

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

PRINTED: 06/08/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/25/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE LIVING CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1175 MORNINGSIDE DRIVE CONWAY, AR 72034</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 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 observation, record review and interview the facility failed to ensure that staff knocked on resident doors and waited for an answer before entering and that personal care and equipment was not exposed to others for 4 (Residents #1, #5, #8 and #16) of 18 (Residents #1 thru #18) case mix residents. This failed practice had the potential to effect all 107 resident's in the facility, 3 residents who resided in the facility with an indwelling Foley catheter and 8 residents who received wound care, as documented on the Resident Census and Conditions of Residents 5/21/06 The findings are:</p> <p>1. Resident #1 had a diagnosis of End Stage Dementia. The Quarterly Minimum Data Set (MDS) dated 4/23/06 documented the resident had severely impaired cognitive skills for daily decision making, was incontinent of Bowel and Bladder and required total performance by staff for toileting, hygiene and bathing.</p> <p>On 5/22/06 at 2:20 p.m., Certified Nursing Assistant (CNA) #2 and CNA #3 entered the resident's room to perform care without knocking.</p> <p>2. Resident #5 had diagnoses of Alzheimer's Disease, Parkinson's Disease, and was legally blind. The Annual MDS dated 3/26/06</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	<p>Continued From page 1</p> <p>documented the resident as had severely impaired cognitive skills for daily decision making, contractures of the elbows, hands and knees, required total staff performance for all activities of daily living and was incontinent of bowel and bladder.</p> <p>On 5/22/06 at 2:12 p.m., CNA #1 entered the resident's room to check the resident for incontinence, without knocking on the resident's door.</p> <p>3. Resident #8 had a diagnosis of End Stage Dementia. The Initial MDS dated 4/18/06 documented the resident had severely impaired cognitive skills for daily decision making and required total staff performance for all activities of daily living.</p> <p>On 5/22/06 at 2:44 p.m., CNA #1 and CNA #3 entered the resident's room to perform care, without knocking.</p> <p>4. Resident #16 had diagnoses of End Stage Dementia. The Admission MDS dated 5/7/06 documented the resident had moderately impaired cognitive skills for daily decision making, short-term memory problems, required extensive assistance of staff for toileting and hygiene and had an indwelling catheter. A Physician order dated 4/30/06 documented: Cleanse 4th toe on R/ (right) foot w/ (with) Saf-Clens; apply Duoderm and Telfa QD (everyday) on 7-3 (7:00 a.m. to 3:00 p.m. shift).</p> <p>a. On 5/21/06 at 3:08 p.m., the resident's Foley catheter bag was uncovered and lying on a towel on the floor, beside the resident's recliner. The resident's hallway door was open. The resident's</p>	F 241			

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F 241	Continued From page 2 Foley catheter bag contained cloudy yellow urine and was in full view of staff, visitors and residents passing the resident's room.  b. On 5/24/06 at 9:58 am, Licensed Practical Nurse (LPN) #2 performed wound care for the resident; the LPN did not pull the resident's privacy curtain during the care. The resident's room mate was ambulatory in the room during the wound care and had full visual access to the procedure.	F 241			
F 246 SS=D	483.15(e)(1) ACCOMODATION OF NEEDS  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interview the facility failed to ensure individual needs and preferences during meals were met for 1 (Resident #13) of 13 (Residents #1 thru #13) case mix residents. This failed practice had the potential to effect 42 residents with mechanically altered diets, according to the Diet List dated 5/21/06. The findings are:  1. Resident #13 had diagnoses of Gastrointestinal Reflux Disease, Chronic Obstructive Pulmonary Disease and Esophageal Stricture. A Minimum Data Set dated 3/23/06 documented the resident had independent cognitive skills for daily decision making and had a chewing and swallowing	F 246			

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F 246	Continued From page 3 problem.  a. A Physician's Telephone Order dated 12/20/05 at 1420 (2:20 p.m.) documented: "Diet change to Puree food with liquids of choice per resident."  b. The Resident Plan of Care dated 3/20/06 documented: "Requires supervision with set up assistance and has a potential for complications related to history of poor appetite and chewing/swallowing problems." Interventions included: "Provide regular pureed diet per orders. Set up meal tray in order that it is readily accessible to resident. Encourage additional fluids while giving care to resident."  c. On 5/22/06 at 8:15 a.m., the resident was sitting on the side of the bed eating breakfast. The resident ate very slow and swallowed repeatedly after each bite. The resident had received orange juice, water and coffee on the breakfast tray. When asked about meal, the resident stated he "liked liquids thick."  d. On 5/22/06 at 9:30 a.m., the facility's Dietary Manager was notified by the surveyor of the resident's preference for thickened liquids.  e. On 5/22/06 at 12:40 p.m., the resident was sitting on the side of the bed eating lunch. The resident received water, coffee and a Mighty Shake. None of the liquids received were thickened, as requested by the resident.	F 246		
F 253 SS=E	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 4  This REQUIREMENT is not met as evidenced by:  Based on observation the facility failed to ensure equipment and holiday decorations were not stored in resident areas, exterior facing was not missing, shower and floor tiles were not broken, floors were not stained and/or dirty, door facings were not rusted and showers and shower chairs were not dirty, stained and/or molded. This failed practice had the potential to effect 107 residents in the facility, according to the Resident Census and Conditions of Residents form dated 5/21/06. The findings are:  1. On 5/22/06 at 8:44 a.m., an out-of-order Vander Lift was stored in the 100-200 Hall Resident Shower Room; a wheel chair and one Halloween decoration were being stored in the Resident smoking room.  2. On 5/22/06 at 11:30 a.m., during general observation of the facility, the following was noted:  a. The facing was missing on the header on the front portico.  b. In the 100/200 Shower Room there were broken tiles in the corner of the first shower stall.  c. On 200 hall, the bottoms of door facings were rusted and there was a debris build-up on the floor at the corner of the hallway door.  d. In the Shower #3 area, there were holes in the wall board, left of the handwashing sink.	F 253		

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F 253	Continued From page 5  e. Showers 3 and 4 had mold build up on the tiles. The Shower chairs were stained and molded.  f. There was a debris buildup in corner of the 100 hallway doorway.  g. In the 300/400 Shower Room:  1) Debris was in the corner of the doorways and tile was missing.  2) There were 2 showers with mold buildup and yellow stains.  3) The high back shower chair had feces on the foot rest.  4) There was gray fuzz on the heater vent and ceiling.  5) There were stained areas on all of the shower curtains and a brown yellow stain on 2 privacy curtains.  h. The 300 hallway door threshold had broken, dirty tiles.  i. The cove around the base of the dining room wall had buildup of 1/4 to 1/2 inch of dried, brown gummy material.  There was dried, white material on the curtains in the feeder section of the dining room.  There was food debris and stains on the dining room walls, chipped paint on the window sills and the base of the wall under the serving window had	F 253		

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F 253	Continued From page 6 food spillage.  j. On 5/22/06 at 3:00 p.m., during observations, there were too numerous to count resident door frames and common area door frames with peeling paint and rusted areas.  Resident rooms and hall floors on 200, 300 and 400 halls and the sitting area by the Nurse's station and Dining Room had dried brown/black gummy substances between floor tiles that could be scraped off with a finger nail. The thresholds had a build up of a dark brown substance.  k. Hallways on the 200, 300 and 400 halls and the Resident room walls, the dining room, common areas, shower room walls had dried substances present, with scuffed areas.  l. Resident doors, bathroom doors and shower room doors on hallways 200, 300 and 400 had multiple scuffed and stained areas.  3. On 5/23/06 at 8:21 a.m., two Vander Lifts, one wheelchair and one Halloween decoration were stored in the resident smoking area.	F 253		
F 309 SS=D	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	F 309		

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F 309	Continued From page 7 by: Based on observation and record review the facility failed to ensure an indwelling catheter drainage bag was not placed on the floor for 1 of 1 (Resident #16) case mix resident that had an indwelling catheter. This failed practice had the potential to affect 3 residents who had an indwelling catheter, according to the Resident Census and Conditions of Residents form dated 5/21/06. The findings are:  Resident #16 had a diagnosis of End Stage Dementia. The initial MDS dated 5/7/06 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance of staff for hygiene and had an indwelling catheter.  On 5/21/06 at 3:08 p.m., the resident's Foley catheter bag was lying, uncovered, on a towel 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 on observation the facility failed to ensure that the buttocks and thighs were cleansed and/or the skin was dried after incontinent care for 2 (Residents #5 and #6) of 8 case mix residents (Residents #1, #2, #5, #6, #7,	F 312			

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F 312	<p>Continued From page 8</p> <p>#9, #10 and #19) who were incontinent and that nail care was provided for 2 (Residents #5 and #6) of 19 (Residents #1 thru #19) case mix residents. This failed practice had the potential to affect 50 residents who were occasionally or frequently incontinent of bladder, 44 residents who were occasionally or frequently incontinent of bowel and 63 residents who required assistance with hygiene, as documented on the Resident Census and Condition of Residents form dated 5/21/06. The findings are:</p> <p>1. Resident #5 had diagnosis of Alzheimer's Disease, Parkinson's Disease, and was legally Blind. The Annual Minimum Data Set (MDS) dated 3/26/06 documented the resident had severely impaired cognitive skills for daily decision making, contractures of the elbows, hands and knees, was incontinent of Bowel and Bladder and required total staff performance for all activities of daily living.</p> <p>a. The facility's Policy and Procedure for Perineal Care (male resident) documented: "b. (3) Continue to wash the perineal area including the penis, scrotum and inner thighs...h. Wash and rinse the rectal area thoroughly., including the area under the scrotum, the anus, and the buttocks. i. Dry area thoroughly."</p> <p>b. The label on the DermaCen Perineal Wash used to cleanse the residents documented: "Gently clean and pat dry."</p> <p>c. On 5/24/06 at 9:35 a.m., during the provision of incontinent care by Certified Nursing Assistant (CNA) #1 and CNA #5. CNA #1 did not cleanse the resident's buttocks and CNA #5 did not cleanse the resident's thighs. The resident was</p>	F 312			

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F 312	Continued From page 9 not dried, before a clean incontinent brief was applied.  d. On 5/24/06 at 9:35 a.m., the resident's fingernails were thick, yellow-colored, uneven and extended past the finger tips approximately 1/4 inch.  e. The resident's plan of care dated 3/26/06 documented: "Keep fingernails trimmed short."  2. Resident #6 had diagnoses of Peripheral Ulcer with Peripheral Vascular Disease, Right Wrist Fracture, Rib Fracture, Vascular Dementia with Delusions, Depression, Coronary Artery Disease, Anemia, Esophagitis, Psychosis and Osteoarthritis. The Quarterly MDS dated 2/27/06 documented the resident was moderately impaired in cognitive skills for daily decision making, required total assistance with bathing and hygiene needs and was incontinent of bowel and bladder.  a. The Resident Plan of Care dated 2/7/06 documented: "Requires extensive to total assistance with ADLs (activities of daily living) due to Vascular Dementia with Delusions, Depression, Anemia, Non-ambulatory, and Incontinence and had a potential for skin breakdown." Interventions included: "Resident will be assisted with ADLs, i.e. Bathing x's (times) 1 assist, Transfers x's 2 assist, Dressing x's 1 assist, Personal Hygiene and Locomotion x's 1 assist. Moisturizing lotion applied after bathing."  "Potential for skin breakdown related to Anemia, Arthritis, Non-Ambulatory, Incontinence and Requires extensive to total assistance with ADLs," with an intervention for "Incontinence care	F 312		

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F 312	Continued From page 10 after each incontinent episode using soap and water or Peri-Wash."  b. On 5/21/06 at 2:06 p.m., 5:42 p.m. and 6:00 p.m., the resident's chin was covered with facial hair approximately 1-inch in length.  c. On 5/22/06 at 8:00 a.m., 11:15 a.m., 12:25 a.m. and 4:10 p.m., the resident's chin was covered with facial hair approximately 1-inch in length.  d. On 5/23/06 at 8:30 a.m. and 10:15 a.m., the resident's chin was covered with facial hair approximately 1-inch in length.  e. On 5/23/06 at 9:20 a.m., a body audit was performed on the resident. The resident's skin, on both feet, was dry. The resident's toenails were approximately 1/4-inch in length and curved over the end of the toes. The Great Toes had thick, yellow, discolored, nails approximately 1/4-inch thick; the nails extended past the end of the resident's toes.  CNA #4 performed incontinent care on the resident. The CNA did not cleanse between the resident's labia. After cleansing the resident's perineal area with no-rinse peri-wash solution, the CNA failed to dry the resident's perineal area.	F 312			
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	F 315			

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F 315	<p>Continued From page 11</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, the facility failed to ensure incontinent care was provided in a manner to prevent the potential for urinary tract infections for 1 (Residents #1) of 7 (Residents #1, #2, #6, #7, #9, #10 and #19) case mix residents who were incontinent and required staff assistance for incontinent care. This failed practice had the potential to affect 50 residents who were occasionally or frequently incontinent of bladder, as documented on the Resident Census and Conditions of Residents form dated 5/21/06. The findings are:</p> <p>1. The facility's Policy and Procedure for Perineal Care documented: "(1) Separate Labia and wash area downward from front to back. (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. Do not reuse the same washcloth or water to clean the urethra or labia. e.) Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same washcloth or water to clean the labia. f. Rinse thoroughly using the same technique as described in "e" above. g. Dry area thoroughly."</p> <p>2. Resident #1 had a diagnosis of End Stage Dementia. The Quarterly Minimum Data Set (MDS) dated 4/23/06 documented the resident</p>	F 315		

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F 315	Continued From page 12 had severely impaired cognitive skills for daily decision making, was incontinent of bowel and bladder and required total performance by staff for toileting, hygiene and bathing.  On 5/22/06 at 2:20 p.m., Certified Nursing Assistant (CNA) #3 wiped down the resident's left groin, changed to a clean area of the cloth and washed back and forth across the Mons Pubis four times and up the left groin three times, without turning the cloth to a clean area. The CNA did not spread the labia for cleansing.  The resident had been incontinent of feces. CNA #2 wiped from the resident's vaginal area and across the rectum two times, without turning the cloth to a clean area. The areas were not rinsed or dried after care.	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 that positioning devices were implemented to prevent the potential for further decline in range of motion and the potential for skin breakdown for 2 (Residents #5 and #19) of 14 case mix (Residents #2 thru #8, #10 and #14 thru #19)	F 318			

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F 318	<p>Continued From page 13</p> <p>residents with contractures. This failed practice had the potential to affect 19 residents with contractures, as documented on the Resident Census and Conditions of Residents form dated 5/21/06. The findings are:</p> <p>1. Resident #5 had diagnosis of Alzheimer's Disease, Parkinson's Disease and Legally Blind. The Annual Minimum Data Set (MDS) dated 3/26/06 documented the resident had severely impaired cognitive skills for daily decision making, contractures of the elbows, hands and knees, required total staff performance for all activities of daily living and was incontinent of bowel and bladder.</p> <p>a. On 5/21/06 at 2:38 p.m. and 5:34 p.m., the resident's arms were bent at the elbow lying on his chest; the resident's hands were clinched into fists, without handrolls or other positioning devices in place.</p> <p>b. On 5/22/06 at 8:10 a.m., 10:15 a.m. and at 2:12 p.m., the resident's arms were bent at the elbow, lying on his chest; his hands were clinched into fists, without handrolls or other positioning devices in place.</p> <p>c. On 5/23/06 at 8:25 a.m. and 9:45 a.m., the resident's arms were bent at the elbow, lying on his chest; his hands were clinched into fists, without handrolls or other positioning devices in place.</p> <p>d. On 5/24/06 at 9:35 a.m., the resident's arms were bent at the elbow, lying on his chest; his hands were clinched into fists, without handrolls or other positioning devices in place.</p>	F 318		

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F 318	<p>Continued From page 14</p> <p>Certified Nursing Assistant (CNA) #1 and CNA #5 were unable to completely extend the resident's elbows, and after releasing his arms, the resident's arms reverted back into the same position as before, with his hands clinched.</p> <p>When asked if the resident ever used hand rolls, both CNAs replied, "The restorative CNAs do that." The CNAs stated that the resident currently did not wear hand rolls.</p> <p>e. The last Restorative Care Flow Record found on the resident was dated February 2006 and documented that the last handroll application was on 2/28/06.</p> <p>f. On 5/24/06 at 10:30 a.m., the restorative CNA was asked if restorative CNAs provide any treatment or services for the resident; she responded, "No." When asked, "What about handrolls?" the restorative CNA responded, "He should have handrolls in place."</p> <p>g. The resident's plan of care dated 3/26/06 documented "May provide handrolls or wash cloths to prevent contractures."</p> <p>2. Resident #19 had diagnoses of End Stage Alzheimer's Disease, Transient Ischemic Attacks, Dementia and Weakness. The Quarterly MDS dated 2/15/06 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistance with all activities of daily living and had partial loss of voluntary movement a hand.</p> <p>a. The Resident Plan of Care, dated 2/16/06, did not address the resident's limited hand range of motion.</p>	F 318			

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F 318	Continued From page 15  b. On 5/21/06 at 3:05 p.m., the resident had no positioning device in place to prevent further hand contracture of the right hand and the hand was folded closed.  c. On 5/23/06 at 1:30 p.m. and 3:15 p.m., the resident had no positioning device in place to prevent further hand contracture of the right hand and the hand was folded closed.  d. On 5/24/06 at 8:30 a.m., the resident had no positioning device in place to prevent further hand contracture of the right hand and the hand was folded closed.	F 318		
F 323 SS=E	483.25(h)(1) ACCIDENTS  The facility must ensure that the resident environment remains as free of accident hazards as is possible.  This REQUIREMENT is not met as evidenced by:  Based on observation the facility failed to ensure Dining Room chair rails were free of splinters and the arm covers on a Geri-chair were free of torn, sharp edges to prevent the potential for accidents/hazards. The failed practice had the potential to effect all 106 residents in the facility, according to the Resident Census and Conditions of Residents form dated 5/21/06. The findings are:  1. On 5/22/06 at 2:30 p.m., the chair rails in the Dining Room were scraped and had splintered areas.	F 323		

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F 323	Continued From page 16 2. On 5/21/06 at 3:05 p.m. and on 5/23/06 at 3:15 p.m., the plastic arm covers on the Geri chair in Resident Room 209a were torn, with sharp edges.	F 323			
F 371 SS=C	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE  The facility must store, prepare, distribute, and serve food under sanitary conditions.  This REQUIREMENT is not met as evidenced by:  Based on observation the facility failed to ensure a vent screen and a fan were not dirty in the kitchen. This failed practice had the potential to effect 106 residents in the facility that received food from the kitchen, according to the Diet List dated 5/21/06. The findings are:  On 5/22/06 at 9:30 a.m., the vent screen that was on the left of the entrance door in the kitchen, was covered entirely with a black sticky substance.  The oscillating floor fan that sat in the kitchen, in front of the Certified Dietary Manager's office, was covered with a black lint substance over the entirety of the fan.	F 371			
F 372 SS=C	483.35(i)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL  The facility must dispose of garbage and refuse properly.	F 372			

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F 372	Continued From page 17 This REQUIREMENT is not met as evidenced by:  The facility failed to ensure that the facility trash and garbage was contained to prevent the potential for pest infestation. This failed practice had the potential to effect all 107 residents in the facility. The findings are:  On 5/22/06 at 8:32 a.m., the covers were open on two trash bins, with bagged trash overflowing the trash bins. There was also trash on top of the trash bins.	F 372			
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 interview the facility failed to ensure a contaminated cloth, gloves and/or peri-wash were not used to provide incontinent care for 2 (Residents #1 and #5) of 3 (Residents #1, #5 and #6) case mix residents that required assistance with incontinent care. The facility further failed to ensure supplies used for wound care were not	F 441			

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F 441	<p>Continued From page 18</p> <p>contaminated and that wound care was performed in a clean manner to prevent possible cross contamination for 1 (Resident #6) of 3 (Residents #3, #6 and #12) case mix residents who required wound care. This failed practice had the potential to affect 50 bladder incontinent residents, 44 bowel incontinent residents, who required assistance with or total staff performance for toileting hygiene and 8 residents who required wound care, according to the Resident Census and Conditions of Residents form dated 5/21/06. The findings are:</p> <p>1. Resident #1 had a diagnosis of End Stage Dementia. The Quarterly Minimum Data Set (MDS) dated 4/23/06 documented the resident had severely impaired cognitive skills for daily decision making, was incontinent of bowel and bladder and required total performance of staff for toileting, hygiene and bathing.</p> <p>On 5/22/06 at 2:20 p.m., Certified Nursing Assistant (CNA) #3 draped a wet cloth over the resident's bed rail and then used it to perform incontinent care on the resident.</p> <p>2. Resident #5 had diagnoses of Alzheimer's Disease, Parkinson's Disease and Legally Blind. The Annual MDS dated 3/26/06 documented the resident had severely impaired cognitive skills for daily decision making, contractures of the elbows, hands and knees, required total staff performance for all activities of daily living and was incontinent of bowel and bladder.</p> <p>On 5/24/06 at 9:35 a.m., CNA #1 took a spray bottle of DermaCen Perineal Wash out of her pocket, sprayed the cleanser on a cloth during incontinent care four times, with soiled gloves on;</p>	F 441			

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F 441	<p>Continued From page 19</p> <p>then replaced the bottle in her pocket. The CNA stated the peri-wash was hers to use on all residents.</p> <p>3. Resident #6 had diagnoses of Peripheral Ulcer with Peripheral Vascular Disease, Coronary Artery Disease, Anemia, Psychosis and Osteoarthritis. The Quarterly MDS dated 2/27/06 documented the resident was moderately impaired in cognitive skills for daily decision making, required total assistance with bathing and hygiene needs and required application of ointment/medications and dressings to an area other than the feet.</p> <p>a. The Resident Plan of Care dated 2/7/06 documented: Potential for skin breakdown related to Anemia, Arthritis, Non-Ambulatory, Incontinence, and Requires extensive to total assistance with ADLs (activities of daily living) with an intervention dated 5/21/06 for wound care protocol.</p> <p>b. A Physician's Telephone Order dated 5/21/06 at 9:45 a.m. documented: "W to D (wet to dry) with Normal Saline to wound bed only. Cover with Non-Stick Telfa on surrounding area and wrap with Kerlix Q-shift (every shift). "</p> <p>c. On 5/23/06 at 10:15 a.m., Licensed Practical Nurse (LPN) #1 performed wound care on the resident's right lateral malleolus. After applying gloves, the LPN opened and sprayed wound cleanser on several 4-by-4 gauze sponges. The LPN then reached into the treatment cart to get more supplies and, with the same contaminated gloves on, proceeded to perform the resident's wound care.</p>	F 441			

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F 441	<p>Continued From page 20</p> <p>With same contaminated gloves on, the LPN wiped across the weeping wound bed in a downward motion, spreading moisture from the weeping area down toward the resident's foot. At the same time, the LPN tried to pick and wipe large pieces of dry, sloughing skin from the reddened area of the wound.</p> <p>The LPN then used scissors obtained from a uniform pocket to cut the Kerlix used to wrap the resident's wound.</p> <p>When finished with the wound dressing, the LPN washed hands, then with bare hands, pushed the contaminated Kerlix, removed from the resident's wound, down into the red trash bag. The LPN then pushed the treatment cart to the locked storage room and with bare, contaminated hands, opened the storage room door.</p> <p>The LPN did not tie off or close the trash bag before leaving the resident's room and carried the trash bag into the biohazard closet and disposed of it.</p> <p>Then LPN then, with bare contaminated hands, opened the Nurse's break room door and went inside to wash hands.</p> <p>d. The facility's policy and procedure titled, "Wound Care" documented: "Use disposable cloth (paper towel is adequate) to establish clean field on resident's over bed table. Place all items to be used during the procedure on the clean field. Arrange supplies so they can be easily reached.</p> <p>Wash and dry hands thoroughly. Put on exam gloves. Loosen tape and remove dressing. Pull</p>	F 441			

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F 441	Continued From page 21 glove over dressing and discard into appropriate receptacle.  Wash and dry hands thoroughly. Put on gloves. Use no touch technique. Pour liquid solutions directly on gauze sponges on their papers. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound.  Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. Place 1 gauze to cover all broken skin. Wash tissue around the wound that is usually covered by the dressing, tape or gauze, with antiseptic or soap and water. Remove dry gauze. Apply treatments as indicated.  Be certain all clean items are on a clean field. Discard disposable items into the designated container.  Wash and dry hands thoroughly. Wipe reusable supplies with alcohol as indicated (i.e., outsides of containers that were touched with unclean hands, scissor blades, etc.). Return reusable supplies to resident's drawer in treatment cart."	F 441			