet use.

a. The Resident Incident Report dated 10/1/08 at 9:30 a.m. documented, "...resident receiving shower via [CNA (Certified Nursing Assistant) #4]. CNA noticed long bruise to Left side, approx. (approximately) 5 inch long and 1 inch wide."

b. The witness statement by CNA #4 dated 10/1/08 at 9:30 a.m. documented, "When I was giving [Resident #8] her shower I found a deep

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bruise on her left side. When giving shower I told our administrator and then reported it to [Resident #8]'s nurse [LPN #2]. The nurse then wrote out an I/A... Possible cause of event: gait belt... Additional Follow-ups: 10/3/08 Inservice CNAs on gait belt training."

c. On 10/13/08 at 9:40 a.m., CNA #4 stated, "When I was giving [Resident #8] a shower, I saw a deep dark purple bruise 5 - 6 inches long on the left side of her rib cage. I stated to [Administrator] that was done by a gait belt." She also stated, "If you do this long enough you can tell how bruises are caused. When I found it I ask the nurse if she would look at the chart and see if an I/A had been filled out. Me and [LPN #2] looked. There wasn't one, so me and [LPN #2] filled one out."

d. On 10/13/08 at 11:46 a.m., LPN #2 was asked when she saw the bruising on Resident #8 and how did she think the bruise occurred. She stated, "It could've possibly been caused by a gait belt. I don't know that for a fact." The LPN was asked, "Are the nurses required to investigate how bruising occurred?" She stated, "Yes." She was asked if she had other staff members fill out witness statements. She stated, "No."

e. On 10/13/08 at 12:35 p.m., the Assistant Director of Nursing (ADON) was asked if she conducted any type of investigation such as obtaining witness statements. She stated, "I did not."

f. On 10/13/08 at 12:45 p.m., the Administrator, was asked if the facility conducted investigations on injuries such as bruising if staff was unsure how they occurred. She indicated they did and stated, "...We get witness statements from other

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F 225	Continued From page 3 residents and staff on other shifts." g. On 10/13/08 at 1:45 p.m., the resident was in the shower with CNA #5 and a body audit was conducted. There was a bruise on the left rib cage area approximately 4 - 5 inches long, 1 inch wide, dark purple in color. A bruise was also noted to left anterior shoulder. It was round in size and approximately 2 - 3 cm. (centimeters) in width. h. As of 10/13/08, there was no documentation from the Administrator than an investigation was completed and reported to the Office of Long Term Care and other State agencies in accordance with State law for an injury of unknown origin.	F 225		
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Complaint #13969, substantiated, all or in part, in these findings. Based on record review and interview, the facility failed to ensure their abuse policy and procedure was implemented by not completing an investigation and reporting an injury of unknown origin to the Office of Long Term Care (OLTC) and other State agencies in accordance with State law for an injury of unknown origin for 1 (Resident #8) of 1 case mix residents who had an injury of unknown origin. This failed practice had	F 226		

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the potential to affect 74 residents who were cognitively impaired according to a list dated 10/22/08. The findings are:

1. The facility's Abuse Policy and Procedure (no effective date given) documented, "...Investigation - ...the facility will thoroughly investigate, under the direction of the Administrator, all injuries of unknown origin to determine if abuse or neglect was involved... An immediate investigation into the alleged incident, during the shift it occurred on, is initiated as follows: 1. Interview the resident or other resident witnesses (roommate, if appropriate)... 3. Interview all staff on that unit, as well as other staff or other available witnesses... The Administrator, or his/her designee, will ensure that the investigation is completed within 48 to 72 hours..."

2. Resident #8 had a diagnosis of Alzheimer's Disease. The Quarterly Minimum Data Set dated 8/18/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required limited assistance with bed mobility, extensive assistance of one person for transfers and limited assistance of one person for toilet use.

a. The Resident Incident Report dated 10/1/08 at 9:30 a.m. documented, "...resident receiving shower via [CNA (Certified Nursing Assistant) #4]. CNA noticed long bruise to Left side, approx. (approximately) 5 inch long and 1 inch wide."

b. The witness statement by CNA #4 dated 10/1/08 at 9:30 a.m. documented, "When I was giving [Resident #8] her shower I found a deep bruise on her left side. When giving shower I told our administrator and then reported it to [Resident

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F 226	Continued From page 5 #8]'s nurse [LPN #2]. The nurse then wrote out an I/A... Possible cause of event: gait belt... Additional Follow-ups: 10/3/08 Inservice CNAs on gait belt training." c. On 10/13/08 at 9:40 a.m., CNA #4 stated, "When I was giving [Resident #8] a shower, I saw a deep dark purple bruise 5 - 6 inches long on the left side of her rib cage. I stated to [Administrator] that was done by a gait belt." She also stated, "If you do this long enough you can tell how bruises are caused. When I found it I ask the nurse if she would look at the chart and see if an I/A had been filled out. Me and [LPN #2] looked. There wasn't one, so me and [LPN #2] filled one out." d. On 10/13/08 at 11:46 a.m., LPN #2 was asked when she saw the bruising on Resident #8 and how did she think the bruise occurred. She stated, "It could've possibly been caused by a gait belt. I don't know that for a fact." The LPN was asked, "Are the nurses required to investigate how bruising occurred?" She stated, "Yes." She was asked if she had other staff members fill out witness statements. She stated, "No." e. On 10/13/08 at 12:35 p.m., the Assistant Director of Nursing (ADON) was asked if she conducted any type of investigation such as obtaining witness statements. She stated, "I did not." f. On 10/13/08 at 12:45 p.m., the Administrator, was asked if the facility conducted investigations on injuries such as bruising if staff was unsure how they occurred. She indicated they did and stated, "...We get witness statements from other residents and staff on other shifts."	F 226		

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F 226	Continued From page 6 g. On 10/13/08 at 1:45 p.m., the resident was in the shower with CNA #5 and a body audit was conducted. There was a bruise was on the left rib cage area approximately 4 - 5 inches long, 1 inch wide, dark purple in color. A bruise was also noted to left anterior shoulder. It was round in size and approximately 2 - 3 cm. (centimeters) in width. h. As of 10/13/08, there was no documentation from the Administrator than an investigation was completed and reported to the Office of Long Term Care and other State agencies in accordance with State law for an injury of unknown origin.	F 226		
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 #13969, substantiated, all or in part, in these findings. Based on observation, record review and interview, the facility failed to ensure a wound treatment was performed as ordered for 1 of 1 case mix resident (Resident #4) who had a physician order for treatment to a skin tear. These failed practices had the potential to affect 13 residents who received wound treatment according to a list received on 10/13/08 at 1:40 p.m. The findings are:	F 282		

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F 282	Continued From page 7 Resident #4 had diagnoses of Alzheimer's Disease and Acute Renal Failure. The Annual MDS dated 9/15/08 documented the resident was severely impaired in cognitive skills for daily decision-making and totally dependent on staff for activities of daily living (ADLs). a. A Nurse's Note dated 9/30/08 at 4:30 p.m. documented, "CNAs lifted resident up to geri chair for supper, right lower leg hit geri chair causing 2 cm (centimeter) skin tear." b. A Physician Order dated 10/1/08 documented to clean the skin tear on the right leg with normal saline, apply Triple Antibiotic Ointment, cover it with a dressing and to change the dressing every other day. c. On 10/9/08 at 8:20 a.m., the resident had a dressing on the right lower leg dated 10/6/08. d. On 10/9/08 at 3:00 p.m., LPN #1 was asked why the treatment for the resident's leg wasn't done yesterday, 10/8/08. She stated, "That was an oversight on my part." e. On 10/10/08 at 10:16 a.m., the skin tear was horseshoe shaped with a small amount of bloody drainage. The entire perimeter of the wound was red in color and the redness extended 2-3 cm outward. LPN #1 stated, "An oral antibiotic was requested yesterday."	F 282		
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	F 309		

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and plan of care.

This REQUIREMENT is not met as evidenced by:
Complaint #13970 and 13969, substantiated, all or part, in these findings.

Based on observation, record review and interview, the facility failed to ensure staff reported opened and tender sores to the scrotum so treatment could be initiated for 1 of 1 case mix resident (Resident #3) who had opened and tender sores to the scrotum. The facility failed to ensure weekly body audits were completed for 1 (Resident #7) of 5 case mix residents (Resident #1, #3, #4, #5 and #7) who were at risk for skin breakdown. These failed practices had the potential to affect 82 residents who were at risk for skin breakdown according to a list provided by the Assistant Director of Nursing (ADON) on 10/13/08 at 1:40 p.m. The findings are:

1. Resident #3 had diagnoses of Cerebrovascular Accident (CVA) and Hypertension. The Quarterly Minimum Data Set (MDS) dated 8/19/08 documented the resident was severely impaired in cognitive skills for daily decision-making, required extensive assistance with 2 people for bed mobility and was totally incontinent of bowel and bladder.

a. The Care Plan dated 8/27/08 documented in the Problem section, "At risk for skin breakdown due to inability to adequately reposition self without assistance and bowel and bladder incontinence related to CVA." The Approach section documented, "Monitor skin condition

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F 309	Continued From page 9 when providing care and report changes to MD (Medical Doctor)." b. A Weekly Skin Integrity Assessment sheet dated 10/6/08 documented no skin problems to the scrotal area. c. On 10/9/08 at 10:50 a.m., Licensed Practical Nurse (LPN) #1 provided treatment to the resident's buttocks. Certified Nursing Assistant (CNA) #1 assisted with the resident's positioning. The perineal area had numerous small open areas to the scrotum. The areas were pink in color and the scrotum had an irritated appearance. The resident was asked if the area was tender. He stated, "Yes." LPN #1 was asked if she was aware of the open areas on the resident's scrotum. She stated, "No." CNA #1 was asked if she had provided incontinent care for the resident today. She stated yes, that incontinent care was given when the resident was put to bed (9:00 a.m.). The CNA was asked if she had noticed the open areas. She stated, "Yes ma'am. He's had them. He had those areas the last time I worked with him." CNA #1 was asked when was the last time she took care of the resident. She stated, "Yesterday." The CNA was asked if she had reported the areas to the treatment nurse. She stated, "I thought she knew." CNA #1 was asked if any creams were used on the resident after incontinent care to help prevent breakdown. She stated, "We go to the nurse and get Zinc Oxide." She was asked if she had gotten some Zinc Oxide today. She stated, "We didn't get any earlier. We have to get it from the nurse." 2. Resident #7 had a diagnosis of Presenile Dementia. The Annual Medicare Re-admission	F 309		

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F 309	Continued From page 10 MDS dated 7/16/08 documented the resident was moderately impaired in cognitive skills for daily decision-making and required limited to total assistance with ADLs. a. The care plan dated 7/16/08 documented, "Risk for skin breakdown d/t (due to) decreased mobility and bowel and bladder incontinence related to dementia and bladder disorder... Monitor skin condition when providing care and report changes to MD." b. The "Daily Skin Integrity Assessment" dated 9/24/08 documented the most recent body audit. The Audit documented the resident's skin was dry and was intact, "no redness noted." c. On 10/9/08 at 4:17 p.m., there was an area under the resident's right breast that was bright red with a moist appearance. The area extended under the entire breast around toward the armpit in the skin fold and when the resident raised her breast there was a noticeable foul odor. In the skin fold and crease under the breast was a yellowish line. The resident was asked if the area was tender. She stated, "Yes." She was asked how long the area had been there. She stated she didn't know, but that it had been there awhile. The facility was made aware of the area. d. The "Daily Skin Integrity Assessment"dated 10/9/08 and completed by the Director of Nursing (DON) documented, "...redness noted under R/L (right and left) breasts and under arms." Fifteen days had lapsed since the last body audit on 9/24/08. e. The nurse's notes dated 10/9/08 documented by LPN #1, "Excoriation noted under right breast,	F 309		

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F 309	Continued From page 11 right arm. Family notified. Doctor notified orders received and noted..."	F 309		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #13970, substantiated, all or in part, in these findings. Based on observation, record review and interview, the facility failed to ensure 2 staff persons performed transfers to prevent the potential for injuries for 2 (Residents #3 and #2) of 4 (Residents #2, #3, #4, #5) case mix residents who required 2 people for assistance with transfers. This failed practice had the potential to affect 26 residents in the facility who required 2 people for assistance with transfers according to the Medicare Care Plan Coordinator on 10/13/08 at 3:00 p.m. The findings are: 1. Resident #3 had a diagnosis of Cerebrovascular Accident (CVA). The Quarterly Minimum Data Set (MDS) dated 8/19/08 documented the resident was severely impaired in cognitive skills for daily decision making and required extensive assistance of 2 plus persons for transfers. a. The Care Plan dated 8/27/08 documented in	F 323		

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the Problem section, "At risk for falls due to left sided weakness and impaired ROM (Range of Motion) related to CVA."

b. On 10/8/08 at 2:20 p.m., the resident was in a wheelchair in his room. CNA (Certified Nursing Assistant) #2 and the ADON (Assistant Director Nursing) was present in the room. CNA #2 placed a gait belt around the resident's waist to transfer him from the wheelchair to the bed. The CNA lifted the resident by herself, grabbing the gait belt and the waist band of the resident's pants resulting in the pants being pulled up tight in the perineal area. The resident was not capable of bearing weight. He was then placed on the bed. The Vital Sign & Weight Flow Sheet dated 9/29/08 documented the resident's weight was 192 pounds

c. On 10/10/08 at 11:15 a.m., CNA #2 was asked if she had been trained on how to transfer a resident who was totally dependent, such as Resident #3. She stated, "Well, that was my first time on that hall. They really didn't show me much. I know he's a two person, or at least I think he is." CNA #2 was asked why she transferred the resident by herself if she felt he was a two person assist. She stated, "I thought the other lady in there was gonna help me, but I guess because I had the gait belt, I just did it." The CNA was asked if she had been instructed not to transfer a resident by grabbing the waist band of their pants. She stated, "Yes."

d. On 10/13/08 at 1:20 p.m., the ADON was asked why she didn't intervene when CNA #2 transferred the resident by herself. She stated, "Really, it was because I didn't want to make a big scene because ya'll were in the room. I did say

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045408	A. BUILDING ___ B. WING ___	C 10/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF BENTON	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 323	Continued From page 13	F 323		

something to her afterward." The ADON was asked why she didn't assist the CNA with the transfer. She stated, "Well she had already started getting him up and I couldn't."

e. The facility's Transfer Policy and Procedure 2006 documented, "...Procedure: Obtain assistance of another individual if necessary for safe transfer."

2. Resident #2 had a diagnosis of Bilateral Above the Knee Amputations. The resident was readmitted to the facility on 9/25/08. The MDS dated 6/10/08 documented the resident had modified independence in cognitive skills for daily decision making and required total assistance of one person with transfers.

a. The Care Plan dated 9/26/08 documented, "Functional Status for Transfers: 2 person assist and total assist."

b. On 10/10/08 at 1:35 p.m., CNA #3 lifted the resident from the w/c (wheelchair) to the bed. CNA #3 wrapped her arms around the resident's waist and requested the resident place her arms around the CNA's neck. The CNA began to lift and transfer the resident on to the bed by herself without assistance. She was asked why did she transfer the resident like that. She stated, "I didn't know how she was to be transferred. I know not to use a gait belt to lift like that. That's the only way I know to transfer her."

c. The closet care plan located behind the resident's closet door did not document how the resident was to be transferred.

d. On 10/10/08 at 3:45 p.m., the Medicare

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	045408	A. BUILDING ______ B. WING ______	C **10/13/2008**

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F 323	Continued From page 14 MDS/Care Plan (C/P) Coordinator was asked who was responsible for updating the closet care plans. She indicated the last C/P Coordinator was responsible for updating them. She no longer works at the facility.	F 323		