STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045220	A. BUILDING ______ B. WING ______	05/16/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE HEALTH AND REHABILITATION CENTER	**3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703**

(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 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure care was provided in a manner to promote residents' dignity, as evidenced by failure of staff to gain permission prior to entering resident rooms and failure to administer eye drops, injections and inhalers in a private area. The failed practice had the potential to affect 27 residents who resided on the "E" and "F" Halls, as documented on the Resident Roster Report dated 5/12/08. The findings are: 1. On 5/14/08 at 11:19 a.m., Licensed Practical Nurse (LPN) #4 entered Resident #15's room without knocking, left the door open and administered the resident's eye drops. 2. On 5/14/08 at 11:30 a.m., LPN #4 entered Resident #28's room without knocking, left the door open and administered the resident's insulin injection. 3. On 5/14/08 at 11:55 a.m., LPN #4 entered Resident #28's room without knocking, left the door open and administered the resident's oral inhalers. 4. On 5/15/08 at 7:35 a.m., LPN #5 entered a non case mix resident's room without knocking, left the door open and administered the resident's nasal spray.	F 241		

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 241	Continued From page 1 5. On 5/15/08 at 7:37 a.m., LPN #5 entered a non case mix resident's room without knocking, left the door open and administered the resident's eye drops. 6. On 5/15/08 at 7:50 a.m., LPN #5 entered Resident #29's room without knocking, left the door open and administered the resident's pain patch to his lower back. The LPN returned at 8:07 a.m., failed to knock on the door, entered the room, left the door open and administered the resident his oral inhalers. The LPN returned at 8:15 a.m. and again entered the room without knocking.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure an activity plan based on individual interests was developed and implemented, failed to ensure in-room activities were provided and failed to ensure outcomes/responses to activities were documented for 4 (Residents #14, #4, #20 and #21) of 4 case mix residents who required in-room activities. The failed practices had the potential to affect 38 residents who required one-on-one activities, as documented on a list provided by the Activity Director on 5/16/08. The findings are:	F 248		

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1. Resident #14 had a diagnosis of Anoxic Brain Syndrome. The Annual Minimum Data Set (MDS) dated 8/6/07 documented the resident had short/long term memory problems, was dependent on staff for all activities of daily living, was rarely/never understood, was sometimes able to understand others, had unclear speech, was awake morning, afternoon and evening and spent 1/3 to 2/3 of the time involved in activities, preferred activities in the day/activity room and inside the facility/off the unit and had activity preferences which included music, spiritual/religious activities and talking or conversing.

a. The Quarterly Minimum Data Set (MDS) dated 2/8/08 documented the resident had short/long term memory problems, was dependent on staff for all activities of daily living, was awake morning, afternoon and evening and spent less than 1/3 of the time involved in activities.

b. The Plan of Care developed 8/16/07 and updated on 10/25/07 and 2/1/08 documented the following:

1.) "Impaired communications r/t [related to] cognitive deficits, expressive aphasia, blindness, unable to voice needs... Take her to activities such as Music Programs, Church, Bible Sturdy, Birthday Programs, Etc [et cetera]. Get her out of room often."

2.) "Alteration in Nutrition - Potential for weight loss r/t spits out food at times, having own teeth, wt. [weight] loss since admission... Involve Resident in food related activities as tolerated."

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F 248	Continued From page 3 3.) "Mood/behavior of restlessness, constantly thrashing legs, spitting out meds [medications] or food... Provide activities resident does not have to participate in such as Music, Church, Etc." c. The Activity Progress Notes dated 2/1/08 documented: "[Resident] remains the same at this time with no changes. Resident loves TV [television], music and pet therapy. When we show resident a puppy she smiles and says puppy. Resident is invited to all activities but has the right to refuse. Resident has meals in DR [dining room]." d. On 5/13/08 from 8:25 a.m. to 11:48 a.m., the resident was sitting in a Broda chair in her room. The radio on top of the dresser was turned off and there was no television in the room. e. On 5/13/08 at 12:40 p.m., the resident was transferred to bed by Certified Nursing Assistant (CNA) #7 and Registered Nurse (RN) #1. The radio remained off when the staff left the resident's room. f. On 5/13/08 at 2:10 p.m., the resident remained in bed with the radio off. f. The Nursing Assistant Information form obtained on 5/14/08 documented: "Take her to activities such as Music Programs, Church, Bible Study, Birthday Programs, Etc. Get her out of room often." g. On 5/15/08 at 12:47 p.m., the resident was sitting in her room in a Broda chair. The radio was off. h. On 5/15/08 at 3:10 p.m., the Activity Calendar	F 248		

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F 248	Continued From page 4 was reviewed. The calendar documented: "Gospel Music w/ [with] 2nd mile" as the activity for 5/14/08 at 10:30 a.m. The Activity Director was interviewed on 5/15/08 at 3:10 p.m. and stated the resident did not attend the music activity on 5/14/08 because she had to help with the barbecue. She stated the resident enjoyed watching TV. When asked where the resident watched TV, the Activity Director stated, "Well, she doesn't have one in her room, but usually watches TV at the nursing circle." She also stated the resident enjoyed listening to country music on her radio. The Activity Director was asked for documentation of activities provided to this resident. She furnished copies of her one-on-one visits for the year 2008. These notes documented on 1/2/08, the resident was read a story. On 2/6/08, the resident was read a story out of a Reader's Digest. On 4/7/08, the resident received Sensory Therapy and pet therapy. There was no other documentation of any one-one activities provided to this resident. 2. Resident #4 had a diagnosis of Alzheimer's Disease with Dementia. The Annual MDS dated 3/14/08 documented the resident had short/long term memory problems, was severely impaired in cognitive skills for daily decision making, dependent on staff for transfers, was awake all or most of time in the morning and afternoon, spent little time in activities, preferred activities in her own room and the Day/Activity room and had activity preferences including music, spiritual/religious activities and watching TV. a. The Plan of Care developed 3/21/07 and updated 3/20/08 documented: "Unable to perform self-care... Assist to activities as needed attends spiritual and musical programs, TV, Movies...	F 248		

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F 248	Continued From page 5 Resident has mood indicators of occasional crying, restless, picking, resist care at times... Provide activities resident is capable of participating in." b. The Activity Progress Notes dated 3/20/08 documented: "Resident remains the same at this x [time] with no changes. Resident is now on Hospice. Resident will smile when music is playing. Resident comes to church and enjoys sensory therapy. Resident is invited to all activities but has the right to refuse. Resident has meals in DR [dining room] x 3 [times 3 meals per day]." c. The one-on-one activity visit documentation for the year 2008 (provided by the Activity Director) documented an entry dated 4/14/08, "I did sensory therapy with [Resident #4] she smiled." No other one-on-one activity visits were documented for this resident for 2008. d. On 5/12/08 at 1:46 p.m. during the initial tour of the facility, the resident was in bed on her left side. e. On 5/13/08 at 8:20 a.m.,9:55 a.m. and 10:15 a.m., the resident was in bed. The TV was off. f. On 5/13/08 at 10:50 a.m., 10:55 a.m. and 11:35 a.m., the resident was sitting in a wheelchair at her bedside. The TV was off. At 1:45 p.m., Certified Nursing Assistants (CNA's) #6 and #8 transferred the resident to bed. The TV was not turned on for the resident. g. On 5/14/08 at 8:15 a.m., the resident was in bed on her left side. The television was off.	F 248		

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F 248	Continued From page 6 h. On 5/15/08 at 3:10 p.m., the Activity Director stated the resident enjoyed Country Music and the dog. The Activity Director accompanied the Surveyor to the resident's room. The resident was in bed and the TV was off. 3. Resident #20 had a diagnosis of Congestive Heart Failure. The Annual MDS dated 4/22/08 documented the resident had short/long term memory problems, rarely/never understood and rarely/never understands, was dependent on staff for all activities of daily living, was awake in the morning, afternoon and evening, spent 1/3-2/3 of the time involved in activities, preferred activities in the day/activity room and had activity preferences which included spiritual/religious activities, watching TV and talking/conversing. a. The Activity Progress Notes dated 2/1/08 documented: "Resident is so sweet and loves to sing. Resident loves music, visits with fam [family] and TV. Resident comes to gospel music and claps her hands at times. Resident is invited to all activities but has the right to refuse. Resident has meals in DR x 3." b. The Activity Progress Notes dated 4/24/08 documented: "Resident remains the same at this time with no changes. Resident seems to be declining. I just love her, I hate to see her get worse. Resident has family visit every day. Resident is invited to all activities but has the right to refuse. Resident is a feeder in the DR x 3." c. The One-on-one Activity Log documented the following entries: 1.) On 1/28/08: "[Resident] and I sung songs. She sings in Japanese. She laughed at my	F 248		

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F 248	Continued From page 7 singin. I don't blame her." 2.) On 4/8/08: "Did extra sensory therapy with [Resident]." There was no other documentation of one-on-one activity visits on the log. d. On 5/12/08 at 1:47 p.m. during the initial tour, the resident was in bed on her left side. The room was dark with the curtain drawn. There was no TV or radio on. e. On 5/15/08 at 11:45 a.m., the resident was sitting in a wheelchair at the bedside. The room was dark. There was no TV for this resident. Her roommate had a TV on the large dresser but it was turned off. At 1:30 p.m. and 4:00 p.m., the resident was in bed. She was turned to her left side. She had no TV or radio in her area of the room. f. On 5/16/08 at 8:20 a.m., the resident was sitting in a wheelchair in her room at the bedside. She was facing the wall. The room was dark and there was no radio or TV in her area of the room. The roommate's TV was off. g. On 5/16/08 at 10:30 a.m., the Activity Director was asked, "Have you checked into getting any music in her language since she does not understand English?" She replied "No, that's a good idea. We have joined the library club, so maybe we can find someone to read to her in Japanese, or I could ask her family to tape some music for her." 4. Resident #21 had a diagnosis of Arteriosclerosis Delusion/Dementia. The Annual MDS dated 4/17/08 documented the resident had short/long term memory problems, was	F 248		

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moderately impaired in cognitive skills for daily decision making, had indicators of depression, anxiety, sad moods that were exhibited up to five days per week and were easily altered, exhibited physically abusive behaviors, resisted care and required extensive to total assistance for activities of daily living. The Activities section of the MDS documented the resident spent time awake in the morning, spent little (less than 1/3 of the time) involved in activities, preferred activities in her own room, the day/activity room and inside the nursing home/off the unit and had activity preferences which included reading/writing, spiritual/religious, watching TV, gardening/plants and talking/conversing.

a. The Plan of Care updated 4/17/08 documented: "Behavior problems of threatening other resident with bodily harm... thinks roommate is another woman with her husband... Provide Activities resident is capable of participating... Impaired communication r/t hearing loss, Dx [diagnosis] of Alzheimers Dementia, loses train of thought, Does voice occasional concrete need... Spend one on one time with her, She does respond to visits with staff."

b. The one-on-one visit documentation for the year 2008 (provided by the Activity Director) documented the resident received a one-on-one activity visit on 4/8/08, "Did extra sensory therapy." There was no other documentation of one-on-one activities for this resident.

5. On 5/15/08 at 3:10 a.m., the Activity Director was interviewed as follows:

Surveyor: "Who is responsible for ensuring radios

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F 248	Continued From page 9 and televisions are turned on in resident rooms?" Activity Director (AD): "I check and turn on what they want to listen to." Surveyor: "Where do you document one-on-one activities?" AD: "In the activity room, I have a pad that I carry around with me, then put it into a folder. I go around to people that don't want to go to activities... I could not do the Parachute [activity] this morning because they laid them down after breakfast." Surveyor: "What do you do for [Resident #14]?" AD: "She watches TV at the nursing circle quite a bit and country music on her radio." Surveyor: "What do you do for [Resident #4]?" AD: "She loves country music on her TV." Surveyor: "What do you do for [Resident #20]?" AD: "They lay her down a lot - I've said, 'please get her to music.'" Surveyor: "What do you do for [Resident #21]?" AD: "She will do kick ball - catch ball and throws back. She comes [to activities] at times."	F 248		
F 282 SS=E	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	F 282		

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F 282	Continued From page 10 care. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure the physician's plan of care was implemented for 2 (Residents #5 and #20) of 13 case mix residents with physician orders for therapeutic diets (Residents #2, #3, #4, #5, #9, #11, #13, #15, #17, #20, #21, #22 and #24). The failed practice had the potential to affect 72 residents with physician orders for therapeutic diets, as documented on the Resident Diet Report provided by the facility on 5/12/08 at 5:20 p.m. The findings are: 1. Resident #5 had diagnoses of Dementia with Behavior Disturbances, Diabetes, Hypertension and Cerebrovascular Disease. A physician order dated 1/22/08 documented the resident was to receive a carbohydrate controlled, heart healthy diet. a. On 5/13/08 at 12:48 p.m., the resident was served fried chicken, mashed potatoes, stewed tomatoes, fruit cobbler, margarine and salt. The facility's menu for this date did not document a meal plan for a heart healthy diet. b. On 5/14/08 at 8:02 a.m., the resident was served a breakfast tray of scrambled eggs, toast with gravy, sausage and oatmeal with margarine. The facility's menu for this date did not document a meal plan for a heart healthy diet. 2. Resident #20 had a diagnosis of Dehydration. A physician order dated 1/24/08 documented the resident was to	F 282		

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F 282	Continued From page 11 receive a pureed diet, chocolate Mighty Shakes with each meal and liquids thickened to nectar consistency. a. On 5/13/08 at for the lunch meal, the resident received a bowl of cottage cheese that was not pureed and the pureed chicken with this meal had chunks of chicken that were not thoroughly pureed. b. On 5/14/08 for the lunch meal, the resident sat at the assist table in the dining room and was served cottage cheese that was not pureed and a chocolate Mighty Shake with no thickener.	F 282		
F 314 SS=E	483.25(c) PRESSURE SORES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure pressure relief for the feet and turning/repositioning were provided and failed to ensure a physician-ordered protein supplement was obtained and administered to promote healing of a Stage IV pressure ulcer for 1 of 1 case mix resident with a Stage IV pressure ulcer (Resident #6). The facility failed to ensure turning/repositioning were provided at least every 2 hours in accordance	F 314		

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with the Plan of Care or accepted standards of nursing practice to prevent potential pressure ulcer development for 2 (Residents #4 and #14) of 4 case mix residents who resided on the B Hall and were at risk for pressure ulcers (Residents #4,#14, #20 and #21). The failed practices had the potential to affect 7 residents with existing pressure ulcers, as documented on the Resident Census and Conditions of Residents form dated 5/12/08 and 18 residents who resided on the B Hall and were at risk for pressure ulcers, as documented on a list provided by Licensed Practical Nurse (LPN) #6 on 5/16/08 at 11:30 a.m. The findings are:

1. Resident #6 had a diagnosis of Open Wound Coccyx. The Quarterly Minimum Data Set dated 5/1/08 documented the resident was severely impaired in cognitive skills for daily decision making, dependent on two or more staff for bed mobility and transfers, had a Stage IV pressure ulcer, was on a turning/repositioning program and received nutrition or hydration interventions to manage skin problems.

a. As of 5/16/08, the most recent pre-albumin level documented in the resident's clinical record was a Laboratory Report dated 2/7/08 which documented the pre-albumin was 8, with normal levels documented as 18 to 45.

b. The Plan of Care updated 4/4/08 documented: "Potential for skin breakdown r/t [related to] immobility and incontinence and combativeness with Stage IV coccyx 8 cm [centimeters] x [by] 9 cm x 3cm, Rt. [right] Lateral Heel 0.3 cm x 0.2 cm and right lateral foot 1 cm x 1 cm... hard & [and] dry... RD [Registered Dietitian] consult as needed, wound vac [vacuum], and Multi Podus boots."

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The Plan of Care did not address the need to turn and reposition the resident when in the bed or chair.

c. The Dietary Progress Notes dated 5/7/08 by the RD documented: "...Treatment continues to St [Stage] IV decub [decubitus] on coccyx. Suggest adding 1 scoop protein powder 2 x [twice per] day..."

1.) A physician order dated 5/8/08 documented: "Promod protein powder 1 scoop w/ [with] bolus feedings BID [twice daily]."

2.) The May 2008 Medication Administration Record (MAR) documented the physician order for Promod twice daily. A handwritten entry written across the columns for 5/9/08 through 5/12/08 documented: "Unavailable see nn [Nurses' Notes]." The MAR documented the resident received the first dose of Promod on 5/13/08 at 6:00 a.m.

3.) Nurses' Notes dated 5/13/08 documented: "Promod has been ordered from Durable Medical Supply. Will start when available."

4.) On 5/16/08 at 12:20 p.m., the Supply Clerk stated the Promod did not arrive at the facility until 5/14/08. The Medical Supply Invoice documented the Promod was ordered on 5/13/08 and was delivered to the facility on 5/14/08.

d. On 5/13/08 at 9:30 a.m., the resident was in bed on her left side. There was no padding/boots on the resident's feet. The resident was transferred to the Broda Chair by Certified Nursing Assistants (CNA's) #3 and #5 at this time. The resident's position in the Broda chair

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was marked by the Surveyor with a white piece of paper under the resident's left thigh.

e. On 5/13/08 at 10:30 a.m., the resident remained in the same marked position. At 11:45 a.m., the resident was wheeled into the dining room. She remained in the same marked position in the Broda Chair and had no Podus boots or padding to her feet.

f. On 5/13/08 at 1:13 p.m., the resident remained in the Broda Chair in the same marked position. At 1:15 p.m., Certified Nursing Assistant (CNA) #3 stated the resident had to stay up in her chair until after her tube feeding bolus. At 1:50 p.m., the resident received one can of Jevity 1.5.

g. On 5/13/08 at 3:45 p.m., the resident remained in the same marked position in the Broda Chair. The resident had been in the same marked position for 6 hours and 15 minutes.

h. On 5/14/08 at 9:25 a.m., the Director of Nursing (DON) and Treatment Nurse were asked about the resident remaining up in the Broda Chair for 6 hours and 15 minutes. Both Nurses stated the resident should have been laid down or walked after lunch.

2. Resident #14 had a diagnosis of Anoxic Brain Syndrome. The Quarterly Minimum Data Set (MDS) dated 2/8/08 documented the resident was dependent on two or more staff for transfers, incontinent of bowel and bladder, had no pressure ulcers and was on a turning/repositioning program.

a. The Plan of Care developed 8/16/07 and updated on 10/25/07 and 2/1/08 documented: "At

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F 314	Continued From page 15 risk for skin breakdown r/t immobility, contractures, Raynaud Syndrome, Incontinence, present cellulitis left leg and restraint use... Turn her q [every] 2 hrs [hours] and check for incont [incontinence]." b. On 5/13/08 at 10:00 a.m., the resident was sitting in a Broda Chair at the bedside with a belt restraint in place. Her position was marked by the Surveyor at this time, with a white piece of paper under the left thigh between the lift sling and the chair. c. On 5/13/08 at 11:38 a.m., the resident remained in the same marked position. CNA #6 was asked if the resident had been moved since 8:25 a.m. She stated, "No." The CNA was then asked, "Did you get her up this morning or was she already up when you came in?" She stated, "She was up when I got here. Night shift gets her up." The CNA was asked what time her shift began. She stated, "6:00 a.m." The CNA was asked if she checked the resident for incontinence that morning. She stated, "Yes, we checked her around 8:30 a.m." She was then asked if the resident had been laid down for the incontinence check. The CNA stated, "No, we check her in the chair." d. On 5/13/08 at 11:48 a.m., the resident remained in the same marked position in the chair and was wheeled to the dining room by staff. e. On 5/13/08 at 12:40 p.m., CNA #7 and Registered Nurse (RN) #1 transferred the resident to the bed using the lift. The RN was asked " Were you aware of the resident being up in the chair since before 6:00 a.m. without having	F 314		

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a position change?" She replied " Yes, I know. If we lay her down, she sometimes will attempt to throw herself out of bed." She was then asked, " Were you aware that the last time this resident was checked for incontinence was at 8:30 a.m.?" She stated, "No, I wasn't." The incontinent brief was removed from the resident. The brief was dry but had a brown substance in the anal area. RN #1 used a peri wipe to cleanse the resident from the vaginal area back over the anus twice. The wipe had a brown substance on it. A clean brief was then applied. No barrier cream was applied.

3. Resident #4 had a diagnosis of Alzheimer's Disease with Dementia. The Annual MDS dated 3/14/08 documented the resident was severely impaired in cognitive skills for daily decision making, dependent on staff for bed mobility and transfers, incontinent of bowel/bladder, had a Stage II pressure ulcer and was on a turning/repositioning program.

a. The Plan of Care developed 3/21/07 and updated 3/20/08 documented: "Increased risk for skin breakdown r/t present Stage II to coccyx, rash to L [left] side of neck, incont. [incontinent], restraint use & [and] low body wt [weight] & dementia... Bed mobility: Dependent on staff assist [assistance]. Follow turn schedule, reposition res. [resident] Q [every] 2 hours & PRN [as needed] and bed positioner to be placed between resident knees at all x's [times] when she is in bed."

b. On 5/12/08 at 1:46 p.m. during the initial tour, the resident was in bed on her left side. There was no positioner or padding between her knees or ankles.

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c. On 5/13/08 at 8:20 a.m., the resident was in bed on her left side. There was no padding between her ankles, which were lying on top of each other. Her position was marked by the Surveyor at this time with a pen mark on the incontinent pad at the left buttock. At 10:50 a.m., the resident was transferred to the chair after lying in the same marked position for 2.5 hours.

d. On 5/13/08 at 10:55 a.m., the resident was sitting in a wheelchair with a belt restraint in place. Her position was marked by the Surveyor at this time with a white piece of paper under her right buttock. At 11:40 a.m., the resident was wheeled to the dining room. She remained in the same marked position in the wheelchair.

e. On 5/13/08 at 1:45 p.m., the resident remained in the same marked position in the wheelchair. CNA's #6 and #8 transferred the resident to bed. The resident was turned to her left side. No padding was placed between her knees or ankles. The resident had remained up in the chair for 2 hours and 55 minutes.

f. On 5/14/08 at 8:15 a.m., the resident was in bed on her left side with no positioner or cushion between her knees or ankles. A sign over the resident's bed documented the resident was to have a Abductor/Contraction Cushion when in bed. RN #1 was asked at this time if the resident was to have any padding between bony prominences. She stated, "Yes, she has a special cushion for her knees." RN #1 began to search the resident's room for the cushion and located it in the floor of the resident's closet. RN #1 removed the resident's socks and there was a dark red blanchable area to the right medial

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F 314	Continued From page 18 metatarsal head.	F 314		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the perineal area was cleansed of feces after an incontinent bowel movement to decrease the risk of Urinary Tract Infections (UTI's) for 1 (Resident #5) of 6 case mix residents who were dependent on staff for incontinent care (Residents #4, #5, #6, #7, #9 and #10. The failed practice had the potential to affect 57 residents who were occasionally or frequently incontinent of bladder and 47 residents who were occasionally or frequently incontinent of bowel, as documented on the Resident Census and Conditions of Residents form dated 5/12/08. The findings are: Resident #5 had diagnoses of Bowel and Bladder Incontinence and Cerebrovascular Accident. The Minimum Data Set dated 3/26/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with personal hygiene, bathing and toilet use and was incontinent of bowel and	F 315		

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bladder.

a. The Care Plan dated 3/10/06 documented: "Frequently incontinent of urine and occasional bowel incontinence r/t [related to] DX [diagnosis] of Dementia, routine Lasix use, and impaired mobility... utilizes brief - staff to toilet resident Q [every] 2 hours and PRN [as needed] providing pericare when toileting and after each incontinent episode."

b. A Laboratory Report dated 10/16/07 documented results of a Urinalysis with Culture as, "heavy Group B Beta Strep > [greater than] 1,000,000."

c. A Laboratory Report dated 10/19/07 documented results of a Urinalysis with Culture as, "heavy Streptococcus Agalactiae > 1,000,000."

d. A Laboratory Report dated 12/23/07 documented results of a Urinalysis with Culture as, "heavy Streptococcus Agalactiae > 1,000,000."

e. On 5/12/08 at 2:15 p.m., the resident was incontinent of soft brown stool that ran out of the incontinent brief and onto the bed linens. Certified Nursing Assistant (CNA) #1 turned the resident to her right side and, without cleansing her left buttock/hip, inner thighs, perineum, supra-pubic area or groin area, applied Lantiseptic barrier cream and placed a clean brief on the resident. As CNA #1 and CNA #2 were preparing to tape the brief into place, they were asked if incontinent care was completed. Both CNA's nodded their heads. CNA #1 was asked by the Surveyor to pull back the brief, get a clean

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F 315	Continued From page 20 peri-wipe and wipe the resident's perineal area and show the wipe to the Surveyor. CNA #1 complied with this request and the peri-wipe was soiled with a significant amount of soft feces upon wiping the perineal area. The mid to front area of the clean brief was also soiled with fecal material. Four additional peri-wipes were needed to remove the feces from the resident's perineal area.	F 315		
F 318 SS=E	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure positioning devices were utilized in accordance with the Plan of Care to prevent further declines in range of motion for 3 (Residents #4, #5 and #14) of 6 case mix residents with contractures (Residents #1, #4, #5, #6, #11 and $14). The failed practice had the potential to affect 8 residents with contractures, as documented on the Resident Census and Conditions of Residents form dated 5/12/08. The findings are: 1. Resident # 5 had diagnoses of Cerebrovascular Accident (CVA), Dementia with Behavior Disturbance and Depressive Disorder. The Minimum Data Set (MDS) dated 3/26/08 documented the resident had short and long term	F 318		

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F 318	Continued From page 21 memory problems, was moderately impaired in cognitive skills for daily decision making, required extensive assistance with bed mobility, transfers, hygiene, bathing and toilet use, was totally dependent on staff for dressing and had partial loss of voluntary movement with limitation of range of motion in one arm, hand, leg and foot. a. The Care Plan dated 10/30/06 and updated 2/18/08 documented, "Actual contractures related to contractures left arm and hand... use positioning devices for support, encourage proper body alignment." b. On 5/12/08 at 2:00 p.m. during the initial tour, Registered Nurse (RN) #1 stated the resident had contractures in her left arm and hand. There was no hand roll or other positioning device in place to her left hand, which was was severely contracted at the fingers and wrist. The left elbow was also contracted into a flexed position at the resident's chest. c. On 5/13/08 at 10:25 a.m., there was no hand roll or other positioning device in the resident's contracted left hand. d. On 5/13/08 at 11:45 a.m., RN #1 was asked to open the resident's left hand. She was only able to move the fingers out slightly, as they were severely contracted into a flexed position. There was a strong, offensive odor inside the resident's hand and the RN stated she could smell it and would wash the resident's hand. At 11:50 a.m., RN #1 was asked if the facility had used hand rolls on this resident. She stated, "Oh yeah, I try to take care of her hand using washcloths and keeping it clean, but sometimes the CNA's [Certified Nursing Assistants] don't use it." The	F 318		

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RN asked the resident if she would allow her to use a hand roll after cleaning her hand. The resident stated, "Yes."

e. On 5/14/08 at 7:08 a.m. and 9:35 a.m., there was no hand roll or other positioning device in the resident's contracted left hand.

2. Resident #14 had a diagnosis of Anoxic Brain Syndrome. The Quarterly Minimum Data Set (MDS) dated 2/8/08 documented the resident had short/long term memory problems, was dependent on staff for all activities of daily living and had full loss of functional range of motion in both hands.

a. The Plan of Care developed 8/16/07 and updated 10/25/07 and 2/1/08 documented: "Actual contractures r/t arms and hands fully contracted... Bilat [bilateral] air splints to hands for contractures."

b. The Functional Maintenance Plan dated 1/28/08 by Occupational Therapy documented: "[Resident] to wear [bilateral] air splints daily."

c. On 5/12/08 at 2:00 p.m. during the initial tour, the resident was in bed. Both hands were contracted and there was a rolled washcloth in the right hand. No air splints were in use.

d. On 5/13/08 at 8:25 a.m., 10:00 a.m., 11:38 a.m., 12:25 p.m. and 12:40 p.m., the resident was sitting in a Broda chair. There were no washcloths, handrolls or splints to the resident's hands. At 12:40 p.m., RN #1 was asked why the resident did not have washcloths in her hands. She stated, "I don't know."

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F 318	Continued From page 23 e. On 5/14/08 at 7:15 a.m., the resident was sitting in the dining room in a Broda chair. There were no washcloths, handrolls or splints to either hand. f. On 5/14/08 at 9:10 a.m., Certified Nursing Assistant (CNA) #8 was asked, "Why does [Resident #14] not have washcloths in her hands as she did on Monday?" The CNA stated, "We sometimes put washcloths in there because they don't always get the palms of her hands dry after her bath." g. On 5/14/08 at 2:10 p.m., Licensed Practical Nurse (LPN) #1 was asked to check the palms of the resident's hands. He took cotton swabs and swabbed across the palms of both hands. He then smelled the swabs and stated they had a sour, pungent odor. h. On 5/14/08 at 2:20 p.m., CNA #9 stated she had worked at the facility for 4 months and always worked the hall where this resident resided. She was asked if she had ever applied washcloths or hand rolls to this resident's hands. She stated, "No, I didn't know they were ordered." She was then asked, "Do you have a care plan to advise you of the care this resident needs?" She stated, "I think so." She was asked, "Where is it located?" The CNA stated, "I think they are in the ADL [Activities of Daily Living] books in the break room." i. On 5/14/08 at 2:30 p.m., LPN #2 (the Charge Nurse assigned to this resident) was asked, "Who is responsible for applying handrolls/splints?" She stated, "The CNA." j. On 5/14/08 at 2:45 p.m., LPN # 3 stated the RN	F 318		

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F 318	Continued From page 24 Supervisor should be responsible and, "We have turned [Resident #14's] room inside-out and cannot find those air splints. This is the second pair they have lost." 2. Resident #4 had a diagnosis of Alzheimer's Disease with Dementia. The Annual MDS dated 3/14/08 documented the resident had short/long term memory problems, was severely impaired in cognitive skills for daily decision making, was dependent on staff for bed mobility and transfers and had full loss of functional range of motion in one leg. a. The Plan of Care developed 3/21/07 and updated 3/20/08 did not include a problem with contractures or potential for contractures. The Plan of Care did document a problem of, "Increased risk for skin breakdown r/t present Stage II to coccyx, rash to L [left] side of neck, incont. [incontinent], restraint use & [and] low body wt [weight] & dementia... Bed mobility: Dependent on staff assist [assistance]... Reposition res. [resident] Q [every] 2 hours & PRN [as needed] and bed positioner to be placed between resident knees at all x's [times] when she is in bed." b. The Functional Maintenance Plan dated 1/4/08 by Occupational Therapy documented: "Programs/Activities: Positioning in bed. Positioning in wheelchair... Bed positioner to be placed between resident's knees when she is bed at all times. See visual guide." The attached Visual Guide documented the resident was to have an Abductor/Contraction Cushion and, "Purpose: A new design for leg abduction and contraction control..." The illustrations on the Visual Guide indicated the device was a	F 318		

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F 318	Continued From page 25 cylindrical shaped cushion that was to be positioned behind the resident's knees to prevent further drawing up of the legs. c. On 5/12/08 at 1:46 p.m. during the initial tour, the resident was in bed on her left side. There was no positioner between her knees. Licensed Practical Nurse (LPN) #7 stated the resident required total care and had bilateral knee contractures. d. On 5/13/08 at 8:20 a.m., the resident was in bed on her left side. There was no positioner between her knees. e. On 5/13/08 at 1:45 p.m., CNA's #6 and #8 transferred the resident to bed and turned her to her left side. No positioner was placed between the resident's knees. f. On 5/14/08 at 8:15 a.m., the resident was in bed on her left side. There was no positioner or cushion between the resident's knees. The sign over the bed documented the resident was to have an Abductor/Contraction Cushion when in bed. RN #1 was asked if the resident was to have any padding between bony prominences. She stated, "Yes, she has a special cushion for her knees." The RN searched the resident's room and located the cushion on the floor of the resident's closet.	F 318		
F 323 SS=D	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.	F 323		

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F 323	Continued From page 26	F 323		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure a soft belt restraint was applied in accordance with the manufacturer's recommendations to prevent potential accident/injury for 1 (Resident #10) of 5 case mix residents with restraints in use (Residents #4, #5, #7, #10 and #11). The failed practice had the potential to affect 14 residents with restraints in use, as identified by the Administrator on 5/12/08. The findings are:

Resident #10 had diagnoses of Anxiety and Urinary System Symptom. The Significant Change Minimum Data Set (MDS) dated 3/27/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance for transfers and bed mobility and had a trunk restraint in use daily.

a. A physician order dated 3/5/08 documented: "Soft belt. May use soft belt while up in wheelchair. Release Q [every] 2 hr [hours] and PRN [as needed] for toileting..."

b. The manufacturer's instructions for proper application of the soft belt restraint were provided by the Administrator on 5/14/08 at 11:28 a.m. and documented: "...Wheelchair Application... Place the belt at the patient's waist. Place both straps behind the patient and pass the ends through the space between the wheelchair seat and backrest. Behind the wheelchair, cross the straps and place the right loop over the left kick-spur and the left

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F 323	Continued From page 27 loop over the right kick-spur..." c. On 5/12/08 at 2:34 p.m. during the initial tour, the Registered Nurse (RN) reported a soft belt restraint was being used while the resident was in the wheelchair. The resident was sitting in the wheelchair with a soft belt around her waist. The restraint straps went around the back of the wheelchair at the level of the resident's waist, directly behind the resident, crossed in the back and tied to the bars of the chair. The straps were not fed between the seat and back of the chair. d. On 5/13/08 at 8:45 a.m., the soft belt straps were fed through the back corners of the wheelchair at the seat, then crossed and secured to the bars of the chair. e. On 5/14/08 at 7:05 p.m., the soft belt was tied at waist level to the back of the wheelchair, then crossed in back to the bars. f. On 5/14/08 at 10:40 a.m., the resident was asleep in the wheelchair. The soft belt was at the level of her breasts. The straps were fed straight behind the resident. g. On 5/14/08 at 11:35 a.m., the soft belt straps were fed over the outside of the frame of the wheelchair, beneath the armrests of the wheelchair then crossed and tied to the bars of the wheelchair.	F 323		
F 326 SS=E	483.25(i)(2) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem.	F 326		

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F 326	Continued From page 28	F 326		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure a therapeutic diet was provided for 1 (Resident #16) of 14 case mix residents with physician orders for therapeutic diets (Residents #1, #2, #4 - #7, #9, #11, #13 - #17 and #20). The failed practice had the potential to affect 71 residents physician orders for therapeutic diets, as documented on the Diet List dated 5/12/08. The findings are:

Resident #16 had diagnoses of Renal Failure, Congestive Heart Failure and Type II Diabetes Mellitus. A physician order dated 5/4/08 documented the resident was to receive a renal, controlled carbohydrate diet. The resident had dialysis three times weekly.

a. The facility's menu for the evening meal on 5/12/08 documented the residents on renal diets were to receive baked fish, salt-free green peas, buttered noodles and bread.

On 5/12/08 for the dinner meal, the resident received 2 regular, crispy pieces of battered fish instead of baked fish, green peas, a cheese biscuit instead of bread and potato salad instead of buttered noodles. The resident stated he did not like the fish and peas and asked for a peanut butter and jelly sandwich. The resident's tray ticket documented, "renal, low phosphorous, controlled carbohydrate, no added salt."

b. The facility's menu for the lunch meal on 5/13/08 documented the residents on renal diets were to receive baked chicken, green beans, rice,

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F 326	Continued From page 29 bread, 2 pats of margarine and fruit cobbler. On 5/13/08 for the lunch meal, the resident received a fried chicken leg and thigh instead of baked chicken, mashed potatoes and gravy instead of rice, stewed tomatoes instead of green beans, cornbread instead of bread and fruit cobbler. At 3:00 p.m., the resident stated he ate all of the chicken, cornbread and fruit cobbler he was served at lunch that day. He stated he did not eat the potatoes because he was not supposed to have them. When asked about his renal diet, the resident stated, "[Former Dietary Manager] said they couldn't cook just for me."	F 326		
F 328 SS=E	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 a physician order for increased oxygen flowrate was obtained when nursing staff determined an increase was necessary based on the resident's complaints of shortness of breath and failed to ensure the oxygen concentrator filter was maintained in clean condition for 1 (Resident #8) of 3 case mix	F 328		

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F 328	Continued From page 30 residents with physician orders for oxygen therapy (Residents #8, #9 and #13). The failed practices had the potential to affect 5 residents with physician orders for respiratory therapy, as documented on the Resident Census and Conditions of Residents form dated 5/12/08. The findings are: Resident #8 had diagnoses of Emphysema and Chronic Obstructive Pulmonary Disease (COPD). The Annual Minimum Data Set (MDS) dated 5/6/08 documented the resident was independent in cognitive skills for daily decision making and received oxygen therapy. a. A physician order dated 8/30/06 documented: "Oxygen 2 L/M [liters per minute] per N/C [nasal cannula] PRN [as needed] SOB [shortness of breath]." b. The Plan of Care updated 2/21/08 documented: "Potential for alteration in cardiac function r/t [related to] CHF [Congestive Heart Failure]/COPD... Follow physician orders... Oxygen at 2L/Min [liters per minute] per NC [nasal cannula] as ordered... Requires minimal assist [assistance] with ADLS [activities of daily living] r/t Dx [diagnoses] of Joint Disease, Arthritis, COPD, Emphysema and CHF... Oxygen at 2L/M [liters per minute] per nasal cannula, clean filter and change tubing per protocol." c. On 5/12/08 at 2:05 p.m. during the initial tour, the resident was in bed with oxygen at 2 liters per minute via nasal cannula by way of an oxygen concentrator. The black filter on the side of the concentrator was covered with white lint. d. Nurses' Notes dated 5/14/08 at 1:30 p.m.	F 328		

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documented: "CNA [Certified Nursing Assistant] reports to nurse that [resident] c/o [complained of] SOB. O2 [oxygen] Sat [saturation] 83% on 2 L [liters]. [Increased] to 3 L, [Increased] O2 sat 90%. [Resident] [with] productive cough of thick greenish yellow sputum. [Right] lobe coarse. Resident c/o being too tired & [and] weak to eat. Did [not] eat breakfast or lunch."

e. Nurses' Notes dated 5/14/08 at 1:50 p.m. documented: "Placed call to [Physician's] office. Will wait for return call." Nurses' Notes on the same date at 2:15 p.m. documented: "NO [new order] rec'd [received]. Family notified - Xray called to come take CXR [chest x-ray]." There was no physician order for oxygen at 3 liters per minute.

f. A physician order dated 5/1408 at 2:15 p.m. documented: "CXR Cough."

g. Nurses' Notes dated 5/14/08 at 6:15 p.m. documented: " CXray [chest x-ray] taken will wait for results then notify MD [Medical Doctor], report given to oncoming nurse will continue POC [Plan of Care]."

h. "Best Practices, A Guide to Excellence in Nursing Care," by Lippincott Williams & Wilkins, page 336 documented: "...Never administer oxygen by nasal cannula at more than 2 L/minute to a patient with chronic lung disease unless you have a specific order to do so because some patients with chronic lung disease have become dependent on a state of hypercapnia and hypoxia to stimulate their respirations, and supplemental oxygen could cause them to stop breathing."

F 332 SS=E	483.25(m)(1) MEDICATION ERRORS	F 332		

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The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
Based on observation of the 12:00 p.m. medication pass on 5/14/08 and the 8:00 a.m. medication pass on 5/15/08 and record review, the facility failed to follow physician orders to ensure the medication error rate was less than 5%. Physician orders were not followed for 4 (Residents #13, #28, #29 and #30) of 18 residents observed during the medication pass, which resulted in medication errors. Medication errors were made by 2 Licensed Practical Nurses (LPN's #4 and #5) of 2 licensed nurses observed administering medications. The failed practice had the potential to affect 65 residents who received medications from these LPN's, as identified by the Director of Nursing (DON) on 5/15/08. The medication error rate was 7.27%, based on observation of 54 medications administered, 1 medication ordered but not administered and a total of 4 errors detected. The findings are:

1. Resident #13 had a physician order dated 12/21/07 which documented: "Albuterol inhaler, 2 puffs, 4 times a day, wait 1-2 minutes between puffs. Wait 5 minutes, then use Atrovent Inhaler 2 puffs 4 times a day."

On 5/14/08 at 11:55 a.m., LPN #5 instructed the resident to self-administer one puff of the Albuterol inhaler. At 11:56 a.m., the LPN instructed the resident to self-administer the second puff. At 11:57 a.m., the LPN handed the

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F 332	Continued From page 33 resident the Atrovent inhaler to self-administer and reminded him to wait one minute until 11:58 a.m. At 11:58 a.m., the LPN told the resident he could administer the next dose. The nurse failed to instruct the resident to wait 5 minutes between puffs of the 2 different medications, as ordered by the physician. 2. Resident #28 had a physician order dated 2/21/08 which documented, "Sliding scale with Novolog Insulin SQ [subcutaneously]. Give insulin AFTER meals." The sliding scale documented: "CBG [capillary blood glucose] = 150-200 give 1 U [unit of Novolog Insulin]. CBG = 201-250, give 2 U. CBG = 251-300, give 3 U. CBG = 301-400, give 5 units... CBG's AC meals [check capillary blood glucose before meals]." On 5/14/08 at 11:25 a.m., LPN #4 performed a blood glucose test on the resident, with a result of 277 milligrams per deciliter (mg/dL). At 11:30 a.m., the LPN gave the resident an injection of Novolog Insulin 3 units. This was 30 minutes prior to lunch, instead of after the meal as ordered by the physician. 3. Resident #29 had a physician order dated 3/5/08 for Miralax Powder one heaping tablespoon with eight ounces of water or juice twice a day. On 5/15/08 at 7:50 a.m., LPN #5 administered the resident's other 8:00 a.m. medications, but failed to administer the Miralax. 4. Resident #30 had a physician order dated 4/11/08 for Lactobacillus/Acidophilus/Bulgarious one packet by mouth three times a day with	F 332		

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F 332	Continued From page 34 meals. On 5/15/08 at 7:50 a.m., LPN #5 administered Lactase Original Strength, one tablet. The label on the container of this medication documented: "Lactase Enzyme, Mannitol, Microcrystalline Cellulose, Dextrose, Sodium Citrate, Calcium Carboxymethylcellulose, Magnesium Stearate, Wheat and Soy." The tablets did not contain Acidophilus/Bulgarious as ordered by the physician.	F 332		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation of the 12:00 p.m. medication pass on 5/14/08 and record review, the facility failed to ensure physician orders were followed to prevent a significant medication error for 1 (Resident #28) of 18 residents observed during the medication pass. A significant medication error was made by one Licensed Practical Nurse (LPN) of 2 nurses who administered medications during this medication pass. The failed practice had the potential to affect 8 residents with physician orders for insulin who received medication from this nurse, as identified by the Director of Nursing (DON) on 5/15/08. The findings are: Resident #28 had a diagnosis of Diabetes Mellitus Type II. a. A physician order dated 2/21/08 documented the resident was to receive sliding scale Novolog	F 333		

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F 333	Continued From page 35 Insulin subcutaneously after meals. The sliding scale order documented for a blood glucose of 251 to 300, the resident was to receive 3 units. b. On 5/14/08 at 11:25 a.m., LPN #4 performed a blood glucose test on the resident with a result of 277 milligrams per deciliter (mg/dL). At 11:30 a.m., the LPN administered 3 units of Novolog insulin in the resident's left lower abdomen. This was 35 minutes before the resident was to receive lunch, instead of after the meal as ordered by the physician. c. This medication error was significant due to the classification of the medication, an anti-diabetic agent.	F 333		
F 362 SS=F	483.35(b) DIETARY SERVICES - SUFFICIENT STAFF The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure sufficient qualified dietary staff were available to prepare and serve palatable meals at the correct temperature and facilitate the utilization of sanitary techniques. This failed practice had the potential to affect all 97 residents who received meals from the kitchen, as documented on the Diet List dated 5/12/08. The findings are: 1. On 5/12/08 at 1:35 p.m. during the initial kitchen observation, kitchen equipment was dirty.	F 362		

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F 362	Continued From page 36 The ice cream freezer had melted ice cream and sherbet. The milk box had a foul odor and the drain in the dish area was filled with dark brown debris. 2. From 5/12/08 through 5/14/08, multiple observations were made of failed practices in the kitchen area due to insufficient staff. (Refer to F371 for details): a. Dirty kitchen equipment, including dishes with dried food particles on them were used during meal preparation and service. b. Staff asked surveyors advice on appropriate utensil/scoop sizes documented on the menu for serving of menu items. c. Molded bread dated as far back as January 2008 was stored in the storage room (because no one had time to discard it according to the Dietary Staff). d. Improper handwashing was observed multiple times. e. On 5/12/08 during the dinner meal and 5/13/08 during the lunch meal, food was not prepared in sufficient quantities to feed all residents (Refer to F366). f. Food consistencies were incorrect for mechanical and pureed entrees (Refer to F365). g. On 5/12/08 and 5/13/08, the meat entrees were baked in the oven instead of frying as documented on the menu (Refer to F363). h. On 5/13/08 at 4:00 p.m., the Activity Director	F 362		

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FAYETTEVILLE HEALTH AND REHABILITATION CENTER	3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703

(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 362	Continued From page 37 sliced the desserts for the evening meal, because not enough dietary staff were available to complete all tasks of meal preparation. i. On 5/14/08 at 8:35 a.m., the Housekeeper did the floor care in the kitchen, even though the Maintenance Supervisor stated on 5/13/08 that this was a Dietary Staff responsibility. j. On 5/14/08, a Certified Nursing Assistant assigned to the F Hall cooked breakfast for the residents because insufficient Dietary Staff were available to complete all tasks of meal preparation. k. Dietary employees were not trained on how to follow recipes for pureeing and how to follow adequate portions for each resident (Refer to F364 and F365). 3. On 5/14/08 at 2:10 p.m., Dietary Employee #2 stated the facility had been without a Dietary Manager for at least 1 month and the staff currently working in the Dietary Department had worked for the facility between 2 and 9 months.	F 362		
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 363		

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interview, the facility failed to ensure meals were prepared and served according to the planned, written menu. The failed practice had the potential to affect 97 residents who received meals from the kitchen, as documented on the Diet List dated 5/12/08. The findings are:

1. On 5/12/08, the following deviations from the facility's planned, written menu occurred:

a. The facility's dinner menu documented buttered noodles would be served to the residents on mechanical diets. On 5/12/08 at 4:30 p.m. when all food items had been placed on the steamtable for the evening meal service, no buttered noodles had been prepared.

b. The dinner menu documented pureed cheese biscuits would be served to residents on pureed diets. As of 4:30 p.m., when all foods had been placed on the steamtable, no pureed cheese biscuits were prepared. The residents on pureed diets did not receive pureed cheese biscuits with their meal.

c. The renal diet menu documented baked fish, buttered noodles, salt-free green peas and 1 slice of bread. At 4:42 p.m., the one resident on a renal diet was served breaded fish, regular potato salad, regular green peas and a cheese biscuit, because the Dietary Staff did not prepare the food items for a renal diet meal. At 5:08 p.m., Dietary Employee #2 stated no alternates had been prepared for the breaded fish and green peas.

d. The Diet List documented one resident on a heart healthy diet, one resident on a low cholesterol diet and one resident on a liberal renal diet. There were no meal plans or guidelines

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F 363	Continued From page 39 documented on the planned menu for these diets on 5/12/08. e. Controlled carbohydrate diets were served a regular serving of green peas (1/2 cup) instead of 1/4 cup as documented on the planned menu. f. No diet chocolate pudding was prepared for controlled carbohydrate diets. 2. On 5/13/08, the lunch menu documented fried chicken, baked beans, potato salad, biscuit and fruit cobbler would be served. a. At 12:17 p.m., the facility served baked breaded chicken instead of fried chicken, mashed potatoes and stewed tomatoes instead of baked beans and potato salad, and cornbread was substituted for the biscuit. b. Regular and mechanical diets were served apple cobbler for the 5/13/08 lunch meal, but pureed diets received pureed canned pear halves and mechanical diets were served diced pears. c. Pureed diets were served frozen diced chicken cooked in water with an unmeasured amount of butter instead of pureed fried chicken as documented on the planned menu. d. Controlled carbohydrate diets were served 1/2 cup of apple cobbler instead of 1/4 cup of apple cobbler as documented on the planned menu and no bread was served to these residents. e. At 12:50 p.m., the kitchen ran out of cornbread squares for the residents. Controlled carbohydrate trays, one regular tray and 5 of ten hall trays received no cornbread; however, 10	F 363		

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F 363	Continued From page 40 guest trays and 10 employee trays were served cornbread before the resident trays were served.	F 363		
F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a variety of foods were served to meet the needs and preferences of the residents. The facility also failed to ensure meals were palatable, as evidenced by overcooked or mushy food items served due to sitting an extended period on the steam table. The facility failed to ensure the nutritive content of pureed food was not diluted by pureeing with water instead of milk, broth or another nutritive liquid and failed to ensure the food was served at a temperature that was acceptable to the residents. The failed practices had the potential to affect 97 residents who received meals from the kitchen, as documented on the Diet List dated 5/12/08. The findings are: 1. On 5/13/08 at 9:00 a.m., 2 of 4 alert and oriented residents who participated in the group interview stated the food was not good and there was not enough variety. "We get too many starches - too much corn and mashed potatoes on the same day, too much pasta, corn and potatoes." a. On 5/12/08 at 2:46 p.m., Dietary Employee #2	F 364		

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F 364	Continued From page 41 pureed fish for the evening meal with an unmeasured amount of tap water. She stated, "I don't know what else to puree it with. I don't want to use juice." b. On 5/12/08 for the dinner meal, mashed potatoes and whole kernel corn were served as alternates. The fish had a soft, mushy batter and fell apart on the steam table during meal service. c. On 5/13/08, all of the lunch meal items were on the steam table at 10:45 a.m. for service to the residents at 11:45 a.m. Dietary Employee #1 stated she had to put the food on the steam table that early because she had to serve the employees. d. On 5/13/08 at 11:47 a.m., more than one hour after the food was placed on the steam table, the residents were served lunch. A brown edge had formed on the pan around the mashed potatoes. The mashed potatoes had a dry appearance and had separated from the sides of the pan. e. On 5/13/08 at 11:47 a.m., for the lunch meal, mashed potatoes were served with the chicken and whole kernel corn was served at the evening meal the same day (mashed potatoes and corn were also the alternates for the evening meal on 5/12/08). The chicken was baked instead of fried and had a soft, mushy batter from sitting more than 1 hour covered on the steamtable. The cornbread was dry and crumbled into small chunks as it was served onto the residents' plates. 2. Resident #18 had a diagnosis of Psychosis and a physician order dated 10/16/07 for a regular diet.	F 364		

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F 364	Continued From page 42 On 5/13/08 at 10:15 a.m. when asked about the food, the resident stated, "It's really bad... When I first got here, it wasn't too bad... getting worse... sandwiches, sandwiches, sandwiches... served boiled egg with mustard on it as a sandwich, served some kind of ham salad sandwich with 2 slices bread and a little spot of ham salad in the middle... The other day we had green beans 4 days in a row... served biscuits with a tablespoon of gravy... biggest part of the food we get is cold... On Mother's Day, they served cold salami with gravy poured over it for roast beef." 3. Resident #11 had a diagnosis of Depression and a physician order dated 9/11/07 for a controlled carbohydrate diet. a. On 5/12/08 at 3:20 p.m. during the initial tour, Registered Nurse (RN) #1 stated the resident was alert and oriented times 3 and was interviewable. b. On 5/13/08 at 10:17 a.m., the resident stated, "Last couple of months, food's gotten worse... food is just bad... is usually warm, would like it hotter." This resident also stated that, "cold lunch meat with gravy poured over it" was served on Mother's Day. 4. On 5/13/08 at 1:12 p.m., a test tray on the last cart of 10 trays to E and F Halls registered the following temperatures: a. Fried chicken - 84 degrees Fahrenheit. b. Stewed tomatoes - 88 degrees Fahrenheit. c. Mashed potatoes with gravy - 115 degrees Fahrenheit.	F 364		

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F 365 SS=E	483.35(d)(3) FOOD Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that pureed food was prepared at a consistency to meet individual needs for 3 (Residents #4, #14 and #20) of 6 case mix residents with physician orders for pureed diets (Residents #1, #4, #6, #7, #14 and #20). The failed practice had the potential to affect 21 residents with physician orders for pureed diets, as documented on the Diet List dated 5/12/08. The findings are: 1. On 5/13/08 at 10:45 a.m. during the lunch meal, the pureed chicken was already on the steamtable. The pureed chicken had pooled water that separated out from the chicken and the chicken had a lumpy consistency similar to the mechanical chicken instead of a creamy smooth texture. a. Resident #4 had diagnoses of Alzheimer's Disease with Dementia and a physician order dated 10/17/07 for a pureed diet. On 5/13/08 at 12:24 p.m., the resident was served the lumpy pureed chicken, bread, tomatoes, mashed potatoes and a Mighty Shake. At 1:10 p.m., when the resident was finished with her meal, she had consumed 50% of the potatoes and none of the pureed chicken. b. Resident #14 had Anoxic Brain Syndrome,	F 365		

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F 365	Continued From page 44 Hypertension and Blindness. The Quarterly Minimum Data Set (MDS) dated 2/8/08 documented the resident was totally dependent on staff for eating and had chewing problems. 1.) A physician order dated 8/10/07 documented the resident was to receive a pureed diet. 2.) On 5/13/08 at 12:25 p.m., the resident was served the lumpy pureed chicken, mashed potatoes, 2 Mighty Shakes and 1 carton of chocolate milk. The resident consumed 100% of everything except the chicken. Certified Nursing Assistant (CNA) #3 was asked, "Why did she not eat her meat?" The CNA stated, "It's too chunky and she will spit it out." c. Resident #20 had a diagnosis of Dehydration and a physician order dated 1/24/08 for a pureed diet with nectar thick liquids and chocolate Mighty Shakes with each meal. 1.) On 5/13/08 during the noon meal, the resident was served the lumpy pureed chicken and a bowl of cottage cheese that was not pureed. 2.) On 5/14/08 during the noon meal, the resident was served cottage cheese that was not pureed and a chocolate Mighty Shake with no thickener.	F 365		
F 366 SS=E	483.35(d)(4) FOOD Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 366		

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F 366	Continued From page 45 interview, the facility failed to ensure residents' food preferences and dislikes were honored and substitutes were provided for food items not eaten. The failed practice had the potential to affect 97 residents who received meals from the kitchen, as documented on the Diet List dated 5/2/08. The findings are: 1. On 5/13/08 at 9:00 a.m., 2 of 4 residents in the group meeting stated that there was no variety in meals, too much starch served, too much corn and potatoes at the same meal. a. On 5/12/08 during the dinner meal, whole kernel corn and mashed potatoes were served. b. On 5/13/08 at the lunch meal and dinner meal whole kernel corn and potatoes were served. 2. Resident #15 had diagnoses of Emphysema and Reflux Esophagitis and a physician's order dated 9/13/07 for a controlled carbohydrate diet. On 5/14/08 at 7:35 a.m., the resident was served toast with gravy and eggs on his breakfast tray. The resident shoved his plate with both hands and stated, "I can't eat this [expletive]. I don't like gravy on my toast... these eggs are cooked way too hard... they won't fix me another tray. I like my eggs over easy but done." 3. Resident #19 had diagnosis of Alzheimer's Disease and a physician's order dated 6/6/07 for a regular diet. a. On 5/12/08 the resident's tray ticket documented that he disliked green peas and to give supercereal.	F 366		

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F 366	Continued From page 46 b. On 5/12/08 at 5:08 p.m. when preparing the resident's tray, Dietary Employee #1 asked Dietary Employee #2 if there was an alternate vegetable. She replied "No, I know there's supposed to be." The resident was not served a vegetable in place of the green peas. 5. Resident #17 had diagnoses of Congestive Heart Failure and Gastrointestinal Hemorrhage and a physicians's order dated 4/15/08 for a mechanical soft diet . On 5/13/08 during the lunch meal the resident's tray ticket documented no corn or tomatoes. Dietary Employee #1 stated, "Maybe we can get her a sandwich of some kind... let's make her a little salad." Dietary Employee #2 asked, "Didn't we get salad mix?" Dietary Employee #1 instructed Dietary Employee #2 to, "Just kind of chop up a little lettuce." 6. Resident #18 had diagnoses of Psychosis and Hypertension and a physician's order dated 10/16/07 for a regular diet. a. The resident's tray ticket documented a dislike for fish and chicken. On 5/12/08 at the dinner meal, the resident was served fish. b. On 5/12/08 at 4:42 p.m., Dietary Employee #2 stated, "I forgot to do alternates..." c. On 5/13/08 for the lunch meal, the resident was served fried chicken. d. On 5/13/08 at 9:46 a.m., the resident stated, "The food is miserable."	F 366		
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE	F 371		

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The facility must store, prepare, distribute, and serve food under sanitary conditions.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure Dietary Employees washed their hands between dirty and clean tasks to prevent cross-contamination, failed to ensure kitchen equipment was maintained in clean condition and working order, failed to ensure foods were covered or sealed to maintain freshness and prevent contamination and failed to ensure outdated or spoiled food items were removed from stock. The failed practices had the potential to affect all 97 residents who received meals from the kitchen, as documented on the Diet List dated 5/12/08. The findings are:

1. On 5/12/08 at 1:35 p.m., the following dirty equipment was observed in the kitchen and dining areas:

a. The ice machine in the dining room had a slimy, black and pink substance across the entire black plastic border against the ice.

b. The 3-door refrigerator in the storeroom had brown, crusted food spills and debris on the inside bottom and on the outside doors and door handles.

c. The 3-door freezer in the storeroom had round cranberry colored spills on the inside bottom approximately 1/2 inch in diameter and dirty white

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smudges over the outside doors and brown dirt on the door handles. Purple grape colored stains and debris were on the floor in front of this freezer.

d. A half covered drain approximately 10 inches by 10 inches by 6 inches deep exposed thick, brown debris and decayed matter and a jelly packet, providing a harboring area for pests.

e. The milk box had a strong, foul, spoiled milk odor that emanated when the lid was lifted.

f. The vertical ice cream freezer in the kitchen behind the oven registered 30 degrees Fahrenheit. Dietary Employee #1 stated they had trouble with the freezer about a week ago. The Maintenance Man stated he had checked it and it was unplugged. Two cases of vanilla ice cream, 2 cases of orange sherbet, 1 case of chocolate Mighty Shakes and 1 case of 6 apple cobblers were in this freezer. The Mighty Shakes and apple cobblers were frozen. The ice cream and orange sherbet had melted. The orange sherbet in cups had separated to clear liquid on top and milk solids on the bottom.

2. On 5/12/08, the following observations were made of Dietary Staff:

a. At 2:38 p.m., Dietary Employee #2 wore gloves as she touched different pans and her cell phone while pureeing Italian pasta salad for the evening meal. She stuck 2 of her gloved fingers in the mixture, took a sample and rubbed it between her fingers to assess the texture. She stated, "It's too gritty... have to grind til it's not gritty." After pureeing the salad, she used her gloved hand to sweep the pureed mixture from

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the Robocoupe bowl without changing gloves.

b. At 4:49 p.m., Dietary Employee #2 gathered clean serving utensils with her hands and held them on her side, against her uniform top.

c. At 4:51 p.m., Dietary Employee #2 started the serving line. She placed biscuits onto the residents' plates with her bare hands and wiped her hands on her uniform.

d. At 5:05 p.m., Dietary Employee #2 threw an empty cream of chicken soup in the garbage can by lifting the trash can lid with her bare hand, then returned to the serving line and picked up a plate without washing her hands.

3. On 5/12/08, the following expired, spoiled or improperly stored food items were observed:

a. At 1:49 p.m., one 48 ounce box of cream cheese in the storeroom refrigerator had one end of the plastic covering opened exposing the cream cheese to air.

b. At 1:49 p.m., three dented cans of Ensure and one dented can of 2 Cal HN [high nitrogen] were stored on the second shelf of the storeroom refrigerator.

c. At 2:00 p.m., on a storeroom shelf, there was a large opened 28-ounce bag of potato chips with the top folded over once and one strip of tape down the middle of the fold. There was a handwritten date of 1/25/08 on the bag. The bag was not securely sealed and potato chips had spilled out onto the shelf.

d. At 2:00 p.m., a 24-ounce bottle of Mountain

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(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 371	Continued From page 50 Dew soda was on the preparation counter beside the oven and had been opened and partially consumed. The bottle had no name or date on the label. e. At 2:00 p.m., four 10 ounce loaves of garlic bread with a "sell by" date of 3/18/08 and labeled, "product can be kept 48 hours in a 40 degree refrigerator" were stored on a top shelf underneath potato chips. The bread had patches of a green mold-like substance. One package of 12 wheat sandwich rolls/buns dated 12/07 had dark green circles of mold-like substance approximately 1 to 1 and 1/2 inches in diameter on all buns. Three packages of 12 hot dog buns had random circles of greenish-brown mold, approximately 1 to 1 and 1/2 inches in diameter and none were dated. 1.) At 4:15 p.m., a thermometer was placed on the top shelf where the breads were stored. 2.) On 5/12/08 at 4:30 p.m., the temperature in the storeroom registered 81.7 degrees Fahrenheit. 3.) On 5/12/08 at 4:52 p.m., the temperature registered 82.4 degrees Fahrenheit. f. From 4:00 p.m. to 4:15 p.m., a cart of snacks had 17 bowls of exposed pineapple chunks, partially covered with lids that were too small and exposed the pineapple to potential contamination. g. At 4:57 p.m., 6 bowls of cottage cheese stored on a tray in the 3-door refrigerator were covered with improperly fitted lids, which exposed the cottage cheese to potential contamination.	F 371		

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	045220	A. BUILDING ______ B. WING ______	05/16/2008

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F 371	Continued From page 51 4. On 5/12/08 for the evening meal and 5/13/08 at the onset of the lunch meal service, 10 of 20 plates stacked for meal service had food particles stuck on their inner surfaces. 5. On 5/13/08 at 8:45 a.m., two 20-pound tubes of frozen ground beef were stored on the top shelf in the 3-door freezer, above 8 lemon cream pies in the bottom of the freezer. 6. On 5/13/08 at 11:47 a.m., Dietary Employee #3 washed her hands by running clear water from the handwashing sink, then used a paper towel to dry her hands, wiped her hands on her apron and proceeded to the steam table to serve lunch. 7. On 5/13/08 at 11:50 a.m., Dietary Employee #4 washed her hands by running clear water from the 3-compartment sink, wiped her hands on her apron, then proceeded to wrap silverware for lunch.	F 371		
F 441 SS=E	483.65(a) INFECTION CONTROL 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 441		

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F 441	Continued From page 52 interview, the facility failed to ensure an infection control program was maintained in which infections were logged and investigated to determine their cause and to identify any patterns of infection among residents who lived in close proximity to one another or received direct care from the same staff members. The failed practice had the potential to affect all 101 residents, as documented on the Resident Census and Conditions of Residents form dated 5/12/08. The facility also failed to ensure staff followed Contact Isolation Precautions in order to prevent the potential spread of Clostridium difficile (C-diff) from 1 (Resident #5) of 1 case mix resident with a C-diff infection. The failed practice had the potential to affect 20 residents who resided on the "A" Hall, as documented on the Resident Roster Report dated 5/12/08. The findings are: Resident #5 had diagnoses of Cerebrovascular Accident (CVA) and Dementia with Behavior Disturbance. The Minimum Data Set dated 3/26/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance for bed mobility, transfers, hygiene, bathing and toilet use, was totally dependent on staff for dressing and was incontinent of bowel and bladder. a. On 5/14/08 at 8:30 a.m., staff were setting up a supply cart in the hallway just outside the resident's room and 2 stainless steel barrels inside the room. Staff explained to the resident that her roommate would be moving to another room. When staff were asked by the Surveyor why the roommate was moving, they said because Resident #5 had tested positive for C-diff and was being placed in isolation. A	F 441		

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F 441	Continued From page 53 resident who resided directly across the hall (Resident #24) was also on contact isolation for C-diff at this time, per a physician order dated 5/3/08. b. On 5/14/08 at 9:25 a.m., Certified Nursing Assistant (CNA) #4 provided incontinent care to the resident, whose incontinent brief was soiled with feces. The feces had leaked out of the brief and onto the bed linens. The CNA did not put on a gown prior to or after entering the resident's room. When the CNA leaned against the bedframe as she turned the resident from side to side and rolled the sheets under the resident, the resident's skin and bed linens touched the CNA's uniform. The CNA placed the soiled brief, peri-wipes and bed linens in clear trash bags instead of red biohazard bags, then placed the bags into the barrels, which were not lined with any type of bags. CNA #4 stated she did not realize there were no bags in the barrels. The CNA was asked to open the barrel lid after she placed the soiled items in the can. There was no foot pedal lid-release on the can. It had been removed or broken off. The CNA had to touch the barrel in order to open the lid. c. On 5/14/08 at 9:25 a.m., CNA #5 entered the resident's room to assist CNA #4 with pulling the resident up in bed. CNA #5 did not put on a gown prior to or after entering the room. Both CNA's uniforms touched the resident's gown, bedding and side rails during the procedure. d. On 5/14/08 at 1:45 p.m., CNA #4 was asked what kind of isolation precautions were in place for this resident. The CNA stated, "Contact." When asked how contact isolation precautions were incorporated into providing care to the	F 441		

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F 441	Continued From page 54	F 441		

resident, the CNA stated, "It means if you're going to do anything that you might get body fluids on you, you have to wear full gear to prevent getting body fluids on you."

e. On 5/14/08 at 1:50 p.m., the Infection Control Nurse (ICN) was asked how many residents in the facility were on Contact Isolation. She stated, "Three are on Contact Isolation now." The ICN was asked for the facility's infection control log. She stated she was, "behind with trying to get the program going" and did not have an infection control log. The ICN was asked how she tracked and trended infections in the facility. She stated this was done from a report that was generated by the lab company. She was asked to see that report. She presented a report dated March 2008. When asked for a more recent report, she stated she did not have one more recent than March 2008. She was asked how she tracked and monitored recent infections in the facility if it took 2 months to obtain reports from the lab company. She stated, "Oh, I see what you're saying. That makes sense. I don't have a system in place that does that... not going to tell you something that's not true. We don't have a system in place for that." The ICN was asked about the facility's system for setting up isolation supplies. She stated, "Housekeeping staff sets up those supplies and puts a sign on the doors to check at the nurses station before entering the room."

f. On 5/14/08 at 2:43 p.m., the DON was asked how the facility tracked, trended and investigated infections. She stated, "The Infection Control Nurse takes care of that. I assumed she was doing that." The DON stated infections were discussed in a meeting every morning. When

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asked if Resident #5's need for contact isolation due to C-diff had been discussed in their meeting that morning. She stated, "No, the meeting was not held this morning because y'all [surveyors] were here, so it wasn't held and the new isolation was not discussed." The DON was asked if Resident #5's C-diff infection had been investigated, since the resident resided across from the hall from another resident with a C-diff infection. The DON asked the ICN if she had investigated and the ICN said, "No, haven't investigated it." The DON asked the Resident Care Coordinator (RCC) if she had observed the CNA's provide incontinent care to determine if it was being done appropriately. The RCC stated, "No, not yet."

g. On 5/14/08 at 3:10 p.m., the ICN was asked for the facility's infection control policy and procedure. She presented isolation procedures from the, "Nursing Procedure Manual." The section titled, "Contact Isolation" documented: "...Contact Isolation is designed to prevent the transmission of highly transmissible infections. All diseases and conditions listed in this category [category included C-diff] are spread by direct contact. Thus mask, gowns and gloves are recommended for anyone in direct contact with any resident who has this infection. C-Diff is most often transmitted through healthcare personnel who have had contact with feces or environmental surfaces contaminated with the organism, as it may live on environmental surfaces for a prolonged period of time. Key points for isolation indicate that gowns are necessary if soiling of your clothing is likely. When isolation precautions are implemented, the charge nurse should post the appropriate sign on the room entrance door so that personnel and

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F 441	Continued From page 56 visitors are made aware of the precautions. The nursing care isolation documents any person who has contact with the resident should wear a gown as indicated. This includes the physician, resident care personnel and other health care persons/visitors. Gowns should be put on prior to entering the resident's room. When resident care is completed, the gown should be removed and placed in the biohazard barrel inside the room."	F 441		