

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

PRINTED: 06/29/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045357	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/16/2006
NAME OF PROVIDER OR SUPPLIER BEVERLY HEALTHCARE NORTH LITTLE ROCK			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 RICHARDS ROAD NO LITTLE ROCK, AR 72117	
(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 Complaint #11566 was substantiated (all or in part) with a deficiency cited at F253. Complaints #11597, #11646 and #11692 were unsubstantiated. Complaint #11741 was substantiated (all or in part) with a deficiency cited at F253. Complaint #11763 was substantiated (all or in part) with deficiencies cited at F225 and F226.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of	F 164		

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 164	<p>Continued From page 1</p> <p>the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure privacy was provided in the shower room for 1 (Resident #13) of 14 case mix residents who required assistance with bathing (Residents #1 through #14), which resulted in the unclothed resident being exposed to two other residents. The failed practice had the potential to affect 111 residents who required assistance with bathing, as documented on the facility's Resident Census and Conditions of Residents form dated 6/13/06. The findings are:</p> <p>Resident #13 had diagnoses of Diabetes, Cerebrovascular Accident and Neurogenic Bladder. The Minimum Data Set (MDS) dated 4/18/06 documented the resident was moderately impaired in cognitive skills for daily decision-making and totally dependent on staff for bathing.</p> <p>a. On 6/14/06 at 9:10 a.m., Certified Nursing Assistant (CNA) #1 provided a shower to the resident in the shower room. After the shower, the CNA moved the resident to the center of the shower room. The resident was nude and no sheet or drape was provided to cover her. The curtain was pulled in front of the door to the room, but 2 other CNA's entered the room, each transporting a resident. Resident #13's nude body was exposed to the 2 other residents. No</p>	F 164			

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F 164	Continued From page 2 effort was made by any of the CNA's to protect Resident #13's privacy.	F 164		
F 167 SS=B	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the most recent long-term care survey results were posted in an area that would be easily accessible for residents in wheelchairs. The failed practice had the potential to affect 49 residents who required wheelchairs for locomotion, as documented on a list provided by the Assistant Director of Nursing on 6/17/06 at 4:25 p.m. The findings are: 1. On 6/13/06 at 10:15 a.m., the survey results for the 300 Hall were posted in a plastic holder	F 167		

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F 167	Continued From page 3 mounted on the day room wall. The holder was mounted approximately 58 inches from the floor in a corner between a table and a wing back chair. There was approximately 1 foot of space between the table and chair, which would prevent a resident in a wheelchair from accessing the holder. 2. On 6/13/06 at 10:20 a.m., the survey results on the 200 Hall were posted in a plastic holder mounted on the day room wall. The holder was approximately 60 inches from the floor. 3. On 6/13/06 at 3:20 p.m. during the environmental tour of the facility, the Administrator was asked if the survey results on the wall of the 300 Hall day room were accessible to residents in wheelchairs. The Administrator stated, "No."	F 167			
F 225 SS=E	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225			

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F 225	<p>Continued From page 4</p> <p>immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #11763 was substantiated (all or in part) with these findings.</p> <p>Based on record review and interview, the facility failed to ensure an allegation of physical abuse was investigated for 1 (Resident #9) of 10 Phase I case mix residents who were cognitively impaired (Residents #2, #3, #5, #7 through #11, #13 and #14). This failed practice had the potential to cause more than minimal harm to 49 residents with Dementia and 33 residents with documented psychiatric diagnoses (excluding dementias and depression), as documented on the facility's Resident Census and Conditions of Residents form dated 6/13/06. The facility also failed to immediately notify the local law enforcement agency of an allegation of abuse for 1 (Resident</p>	F 225			

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F 225	<p>Continued From page 5</p> <p>#25) of 22 case mix residents who currently reside in the facility (Residents #1 through #21 and #25). This failed practice had the potential to affect all 120 residents, as documented on the facility's Resident Census and Conditions of Residents form dated 6/13/06. The findings are:</p> <p>1. The Division of Medical Services (DMS) Form 762 (Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property & Exploitation of Residents in Long Term Care Facilities form) submitted by the facility to the Office of Long Term Care (OLTC) on 5/2/06 regarding Resident #4 documented: "...Later still when the DNS [Director of Nursing Services] interviewed the witnessing resident [Resident #9], she reported that [Certified Nursing Assistant (CNA) #8] hit her on the butt and [CNA #9] hit her on the head. The DNS continued questioning and everything that was asked to resident, she stated 'yes' including being thrown down in the shower and rolled around on the floor naked..."</p> <p>a. On 6/15/06 at 8:00 a.m., the DMS-762 was reviewed with the Administrator. The Administrator was asked if the entry which documented: "hit her on the butt and... hit her on the head" referred to Resident #4 or Resident #9. The Administrator stated, "No, that's supposed to be [Resident #4] that was hit." When asked if there was an investigation of Resident #9's allegation that she was thrown down in the shower and rolled around naked on the floor, the Administrator stated, "No."</p> <p>b. On 6/15/06 at 8:05 a.m., the DMS-762 was reviewed with the DNS. The DNS was asked if the facility was working on an investigation into the allegation that Resident #9 was thrown down</p>	F 225			

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F 225	Continued From page 6 in the shower. The DNS stated, "No. I told the Administrator and Nurse Consultant I didn't think [Resident #9] was reliable when she stated that she had been rolled on the floor naked and beat up in the shower. The person that [Resident #9] named as doing this has never worked here." When asked if this allegation should be investigated, the DNS stated "Yes, I see what you're saying." 2. The DMS-762 submitted by the facility to the Office of Long Term Care regarding Resident #25 documented the date and time of the incident as 5/1/06 at 2:30 p.m. The form documented a bruise was found on the resident's left lower back. The date and time the local law enforcement agency was contacted regarding the incident was documented as 5/2/06 at 1:00 p.m. On 6/15/06 at 2:40 p.m., the Administrator was asked if the date documented as the 'law enforcement notified' date on the DMS-762 was accurate. The Administrator stated, "Yes, on 5/1/06, I didn't think it was reportable. On 5/2/06, I found out it was and notified OLTC and the Police."	F 225			
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Complaint #11763 was substantiated (all or in part) with these findings.	F 226			

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F 226	Continued From page 7 Based on record review and interview, the facility failed to ensure the facility policies and procedures for abuse prohibition were implemented, as evidenced by failure to investigate an allegation physical abuse for 1 (Resident #9) of 10 Phase I case mix residents who were cognitively impaired (Residents #2, #3, #5, #7 through #11, #13 and #14). This failed practice had the potential to cause more than minimal harm to 49 residents with Dementia and 33 residents with documented psychiatric diagnoses (excluding dementias and depression), as documented on the facility's Resident Census and Conditions of Residents form dated 6/13/06. The facility also failed to immediately notify the local law enforcement agency of an allegation of abuse for 1 (Resident #25) of 22 case mix residents who currently reside in the facility (Residents #1 through #21 and #25) and failed to conduct a State Employee Clearance Registry (ECR) check prior to allowing an employee to work in the facility for 1 of 5 employees whose personnel files were reviewed. These failed practices had the potential to affect all 120 residents, as documented on the facility's Resident Census and Conditions of Residents form dated 6/13/06. The findings are: 1. The facility's policy titled, "Reporting Alleged Violations" documented: "...It is also the policy of this facility to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property... are reported immediately to the executive director of the facility... Such violations are also reported to state agencies in accordance with existing state law. The facility	F 226			

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F 226	<p>Continued From page 8</p> <p>investigates each such alleged violation thoroughly and reports the results of all investigations to the executive director or his or her designee, as well as to state agencies as required by state and federal law... Staff screening: All applicants for employment in the facility shall, at a minimum have the following screening checks conducted: ...Appropriate licensing board or registry check..."</p> <p>2. The Division of Medical Services (DMS) Form 762 (Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property & Exploitation of Residents in Long Term Care Facilities form) submitted by the facility to the Office of Long Term Care (OLTC) on 5/2/06 regarding Resident #4 documented: "...Later still when the DNS [Director of Nursing Services] interviewed the witnessing resident [Resident #9], she reported that [Certified Nursing Assistant (CNA) #8] hit her on the butt and [CNA #9] hit her on the head. The DNS continued questioning and everything that was asked to resident, she stated 'yes' including being thrown down in the shower and rolled around on the floor naked..."</p> <p>a. On 6/15/06 at 8:00 a.m., the DMS-762 was reviewed with the Administrator. The Administrator was asked if the entry which documented: "hit her on the butt and... hit her on the head" referred to Resident #4 or Resident #9. The Administrator stated, "No, that's supposed to be [Resident #4] that was hit." When asked if there was an investigation of Resident #9's allegation that she was thrown down in the shower and rolled around naked on the floor, the Administrator stated, "No."</p> <p>b. On 6/15/06 at 8:05 a.m., the DMS-762 was</p>	F 226			

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F 226	<p>Continued From page 9</p> <p>reviewed with the DNS. The DNS was asked if the facility was working on an investigation into the allegation that Resident #9 was thrown down in the shower. The DNS stated, "No. I told the Administrator and Nurse Consultant I didn't think [Resident #9] was reliable when she stated that she had been rolled on the floor naked and beat up in the shower. The person that [Resident #9] named as doing this has never worked here." When asked if this allegation should be investigated, the DNS stated "Yes, I see what you're saying."</p> <p>3. The DMS-762 submitted by the facility to the Office of Long Term Care regarding Resident #25 documented the date and time of the incident as 5/1/06 at 2:30 p.m. The form documented a bruise was found on the resident's left lower back. The date and time the local law enforcement agency was contacted regarding the incident was documented as 5/2/06 at 1:00 p.m.</p> <p>On 6/15/06 at 2:40 p.m., the Administrator was asked if the date documented as the 'law enforcement notified' date on the DMS-762 was accurate. The Administrator stated, "Yes, on 5/1/06, I didn't think it was reportable. On 5/2/06, I found out it was and notified OLTC and the Police."</p> <p>4. On 6/15/06 at 11:45 a.m., Maintenance Employee #1's employee file was reviewed. The employee's date of hire was documented as 5/22/06, but no ECR check was documented until 5/30/06.</p> <p>On 6/15/06 at 12:40 p.m., the Assistant Administrator confirmed that Maintenance Employee #1's date of hire was 5/22/06 and the</p>	F 226			

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F 226	Continued From page 10 ECR check was completed 8 days later on 5/30/06. The Assistant Administrator provided a computer print-out of the employee's time for the week of 5/21/06 which documented the employee's first day of work as 5/22/06.	F 226			
F 253 SS=C	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Complaints #11566 and #11741 were substantiated (all or in part) with these findings. Based on observation and interview, the facility failed to ensure furniture was clean and in good repair, walls were clean and free of gouged areas and holes, exit doors were properly fitted to allow complete closure, water fountains and showers were clean and sanitary, floor tiles were clean and free of cracks, air conditioner vent covers were free of gaps and privacy curtains were clean and properly attached. The failed practices had the potential to affect 59 residents who resided on the 200 Hall and 61 residents who resided on the 300 Hall, as documented on the facility's Roster/Sample Matrix dated 6/12/06 at 5:20 p.m. The findings are: 1. On 6/12/06 from 3:30 p.m. to 4:46 p.m. during the initial tour of the facility, the following observations were made: a. The headboard in Resident Room 326, Bed B was wobbly.	F 253			

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F 253	Continued From page 11 b. The footboard in Resident Room 316, Bed B was at a 100 degree angle, tilted outward from the bed and wobbly when touched. c. The headboard in Resident Room 302, Bed B, was wobbly. 2. On 6/13/06 at 8:50 a.m. in Room 324, the wall between the room and the bathroom had a large gouged area and the wall to the left of the entryway had a large, scuffed area with black streaks and smudges. 3. On 6/13/06 at 12:30 p.m., the following observations were made in Room 321 (Bed B): a. The wall where the overhead light fixture was mounted had an area of missing paint which measured approximately 2 inches by 1/4 inch. There were also two areas of a dried yellow substance and a gray scuff mark on the same wall. b. The bedside table had an accumulation of gray dirt/dust along the table base. c. The rocking/glider chair had an accumulation of dust/dirt/food particles surrounding the entire cushion of the chair. d. On 6/14/06 at 11:20 a.m., Housekeeper #2 had just finished cleaning the resident's room. The bedside table and rocking/glider chair remained dirty. 4. On 6/13/06 at 3:20 p.m. during the environmental tour of the facility, the following observations were made:	F 253			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045357	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/16/2006
NAME OF PROVIDER OR SUPPLIER BEVERLY HEALTHCARE NORTH LITTLE ROCK			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 RICHARDS ROAD NO LITTLE ROCK, AR 72117		
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F 253	Continued From page 12 On the 200 Hall: a. In Room #212, the air conditioner vent cover was warped, which left a gap approximately 1 inch wide by 24 inches long. The night stand for both beds in the room had a build-up of dirt in the crevices of the drawers and the base of the unit. b. In the day room across from the 200 Hall nurses' station, there were 3 dining tables with a build-up of dirt on the table legs. c. The door leading outside to the courtyard from the 200 Hall day room did not fully close, which left a 1/4 inch gap to the outside. d. In the 200 Hall day room, the water fountain had a build-up of a pink residue around the drain. The stain was approximately 2.5 inches in diameter. e. The floor in the 200 Hall shower entry was missing its covering, which left the uneven concrete subfloor exposed. f. The first stall on the left in the 200 Hall shower room had a brownish-green residue in the right back corner. The right front corner wall had a broken/chipped tile. g. The 200 Hall shower room had a build-up of grayish/white residue on the floor at the base of the wall, approximately 12 inches in length and approximately 1/4 in width to the right of the whirlpool tub. h. In Room 244, there was a chipped floor tile in the doorway. There was a dried crusty stain on	F 253			

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F 253	<p>Continued From page 13</p> <p>the left upper side of the chair back. The night stand had dirt in the crevices at the bottom for Bed B.</p> <p>i. The clean utility room on the 200 Hall had several pieces of paper particles and paper medication cups scattered across the floor.</p> <p>j. On the back corridor between the 200 Hall and the kitchen, there were 16 cracked floor tiles.</p> <p>k. On the back hallway Personal Care room, the floor was littered with small pieces of trash and debris. The trash container was overflowing.</p> <p>l. The Fine Dining room door from the 300 hall had a piece of laminate missing, approximately 4 inches long by 3 inches wide.</p> <p>m. The hallway from the fine dining room and the 300 hall had 6 split/cracked floor tiles extending from one side of the hall to the other side of the hall approximately midway down the hallway.</p> <p>On the 300 Hall:</p> <p>a. In Room 319, the heating/cooling vent was warped, which left a gap of approximately 1/2 inch in width and 24 inches in length.</p> <p>b. In Room 316, the night stand for Bed A had dirt in the crevices at the bottom. The heating/cooling vent was warped with a gap approximately 1/2 inch in width and 24 inches in length. The footboard on bed B was loose, wobbly and tilted out at a 110 degree angle.</p> <p>c. The door leading out to the courtyard from the 300 Hall day room did not fully close, which left a</p>	F 253			

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F 253	<p>Continued From page 14 1/4 inch gap to the outside.</p> <p>d. The 300 Hall shower room had a dirty privacy curtain extending across the width of the shower room. The tan curtain had an area of brown stains which measured approximately 1.5 feet in width and approximately 5 feet in length. There were 5 hooks on the left hand side of the curtain that were not attached to the ceiling track which left the end of the curtain unsupported.</p> <p>e. In the alcove just past the nurses' station, the area designated for mechanical lift storage had 3 gouged areas in the wall.</p> <p>f. The column to the right of the facility's main entrance had cracks in the bottom panel. On the front side of the 4 sided column, the left corner trim was split and gapped approximately 1/2 inch.</p> <p>5. On 6/14/06 at 9:50 a.m., there was a dried brownish-green stain and scattered brown flakes on the floor in Room 302, Bed B.</p> <p>6. On 6/14/06 at 10:35 a.m., Housekeeper #2 was asked if she had been trained on how to clean resident rooms. Housekeeper #2 stated, "Yes." When asked to explain the steps involved in cleaning a resident's room, the Housekeeper stated, "We clean the furniture, sweep and mop the floors and clean the bathrooms." When asked if cleaning the chairs would be included, the Housekeeper stated, "Yes."</p> <p>7. On 6/14/06 at 11:30 a.m., the following observations were made in Room 346, Beds A and B:</p> <p>a. There was a gray scuff mark on the outside of</p>	F 253			

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F 253	<p>Continued From page 15</p> <p>the bathroom wall to the left of the bathroom door, which measured approximately 12 inches long and 2 inches wide.</p> <p>b. There was a gray scuff mark at the level of the door handle on the outside of the bathroom door approximately 6 inches long and 1/4 inch wide.</p> <p>c. There were 3 black scuff marks on the inner edge of the bathroom door. Each scuff mark was approximately 1.5 inches long and 1/2 inch wide.</p> <p>d. There was a gray scuff mark at the level of the door handle on the inside of the bathroom door measuring approximately 5 inches long and 1/4 inch wide.</p> <p>e. There were brown/tan streaks in the corner of the wall by Bed A. The streaks measured approximately 12 inches long and 12 inches wide and were approximately 3 feet up from the floor. The streaks were present on both corner walls.</p> <p>f. On the wall between the closet/drawer area, there were multiple scuff marks, streaks and 1 gouge in the drywall. The scuff marks/streaks extended up from the floor approximately 3 feet and across the wall approximately 8 feet. The gouge in the drywall was on the right side of the wall, next to the built-in drawers for Bed A. The gouge measured approximately 5.5 inches long and 1/4 inch wide.</p> <p>g. There were multiple black/brown marks on the wall by Bed B on the area at the head of the bed. The marks ranged from 1/4 inch to 1/2 inch in diameter.</p> <p>h. The headboard and footboard of Bed B were</p>	F 253			

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F 253	Continued From page 16 wobbly and the footboard was tilted outward approximately 100 degrees. 8. On 6/14/06 at 11:50 a.m., the floor in Resident #14's room had a dried, brown residue on the floor tiles. 9. On 6/15/06 at 2:20 p.m., Resident #21's privacy curtain was not attached to the last 5 ceiling hooks, which caused the end of the curtain to dangle loosely from the track.	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 a urinary drainage tubing and bag were positioned off of the floor to prevent potential contamination and positioned below the level of the bladder at all times to facilitate drainage for 1 (Resident #13) of 2 case mix residents with indwelling urinary catheters (Residents #1 and #13). The facility also failed to ensure catheter care was provided in a manner to prevent potential Urinary Tract Infections (UTI's) for 1 (Resident #1) of 2 case mix residents with indwelling urinary catheters (see identifiers above). The failed practices had the potential to affect 2 residents with indwelling urinary catheters, as documented on a list	F 309			

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F 309	<p>Continued From page 17</p> <p>provided by the Nursing Consultant on 6/15/06 at 2:30 p.m. The facility also failed to ensure post-dialysis assessments were consistently conducted for 2 of 2 (Residents #17 and #18) case mix residents who received dialysis services. The failed practice had the potential to affect 2 residents who received dialysis services, as documented on the Resident Census and Conditions of Residents form dated 6/13/06. The findings are:</p> <p>1. Resident #13 had diagnoses of Diabetes, Cerebrovascular Accident and Neurogenic Bladder. The Minimum Data Set (MDS) dated 4/18/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, required extensive assistance of staff for personal hygiene and had an indwelling urinary catheter.</p> <p>a. The Plan of Care dated documented: "...Problem - At risk for complication of indwelling catheter... Interventions: ...Catheter care Q [every] shift per protocol & [and] PRN [as needed]... Assure placement... Keep off floor"</p> <p>b. On 6/14/06 at 9:10 a.m., the following observations were made in the shower room and resident's room:</p> <p>1.) Certified Nursing Assistant (CNA) #1 provided a shower to the resident. The CNA hung the urinary drainage bag on the arm of the shower chair, which was above the level of the resident's bladder. After the shower was completed, the CNA transferred the resident to her wheelchair using the sit-to-stand mechanical lift. The CNA hung the urinary drainage bag on the handle of the lift, which was at the resident's shoulder level.</p>	F 309			

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F 309	Continued From page 18 2.) The resident was wheeled back to her room and CNA #1 and the Education Nurse Consultant transferred the resident from the wheelchair to the bed with the sit-to-stand lift. The urinary drainage bag was placed on the floor under the wheelchair, then hung on the handle of the lift for the transfer. After the resident was in bed, the CNA provided perineal care. 3.) The CNA cleansed the vaginal area using a downward motion, but did not separate and cleanse between the labia. The resident was turned to the side, feces were removed from the buttocks, then the resident was returned to a supine position. The CNA provided catheter care but did not separate the labia to cleanse the urethral meatus/catheter insertion site. During the catheter care, the urinary drainage bag was hung on the foot bed cradle which was approximately 5 inches above the level of the resident's bladder. c. On 6/13/06 at 11:15 a.m., the Nurse Consultant was asked if the drainage bag was an anti-reflux bag. She stated, "Yes, that's all we use." The Consultant was asked to check the resident's bag. The Consultant crimped the tubing to prevent backflow to the resident, then held the bag upward. Urine flowed backward from the bag into the tubing. 2. Resident #1 had diagnoses of Encephalopathy, Diabetes and Cerebrovascular Accident. A physician order dated 3/6/06 documented: "Foley cath [catheter] care with soap and water daily." a. The Minimum Data Set dated 3/22/06	F 309			

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F 309	<p>Continued From page 19</p> <p>documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for personal hygiene, incontinent of bowel and bladder and did not have an indwelling catheter.</p> <p>b. The Plan of Care dated 3/28/06 documented: "...Problem - at risk for complications due to Foley catheter... Catheter care Q [every] shift per protocol and PRN [as needed]."</p> <p>c. On 6/14/06 at 11:30 a.m., Nursing Assistant (NA) #3 and the Hospice CNA provided a shower on a shower stretcher in the large shower stall. The NA bathed the resident with a washcloth and liquid soap. The NA rinsed the washcloth and applied more soap several times throughout the shower. The NA provided perineal care with the same washcloth, then changed to a different area of the same washcloth that had been used throughout the bath and used it to provide catheter care.</p> <p>3. On 6/15/06 at 10:40 a.m., the facility's policy and procedure titled, "Catheter Care" was received from the Director of Nursing. The policy documented: "...Wash perineum well with soap and water, taking care to wash from front to back... Wash your hands and obtain clean equipment for catheter care... Cleanse area well at catheter insertion, taking care not to pull on catheter or advance further into urethra... All debris must be removed from the catheter at insertion site..."</p> <p>4. Resident #17 had diagnoses of Renal Failure and Diabetes Mellitus. The Admission Minimum Data Set (MDS) dated 4/21/06 documented the resident was independent in cognitive skills for</p>	F 309			

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F 309	<p>Continued From page 20</p> <p>daily decision-making and received dialysis.</p> <p>a. On 6/15/06 at 8:00 a.m., the resident had a surgical wound with sutures on his left inner arm. There was a dressing on the resident's left chest. The resident stated the dressing on the chest was the catheter that was currently being used for dialysis. The resident stated the facility was not checking vital signs and that the catheter was not being assessed when he returned from dialysis.</p> <p>b. On 6/15/06 at 9:30 a.m., Certified Nursing Assistant (CNA) #6 was asked if she knew of any precautions that needed to be taken before obtaining vital sign for Resident #17. The CNA stated, "No, I check with the charge nurse before taking vital signs."</p> <p>c. The Nursing Aid Care Plan for Resident #17 was provided by the Assistant Director of Nursing on 6/16/06 at 11:50 a.m. The care plan did not address any precautions that should be observed due to the new left arm fistula.</p> <p>d. On 6/15/06 at 11:50 a.m., the Assistant Director of Nursing (ADON) stated no documentation was located to indicate blood pressures and post-dialysis assessments were consistently conducted upon the resident's return from the dialysis clinic. The ADON stated the Care Plan had not been updated to alert the staff of precautions that should be observed due to the new left arm fistula. The ADON stated a Transfer Sheet was sent with the resident to the dialysis unit and if the dialysis unit needed to provide any instructions to the facility, they called and gave a report to the nurse. On 6/15/06 at 12:00 p.m., the Nursing Consultant stated there was not a facility policy for residents on dialysis.</p>	F 309			

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F 309	Continued From page 21 5. Resident #18 had diagnoses of Renal Failure and Anemia. The Quarterly MDS dated 4/3/06 documented the resident had modified independence in cognitive skills for daily decision-making and received dialysis. As of 6/15/06 at 11:30 a.m., the Surveyor was unable to locate documentation in the Nurses' Notes or elsewhere in the clinical record to indicate post-dialysis assessments were consistently conducted. On 6/15/06 at 11:50 a.m., the ADON stated consistent documentation of blood pressures and post-dialysis assessments could not be located for Resident #18.	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 observation, record review and interview, the facility failed to ensure incontinent care was provided for 1 (Resident #8) of 10 case mix residents who were incontinent of bladder (Residents #2 through #8 and #11 through #13) and failed to ensure the perineal area was cleansed during incontinent care for 1 (Resident #14) of 10 case mix residents who were incontinent of bladder (see identifiers above). The failed practices had the potential to affect 73 residents who were incontinent of bladder, as documented on the Resident Census and	F 312			

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F 312	<p>Continued From page 22</p> <p>Condition of Residents form dated 6/13/06. The findings are:</p> <p>1. Resident #8 had diagnoses of Atrial Fibrillation, Congestive Heart Failure and Alzheimer's Disease. The Minimum Data Set (MDS) dated 3/10/06 document the resident was moderately impaired in cognitive skills for daily decision-making, required extensive assistance of staff for toilet use and personal hygiene and was occasionally incontinent of bowel and bladder.</p> <p>On 6/13/06 12:25 p.m., Certified Nursing Assistant (CNA) #2 was dressing the resident. The CNA assisted the resident to stand in order to adjust the resident's clothing. The resident stated, "I peed." The CNA pulled the resident's clothing into place then transferred the resident to a wheelchair. The CNA wheeled the resident to the bathroom and assisted the resident to transfer from the wheelchair to the toilet. During the transfer, while the resident was standing, the CNA pulled down the resident's pants and briefs and the resident was urinating. The urine ran down the resident's legs and onto the pants. After the resident toileted, the CNA cleaned the peri-anal area with toilet tissue then applied a brief and dry pants. The CNA did not cleanse the perineal area and legs to remove the urine from the resident's skin.</p> <p>2. Resident #14 had a diagnosis of Alzheimer's Disease. The Significant Change Minimum Data Set (MDS) dated 5/1/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, totally dependent for bed mobility, personal hygiene and bathing, required extensive assistance for toilet use and was incontinent of bowel and bladder.</p>	F 312			

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F 312	Continued From page 23 a. The Plan of Care dated 5/12/06 documented: "Problem - Incontinence Urinary - Bowel... Approaches - ...Resident will be checked Q [every] 2 HRS [hours]. Incontinence care given as needed, preventive care given." b. On 6/14/06 at 9:05 a.m., Certified Nursing Assistants (CNA's) #4 and #5 provided incontinent care to the resident. CNA #5 stated the resident's brief was wet. CNA #4 positioned the resident on the left side, then cleansed the resident's perianal area and buttocks with a front to back motion, using a towel with water and soap. The CNA's then applied a dry brief to the resident. The CNA did not separate and cleanse between the labia and did not cleanse the mons pubis area.	F 312		
F 322 SS=B	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure feeding tube flushes was provided in accordance with the physician order for 1 (Resident #2) of 3 case mix residents with feeding tubes (Residents #1, #2 and #3). The failed practice had the potential to	F 322		

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F 322	Continued From page 24 affect 8 residents who received enteral feedings, as documented on a list provided by the Director of Nursing (DON) on 6/15/06 at 10:00 a.m. The findings are: Resident #2 had diagnoses of Cerebrovascular Accident and Dysphagia. The Annual Minimum Data Set (MDS) dated 4/19/06 documented the resident was severely impaired in cognitive skills for daily decision-making and had a feeding tube through which 76 to 100% of the resident's total daily caloric intake and 1501 to 2000 cubic centimeters (cc) fluid per day were infused. a. A physician order dated 11/9/05 documented: "Flush g-tube [gastrostomy tube] q [every] 6 hours with 250 cc H2O [water]..." b. On 6/14/06 at 12:05 p.m., Licensed Practical Nurse (LPN) #1 filled a plastic cup with water. After checking placement of the resident's g-tube, the LPN administered three 60 cc syringes full of water through the tube. The LPN went to the bathroom, obtained more water in the plastic cup and returned to administer 2 more 60 cc syringes full of water and a third syringe with 10 cc water. This was a total of 310 cc of water, instead of 250 cc as ordered by the physician. c. On 6/14/06 at 12:25 p.m., LPN #1 was asked if she was aware of the amount of water she had administered to the resident. The LPN stated, "I got confused and lost count when I went to the bathroom. I couldn't remember how much I gave, so I figured it would be better to give too much instead of too little."	F 322			
F 323 SS=E	483.25(h)(1) ACCIDENTS	F 323			

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F 323	<p>Continued From page 25</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure the environment remained free of accident hazards, as evidenced by nails protruding from the wooden columns in the facility's courtyard and a loose metal door stop on a resident's room door. The failed practice had the potential to affect 43 residents who self-propelled their wheelchairs and 16 residents who were ambulatory, as documented on a list provided by the Assistant Director of Nursing on 6/17/06 at 4:25 p.m. The findings are:</p> <p>1. On 6/12 /06 at 5:00 p.m., the outside courtyard patio area had a gazebo type structure with 4 wooden columns. Three of the four columns had nails protruding from the wood approximately 1/4 to 1/2 inch as follows (described as facing the back of the facility):</p> <p>The column on the right: One nail protruding approximately 1/2 inch on the left side of the column, approximately 4.5 inches from the bottom. A second nail located on the right corner trim, approximately 12 inches from the bottom of the column, slightly bent and protruding outward approximately 1/4 inch.</p> <p>The column on the left: A nail was protruding outward approximately 1/2 inch on the left corner trim, approximately 12</p>	F 323			

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F 323	Continued From page 26 inches from bottom of the column. The third column (opposite the column on the left): A nail was protruding outward approximately 1/2 inch on the inner wooden panel, approximately 12 inches from the bottom of the column. 2. On 6/13/06 at 3:20 p.m. during the environmental tour with the Maintenance Supervisor, the protruding nails remained on the wood columns, as previously described. The Maintenance Supervisor stated the nails were left after the facility took down their Christmas decorations (in December 2005). 3. On 6/13/06 at 3:20 p.m. during the environmental tour, Room #316 had a loose metal doorstop strip inside the left side of the doorjamb, approximately 7.5 inches from the floor. A section of the loose metal strip had separated from the doorjamb and extended out into the doorway approximately one inch.	F 323			
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure a transfer from chair to bed was performed in a manner to prevent potential injury to 1 of 1 case mix resident who required non-weight-bearing transfers (Resident #14). The failed practice had the potential to	F 324			

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F 324	<p>Continued From page 27</p> <p>affect 2 residents who required non-weight-bearing transfers, as documented on a list provided by the Director of Nursing on 6/15/06. The findings are:</p> <p>Resident #14 had diagnoses of Alzheimer's Disease and Osteoarthritis. The Minimum Data Set (MDS) dated 5/1/06 documented the resident was moderately impaired in cognitive skills for daily decision-making and totally dependent on staff for bed mobility and transfers.</p> <p>a. The Plan of Care dated 5/12/06 documented: "...Problem - ...At Risk For Decline In ADL [activities of daily living] Function... Transfers with assistance X [times] 1 or 2..."</p> <p>b. On 6/14/06 at 9:05 a.m., Certified Nursing Assistants (CNA's) #4 and #5 transferred the resident from a wheelchair to bed. The CNA's stood to the right and left of the resident and each positioned a forearm under one of the resident's axillae. CNA #4 grabbed the waistband of the resident's pants and the CNA's then lifted the resident up out off the wheelchair and onto the bed. No gait belt was used during the transfer. The resident's left foot did not touch the floor at all and only the toes of the right foot touched the floor during the transfer.</p> <p>c. The facility's Lift/Transfer Program - Resident Transfer and Repositioning Policy and Procedure was provided by the Director of Nursing on 6/15/06 at 10:40 a.m. and documented: "...Residents identified as Totally Dependent or Extensive Assistance, for example, will be transferred by means of lift equipment and/or other resident assist devices instead of manual lift; Gait/transfer belts will be used where manual</p>	F 324			

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F 324	Continued From page 28 assistance ambulation is required for ambulation and transfer activities..."	F 324			
F 364 SS=F	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, record review and interview, the facility failed to ensure food items were prepared in a manner to prevent potential loss of nutrients and palatability, as evidenced by holding the foods for prolonged periods in/on the steamtable, oven and/or stovetop. The failed practice had the potential to affect 92 residents who received meals from the kitchen, as documented on the Diet List dated 6/12/06. The findings are: 1. The facility's written menu documented the evening meal on 6/12/06 was to consist of baked meat loaf, buttered corn, steamed okra and tomatoes. a. On 6/12/06 at 4:00 p.m., the following observations were made: 1.) A pan of stewed tomatoes was sitting on the stove. Cook #1 stated they were keeping the tomatoes warm. 2.) A pan of super mashed potatoes was in the commercial steamer. Cook #1 stated, "Keeping it	F 364			

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F 364	Continued From page 29 warm." 3.) A pan of milk was sitting on the stovetop with the pilot lit. Cook #1 stated, "I will add the butter and potatoes when I come back from break." 4.) A pan of mushroom sauce was being kept warm on the stovetop. 5.) A pan of meat loaf that had already been cooked, a pan of creamed corn and a pan of whole kernel corn were being kept warm in the oven. b. The Meal Time List completed by the facility on 6/12/06 documented the facility's scheduled evening meal time was 5:15 p.m. 2. The facility's written menu documented the noon meal on 6/15/06 was to consist of baked ham, baked sweet potatoes, broccoli and rolls. On 6/15/06 at 10:00 a.m., the food for the pureed and regular diet had been cooked and placed in the commercial steamer and oven to keep warm for the 12:00 p.m. meal service. Cook #2 stated, "I had to prepare it ahead of time because we only have the two gas ovens and the steamer. The convection oven does not work." The Dietary Manager was asked at this time if the broken convection oven had been reported. She stated, "Yes, the Maintenance [person] is new and he hasn't gotten around to it and we have a lot of things that go into the oven today."	F 364			
F 371 SS=F	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and	F 371			

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F 371	<p>Continued From page 30</p> <p>serve food under sanitary conditions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, the facility failed to ensure Dietary Employees washed their hands between handling contaminated items and handling food. The failed practice had the potential to affect 98 residents who received meals from the kitchen, as documented on the Diet List dated 6/12/06. The findings are:</p> <ol style="list-style-type: none"> On 6/14/06 at 2:14 p.m., Cook #1 was mixing the ingredients for a chicken salad. The Cook paused to lift the lid of the gray garbage can under the cook's table. The Cook threw trash into the garbage can then returned to mixing up the chicken salad without washing her hands. On 6/15/06 at 10:00 a.m., Cook #2 lifted the lid of the gray garbage can under the cook's table and disposed of the wrapper from a package of sweet potato patties. Without washing her hands, the Cook opened more packages of sweet potato patties and placed the patties into a pan with her bare hands. On 6/15/06 at 10:30 a.m., Cook #2 lifted up the lid of the gray garbage can under the cook's table, threw away trash, replaced the garbage can lid, picked up a spoon and stirred a pan of food inside the steamer without washing her hands. On 6/15/06 at 10:50 a.m., Dietary Aides #1 and #2 returned to the kitchen from outside. Both Aides scooped ice for the noon meal without washing their hands. 	F 371			

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F 371	Continued From page 31	F 371			
F 441 SS=E	<p>5. On 6/15/06 at 11:00 a.m., Cook #2 lifted the lid of the gray trash can under the worktable, disposed of trash, then took a knife from the drawer and cut portions of ham without washing her hands.</p> <p>483.65(a) INFECTION CONTROL</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure documentation was available for review to indicate that pneumococcal vaccines were offered, education on the vaccine was provided and that the vaccine was either administered or refused for 8 (Residents #2, #3, #5, #6, #8, #9, #11 and #13) of 14 case mix residents whose clinical records were reviewed (Residents #1 through #14). The facility also failed to ensure potentially infectious materials (biohazard waste materials and urine-soiled incontinent briefs) were properly disposed of and contained and that universal precautions were observed to prevent potential cross-contamination while passing ice to</p>	F 441			

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F 441	<p>Continued From page 32</p> <p>residents. The failed practices had the potential to affect 61 residents who resided on the 300 Hall (where the infectious materials and ice were improperly handled), 98 residents who did not receive pneumococcal vaccines and 73 residents who were incontinent of bowel/bladder, as documented on the facility's Resident Census and Conditions of Residents dated 6/13/06 and the Roster/Sample Matrix dated 6/12/06. The findings are:</p> <ol style="list-style-type: none"> 1. Resident #8 had diagnoses of Atrial Fibrillation, Congestive Heart Failure and Alzheimer's Disease. The Minimum Data Set (MDS) dated 3/10/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, required extensive assistance of staff for toilet use and personal hygiene and was occasionally incontinent of bowel and bladder. <p>On 6/13/06 at 12:25 p.m., Certified Nursing Assistant (CNA) #2 was dressing the resident in street clothes. A wet incontinent brief had been removed from the resident and placed on the floor, where it remained until the CNA was finished dressing the resident.</p> <ol style="list-style-type: none"> 2. On 6/13/06 at 3:20 p.m. during the environmental tour of the facility, the Biohazard Room on the 300 Hall was observed. There was an open biohazard bag full of potentially infectious trash in the cardboard biohazard container. The cardboard container also contained loose, unbagged trash including a Styrofoam carry-out tray. Gloves and a small bag of trash were inside the Styrofoam container. 3. Resident #3 was 84 years old and admitted to 	F 441			

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F 441	<p>Continued From page 33</p> <p>the facility on 9/28/05. The Minimum Data Set (MDS) dated 3/23/06 documented no pneumococcal vaccine was offered to the resident.</p> <p>4. Resident #6 was 74 years old and was admitted on 9/28/05. The MDS dated 5/4/06 documented the pneumococcal vaccine was not offered to the resident.</p> <p>5. Resident #9 was 59 years old and was admitted on 9/9/04. The MDS dated 5/26/06 documented the pneumococcal vaccine not offered to the resident.</p> <p>6. Resident #2 was 77 years old and was admitted on 8/9/02. The MDS dated 4/19/06 documented the pneumococcal vaccine was not offered to the resident..</p> <p>7. Resident #13 was 74 years old and was admitted on 1/8/04. The MDS dated 4/18/06 documented the pneumococcal vaccine was not offered to the resident..</p> <p>8. Resident #5 was 92 years old and was admitted on 9/3/02. The MDS dated 11/3/05 documented the pneumococcal vaccine was not offered to the resident..</p> <p>9. Resident #8 was 83 years old and was admitted on 6/22/05. The MDS dated 3/10/06 documented the pneumococcal vaccine was not offered to the resident..</p> <p>10. Resident #11 was 93 years old and was admitted on 4/19/00. The MDS dated 6/8/06 documented the pneumococcal vaccine was not offered to the resident..</p>	F 441			

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F 441	Continued From page 34 11. On 6/15/06 at 4:20 p.m., the Director of Nursing was asked how the facility tracked pneumococcal vaccinations for the residents. The Director of Nursing stated, "On admission, the resident or resident's family is asked if the resident's pneumococcal vaccination is current. If they do not know if it is current, the vaccine is offered. If the vaccine is refused, we educate them about the risks, with information from a pack from the Health Department, but we do not have them sign that they refused the vaccination or that they received the information about the risks of not being vaccinated." 12. The Federal Register, Part III, Department of Health and Human Services - Centers for Medicare & Medicaid Services (CMS), 42 CFR [Code of Federal Regulations] Part 483, Medicare and Medicaid Programs; Condition of Participation: Immunization Standard for Long Term Care Facilities; Final Rule documented (in part): "...Influenza and pneumococcal immunizations - ...Pneumococcal disease. The facility must develop policies and procedures that ensure that - (i) Before offering the pneumococcal immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the	F 441			

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F 441	Continued From page 35 following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal..." 13. On 6/14/06 at 4:30 p.m., the following observations were made of Certified Nursing Assistant (CNA) #7 passing ice on the 300 Hall: a. The CNA knocked on the door to Room 322, entered the room and brought out a water pitcher. The CNA opened the ice chest, reached into the chest, picked up the ice scoop from inside the chest and filled the pitcher with ice. The CNA then dropped the scoop on top of the ice in the chest and closed the lid. The CNA took the water pitcher back to Room 322, Bed A then picked up the water pitcher from Bed B. The CNA followed the same procedure to fill the pitcher for Bed B. b. After returning the ice pitcher to Room 322, Bed B, the CNA moved the ice chest in front of the door to Room 324, knocked on the door, entered and picked up the water pitcher from Bed A. The CNA did not wash or sanitize his hands at any time between handling the different residents' water pitchers.	F 441			
F 468 SS=B	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side.	F 468			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045357	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/16/2006
NAME OF PROVIDER OR SUPPLIER BEVERLY HEALTHCARE NORTH LITTLE ROCK			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 RICHARDS ROAD NO LITTLE ROCK, AR 72117		
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F 468	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure handrails were firmly secured to the corridor walls. The failed practice had the potential to affect 43 residents who self-propelled their wheelchairs and 16 residents who were ambulatory, as documented on lists provided by the Assistant Director of Nursing on 6/17/06 at 4:25 p.m. The findings are: On 6/13/06 at 3:20 p.m. during the environmental tour of the facility, the following observations were made: a. The handrail outside Room 206 was not flush-mounted against the wall and was loose and wobbly to touch. b. The handrails to the right of the Dietary Manager's office, on both sides of the 300 Hall exit doors (next to Room 326), to the left of Room 326 and to the left of Room 319 were loose and wobbly to touch.	F 468			
F 500 SS=B	483.75(h) USE OF OUTSIDE RESOURCES If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in	F 500			

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F 500	Continued From page 37 writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a written agreement was made with the dialysis clinic that provided dialysis services for 2 of 2 case mix residents who received dialysis services (Residents #17 and #18). The failed practice had the potential to affect 2 residents who received dialysis treatments, as documented on the Resident Census and Conditions of Residents form dated 6/13/06. The findings are: 1. Resident #17 had diagnoses of Renal Failure and Diabetes Mellitus. The Admission Minimum Data Set (MDS) dated 4/21/06 documented the resident was independent in cognitive skills for daily decision-making and received dialysis. 2. Resident #18 had diagnoses of Renal Failure and Anemia. The Quarterly MDS dated 4/3/06 documented the resident had modified independence in cognitive skills for daily decision-making and received dialysis. 3. On 6/16/06 at 8:30 a.m., the Nursing Consultant stated there was no written agreement with the dialysis clinic that provided hemodialysis services to Residents #17 and #18.	F 500			
F 518 SS=B	483.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS	F 518			

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F 518	<p>Continued From page 38</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure training on fire safety and preparedness was provided to 1 (Housekeeper #1) of 3 employees who were interviewed regarding fire safety. The failed practice had the potential to affect 61 residents who resided on the 300 Hall, as documented on the Roster/Sample Matrix dated 6/12/06 at 5:20 p.m. The findings are:</p> <ol style="list-style-type: none"> On 6/14/06 at 8:25 a.m., Housekeeper #1 was asked where the fire extinguishers were located. (The Surveyor was standing by a fire extinguisher when the question was posed to the Housekeeper). The Housekeeper stated, "I haven't seen any fire extinguishers." On 6/15/06 at 11:45 a.m., Housekeeper #1's employee file was reviewed. There was no documentation that fire safety training had been provided to the employee. The Director of Operations stated training had been provided, but was unable to provide documentation of any training for this employee. 	F 518			