

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

PRINTED: 09/19/2006
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 R 09/08/2006
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 164} SS=D	<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 by:</p> <p>Based on observation, record review and interview the facility failed to ensure full privacy was provided during personal care services for 1 (Resident #15) of 15 (Residents #1 thru #15) case mix residents. This failed practice had the</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}	Continued From page 1 potential to affect 54 residents on the third floor who required assistance with activities of daily living, as identified by the Director of Nursing on 9/7/06. The findings are: Resident #15 had diagnoses of Cerebral Vascular Disease, Senile Dementia and Atypical Depression with Psychosis. A Quarterly Minimum Data Set dated 7/7/06 documented the resident was moderately impaired in cognitive skills for daily decision making, totally dependent for all activities of daily living and had limited functional range of motion on both sides of the body. The resident occupied Room #323, Bed A and had a roommate in Bed B. a. On 9/6/06 at 2:30 p.m., the resident was provided incontinent care and repositioning by Certified Nursing Assistant (CNA) #2 and CNA #3. After being repositioned in bed, the resident's gown was gathered up around his neck exposing his torso and lower limbs. A visitor walked into the room to visit the resident in Bed B, passed by the foot of Bed A, and thereby gained full visual access to the procedure in progress. b. On 9/7/06 at 2:30 p.m., CNA #3 was interviewed; she stated, "...I should have closed the curtains..."	{F 164}			
{F 282} SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in	{F 282}			

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{F 282}	<p>Continued From page 2</p> <p>accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview the facility failed to ensure Physician orders were followed for 1 (Resident #10) of 9 (Residents #1, #2, #4 thru #7 and #9 thru #11) case mix residents with Physician orders for seat belt restraints and for 1 (Resident #2) of 3 (Residents #1, #2 and #9) case mix residents with Physician orders for heel protectors. This failed practice had the potential to affect 25 residents with Physician orders for seat belt restraints and 3 residents with Physician orders for heel protectors, as documented on a list provided by the Minimum Data Set/Care Plan Coordinator on 9/6/06. The findings are:</p> <p>1. Resident #10 had diagnoses of Fracture of the Humerus, Quadriplegia, Left Hemiplegia and Seizure. A Quarterly Minimum Data Set (MDS) dated 8/15/06 documented the resident was independent in cognitive skills for daily decision making, required total assistance with personal hygiene, had full bed rails on all open sides of bed and a chair that prevented rising.</p> <p>a. The resident's Physician orders dated 6/31/01 documented, "Self Releasable seatbelt while up in w/c (wheelchair) for positioning and safety."</p> <p>b. On 9/5/06 at 1:35 p.m., Licensed Practical Nurse (LPN) #3 stated, "...[Resident #10] has a safety belt when up in wheelchair..."</p>	{F 282}			

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{F 282}	Continued From page 3 c. On 9/6/06 at 10:25 a.m., 11:35 a.m. and 4:45 p.m., the resident was up in the electric wheelchair with no seatbelt in place. 2. Resident #2 had diagnoses of Arthritis and Deep Vein Thrombosis. A Quarterly MDS dated 6/22/06 documented the resident had moderately impaired cognitive skills for daily decision making and had total dependence on staff for locomotion on and off the unit. a. A Physician order dated 3/1/06 documented, "Heel protectors bilaterally to feet while up." b. On 9/05/06 at 3:40 p.m., on 9/6/06 at 10:30 a.m. and 4:50 p.m. and on 9/7/06 at 8:25 a.m. and 10:40 a.m., the resident was in her wheelchair without heel protectors on. c. Review of the resident's September 2006 Treatment Administration Record documented that on 9/5/06, 9/6/06 and 9/7/06, for the 7:00 a.m. to 3:00 p.m. shifts, the heel protectors were on the resident and on 9/5/06 and 9/6/06, on the 3:00 p.m. to 11:00 p.m. shift, the heel protectors were on the resident. d. On 9/7/06 at 11:30 am, Licensed Practical Nurse (LPN) #2 was asked why the resident did not have heel protectors on. The LPN stated, "That's my fault, I didn't get an order to discontinue those [heel protectors]."	{F 282}			
{F 312} SS=D	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}	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure Certified Nursing Assistants (CNA) provided complete incontinent care for 1 (Resident #11) of 15 (Residents #1 thru #15) case mix residents that were incontinent of bowel and/or bladder. This failed practice had the potential to affect 28 residents occasionally or frequently incontinent of bladder and/or bowel, as documented by the Director of Nursing on 9/7/06 at 4:05 p.m. The findings are: Resident #11 had diagnoses of Parkinson's Disease, Alzheimer's and Non-Insulin Dependent Diabetes Mellitus. A Medicare 14-Day Minimum Data Set dated 8/22/06 documented the resident had severely impaired cognitive skills for daily decision making, required total assistance of staff for Activities of Daily Living and was incontinent of bowel and bladder. 1. On 9/6/06 at 2:40 p.m., CNA #1 transferred the resident from a wheelchair to the bed. The CNA removed the resident's brief, which was saturated with urine and bowel movement and then wiped the bowel movement off the resident's perianal area only, using one corner of a wet towel. The mons pubis, penis, scrotum and groin folds were not cleansed. A cleansing agent was not used to clean the resident of bowel. 2. The facility's policy on Pericare provided by the Director of Nursing on 9/7/06 at 4:05 p.m. documented, " Equipment: Soap, water, or	{F 312}			

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{F 312}	Continued From page 5 peri-wash...wash upper thighs-build up of secretions can contaminate surrounding skin areas...Male Care: wash tip of penis at meatal opening outward then down shaft of penis-to reduce risk of microorganisms entering the urethral..."	{F 312}			
{F 441} SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure Licensed Practical Nurses (LPN) washed their hands before and after administering eye drops for 1 of 1 (Resident #16) case mix resident with Physician orders for eye drops during medication pass. The facility further failed to ensure that Certified Nursing Assistants (CNA) washed their hands before and after resident contact for 1 (Resident #11) and that resident nightstands were disinfected after soiled linen and gloves had been placed on them for 2 (Residents #11 and #14) of 14 (Residents #1 thru #12, #14 and #15) case mix residents who were incontinent of bowel and/or bladder. These failed practices had the potential to affect 7 residents	{F 441}			

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{F 441}	<p>Continued From page 6</p> <p>receiving eye drops by LPN #1, 28 residents incontinent of bowel and bladder that resided on the second floor and 30 residents incontinent of bowel and bladder that resided on the third floor, as documented by the Director of Nursing on 9/7/06 at 4:05 p.m. The findings are:</p> <p>1. The facility's policy on Handwashing provided by the Director of Nursing on 9/7/06 at 4:05 p.m. documented, "...You should always wash your hands before and after resident contact."</p> <p>a. Resident #16 had diagnoses of Congestive Heart Failure and Asthma. A Quarterly Minimum Data Set (MDS) dated 6/25/06 documented the resident had independent cognitive skills for daily decision making.</p> <p>On 9/6/06 at 9:25 a.m., LPN #1 administered two Refresh eye drops into each of the resident's eyes with ungloved hands. The LPN did not wash her hands before or after the eye drops were administered.</p> <p>b. Resident #11 had diagnoses of Parkinson's Disease, Alzheimer's and Non-Insulin Dependent Diabetes Mellitus. A Medicare 14-Day MDS dated 8/22/06 documented the resident had severely impaired cognitive skills for daily decision making, required total assistance of staff for Activities of Daily Living and was incontinent of bowel and bladder.</p> <p>On 9/6/06 at 2:40 p.m., CNA #1 provided incontinent care for the resident. After changing gloves, the CNA applied Aloe Vesta Skin Protectant to the resident's buttocks and scrotal area with her gloved hands. The CNA then removed the gloves and laid the soiled gloves on</p>	{F 441}			

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{F 441}	<p>Continued From page 7</p> <p>the resident's nightstand. The nightstand was not disinfected after the CNA threw the gloves away.</p> <p>The CNA exited the room, obtained a bath blanket from the clean linen cart, placed the blanket between the residents' knees, placed the bed linens over the resident and asked the resident in Bed B if he wanted a drink of water.</p> <p>The CNA picked up the Bed B resident's water pitcher, and touching the straw with her hand, gave the resident a drink of water. The CNA did not cleanse her hands between resident to resident contact.</p> <p>2. Resident #14 had diagnoses of Depressive Disorder, Dementia and Cerebral Vascular Accident. A Quarterly MDS dated 8/20/06 documented the resident had modified independence in cognitive skills for daily decision making, required extensive assistance with activities of daily living and was incontinent of bowel and bladder.</p> <p>On 9/7/06 at 10:35 a.m., Certified Nursing Assistant #3 provided care for the resident, who had been incontinent of bowel; after cleansing the rectal area, the CNA placed the used rinse washcloth on the resident's nightstand.</p> <p>The resident was then turned on his back to cleanse the genital area; the CNA retrieved the wet washcloth from the nightstand and used it to cleanse the resident's genitalia.</p> <p>The CNA then placed the soiled washcloths inside the fecal soiled drawsheet and wrapped them into a ball; the wadded up linens were placed on the resident's nightstand while the CNA</p>	{F 441}			

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{F 441}	Continued From page 8 positioned the resident. The CNA then removed her gloves, picked up the soiled linens and disposed of them. The CNA did not return to disinfect the resident's nightstand which also held the resident's water pitcher and updraft machine.	{F 441}			