

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

PRINTED: 04/13/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045147</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/23/2007</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MORRILTON HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 BROOKRIDGE LANE</b> <b>MORRILTON, AR 72110</b>
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F 000	INITIAL COMMENTS	F 000		
F 164 SS=E	<p>Complaint #12417 was substantiated (all or in part) with deficiencies cited at F329.</p> <p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure 4 (Resident #10, #7, #2,</p>	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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>#6,) of 7 case mix residents (#1, #3, #4, #12, #13) were not exposed during incontinent care. This failed practice had the potential to affect 52 residents who were incontinent of bowel and/or bladder as identified on a list provided by the facility on 3/22/07. The findings are:</p> <p>1. Resident #10 had diagnoses of Alzheimer's Disease. A Significant Change Minimum Data Set (MDS) dated 1/10/07 documented the resident had severely impaired cognitive skills for daily decision making, was incontinent bowel and bladder and was totally dependent on staff for personal hygiene.</p> <p>a. On 3/21/07 at 10:00 a.m., Certified Nurse Assistant (CNA) #4 performed pericare. The privacy curtain was pulled around the resident's bed leaving an opening approximate 2 feet nearest the hallway door. The resident's pants were removed. A staff person left the room and re-entered the room with supplies. The resident was naked from the waist down and visible from the hallway when the door was opened.</p> <p>2. Resident #7 had a diagnosis of Alzheimer's Disease. A Quarterly Minimum Data Set dated 2/14/07 documented the resident had severely impaired cognitive skills for daily decision making, was totally dependent on staff for personal hygiene and was incontinent of bowel and bladder.</p> <p>a. On 3/22/07 at 9:39 a.m. CNA#12 and CNA#10 pulled the privacy curtain prior to providing care to the resident. The privacy curtain was too short in width and left an approximately 4 foot opening in front of the door. The resident's pants were removed. The resident had on a disposable adult</p>	F 164			

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F 164	<p>Continued From page 2</p> <p>brief and was checked for incontinence.</p> <p>b. On 3/22/07 at 9:45 a.m., CNA #10 was asked what should have been done to protect the resident's privacy since the curtain was not wide enough. CNA #10 stated, "should pull it toward the door so the resident would not be seen through the door."</p> <p>3. Resident # 2 had diagnoses of Incontinence, Vascular Dementia and Depressive Disorder. A Quarterly Minimum Data Set (MDS) dated 2/27/07 documented the resident had severely impaired cognitive skills for daily decision making, was incontinent of bowel and bladder and was totally dependent on staff for Activities of Daily Living including incontinent care, bathing and hygiene.</p> <p>On 3/21/07 at 12:00 noon, CNAs # 14, # 15 and # 16 were providing incontinent care to the resident. The CNAs failed to pull the privacy curtain around the resident's bed before providing incontinent care. The resident was exposed to anyone passing her door. While the care was being given an employee entered the resident's room three times exposing the resident to any one passing the room.</p> <p>4. Resident # 6 had diagnoses of Foley Catheter and Incontinence of Bowel. A Quarterly MDS dated 12/18/06 documented the resident had modified independence in cognitive skills for daily decision making, was totally dependent on staff for bathing, personal hygiene and toileting.</p> <p>On 3/21/07 at 11:12 a.m., CNA # 5 and # 9 provided incontinent and catheter care to the resident. During the care the privacy curtain that</p>	F 164			

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F 164	Continued From page 3 had been pulled around the bed had approximately a 2 foot gap in the curtain between the bed and the window. The blinds were open exposing the resident from the waist down to anyone that might pass the window.  5. The Perineal Care policy provided by the Registered Nurse Consultant on 3/22/07 documented, "Pull the privacy curtain."  6. Resident #16 had a diagnosis of Alzheimer Disease. The Annual Minimum Data Set (MDS) dated 1/12/07 documented the resident had severely impaired cognitive skills for daily decision-making and required limited assistance of 1 person for personal hygiene.  a. The Care Plan dated 1/12/07 documented, "... Problem/Need ... At risk for decline in [activities of daily living] functions ... Approaches ... Limited assist as need for daily personal hygiene as need. ... "  b. On 3/21/07 at 11:40 a.m. the resident was setting up in a wheel chair in the Day Room seated in a circle with 9 other female residents all facing each other. She had shaving cream across her lower cheeks bi-laterally and across her chin. Certified Nurse Assistant (CNA #3) was shaving her face with the other residents watching.  c. On 3/22/07 at 3/22/07 the Director of Nurses' (DON) stated, "If a female resident needs to be shaved she should be brought into the shower room and provided privacy. She shouldn't be shaved in front of other residents."	F 164			
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS	F 221			

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F 221	<p>Continued From page 4</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure 1 (Resident #2) of 8 (Residents #1, #2, #7, #8, #10, 17, 19, and 26) case mix residents who were restrained was assessed for appropriateness of restraint use and that a physician's order was obtained prior to restraint use. this failed practice had the potential to affect 22 facility residents who were restrained as documented on the Resident Census and Condition form dated 3/20/07. the findings are:</p> <p>Resident # 2 had diagnoses of Osteoporosis and Vascular Dementia. A Quarterly Minimum Data Set dated 2/27/07 documented the resident had severely impaired cognitive skills for daily decision making and was totally dependent on staff for Activities of Daily living.</p> <ol style="list-style-type: none"> <li>On 3/19/07 at 5:22 p.m. and 5:55 p.m., on 3/20/07 at 10:09 a.m. and on 3/22/07 at 10:52 a.m., the resident was in a wheel chair with a lap buddy in place.</li> <li>As of 3/21/07 at 2:10 p.m., there was no documentation in the clinical record of any assessment prior to use of the restraint or that a physician's order was obtained.</li> <li>On 3/22/07 at 10:58 a.m., the Director of Nurses (DON) was shown the resident sitting in the wheel chair with a lap buddy in place. When</li> </ol>	F 221			

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F 221	Continued From page 5 the DON saw the resident she stated, "The resident isn't suppose to be in a lap buddy. Looks like they made a boo boo." She looked at the resident's chart and stated, "The lap buddy was D/C on 3/28/06. Really shouldn't have one now. They put the lap buddy on with out a doctor's order."	F 221			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225			

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F 225	<p>Continued From page 6</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to ensure injuries of unknown origin were fully investigated or reported to a Law Enforcement agency and the Office of Long Term Care as required for 1 (resident # 28) case-mix resident with bruising of unknown origin. There were no other facility residents with bruising of unknown origin. The findings are:</p> <ol style="list-style-type: none"> <li>1. Resident #28 had diagnoses of General Osteoarthritis, Polio Osteopathy and personal History of Fall. A quarterly Minimum Data Set dated 9/14/06 documented modified independence in cognitive skills for daily decision making - some difficulty in new situations only, had no problem with understanding or being understood, required extensive assistance of 1 person for transfer and ambulation.</li> <li>2. An Incident and Accident Report (DMS 7734) submitted to the Office of Long Term Care on 12/19/06 documented, during a shower on 12/6/06, bruising was noted to the resident's chest and breast area. The physician examined the resident the same day and determined the "bruising was the result of improper use/application of the gait belt from care giving staff. He felt the ...bruising was from use of Plavix and ASA [Aspirin].</li> </ol>	F 225			

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F 225	<p>Continued From page 7</p> <p>3. A facility Investigation follow-up form dated 2/7/06 documented "Appears that gait belt or improper lifting caused bruising. [The resident] states 'PM aides lifted me up too hard.'"</p> <p>4. The Summary of Incident on the DMS 7734 documented the resident continued to have bruising and swelling in left chest area. "The bruising was continuing to spread, encompassing the left side and into the left arm. The charge nurse called [physician] on 12/13/06 and made an appointment for the resident to see [physician] in his office on 12/14/06. On 12/14/06 at approximately 5 p.m. The resident returned to the facility with a diagnosis of left Shoulder Fracture with a sling in place encompassing the left arm. [Physician] placed her Plavix and ASA on hold for 1 week."</p> <p>5. The summary documented the resident had not complained of pain "...does have diagnosis of Osteoporosis and always insists on laying on her left side...We have not seen an x-ray report and the physician would only tell us it was a fracture in the shoulder and would not be more specific."</p> <p>6. A DMS-762 "Facility Investigation Report for Resident Abuse..." was submitted to The Office of Long Term Care on 12/19/06. It documented "[the physician] said he could not rule out a pathological fracture but could not say definitively it was a pathological fracture. [Resident] had 2 falls in September (9-4-2006 and 9-14-06) in which she struck her Left side. [The physician] did not feel the shoulder fracture was related to the falls but could not positively rule that out."</p> <p>7. The DMS 762 documented the facility became aware of the fracture on 12/14/06. There was no</p>	F 225			

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F 225	Continued From page 8 documentation the facility interviewed the resident, staff or other witnesses who may have had knowledge of the incident. The report documented". . . I have been unable to positively identify the approximate/exact date of injury or mechanism of injury. The possibility of pathological vs. traumatic unfortunately still remains unclear."  8. The report documented the fracture of unknown origin, identified on 12/14/06 ( Thursday) was not reported to the Office of Long Term Care by 11:00 a.m. the next business day as required. The form documented it was not reported until 12/19/06 ( Tuesday). The Incident and Accident Form documented Law enforcement was not informed. As of 3/23/06 there was no documentation Law enforcement had been notified.	F 225			
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to ensure its Policy and Procedure regarding investigation and reporting of injuries of unknown origin to a Law Enforcement agency and the Office of Long Term Care as required for 1 (resident # 28) case-mix resident with bruising of unknown origin. There were no other facility residents with bruising of unknown origin. The findings are:	F 226			

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F 226	<p>Continued From page 9</p> <p>1. The facility Policy and Procedure for Abuse, Neglect, injuries of unknown source and misappropriation of resident property provided by the Administrator on 3/20/07 documented, "It is the Policy of [the facility]to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown source and misappropriation of resident property and to ensure that all alleged violations of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ("alleged violations"), are reported immediately to the Executive Director of the facility. Such violations will also be reported to State agencies in accordance with existing State law. The facility will investigate each alleged violation thoroughly and report the results of all investigations to the Executive Director or his/her designee, as well as to State agencies as required by State and Federal law. . ."</p> <p>1. Resident #28 had diagnoses of General Osteoarthritis, Polio Osteopathy and personal History of Fall. A quarterly Minimum Data Set dated 9/14/06 documented modified independence in cognitive skills for daily decision making - some difficulty in new situations only, had no problem with understanding or being understood, required extensive assistance of 1 person for transfer and ambulation.</p> <p>2. An Incident and Accident report dated 12/6/07 documented bruising of the left chest area was found during a shower. The physician examined the resident and concluded the bruising was caused by improper transfer with a gait belt and the use of an anti-coagulant medication.</p> <p>3. A Summary of Incident on the DMS 7734</p>	F 226			

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F 226	<p>Continued From page 10</p> <p>documented on 12/13/06 the resident continued to have bruising and swelling in left chest area. "The charge nurse called [physician] on 12/13/06 and made an appointment for the resident to see [physician] in his office on 12/14/06. On 12/14/06 at approximately 5 p.m. The resident returned to the facility with a diagnosis of left Shoulder Fracture with a sling in place encompassing the left arm. [Physician] placed her Plavix and ASA on hold for 1 week."</p> <p>6. A DMS-762 "Facility Investigation Report for Resident Abuse..." was submitted to The Office of Long Term Care on 12/19/06. It documented "[the physician] said he could not rule out a pathological fracture but could not say definitively it was a pathological fracture. [Resident] had 2 falls in September (9-4-2006 and 9-14-06) in which she struck her Left side. [The physician] did not feel the shoulder fracture was related to the falls but could not positively rule that out."</p> <p>7. The DMS 762 documented the facility became aware of the fracture on 12/14/06. There was no documentation the facility interviewed the resident, staff or other witnesses who may have had knowledge of the incident. The report documented". . . I have been unable to positively identify the approximate/exact date of injury or mechanism of injury. The possibility of pathological vs. traumatic unfortunately still remains unclear."</p> <p>8. The report documented the fracture of unknown origin, identified on 12/14/06 ( Thursday) was not reported to the Office of Long Term Care by 11:00 a.m. the next business day as required. The form documented it was not reported until 12/19/06 ( Tuesday). The Incident</p>	F 226			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045147</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/23/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>MORRILTON HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 BROOKRIDGE LANE</b> <b>MORRILTON, AR 72110</b>		
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F 226	Continued From page 11 and Accident Form documented Law enforcement was not informed. As of 3/23/06 there was no documentation Law enforcement had been notified.	F 226			
F 241 SS=D	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, record review and interview the facility failed to ensure privacy while shaving for 1 (Resident #16) of 6 (Residents #2, #4, #6, #12, #16 and #17) female case mix residents with facial hair). This failed practice had the potential to affect 13 facility residents who required assistance with shaving. The findings are:  Resident #16 had a diagnosis of Alzheimer Disease. An Annual Minimum Data Set (MDS) dated 1/12/07 documented the resident had severely impaired cognitive skills for daily decision-making and required limited assistance of 1 person for personal hygiene.  a. A Care Plan dated 1/12/07 documented, "... Problem/Need ... At risk for decline in [activities of daily living] functions ... Approaches ... Limited assist...for daily personal hygiene as need. ... "  b. On 3/21/07 at 11:40 a.m. the resident was sitting up in a wheel chair in the Day Room seated in a circle with 9 other female residents all facing each other. She had shaving cream	F 241			

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F 241	Continued From page 12 across her lower cheeks bi-laterally and across her chin. Certified Nurse Assistant (CNA #3) was shaving her face while the other residents watched.  c. On 3/22/07 at 3/22/07 the Director of Nurses stated, "If a female resident needs to be shaved she should be brought into the shower room and provided privacy. She shouldn't be shaved in front of other residents."	F 241			
F 242 SS=D	483.15(b) SELF-DETERMINATION AND PARTICIPATION  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 (Resident #13) of 4 case-mix residents (resident's #3, # 4, #6 and #12) who required assistance to transfer to bed was allowed to choose when she wanted to go to bed. This failed practice had the potential to affect 76 facility residents who required assistance or were dependent on staff for transfers as documented on the Resident Census And Condition form on 3/20/07. The findings are:  1. Resident # 13 had diagnoses of Asthma and Osteoporosis. A minimum Data set dated 1/16/07 documented the resident ws severely impaired in cognitive skills for daily decision	F 242			

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F 242	<p>Continued From page 13</p> <p>making and required limited one person physical assistance for transfers.</p> <p>2. The Care Plan dated 7/13/06 and last reviewed 2/7/07 documented: "Problem- Resident is at risk for decline in ADL [Activities of Daily Living] function... Approaches: Resident requires extensive assist of 1 for all transfers. Resident requires extensive assistance of 1 for locomotion."</p> <p>3. A Care Plan dated 7/13/06 and last reviewed 2/7/07 documented: Problem- Resident is at risk for falls with significant injury. Under the column titled "Approaches", was documented: "Encourage resident to use call light when needing assistance."</p> <p>4. On 3/19/07 at 6:35 p.m., the resident stated to the DON (Director of Nurses) "I'm ready to lay down". The DON stated, "I'll get somebody."</p> <p>5. On 3/19/07 at 6:39 p.m., the DON was exiting the resident's room. She stated "I'm going to get a C.N.A. [Certified Nurse Assistant]."</p> <p>6. On 3/19/07 at 6:50 p.m., the resident's wheel chair alarm was sounding. License Practical Nurse (LPN) # 2 entered the resident's room in response to the alarm. The surveyor informed the LPN that the resident had stated she wanted to lie down. LPN #2 stated "I've got 2 C.N.A.'s in the dining room feeding and as soon as I get through feeding him [resident #3], I'll lay her down."</p> <p>7. On 3/19/07 at 7:02 p.m. LPN #2 left Resident #3's room and went down the hall gathering trays from rooms.</p>	F 242			

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F 242	Continued From page 14  8. On 3/19/07 at 7:07 p.m., the resident stated to the surveyor "Find me somewhere to lay my head" then propelled herself out of her room.  9. On 3/19/07 at 7:10 p.m., the resident stated to the surveyor, "I've gotta find me somewhere to lay down if I have to lay in the floor".  10. On 3/19/07 at 7:14 p.m., C.N.A. #6 pushed the resident's wheel chair into her room. He stated "I'm getting everything ready to put her to bed, I can be here but there has to be a female in here. She prefers that. He then stated, "Let me get my partner." and left the room.  11. On 3/19/07 at 7:23 p.m. (48 minutes after the resident originally told staff she wanted to lie down), C.N.A. #7 and #8 assisted the resident to bed.  12. On 3/23/07 at 8:20 a.m., the Director of Nurses stated "...put them to bed when they ask, you should not wait 45 minutes".	F 242			
F 258 SS=E	483.15(h)(7) ENVIRONMENT- SOUND LEVELS  The facility must provide for the maintenance of comfortable sound levels.  This REQUIREMENT is not met as evidenced by: Based on observation and interviews the facility failed to ensure comfortable sound levels were maintained when transporting linens down halls or by staff talking loudly on the night shift. This failed practice had the potential to affect all 106 facility residents as documented on the Resident	F 258			

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F 258	Continued From page 15 Census and Condition form dated 3/20/07. the findings are:  1. During the Group Interview on 3/20/07 at 2:30 P.M. 5 cognitively alert residents stated staff on the 11 - 7 shift laughed and talked and turned lights on.  2. During the Group Interview on 3/20/07 at 2:30 P.M. 5 cognitively alert residents stated the linen carts were very loud and disturbing when they were rolled down the hall, especially on the 200 Hall.  3. During initial rounds on 3/19/07 at 12:29 P.M. the wheels on a linen cart that was being rolled down 200 Hall by a staff member was so loud the nurse and the surveyor had to stop conversing because they could not hear each others conversation.  4. On 3/22/07 at 1:58 P.M. a staff member was observed rolling a large gray linen cart down 200 Hall. The noise produced by the cart was very loud and disturbing.	F 258			
F 282 SS=E	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: A. Based on observation, record review and interview, the facility failed to ensure physicians orders were implemented for 2 (Residents # 14	F 282			

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F 282	<p>Continued From page 16</p> <p>and 15) of 3 case mix residents (Residents #12, #14, and #15) case mix residents who had physicians orders for thickened liquids. The failed practice had the potential to affect 8 residents who had a physicians order for thickened liquids according to the facility diet list dated 3/6/07.</p> <p>1. Resident #14 had diagnoses of Cancer of Prostate and Senile Dementia. A Quarterly Assessment dated 2/20/07 documented, the resident was severely impaired in cognitive skills for daily decision making and required one person assist for eating.</p> <p>a. A physician order dated 11/14/07 documented a pureed diet with Honey Thickened liquids.</p> <p>b. On 3/19/07 at 12:55 p.m., the resident was served pureed broccoli, rice, cake honey thickened milk and nectar thickened water, instead of honey thickened water.</p> <p>c. On 3/20/07 at 8:21 a.m., the resident was served honey thickened cranberry juice, milk and was served pudding thickened water. Certified Nursing Assistant (CNA) #1 who was feeding the resident stated, "It was too thick."</p> <p>d. On 3/20/07 at 9:24 a.m., Dietary employee #2 stated she "Used a spoon to scoop up the water served to the resident. She then stated, "It was thicker than honey."</p> <p>2. Resident #15 had diagnoses of Lupus Erythematosus, Osteoporosis and Depressive Disorder. The Minimum Date set dated 2/23/07 documented the resident was severely impaired in cognitive skills for decision making and required one person assist for eating.</p>	F 282			

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F 282	Continued From page 17  a. A Physician's order dated 2/18/07 documented "pureed diet, Feed carefully chokes easily/Nectar thick liquids."  b. On 3/19/07 at 12:59 p.m., the resident was served nectar thickened milk and apple juice and water. The water was thinner than nectar consistency.  c. On 3/19/07 at 6:03 p.m., the resident was served apple sauce, nectar thicken milk, water and tomato juice. The thickener in the water had settled at the bottom of the cup with the unlicensed water on the top. The tomato juice was pudding consistency. The License Practical Nurse was feeding the resident her tomato juice with a spoon.  B. The facility failed to ensure that 1 (Resident #7) of 9 case mix residents (#1, #2, #4, #6, #8, #10, #13,#14, #15) received mighty shakes between meals. This had the potential to affect 33 residents in the facility who received between meal snacks as identified on a list provided by the Dietary Manager on 3/20/07.  1. Resident #7 had a diagnosis of Alzheimer's Disease. A Quarterly Minimum Data Set dated 2/14/07 documented the resident had severely impaired cognitive skills for daily decision making, had short term and long term memory problems, was totally dependent on staff for eating and had a weight loss in the last 30 days .  a. A Dietary Progress Note dated 3/15/07 documented, "...start Mighty Shakes @ [at] 10, 2, & [and] HS [bedtime]."	F 282			

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F 282	<p>Continued From page 18</p> <p>b. The plan of care dated 12/4/06 documented, "Mighty Shake @ [at] 10, 2 &amp; HS".</p> <p>c. On 3/19/07 at 3:00 p.m., 3/21/07 at 2:15 p.m. and 3/22/07 at 10:22 a.m., snacks were passed on the 100 hall where the resident resided. There was no Mighty Shake for Resident #7.</p> <p>d. On 3/22/07 at 10:53 a.m., snacks were passed on the hall. CNA #10, was asked if she had given Resident #7 a snack from the snack cart, stated, "I didn't give her anything from the snack cart. [CNA #11] is doing that." At 11:56 a.m., CNA #11, when asked if there was a snack for Resident #7 on the snack cart, stated, "No."</p> <p>C. The facility failed to implement a plan of care that addressed weight loss for 1 (Resident #13) of 5 (Residents #2 #4 #5 #6 #13) case mix residents with weight loss. This failed practice had the potential to affect 18 facility residents with weight loss as documented on the Resident Census and Condition form dated 3/20/07.</p> <p>2. Resident # 13 had diagnoses of Osteoporosis, Alzheimer's, Asthma and Gastro-duodenal Ulcer. A Quarterly Assessment dated 1/16/07 documented the resident was severely impaired in cognitive skills for daily decision making and required set up help only for eating. The section "K" on a planned weight change program was left blank.</p> <p>a. A Weight Change Audit dated 9/5/06 documented, under recommendations 'Fortified Foods.'</p> <p>b. A care plan dated 3/5/07 documented the resident had 8.7 % weight loss in the last 90 days.</p>	F 282			

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F 282	Continued From page 19 Interventions included fortified foods.  e. On 3/19/07 at 1:00 p.m., the resident was not served any fortified food items. 3. Resident #7 had a diagnosis of Alzheimer's Disease. The Quarterly Minimum Data Set dated 2/14/07 documented the resident had severely impaired cognitive skills for daily decision making, had short term and long term memory problems, was totally dependent on staff for eating and had a weight loss in the last 30 days .  a. A Dietary Progress Note dated 3/15/07 documented, "also start Mighty Shakes @ [at] 10, 2, & [and] HS [bedtime]."  b. There was no physician order for mighty shakes between meals in the clinical record.  c. The plan of care dated 12/4/06 documented, "Mighty Shake @ 10, 2 & HS".  d. On 3/19/07 at 3:00 p.m., 3/21/07 at 2:15 p.m. and 3/22/07 at 10:22 a.m., snacks were passed on the 100 hall. There was no Mighty Shake for Resident #7.  e. On 3/22/07 at 10:53 a.m., snacks were passed on the hall. Certified Nurse Assistant (CNA) #10, when asked if she had given Resident #7 a snack from the snack cart, stated, "I didn't give her anything from the snack cart. [CNA #11] is doing that."  f. On 3/22/07 at 11:56 a.m., CNA #11, when asked if there was a snack for Resident #7 on the snack cart, stated, "No."  4. Resident #10 had a diagnosis of DVT (Deep	F 282			

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F 282	Continued From page 20 Vein Thrombosis). The Significant Change MDS dated 1/10/07 documented the resident had severely impaired cognitive skills for daily decision making and had short term and long term memory loss.  a. A physician's order dated 3/6/07 documented, "DC [discontinue]coumadin 5 mg, change to 7.5 mg continue PT/INR q a.m."  b. There were no PT/INR results in the clinical record 3/11/07 through 3/16/07 and 3/20/07 through 3/23/07.  c. On 3/23/07 at 10:35 a.m., LPN #1 stated, "When I receive the fax from the lab, I fax it to the doctor. Sometimes I got 3 faxes at one time and I faxed all 3 on the same day to the doctor." LPN #1 stated, "I did not call the doctor. I spoke to [DON] about an elevated INR on 3/18." When asked if she had spoken with the doctor about the elevated INR level, LPN #1 stated, "No."  d. Laboratory results for PT/INR dated 3/2/07 were documented as faxed to the physician on 3/6/07; dated 3/3/07 were faxed 3/6/07; dated 3/4/07 documented faxed on 3/6/07; and dated 3/5/07 faxed 3/6/07.	F 282			
F 309 SS=E	483.25 QUALITY OF CARE  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

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F 309	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview the facility failed to ensure indwelling catheters was secured in a manner to prevent possible injury to the urinary meatus and failed to perform catheter care as ordered by the physician for 2 (Resident # 6 and # 20) of three case-mix residents observed receiving catheter care. (Resident # 3, # 6 and # 20) This failed practice has the potential to effect 12 residents in the facility with indwelling catheters as documented on the facility Roster Sample Matrix provided by the facility on 3/19/07. The findings are:</p> <p>1. Resident # 20 had a diagnosis of Urinary Problems secondary to a Trans-Urethral Resection of Prostate. A Minimum Data Set (MDS) dated 2/25/07 documented the resident had a indwelling catheter and was totally dependent on staff for bathing, hygiene and toileting. A Care Plan last updated on 2/10/07 documented "Res (resident) is at risk for complications R/T [related to] indwelling Foley catheter. . . Foley catheter care given per staff per shift. Use soap and water. . ." The resident had a physician's order dated 2/12/07 for, "Foley catheter care with soap and water Q shift."</p> <p>a. On 3/22/07 at 1:58 P.M. (CNA) # 11 and # 13 removed the resident's pants. The catheter was not secured. the tubing was pulled taught and there were streaks of blood on the resident's inner thighs and a small amount of blood coming from the catheter insertion point. CNA # 13 said, "Oh, he should have a catheter strap. I'll have to tell the nurse there is some bleeding."</p> <p>b. On 3/22/07 at 1:58 P.M. catheter care was</p>	F 309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045147</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/23/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>MORRILTON HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 BROOKRIDGE LANE</b> <b>MORRILTON, AR 72110</b>		
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F 309	Continued From page 22 then provided by CNA #11 and #13. They used a peri-wipe, not with soap and water as the physician ordered. During the procedure the catheter was pulled taunt (causing possible trauma to the urinary meatus).  2. Resident # 6 had diagnosis of Urinary Incontinence. A Quarterly MDS dated 12/18/06 documented the resident was totally dependent on staff for bathing, personal hygiene and toileting. The resident had a Care Plan dated 9/10/06 that documented, ". . .Res[ident] is at risk for complications r/t [related to] indwelling Foley catheter. . . Foley catheter care given per staff q [every] shift using soap and water. . ." The resident has a physician's order dated 9/5/06 for a Foley catheter with soap and water every shift, monitor positioning and leg band placement."  a. CNA # 5 and # 9 were observed giving incontinent care and catheter care on 3/21/07 at 11:12 AM. CNA # 5 provided catheter with peri-wipes instead of soap and water. The catheter was not secured.  3. The facility Policy and Procedure for Peri care provided by the facility on 3/22/07 at 6:00 PM documented, "If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter."	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.	F 312			

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F 312	Continued From page 23  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure incontinent care was provided in a manner to promote good personal hygiene for 2 (resident #1 and #12) of 8 (Resident's #1-4, #7, #10, #12 and #13) case-mix residents who were incontinent. This failed practice had the potential to affect 51 resident's in the facility who required assistance with incontinent care as documented on the Resident Census and condition form dated 3/20/07. The facility also failed to ensure that nail care was provided for 1 (Resident #10) of 13 case mix residents (#1 through #13) dependent on staff for nail care. This failed practice had the potential to affect 71 residents in the facility dependent on staff for nail care as identified by the Registered Nurse Consultant on 3/22/07. The findings are:  1. Resident #12 had diagnosis of Presenile Dementia. A Minimum Data Set (MDS) dated 1/3/07 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and totally dependent on 2 person physical assistance for toilet use.  a. On 3/20/07 at 10:25 a.m., Certified Nurse Assistants (CNA) # 9 and # 5 assisted resident to a standing position. The resident was incontinent of urine. CNA # 5 was standing behind the resident. She cleansed the resident's rectal area, then using a clean disposable cloth, she reached between the resident's legs and swiped one time. She did not cleanse the groin area or the buttocks.  2. Resident #1 had diagnoses of End Stage	F 312			

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F 312	<p>Continued From page 24</p> <p>Alzheimer Disease, Coronary Artery Disease, Pressure Ulcers and Lack of Coordination. A MDS dated 2/14/07 documented the resident was severely impaired in cognitive skills for daily decision-making, incontinent of bowel and bladder and was totally dependent on staff for personal hygiene and bathing. The Care Plan "At risk for decline in ADL's (activities of daily living) dated 11/27/07 documented, ". . . [resident] requires total assist for all toileting needs."</p> <p>a. On 3/21/07 at 9:45 a.m. the resident was incontinent of urine. CNAs #1 and #2 provided incontinent care. CNA #1 took a Premium Adult disposable washcloth and in a circular motion cleaned the head of the penis. She then took another disposable washcloth and wiped the inner fold of the residents groin 1 time. She did not wash the shaft of the resident's penis, mons pubis nor the scrotum. The resident was turned onto his left side. CNA #1 rolled the incontinent brief under the resident's left hip then using a clean disposable washcloth swiped 1 time down the rectal area. She did not wash the right buttock. The resident was turned partially on his right so CNA #2 could pull out the incontinent brief and pull the clean incontinent brief under the resident. She fastened the clean incontinent brief. The resident's left buttock was not cleansed.</p> <p>b. On 3/22/07 at 4:00 p.m. the Director of Nurses' (DON) stated, "If a resident is incontinent of bowel or bladder then entire perineal area and buttock should be cleaned."</p> <p>c. The "Perineal Care" policy and procedure provided by the Nurse Consultant on 3/22/07 documented, "The purpose of this procedure are to provide cleanliness and comfort to the resident,</p>	F 312			

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F 312	Continued From page 25 to prevent infections and skin irritation, and to observe the resident's skin condition. . . Steps in the procedure. . . For a male resident: . . Wash perineal area starting with urethra and working outward. . . Wash and rinse urethral area using a circular motion. . .Continue to wash the perineal area including the penis, scrotum and inner thighs. . .Wash and rinse the rectal area thoroughly, including, the area under the scrotum, the anus and the buttocks. . . "	F 312			
F 318 SS=D	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	F 318			

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F 318	<p>Continued From page 26</p> <p>appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure positioning/preventive devices were in place for 1 (Resident #7) of 2 case mix residents (#5) with contractures of the hand. This failed practice had the potential to affect 10 residents in the facility with hand contractures as identified by the Registered Nurse Consultant on 3/22/07. The findings are:</p> <p>Resident #7 had a diagnosis of Alzheimer's Disease. A Quarterly Minimum Data Set dated 2/14/07 documented the resident had severely impaired cognitive skills for daily decision making, had short term and long term memory problems.</p> <p>a. The plan of care dated 3/14/07 documented "Resident has contracted hands and requires a hand roll in each hand" and "Keep hand roll in place in each hand".</p> <p>b. On 3/20/07 at 8:08 a.m. and on 3/21/07 at 11:55 a.m. the resident had no hand rolls in either hand.</p> <p>c. On 3/22/07 at 10:53 a.m., the resident had no hand roll in the right hand.</p> <p>d. On 3/22/07 at 2:25 p.m., Certified Nurse Assistant (CNA) #12 was asked who placed hand rolls in the resident's hands. She stated, "Hand</p>	F 318			

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F 318	Continued From page 27 rolls are put in on 11-7 [shift] when they get her up. After breakfast we check, when we lay her down or turn her we check [the hand rolls]".	F 318			
F 323 SS=E	483.25(h)(1) ACCIDENTS  The facility must ensure that the resident environment remains as free of accident hazards as is possible.  This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure physical restraints were applied correctly for 3 (Resident #10, #19, and #26) of 8 (Residents #1, #2, #7 #8, #10 #17 #19 and #26) case mix residents who were restrained. This failed practice had the potential to affect 23 residents who had a restraint as identified by the Registered Nurse Consultant on 3/22/07. The facility failed to ensure there were no sharp edges on a feeder table in the main dining room. This failed practice had the potential to affect 4 residents who were seated at the feeder table as identified on 3/22/07 by the Registered Nurse Consultant. The facility failed to ensure that a closet containing chemicals was locked on the locked unit. This failed practice had the potential to affect 25 residents who resided on the locked unit as identified on a list provided by the Registered Nurse Consultant on 3/22/07. The findings are:  1. An Application Instruction Sheet for a non-release seat belt, provided by the Director of Nurses on 3/21/07, documented "Bring the strap ends with loops down over the thighs between the seat and the wheelchair skirt guard", "Go around the back post and cross the straps behind the	F 323			

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F 323	Continued From page 28 patient", and "Tighten the straps snugly using the slide buckles."  2. Resident #10 had a diagnosis of Alzheimer's Disease. A Significant Change Minimum Data Set (MDS) dated 1/10/07 documented the resident had severely impaired cognitive skills for daily decision making, had short term and long term memory problems.  a. A physician's order dated 2/10/07 documented, "Apply non-release seat belt while up in wheelchair to prevent unassisted transfers".  b. On 3/20/07 at 2:57 p.m. and at 4:00 p.m., the resident sat in a wheelchair and the non-release seat belt restraint was positioned across the resident's breasts. Both straps were threaded through the back of the wheelchair, not under the side panels, and were loosely connected to the rear kick bars.  c. On 3/21/07 at 8:54 a.m., the resident sat in a wheelchair with one of the non-release seat belt straps was lying on the floor. The restraint remained on the floor until 10:00 a.m.  3. Resident #19 had diagnoses of Parkinsonism, Convulsions and Mental Retardation. A Quarterly MDS dated 12/28/06 documented the resident had severely impaired cognitive skills for daily decision making and had short and long term memory problems.  a. A physician's order dated 7/27/06 documented, "Nonrelease seatbelt due to multiple falls."  b. On 3/22/07 at 10:04 a.m., the resident sat in a	F 323			

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F 323	<p>Continued From page 29</p> <p>wheelchair with a non-release seat belt across the lap. The left strap of the seat belt was not under the side panel of the wheelchair but through to the back between the armrest and back of the wheelchair.</p> <p>4. Resident #26 had diagnoses of Central Cord Syndrome/C1-C4 and Abnormal Posture. A Quarterly MDS dated 1/5/07 documented the resident had modified independent cognitive skills for daily decision making and a long term memory problem.</p> <p>a. A physician's order dated 6/20/06 documented, "Nonrelease seat belt when up in W/C [wheelchair]".</p> <p>b. On 3/21/07 at 2:18 p.m. the resident sat in a wheelchair with a non-release seat belt across the lap. The restraint straps on both sides were inserted through the back of the wheelchair between the arms and the wheelchair back, not beneath the side panels.</p> <p>5. On 3/22/07 at 3:01 p.m. the 300 hall storage room closet door was unlocked. The following hazards were stored on a shelf inside:</p> <p>a. Krylon Rust Tough Enamel Spray. . . "Warning . . . Use with adequate ventilation, Avoid continuous breathing, vapor and spray mist. . . First Aid - In case of eye contact, flush thoroughly with large amount of water for 15 seconds and get medical attention. . . Notice: Reports have associated repeated and prolonged occupational overexposure to solvent with permanent brain and nervous system damage. Warning: this product contains chemicals known to the State of California to cause cancer. . . Do not take internally."</p>	F 323			

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F 323	Continued From page 30  b. Schultz all Purpose Slow Release Plant Food. "Warning . . . This product may be harmful if swallowed and may cause skin and eye irritation. Avoid breathing dust and contact with skin, eyes and clothing. . ."  c. Lysol Disinfectant spray "Warning: Causes eye irritation. Do not spray in eyes, on skin or on clothing. First Aid: In case of eye contact immediately flush eyes thoroughly with water. . . Get medical attention if irritation persists. . ."  d. Force Field Flame Retardant for Fabric and Upholstery.. Fire Guard . . . "Warning. . . Do not spray directly towards the face. In case of eye contact, immediately. . . rinse eyes thoroughly with large quantities of water for at least 15 minutes. Do not mix with bleach, or use of other household products. . ."  e. Citrus Solvent - "Caution: Do Not Take internally, in case of contact with the eyes flush repeatedly with water. . ."  f. Force Field Fabric Protector Spray. . . "Caution: Do not breath vapor. . . may cause light headedness and shortness of breath. Deliberate or direct inhalation may be harmful or fatal. . ."  6. The "Hazards Policy Statement," provided by the Nurse Consultant on 3/22/07 documented, "This facility seeks to ensure that all hazardous chemicals and substances brought onto, stored, or produced on facility property or used by facility employees while performing their jobs are evaluated, and the the hazard information and protective measured of each such chemical and substance are communicated to the facility's	F 323			

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F 323	Continued From page 31 employees. . . 14. All employees must comply with all aspects of the hazard communication program to help protect against incidences of chemical source illnesses, injuries, and accidents. Any violation of this policy could result in disciplinary action. . ."	F 323			
F 328 SS=E	483.25(k) SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure tracheostomy care was provided in a sterile manner for 1 (Resident #11) of 2 case mix residents (#9 and #11) with a tracheostomy. This failed practice had the potential to affect 2 residents in the facility with a tracheostomy as identified by the Registered Nurse Consultant on 3/22/07. The facility failed to ensure the oxygen flow rate was as ordered by the physician for 2 (Resident #6 and #11). This failed practice had the potential to	F 328			

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F 328	<p>Continued From page 32</p> <p>affect 15 residents who had ordered respiratory treatments. The facility also failed to ensure that oxygen tubing was contained in a manner to prevent cross contamination for 4 (Resident #11, #13, #18, and #25) of 6 (#6, #9, #11, #13, #18 and #25) case mix residents with respiratory treatments . The findings are:</p> <p>1. Resident #11 had diagnoses of Chronic Airway Obstruction, Congestive Heart Failure, Sleep Apnea, Dysphagia, Tracheostomy, and Chronic Respiratory Failure. A Quarterly Minimum Data Set dated 1/3/07 documented the resident was independent in cognitive skills for daily decision making and no short term or long term memory problems.</p> <p>a. A physician's order dated 6/26/06 documented, "Trach care q [every] shift and PRN [as needed]".</p> <p>b. The facility's Tracheostomy Care policy documented, "Use sterile technique when suctioning the tracheostomy tube or cleaning the inner cannula.", and "Place...oxygen source over outer cannula."</p> <p>c. On 3/21/07 at 12:27 p.m., Licensed Practical Nurse (LPN) #1 donned sterile gloves and opened a non-sterile container of normal saline with the left hand. Without changing gloves she rinsed the inner tracheostomy cannula. With the same gloved left hand she placed the inner cannula in the outer cannula.</p> <p>2. A physician's order for Resident #11 dated 6/13/06 documented, "Oxygen at 5 L/M [liters per minute] per trach [tracheostomy] comar mask".</p>	F 328			

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F 328	<p>Continued From page 33</p> <p>a. A physician's order dated 9/6/06 documented BiPAP [Bi-level positive airway pressure] on at HS [night] off in AM [morning]</p> <p>b. On 3/20/07 at 9:55 a.m., the oxygen concentrator connected to the bi-pap machine was set on 2.5 liters per minute.</p> <p>c. On 3/20/07 at 3:14 p.m. and on 3/21/07 at 8:05 a.m., the bi-pap tube lay on the bed side table and was not bagged.</p> <p>d. On 3/23/07 at 11:00 a.m., the resident had the bi-pap tubing connected to the tracheostomy. The oxygen concentrator was set at 2.5 liters per minute. LPN#1 stated, "The rate should be set at 5".</p> <p>3. Resident #18 had diagnoses of Angina Pectoris and Congestive Heart Failure. The Significant Change MDS dated 2/5/07 documented the resident was independent in cognitive skills for daily decision making and had oxygen.</p> <p>a. A physician's order dated 1/13/04 documented, "O2 [oxygen] via N/C [nasal cannula] 2 L/M [liters per minute] PRN [as needed] shortness of breath".</p> <p>b. On 3/19/07 at 12:05 p.m. and 2:59 p.m., on 3/21/07 at 4:04 p.m., on 3/22/07 at 8:40 a.m. and 10:04 a.m., the nasal cannula was curled around the top of the E-cylinder stand and not bagged.</p> <p>c. On 3/22/07 at 2:54 p.m., the resident stated she used the oxygen usually at night and anytime she was short of breath.</p>	F 328			

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F 328	<p>Continued From page 34</p> <p>4. Resident #25 had diagnoses of Angina Pectoris and Cerebrovascular Accident. The Quarterly MDS dated 1/19/07 documented the resident had independent cognitive skills for daily decision making and had oxygen therapy.</p> <p>a. A physician's order dated 8/11/06 documented, "O2 via NC [nasal cannula] 2 L/Min [liters per minute] PRN shortness of breath".</p> <p>b. On 3/19/07 at 12:47 p.m., the oxygen nasal cannula was draped over the foot of the bed and between the foot and the mattress, unbagged.</p> <p>c. On 3/22/07 at 8:41 a.m., the nasal cannula was draped over the oxygen concentrator, unbagged. The resident stated she used the oxygen when in bed.</p> <p>5. On 3/23/07 at 10:20 a.m. Licensed Practical Nurse (LPN) #3 stated, "If a resident was using oxygen and removed the oxygen cannula, I would discard it. If the resident wanted to re-use it, I would clean the ends and place it in a plastic bag."</p> <p>6. Resident # 6 has the diagnosis of Asthma and Congestive Heart Failure and had a Quarterly MDS dated 12/18/06 that documented the resident was totally dependent on staff for bathing and hygiene.</p> <p>a. The resident has a physician's order dated dated 9/5/06 documented "O2 (oxygen) @ 2L(Liters)/M (Minute) per NC (nasal canula) PRN (as needed)."</p> <p>b. The resident was observed receiving oxygen at 3L/M per N/C on</p>	F 328			

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F 328	Continued From page 35 3/19/07 at 3:00 p.m., 3/21/07 at 9:00 AM, 3/22/07 at 2:53 p,m.  c. The resident was observed receiving oxygen at 3 1/4 L/M per nasal canula at 5:10 p.m.  d. The Director of Nurses (DON) entered the resident's room on 3/22/07 at 2:58 p.m. The resident was receiving oxygen at 3 L/M per N/C. When the DON was asked what rate the oxygen concentrator was set on she stated, "2.5 L/M." When the DON was asked if the concentrator was set at the proper rate she stated, " No it isn't at the correct rate."  7. Resident # 13 had a diagnosis of Asthma. A Quarterly Assessment dated 1/16/07 documented the resident was severely impaired in cognitive skills for daily decision making and required oxygen therapy.  a. A physician's order dated 9/28/06 documented "O2 [Oxygen] via N/C[Nasal Canula] at 2 L/M [Liters per Minute] to maintain PO[Pulse Ox] of greater than 95 %."  c. On 3/19/07 at 6:39 p.m., the O2 was not in use. The tubing was dated 3/19/07 and was rolled up around the portable O2 tank unbagged.  d. On 3/20/07 at 7:40 a.m., resident was sitting in her wheel chair in the dining room. The O2 tubing was wrapped around the portable O2 tank on the back of the wheel chair. It was not bagged. At 1:05 p.m., the resident was sitting in the dining room with the O2 on. The tubing was dated 3/19/07.	F 328			
F 329 SS=G	483.25(l) UNNECESSARY DRUGS	F 329			

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F 329	<p>Continued From page 36</p> <p>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.</p> <p>Based on a comprehensive assessment of a 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.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #12417, substantiated all or in part with these findings.</p> <p>Based on interview and record review the facility failed to ensure 2 (#10 and #22) of 4 (Residents #3, #6, #10 and #22) case mix residents who required anti-coagulation therapy were assessed and monitored for potential for hemorrhage by failure to contact the physician in a timely manner regarding laboratory tests and failure to consistently assess skin condition for signs of bleeding. This failed practice resulted in actual</p>	F 329			

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F 329	Continued From page 37 harm for Resident #22 and had the potential to affect 13 residents with physician ordered coumadin as identified on a list provided by the Director of Nurses on 3/23/07. The findings are:  1. Resident #22 had diagnoses of Deep Vein Thrombosis, Chronic Venous Insufficiency, Iron Deficiency Anemia and Morbid Obesity. A Minimum Data Set dated 2/20/07 documented the resident as independent in cognitive skills for daily decision making, and was totally dependent on staff for bed mobility, transfer locomotion, dressing, toileting and personal hygiene.  a. The resident was admitted to the facility on 2/12/07. A Hospital Discharge Summary documented the resident was admitted to the hospital hospital on 2/7/07. "History: This is a 71 year old morbidly obese white female who fell several times at home... She presented to the hospital emergency room where she had been 3 to 4 days prior...She was admitted with frequent falls, generalized weakness, and a left rib contusion. Hospital Course: ...She was found to be quite anemic and subsequently has been determined to have Iron Deficiency Anemia. Stool Guaiac was negative...She developed some superficial phlebitis of the left lower extremity and started on Coumadin and Keflex. She is to be transferred to the nursing home today on the fifth hospital day. I will follow her there. Her prognosis is dismal.  b. The Laboratory Report dated 2/11/07 documented: PTT( Prothrombin time) result 28.1, Protime result 10.1 and INR [International Normalized Ratio] result 1.00. The Lab Report dated 2/12/07 documented INR result of 1.24. c. Lab Tests online website dated 4/5/07	F 329			

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F 329	Continued From page 38 documented "The test result for PT depends on the method used, with results measured in seconds and compared to the average value in healthy people. Most laboratories report PT results that have been adjusted to the International Normalized Ratio (INR). Patients on anti-coagulant drugs should have an INR of 2.0 to 3.0 for basic " blood-thinning " needs. For some patients who have a high risk of clot formation, the INR needs to be higher - about 2.5 to 3.5. Your doctor will use the INR to adjust your drug to get the PT into the range that is right for you. A prolonged, or increased, prothrombin time means that your blood is taking too long to form a clot. If you are not taking anti-coagulant drugs and your PT is prolonged, additional testing may be necessary to determine the cause. d. The Heart Health i village total health website dated 4/5/07 documented "A Prothrombin time of 10 to 20 seconds is considered normal, indicating normal blood clotting... A healthy person would have an INR of 1.0. A higher INR/PT indicates that it takes blood longer to clot, while a lower number indicates that blood clots more quickly... Although each person ' s case is different, abnormal or high INR readings may cause a physician to adjust the dosage or dose-schedule of warfarin. For instance, an INR between 3.5 and 5 may result in a recommendation to skip a dose of warfarin or reduction of the maintenance dose. At higher elevations, patients may be advised to skip warfarin and be given vitamin K. Vitamin K is an essential part of the coagulation cascade. Its administration has been shown to reverse the effect of excess anticoagulation faster than suspending warfarin alone. An INR greater than 20 should generally be treated aggressively to reduce the risk of hemorrhage".	F 329			

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F 329	<p>Continued From page 39</p> <p>e. The Physician's Order dated 2/12/06 documented "Warfarin Sodium 5 mg (milligrams) tablet 1 PO (by mouth) QD (every day)." There was no documentation the physician ordered laboratory tests for monitoring INR levels at therapeutic levels.</p> <p>f. Physician's Order's dated 2/12/07 documented: Celebrex 200 mg capsule 1 cap PO QD. The Drug Reference Hand Book 12th Edition documented "Celebrex- Non steroidal Anti-inflammatory. [US Boxed Warning] NSAIDS (Nonsteroidal Anti-inflammatory Drugs) may increase risk of gastrointestinal irritation, ulceration, bleeding and perforation...Use with caution with concurrent therapy with anticoagulants..."</p> <p>g. A laboratory report dated 2/16/07 documented hemoglobin was 10.5 L [low]. Normal range 11.6 to 15.8 Gram/dL and Hematocrit 32.7 L [low] Normal range documented as 36.0 to 48.0%.</p> <p>h. Nurses Notes dated 3/1/07 7 to 3 documented "Bleeding noted from fold under left arm. Cleansed area with Normal Saline. applied Zinc Oxide."</p> <p>i. There was no further documentation the resident was monitored or assessed for signs or symptoms of bleeding.</p> <p>j. Nurses Notes dated 3/6/07 at 11:00 a.m. documented "Discharged to home."</p> <p>k. An Emergency Department Record dated 3/6/07 at 5:50 p.m., obtained from the hospital, documented "Family wanted her brought here due to upper right leg/hip pain. Patient with large</p>	F 329			

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F 329	<p>Continued From page 40</p> <p>bruise on left arm along with numerous other small bruises...Skin tears over abdomen. Bruise on Right thigh covered with Tegaderm..."</p> <p>l. An Emergency Department Record dated 3/6/07 at 6:50 p.m. documented "Family concerned about her pale color and the bruise on left shoulder...21.42 [9:42 p.m..lab called critical values, PT unable to be read, out of critical range, INR unable to be read due to critical PT."</p> <p>m. A Consultation Report completed by a physician at the hospital documented "Elevated INR and anemia...Laboratory studies obtained include complete blood count showing hemoglobin of 4.4...prothrombin time more than 180...Assessment and Plan..."female with anemia secondary to bleed form elevated INR. No evidence of Gastrointestinal bleed so far. Agree with transfusion of fresh frozen plasma...Elevated INR. Stop Coumadin, fresh frozen plasma given vitamin K given. Will monitor..."</p> <p>n. The Doctor's Order Sheet dated 3/6/07 documented "Admit to [hospital] ...Diagnosis-Anemia...Infuse 3 units PRBC'S [Packed Red Blood Cells]."</p> <p>o. On 3/22/07 at 10:45 a.m., LPN (License Practical Nurse) #4 stated, "She (therapist) called me in there (resident's room), she said she was bleeding and there was blood in the bed. The sheets were blood streaked, approximately a 2 foot by 2 foot area. I did not notify the Dr., the next nurse said she was going to do it."</p> <p>p. On 3/22/07 at 3:45 p.m., LPN #4 provided a hand written statement which documented "On 3/1/07 at approximately 2:55 p.m., I was asked to</p>	F 329			

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F 329	<p>Continued From page 41</p> <p>come into R's (Resident's) room by P.T. ( Physical Therapy). P.T. pointed out to me that R had bleeding coming from under a fold in the abd[omen].(abdomen) area under left arm. Upon inspection, this Nurse observed a red area under ABD. fold under left arm that appeared to be bleeding. I called the Dr. to see what he wanted me to do and was told to continue previous order. I failed to write out a T.O ( Telephone Order). I did pass on in report to continue order."</p> <p>q. On 3/22/07 at 11:50 a.m. CNA #4 stated, It (blood) was enough you could see it. Under her fold (abdominal), they were putting a ABD pad there...it was just like when you shave someone and you cut them, it was just a little bit...There were Nurses there and they looked.</p> <p>r. On 3/22/07 at 3:05 p.m., CNA # 5 stated, I saw some (blood) on her gown one time, just a little,approximately the size of a nickel...</p> <p>s. On 3/22/07 at 3:40 p.m., CNA #17 stated, she had some bruises on the back part of her thigh about the size of a baseball. "I can't remember if it was both or just one leg. She had some bleeding under the ABD. fold, just a little, kind of smears."</p> <p>t. On 3/22/07 at 4:00 p.m., CNA #7 stated "When we rolled her over, one of the gauze fell out and it had a streak of blood about 2 to 3 inches in length and 1/4 to 1/2 inch wide."</p> <p>u. On 3/22/07 at 4:07 p.m., LPN #2 stated "I think there was a small spot of blood, 2 to 3 centimeter area under the left arm pit. There was some redness under the Abd fold. She would sweat real bad under there."</p>	F 329			

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F 329	Continued From page 42  v. On 3/22/07 at 9:05 a. m., the DON was asked, what was the standard of practice for someone who is taking warfarin. She stated "Sometimes we have to call the Dr. If she had been on it for awhile and had been stable, I would probably ask for it (Pt/INR) in a month. If I didn't know how long she had been on it, I would have them call and find out. I would have to see if there were any request for lab draw. He (Physician) didn't order any lab... There was no documentation staff contacted the Physician to request an order for lab and no documentation any staff had contacted the Physician in regards to stability of PT/ INR. [US Boxed Warning] NSAIDS (Nonsteroidal Anti-inflammatory Drugs)."  2. Resident #10 had a diagnosis of Deep Vein Thrombosis. A Significant Change MDS dated 1/10/07 documented the resident had severely impaired cognitive skills for daily decision making and had short term and long term memory loss.  a. A physician's order dated 2/28/07 documented "Coumadin 5 mg [milligrams] po [orally] q [every] 5 [5:00] p.m." and "Protime [PT] q a.m. - call results to me daily."  b. PT's and INR's were completed on 3/1/07 through 3/5/07 with the highest level: PT of 13.4 and INR of 1.34.  c. A physician's order dated 3/6/07 documented, "DC coumadin 5 mg, change to 7.5 mg continue PT/INR q a.m."  d. PT and INR's were completed on 3/8/07 through 3/10/07 with the highest levels: PT of 25.4 and INR of 2.5. There were no laboratory	F 329			

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F 329	<p>Continued From page 43</p> <p>reports that documented daily PT/INR's were done as ordered between 3/11/07 through 3/16/07.</p> <p>e. PT and INR's were completed 3/17/07 (levels 26.4 and 2.6), 3/18/07 (31.1 and 3.1).</p> <p>f. On 3/19/07 the PT /INR levels were documented as 38.1 and 3.8 respectively. The laboratory report for the PT/INR documented "For most conditions, low intensity and anticoagulant INR of 2 - 3 is recommended. A print date/Time was documented as 3/19/07 6:15:21 p.m. A handwritten note documented "faxed 3/19/07". There was no documentation the physician was verbally notified of the elevated INR.</p> <p>g. On 3/23/07 a note on the MAR documented, "hold today, 4 mg tomorrow, 5 mg Sun. Alternate 4 and 5. Check PT next Friday."</p> <p>h. On 3/23/07 at 10:35 a.m., LPN #1 stated, "When I receive the fax from the lab, I fax it to the doctor. Sometimes I got 3 faxes at one time and I faxed all 3 on the same day to the doctor." LPN #1 stated, "I did not call the doctor. I spoke to [DON] about an elevated INR on 3/18." When asked if she had spoken with the doctor about the elevated INR level, LPN #1 stated, "No."</p> <p>i. On 3/23/07 at 12:20 a.m. the DON stated, "The lab comes to stick and if they can't, they leave and don't tell a nurse." When asked what the physician had based the new order of 3/23/07 on, the DON stated, "I guess the doctor based the new orders today on the last INR (3/19/07)."</p> <p>j. On 3/23/07 at 1:50 p.m. the Registered Nurse Consultant stated, "the doctor ordered change</p>	F 329			

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F 329	Continued From page 44 today was from the results of the PT/INR done 3/19."	F 329			
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE  The facility must store, prepare, distribute, and serve food under sanitary conditions.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility to ensure food stored in the freezer area was sealed to prevent the potential for freezer burn and the ice machine were freeze of debris. These failed practice had the potential to affect 95 residents who received their meal trays from the kitchen according to the Resident Census And Conations of the Residents form dated 3/19/07 The findings are:  1. On 3/19/07 at 11:20 a.m., the following observations made were:  a. A box of chicken cubes on the shelf in the walk in freezer was not sealed.  b. A box of french bread sticks on the shelf in the walk in freezer was not sealed.  c. Two boxes of hamburger patties on the shelf in the freezer were not sealed.  2. The ice machine located in the kitchen had pinkish matter on the panel where the ice drops into the collection chamber.	F 371			

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F 371	Continued From page 45 a. The ice machine located by the door to the kitchen had wet blackish and pinkish matter on the right corner of the panel where ice drops into the collection chamber.  b. The ice scoop holder on the right side of the machine contained water and the bottom of it had corroded rusty matter on it. Dietary employee # 1 stated, "That was rusty."	F 371		
F 372 SS=E	483.35(i)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure garbage was contained in dumpsters that were covered and the doors to the dumpsters were closed. This failed practice had the potential to affect all 104 residents in the facility as identified by the Residents Census and Conditions of Residents form dated 3/19/07. The findings are:  1. On 3/19/07 at 11:45 a.m., the ground in front of the two dumpsters had had forks, spoons, straws, plates, gloves, incontinent briefs, cups and cigarette butts. There were dark food liquids and small brown particles on the ground in front of dumpster that had a foul odor. Behind the dumpsters were loose cups, straws, and foul smelling, whitish woody substance and whitish/grayish matter on the ground.  2. On 3/19/07 at 11:47 a.m., Dietary employee #1 stated, "The heap of trash in front of the dumpster	F 372		

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F 372	Continued From page 46 look like poop and stink."	F 372		
F 441 SS=E	483.65(a) INFECTION CONTROL  The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure resident care items were handled in a manner to prevent possible cross contamination for 4 (Residents #1, #4, #6 and #7) of 8 (Residents #1, #2, #4, #6, #7, #8, #9, and #12). This failed practice had the potential to affect 51 facility residents who were incontinent of bladder and 50 facility residents who were incontinent of bowel ass documented on the Resident Census and Condition form dated 3/20/07. The findings are:  1. Resident #7 had diagnoses of Alzheimer's Disease Dematiacious Fungi Inf (infection) and Lack of Coordination. The quarterly Minimum Data Set, dated 2/14/07 documented that the resident had severely impaired cognitive skills for daily decision making, required total assistance for all Activities or Daily Living and incontinent of bowel and bladder.	F 441		

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F 441	<p>Continued From page 47</p> <p>a. On 3/22/07 at 9:30 a.m., a plastic bag with pre-moistened wipes was placed on the foot of the residents bed by Certified Nurse Assistant (CNA) #10 and CNA#12 who then checked the resident for incontinence. The resident was not incontinent and the wipes were not used. CNA#10 removed the plastic bag of Premoistened wipes from the foot of the bed and placed it on top of the soiled linen cart in the hallway. CNA#12 stated, "No, those are clean. We'll need them." CNA #10 removed the bag from the top of the soiled linen cart for resident use.</p> <p>2. Resident #1 had a diagnosis of End Stage Alzheimer Disease, Coronary Artery Disease, Pressure Ulcers and Lack of Coordination. A Medicare 30 day Minimum Data Set (MDS) dated 2/14/07 documented the resident was severely impaired in cognitive skills for daily decision-making, incontinent of bowel and bladder and totally dependent on staff for personal hygiene and bathing.</p> <p>a. On 3/21/07 at 9:45 a.m. the resident was incontinent of urine. After incontinent care was completed CNA #2 adjusted the pillow under the resident's head and pulled up the side rail on the resident's right side without removing the soiled gloves used during incontinent care. CNA #2 placed and adjusted the resident's top sheet over the resident and again straightened the pillow without removing the soiled gloves used during incontinent care.</p> <p>3. The Policy on Perineal Care provided by the Nurse Consultant on 3/22/07 documented, ". . . Steps in the Procedure . . . Remove gloves and discard into designated container. Wash and dry</p>	F 441			

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F 441	<p>Continued From page 48</p> <p>your hands thoroughly. . . Reposition the bed covers. Make the resident comfortable.</p> <p>4. Resident #4 had diagnoses of Chr (Chronic) Airway obstruct (Obstruction), Dysphagia and CVA (Cardiovascular Accident). The quarterly MDS documented that the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance with Activities of Daily Living and was incontinent of bowel and bladder.</p> <p>a. On 3/21/07 at 10:30 A.M., while providing incontinent care for the resident, CNA # 5 allowed her name tag to touch the resident's leg and the open soiled brief. She then put the name tag down the front of her shirt. During the incontinent care CNA # 9 handled a tube of barrier cream with soiled gloves. She then laid the contaminated tube of barrier cream on the over bed table. After the incontinent care CNA # 9 placed the contaminated tube of barrier cream in her pocket.</p> <p>5. Resident #6 had diagnoses of CHF (Congestive Heart Failure), Asthma, Rheumatoid Arthritis and Obesity. The quarterly MDS dated 12/26/07 documented that the resident had independent cognitive skills for daily decision making, required total assistance for Activities of Daily Living, was continent of bladder and incontinent of bowel and had an indwelling foley catheter.</p> <p>a. On 3/21/07 at 11:12 a.m. incontinent care was provided by CNA # 5 and #9 to Resident #6. During the incontinent care CNA # 9 removed the tube of contaminated barrier cream she had removed from the Resident # 4's room and</p>	F 441			

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F 441	Continued From page 49 placed it on the over bed table in Resident's room. During the care CNA # 9 removed her gloves and went to the clean linen cart to get a sheet without washing her hands.  6. On 3/22/07 at 2:16 p.m. a pre-moistened wipe box that was almost full sat upside down on the top of the soiled linen container on 100 hall. At 2:25 p.m. CNA #12 stated, "Those are not supposed to be there." CNA #12 removed the pre-moistened wipe box from the lid of the soiled linen container, held it to her uniform, carried it down the hall and placed it on the clean linen cart.	F 441			