

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2008
NAME OF PROVIDER OR SUPPLIER MORRILTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BROOKRIDGE LANE MORRILTON, AR 72110	
(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: Based on observation, record review and interview, the facility failed to ensure privacy was maintained during bathing for 1 (Resident #4) of 11 (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11) case mix residents who required assistance with bathing. This failed practice had</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>the potential to affect 25 residents that were showered in the 400 Hall shower room according to documentation received from the Director of Nursing (DON) on 2/1/08. The findings are:</p> <p>1. Resident #4 had diagnoses of Congestive Heart Failure, Diabetes Mellitus Type 2 and Atrial Fibrillation. The Quarterly Minimum Data Set (MDS) dated 12/13/08 documented the resident was moderately impaired in cognitive skills for daily decision making and had total dependence on staff for bathing.</p> <p>a. On 1/30/08 at 10:00 a.m., Certified Nursing Assistant (CNA) #10 pushed the resident into the Shower room on the 400 Hall, removed the sheet covering the resident and bathed the resident without pulling the privacy curtain. The shower stall was located next to the door leading out into the 400 Hall.</p> <p>b. On 1/30/08 at 10:14 a.m., CNA #11 entered the shower room on the 400 hall while CNA #10 continued to bathe the resident. The shower curtain remained opened and CNA #10 made no attempt to pull the curtain or cover the resident when the door was opened. CNA #11 pushed another resident past Resident #4 who was fully exposed. The other resident had a full frontal view of Resident #4.</p> <p>c. On 1/30/08 at 10:16 a.m., CNA #11 opened the shower room door and exited. The CNA then returned and entered the room opening the door next to the shower stall that leads out to the 400 hallway. CNA #10 continued to bathe the resident and did not pull the privacy curtain. The resident was facing outward towards the center of the room and the door. CNA #10 did not attempt</p>	F 164			

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F 164	Continued From page 2 to cover the resident. d. On 1/30/08 at 10:20 a.m., CNA #11 opened the door and went out of the room. CNA #10 was drying the resident and the privacy curtain remained open. The privacy curtain had an approximately 5-6 inch gap between the curtain and the wall and the other resident looked through the opened area having a full frontal view of Resident #4. e. On 1/30/08 at 10:25 a.m., CNA #10 pulled the resident out of the shower stall and the resident was facing the door. CNA #11 opened the door and entered and exited the shower room 3 times while the resident sat in the shower chair facing the opened door. A resident walked past the opened door and looked into the shower room while Resident #4 was exposed. f. On 1/30/08 at 3:10 p.m., the resident was asked if it bothered her that the curtain was not pulled when she was showered and the door was opened. The resident stated, "Yes, it does bother me." The resident was asked if she preferred to have the curtain pulled during her shower and she stated, "Yes, I want the curtains pulled."	F 164			
F 221 SS=E	2. The Shower/Tub Bath guidelines documented, "Resident's Rights Protocol ...Pull the privacy curtain. Close drapes/lower shades/close blinds, as applicable. ..." 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 treat the resident's medical symptoms.	F 221			

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F 221	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure a pre-restraining assessment was completed for 1 (Resident #5), reassessments were conducted for the appropriateness of the restraint for 2 (Resident #8 and #11) and informed consents were obtained prior to the application of a physical restraint for 2 (Resident #5 and #11) of 6 (Resident #2, #5, #6, #8, #9 and #11) case mix residents with a Physician's Order for a physical restraint. This failed practice had the potential to affect 19 residents with a Physician's Order for a physical restraint according to the Resident Census and Conditions of Residents form dated 1/29/08. The findings are:</p> <p>1. Resident #5 had diagnoses of Musculoskeletal Symptomatic Limbs, Difficulty in Walking and Lack of Coordination. The Quarterly Minimum Data Set (MDS) dated 12/28/07 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for all activities of daily living and used a trunk restraint.</p> <p>a. A Physician's Order dated 10/25/07 documented, "Lap Buddy when up in w/c (wheel chair) d/t (due to) leaning when up in w/c."</p> <p>b. On 1/30/08 at 4:00 p.m., the clinical record was reviewed. There was a partially completed pre-restraining assessment that was not dated or signed. The section of the form for the interdisciplinary team evaluation was blank</p> <p>c. On 1/31/08 at 10:45 a.m., the Director of</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>Nursing (DON) stated the informed consents for restraints were kept in a separate notebook. He was then asked if he would locate the resident's consent. The DON looked and then stated that the facility did not have one for the restraint that was currently being used on the resident.</p> <p>2. Resident #8 had a diagnosis of Secondary Parkinsonism. The quarterly MDS dated 12/21/07 documented the resident was severely impaired in cognitive skills for daily decision making, independent for locomotion on and off unit and a trunk restraint was used daily.</p> <p>a. A telephone order dated 7/27/06 documented, "Non release seatbelt due to multiple falls."</p> <p>b. A Physical Restraint Elimination Assessment dated 3/4/07 documented a score of 23 for the resident. The form documented that a score of 21-35 would make the resident a good candidate for a restraint reduction. On 7/30/07 the resident's score was 27 and on 10/19/07 the resident's score was 22.</p> <p>c. On 1/28/08 at 3:10 p.m., the resident was sitting in a wheel chair with non self releasable belt restraint applied.</p> <p>d. On 1/28/08 at 6:05 p.m., the resident was sitting in a wheel chair with a non self releasable belt restraint applied.</p> <p>e. On 1/29/08 at 9:35 a.m., the resident was sitting in a wheel chair with a non self releasable belt restraint applied.</p> <p>f. On 1/29/08 at 11:00 a.m., the resident the resident was sitting in a wheel chair with a non</p>	F 221			

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F 221	Continued From page 5 self releasable belt restraint applied. g. On 1/29/08 at 4:45 p.m., the resident was sitting in a wheel chair with non self releasable belt restraint applied. h. On 1/30/08 at 12:09 p.m., the DON was asked why the resident had a restraint applied and the Don stated, "It says at risk for seizures, falls. Falls and leans forward when sitting." The DON was asked if the resident was a candidate for restraint reduction or elimination and the DON stated, "I would think anyone would be a candidate for reduction. [Resident # 8] is a good candidate." 3. Resident #11 had diagnoses of Chronic Airway Obstruction, Congestive Heart Failure, Tracheostomy Status and Sleep Apnea. The Quarterly MDS dated 12/18/07 documented the resident had modified independence in cognitive skills for daily decision making, totally dependent for transfers with two person assist, independent with locomotion on and off the unit with setup help only and had full side rails on all open sides of the bed. a. A Physician's Order dated 1/3/08 documented, "Non releasable seat belt Check q (every) 30 min (minutes) and release q 2 hours [times] 10 min for ROME (range of motion exercise), toileting, or ambulation." b. On 1/29/08 at 1:25 p.m., the resident was in a wheel chair in the dining room with a non releasable seat belt restraint applied. c. On 1/31/08 at 1:30 p.m., the resident was self propelling a wheel chair from the dining room with	F 221		

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F 221	<p>Continued From page 6</p> <p>a non releasable seat belt restraint applied.</p> <p>d. A Physical Restraint Informed Consent with no date documented, "... Restraint Type, Frequency: Non release seat belt. Specific Target Behaviors: Prevent unassisted transfers/falls. ..." There was no signature on the form.</p> <p>e. The Physical Restraint Elimination Assessment dated 12/9/07 documented the resident had a score of 9. The form documented a score of 0 - 20 was a priority candidate for restraint reduction.</p> <p>f. On 1/31/08 at 9:15 a.m., the DON was asked if any other less restrictive measures were tried prior to the non releasable seat belt restraint. The DON stated, "No, nothing else was tried." The DON was asked if there was a signed consent for the seat belt. The DON stated, "No, it was not signed." The DON was asked if there was a completed Restraint Elimination Assessment. The DON stated, "No, it was not done."</p> <p>4. The policy and procedure entitled "Physical Restraint Application" documented, "... Designated facility staff must explain the potential risks and benefits of all options under consideration including using a restrain...and alternatives to not using a restraint. Informed consent for the Physical restraint will be obtained from the resident or legal representative. Potential negative outcomes and benefits will be discussed with the resident and/or legal representative..."</p> <p>5. The policy and procedure entitled "General Guidelines for the Use of Physical Restraints" documented, "... Least restrictive devices include</p>	F 221			

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F 221	Continued From page 7 pillows, cushions, bolsters or self-release lap trays, depending on the functional level of the resident. ... 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. ... Administrative policies governing the use of restraints specify which staff member may authorize the use of restraints and clearly delineate the following: a. Orders indicate the specific medical reason for using the device, the circumstances under which it can be used, the type of device, and the length of time over which it can be used. Restraints must be used only as a last resort, and the medical record must indicate the events leading up to the necessity of the restraint. ... The need for restraints will be reevaluated at least quarterly to determine if continued restraint use is necessary to treat the resident's medical symptoms. Every effort will be made to eliminate the use of the restraint. ... Assessment and Care Planning: ... Informed consent for the physical restraint will be obtained from the resident or legal representative. ..."	F 221			
F 241 SS=E	483.15(a) DIGNITY 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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff knocked prior to entering resident rooms. This failed practice had the potential to affect 26 residents that resided on the 100 Hall and 25 residents that resided on the 400	F 241			

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F 241	Continued From page 8 Hall as documented on the Census List received on 1/31/08. The findings are: 1. Resident #9 had diagnoses of Senile Dementia and Chronic Ischemic Heart Disease. The Annual Minimum Data Set dated 11/20/07 documented the resident was severely impaired in cognitive skills for daily decision making. a. On 1/29/08 at 2:11 p.m., Certified Nursing Assistants (CNA) #12 and #13 entered room 411 without knocking. The resident and his room mate were in the room. b. On 1/31/08 at 8:05 a.m., the Maintenance Supervisor entered the resident's room without knocking. The resident was in the bed. 2. On 1/28/08 at 2:53 p.m., Certified Nursing Assistant (CNA) 4 entered room #102 without knocking. 3. On 1/29/08 at 11:30 a.m., Therapist # 1 entered room #104 without knocking and two residents were laying in bed. 5. Resident #4 had diagnoses of Congestive Heart Failure, Diabetes Mellitus Type 2 and Atrial Fibrillation. The Quarterly Minimum Data Set (MDS) dated 12/13/08 documented the resident was moderately impaired in cognitive skills for daily decision making and had total dependence on staff for bathing. a. On 1/30/08 at 10:00 a.m., Certified Nursing Assistant (CNA) #10 pushed the resident into the Shower room on the 400 Hall, removed the sheet covering the resident and bathed the resident without pulling the privacy curtain. The shower	F 241		

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F 241	<p>Continued From page 9</p> <p>stall was located next to the door leading out into the 400 Hall.</p> <p>b. On 1/30/08 at 10:14 a.m., CNA #11 entered the shower room on the 400 hall while CNA #10 continued to bathe the resident. The shower curtain remained opened and CNA #10 made no attempt to pull the curtain or cover the resident when the door was opened. CNA #11 pushed another resident past Resident #4 who was fully exposed. The other resident had a full frontal view of Resident #4.</p> <p>c. On 1/30/08 at 10:16 a.m., CNA #11 opened the shower room door and exited. The CNA then returned and entered the room opening the door next to the shower stall that leads out to the 400 hallway. CNA #10 continued to bathe the resident and did not pull the privacy curtain. The resident was facing outward towards the center of the room and the door. CNA #10 did not attempt to cover the resident.</p> <p>d. On 1/30/08 at 10:20 a.m., CNA #11 opened the door and went out of the room. CNA #10 was drying the resident and the privacy curtain remained open. The privacy curtain had an approximately 5-6 inch gap between the curtain and the wall and the other resident looked through the opened area having a full frontal view of Resident #4.</p> <p>e. On 1/30/08 at 10:25 a.m., CNA #10 pulled the resident out of the shower stall and the resident was facing the door. CNA #11 opened the door and entered and exited the shower room 3 times while the resident sat in the shower chair facing the opened door. A resident walked past the opened door and looked into the shower room</p>	F 241		

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F 241	Continued From page 10 while Resident #4 was exposed. f. On 1/30/08 at 3:10 p.m., the resident was asked if it bothered her that the curtain was not pulled when she was showered and the door was opened. The resident stated, "Yes, it does bother me." The resident was asked if she preferred to have the curtain pulled during her shower and she stated, "Yes, I want the curtains pulled." 2. The Shower/Tub Bath guidelines documented, "Resident's Rights Protocol ...Pull the privacy curtain. Close drapes/lower shades/close blinds, as applicable. ..."	F 241		
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 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure foley catheter tubing was secured with a leg band for 3 (Resident #4, #8 and #13), foley catheter bag and/or tubing was not touching the floor for 2 (Resident #8 and #12), catheter tubing was not pulled taut during care for 1 (Resident #9) and the foley collection bag was not raised above the level of the bladder for 1 (Resident #4) of 5 (Resident #4, #8, #9, #12 and #13) case mix residents who had indwelling urinary catheters. The facility failed to ensure Med Pass supplement was administered for 1 (Resident #2) of 1 case mix resident with a Physician's Order for Med	F 282		

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F 282	<p>Continued From page 11</p> <p>Pass supplement and failed to ensure blood pressures were obtained and documented prior to the application of a nitroglycerin paste patch for 1 (Resident #4) of 1 case mix resident with a Physician's Order for Nitro Paste. These failed practices had the potential to effect 11 residents who had indwelling urinary catheters as identified on the Resident Census and Conditions of Residents form dated 1/29/08, 1 resident with a Physician's Order for Med Pass supplement and 1 resident with a Physician's Order for Nitro Paste as indicated on a list provided by the Administrator on 2/1/08. The findings are:</p> <ol style="list-style-type: none"> 1. The policy and procedure entitled "Catheter Care, Urinary" documented, "... Be sure the catheter tubing and drainage bags are kept off the floor...Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site." 2. Resident #12 had diagnosis of a Neurogenic Bladder. The MDS dated 12/4/07 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for all activities of daily living, had a supra pubic catheter and was incontinent of bowel. <ol style="list-style-type: none"> a. A Physician's Order dated 4/17/06 documented, "... monitor for positioning." b. On 1/31/08 at 8:25 a.m., the resident was up in a wheel chair in his room. The catheter tubing went down through the leg of his pants and the catheter collection bag was lying doubled over of the floor under the right front wheel of his wheel chair. 3. Resident #8 had a diagnosis of Paralysis of 	F 282		

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
NAME OF PROVIDER OR SUPPLIER MORRILTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BROOKRIDGE LANE MORRILTON, AR 72110		
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F 282	<p>Continued From page 12</p> <p>Bladder. The quarterly MDS dated 12/21/07 documented the resident was severely impaired in cognitive skills for daily decision making and had an indwelling catheter.</p> <p>a. A Physician's Order dated 3/26/07 documented, "... monitor positioning and leg band placement."</p> <p>b. On 1/28/08 at 6:25 p.m., the resident was self propelling the wheelchair. The catheter tubing was dragging on the floor.</p> <p>c. On 1/29/08 at 9:35 a.m., 9:50 a.m., 4:45 p.m., 6:00 p.m. and 8:39 p.m., the resident was in the wheelchair and the catheter tubing was dragging on the floor.</p> <p>d On 1/30/08 at 9:30 a.m., Licensed Practical Nurse (LPN) #1 performed suprapubic catheter care and a dry brown substance was noted at the stoma site. The LPN stated, "Looks like you've got some drainage." There was no leg band or any other device used to secure the catheter tubing. The catheter drainage was emptied into a urinal with the bag held above the level of the bladder and then was placed in the bed with the resident and remained there for 53 minutes.</p> <p>e. On 1/31/08 at 3:09 p.m. CNA #5 was asked how should catheter tubing be positioned when the resident was in a wheelchair and the CNA stated, "Down left pant leg underneath chair in a privacy bag, tubing should not be kinked and not pulling."</p> <p>f. On 1/31/08 at 3:20 p.m., CNA #3 was asked how should a catheter tubing be positioned when a resident was in a wheelchair and the CNA</p>	F 282			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 282	<p>Continued From page 13</p> <p>stated, "...the tubing should not be touching the floor and it should not be above the level of the bladder..."</p> <p>4. Resident #9 had diagnosis of Senile Dementia and Chronic Ischemic Heart Disease. The MDS dated 11/20/07 documented the resident was severely impaired in cognitive skills for daily decision making and had suprapubic indwelling catheter.</p> <p>a. A Care Plan dated 11/19/07 documented, "... At risk for complications r/t (related to) suprapubic catheter. Goal: No complications r/t suprapubic catheter this quarter."</p> <p>b. On 1/30/08 at 2:30 p.m., Certified Nursing Assistant (CNA) #11 removed the catheter tubing from the leg band during catheter care. CNA #10 and #11 turned the resident to the right side. The catheter tubing was stretched and taunt. The CNA's were asked what happens if the catheter is tight or pulled and CNA #11 stated, "It can pull out or tear and cause bleeding."</p> <p>4. Resident #13 had diagnosis of Senile Dementia and Diabetes Mellitus. The MDS dated 1/7/08 documented the resident was severely impaired in cognitive skills for daily decision making and had an indwelling catheter.</p> <p>a. A Physician's Order dated 9/14/07 documented, "... Leg band to be used at all times."</p> <p>b. A Care Plan dated 1/7/08 documented, "... At risk for complications r/t indwelling foley catheter use ..."</p>	F 282			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2008
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F 282	Continued From page 14 c. On 1/31/08 at 2:30 p.m., CNA #14 and #15 provided incontinent and catheter care for the resident. The sheet was pulled back off of the resident and a leg band was noted on the right lower thigh. The catheter tubing was underneath the resident's right hip and lower thigh. The tubing was not secured by the leg band. When the care was completed, the resident was covered with a sheet and the catheter tubing remained unsecured. 5. Resident #4 had diagnoses of Congestive Heart Failure and Diabetes Mellitus. The Quarterly MDS dated 12/13/07 documented the resident was moderately impaired in cognitive skills for daily decision making and had an indwelling catheter. a. The Physician Orders dated January 2008 documented, "...Monitor positioning and leg band placement." b. On 1/30/08 at 9:50 a.m., a leg band was on the resident's right thigh but did not have the catheter tubing secured through the band. CNA #11 removed the leg band from the resident's thigh. The resident was then transferred without the catheter being secured. c. On 1/30/08 at 9:50 a.m., CNA #10 picked up the catheter bag and hooked the catheter bag onto the bar on the mechanical lift above the resident's bladder. As the resident was being transferred by the mechanical lift, the CNA picked up the catheter bag and then hung the bag on the front bar of the lift at the height of the resident's chest during the transfer to the shower chair.	F 282		

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 282	<p>Continued From page 15</p> <p>d. On 1/30/08 at 10:25 a.m., the catheter had tension pulled on the tubing when CNA #10 moved the resident in the shower chair.</p> <p>e. On 1/30/08 at 10:30 a.m., CNA #11 picked up the catheter bag and held it above the height of the resident's bladder and then hung the catheter bag onto a bar on the mechanical lift while the resident was being transferred to the wheelchair</p> <p>f. A Physician's Order dated 9/5/06 documented, "Nitropaste 1 inch to chest Q (every) 8 hrs (hours). Do B/P (blood pressure) just prior to applying patch."</p> <p>g. The Medication Administration Record dated January 2008 documented under Time Codes, "6AM BP, 1400 BP, and 2200 BP." There were no blood pressure parameters recorded for the month of January.</p> <p>h. On 1/29/08 at 10:20 a.m., Certified Nursing Assistant (CNA) #10 reapplied the nitropaste patch to the resident's chest and did not check the blood pressure or notify the nurse prior to applying the patch.</p> <p>i. On 1/29/08 at 10:55 a.m., the clinical record was reviewed and there were no blood pressures recorded as prior to the time of the nitropaste administration.</p> <p>j. On 1/31/08 at 10:07 a.m., Licensed Practical Nurse (LPN) #9 was asked who applied nitropaste to resident's skin and she stated, "Nurses, yes licensed." The LPN was asked what should be done before nitropaste was applied and she stated, "Take the blood pressure." The LPN was asked where the blood pressures are</p>	F 282			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 282	<p>Continued From page 16</p> <p>recorded and she stated, "It's not on here. I just make sure it's within normal limits. The CNA's check her blood pressure for me. I don't record them just because they tell me." The LPN was asked who told her what the blood pressure was on the previous day and she stated, "I can't remember."</p> <p>k. On 1/31/08 at 10:30 a.m., LPN #1 was asked what should be done before applying nitropaste to a resident. She stated, "Blood pressure has to be checked. CNA's check and they tell us."</p> <p>l. The Geriatric Dosage Handbook, 12th Edition, 2007, pages #1110 - 1113 documented, "Nitroglycerin, ...Warnings/Precautions ...use with caution in patients with hypovolemia, ...hypertension and hypotension;...Overdosage/Toxicology Symptoms include hypotension,...Monitoring Parameters Orthostatic blood pressure, blood pressure, heart rate; therapeutic dose may be determined by observing for a decrease in systolic blood pressure by 15 mm (millimeters) Hg (mercury), diastolic reduction of 10 mm Hg or an increase in heart rate of 10 bpm (beats per minute)...Special Geriatric Considerations Caution should be used when using nitrate therapy in older adults due to hypotension; hypotension is enhanced in older adults due to decreased baroreceptor response, decreased venous tone, and often hypovolemia (dehydration) or other hypotensive drugs."</p> <p>6. Resident #2 had diagnoses of Anxiety Disorder, Constipation, Difficulty in Walking, Alzheimer's Dementia with Behavior Disturbance End Stage, Depressive Disorder and Psychosis. The Quarterly Minimum Data Set (MDS) dated 1/7/08 documented the resident was severely</p>	F 282			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 282	Continued From page 17 impaired in cognitive skills for daily decision making and had a weight loss of 5% or more in the last 30 days and 10% in the last 180 days. a. A Physician's Order dated 1/15/08 documented, "60cc (cubic centimeters) Med Pass TID (three times a day) [with] med (medication) pass." b. A Dietary Progress Notes dated 1/15/08 documented, "9.5% wt. (weight) loss in the last 6 mo. (months). [Resident #2] is on House Supp. (supplement) with meals, ff (fortified foods), Mighty Shake at 10, 3, Magic Cup at hs (hour of sleep), Remeron 15 mg (milligrams) po (by mouth) QD (every day), and start new order of Med Pass 60cc TID with med pass. Appetite fair - poor 25-50% of meals, 75% of house supplements. Cont. (Continue) to monitor wt. and intake. Wt. 109.2# at this time. 67 inches tall ..." c. On 1/30/08 at 6:00 p.m., the Medication Administration Record (MAR) for January 2008 was reviewed and there was no documentation of the Physician's Order for Med Pass 60cc TID. d. On 1/31/08 at 9:00 p.m. the DON (Director of Nursing) was asked if the Med Pass had been given to the resident. The DON stated, "I will have to check on this." At 2:37 p.m. the DON stated, "I have a telephone order for the Med Pass, but it didn't get on the MAR."	F 282			
F 309 SS=J	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	F 309			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 309	Continued From page 18 and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure CPR (Cardiopulmonary Resuscitation) was performed on 1 (Resident #22) case-mix resident who was found without vital signs and had a directive that cardiopulmonary resuscitation be performed. This resulted in a past Immediate Jeopardy to Resident #22. The findings are: 1. Resident #22 had diagnoses of Anoxic Brain Damage, Atrial Fibrillation and Cardiomyopathy. The Minimum Data Set dated 12/17/07 documented the resident was severely impaired in cognitive skills for daily decision making. a. The January 2008 printed Physician orders documented: Full Code with the original order date of 9/27/03. b. Resuscitation Orders dated 1/17/03 documented:...The resident or resident's decision maker is aware of the medical condition of the resident . After fully discussing and considering the risks/benefits and alternatives to the initiation of CPR in a cardiac or respiratory arrest, the resident or resident's representative has made the following decision: In the event of a cardiac or respiratory arrest, initiate CPR. c. The DMS (Division of Medical Services) 7734 form documented: Date of I&A (Incident and Accident): 1/24/08, Time 8:05 p.m....Resident was found with no vital signs. Coroner was called	F 309	Past noncompliance: no plan of correction required.		

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 19</p> <p>to pronounce resident. LPN (License Practical Nurse) failed to look at chart to see resident was a full code. The steps taken to prevent continued abuse or neglect during the investigation...documented: Counseled LPN in charge of [Resident #22]. Re-inservice all LPN's of code status policy and procedure. This will be taken to the QA&A (Quality Assurance and Assessment) committee for further implementations."</p> <p>d. On 2/1/08 at 10:20 a.m., the Administrator stated, "I received a call about 7:30 p.m. [LPN # 2] said the resident had expired and the father was outside the room. He asked if something was wrong. [LPN #2] told him she could not find any vital signs. He went to get his wife. At 8:05 p.m., another LPN [LPN #3] called me and said [LPN #2] just told me about [Resident #22]. [LPN #3] said [Resident #22] is a full code. While [LPN #3] was on the phone, the coroner walked in the door so CPR was never initiated...."</p> <p>e. On 2/1/08 at 10:45 a.m., LPN #2 stated, "I gave [Resident #22] medication at about 4:30 p.m. About 7:25 or 7:30 p.m., Certified Nurse Assistant (CNA) #4 came to the med room and asked if I would come look at [Resident #22]. [CNA # 4] said, I don't think [Resident #22] is breathing. So I went down there. On the way down the hall [Resident #22's] father was standing outside the hall talking on the phone. He asked me if [Resident #22] was all right. I said the aide wanted me to check on [Resident #22]. When I got there, [Resident #22] was laying in the bed, eyes were open, pupils were fixed and dilated, there was no response at all to any kind of stimuli. I felt for a pulse, didn't find a pulse. [Resident #22] skin was extremely cold. I listened</p>	F 309			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 309	<p>Continued From page 20</p> <p>with a stethoscope and didn't hear a heart rate. I took a blood pressure and didn't find a blood pressure.... I explained my assessment findings to the father.... He said he was going to leave and let the family know. I did not know if [Resident #22] was a DNR (Do Not Resuscitate) or a full code and [Resident #22] chart was not in the rack. It was lying on the desk. I didn't do CPR because [Resident #22] didn't have any vital signs and was cold. I have worked off and on with [Resident #22] and I knew her medical condition and in error I assumed that [Resident #22] was a DNR. I was counseled. There is a book out there now that tells if someone is a DNR or a full code.</p> <p>f. The "Employee Disciplinary Action Form" documented: First written warning , Description of violation or area of performance needing improvement: failure to start CPR on a full code resident. Inservice on policy...</p> <p>g. The Inservice dated 1/25/08 documented: When a resident is found unresponsive, you must determine code status, if you don't already know. If they are a full code, start CPR immediately and continue until the EMT's arrive. There are no exceptions.</p> <p>h. Staff were interviewed regarding what they would do if they found someone unresponsive and without vital signs and how they would know if someone was a full code or no code (DNR):</p> <p>1) On 2/1/08 at 10:05 a.m., the Director of Nurses (DON) stated, "If I didn't know the code status, I would check that...Check the chart and we have a new binder at the Nurses station on the chart rack that has the resident names in alphabetical order</p>	F 309			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 21</p> <p>that has a stop sign with no code written in the middle of it if they are a DNR and a green arrow with their name if they are a full code. We initiated this book so we wouldn't even have to look for the chart. We had a resident who had been sick for a long time, they were found....and was a full code, the Nurse wrongfully assumed the resident was a no code and did not start CPR."</p> <p>2) On 2/1/08 at 9:58 a.m., LPN #5 stated, "Check for a pulse...they have advance directives and paper work in the front of the chart, on their doors, if it's red they are a DNR if it's green they are a full code..." At 1:26 p.m., she was asked if she had a resident who had conflicting information or she could not determine the code status, what would she do. She stated, "I would code them to be safe."</p> <p>3) On 2/1/08 at 10:00 a.m., LPN #4 stated, "I would send a CNA to check the chart to see if they are a DNR and start CPR if they aren't. We have little things on the outside of the residents door (resident name) red strip means no CPR, green strip means CPR....In the front of the chart under advance directives you can find the information and [DON] put a code status book up[at nurses station], he did an inservice..." At 1:30 p.m., LPN #4 was asked, if she had conflicting information or she could not determine the code status, what would she do. She stated, "Start CPR."</p> <p>4) On 2/1/08 at 10:00 a.m., the Activity Director stated she would get the Nurse, the name tags on the outside of the door, red means a DNR and green means code, the information is on the front of the chart.</p>	F 309		

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 309	Continued From page 22 5) On 2/1/08 at 10:05 a.m., CNA #7 stated she would get the charge nurse and "we have a little black book at the desk", on their doors there is a red tag that means they are a DNR and green that they are a code. 6) On 2/1/08 at 10:25 a.m., LPN #6 stated, "First look on the door and see if they are DNR and if they are a code, I'm going to yell down the hall and initiate CPR. Our door tags, red is for DNR and green is full code. The information is on the chart, but if I don't know for sure, I'm going to start CPR." 7) On 2/1/08 at 10:30 a.m., LPN #7 stated, "Find out if they are a code or not. We have name tags on the door the red is DNR and green is CPR. If they don't have the name tag, they are automatically CPR. The information is in the front of the chart... Now we have a note book with resident status listed, a code status book." At 1:39 p.m., she was asked if she had a resident who had conflicting information or she could not determine the code status, what would she do. She stated, "Initiate CPR." 8) On 2/1/08 at 10:00 a.m., LPN #8 stated, "First check the code book and see if they are a DNR or full code... we have a code book and it is also in their charts." At 1:14 p.m., she was asked if she had a resident who had conflicting information or she could not determine the code status, what would she do. She stated, "I would do CPR... The red tag on the outside of the door means DNR and green means code." 9) On 2/1/08 at 9:50 a.m., LPN #9 stated, "Look at the chart and determine what their code status	F 309			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
NAME OF PROVIDER OR SUPPLIER MORRILTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BROOKRIDGE LANE MORRILTON, AR 72110		
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F 309	Continued From page 23 was. If they were a full code, would start CPR. The name tag on the wall outside the room, if it is red they are no code, if it is green they are a full code. We've got a code status book up there [nurses station] now. That was initiated within the last week." At 1:22 p.m., she was asked if she had a resident who had conflicting information or she could not determine the code status, what would she do. She stated, "I'd do CPR."	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, interview and record review, the facility failed to ensure personal care was provided in a manner to promote good personal hygiene for 1 (Resident #8) and failed to ensure nail care was provided for 1 (Resident #4) of 10 (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10) case mix residents who required assistance with personal hygiene. This failed practice had the potential to affect 74 residents that required assistance with personal hygiene	F 312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 312	<p>Continued From page 24</p> <p>according to a list provided by the Administrator on 2/1/08. The findings are:</p> <p>1. Resident #8 has a diagnoses Paralysis of Bladder and Obesity. The Quarterly Minimum Data Set (MDS) dated 12/21/07 documented the resident was severely impaired in cognitive skills for daily decision making and extensive assistance was needed with personal hygiene.</p> <p>a. A Care Plan updated on 9/25/07 documented, "... Extensive assistance of 1 for bathing ..."</p> <p>b. On 1/30/08 at 9:30 a.m., the resident's right abdominal fold had a flaky, white substance noted with foul odor. Certified Nursing Assistant (CNA) # 6 stated, "Been applying cream to it." The area of redness extends from the right abdominal fold to right hip area. Licensed Practical Nurse (LPN) #1 was asked what was the flaky stuff noted to resident's right abdominal fold area. The LPN stated, "Skin mixed with cream, maybe some sweat, a yellowish creamy substance." The LPN stated to the CNA's, "Don't put any cream to it. I will call the doctor, it may need some Nystatin, it could be yeast."</p> <p>2. Resident #4 had diagnoses of Congestive Heart Failure and Diabetes Mellitus. The Quarterly MDS dated 12/13/08 documented the resident was moderately impaired in cognitive skills for daily decision making and had total dependence on staff for personal hygiene.</p> <p>a. On 1/29/08 at 8:05 a.m., the resident had dirty fingernails to several fingers on each hand.</p> <p>b. On 1/30/08 at 9:50 a.m., the resident had 2 dirty fingernails on each hand.</p>	F 312			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2008
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F 312	Continued From page 25 c. On 1/30/08 at 10:20 a.m., CNA #10 was asked who cleans and trims the resident's fingernails and she stated, "The nurses because she is a diabetic." d. 1/30/08 at 1:10 p.m., the resident had dirty fingernails on each hand to the fingers that were contracted. e. The facility's guidelines entitled Care of Fingernails/Toenails documented, "... Nails can be partially cleaned during bath care. ...Nail care includes daily cleaning..."	F 312		
F 318 SS=E	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a hand roll was placed for 1 (Resident #3) of 1 case mix resident who had contractures and required a hand roll. This failed practice had the potential to affect 10 residents that required a hand roll as documented on a list provided by the Administrator on 2/1/08. The findings are: Resident #3 had a diagnoses of Muscskel Sympt Limb Nec (Musculoskeletal Symptomatic Limb Not Elsewhere Classified) and Alzheimer	F 318		

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 318	Continued From page 26 Disease. The Quarterly Minimum Data Set dated 1/7/08 documented the resident was severely impaired on cognitive skills for daily decision making and had partial loss of voluntary movement of hand including wrist or fingers. a. A Care Plan updated on 10/07 documented, "Resident has partially contracted hands and requires a hand roll in each hand. ...Keep hand roll in place..." b. On 1/29/08 at 2:02 p.m., 4:51 p.m. and 6:07 p.m., the resident's right hand was closed. There was no hand roll present. c. On 1/30/08 at 8:15 a.m., 12:05 p.m. and 2:05 p.m. the resident's right hand was closed. There was no hand roll present. d. On 1/31/08 at 3:20 p.m., Certified Nursing Assistant (CNA) #3 was asked if the resident was supposed to have hand rolls. The CNA stated, "No." The CNA was asked where to find information on which residents required hand rolls and the CNA stated, "Look on the ADL's (Activity of Daily Living) or the nurse reports it to us." The CNA then looked in the ADL book and found the resident's name on a list located in the front of the ADL book that documented the resident was to have hand rolls. The CNA stated, "I was unaware of that." e. On 1/31/08 at 6:24 p.m., CNA #4 was asked if the resident was supposed to have hand rolls. The CNA stated, "Yes, that one hand is contracted up."	F 318			
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident	F 323			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2008
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F 323	Continued From page 27 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: Based on observation and interview, the facility failed to ensure that the environment was free from accident hazards by not identifying and removing chemical hazards, splintered wood bed boards, nails/staples in walls from resident rooms and common areas accessed by residents. This failed practice had the potential to affect 20 cognitively impaired, self mobile residents in the Alzheimer's Unit (300 Hall) and 41 cognitively impaired, self mobile residents that resident on the 100, 200, and 400 Halls as documented on the Census List received on 1/31/08 and 91 residents who had wooden head/footboard beds as stated by the Administrator on 2/4/08. The findings are: 1. Resident #9 had diagnoses of Senile Dementia. The Annual Assessment Minimum Data Set (MDS) dated 11/20/07 documented that the resident was severely impaired in cognitive skills for daily decision making. a. On 1/28/08 at 3:10 p.m., there was an 8 ounce bottle of Aloe Vesta Multipurpose Cleansing Foam sitting on the cabinet next to the front of the television. The label read: "Warning: For external use only. May cause eye irritation. Rinse eyes with water if contact should occur. Consult a physician if irritation persists." The Licensed	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 323	<p>Continued From page 28</p> <p>Practical Nurse (LPN) #7 was asked if it was all right for the cleanser to be out on the cabinet. She stated, "It should be in the drawer."</p> <p>b. On 1/29/08 at 8:10 a.m., the resident's bed headboard had an approximately 6 inch long splintered piece of wood on the outer edge of the headboard.</p> <p>2. Resident #17 had diagnoses of Alzheimer's Disease and Chronic Ischemic Heart Disease. The Quarterly MDS dated 12/11/08 documented the resident was severely impaired in cognitive skills for daily decision making.</p> <p>a. On 1/29/08 at 8:30 p.m., the resident was in the locked Alzheimer's/Dementia unit in the dining/day room sitting in a wheelchair. The resident held a 15 ounce bottle of Derma-Cen instant hand sanitizer clutched next to him. The pump style lid was intact on the bottle. The sanitizer label documented, "Warnings: For external use only. Avoid contact with eyes. In case of eye contact, flush with water for 15 minutes. Discontinue use and see a doctor if irritation occurs. Avoid contact with broken skin." There were 4 other residents seated in the day room. No staff was present in the dining/day room nor in view.</p> <p>b. On 1/29/08 at 8:30 p.m., the door to the Nurse's station was unlocked and opened in the Alzheimer/Dementia unit dining/day room. A 12 ounce bottle of Purell brand Instant hand sanitizer was sitting in full view on the desk. The Purell hand sanitizer was labeled, "Warnings ...for external use only. When using this product do not use in or near the eyes. If contact occurs, rinse</p>	F 323			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 29</p> <p>thoroughly with water....If swallowed, get medical help or contact a Poison Control Center right away." There were 5 residents sitting in the dining/day room and there was no staff in view.</p> <p>c. On 1/29/08 at 8:35 p.m., LPN #3 was told by the surveyor that the resident had hand sanitizer. The hand sanitizer was removed from the resident by the LPN.</p> <p>d. On 1/29/08 at 8:40 p.m., LPN #3 was asked if the door into the nurse's desk was kept locked and she stated, "Yes."</p> <p>e. The Material Safety Data Sheet for the hand sanitizer documented, "...Section 3-Hazards Identification (Potential Health Effects) Possible routes of entry into the body: Eyes Ingestion Inhalation Health Hazards: Can be harmful if swallowed. Ingestion may cause diarrhea, distention, and/or vomiting. Signs and Symptoms of Exposure: If in eyes: Burning, watering, redness. If swallowed: Possible gastrointestinal irritation or disturbance. If vapors are inhaled: Possible giddiness or loss of consciousness. ...Section 4-First Aid Measures If in eyes: Flush with water for 15 minutes. If swallowed: If patient is conscious and alert, dilute by drinking large quantities of water. Allow vomiting to occur, then get medical attention. If inhaled: Remove to fresh air. Always get medical attention when product is swallowed or when symptoms are significant or persist."</p> <p>3. Resident #3 had a diagnoses of Muscskel Sympmt Limb Nec (Musculoskeletal Symptomatic Limb Not Elsewhere Classified) and Alzheimer Disease. The Quarterly MDS dated 1/7/08</p>	F 323		

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2008
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F 323	Continued From page 30 documented the resident was severely impaired in cognitive skills for daily decision making. On 1/30/08 at 9:20 a.m., there was a long nail that measured approximately one inch protruding out of the wall located next to the closet approximately 2 feet up from the floor. 4. Resident #8 had a diagnoses of Secondary Parkinsonism and Convulsions. The quarterly MDS dated 12/21/07 documented the resident was severely impaired in cognitive skills for daily decision making. a. On 1/30/08 at 9:22 a.m., there were two round pieces of wood at the foot of the bed that were broken leaving sharp, splintered edges. b. On 1/30/08 at 9:30 a.m., Licensed Practical Nurse (LPN) #1 stated, "[Resident # 8] could get skin tears" when asked about the two round pieces of wood at the foot of the bed. 5. On 1/31/08 at 9:40 a.m., there was a staple with a sharp edge sticking out of the wall beside room 307.	F 323		
F 329 SS=E	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329		

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	Continued From page 31 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure dose reductions were attempted on 5 (Resident #2, #3, #7, #8 and #10) of 7 (Resident #2, #3, #4, #5, #7, #8 and #10) case mix residents that received anti-psychotic medications, 4 (Resident #2, #3, #4 and #5) of 6 (Resident #1, #2, #3, #4, #5 and #7) case mix residents that received anxiolytic medications, 1 (Resident #2) of 1 case mix resident that received hypnotic medications, 1 (Resident #1) of 4 (Resident #1, #4, #9 and #11) case mix residents that received Proton pump inhibitors, 2 (Resident #9 and #11) of 3 (Resident #1, #9 and #11) case mix residents that received H-2 Antagonists, 1 (Resident #4) of 1 case mix resident that received Reglan, 1 (Resident #2) of 2 (Resident #2 and 3) case mix residents that received Antihistamines and 1 (Resident #4) of 4 (Resident #3, #4, #5 and #7) case mix residents that received Anti-depressants. This failed practice had the potential to affect 40 residents with a Physician's Order for anti-psychotic	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	Continued From page 32 medications, 38 residents with a Physician's Order for anxiolytic medications, 10 residents with Physician's Order for hypnotic medications, 33 residents with Physician's Order for proton pump inhibitors, 21 residents with a Physician's Order for H-2 Antagonist medications, 6 residents with a Physician's Order for Reglan, 11 residents with a Physician's Order for anti-histamine medications, and 58 residents with a Physician's Order for anti-depressants according to lists provided by the Administrator on 2/1/08. The findings are: 1. Resident #2 had diagnoses of Anxiety Disorder, Constipation, Difficulty in Walking, Alzheimer's Dementia with Behavior Disturbance End Stage, Depressive Disorder, and Psychosis. The Quarterly Minimum Data Set (MDS) dated 1/7/08 documented the resident was severely impaired in cognitive skills for daily decision making, with depression, and had a weight loss of 5% or more in last 30 days: or 10% in last 180 days. a. A Physician's Order dated 6/21/07 documented, "Clonazepam 1 mg (milligram) tablet 1 tab (tablet) po (by mouth) BID (twice a day)." b. A Physician's Order dated 10/30/06 documented: "Xanax 0.5 mg tablet 1 tab po Q (every) 6 hr (hours) prn (as needed) severe agitation." c. A Physician's Order dated 10/17/06 documented, "Vistaril 50 mg capsule 1 cap (capsule) po QD (every day) prn agitation." d. A Physician's Order dated 12/21/06 documented, "Lunesta 1 mg tablet 1 tab po at hs	F 329			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	Continued From page 33 (hour of sleep)." e. A Physician's Order dated 11/17/06 documented, "Haldol 5 mg/ml (milliliters) ampul give 5 mg as needed for agitation." f. A Physician's Order dated 11/01/06 documented, "Seroquel 50 mg tablet 1 tab po TID (three times a day)." g. A Consultant Pharmacist Communication dated July 26, 2007 documented, "This resident is receiving Seroquel 50 mg TID to manage behavior, stabilize mood, or treat a psychiatric disorder. Federal guidelines require periodic dose reduction trials in an attempt to minimize or discontinue medications that are unnecessary. Please consider a trial dose reduction to Seroquel 25 mg a.m. and 50 mg BID. If the currently dose maintains functional status and a reduction attempt would likely cause a return or worsening of symptoms or an increase in distressed behaviors please document this in the medical record. ..." The physician response was, "No change." h. A Consultant Pharmacist Communication dated July 26, 2007 documented, "This resident has current orders for Hydroxyzine (Vistaril PRN), a potent anticholinergic agent. Current clinical guidelines indicate that hydroxyzine should be avoided in the elderly particularly when used for anxiety or as a hypnotic. Please evaluate the use of this medication and if this medication maintains functional status and is deemed necessary for this resident, please document to that effect in the space provided below." The physician indicated the answer with an x in the box to "Continue Hydroxyzine. Please address Risk vs Benefit for	F 329			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
NAME OF PROVIDER OR SUPPLIER MORRILTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BROOKRIDGE LANE MORRILTON, AR 72110		
(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 329	<p>Continued From page 34</p> <p>this resident." Risk vs. benefit was not addressed by the physician.</p> <p>i. The Consultant Pharmacist Drug Regimen Review dated 9/21/07 documented, "Remeron, Klonopin, Xanax, Lunesta, Haldol, Seroquel. D/C (discontinue) lunesta next time." No response from the attending physician was noted.</p> <p>j. A Consultant Pharmacist Communication dated December 18, 2007 documented, "This resident is receiving Klonopin 1 mg po BID to manage behavior, stabilize mood, or treat a psychiatric disorder. Federal guidelines require periodic dose reduction trials in an attempt to minimize or discontinue medications that are unnecessary. Please consider a trial dose reduction to Klonopin 0.5 mg po BID. If the current dose maintains functional status and a reduction attempt would likely cause a return or worsening of symptoms or an increase in distressed behaviors please document this in the medical record. ..." The physician responded, "No Change."</p> <p>k. A Consultant Pharmacist Communication dated January 22, 2008 documented, "Patient is on Lunesta 1 mg po q hs for insomnia. Please provide clinical rationale for why patient has continued need and is receiving benefit from this medication. Patient is lowest dose possible without discontinuing the drug. Federal guidelines explicitly ask for clinical rationale to explain continued need and documented benefit. ..." The physician responded, "No change."</p> <p>l. On 1/31/08 at 9:00 p.m., the Director of Nursing (DON) was asked if dosage reductions were attempted on Lunesta, Klonopin, Seroquel, Vistaril, Haldol, Xanax, and if not is there a risk</p>	F 329			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	Continued From page 35 versus benefit documented in the clinical record. The DON stated, "I will check." At 1:20 the DON answered, "No, it is not written down anywhere." m. The Drug Information Handbook for Nursing 2007, 8th Edition, Page #284 documented, "Clonazepam: ... U.S. Brand Names Klonopin ... Pharmacologic Category: Benzodiazepine ... Warnings/Precautions: Use with caution in elderly ... Use with caution in patients receiving other CNS [central nervous system] depressants, or ethanol. Benzodiazepines have been associated with falls and traumatic injury and should be used with extreme caution in patients who are a risk of these events (especially the elderly). Increased Effect/Toxicity: Clonazepam potentiates the CNS depressant effects of narcotic analgesics, barbiturates, phenothiazines, ethanol, antihistamines, ... sedative-hypnotics, and cyclic antidepressants. ... Adverse Reactions: Central Nervous system: ... behavior problems, insomnia, ... agitation, anxiety, ... Gastrointestinal: ... anorexia, ... constipation, ... Elderly: Refer to adult dosing Initiate with low doses and observe closely. ... Geriatric Considerations: Hepatic clearance may be decreased allowing accumulation of active drug. Also, metabolites of clonazepam are renally excreted and with age. Observe for signs of DNS and pulmonary toxicity." n. The Drug Information Handbook for Nursing 2007, 8th Edition, Page #58 documented, "Alprazolam ... U.S. Brand Names ... Xanax ... Pharmacologic Category: Benzodiazepine ... Warnings/Precautions: ... Use with caution in elderly or debilitated patients, ... Causes DNS depression ... which may impair physical and mental capabilities. Benzodiazepines have been	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	Continued From page 36 associated with falls and traumatic injury and should be used with extreme caution in patients who are at risk of these events (especially in the elderly) ... Increased Effect/Toxicity: ... Alprazolam potentiates the CNS depressant effects of narcotic analgesics, ... antihistamines, sedative-hypnotics, ... and cyclic antidepressants. ... Dosing: Adults: Note: Treatment greater than 4 months should be re-evaluated to determine the patient's continued need for the drug. ... Periodic reassessment and consideration of dosage reduction is recommended. ..." o. The Drug Information Handbook for Nursing 2007, 8th Edition, Page #627 documented, "Hydroxyzine: ... U.S. Brand Names: ... Vistaril ... Pharmacologic Category: Antiemetic: Antihistamine. ... Warnings/Precautions: ... Not recommended for use as a sedative or anxiolytic in the elderly. ... Geriatric Considerations; Anticholinergic effects are not well tolerated in the elderly. Hydroxyzine may be useful as a short-term antipruritic, but it is not recommended for use as a sedative or anxiolytic in the elderly. ..." p. The Drug Information Handbook for Nursing 2007, 8th Edition, Page #465 documented, "Eszopiclone ... US. Brand Names: Lunesta ... Pharmacologic Category: Hypnotic Warnings/Precautions: ... Use with caution in patients with depression ... receiving other CNS depressants or psychoactive medications. May impair physical and mental capabilities. ... Adverse Reactions: ... hallucinations ... anxiety, ...confusion, ... depression, ..." q. The Drug Information Handbook for Nursing 2007, 8th Edition, Page #602 documented,	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	Continued From page 37 "Haloperidol ... U.S. Brand Names: Haldol; Haldol Decanoate ... Pharmacologic Category: Antipsychotic agent ... Warnings/Precautions: May be sedating, use with caution in disorders where CNS depression is a feature. ... Adverse Reactions: Central nervous system: Restlessness, anxiety, ... insomnia, ... agitation, ... depression, ... confusion, ... Gastrointestinal: ... anorexia, ... Geriatric Considerations: ... Adverse Reactions, ... Elderly patients have an increased risk of adverse response to side effects or adverse reactions to antipsychotics. ..." r. The Drug Information Handbook for Nursing 2007, 8th Edition, Page #1055 documented, "Quetiapine ... Pharmacologic Category: Antipsychotic Agent, ... Warnings/Precautions: ... May be sedating, use with caution in disorders where CNS depression is a feature. ... Adverse Reactions: Central nervous system: Agitation, ... anxiety, ... Gastrointestinal: ... constipation, ... Dosing: Adults: ... Note: Dose reductions should be attempted periodically to establish lowest effective dose in patients with psychosis or to establish need to continue treating agitated symptoms in demented older adults. ... Elderly: Lowered clearance in elderly patients resulting in higher concentrations. Dosage adjustment may be required. ... Geriatric Considerations: ... Elderly patients have an increased risk of adverse response to side effects or adverse reactions to antipsychotics. ..." 2. Resident #11 had diagnoses of Chronic Airway Obstruction, Congestive Heart Failure, General Osteoarthritis, Tracheostomy Status, and Gastroesophageal Reflux (GERD). The Quarterly MDS dated 12/18/07 documented the resident had modified independence in cognitive skills for	F 329			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	Continued From page 38 daily decision making. a. A Physician's Order dated 4/30/08 documented, "Ranitidine (Zantac) Tabs 150 mg 1 po QD. b. The January 2008 Medication Administration Record (MAR) documented Ranitidine Tabs 150 mg 1 po QD with a start date of 4/30/07. Under "Time Codes" the documentation was 9 a.m. The record was initialed by the nurse that gave the medication on each day through the 30th. c. Correspondence from the Consultant Pharmacist to the resident's attending physician dated 1/22/08 documented, "... This resident has been on Zantac 150 mg po QD. Acute dose therapy of H-2 antagonists for PUD (peptic ulcer disease), gastritis, and duodenitis is usually not indicated for a duration longer than 60 days. Patients who are at high risk for ulcer recurrence may benefit from maintenance doses of H-2 antagonists, Please consider decreasing to a maintenance dose of Zantac 75 mg po QD. ..." The physician response was documented, "No change ... GERD. ..." d. The Drug Information Handbook for Nursing 2007, 8th Edition, Page #1067 documented: "Ranitidine ... Brand Names: Zantac ... Use: ... Short-term and maintenance therapy of duodenal ulcer, gastric ulcer, gastroesophageal reflux, ... Adverse Reactions: ... Neuromuscular and skeletal: Arthralgia, ... myalgia ... Dosing: Adults and Elderly: ... Prevention of Heartburn: ... 75 mg ... 3-60 minutes before eating food or drinking beverages which cause heartburn; maximum: 150 mg in 24 hours; do not use for more than 14 days."	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	Continued From page 39 e. On 1/1/08 at 1:25 p.m. the Director of Nursing (DON) was asked if there was a risk versus benefit statement in the resident's clinical record. The DON stated, "No." The DON was asked if there was documentation in the clinical record that the resident had exhibited symptoms of GERD. The DON stated, "The doctor noted that the resident has excessive sputum and a diagnosis of GERD. Nothing else." 3. Resident # 3 had a diagnoses of Alzheimer Disease, and Vascular Dementia. The Quarterly Minimum Data Set (MDS) dated 1/7/08 documented the resident was severely impaired in cognitive skills for daily decision making. a. A Physician's Order dated 10/6/06 documented, "Stelazine 5mg 1 po at HS dt (due to) Dementia and Xanax 1mg tablet 1 po q 6 hours prn." b. A Consultant Pharmacist Communication dated July 26, 2007 documented, "...consider a trial dose reduction to Stelazine 2.5mg HS. If the current dose maintains functional status and a reduction attempt would likely cause a return or worsening of symptoms or an increase in distressed behaviors please document this in the medical record..." The physician's response documented was "No Change." c. A Consultant Pharmacist Communication dated October 30, 2007 documented, "...consider a trial dose reduction to Xanax 0.5mg po (by mouth) q (every) 6 H (hours) prn (as needed). If the current dose maintains functional status and a reduction attempt would like cause a return or worsening of symptoms or an increase in	F 329			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	Continued From page 40 distressed behaviors please document this in the medical record..." The physician's response documented, "No Change." d. The Physician's Progress Notes dated 6/27/07, 7/25/07, 9/26/07, 10/24/07, 11/28/07, and 12/26/07 documented the resident had no new problems. e. The MAR documented the resident had received Stelazine 5mg 1 po daily at 8:00p.m. since 10/6/06. f. On 1/28/08 at 3:16 p.m., the resident was lying in bed with eyes closed. g. On 1/29/08 at 8:12 a.m., the resident was lying in bed on right side resting with eyes closed. h. On 1/29/08 at 8:30 a.m., the resident was difficult to arouse for meal. i. On 1/29/08 at 9:40 a.m., the resident's eyes remained closed. j. On 1/30/08 at 9:15 a.m., the DON stated "Every four to five days the resident becomes lethargic." k. On 1/30/08 at 2:05 p.m., the resident was in a geri-chair with eyes closed. l. On 1/30/08 at 2:05 p.m., Certified Nursing Assistant (CNA) #1 and CNA # 2 were asked if the resident is always sleepy and hard to wake. The CNA's stated "Yes, [Resident # 3] is lethargic a lot." m. On 1/30/08 at 12:35 p.m., the DON was asked what non pharmacological interventions	F 329			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	<p>Continued From page 41</p> <p>were tried prior to the use of an antipsychotic. The DON stated, "None." The DON was asked why the antipsychotic drug used and the DON stated, "Alzheimer Dementia, I thought Stelazine was an Alzheimer drug." The DON was asked if it had a sedating affect. The DON stated, "Probably could be sedating most drugs give at HS (hour of sleep) are." The DON was asked why was the antipsychotic not reduced. The DON stated, "Other than the doctor saying he didn't want to do it, I don't know. The pharmacist made a recommendation to reduce in July."</p> <p>n. The January 2008 MAR documented the resident received Xanax 1mg 1 po on 1/1, 1/3, 1/5, 1/6, 1/14 twice, 1/18, 1/28 and 1/29 twice.</p> <p>o. There was no documentation in the nurse's notes as to why the medication was administered on 1/3/08 or 1/5/08, 1/18/08 or 1/28/08.</p> <p>p. The Antecedent Behavior Monitoring Log had no documentation for 1/3/08, 1/5/08, 1/6/08, 1/14/08, 1/18/08 or 1/29/08.</p> <p>q. The Drug Information Handbook for Nursing 2007, 8th edition documented Stelazine use for treatment of schizophrenia.</p> <p>r. The Drug Information Handbook for Nursing 2007, 8th edition documented Xanax use as treatment of anxiety disorder, panic disorder with or without agoraphobia, anxiety associated with depression.</p> <p>4. Resident #10 had a diagnoses of Affective Personality. The Quarterly MDS dated 12/4/07 documented the resident was moderately impaired in cognitive skills for daily decision</p>	F 329			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	Continued From page 42 making. a. A Physician's Order dated 11/22/06 documented Risperdal 1 mg tablet 1 tab po at p.m. and Risperdal 0.25mg tablet 1 tab po q am. b. The Consultant Pharmacist Communication forms dated 7/26/07 and 9/21/07 documented... Please consider a trial dose reduction to Risperdal 0.25mg po bid (twice a day). If the current dose maintains functional status and a reduction attempt would liked cause a return or worsening of symptoms or an increase in distressed behaviors please document this in the medical record. The physicians responses dated 7/30/07 and 9/29/07 documented "No change." c. The January 2008 MAR documented the resident received Risperdal 0.5mg at 5 p.m. with a start date of 11/22/06. d. The January 2008 MAR documented the resident received Risperdal 0.25mg at 8 a.m. with a start date of 12/1/06. e. The Monthly Behavior Monitoring Flowsheet from September 2007 to present did not document any behavior symptoms. f. On 1/30/08 at 12:45 p.m. the DON was asked what non-pharmacological interventions were attempted prior to the use of antipsychotics? The DON stated, "I don't know." The DON was asked why is the antipsychotic used? The DON stated "She's an MR (Mental Retardation), Affective Personality is what it says." The DON was asked if that was the diagnosis? The DON stated, "As far as I can tell." The DON was asked what behaviors the resident displayed? The DON	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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(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 329	Continued From page 43 stated, "We have a behavior sheet." The DON was asked why hasn't the antipsychotic been reduced? The DON stated, "It was suggested to reduce by pharmacy consultant in July 26th and September 21st, and doctor wrote no change." The DON was asked have you seen any behaviors? The DON stated, "Get excited, caught up with what's going on." The DON was asked can you redirect her? The DON stated "Yes." g. The Monthly Behavior Monitoring Flowsheet had no behaviors documented for September 2007 through December 2007. The Antecedent Behavior Monitoring Log had no behaviors documented for January 2008. h. The Drug Information Handbook for Nursing 2007, 8th edition documented use for treatment of schizophrenia; treatment of acute mania or mixed episodes associated with bipolar disorder (as monotherapy or in combination with lithium or valproate) 5. Resident # 8 had a diagnoses of Schizophrenia and MR (Mental Retardation). The quarterly MDS dated 12/21/07 documented the resident was severely impaired in cognitive skills for daily decision making and had repetitive verbalizations. a. A Physician's Order dated 11/1/06 documented Seroquel 50mg tablet 1 tab po bid. b. The Consultant Pharmacist Communication form dated October 30, 2007 documented, "...consider a trial dose reduction to Seroquel 25mg po bid. If the current dose maintains functional status and a reduction attempt would likely cause a return or worsening of symptoms or	F 329			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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(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 329	<p>Continued From page 44</p> <p>an increase in distressed behavior please document this in the medical..." The physician's response documented, "This applies no change."</p> <p>c. The January 2008 MAR documented the resident had received Seroquel 50mg tablet 1 tab po bid since 11/01/06.</p> <p>d. On 1/30/08 at 12:09 p.m. the DON was asked what non-pharmacological interventions were tried prior to the use of antipsychotics. The DON stated, "No, I don't know what was tried before that." The DON was asked what is the diagnoses or reason the antipsychotic is being administered. The DON stated, "Organic Brain Syndrome, Seizure Disorder." The DON was asked are those a reason to give an antipsychotic. The DON stated, "I'm not sure." The DON was asked what behaviors does the resident display. The DON stated, "Recently we haven't had any behaviors." The DON was asked has there been a reduction attempt for the antipsychotics. The DON stated, "There hasn't been a reduction, it wasn't what the physician wanted to do." The doctor circled what the pharmacist wrote and he wrote if this applies, wrote no change.... The DON was asked have you read this regulation. The DON stated, "No, I have not read it in the red book."</p> <p>e. The Monthly Behavior Monitoring Flowsheets for September 2007, October 2007, November 2007 and December 2007 had no behaviors documented.</p> <p>f. The Antecedent Behavior Monitoring Log for January 2008 had no behaviors documented.</p> <p>g. The Drug Information Handbook for Nursing</p>	F 329			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	<p>Continued From page 45</p> <p>2007, 8th edition documented use for treatment of schizophrenia, treatment of acute manic episodes associated with bipolar disorder (as monotherapy or in combination with lithium or valproate)</p> <p>6. Resident #7 had diagnoses of Anxiety State, Alzheimer's Disease, Vascular Dementia with Delusions, and Depressive Disorder. The Quarterly MDS dated 12/3/07 documented the resident was moderately impaired in cognitive skills for daily decision making.</p> <p>a. A Physician's Order dated 4/19/07 documented, "Seroquel Tabs 25 mg 1 PO QD [at] 5:00 p.m."</p> <p>b. A Consultant Pharmacist Communication dated 11/26/07 documented the consulting pharmacist made a recommendation to the physician to decrease the Seroquel from 25 mg every p.m. and 50 mg every hour of sleep to Seroquel 25 mg twice a day. The physician's response was "no change." There was no risk versus benefits statement documented.</p> <p>c. Drug Information Handbook for Nursing 2007 page 1055 documented under Warnings/Precautions, "Patients with dementia-related behavioral disorders treated with atypical antipsychotics are at an increased risk of death compared to placebo. It further documented under Dosing: Note: Dose reductions should be attempted periodically to establish lowest effective dose in patients with psychosis or to establish need to continue treating agitated symptoms in demented older adults.</p>	F 329			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
NAME OF PROVIDER OR SUPPLIER MORRILTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BROOKRIDGE LANE MORRILTON, AR 72110		
(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 329	<p>Continued From page 46</p> <p>7. Resident #5 had diagnoses of Dementia with Behavior Disturbances, and Senile Delusions. The Quarterly MDS dated 12/28/07 documented the resident was severely impaired in cognitive skills for daily decision making.</p> <p>a. A Physician's Order dated 9/19/07 documented, "Xanax 0.5 mg tab. 1 tab. PO QD at 3:00 p.m."</p> <p>b. A Consultant Pharmacist Communication dated 1/22/08 documented the consulting pharmacist recommended a dose reduction of Xanax from 0.5 mg to 0.25 mg by mouth at the hour of sleep. The physician documented "no change" with no risk versus benefits statement.</p> <p>c. The Drug Information Handbook for Nursing 2007 documented on page 60 that alprazolam (Xanax) is not intended for management of anxieties and minor distresses associated with everyday lift. Treatment longer than 4 moths should be re-evaluated to determine the patient's need for the drug. Patients who become physically dependent on alprazolam tend to have a difficult time discontinuing it; withdrawal symptoms may be severe. To minimize withdrawal symptoms, taper dosage slowly, do not discontinue abruptly.</p> <p>8. Resident #4 had diagnoses of Congestive Heart Failure, Diabetes Mellitus Type 2, and Esophageal Reflux. The Quarterly MDS dated 12/13/08 documented the resident was moderately impaired in cognitive skills for daily decision making.</p> <p>a. A Physician's Order dated 9/5/06 documented,</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
NAME OF PROVIDER OR SUPPLIER MORRILTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BROOKRIDGE LANE MORRILTON, AR 72110		
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F 329	Continued From page 47 "Nexium caps 50mg 1 PO Q AM." b. The Medication Regimen Review Dated 12/10/07 documented, "Recommendations PPI (Proton Pump Inhibitor) eval/No." c. The Consultant Pharmacist Communication to the attending physician dated 12/18/07 documented, "Manufacturer literature recommends a periodic evaluation be done for PPI's. The resident is taking Nexium 40 mg PO Q AM. Please provide a benefit/risk statement for continued use and documentation purposes. ...Your response ...No change." d. On 1/29/08 the clinical record was reviewed. There was no documentation in the Nurse's Notes of Physician's Progress Notes that the resident had epigastric discomfort or reflux symptoms during the past 3 months to indicate the need for continued proton pump inhibitor therapy. f. The January 2008 MAR documented the resident had received Nexium 40mg daily with a start date of 9/5/06. g. The Drug Information Handbook for Nursing 2007, 8th Edition, page #449 documented under Use, "Oral: Short term (4-8 weeks) treatment of erosive esophagitis; maintaining symptom resolution and healing of erosive esophagitis, treatment of symptomatic gastroesophageal reflux disease (GERD); ...Increased Effect/Toxicity: Esomeprazole and omeprazole may increase the levels of ...substrates, including benzodiazepines metabolized by oxidation (eg, diazepam, midazolam, triazolam)".	F 329			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
NAME OF PROVIDER OR SUPPLIER MORRILTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BROOKRIDGE LANE MORRILTON, AR 72110		
(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 329	<p>Continued From page 48</p> <p>h. The Physician's Order dated 9/05/06 documented, "Reglan 5 mg 1 tab PO AC & HS (before meals and at bedtime)."</p> <p>b. The Consultant Pharmacist Medication Regimen Review record documented on 6/18/07 a recommendation that the Reglan dosage be decreased to 5mg. There was no further documentation by the pharmacist regarding Reglan.</p> <p>c. On 1/29/08 the clinical record was reviewed that included the nurses notes dated from 8/07 to current. There was no documentation in the notes of signs or symptoms to indicate the need for Reglan.</p> <p>d. On 1/29/08 the Physician's progress notes were reviewed and there was no documentation that the resident had epigastric discomfort or complaints that would indicate the rationale to continue Reglan.</p> <p>e. The January 2008 MAR was reviewed and the resident received Reglan daily before meals and at bedtime.</p> <p>f. The Drug Information Handbook for Nursing 2007, 8th Edition, page #810-811 documented, Metoclopramide ... Geriatric Considerations Elderly are more likely to develop tardive dyskinesia syndrome (especially elderly females) reactions than younger adults. Use lowest recommended doses initially. Must consider renal function (estimate creatinine clearance). It is recommended to do involuntary movement assessments on elderly using this medication at high doses and for long-term therapy."</p>	F 329			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2008
NAME OF PROVIDER OR SUPPLIER MORRILTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BROOKRIDGE LANE MORRILTON, AR 72110	
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F 329	Continued From page 49 g. A Physician's Order dated 10/18/06 documented, "Clonazepam (Klonopin) 1 mg 1 tablet PO at HS." b. The Consultant Pharmacist Medication Regimen Review dated 9/21/07 documented a referral to the attending physician for gradual dosage reduction for Klonopin. c. The Consultant Pharmacist Medication Regimen Review dated 10/30/07 documented the attending physician's response to decrease gradual dose reduction for Klonopin, "No." d. The January 2008 MAR documented that the resident received Clonazepam 1 mg po at HS daily. e. on 1/29/07, the clinical record was reviewed. The Nurse's Notes and Behavior Monitoring Log documented no behaviors or anxiety to indicate the need for the the continued Clonazepam without a dosage reduction. f. The Drug Information Handbook for Nursing 2007, 8th Edition, page #284-286 Clonazepam documented, "...Warnings/Precautions Use with caution in elderly debilitated patients,...Geriatric Considerations Hepatic clearance may be decreased allowing accumulation of active drug. Also, metabolites of clonazepam are renally excreted and may accumulate in the elderly as renal function declines with age. Observe for signs of CNS (Central Nervous System) and pulmonary toxicity. ..." g. A Physician's Order dated 3/21/07 documented, "Lexapro 20mg tablet 1 tab PO Q D (day)."	F 329		

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	Continued From page 50 h. The Consultant Pharmacist Medication Regimen Review dated 9/21/07 documented that a referral was sent to the attending physician for dosage reduction. i. The Consultant Pharmacist Medication Regimen Review dated 10/30/07 documented the physician response as, "No." j. On 1/29/07 the clinical record was reviewed that included the physician progress notes, Behavior Monitoring Log, and Nurse's Notes. No behaviors were documented to indicate that the dosage could not be reduced for Lexapro. 11. Resident #9 had diagnoses of Senile Dementia and Chronic Ischemic Heart Disease. The MDS dated 11/20/07 documented the resident was severely impaired in cognitive skills for daily decision making. a. A Consultant Pharmacist Communication dated 7/26/07 documented, "This resident is currently receiving Zantac 150mg (milligrams) BID (twice daily). It is recommended that the patient be re-evaluated after 8 weeks of Anti-Ulcer medication to determine if the dosage could be reduced to a maintenance level (or discontinued altogether). The physician's response was marked "Continue as ordered due to: RISK vs BENEFIT) please brief comment as to why current dosage regimen is medically necessary." b. A Physician's Order dated 11/13/06 documented, "Zantac 150mg one tab PO BID." c. A Medication Regimen Review dated 11/26/07	F 329			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	Continued From page 51 documented, "decrease Zantac/No." d. A Consultant Pharmacist Communication to the attending physician dated 11/26/07 documented, "This resident has been on Zantac 150mg (milligrams) PO (by mouth) BID (twice daily). Acute dose therapy of H-2 antagonists for PUD (peptic ulcer disease), gastritis, and duodenitis is usually not indicated for a duration longer than 60 days. Patients who are at high risk for ulcer recurrence may benefit from maintenance doses of H-2 antagonists. Please consider decreasing to a maintenance dose of Zantac 150 mg PO Q HS." The physician's response was documented, "No change." e. On 1/29/08 the clinical record was reviewed including the monthly physician progress notes. There was no diagnoses documented to indicate the need for Zantac/H2 antagonist for this resident. The monthly notes documented that the resident had no new problems, no complaints, and was stable. f. On 1/29/08 the clinical record nurses notes were reviewed and there were no symptoms or complaints to indicate the need for Zantac. g. The January 2008 MAR documented the resident received Zantac twice a day. h. The Drug Information Handbook for Nursing 2007, 8th Edition, page #1067-1069 documented under Use, "Zantac: Short term and maintenance therapy of duodenal ulcer, gastric ulcer, gastroesophageal reflux, active benign ulcer, erosive esophagitis, and pathological hypersecretory conditions; as part of a multidrug regimen for H. pylori eradication to reduce the risk	F 329			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2008
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F 329	Continued From page 52 of duodenal ulcer recurrence. Zantac 75 OTC (over the counter) Relief of heartburn, acid indigestion, and sour stomach....Geriatric Considerations ...Treatment for PUD (peptic ulcer disease) in elderly is recommended for 12 weeks since their lesions are larger; therefore, take longer to heal...."	F 329		
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a shower stalls and shower chair in the 400 Hall Shower Room was disinfected prior to use for 1 (Resident #18) of 11 (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11)) case mix residents who required assistance with showers and failed to ensure their infection control program tracked/trended infectious processes from one month to the next unless the infections were resolved by not maintaining a complete infection control log. These failed practice had the potential to affect 25 residents that received showers in the 400 Hall shower room and 16 residents that used the shower chair in the 400	F 441		

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
NAME OF PROVIDER OR SUPPLIER MORRILTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BROOKRIDGE LANE MORRILTON, AR 72110		
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F 441	<p>Continued From page 53</p> <p>Hall shower room as documented by the Director of Nursing on 2/1/08 and all 95 residents had the potential to be affected by the current infection control program as identified on the Resident Census and Conditions of Residents form dated 1/29/08. The findings are:</p> <p>1. Resident #18 had diagnoses of Alzheimer's Disease and Cerebrovascular Disease. The Quarterly Minimum Data Set dated 12/28/07 documented the resident was severely impaired in cognitive skills for daily decision making and had total dependence on staff for bathing.</p> <p>a. On 1/30/08 at 10:42 a.m., Certified Nursing Assistant (CNA) #11 wiped bowel movement (BM) from the previous resident from the shower stall floor then picked up a bottle of Dawn Mist Shampoo and Body Bath and poured it onto the shower stall floor. The CNA then took the shower sprayer and rinsed the floor of the shower. There was no disinfectant sprayed onto the shower stall flooring prior to another resident using the shower. The previous resident that used the shower stall had BM while seated on the shower chair in the stall.</p> <p>b. On 1/30/08 at 10:43 CNA #11 poured Dawn Mist Shampoo and Body Bath onto a washcloth and wiped the shower chair seat. The CNA then transferred the resident onto the the shower seat. There was no disinfectant sprayed on the shower chair to properly disinfect the shower chair seat between resident use.</p> <p>c. On 1/30/08 at 10:45 a.m. CNA #11 was asked what the shower and shower chair was cleaned with and she stated, "I couldn't find any disinfectant so I used soap. The body wash in</p>	F 441			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
NAME OF PROVIDER OR SUPPLIER MORRILTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BROOKRIDGE LANE MORRILTON, AR 72110		
(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 441	Continued From page 54 this bottle." The CNA picked up the bottle of Dawn Mist and showed it to the surveyor. The indication for use labeled on the bottle documented, "Use: As a shampoo or body wash." d. On 1/31/08 at 11:00 a.m. the Director of Nursing (DON) was asked who was responsible for cleaning the shower stalls and shower chairs between resident use. The DON stated, "The aides." The DON was then asked who should clean the showers and shower chairs when a resident has a bowel movement during bathing. The DON stated, "The aides using disinfectant. The housekeepers clean daily but between residents it would be the aides." 2. The facility's shower/tub bath policy documented, "...Be sure the tub or shower is clean. (Note: If the tub or shower is not clean, clean it with a disinfectant solution.)..." 3. The Infection Control Logs from July 2007 through December 2007 documented the resident's name, onset date, site, antibiotic and date resolved. 96 of 107 entries did not identify if a culture was obtained, 106 of 107 did not identify if the resident was isolated, 107 of 107 did not identify an organism, 107 of 107 did not identify if the infection was nosocomial. The July 2007 "Infection Control Log" documented: Total number of infections- Skin-2, Urinary Tract Infections-2, Upper Respiratory Infections-13, 0 eye infections and 2 other. There was no documentation of the hall those infections were located on. The August 2007 "Infection Control Log" documented: Total number of infections- Skin-2, Urinary Tract Infections-3, Upper Respiratory Infections-7, eye was blank and	F 441			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
NAME OF PROVIDER OR SUPPLIER MORRILTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BROOKRIDGE LANE MORRILTON, AR 72110		
(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 441	<p>Continued From page 55</p> <p>other- 1. There was no documentation of the hall those infections were located on. The September 2007 "Infection Control Log" documented: Total number of infections- Skin-2, Urinary Tract Infections-5, Upper Respiratory Infections-3, eye was blank and other- 2. There was no documentation of the hall those infections were located on. The October 2007 "Infection Control Log" documented: Total number of infections- Skin-7, Urinary Tract Infections-4, Upper Respiratory Infections-3, eye-1 and other was blank. There was no documentation of the hall those infections were located on. The November 2007 "Infection Control Log" documented: Total number of infections- Skin-3, Urinary Tract Infections-3, Upper Respiratory Infections-9, eye was blank and other-2. There was no documentation of the hall those infections were located on . There was no documentation for the total number of Infections for December 2007 and the January 2008 Infection Control Log could not be provided.</p> <p>4. On 1/31/08 at 1:10 p.m., the Director of Nurses (DON) was asked how infections were monitored. He stated, "We use the infection control log." He was asked how trends or clusters were monitored. He stated, "I guess we or I haven't set up a way to do that." He stated, "A stomach virus had been going around for about 10 days. We have a watch list...It hasn't been in any one area. We are just writing down who has it."</p> <p>5. On 1/31/08 at 1:30 p.m., Licensed Practical Nurse (LPN) #7 was asked how infections were tracked and she stated, "The DON from another facility came last week and told me I needed to put change of conditions and when the physician</p>	F 441			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
NAME OF PROVIDER OR SUPPLIER MORRILTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BROOKRIDGE LANE MORRILTON, AR 72110		
(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 441	<p>Continued From page 56</p> <p>was notified in a note book by month." The LPN was asked for the January 2008 Infection Control Log and she stated, "I haven't ran it yet. In June 2007 the previous DON gave me this [Infection Control Log] and told me to pull up at the end of the month who had been on an antibiotic and what the antibiotic was for....I had never done it before and I was doing it the way I was told." The LPN was asked how clusters were identified and she stated, "I know which hall the residents are on." She was asked if the Infection Control Log identified clusters and she stated, "No probably not." The LPN was asked if the infection control log identified if cultures were completed and she stated, "No." The LPN was asked if she had ever read the federal regulation on infection control and she stated, "I probably have but to remember everything it said, no. It's [infection control log] not labeled by hall, clustered, no organisms are identified or if cultures were done." The LPN was asked how the stomach virus was being monitored and she stated, "We've had a list of who has had it...Nurses should have one (list) at the Nurse's station." A copy of a sticky note was provided which documented 1/21/08-stomach virus. The list contained names and did not identify the hall where the resident resided. On 1/29/08 at 6:45 p.m., the Administrator provided forms dated 1/23 and 1/25 which documented: virus and listed the resident name and hall.</p> <p>6. On 1/31/08 at 1:58 p.m., Certified Nurse Assistant (CNA) # 8 was asked if she knew which residents had the virus. The CNA stated, "I couldn't name them all off. It's like it's going by halls. The nurses tell us who has had it. There is not a list that I know of."</p> <p>7. On 1/31/08 at 2:03 p.m., License Practical</p>	F 441			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
NAME OF PROVIDER OR SUPPLIER MORRILTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BROOKRIDGE LANE MORRILTON, AR 72110		
(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 441	Continued From page 57 Nurse (LPN) #9 was asked if there was anything she could look at to tell her who had the virus. The LPN stated, "Their chart. There is not a list that I know of." 8. On 1/31/08 at 2:10 p.m., LPN #8 stated, "We did have a list...I don't know where the list is. We have a report book it is in."	F 441			
F 445 SS=D	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure soiled linens were handled in a manner to prevent the potential spread of infection for 1(Resident #9) of 11 case mix residents (Resident #1 through #11). This had the potential to affect 25 residents that resided on the 400 Hall in the facility according to a Census List received on 1/31/08 that use linen from this cart. The findings are: Resident #9 had diagnoses of Senile Dementia and Chronic Ischemic Heart Disease. The Annual Assessment Minimum Data Set dated 11/20/07 documented the resident was severely impaired in cognitive skills for daily decision making. a. On 1/29/08 at 2:18 p.m., the resident had an episode of diarrhea and liquid stool was on the pillow underneath the resident's legs. Certified Nursing Assistant (CNA) #12 was not wearing gloves when she picked up the pillow from	F 445			

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

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2008
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F 445	Continued From page 58 underneath the resident's legs and removed the pillowcase using both of her hands. The CNA did not bag the soiled linen before removing it from the resident's room and then carried the pillowcase out of the room in her ungloved hands. The CNA stopped at the clean linen cart on the 400 Hall, lifted the cart cover with her ungloved hand, replaced the cover, and continued on to the dirty linen cart in the hallway and placed the soiled pillowcase in the dirty linen cart. b. On 1/29/08 at 2:20 p.m., CNA #12 was asked if there was bowel movement on the pillowcase and she stated, "Yes." c. The facility's linen policy documented, "Separate soiled and clean linen at all times. Wash hands after handling soiled linen and before handling clean linen. Consider all soiled linen to be potentially infectious. ...In Resident Rooms ... Handle all soiled linen as though it is potentially infectious ...Wash and dry your hands thoroughly after contact with soiled linen. ..."	F 445			
F 498 SS=D	483.75(f) PROFICIENCY OF NURSE AIDES The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a Certified Nursing Assistant (CNA) did not remove or apply a medication patch for 1 (Resident #4) of 1 case mix resident that received a nitroglycerin paste	F 498			

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

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F 498	<p>Continued From page 59</p> <p>patch. This failed practice had the potential to affect 1 resident that had a Physician's Order for a nitroglycerin paste patch as documented by the Director of Nursing (DON) on 1/31/08. The findings are:</p> <ol style="list-style-type: none"> 1. Resident #4 had diagnoses of Congestive Heart Failure, Atrial Fibrillation and Coronary Artery Anomaly. The Quarterly Minimum Data Set dated 12/13/07 documented the resident was moderately impaired in cognitive skills for daily decision making. <ol style="list-style-type: none"> a. A Physician's Order dated 9/5/06 documented, "Nitropaste 1 inch to chest Q (every) 8 hrs (hours). Do B/P (blood pressure) just prior to applying patch." b. On 1/30/08 at 10:00 a.m., Certified Nursing Assistant (CNA) #10 removed the nitropaste patch from the resident's upper chest and placed it on an overbed table in the shower room. Paste was still on the paper patch. c. On 1/30/08 at 10:20 a.m. CNA #10 reapplied the nitropaste patch to the resident's chest and did not check the blood pressure or notify the nurse prior to applying the patch. d. On 1/30/08 at 10:40 a.m. CNA #10 was asked if she replaced the nitro patch and she stated, "That's what the nurse put on there. I just put it back on there." e. On 1/30/08 at 10:55 a.m., the clinical record was reviewed and there were no orders documented that CNA's could administer this medication. There were no blood pressures recorded prior to the time when the CNA 	F 498			

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F 498	<p>Continued From page 60 reapplied the patch.</p> <p>f. On 1/31/08 at 10:00 a.m., CNA #10 was asked if she was trained to give or apply medications to residents and she stated, "No." The CNA was asked if she was trained as a medication assistant and she stated, "No, ma'am." The CNA was asked if the LPN (Licensed Practical Nurse) applied the nitropaste after the resident's shower. The CNA stated, "They just told me to take it off and put it back on." The CNA was asked what should be done before nitropaste is applied. She stated, "I just do it because when I started back last May one of the LPN's told me to do it. The CNA was asked if she remembered which LPN told her and she responded, "No, I'm not sure who."</p> <p>g. On 1/31/08 at 10:07 a.m., LPN #9 was asked who applied nitropaste to resident's skin and she stated, "Nurses, yes licensed." The LPN was then asked if she was notified at shower time to remove the nitropaste patch and replace it afterwards. The LPN stated, "Yes." The LPN was asked if she was notified on the previous day to remove and reapply the patch and she stated, "No."</p> <p>h. On 1/31/08 at 10:30 a.m., LPN #1 was asked who was trained to administer medications. The LPN stated, "Any medications, LPN or RN (Registered Nurse) those that are prescription med. Anything that is a prescription has to be given or applied by an LPN or RN." The LPN was then asked who would remove or apply nitropaste and she stated, "Nurses." The LPN was then asked what should be done before applying nitropaste to a resident. She stated, "Blood pressure has to be checked. CNA's check and</p>	F 498			

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F 498	<p>Continued From page 61 they tell us."</p> <p>i. On 1/31/08 at 11:00 a.m., the DON was asked who can administer medications and he responded, "Licensed nurses." The DON was asked if the facility had Certified Medication Assistants on staff and he stated, "No." The DON was next asked if topical medications are to be administered by licensed staff only and he stated, "Yes." The DON was asked if a resident has a topical patch removed who can reapply this and he stated, "The nurse."</p> <p>j. The facility's Certified Nursing Assistant (CNA) job description received 1/31/08 at 4:45 p.m. was reviewed and medication administration was not included as a job duty.</p> <p>2. The Geriatric Dosage Handbook, 12th Edition, 2007, pages #1110 - 1113 documented, "Nitroglycerin, ...Warnings/Precautions ...use with caution in patients with hypovolemia, ...hypertension and hypotension;...Overdosage/Toxicology Symptoms include hypotension,...Monitoring Parameters Orthostatic blood pressure, blood pressure, heart rate; therapeutic dose may be determined by observing for a decrease in systolic blood pressure by 15 mm (millimeters) Hg (mercury), diastolic reduction of 10 mm Hg or an increase in heart rate of 10 bpm (beats per minute)...Special Geriatric Considerations Caution should be used when using nitrate therapy in older adults due to hypotension; hypotension is enhanced in older adults due to decreased baroreceptor response, decreased venous tone, and often hypovolemia (dehydration) or other hypotensive drugs."</p> <p>3. The Arkansas State Board of Nursing</p>	F 498			

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F 498	Continued From page 62 regulations concerning medication assistants documented, "Act 1423 of the 2005 Arkansas legislative session authorized the use of trained and certified medication assistants in nursing homes in Arkansas. Medication Assistants are required to successfully complete an education program and pass a certification exam before being allowed to function in the role of Medication Assistant Certified (MA-C) in a nursing home." 4. The Arkansas Nurse Practice Act, Subchapter 7--Medication Assistive Persons documented, "...17-87-702 Certificate required. In order to safeguard life and health, any person serving or offering to serve as a medication assistive person shall: (1) Submit evidence that he or she is qualified to so serve; and (2) Be certified as provided in this subchapter. 17-87-703. Designated facilities. (a) The Arkansas State Board of Nursing shall designate the types of facilities that may use medication assistive persons. (b)(1) Designated facilities may not be required to use medication assistive person. (2) However, if a designated facility elects to use medication assistive personnel, the facility shall notify the board in a manner prescribed by the board. 17-87-704. Qualifications. (a) In order to be certified as a medication assistive person, an applicant shall submit to the Arkansas State Board of Nursing written evidence, verified by oath, that the applicant: ...(G) Has successfully completed a medication assistive person training course of not less than one hundred (100) hours approved by the board; and (H) Has successfully passed an examination on subjects the board determines; (2)(A) Has completed a portion of a nursing education program equivalent to the medication assistive person training course; and (B) Passed	F 498			

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F 498	Continued From page 63 the medication aide examination. ..."	F 498			
F 518 SS=E	<p>5. The Arkansas State Board of Nursing Position Statement 97-2 documented, "...Position The Arkansas State Board of Nursing is authorized by ACA 17-87-203 to regulate nurses, and nursing education and practice and to promulgate regulations in order to assure that safe and effective nursing care is provided by nurses to the public. ...A licensed nurse shall not delegate to any unlicensed person the administration of medication. ..."</p> <p>483.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS</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: Based on interview, the facility failed to ensure 3 of 5 Certified Nurse Assistants (CNA) and 1 of 4 License Practical Nurses (LPN) were prepared for an emergency involving a power outage. This failed practice had the potential to affect all 95 residents according to the Resident Census and Conditions of Residents form dated 1/29/08. The findings are:</p> <p>1. On 1/31/08 at 3:11 p.m., CNA #5 was asked which outlets would have power in the event of an emergency and she stated, "That I am going to have to find out."</p> <p>2. On 1/31/08 at 3:30 p.m., CNA #3 was asked</p>	F 518			

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F 518	Continued From page 64 which outlets would have power in the event of an emergency and she stated, "I don't know. No one told me that." 3. On 1/31/08 at 3:40 p.m., LPN #10 was asked which outlets would have power in the event of an emergency and the LPN stated, "I have no idea." She was asked if she had received training on emergency procedures and stated, "I'm sure that when we filled out paper work, that was part of it." 4. On 1/31/08 at 9:50 a.m., CNA # 9 was asked which outlets would have power in the event of an emergency and the CNA stated, "I don't know." 5. On 1/31/08 at 4:00 p.m., the Administrator was asked which outlets would have power in the even of an emergency and she stated, "The red outlets." The administrator was unable to provide documentation of staff training or inservices on emergency readiness and power outages.	F 518			