STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045422	A. BUILDING ______ B. WING ______	R-C **12/31/2008**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF MAUMELLE	**103 ALEXANDRIA DRIVE** **MAUMELLE, AR 72113**

(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 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: This is a rewritten deficiency. Based on observation, record review and interview, the facility failed to ensure a urinary drainage bag and tubing were positioned lower than the bladder at all times and catheter care was provided after each incontinent episode for 1 (Resident #5) of 2 (Resident #5 and #6) case mix residents who required the use of a foley catheter. The failed practice had the potential to affect 4 residents in the facility with an indwelling foley catheter according to the number provided by the Administrator on 12/31/08. The findings are: 1. Resident #5 had a diagnosis of Presenile Dementia. The Minimum Data Set dated 10/28/08 documented the resident was severely impaired in cognitive skills for daily decision making, was dependent on staff for toilet use, was incontinent of bowel and bladder and had a foley catheter. a. On 12/29/08 at 5:05 p.m., CNA (Certified Nursing Assistant) #1 provided incontinent care.	{F 309}		12/14/08

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 309}	Continued From page 1 The CNA stated that the resident's foley catheter had been leaking. The disposable brief was saturated with urine. The CNA cleansed the perineum. The CNA did not separate the labia and cleanse around the urinary meatus or perform catheter care when providing incontinent care. During the transfer from the bed to the wheelchair using a mechanical lift CNA #2 placed the catheter bag on the resident's chest. There was urine in the tubing and it flowed back towards the resident's urinary meatus. b. The facility ' s Policy and Procedure entitled "Foley Catheter Care " documented, " Purpose: to promote hygiene, comfort and decrease risk of infection for catheterized residents. Policy: Each resident with an indwelling catheter will receive catheter care daily and PRN (as needed) for soiling. . . 9. Using the soapy gauze, clean the catheter insertion in a downward motion (front to back). Use each gauze for one cleaning motion. Clean the length of the Foley catheter (from patient toward bag). . ."	{F 309}		
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. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure the mons pubis area, underneath the folds of the abdomen or between the crease of the leg on the right side where stool had leaked from the colostomy bag was cleansed	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 312	Continued From page 2 for 1 (Resident # 8) of 7 (Resident # 1, #3, #4, #5, #6, #7, and #8) case mix residents who required assistance with personal care. The failed practice had the potential to affect 31 residents who were incontinent and required assistance with personal hygiene as identified by the Administrator on 12/31/08. The findings are: Resident # 8 had a diagnosis of Multiple Sclerosis with paraplegia, Seizure disorder, Decubitus Ulcers and Esophageal Reflux. The Quarterly Minimum Data Set dated 9/30/08 documented the resident had severely impaired cognitive skills for daily decision making and was totally dependent in all Activities of Daily Living (ADL's), was continent of bowel and bladder, had an indwelling foley catheter and had an ostomy present. a. The Plan of Care dated 12/30/08 documented, "Problem: Decubitus on Right (R) buttock. ... Approaches: ... Peri Care Q (every) shift and PRN (as needed). ... " . b. On 12/29/08 at 1:44 p.m., during initial rounds, Licensed Practical Nurse (LPN) #1 stated the resident was incontinent of bladder and had a colostomy. c. On 12/29/08 at 4:00 p.m., Certified Nursing Assistant (CNA) # 2 and # 3 performed incontinent care. The colostomy bag was leaking and there was liquid stool over the mons pubis, between the creases of the legs and underneath the folds of the abdomen. The resident was placed on her left side with her buttocks and vaginal area exposed. CNA # 2 cleansed from back to front and changed the cloth, then cleansed from front to back and changed the cloth and then cleansed from back to front again.	F 312		

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F 312	Continued From page 3 A disposable brief was positioned underneath the resident and the resident was then repositioned onto her back and the brief was pulled up between the resident ' s legs. CNA #2 did not cleanse the mons pubis area, underneath the folds of the abdomen or between the crease of the leg on the right side where stool had leaked from the colostomy bag. d. The facility ' s Policy and Procedure entitled, ' Incontinent Care ' documented, " ... Procedure ... 5. Wash all soiled skin areas, washing from front to back, rinse, and dry very well, especially between skin folds. ..."	F 312		
{F 314} SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: This is a rewritten deficiency. Based on observation, record review, and interview the facility failed to ensure that pressure relief devices were consistently used for off-loading pressure points for 1 (Resident #3), wound care was completed every other day as ordered by the physician for 1 (Resident #6) of 7 (Resident #1, #3, #4, #5,#6, #7, and #8) case mix residents who were at risk for or who had actual	{F 314}		12/14/08

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{F 314}	Continued From page 4 pressure ulcers and failed to ensure an excoriated area was cleansed and barrier cream was applied after a resident had been exposed to a urine saturated brief due to a leaking catheter for 1 (Resident #5) of 2(Residents #5 and #6) case mix residents who used a foley catheter and 7 (Resident # 1, #3, #4, #5, #6, #7, and #8) case mix resident who were incontinent and required the assistance of staff for personal care. The failed practices had the potential to affect 13 residents who were at risk for pressure ulcer, 4 residents who used a foley catheter and 31 residents who were incontinent and required the assistance of staff for personal hygiene according to the Administrator on 12/31/08 at 8:50 a.m. The findings are: 1. A Pressure Ulcer Treatment Policy and Procedure received from the Administrator on 12/31/08 at 8:45 a.m. documented, "Purpose; The Purpose of this procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. General Guidelines; ... c. Implement pressure-relieving devices in according with resident's assessed needs; d. Evaluate until redness is no longer persistent; ... 2.. Incontinence; a. Cleanse with incontinence cleanser; b. Pat dry and evaluate need for protective barrier cream, and c. Consider scheduling toileting program. 3. Friction or Shearing; a. Reduce cause by using transfer techniques and devices as needed. 4. Immobility; a. Turn Schedule; and b. Restorative Nursing (range of motion, waling, bed mobility).... 2. Resident #3 had diagnoses of Pressure Ulcer Heel, Edema, Dementia, and Abnormal Weight Loss. The Quarterly Minimum Data Set (MDS)	{F 314}		

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{F 314}	Continued From page 5 dated 12/14/08 documented the resident had modified independent cognitive skills for daily decision-making, required limited assistance for bed mobility, required extensive assistance of two staff members for transfer; and had no pressure ulcers. a. A physician order dated 4/17/08 documented, " Bed Cradle at foot of bed (decubiti heel/pain to feet). ... 9/3/08 ...Heel float boots at all times." b. The Plan of Care dated 9/25/07 documented, "Related Dx (Diagnoses) Pressure Ulcer, Heel, History of Skin Breakdown on heels measures continue with preventive measures. Goal: No further skin breakdown on heels times 90 days. 3/22/08. Approaches; Heel float boots at all times, Bed cradle to foot of bed, treatment as ordered, check heels daily." c. On 12/29/08 at 2:15 p.m., during initial rounds, and at 3:35 p.m., the resident was in bed asleep. The foot cradle was at the foot of the bed. The sheets and bedspread was not over the foot cradle but were directly on the residents feet. A pair of off-load boots was laying in the recliner in the room. The resident did not have any off-load boots on here feet. d. On 12/30/08 at 7:15 a.m., the resident was in the day area waiting for breakfast. She was sitting in a wheel chair with her feet on the foot rests and had on a pair of gray house shoes. The resident did not have on the off load boots that had been ordered to be put on at all times. e. On 12/30/2008 at 12:55 p.m., Licensed Practical Nurse #1 was asked if the resident had a history of skin breakdown and he stated, "Yes,	{F 314}		

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{F 314}	Continued From page 6 the resident has a history of skin breakdown and pressure sores, stage III or more on her heels. I have been here over a year." f. On 12/30/08 at 1:40 p.m., the resident was asleep in bed. A pair of off-load boots were in the recliner. The resident did not have anything in place to off load her feet. 3. Resident #6 had diagnoses of Malnutrition Mild Degree, Peripheral Vascular Disease (PVD), and Amputee Above Knee, Unilateral. The Medicare 30 day MDS dated 11/20/08 documented, the resident had modified independent cognitive skills for daily decision-making, required limited assistance for bed mobility, required extensive assistance of one person for transfer, and had 1 Stage I, Pressure Ulcer. a. The Care Plan dated 10/14/08 documented, "Muscle Weakness-General, Problem onset 10/14/08 Potential for skin breakdown related to PVD, and impaired mobility; Approaches; ... Place resident in skin-breakdown-prevention program... Assist resident with frequent position changes.... treatments as ordered to current skin issues. Problem 10/14/08; open area to right knee(R) ; resolved 12/4/08. 12/24/08 Problem; R buttock open area. Approaches; 1. [Treatment] as ordered. 2. Keep area clean, dry [decrease] pressure to area with T/R (turn/reposition) every (q) 2 hours and prn (as needed)." b. A Physician's Telephone Order dated 12/24/08 timed 11:00 a.m. documented, "Duoderm to [right] buttock proximal to coccyx QOD (every other day) until resolved."	{F 314}		

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{F 314}	Continued From page 7 c. On 12/30/2008 at 12:30 p.m., LPN (Licensed Practical Nurse) #1 was asked to do a dressing change and body audit on the resident. The LPN removed the duoderm which was wrinkled. The duoderm dressing was dated 12/24/08. The resident had 4 open areas on his buttocks which measured approximately 1/2 centimeter each. Two of the open areas were on the left buttock and one of these areas was bleeding and there were two open areas on the right buttock. The areas were cleansed with normal saline and then covered with duoderm. The dressing that was removed had not been changed QOD, according to physician orders, since the dressing had been place on the wound on 12/24/08. The dressing next scheduled date for change would have been on 12/26/2008, and then 12/28/2008. 4. Resident #5 had a diagnosis of Presenile Dementia. The MDS dated 10/28/08 documented that the resident was severely impaired in cognitive skills for daily decision making, was dependent on staff for toilet use, was incontinent of bowel and bladder, had an indwelling foley catheter and was receiving treatment for excoriation on the buttocks and the perineum. a. The Plan of Care dated 5/1/08 and updated 10/28/08 documented, "Resident is at risk for skin breakdown due to incontinence of bowel and bladder, needs assist with bed mobility, and pads and briefs used daily. . . Keep skin clean and dry. Provide pericare q2hours (every two hours) and prn (as needed). Apply protective/preventive barrier creams after each incontinent episode as indicated and ordered. . . 12/18/08 . . . Nystatin-TMC tid to buttocks x 14 days for excoriation."	{F 314}		

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{F 314}	Continued From page 8 b. A Weekly Skin Integrity Assessment sheet dated 12/8/08 documented ". . . 2. R (resident) has rash to buttocks resolving. Calmoseptine applied prn (as needed). Skin is peeling from previous outbreak. Surface hard to touch. . . . 12/18/08 ... 4. N/O (new order) for Nystatin/TMC tid (three times a day) for excoriation. Foley 16 F (french) 10 cc (cubic centimeter) to aide/prevent excoriation of buttocks. c. A Physician's telephone order dated 12/18/08 documented, ". . . Start Nystatin - TMC ointment tid (three times a day) x (times) 14 days to buttocks. . . " d. On 12/29/08 at 5:05 p.m., CNA #1 provided incontinent care for the resident. The CNA stated that the resident's foley catheter was leaking. The disposable brief was saturated with urine. The CNA cleansed the perineum, then turned the resident onto her side and cleansed the resident over her anal area. She did not cleanse the resident's buttocks. The buttocks and perineum was slightly red. The CNA did not apply any protective barrier cream.	{F 314}		
{F 315} SS=E	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	{F 315}		12/14/08

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{F 315}	Continued From page 9 This REQUIREMENT is not met as evidenced by: This is a rewritten deficiency. Based on observation and record review the facility failed to ensure that there was a clinical justification for the insertion of a indwelling foley catheter for 1 (Resident #5) of 1 case mix residents who had a foley catheter and a back to front motion was not used during incontinent care for 1 (Resident # 8) of 7 (Residents #1, #3, #4, #5, #6, #7, and #8) case mix residents who required assistance with personal care. This failed practice had the potential to affect 4 residents in the facility with a indwelling foley catheter and had the potential to affect 31 residents who were incontinent as identified by the Administrator on 12/31/08 according to the number provided by the Administrator on 12/31/08 at 8:50 a.m. The findings are: 1. Resident #5 had a diagnosis of Presenile Dementia. The Minimum Data Set dated 10/28/08 documented the resident was severely impaired in cognitive skills for daily decision making, was dependent on staff for toilet use, was incontinent of bowel and bladder, and had an indwelling foley catheter a. A Physician's Telephone Order dated 12/18/08 documented, "Insert F/C (Foley Catheter) 16 F (french) 10 cc (cubic centimeter) until further notice. Foley cath care per facility protocol. . . " There was not a clinical justification or diagnosis for the catheter. b. A Nurses' Note dated 12/18/08 at 11:20 a.m. documented, "Notified [name of physician's	{F 315}		

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{F 315}	Continued From page 10 nurse]. New orders noted for F/C insertion/monitoring via facility protocol. . . This new intervention was initiated to improve current implemented modalities for ASE (adverse side effects) d/t (due to) incontinence. Standard incontinent protocols will cnt (continue) in addition to new interventions. " The note was signed by LPN (Licensed Practical Nurse) #1. c. The Weekly Skin Integrity Assessment dated 12/18/08 documented, "4. N/O new order for . . . Foley 16 F 10 cc to prevent excoriation of buttocks.." The documentation did not have clinical justification or diagnosis to warrant the insertion of an Indwelling Foley Catheter. d. On 12/29/08 at 1:30 p.m. , during initial round, resident was up in wheel chair in dinning room area. Licensed Practical Nurse (LPN) #2 stated the resident had an irritation on her buttocks. The resident had a foley catheter to drainage bag. e. On 12/29/08 at 5:05 p.m., CNA #1 provided incontinent care for the resident. The areas on the buttock and perineum were slightly reddened. The resident had a foley catheter in place. f. On 12/29/08 at 5:42 p.m. and on 12/30/08 at 7:15 a.m. 10:00 a.m. and 12:50 p.m. the resident was observed with an indwelling Foley catheter. g. On 12/30/08 after review of the Nurses Notes, the physician orders and all other parts of the clinical record, no clinical justification could be found for the insertion of the foley catheter. h. A Policy and Procedure documented, "Urinary Catheters . . . Policy: I. Catheters should be inserted only when necessary and left in place	{F 315}		

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{F 315}	Continued From page 11 only as long as needed. . . " 2. Resident # 8 had a diagnosis of Multiple Sclerosis with paraplegia, Seizure disorder, Decubitus Ulcers and Esophageal Reflux. The Quarterly Minimum Data Set dated 9/30/08 documented the resident had severely impaired cognitive skills for daily decision making and was totally dependent in all Activities of Daily Living (ADL's), was continent of bowel and bladder, had an indwelling foley catheter and had an ostomy present. a. The Plan of Care dated 12/30/08 documented, "Problem: Decubitus on Right (R) buttock. ... Approaches: ... Peri Care Q (every) shift and PRN (as needed). ... " . b. On 12/29/08 at 1:44 p.m., during initial rounds, Licensed Practical Nurse (LPN) #1 stated the resident was incontinent of bladder and had a colostomy. c. On 12/29/08 at 4:00 p.m., Certified Nursing Assistant (CNA) # 2 and # 3 performed incontinent care. The colostomy bag was leaking and there was liquid stool over the mons pubis, between the creases of the legs and underneath the folds of the abdomen. The resident was placed on her left side with her buttocks and vaginal area exposed. CNA # 2 cleansed from back to front and changed the cloth, then cleansed from front to back and changed the cloth and then cleansed from back to front again. A disposable brief was positioned underneath the resident and the resident was then repositioned onto her back and the brief was pulled up between the residents legs. CNA #2 did not cleanse the mons pubis area, underneath the	{F 315}		

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GRACE HEALTHCARE OF MAUMELLE	103 ALEXANDRIA DRIVE MAUMELLE, AR 72113

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{F 315}	Continued From page 12 folds of the abdomen or between the crease of the leg on the right side where stool had leaked from the colostomy bag. d. The facility ' s Policy and Procedure entitled, ' Incontinent Care ' documented, " ... Procedure ... 5. Wash all soiled skin areas, washing from front to back, rinse and dry very well, especially between skin folds. ..."	{F 315}		
{F 323} SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This is a rewritten deficiency. Based on observation and record review the facility failed to ensure the plan of care was followed when transferring a resident and the axilla and the waistband of the residents pants was not used to support a residents weight during a transfer for 1(Resident # 4) of 4 (Resident # 1, #6, #7, and # 4) case mix residents who required the assistance of 2 staff members and the use of a mechanical lift for transfers. This failed practice had the potential to affect 32 residents who were manually transferred as identified by the administrator on 12/31/08. The findings are: 1. Resident # 4 had a diagnosis of Alzheimer's Dementia, Depression, Osteoporosis and	{F 323}		12/14/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045422	A. BUILDING ______ B. WING ______	R-C 12/31/2008

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{F 323}	Continued From page 13 Congestive Heart Failure. The Quarterly Minimum Data Set dated 12/09/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with transfers and was non ambulatory. a. The Plan of Care dated 5/15/08 updated 12/08 documented, " Problem- Self care deficit resident needs extensive dependent assist of 1 - 2 staff with all ADLS (Activities of Daily Living). . . Approaches. . . 2 staff and mechanical lift for all transfers. . ." b. On 12/29/08 at 4:45 p.m., CNA (Certified Nursing Assistant) # 2 transferred the resident to a gerichair without assistance. When CNA # 2 and #3 attempted to reposition the resident in the geri chair they applied the gait belt very loosely and grasped the resident underneath the arm and tried to slide her up in the chair. The geri chair rolled out from under the resident and all her weight was placed on the axilla area. The gait belt had slid upwards underneath the residents' breast. The resident was saying OW OW OW repeatedly. The CNA's had their arms under the resident's axilla area and grabbed her pants and placed her in the chair. The resident's feet never touched the floor during the position and getting the resident back into the gerichair.	{F 323}		
{F 444} SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.	{F 444}		12/14/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 444}	Continued From page 14	{F 444}		

This REQUIREMENT is not met as evidenced by:
This is a rewritten tag.

Based on observation and record review the facility failed to ensure that the staff washed their hands after providing incontinent care for 1 (Resident # 4) of 1 case mix residents who required assistance from the staff. This failed practice had the potential to affect all 54 residents of the facility who resided in the facility as identified on the Roster Sample Matrix provided by the Administrator on 12/29/08 at 2:00 p.m. The findings are:

1. The Policy and Procedure for Handwashing provided by the administrator on 12/31/08 documented, " Purpose To decrease the risk of transmission of infection by appropriate handwashing. Policy Handwashing is generally considered the most important single procedure for preventing nosocomial infections.. . "

2. Resident # 4 had a diagnosis of Alzheimer's Dementia. The Quarterly Minimum Data Set dated 12/09/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with transfers and was incontinent of bowel and bladder.

On 12/29/08 at 4:45 p.m., Certified Nursing Assistant (CNA) # 2 performed incontinent care. She did not wash her hands before leaving the room. After completing incontinent care and transferring the resident to a gerichair. The CNA removed the sling from the room, that was to be used for transferring the resident, and placed it with the mechanical lift that was located down the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 444}	Continued From page 15 hall way to be used for the next transfer.	{F 444}		