

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

PRINTED: 07/28/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/14/2006
NAME OF PROVIDER OR SUPPLIER LITTLE ROCK HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 5720 WEST MARKHAM LITTLE ROCK, AR 72205	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 164 SS=D	<p>Complaint #11740 was substantiated (all or in part) with a deficiency cited at F164.</p> <p>Complaint #11744 was unsubstantiated.</p> <p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of 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</p>	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>by:</p> <p>Complaint #11740 was substantiated (all or in part) in these findings:</p> <p>Based on observation the facility failed to ensure privacy was provided while applying an incontinent brief for 1 (Resident #8) and during showers for 2 of (Residents #12 and #15) 21 case mix residents (Residents #1 through #21) who were dependent on staff for personal hygiene. This failed practice had the potential to affect 82 residents who were dependent on staff for bathing and 72 residents incontinent of bladder, as identified by the Resident Census and Conditions of Residents form dated 7/10/06. The findings are:</p> <p>1. Resident #8 had diagnoses of Mental Retardation, Cerebral Palsy, Dysphagia and Seizures. The Quarterly Minimum Data Set (MDS) dated 6/11/06 documented the resident had moderately impaired cognitive skills for daily decision making, was dependent on staff for all activities of daily living and was incontinent of bowel and bladder.</p> <p>On 7/12/06 at 11:53 a.m., the resident's door was ajar and the privacy curtain was drawn only to the end of the bed. Upon entry into the resident's room, the resident was exposed as CNA #4 was applying an incontinent brief on the resident.</p> <p>2. Resident #12 had diagnoses of Vascular Dementia with Delusions and Behavior Disturbance. The Quarterly MDS dated 6/23/06 documented the resident had severely impaired cognitive skills for daily decision-making, was dependent on staff for bathing.</p>	F 164			

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F 164	Continued From page 2 On 7/12/06 at 11:12 a.m., the resident was taken to the shower in a shower chair covered with a bath blanket. In the shower on the 3rd floor, the resident was disrobed. There was no door or privacy curtain over the shower stall entrance; a privacy curtain was used for a door between the nude resident and the main hallway, leaving the resident vulnerable to anyone opening the curtain and passers-by in the hallway. 3. Resident #15 had diagnoses of Dementia with Behavioral Disturbances and Delirium with Psychosis. The Quarterly MDS dated 7/6/06 documented the resident had moderately impaired cognitive skills for daily decision-making and required physical help during bathing. On 7/12/06 at 9:10 a.m., the resident was sitting on a shower chair with a seat belt on receiving a shower. There was no door or privacy curtain over the shower stall entrance; a privacy curtain was used for a door between the resident and the main hallway, leaving the resident vulnerable to anyone opening the curtain and passers-by in the hallway. 4. The Privacy and Dignity policy provided by the Director of Nursing on 7/14/06 documented, "...Resident should never be left naked or have any of their private parts exposed to the public..." and "...When providing care, privacy curtains to be pulled...and doors closed."	F 164			
F 221 SS=E	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to	F 221			

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F 221	<p>Continued From page 3</p> <p>treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure assessments were completed to determine whether a restraint reduction would be appropriate for 3 (Residents #2, #3 and #17) of 18 (Residents #2 thru #5, #7 thru #14 and #16 thru #21) case-mix residents with restraints. This failed practice had the potential to affect 27 residents with restraints, according to the Resident Census and Conditions of Residents form dated 7/10/06. The findings are.</p> <p>1. Resident #2 had diagnoses of Osteoporosis, Parkinson's, Dementia and Hallucinations. The Minimum Data Set (MDS) dated 6/17/06 documented the resident had modified independence in cognitive skills for daily decision-making, required limited assistance for transfers and extensive assistance with personal hygiene and bathing.</p> <p>a. A Physician order dated 12/17/05 documented, "Releasable seat belt while up in wheelchair."</p> <p>b. A Physical Restraint Elimination Assessment dated 6/24/05 documented the resident was a "Priority Candidate for a restraint elimination;" however, the explanation of the type and reason for the restraint was incomplete. There was no documentation on the assessment that the resident was assessed for less restrictive measures.</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>The next Physical Restraint Elimination Assessment was dated 3/27/06. Again, there was no explanation of type or reason for restraint. There was no documentation on the assessment that the resident was assessed for less restrictive measures.</p> <p>There was no assessment documented for the next quarter, June 2006.</p> <p>c. On 7/11/06 at 1:10 p.m. and 3:15 p.m. and on 7/12/06 at 10:30 a.m., the resident was sitting up in a wheelchair with a seat belt restraint on.</p> <p>d. The "Resident Plan of Care" dated 3/27/06 did not care plan the use of any type of restraint.</p> <p>2. Resident #17 had diagnoses of Alzheimer's Disease, Dementia and Degenerative Joint Disease. The Quarterly MDS dated 6/29/06 documented the resident had severely impaired cognitive skills for daily decision-making and was totally dependent on the staff for all transfers, mobility and hygiene and bathing.</p> <p>a. The Physician's order dated 12/19/05 documented, "Releasable seat belt when up in chair to prevent attempts at ambulation while physically unable."</p> <p>b. The Physical Restraint Elimination Assessment dated, 12/20/05 documented the resident was a "Priority Candidate for a restraint elimination, but does continue with a forward lean, Wife wants a seatbelt." There was no documentation on the assessment that the resident was assessed for less restrictive measures.</p> <p>The next documentation on the Physical Restraint</p>	F 221			

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F 221	<p>Continued From page 5</p> <p>Elimination Assessment dated 3/2/06 documented, "Oriented to self only leans forward O.T. [Occupational Therapy] has screened and resident is now in a highback wheelchair with footrest in place. Will do a trial reduction seatbelt."</p> <p>There was no further documentation of an assessment for restraints or for other less restrictive measures.</p> <p>c. On 7/12/06 at 5:45 p.m., on 7/13/06 at 9:00 a.m., 11:45 a.m. and 1:30 p.m. and on 7/14/06 at 9:00 a.m., the resident was sitting up in a wheelchair with a releasable belt restraint on.</p> <p>d. On 7/13/06 at 11:45 p.m., the resident was asked if he could release the restraint; the resident was unable to release the belt and did not understand the request.</p> <p>e. The was no plan of care for any type of restraint.</p> <p>3. Resident #3 had diagnoses Arthritis, Deep Vein Thrombosis, Malnutrition and Anemia. An MDS dated 6/22/06 documented the resident had moderately impaired cognitive skills for daily decision-making, was totally dependent on staff for bed mobility and transfer and was non-ambulatory.</p> <p>a. A Physician order dated 7/8/06 documented, "Safety Belt While Up In Wheelchair To Prevent Falling."</p> <p>b. A Physical Restraint Elimination Assessment dated 3/30/06 documented "continue releasable seat belt to remind resident to call for assist with</p>	F 221			

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F 221	Continued From page 6 transfers due to short attention span." c. On 7/10/06 at 4:32 p.m., 7/11/06 at 8:40 a.m. and 10:26 a.m. and 7/11/06 at 4:24 p.m., the resident was sitting up in a wheelchair with a releasable belt restraint on. d. On 7/13/06 at 4:40 p.m., the resident was asked by RN #3 to demonstrate how to release her belt restraint; the resident was unable to release the restraint and stated, "I have never been able to open it. I am too weak to open." e. There was no documentation in the resident's clinical record that the resident was assessed for other less restrictive measures. 4. The Policy and Procedure for Restraints documented, "The resident must be physically and cognitively able to self-release devices such as Velcro lap trays or tables, seat belts with Velcro, or easy snap seat belts, If a resident cannot mentally and physically self-release, then the device is considered a restraint." "Restraints will only be used after alternative methods have been tried unsuccessfully and upon the written order of a physician that specifies the circumstances for the use of the restraint." "The need for restraint will be reevaluated at least quarterly to determine if continued restraint use in necessary to treat the resident's medical symptoms. Every effort will be made to eliminate the use of the restraint."	F 221			
F 241 SS=D	483.15(a) DIGNITY	F 241			

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F 241	<p>Continued From page 7</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 and record review the facility failed to ensure that dignity was maintained for 2 (Residents #7 and #12) of 21 (Residents #1 through #21) case mix residents who were assisted by and/or dependent on staff for bathing, as evidence by pulling the resident backwards in a shower chair, clothed only in a bath blanket, into the room of other residents and transporting a resident in a shower chair, in a hallway with legs and buttocks exposed. This failed practice had the potential to affect 112 residents who were assisted and/or dependent for bathing, as documented by the Resident Census and Conditions of Residents form dated 7/10/06. The findings are:</p> <p>1. Resident #7 had diagnoses of Cerebrovascular Accident with Left Sided Weakness, Hemiplegia and Breast Mastectomy. The Annual Minimum Data Set (MDS) dated 5/26/06 documented the resident had modified independence in cognitive skills for daily decision-making and was dependent on one staff for bathing.</p> <p>On 7/12/06 at 1:40 p.m., Certified Nursing Assistant (CNA) #3 was pushing the resident down the hall on a shower chair. The Resident was covered with a sheet, front to back, with the back open; this exposed the Resident's bare legs and buttocks.</p>	F 241			

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F 241	Continued From page 8 2. Resident #12 had diagnoses of Vascular Dementia with Delusions and Behavior Disturbance. A Quarterly MDS dated 6/23/06 documented the resident had severely impaired cognitive skills for daily decision-making and was dependent on staff for bathing. The Resident ' s Room was #310. a. On 7/12/06 at 11:12 a.m., Certified Nursing Assistant (CNA) #1 was transporting the resident down the hall, to the shower, in a shower chair; the resident was covered with a bath blanket. The CNA got to Resident Room #314, stopped and grabbed the resident's shower chair by the back and pulled the resident backwards into Resident Room #314, where two other residents lived. b. The Privacy and Dignity policy provided by the Director of Nursing on 7/14/06 documented, "...Every resident deserves to be treated with dignity and respect at all times."	F 241			
F 246 SS=E	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, the facility failed to ensure wheelchair foot rests were in place for 1 (Resident #5) of 16 (Residents #1, #2, #4, #5, #6 thru #9, #11 thru #14, #16, #17, #20 and #21)	F 246			

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F 246	<p>Continued From page 9</p> <p>case mix residents in wheelchairs and a padded side rail was in place for 1 (Resident #12) of 4 (Residents #5, #8, #12 and #14) case mix residents who had padded side rails. This failed practice had the potential to affect 86 residents in wheelchairs and 13 residents with padded side rails, as identified by the facility on 7/14/06. The findings are:</p> <p>1. Resident #5 had diagnoses of Hypertension, Gastroesophageal Reflux Disease, Dementia, Diabetes, Degenerative Joint Disease and Cerebral Atrophy. A Quarterly Minimum Data Set (MDS) dated 4/2/06 documented the resident had moderately impaired cognitive skills for daily decision making, was dependent on staff for activities of daily living and had range of motion limitation on both sides with full loss of voluntary movement of the leg and foot.</p> <p>On 7/11/06 at 9:56 a.m., 7/12/06 at 10:18 a.m. and 1:50 p.m., the resident was sitting in her wheelchair with her feet dangling down. There were no footrests present for the resident to put her feet on.</p> <p>2. Resident #12 had diagnoses of Vascular Dementia with Delusions and Behavior Disturbance. A Quarterly MDS dated 6/23/06 documented the resident had severely impaired cognitive skills for daily decision-making and had abrasions and bruises.</p> <p>a. The resident's care plan dated 6/29/06, on Page 7, documented a problem of, "R [Resident] c [with] poor body alignment due to advanced dementia R prefers to lay in fetal position, leans forward & [and] to side, moves body into side rails" and an approach of "11) Pad side rails."</p>	F 246			

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F 246	Continued From page 10	F 246			
F 272 SS=B	<p>b. On 7/11/06 at 9:30 a.m., 3:15 p.m., 4:53 p.m., on 7/12/06 at 8:20 a.m., 10:15 a.m. and 11:34 a.m., the resident's padding on the left middle side rail was not in place.</p> <p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p>	F 272			

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F 272	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure comprehensive assessments were completed for 2 (Residents #5 and #15) of 21 (Residents #1 thru #21) case mix residents. This failed practice had the potential to affect all 121 residents in the facility, according to the Resident Census and Conditions of Residents form dated 7/10/06. The findings are: 1. Resident #15 had diagnoses of Dementia with Behavioral Disturbances and Delirium with Psychosis. a. The resident ' s Quarterly Minimum Data Set (MDS) due 7/6/06 was incomplete. Sections AB, AC, AD and A were blank. Sections B, E, G, K, P and R were all incomplete. b. On 7/13/06 at 10:50 a.m., the MDS Coordinator stated that the July MDS was completed but not entered. 2. Resident #5 had diagnoses of Hypertension, Gastroesophageal Reflux Disease, Dementia, Diabetes, Degenerative Joint Disease and Cerebral Atrophy. a. The resident ' s Annual MDS due 7/1/06 was incomplete. Sections AA, AB, AC, AD, A were blank. Sections E, G, M, N, P and R were incomplete. The Resident Assessment Protocol Summary was blank. b. On 7/13/06 at 8:40 a.m., the MDS Coordinator stated the resident's Annual MDS had not yet	F 272			

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NAME OF PROVIDER OR SUPPLIER LITTLE ROCK HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 5720 WEST MARKHAM LITTLE ROCK, AR 72205		
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F 272	Continued From page 12 been completed.	F 272			
F 282 SS=E	<p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and record review the facility failed to ensure therapeutic diets were provided as ordered by the physician for 3 (Residents #1, #7 and #8) and that the nursing plan of care was followed for 1 (Resident #4) of 12 (Residents #1, #2, #4, #6, #7, #8, #10, #12, #13, #19 and #21) case mix residents with therapeutic diets. This failed practice had the potential to affect 79 residents in the facility that received a therapeutic diet, as documented on the facility's Diet Roster dated 7/10/06. The findings are:</p> <p>1. Resident #8 had diagnoses of Mental Retardation, Cerebral Palsy, Dysphagia and Seizures. A Quarterly Minimum Data Set (MDS) dated 6/11/06 documented the resident had moderately impaired cognitive skills for daily decision making and was dependent on staff for all activities of daily living.</p> <p>a. A Fiberoptic Endoscopic Evaluation of Swallowing report dated 12/5/05 documented: "Impressions: Dysphagia consistent with aspiration of thin liquids, penetration of pureed and mechanical soft foods. Pt. [Patient] had no</p>	F 282			

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F 282	<p>Continued From page 13</p> <p>penetration aspiration of nectar consistency liquids. [Patient] did not chew up mechanical soft properly and swallowed pieces whole"</p> <p>"Recommendations: Pt to receive puree diet with all liquids thickened to nectar consistency." "Swallowing Precautions: Patient to drink from straw"</p> <p>b. A Speech Therapy Screen/Worksheet Note dated 5/31/06 documented, "[Resident #8] was screened today. She remains on puree diet c [with] nectar liquids.</p> <p>c. On 7/12/06 at 7:41 a.m., the resident was given a 4-ounce nectar thickened carton of apple juice without a straw and an 8-ounce plastic glass of water that was not thickened with her breakfast. During the meal, the resident spilled the water and was given another 8-ounce plastic glass of water.</p> <p>d. On 7/12/06 at 7:52 a.m., there was a full quart pitcher of unthickened water, with a straw in the lid, on the resident's over bed table. At 10:22 a.m., the resident was awake in bed with the over the bed table by the right side of her bed. The pitcher of water, without thickener, was on the over bed table, within the resident's reach.</p> <p>e. On 7/12/06 at 1:42 p.m., the resident was sitting up in her wheelchair with a tray. The pitcher of unthickened water was setting on the over the bed table next to the resident. The resident reached over and picked up the pitcher and placed it on the tray.</p> <p>f. On 7/12/06 at 5:40 p.m., the resident was served 8-ounces of unthickened water with her</p>	F 282			

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F 282	<p>Continued From page 14 evening meal.</p> <p>2. Resident #1 had diagnoses of Diabetes and Diverticulitis. The Quarterly MDS dated 6/25/06 documented the resident was independent in cognitive skills for daily decision making with short-term memory problem.</p> <p>a. The Physician's order sheet for July 2006 documented, "Regular, No Concentrated Sweets, No Added Salt, No Fried Foods; snack Q [every] HS [hour of sleep]."</p> <p>b. On 7/12/06 at 7:56 a.m., the resident was served one fried egg and consumed 100% of all food on her breakfast tray, but did not drink her Resource.</p> <p>3. Resident #4 had diagnoses of Diabetes Mellitus, Hypertension and Glaucoma. A Medicare Minimum Data Set dated 5/3/06 documented the resident was moderately impaired in cognitive skills for daily decision making and needed limited assistance and set up only for eating.</p> <p>a. The resident's Physician order sheet for 6/1/06 through 6/30/06 documented, "Diet: Soft NCS [No Concentrated Sweets] NAS [no added salt] increased portions."</p> <p>b. The resident's Nursing care plan dated 3/31/06 documented, Resident utilizes guard and fingers to feed himself. Have plan to cleanse hands after meals.</p> <p>c. On 7/11/06 at 12:20 p.m., the resident was served stewed tomatoes, ground meat, beans, cornbread, apple pie, 4 ounces (oz) juice, 8 oz of</p>	F 282			

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F 282	Continued From page 15 water and 8 oz of iced tea. There was a plate guard around the resident's plate; he was eating with his fingers, except when a Certified Nursing Assistant would place a spoon in his hand, which he would use one time and then lay it down and use his fingers, again. Staff did not cleanse the resident's hands before he left the dining room. d. On 7/12/06 at 7:40 a.m., the resident's breakfast tray contained ground sausage, scrambled eggs, hot cereal (oatmeal), a whole piece of toast, 4-oz of juice, 8 oz of milk, 8 oz of water, and 8 oz of coffee. The resident ate his breakfast with his fingers. Staff did not cleanse the resident's hands before he left the dining room. 4. Resident #7 had diagnoses of Cerebrovascular Accident with Left Sided Weakness, Hemiplegia and Breast Mastectomy. The Annual MDS dated 5/26/06 documented the resident had modified independence in cognitive skills for daily decision-making and had a chewing problem. a. A Physician order dated 6/19/01 documented a soft diet with chopped meat. b. On 7/12/06 at 5:35 p.m., the resident was served 1/2 sandwich with white bread, cheese and a slice of ham. The ham was not chopped.	F 282			
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.	F 312			

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F 312	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview the facility failed to ensure nail care was provided for 5 (Residents #8, #12, #14, #16 and #20) of 18 (Residents #1 thru #5, #7, #8, #10, #11, #12 thru #19 and #21) case-mix residents and assistance for changing soiled clothing was provided for 1 (Resident #16) of 20 (Residents #1 thru #14 and #16 thru #21) dependent case-mix residents. This failed practice had the potential to affect 79 residents that were dependent on staff for nail care and 31 residents dependent on staff for dressing assistance, as documented by the Director of Nursing on 7/14/06. The findings are:</p> <p>1. Resident #14 had diagnoses of Ischemic Heart Disease, Dementia and Coronary Atherosclerosis. An Annual Minimum Data Set (MDS) dated 6/16/06 documented the resident was severely impaired in cognitive skills for daily decision making and totally dependent on staff for all activities of daily living.</p> <p>On 7/12/06 at 11:30 a.m., during a dressing change observation, the resident's toenails on both were long and had dark debris under them.</p> <p>2. Resident #20 had diagnoses of Dementia with Delusions, Depression and Hypertension. An Annual MDS dated 6/2/06 documented the resident was severely impaired in cognitive skills for daily decision making and totally dependent on staff for all activities of daily living.</p> <p>On 7/13/04 at 8:45 a.m. and 10:00 a.m., the resident's fingernails on both hands had dark</p>	F 312			

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F 312	<p>Continued From page 17</p> <p>debris under them and were long.</p> <p>3. Resident #8 had diagnoses of Mental Retardation, Cerebral Palsy, Dysphagia and Seizures. A Quarterly MDS dated 6/11/06 documented the resident had moderately impaired cognitive skills for daily decision making, was dependent on staff for all activities of daily living and had limitation in range of motion on both sides with partial loss of voluntary movement of a arm and hand.</p> <p>On 7/11/06 at 9:12 a.m., the resident's fingernails were long with chipped nail polish; there was gray-colored debris under each of her nails.</p> <p>4. Resident #16 had diagnoses of Senile Dementia, Cerebral Vascular Accident, Diabetes and Paranoia. A Quarterly MDS dated 5/22/06 documented the resident had modified independence in cognitive skills for daily decision making, short term memory problems, was dependent on one staff person for dressing and personal hygiene, frequently incontinent of bladder and incontinent of bowel most of the time.</p> <p>On 7/13/06 at 8:32 a.m., the resident had spilled oatmeal down the front of his Tee shirt. At 10:50 a.m. and 12:58 p.m., the resident was still wearing the same soiled Tee shirt.</p> <p>The fingernails on the resident's right hand were short with sharp edges and gray debris under each nail. The resident could not remember for sure when someone had last cleaned his nails.</p> <p>5. Resident #12 had diagnoses of Vascular Dementia with Delusions and Behavior Disturbance. The Quarterly MDS dated 6/23/06</p>	F 312			

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F 312	Continued From page 18 documented the resident had severely impaired cognitive skills for daily decision-making and was dependent on staff for personal hygiene.	F 312			
F 324 SS=D	On 7/10/06 at 5:57 p.m., on 7/11/06 at 11:13 a.m. and on 7/12/06 at 8:20 a.m., the resident had a black substance under the fingernails. 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, record review and interview the facility failed to ensure that two person transfers were conducted in a manner to prevent possible injury and accidents for 1 (Resident #12) of 16 (Residents #1 through #9, #12, #13, #16 through #19 and #21) case mix residents who required assistance with transfers. This failed practice had the potential to affect 90 residents who required assistance with transfers, as documented by the Resident Census and Conditions of Residents form dated 7/10/06. The findings are: 1. Resident #12 had diagnoses of Vascular Dementia with Delusions and Behavior Disturbance, Peripheral Edema and Alzheimer's Disease. The Quarterly Minimum Data Set dated 6/23/06 documented the resident had severely impaired cognitive skills for daily decision-making and was dependent on staff for transfers. a. On 7/12/06 at 11:34 a.m., Registered Nurse	F 324			

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F 324	Continued From page 19 (RN) #1 and Certified Nursing Assistant (CNA) #1 transferred the resident from a shower chair to the bed by lifting by each arm, under the shoulder joint; the resident's feet were dragging the floor. CNA #1 left the room. RN #1 stated she thought the resident had her weight on the floor. The CNA walked back into the room and when asked if the resident had any weight on the floor, CNA #1 stated, "No." b. The facility policy on Transfer Activities received on 7/14/06 documented, "...The nurse may either support the resident on his/her affected side or stand in front of the resident. Support may be provided by use of a waist belt. Do not support the resident under the arms as this prevents the resident from using his/her unaffected extremity..."	F 324		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the 8:00 a.m. and 9:00 a.m. medication passes on 7/13/06, record review and interview, the facility failed to ensure that the medication error rate was less than 5%. Physician orders were not followed for 3 (Residents #6, #9 and #26) of 8 residents observed during medication pass, resulting in medication errors. Medication errors were made by 3 Licensed Practical Nurse (LPN) (LPN #1, #2 and #3) of 5 nurses administering medications in the facility. This failed practice had the potential to affect 70	F 332		

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F 332	<p>Continued From page 20</p> <p>residents in the facility, according to the Director of Nursing (DON) on 7/13/06 at 2:00 p.m. The medication error rate was 13.2% based on administration of 53 medications with 7 medication errors observed. The findings are:</p> <p>1. Resident #25 had a Physician order dated 12/01/05 for Docusate Sodium 200 mg po (by mouth) bid (twice a day)</p> <p>During the 8:00 a.m. medication pass on 7/13/06, LPN #1 administered Docusate Sodium 100 mg (milligrams) to the resident.</p> <p>2. Resident #9 had a Physician ordered dated 12/06/05 for Muro 128 - 5% 1 gtt (drop) R (right) eye QID (four times a day).</p> <p>During the 8:00 a.m. medication pass on 7/13/06, LPN #1 administered Muro 128 - 2% to the resident.</p> <p>3. Resident #9 had a Physician order dated 10/6/05 for Betoptic 0.25 % 1 drop in right eye bid and Pilocarpine 2% 1 drop both eyes qid and a Physician order dated 12/6/05 for Muro 128 - 5% 1 drop right eye qid.</p> <p>a. During the 8:00 a.m. medication pass on 7/13/06 at 8:06 a.m., LPN #1 administered Pilocarpine 2% and 1 minute and 45 seconds later, administered the Muro 128 2% 1 gtt (R) eye.</p> <p>b. During the 8:00 a.m. medication pass on 7/13/06 at 8:10, LPN #1 administered Betoptic 0.25% 1 gtt. (R) eye. This was 2 minutes from the administration of Muro 128 2% 1 gtt (R) eye.</p>	F 332			

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F 332	<p>Continued From page 21</p> <p>c. According to Medicare and Medicaid Services (CMS) Medications instilled into the eye, the drop must contact the eye for a sufficient period of time before the next eye drop is instilled. The time for optimal eye drop absorption is approximately 3 to 5 minutes. (It should be encouraged that when the procedures are possible, systemic effects of eye medication can be reduced by pressing the tear duct for approximately three minutes after the administration).</p> <p>d. On 7/13/06 at 8:06 a.m., LPN #1 stated to the resident, "I have to wait 1 to 3 minutes between eye drops."</p> <p>e. This resulted in two medication errors.</p> <p>4. Resident #26 had a Physician order dated 4/01/06 for Depakote XL 500 mg po every morning.</p> <p>During the 8:00 a.m. medication pass on 7/13/06 at 8:38 a.m., LPN #2 administered Depakote EC (enteric coated) to the resident.</p> <p>5. Resident #6 had a Physician order dated 10/26/04 for Slow-Mag 64 mg/2 tabs (tablets) po QD (every day).</p> <p>During the 8:00 a.m. medication pass on 7/13/06 at 8:55 a.m., LPN #3 administered Slow-Mag 64 mg/1 tablet to the resident.</p> <p>6. Resident #6 had a Physician order dated 4/28/04 for Liquid Tears 2 drops both eyes bid - allow 3 minutes other drop.</p> <p>During the 8:00 a.m. medication pass on 7/13/06 at 8:59 a.m., LPN #3 administered Refresh Liquid</p>	F 332			

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F 332	Continued From page 22 Tears 1 drop each eye.	F 332			
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the menu was followed to ensure nutritional adequacy. This failed practice had the potential to affect 102 residents in the facility that received meals from the kitchen, according to the Resident Census and Condition of Residents form dated 7/10/06. The findings are: 1. On 7/11/06, the menu for the low concentrated sweet diet documented a 1 x 3 inch iced brownie for the noon meal. On 7/11/06 at the noon meal, a regular 2 x 3 inch brownie was served. 2. On 7/12/06, the menu for the low concentrated sweet diet documented 1/2 serving of a slice of cream pie. According to the regular menu 1 slice is 1/10 of a pie. On 7/12/06, at the noon meal, residents on low concentrated were served 1 slice of regular chocolate cream pie instead of 1/2 slice.	F 363			

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F 363	Continued From page 23 3. On 7/12/06 at 10:00 a.m., a dietary aide was observed slicing pieces of chocolate cream pie. When asked how many slices she got from each pie she said "I get about 11 pieces from each pie. I try to give every one a cookie. (Referring to the number of cookies around the sides of the pie. When she counted the cookies around the pie there were 10. 4. On 7/12/06, the menu documented fried squash or squash casserole for the noon meal. On 7/12/06, at the noon meal, the cook served canned buttered squash instead of fried squash or squash casserole. 5. On 7/12/06, the menu for the supper meal documented 6 ounces of chicken noodle soup for all diets. a. On 7/12/06 at 5:00 p.m., the chicken noodle soup served was clear broth with no chicken and few noodles. b. The residents were served 1/2 cup, instead of 6 ounces of soup.	F 363			
F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by:	F 364			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/14/2006
NAME OF PROVIDER OR SUPPLIER LITTLE ROCK HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 5720 WEST MARKHAM LITTLE ROCK, AR 72205		
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F 364	<p>Continued From page 24</p> <p>Based on observation, record review and interview the facility failed to ensure residents at the noon meal on 7/10/06 were served meat they could chew. This failed practice had the potential to affect 102 residents in the facility that received food from the kitchen. The findings are.</p> <p>1. On 7/12/06 at 10:00 a.m., residents at the group meeting complained that the Roast Beef was tough when served.</p> <p>a. On 7/12/06, the menu for the noon meal documented roast beef as the entree' for the noon meal.</p> <p>b. On 7/12/06 at 11:55 a.m., prior to the noon meal being served, the roast beef in gravy was cut into large thick uneven slices. At this time a sample of the roast beef was tasted and found to be very tough to chew. The meat was thick and coarse.</p> <p>c. On 7/12/06 at 12:17 p.m., residents in the dining room on the 1st floor voiced the following concerns:</p> <p>1) I'm trying to get it cut up. I have to saw on it. I'm going to have to have some help.</p> <p>2) A resident chewed on the roast beef and spit large balls of it back in her plate.</p> <p>3) A resident stated, "I'm an old Chef cook. It's too tough. They need to cut it with the grain."</p> <p>4) A resident stated, "It's too tough, I can't cut it."</p> <p>5) A resident stated, "It's too tough, my jaw hurts."</p>	F 364			

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F 371 F 371 SS=C	Continued From page 25 483.35(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 dishes were allowed to air dry prior to being stacked to prevent potential contamination, food in the storage room was coded for first-in first-out stock rotation and the kitchen was free of pest. This failed practice had the potential to affect 102 residents who received meals from the kitchen, according to the Resident Census and Conditions of Residents form dated 7/10/06. The findings are. 1. On 7/10/06 at 3:40 p.m., 2 racks of stacked cups and 6 racks of stacked bowls were stored wet and not allowed to air dry. 2. On 7/12/06 at 9:45 a.m., 10 46-ounce cans of V-8 juice on storage racks were not coded for first in first out stock rotation. 3. On 7/12/07 at 11:40 a.m., 3 flies were flying around the cook ' s table where a pan of yeast rolls was on top of the table wrapped in bread bags. 4. On 7/12/07 at 3:40 p.m., 2 flies were flying around the cook ' s table where the cook was preparing ham and cheese sandwiches for the	F 371 F 371		

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F 371	Continued From page 26 supper meal.	F 371			
F 441 SS=E	<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 and record review, the facility failed to ensure clean wound care supplies were not placed on contaminated surfaces, soiled gloves, linens and clothing were not placed on resident furniture and personal items and soiled briefs were not placed in the floor for 4 (Residents #2, #5, #8 and #16) of 14 (Residents #2 thru #5, #8, #10 thru #14, #16 thru #18 and #20 thru #21) who required assistance with hygiene. This failed practice had the potential to affect 97 residents who required assistance of staff for toilet use and 112 residents who required assistance of staff for bathing, according to the Resident Census and Conditions of Residents form dated 7/10/06. The facility further failed to ensure that wound care was performed in a sanitary manner for 1 (Resident #2) of 4 (Residents # 1, #2, #8 and #14) case mix residents who received wound care. This failed practice had the potential to affect 16 residents in the facility who received</p>	F 441			

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F 441	<p>Continued From page 27</p> <p>wound care, according to a list provided by the Director of Nursing on 7/19/06. The findings are:</p> <p>1. Resident #2 had diagnoses of Osteoporosis, Parkinson's, Dementia and Hallucinations. A Minimum Data Set (MDS) dated 6/17/06 documented the resident had modified independence in cognitive skills for daily decision-making and required extensive assistance with personal hygiene and bathing.</p> <p>a. A Culture and Sensitivity test dated 4/27/06 documented the resident tested positive for Methicillin Resistant Staph Aurous.</p> <p>b. A Physician's order for wound care dated 6/29/06 documented, "Cleanse right ankle with N/S (normal saline) and apply Xeroform gauze. Cover with 4 x 4's and wrap with Kerlix qd (every day) for 2 weeks."</p> <p>c. On 7/12/06 at 2:30 p.m., while preparing to perform wound care, Licensed Practical Nurse (LPN) #2 placed supplies to be used on the sheet at the end of the resident's bed and pulled a strip of tape away from the roll and stuck the entire roll to the side rail until its use.</p> <p>After the LPN cleansed the wound and applied a dressing, he proceeded to wrap the site with Kling. When the LPN was satisfied with the amount of Kling used, he cut the Kling and placed the remainder of Kling on the bed of the resident. The LPN then taped the loose end of the Kling and placed the tape on the bed. Without changing gloves he reached into the wound care tray and obtained a Sharpie to date and initial the tape on the dressing.</p>	F 441			

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F 441	<p>Continued From page 28</p> <p>When the LPN completed this task, he replaced the Sharpie to the wound care tray. The nurse removed his gloves, picked up the Kling and tape and placed these items on the wound care tray before exiting the room.</p> <p>d. The Policy and Procedure for Infection Control Protocol and Safety, "Pull strips of tape adequate for securing dressing at the end of the procedure and add date, and initials. Place on edge of bedside table to enable easy access when needed." And, "Discard disposable items into the designated container."</p> <p>e. On 7/12/06 at 9:40 a.m., while performing a bed bath, Certified Nursing Assistant (CNA) #2 lay a pair of soiled gloves on top of a book belonging to the resident on the bed side table. After completing pericare, the CNA placed a soiled towel on the bedside table. She removed the linens from the room to the soiled linen barrels and returned to the resident's room, but she did not clean the table.</p> <p>2. Resident #8 had diagnoses of Mental Retardation, Cerebral Palsy, Dysphagia and Seizures. A Quarterly MDS dated 6/11/06 documented the resident had moderately impaired cognitive skills for daily decision making, was dependent on staff for all activities of daily living and was incontinent of bowel and bladder.</p> <p>On 4/11/06 at 12:35 p.m., CNA #5 was providing incontinent care to the resident. After removing the urine soaked sweat pants, incontinent pad and mechanical lift pad, the CNA placed the items on the seat of an armchair setting by the nightstand. The CNA did not clean the chair after removing the wet items.</p>	F 441			

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F 441	<p>Continued From page 29</p> <p>3. Resident #16 had diagnoses of Senile Dementia, Cerebral Vascular Accident, Diabetes and Paranoia. The Quarterly MDS dated 5/22/06 documented the resident had modified independence in cognitive skills for daily decision making, dependent on one staff for personal hygiene, was frequently incontinent of bladder and incontinent of bowel most of the time.</p> <p>On 7/10/06 at 4.21 p.m., a soiled incontinent brief was on the floor beside the wastebasket in the resident's room.</p> <p>4. Resident #5 had diagnoses of Hypertension, Gastroesophageal Reflux Disease, Dementia, Diabetes, Degenerative Joint Disease and Cerebral Atrophy. A Quarterly MDS dated 4/2/06 documented the resident had moderately impaired cognitive skills for daily decision making, was dependent on staff for activities of daily living and incontinent of bowel and bladder.</p> <p>On 7/13/06 at 9:23 a.m., the resident had been incontinent of bladder; Registered Nurse (RN) #3 was assisting CNA #1 with incontinent care. The CNA placed the soiled incontinent pad and towels at the foot of the resident's bed after she had cleansed the resident.</p> <p>After the clean incontinent brief had been applied, the RN picked up the soiled articles and placed them by the washbasin on the resident's over bed table. The CNA removed the soiled top sheet, picked up the wash basin and emptied it in the bathroom sink then picked up the soiled articles off the over bed table and put them in the dirty linen barrel outside the resident's room.</p>	F 441			

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F 441	Continued From page 30 The CNA returned to the room, washed her hands and then picked up a clean towel, gown and Vitamin A and D ointment, that had been setting by the wash basin, off of the over bed table and went to Resident Room 312. The over bed table was not cleansed. 5. The Policy and Procedure for Soiled Laundry and Bedding documented, "Soiled laundry and bedding (e.g., personal clothing, uniforms, scrub suits, gowns, bedsheets, blankets, towels, etc.) contaminated with blood or other potentially infectious materials must be handed as little as possible and with a minimum of agitation." and "Place and transport contaminated laundry in bags or containers that are labeled or colorcoded in accordance with our established policies governing the handling and disposal of contaminated items."	F 441			