

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

PRINTED: 05/02/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045158</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/07/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY HEALTHCARE HEBER SPRINGS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1040 WEDDINGFORD RD</b> <b>HEBER SPRINGS, AR 72543</b>	
(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 241 SS=B	<p>483.15(a) DIGNITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and observations, the facility failed to ensure clothing that contained spilled food items/stains were changed and failed to ensure bowel movement odors were not present in a residents room while the resident was trying to eat for 2 (Residents #6, and #11) of 13 case mix residents (Residents #1-#5, #7-#10, #12, and #13) who were dependent on staff for personal care. The failed practice had the potential to affect 66 residents who were dependent on staff for dressing and 74 residents who were responsible for staff for toileting as documented on the Resident Census and Condition of Residents form dated 4/3/06. The findings are:</p> <p>1. Resident #6 had diagnoses of Alzheimer's Disease and Depression. The Quarterly MDS ( Minimum Data Set) dated 1/31/06 documented the resident required extensive assistance of staff for dressing and hygiene.</p> <p>a. On 4/4/06 at 3:45 p.m., thru 4:05 p.m., the resident was sitting in the doorway of the front lobby and by the Nurses Station and had a</p>	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 chocolate colored liquid substance splattered on her shirt and pants. Visitors, residents, staff, and administration were seen passing by the resident without stopping.  b. At 4:05 p.m., the Dietitian stopped and told the resident, "Someone will be here in just a minute to clean you up." She then went to the kitchen and returned to the resident and offered her another shake.  c. At 4:08 p.m., the Dietician stated to the resident again, "Someone will be here in a minute to clean you up."  d. At 4:25 p.m., the resident was finally taken to her room and her clothes were changed.  2. Resident # 11 had diagnoses of Profound Blindness and Psychosis. The Quarterly MDS dated 3/29/06 documented the resident required limited assistance of one staff person for transfers and required set up help for eating.  a. On 4/3/06 at 1:27 p.m., during initial observation rounds by the Surveyor the resident was laying in bed with the head of the bed elevated. The resident was feeding himself lunch. A strong bowel movement odor and urine odor permeated the room. The resident was eating his lunch. A bedside commode at the bedside that contained a large amount of urine and a large amount of stool.	F 241			
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253			

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F 253	Continued From page 2  This REQUIREMENT is not met as evidenced by:  Based on observation and interview, the facility failed to ensure ceiling tiles were not stained/cracked, the patio door was not broken and carpet was not stained. The failed practice had the potential to affect 88 residents who ambulated per self or with assistive devices as documented on the Resident Census and Condition of Residents form dated 4/3/06. The findings are:  On 4/6/06 at 9:40 a.m., the following was noted:  100 Hall a. There were 3 cracked ceiling tiles in the hallway. b. There was 1 yellow stained ceiling tile in the hallway. c. There were 2 cracked floor tiles in the hallway.  200 Hall d. There was a piece of wood missing on the bottom of the door. e. There were 4 stained ceiling tiles in the hallway.  300 Hall e. The carpet in the Alzheimer's Unit lounge area had dark stains, and a white dried material.  400 Hall f. There were 5 cracked ceiling tiles in the hallway.  500 Hall	F 253			

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F 253	Continued From page 3 g. The Shower Room had missing tiles on the floor of the shower and in front of the shower entry. h. In Resident Room #505B there was a whole in a floor tile beside the resident's bed approximately the size of a half dollar.	F 253		
F 309 SS=E	483.25 QUALITY OF CARE  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interview, the facility failed to ensure that resident Foley catheter and tubing were maintained in a manner to prevent possible contamination or trauma for 3 (Resident #11, #14 and #15) of 6 case mix residents (Residents #7, #8, #14, #15, #16 and #18) who had catheters. The failed practices had the potential to effect 9 residents who had catheters as documented on the Resident Census and Condition of Residents form dated 4/3/06. The findings are:  1. Resident # 7 had a diagnosis of Cerebral Vascular Accident. The Minimum Data Set (MDS) dated 2/6/06 documented the resident had a foley catheter.  a. A physician order dated 1/27/06 documented: "F/C [Foley Catheter] # 18 fr [French] 5 cc [cubic centimeters], 10 cc inflation bulb, chg [change] Q	F 309		

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F 309	Continued From page 4 [every] month and prn [as needed] nonpatency."  b. On 4/4/06 at 9:55 a.m., the Foley catheter bag was in a privacy bag hanging on the bed frame. The privacy bag was touching the floor.  c. On 4/5/06 at 10:56 a.m., CNA (Certified Nursing Assistant) #1 and CNA #2 were providing incontinent care and foley catheter care for the resident. The resident was positioned onto her right side. CNA #2 cleansed the rectal area with a wet soapy face cloth. She then cleansed the vaginal area and the Foley catheter repeatedly with the same wash cloth without turning the wash cloth. She rinsed the rectum, vagina and catheter with a wet washcloth repeating the action several times with out turning the washcloth or obtaining a new cloth. She dried the resident in the same manner. During the incontinent care and catheter care although the catheter tubing was under the Velcro strap on the catheter strap it was not secured properly and allowed the catheter tubing to slide freely pulling against the meatus causing discomfort to the resident. After the care was given the resident was repositioned. The catheter tubing was not secured properly to the catheter strap or secured with a clamp to secure the catheter and catheter tubing.  2. Resident #14 had diagnoses of UTI (Urinary Tract Infection), and Methicillin Resistant Staphylococcus Aureus- Decubitus Ulcers. The Admission MDS Assessment dated 3/31/06 documented the resident had an indwelling catheter. The clinical record documented the resident was on Contact Isolation.  a. On 4/3/06 at 1:39 p.m., the resident was lying in bed and the Foley catheter bag and part of the	F 309			

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F 309	Continued From page 5 tubing were lying on the floor.  3. Resident #15 had a diagnosis of Alzheimer's Disease. The Significant Change MDS dated 3/13/06 documented the resident had an indwelling catheter.  a. On 4/3/06 at 2:30 p.m., the resident was lying in a low bed and the Foley catheter bag and part of the tubing were lying on the floor.	F 309			
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by:  Based on record review and observations, the facility failed to ensure toe nails were not long/jagged which caused the potential for skin tears for 3 residents (Residents #2, #16 and #17) of 18 casemix residents (Residents #1-#15 and #18) who were dependent on staff for Activities of Daily Living. The failed practice had the potential to affect 93 residents who were partially or totally dependent on staff for personal hygiene as documented on the Resident Census and Conditions of Residents form dated 4/3/06. The findings are:  1. Resident #2 a diagnosis of Dementia. The MDS (Minimum Data Set) dated 2/19/06 documented the resident had moderately impaired cognitive skills for daily decision making	F 312			

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F 312	<p>Continued From page 6</p> <p>and required extensive assistance of staff for personal hygiene.</p> <p>a. On 4/4/06 at 9:41 a.m., the resident's 2nd, 3rd, 4th, and 5th Toe Nails on the right Foot were long, extending approximately 1/4 inch over the tips of the Toes. The Toe Nails on the resident's left Foot were thick and extended approximately 1/4 inch over the tips of the Toes.</p> <p>2. Resident #16 had diagnoses of Alzheimer Disease and Senile Delusions. The quarterly MDS dated 2/20/06 documented the resident was totally dependent on staff for personal hygiene and bathing.</p> <p>a. The Resident's Care Plan updated on 2/20/06 documented: "...Requires ext [extensive] assist with most ADLs [Activities of Daily Living]...bathing..."</p> <p>a. On 4/3/06 at 2:00 p.m., the resident's toe nails were long extending over the edge of the toes and curling downward under the resident's toes.</p> <p>c. On 4/6/06 at 3:24 p.m., the Administrator (upon examining the resident's toe nails) stated the length of the resident's toe nails was not acceptable.</p> <p>3. Resident # 17 had diagnoses of Alzheimer Disease, Other Symbolic Disfunction and Osteoarthritis. The Quarterly MDS dated 2/14/06 documented the resident required extensive staff assistance for hygiene.</p> <p>a. The Plan of Care dated 2/14/06 documented: "Recent decline in ADL [Activities of Daily Living] function, requires extensive assist with ...personal</p>	F 312			

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F 312	Continued From page 7 hygiene..."  b. On 4/3/06 at 4:40 p.m., and on 4/6/06 at 3:25 p.m., the resident's toe nails were long and extended past the end of the resident's toes, the nails were curling downward over the front and under the resident's toes.  c. On 4/6/06 at 3:26 p.m., the Administrator (upon examining the resident's toe nails) stated the length of the resident's toe nails was not acceptable.	F 312			
F 315 SS=E	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 and record review, the facility failed to provide incontinent care to prevent the possible occurrence of Urinary Tract Infections for 3 residents (Residents #2, #4, and #6) of 7 casemix residents (Residents #2, #3, #4, #6, #8, #9, and #10) who were incontinent and required staff assistance for incontinent care. The failed practices had the potential to affect 51 residents who were occasionally or frequently incontinent of Bladder and 39 residents who were	F 315			

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F 315	<p>Continued From page 8</p> <p>occasionally or frequently incontinent of bowel as documented on the Resident Census and Conditions of Residents form dated 4/3/06. The findings are:</p> <p>1. Resident #2 had diagnoses of Dementia, Peripheral Vascular, and a Stage 2 Ulcer on his right Heel. The Minimum Data Set (MDS) dated 2/19/06 documented the resident was incontinent of Bowel and Bladder, and required extensive assistance of staff for personal hygiene.</p> <p>a. On 4/4/06 at 8:53 a.m., CNA (Certified Nursing Assistant) #2 was providing incontinent care for the resident. CNA #2 wiped down each Groin twice, wiped the Rectal area below the Scrotum, then wiped up, down and across the tip of the Penis 3 times without turning the cloth to a clean area each time. She then rinsed and dried the areas in the same manner. The soiled washcloth was then placed on top of the resident's used brief and dirty bed linens while the bed linens were changed.</p> <p>2. Resident #6 had diagnoses of Alzheimer's Disease and Depression. The Quarterly MDS dated 1/31/06 documented the resident was frequently incontinent of Bowel, totally incontinent of Bladder, and required extensive assistance of staff for personal hygiene.</p> <p>a. On 4/4/06 at 9:23 a.m., CNA #3 was providing incontinent care for the resident. CNA #3 wiped from the resident's Rectum and up the Vagina 3 time without turning the cloth to a clean area. The Labia was not separated. During the incontinent care the resident urinated. The CNA then wiped up and down the resident's Vagina again twice without turning the cloth or separating the Labia.</p>	F 315			

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F 315	<p>Continued From page 9</p> <p>The resident's rectal area was not recleansed. The areas were not dried. The incontinent care was performed while the resident was in a standing position.</p> <p>3. Resident #4 had diagnoses of Aplastic Anemia, Alzheimer's Disease, Osteoarthritis, and Urinary Tract Infection. The Quarterly Minimum Data Set dated 2/18/06 documented the resident required extensive to total assistance with all activities of daily living, and was incontinent of bowel and bladder.</p> <p>a. The RAPs [Resident Assessment Protocol] dated 5/26/05 documented: "Resident is incontinent of bladder due to cognitive impairment. Resident cannot always tell when needs to void. Is at risk for UTI (Urinary Tract Infection). Will proceed to care plan to control risks for complications."</p> <p>b. The Resident's Plan of Care dated 2/27/06 documented: "At risk for complications such as UTI and skin problems related to Urinary Incontinence. Due to cognitive impairment. Cannot tell when needs to void. Wears adult briefs per family request. Hx. [history] of UTI. Interventions included: Incontinent care after each episode with protective barrier as needed. Assess/monitor for signs and symptoms of UTI including elevated temperature, cloudy urine, odorous urine, and fever. Toilet before meals and at bedtime."</p> <p>c. On 4/3/06 at 4:45 p.m., CNA #5 provided incontinent care to the resident following an incontinent episode of a large amount of stool. The resident was in bed laying on a urine saturated bed pad. CNA #5 did not provide any</p>	F 315			

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F 315	Continued From page 10 frontal perineum care. After cleansing the rectal area with a cloth wet with soap and water the CNA did not rinse or dry the rectal area. CNA #5 did not cleanse the resident's buttocks after the resident had been laying on the urine soaked bed pad.  4. The facility's Policy and Procedure for Perineal Care documented:  "If the resident is a man: Gently wash pubis and penis. Make sure shaft of penis is dry. Wash scrotum carefully. Rinse and pat dry. Use a new washcloth and wash around anus. Rinse area and dry."  "If the resident is a woman: Use one gloved hand to stabilize and separate the labia, with other hand wash from front to back. Rinse and pat dry with towel"	F 315			
F 323 SS=D	483.25(h)(1) ACCIDENTS  The facility must ensure that the resident environment remains as free of accident hazards as is possible.  This REQUIREMENT is not met as evidenced by:  Based on observation, the facility failed to ensure the yard located off of the 200 Hall Alzheimers unit, did not have wholes in the yard that had the potential to cause falls for residents. The failed practice had the potential to affect 16 residents (who used this area). The findings are:	F 323			

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F 323	Continued From page 11	F 323			
F 328 SS=E	<p>On 4/6/06 at 9:40 a.m., off of the 200 Hall Alzheimers unit, there were 18-20 holes approximately 5 inches across and approximately 1 to 2 inches deep (that were dug in the grassy area by the facility's former dog). Residents who reside on the 200 Hall Alzheimers unit used this grassy area to walk/exercise.</p> <p>483.25(k) SPECIAL NEEDS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure "Oxygen in Use" signs were posted, oxygen humidifier bottles were dated, oxygen filters did not have dust/lint, oxygen tubing and mouth pieces were covered and stored in a sanitary manner and that oxygen was administered per the physician order at the proper flow rate for 2 residents (Residents Resident #7 and #11) of 3 case-mix residents (Residents #1, #7 and #11) who required oxygen therapy. These failed practices had the potential to affect 10 residents who required oxygen therapy as documented on the Resident Census</p>	F 328			

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NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY HEALTHCARE HEBER SPRINGS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1040 WEDDINGFORD RD</b> <b>HEBER SPRINGS, AR 72543</b>		
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F 328	Continued From page 12 and Condition of Residents form dated 4/3/06. The findings are:  1. Resident # 7 had diagnoses of Cerebral Vascular Accident and Shortness of Breath.  a. A physician order dated 2/15/06 documented for Oxygen at 2-4 liters per minute.  b. On 4/3/06 at 1:51 p.m., the oxygen concentrator had a humidifier bottle that documented the date: "3/19/06." The filters on the oxygen concentrator were covered with a thick layer of dust/lint. The oxygen was not being administered at this time. The Oxygen machine was off.  c. On 4/4/06 at 9:55 a.m., the resident was lying in bed on the left side. The oxygen concentrator was turned off. The humidifier bottle and oxygen tubing had been removed. The filters on the oxygen concentrator were still covered with a film of dust/lint.  2. Resident #11 had diagnoses of Obstructive Chronic Bronchitis and Chronic Airway Obstruction.  a. A physician order dated 2/25/06 documented for Oxygen at 2 liters per minute by Nasal Canula PRN (as needed) for Shortness of Breath. The order further documented to the oxygen tubing to be changed weekly on Sundays.  a. On 4/3/06 at 1:27 p.m., the resident was resting in bed. The oxygen concentrator was turned off. The nasal canula and tubing were laying across the oxygen concentrator and were uncovered. The filters on the oxygen	F 328			

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F 328	Continued From page 13 concentrator had an accumulation of dust/lint. The humidifier bottle and oxygen tubing were not dated to indicate when the bottle and tubing had been changed. There was not an oxygen sign posted on the resident's door to indicate that oxygen was in use.  b. On 4/3/06 at 4:47 p.m., the nasal canula and tubing continued to lay across the oxygen concentrator uncovered.  c. On 4/4/06 at 9:18 a.m., the oxygen concentrator filters continued to be covered with dust/lint.  d. On 4/4/09 at 3:55 p.m., the resident was sitting in a recliner at the bedside. The resident was receiving oxygen at 3 1/2 L (Liters) a minute per N/C (Nasal Canula) instead of the 2 liters per minute as ordered by the physician.  3. The facility Policy and Procedure for Oxygen Administration provided by the facility on 4/6/06 at 9:00 a.m., documented: "...1. Check physicians's order for liter flow and method of Administration. 2. Place " Oxygen in use" sign per facility policy...8. Check and clean oxygen equipment, masks,tubing and cannulas at regular intervals..."	F 328			
F 441 SS=C	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	F 441			

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F 441	<p>Continued From page 14</p> <p>isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure a system was in place to ensure pneumonia vaccines were offered to residents for 12 (Residents, #1, and #3 - #13) of 13 case mix residents (Resident #1 through #13) who were monitored for Pneumonia vaccinations. The facility also failed to ensure food items were kept off of the floor for 1 resident (Resident #6) and failed to ensure latex gloves used during personal care were disposed of in a sanitary manner and not left in a residents room (Resident #7) of 13 case mix residents (Residents #1-#13) who required staff assistance for Activities of Daily Living. This failed practice had the potential to affect 95 residents who were 65 years or older according to the Resident Age List provided by the Administrator on 4/7/06 and all 101 residents who would have interaction with staff as documented on the Roster Matrix dated 4/3/06. The findings are:</p> <p>1. On 4/5/06 during record review of client's Minimum Data Sets the following was noted:</p> <p>a. Resident #1, DOB (Date of Birth) 6/28/39, was admitted to the facility 1/5/04. Consent for vaccination was blank. No vaccination was given.</p> <p>b. Resident #3, DOB 1/8/12, admitted to facility 9/13/02. Consent given for vaccination 11/7/05. No vaccination was given.</p>	F 441			

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F 441	Continued From page 15  c. Resident #4, DOB 7/21/19, admitted to facility 2/18/05. Consent given for vaccination 11/27/05. No vaccination was given.  d. Resident #5, DOB 10/7/22, admitted to facility 3/12/05. Consent for vaccination was blank. No vaccination was given.  e. Resident #6, DOB 1/9/13, admitted to facility 8/11/04. Consent given for vaccination 11/7/05. No vaccination was given.  f. Resident #7, DOB 8/24/34, admitted to facility 1/12/06. No consent form found. No vaccination was given.  g. Resident #8, DOB 3/27/12, admitted to facility 10/20/05. Consent for vaccination was blank. The Minimum Data Set dated 2/21/06 documented resident's Pneumococcal Vaccine status was up to date. No record that the Pneumonia vaccination was given could be found in the facility or the physician's office.  h. Resident #9, DOB 9/10/27, admitted to facility 7/20/04. Consent for vaccination was blank. No vaccination was given.  i. Resident #10, DOB 3/15/14, admitted to facility 10/4/05. Consent given for vaccination 11/8/05. No vaccination was given.  j. Resident #11, DOB 2/28/07, admitted to facility 1/24/00. Consent was given for vaccination 11/11/05. No vaccination was given.  k. Resident #12, DOB 5/8/13, admitted to facility 8/30/05. Consent for vaccination was blank. No	F 441			

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F 441	<p>Continued From page 16 vaccination was given.</p> <p>I. Resident #13, DOB 11/18/29, admitted to facility 3/12/05. Consent for vaccination was blank. No vaccination was given.</p> <p>m. The Minimum Data Sets for the remaining 11 residents revealed no documentation that the vaccination record was up to date or that the vaccination was given to the residents.</p> <p>n. On 4/5/06 at 3:00 p.m. the DON stated, (relating to the Pneumococcus Vaccinations for the residents) "The Health Department did not send us any Pneumonia Vaccines. Our Physicians had us to send the residents to their offices for them to receive them there." A request was made by the surveyor for documentation from the Physicians' Offices showing that the vaccination had been given for the case mix residents (Residents #1-#13).</p> <p>o. On 4/6/06 at 9:00 a.m. the DON stated, "I called all the physicians and no one had any documentation of the Pneumonia Vaccinations for the residents."</p> <p>p. On 4/6/06 at 10:00 a.m., the Director of Nurses was asked if pneumonia vaccinations were offered to the residents? The DON stated, "We sent a letter to the families for the Pneumonia and Flu Vaccinations to obtain their permission to administer them. A lot of the families just marked the flu portion and did not mark the pneumonia portion. If the pneumonia portion was left blank, I assumed we were not to give it. I did not follow up on it any further. I dropped the ball."</p>	F 441			

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F 441	<p>Continued From page 17</p> <p>q. On 4/6/06 at 10:15 a.m., the Director of Nurses was asked if the residents who had signed consents for the Pneumonia Vaccine had received the vaccine at their physicians offices and the Director of Nurses stated, "I called all the doctors and asked for copies of their Pneumococcus Vaccinations received at the office, and no records were found at the offices and we did not give them here." When questioned if anyone from the facility had followed up on the resident's request for the vaccine and the Director of Nurses stated, "No we didn't."</p> <p>r. The facility's Policy and Procedure for Vaccination/Immunization received from the DON (Director of Nursing) on 4/6/06 at 2:00 p.m. documented: "Vaccinations/Immunizations should be done according to the following criteria: Pneumococcus Vaccine-Upon admission or during the year if: An individual is age 65 or older. An individual is immunocompromised and is two years of age or older. An individual received the vaccine more than 5 years prior to reaching age 65. If you are unable to determine the vaccination status of individuals in either of the first two categories the vaccine should be administered. NOTE: If the patient/resident is scheduled to receive the influenza vaccine in the fall and meets the criteria for receiving the pneumococcus vaccine, both may be administered at the same time in different injection sites."</p> <p>2. Resident #6 had diagnoses of Alzheimers Disease and Deression. The Quarterly Minimum Data Set dated 1/31/06 documented the resident required extensive assistance of staff for dressing and hygiene.</p>	F 441			

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F 441	Continued From page 18 a. On 4/3/06 at 3:40 p.m., CNA (Certified Nursing Assistant) #4 opened a carton of Mightly Shake then set it on the floor beside the resident's wheelchair. The CNA then picked the carton up from the floor and gave it to the resident to drink.  3. Resident #17 had a diagnosis of Alzheimers Disease. A Quarterly MDS dated 2/14/06 documented the resident required staff assistance with Activities of Daily Living.  a. On 4/3/06 at 1:48 p.m., in the resident's room, located beside the resident's water pitcher there was a soiled latex glove. The glove had been partially turned inside out.	F 441			
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION  The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.  This REQUIREMENT is not met as evidenced by:  Based on record review and observations the facility failed to ensure staff maintained hand washing techniques that prevented the potential for the spread of infection after providing personal hygiene care for 1 resident (Resident #4) of 7 case mix residents (Resident #2-#4, #6, #8, #9, and #10) who required staff assistance for incontinent care. This failed practice had the potential to affect 14 residents who resided on the Alzheimer's Locked Unit on the 300 hall according to the Roster/Sample Matrix provided by the administrator on 4/4/06 at 11:45 a.m. The	F 444			

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F 444	Continued From page 19 findings are:  1. Resident #4 had diagnoses of Aplastic Anemia, Alzheimer's Disease, Osteoarthritis, and Urinary Tract Infection. The Quarterly Minimum Data Set dated 2/18/06 documented the resident was incontinent of bowel and bladder and required staff assistance with all Activities of Daily Living.  a. On 4/3/06 at 4:45 p.m., CNA (Certified Nurse Aide) #5 provided incontinent care to the resident following a large bowel movement. When finished with the care, CNA #5 exited the room and did not wash their hands. CNA #5 carried the dirty linen to the dirty linen can located outside on the patio then reentered the unit and continued to do resident care in other areas.  2. The facility's Policy and Procedure for Hand Washing documented: "The purpose of hand washing is to: Control infection through medical asepsis. Reduce transmission of organisms from resident to resident. Reduce transmission of organisms from nursing staff to resident. Reduce transmission of organisms from resident to nursing staff. General Instructions: Hands should be thoroughly washed before and after providing resident care. Proper hand-washing techniques must be followed at all times."	F 444			
F 445 SS=E	483.65(c) INFECTION CONTROL - LINENS  Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced	F 445			

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F 445	Continued From page 20 by:  Based on observation record review and interview, the facility failed to ensure contaminated linens were handled in a manner to prevent possible cross contamination after performing incontinent care for 2 residents (Residents #4 and #7) of 4 case-mix residents (Residents #2, #4, #6 and #7) who were incontinent and required staff assistance with incontinent care and hygiene. These failed practices had the potential to affect 51 residents who were incontinent and require staff assistance with incontinent care as documented on the Resident Census and Condition of Residents form dated 4/3/06 at 2:30 p.m. The findings are:  1. Resident # 7 had diagnoses of Cerebral Vascular Accident and Shortness of Breath. The Minimum Data Set dated 2/6/06 documented the resident was incontinent of bowel and bladder and had a foley catheter. The resident required staff assistance with all Activities of Daily Living.  a. On 4/5/06 at 10:56 a.m., CNA (Certified Nursing Assistant #1 and CNA #2 were providing incontinent care for the resident. The CNAs placed the contaminated bed linens from the residents bed onto the floor. CNA # 1 then removed more contaminated linens and a contaminated incontinent pad and deposited them onto the pile of contaminated linens that was already on the floor.  2. Resident #4 had diagnoses of Aplastic Anemia, Alzheimer's Disease, Osteoarthritis, and Urinary Tract Infection. The Quarterly Minimum Data Set dated 2/18/06 documented the resident was incontinent of bowel and bladder and required staff assistance with toileting and	F 445			

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F 445	Continued From page 21 hygiene.  a. On 4/3/06 at 4:45 p.m., CNA (Certified Nurse Aide) #5 provided incontinent care after an episode of stool incontinence. CNA #5 did not change gloves after cleaning feces from the resident rectal area and with the same dirty contaminated gloves on changed the resident's bottom sheet and bed pad. With the same contaminated gloves on the CNA handled 2 other clean bed pads that were folded and resting on top of the resident's bedside table. CNA #5 placed the contaminated linen into a pillow case and placed the dirty contaminated pillow case on top of the resident's clean bed linen that was on the seat of the resident's wheelchair. CNA #5 placed the dirty contaminated pillow case on the resident's floor and used the bed linen from the wheelchair seat to change the resident's bed.	F 445			