

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

PRINTED: 01/05/2007
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 C 12/08/2006
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF BENTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 ALCOA ROAD BENTON, AR 72015	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 176 SS=D	<p>Complaint #12163 was substantiated (all or in part) with deficiencies cited at F176 and F514.</p> <p>483.10(n) SELF ADMINISTRATION OF DRUGS</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #12163 was substantiated (all of in part) in these findings:</p> <p>Based on observation, record review and interview the facility failed to ensure that before residents were allowed to self-administer updraft treatments, the Interdisciplinary Team determined this practice was safe for 1 (Resident #1) of 2 (Residents #1 and #2) case-mix residents with an order for updraft treatment. This failed practice had the potential to effect 9 residents in the facility with orders for updraft treatments, according to a list provided by the Director of Nurses on 12/7/06. The findings are:</p> <ol style="list-style-type: none"> 1. Resident #1 had diagnoses of Emphysema and Chronic Airway Obstruction. A 30-Day Medicare Minimum Data Set dated 12/1/06 documented the resident had independent cognitive skills for daily decision making, Chronic Obstructive Pulmonary Disease, shortness of breath, was unable to lie flat due to shortness of breath and received oxygen therapy. 2. The resident had a Physician order dated 11/1/06 that documented, "Proventil/Albuterol 	F 176		1/11/07

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 176	Continued From page 1 Updraft QID (4 times a day) [May use Duoneb]." 3. On 12/5/06 at 5:13 p.m., the resident was sitting on the side of the bed receiving an updraft treatment via a mask. There was not a nurse present in the room. Registered Nurse (RN) #1 was in the hall, at the medication cart, preparing medications for administration. The RN was then in and out of other resident's rooms administering the medications and entered one resident's room and shut the door, leaving the resident out of the RN's eye sight several times. 4. On 12/5/06 at 5:31 p.m., when she entered the resident's room, the resident had completed the updraft treatment; the resident stated that she had finished her updraft, turned off the updraft machine, had put the updraft mask in a plastic bag and had put the mask into the drawer of the bedside table. 5. 12/6/06, the clinical record contained no documentation of an interdisciplinary team assessment, a Physician order or care plan for self-administration of medications. 6. On 12/6/06 at 2:19 p.m., when asked if there was a Physician order for the resident to self-administer the updraft, RN #2 stated she was not able to self administer medication. She stated that she was unable to provide a care plan for self-administration or provide documentation that the resident was assessed by the interdisciplinary team for self-administration. 7. The Policy and Procedure provided by the facility on 12/6/06 documented, "...If the resident wishes to self-administer medications, the interdisciplinary team must assess the resident's	F 176			

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F 176	Continued From page 2 cognitive, physical, and visual ability to administer his own medications. . . A care plan for the resident that includes the policy and procedures for the self administering of medications (including the storage and documentation of administration) will be written to assure the safely and appropriate use of the medications and the safety of other residents in the facility when a resident chooses to self administer medications. . . A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician. . . The physician's order must be signed and dated prior to self-administration. . ."	F 176		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that oxygen was administered at the rate ordered by the Physician for 1 (Resident #3) of 3 (Resident #2, #3 and #4) case-mix residents with oxygen. This failed practice has the potential to effect 13 residents in the facility that received oxygen therapy, according to a list provided by the	F 328		1/7/07

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F 328	Continued From page 3 Director of Nurses on 12/7/06. The findings are: 1. Resident #3 had diagnoses of Chronic Obstructive Pulmonary Disease, Chronic Airway Obstruction and Bronchitis. An Admission Minimum Data Set (MDS) dated 11/23/06 documented the resident had independent cognitive skills for daily decision making, shortness of breath and received oxygen therapy. a. The resident had a Physician order dated 11/19/06 that documented, "O2 (oxygen) 2 L (Liters) via N/C (Nasal Canula)." b. On 12/6/06 at 9:21 a.m., the resident was receiving oxygen from an oxygen concentrator at 3 and 1/2 liters per minute via nasal cannula. c. On 12/6/06 at 12:00 noon, the resident was receiving oxygen from an oxygen concentrator at 3 and 1/4 liters per minute via nasal cannula. d. The Policy and Procedure of Oxygen Administration provided by the facility documented, "...The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration..."	F 328		
F 514 SS=B	483.75(I)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514		1/7/07

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F 514	<p>Continued From page 4</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #12163 was substantiated (all of in part) in these findings:</p> <p>Based on observation, record review and interview the facility failed to ensure updraft treatments were properly documented for 1 (Resident #5) of 3 (Resident #1, #2 and #5) case-mix residents with updrafts. This failed practice had the potential to effect 9 residents in the facility that received updraft treatments, according to a list provided by the Director of Nurses on 12/7/06. The findings are:</p> <p>1. Resident #5 had diagnoses of End Stage Chronic Obstructive Pulmonary Disease, Emphysema, Acute Myocardial Infarction and Congestive Heart Failure. A Medicare 30-Day MDS dated 10/26/06 documented the resident had modified independence in cognitive skills for daily decision making, required extensive physical assistance of one staff person for activities of daily living and had emphysema and shortness of breath.</p> <p>a. The resident had a Physician order dated 9/27/06 that documented, "Duo Neb updrafts PRN (as needed) and another Physician order dated 11/14/06 that documented," D/C (discontinue) Duo Neb updraft q (every) 6 hrs (hours)." Then: " Duo Neb up Drafts QID (4 times</p>	F 514		

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F 514	Continued From page 5 a day)." b. Review of the resident's medication administration record, copied 12/6/06, determined that although the count of the remaining Duo Neb vials on the medication cart indicated the medication had been administered, there was no documentation since 11/10/06 that indicated the resident had received the Duo Neb four times a day, as ordered by the Physician. c. During an interview on 12/7/06 at 10:23 a.m., Registered Nurse #3 stated she was unable to provide documentation that indicated the Duo Neb Updraft had been administered to the resident since 11/10/06.	F 514			