

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

PRINTED: 08/02/2005
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 C 07/19/2005
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 000	INITIAL COMMENTS Complaint #10395, unsubstantiated.	F 000		
F 309 SS=D	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. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure a leg band was in place for 1 (Residents #4) of 5 case mix residents (Resident #2, 4, 5, 7 and 8) who had a Foley catheter. This failed practice had the potential to affect 7 resident who had a Foley catheter according to the Resident Census and Conditions of Resident form dated 7/12/05. The findings are: Resident # 4 had a diagnoses of Hypertension and Status Post Hip Fracture. The Significant Minimum Data Set dated 4/28/05 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistants with all Activities of Daily Living, was incontinent of bowel and had a Foley catheter. a. A physician order dated 5/10/02 documented, "Change Foley Catheter (catheter) monthly and	F 309		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 PRN (as needed) with #16 with 5 cc (cubic centimeter) balloon." b. The facility's policy and procedure "Catheter Care, Urinary" documented, "15. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. [Note: Catheter tubing should be strapped to the resident's inner thigh]." c. On 7/12/05 at 8:30 a.m., 4:05 p.m. and 7/13/05 at 3:40 p.m., the resident's catheter tubing was not secured by a leg band.	F 309		
F 314 SS=D	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a current physician order was available for treatment of pressure ulcers for 1 (Resident # 4) of 4 (Resident # 4, # 9, # 16 and # 18) case mix residents who had pressure ulcers. This failed practice had the potential to affect 5 resident who had pressure ulcers according to the Director of Nursing on 7/14/05. The findings are:	F 314		

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F 314	<p>Continued From page 2</p> <p>Resident #4 had diagnoses of Myocardial Infarction and Transient Ischemic Accident. The Significant Minimum Data Set dated 4/20/05 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistants with all Activities of Daily Living, was incontinent of bowel and had no pressure ulcers.</p> <p>a. A physician order dated 6/23/05 documented, "Do treatments as follows QD (every day) X (times) 14 D (days) 1. Rt (right) hip Apply Panafil to wound base cover [with] Fibracol & (and) foam dressing 2. Coccyx Panafil to wound base then pack lightly [with] Silver Alginate pad & foam dressing X 7 D then DC (discontinue) Silver Alginate & use Fibracol X 7 D 3. Lt (left) hip apply Panafil to wound base then Fibracol and foam dressing 4. Apply Xenederm to outer edge of coccyx & wound qd X 14 D."</p> <p>b. The facility's "Weekly Skin Report" dated 7/06/05 documented Stage III decubitus on left hip, Stage II decubitus on the Coccyx and a Stage II decubitus on the right hip.</p> <p>c. On 7/12/05 at 1:35 p.m., there was a dressing on the right hip and on the coccyx.</p> <p>d. On 7/12/05 at 4:05 p.m., there was a dressing on the left hip.</p> <p>e. The facility's "Treatment" record date July 2005 documented the right hip, left hip and coccyx treatment ended on 7/7/05.</p> <p>f. On 7/13/05 at 10:00 a.m., the License Practical Nurse (LPN) Supervisor was asked if there was a current physician order for wound treatment on</p>	F 314			

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F 314	Continued From page 3 Resident #4 and she stated, "I'm writing an order right now." The LPN Supervisor was asked what treatment was being used since 7/7/05 and she stated, "What was previously ordered."	F 314			
F 323 SS=E	483.25(h)(1) QUALITY OF CARE 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, the facility failed to ensure the environment was free of accident hazards by ensuring medications were not left on the floor, wood edging around the central nurses work area was in good repair, and mesh material with sharp edges was not protruding from the wall. This failed practice had the potential to affect all 108 residents. The findings are: 1. On 7/13/05 at 9:50 a.m., the wood edging around the desk top at the central nurse work area, approximately 4 feet up from floor and 4 inches in width, had sharp and splintered areas at the corners and along the bottom edge. 2. On 7/13/05 at 4:25 p.m., the wall located between the bathroom and Bed A of Resident Room 414 had approximately a 2 inch hole in the corner of the sheetrock approximately 3 1/2 feet from the floor and 2 inches in length that had metal mesh exposed with sharp edges. 3. On 7/14/05 at 7:40 a.m., LPN (Licensed Practical Nurse) #3 dropped a Cozaar 50	F 323			

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F 323	Continued From page 4 milligram tablet on the top of the medication cart. The LPN then went to waste the tablet and dropped it on the hall floor in front of Resident Room 112. The LPN did not notice the tablet on the floor and went to move her cart back up the hall and the surveyor stopped the LPN for her to pick the tablet up before moving on.	F 323			
F 328 SS=E	483.25(k) QUALITY OF CARE 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; Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure oxygen rates were correct for 3 (Resident # 4, # 14 and # 19) case mix residents, filters on concentrator were clean and lint free for 3 (Resident 15, # 16, and # 4) case mix, "No Smoking" sign is posted on	F 328			

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F 328	Continued From page 5 resident's room doors for 4 (Resident # 4, # 15, # 16, and # 19) case mix resident and oxygen tubing was changed every 7 days for 1 (Resident # 14) of 7 case mix residents (Resident #4, and 14-19) who received oxygen therapy. This failed practice had the potential affect 10 residents with oxygen therapy. The findings are: 1. The facility's policy and procedure, "Oxygen Therapy" documented, "13. Post "Oxygen in Use - No Smoking" signs on the door in view of visitors and reinforce to the resident. 2. Resident #4 had a diagnosis of Congestive Heart Failure. The Significant Minimum Data Set (MDS) dated 4/20/05 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for all Activities of Daily Living and required oxygen therapy. a. A physician order dated 4/9/05 documented, "O2 (oxygen) at 1.5 L (liters)/Min (per minute) N/C (nasal canula) Cont. (continuous)." b. On 7/11/05 at 10:12 a.m., the oxygen rate was set at 2 L/M. c. On 7/11/05 at 3:15 p.m. and 7/12/05 at 8:30 a.m., 10:45 a.m. and 4:05 p.m., the oxygen concentrator filter on the left side was covered in white lint and there was no "Oxygen in Use -No Smoking" sign posted on the door of the resident's room. 3. Resident #19 had a diagnosis of Chronic Obstructive Pulmonary Disease. The Quarterly MDS dated 4/21/05 documented the resident was severely impaired in cognitive skills for daily	F 328			

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F 328	<p>Continued From page 6</p> <p>decision making and required oxygen therapy.</p> <p>a. A physician order dated 12/20/04 documented, "O2 @ (at) 2L/Min via NC Cont. (continuous)."</p> <p>b. On 7/13/05 at 2:00 p.m., 7/14/05 at 8:30 a.m., 10:45 a.m., and 1:30 p.m., the resident oxygen concentrator flow rate was 1 1/2 L/M and there was no "Oxygen in Use -No Smoking" sign posted on the door of the resident's room.</p> <p>4. Resident #15 had diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension and Cerebrovascular Accident. The Quarterly MDS dated 6/20/05 documented the resident was severely impaired in cognitive skills for daily decision making and did not require oxygen therapy.</p> <p>a. A physician order dated 7/4/05 documented Oxygen at 2 liters per minute via NC to keep Pulse Ox (oxygen) above 92%.</p> <p>b. On 7/14/05 at 10:00 a.m. and at 12:30 p.m., the filter on the concentrator had scattered clumps of white, fluffy particles on the exterior surface and scattered white clumps of fluffy materials on the interior surface. Fine, light particles released from filters with movement. There was no "Oxygen in Use - No Smoking" sign posted on the resident's door.</p> <p>5. Resident #16 had diagnoses of Cerebral Embolism with Infarct, Right Lower Lobe Pneumonia and Insulin-Dependent Diabetes Mellitus. The Significant Change MDS dated 6/23/05 documented the resident had was severely impaired in cognitive skills for daily decision making and required oxygen therapy.</p>	F 328		

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F 328	Continued From page 7 a. A physician order dated 6/17/05 documented Oxygen at 4 liters per minute via NC. b. On 7/14/05 at 8:30 a.m., 9:45 p.m. and 12:35 p.m., the filter on the concentrator had scattered clumps of white, fluffy particles on the exterior surface and scattered white clumps of fluffy materials on the interior surface. Fine, light particles released from filters with movement. There was no "Oxygen in Use - No Smoking" sign posted on the resident's door. 6. Resident #14 had diagnoses of Chronic Obstructive Pulmonary Disease, Congestive Heart Failure and Chronic Airway Obstruction. The Annual MDS dated 3/3/05 documented the resident was independent in cognitive skills for daily decision making, and received tracheostomy care and oxygen therapy. a. A physician order dated 12/7/01 documented, "May administer oxygen per self as needed at 3.5 liters via trach (tracheostomy) collar. Licensed staff to assist as needed." b. On 7/11/05 at 11:10 a.m., 7/13/05 at 2:25 p.m. and 7/14/05 at 8:32 a.m. and 2:04 p.m., the resident's oxygen concentrator was set at 4 liters per minute when read at eye level. c. On 7/14/05 at 2:10 p.m., Licensed Practical Nurse (LPN) #3 stated the resident moves his oxygen setting up after the nurses go in and sets it at "2 liters" per minute. The LPN went to the room and the setting was on 2 liters per minute. The top of the ball was on 1.5 and the bottom of the ball was on 2. The LPN stated, "It is on 2 liters per minute."	F 328			

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F 328	Continued From page 8 d. On 7/14/05 at 2:55 p.m., the Director of Nurses (DON) stated the LPN was to be at eye level, squat down, get at eye level and the middle of the ball goes on the line to read the setting on the oxygen concentrator. When a demonstration was given as to how the LPN was standing to read the setting, the DON stated, "No, they (LPN) are to get at eye level." e. The Oxygen Therapy Policy documented, "Change the cannula/mask every seven days, or more frequently as indicated." f. On 7/14/05 at 8:32 a.m.. the resident's tracheostomy collar tubing was dated 7/3/05.	F 328		
F 371 SS=F	483.35(h)(2) DIETARY SERVICES 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 failed to ensure food was stored properly, cold food was maintained at 41 degrees Fahrenheit (F) or below and food and clean dishes were handled properly to prevent potential cross contamination. This failed practice had potential to affect 103 residents who received their meal trays from the kitchen according to the Residents Census and Conditions of Residents form dated 7/12/05. The findings are: 1. On 7/11/05 at 10:15 a.m., the following observations made were:	F 371		

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F 371	Continued From page 9 a. A can opener located on the food preparation counter facing the storage room had whitish food substance around the blade. b. A box of raw chicken stored on the bottom shelf in the walk-in refrigerator was not covered. There was an uncovered box of sausage stored beside the box that contained raw chicken. c. Cheese slices stored on the shelf in the walk-in refrigerator were not covered. d. A box of breaded cod fish stored on the shelf in the walk-in freezer was not covered exposing it to freezer burn. e. A box of beef patties stored on the shelf in the walk-in freezer was not covered exposing it to cross contamination. f. A box that contained raw fish was torn on the side and opened in the middle. This box was stored on the shelf in the freezer and had another box that contained fish stored directly on top which caused a direct cross contamination to the fish in the bottom box. g. A box of chicken stored on the shelf in the freezer was not covered. f. A torn bag of potato wedges was stored in a box that contained zucchini. There were loose potatoes from the torn bag inside the vegetable box. g. A bag of coca mix dated 10/14/04 stored on the top shelf in the storage room was not covered.	F 371			

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F 371	Continued From page 10 h. A box of pearl potatoes dated 6/14/05 kept on the counter by the stove was not covered. i. Two bags of hamburger buns and two bags that contained bread slices on the bread counter were not covered exposing them to cross contamination. j. A clear plastic container attached on the right side of the ice machine where the ice scoop was kept had water standing in it. There were pieces of grayish substance floating on the water. k. Dietary Employee #1 scraped left over food off of breakfast plates. The employee then picked up the water hose and sprayed the plates before placing them in the dish racks. Without washing her hands, she stacked up clean dishes. l. On 7/11/05 at 12:32 p.m., the temperature of the potato salad, when tested by the Dietary Employee #2 on the counter registered 52 degrees F. m. On 7/11/05 at 5:00 p.m., Dietary Employee #3 had gloves on both hands and opened the door to the walk-in refrigerator. The employee brought out two containers of yogurt, picked up a container of peanut butter from the storage room placed it on the counter, picked up bread bag from the bread counter placed it on the food preparation counter and without washing her hands, she opened the bread bag and took out slices of bread, then picked up a knife and started spreading peanut butter on the bread to be served to the resident who asked for peanut butter sandwich.	F 371			
F 514	483.75(l)(1) ADMINISTRATION	F 514			

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F 514 SS=E	Continued From page 11 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain accurate and complete clinical records for 1 of 1 case-mix resident (Resident # 23) and had the potential to affect 3 residents who were admitted in the past 30 days according to a Detail Admission/Discharge List report dated 7/11/05. The findings are: Resident #23 had an admission dated of 7/1/05. a. The Doctors Orders and Progress Notes dated 7/1/05 documented the following medications: 1) Novolin 70/30 units every morning at 7 a.m. and every 7 p.m., 2) Zolof 50 milligrams (mg) twice a day (bid), 3) Sinemet 25/100 2 pills morning & 2 pills in evening, 4) Micro K 16 mEq (milliequivalent) every other day, 5) Calan 240 mg take 1/2 (120 mg) every morning, 6) Synthroid 0.1 mg every morning, 7) Lasix 40 mg every morning,	F 514			

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F 514	Continued From page 12 8) Depakote ER (extended release) 500 mg one every night, 9) Clonazepam 0.5 mg one every night, 10) Remeron 15 mg one every night, and 11) Novolin R sliding scale. b. On 7/14/05 at 8:42 a.m., LPN (Licensed Practical Nurse) #1 administered: 1) Darvocet N 100, 2) Novolin 70/30, 3) Zolof 50 mg, 4) Sinemet 25/100 SA 2 tablets, 5) Micro K 8 mEq 2 capsules, 6) Xanax 1 mg, 7) Verapamil 120 mg SA, 8) ASA 325 mg, 9) Synthroid 0.1 mg, and 10) Lasix 40 mg. c. On 7/14/04 at 10:40 a.m., LPN #2 provided a July 2005 Physician Order sheet that had not been signed by the physician that documented: 1) Sinemet CR 25/100 tab bid (twice a day),	F 514			

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

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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 C 07/19/2005
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 514	Continued From page 13 2) Micro K 16 mEq po bid, 3) Calan SR 240 mg po every morning, 4) Lasix 40 mg po every day, 5) ASA 81 mg po every day, 6) Synthroid 0.1 mg every day, 7) Zolof 100 mg bid, 8) Xanax 1 mg every morning, and 9) Novolin 70/30 30 units at 7 a.m. c. On 7/14/05 at 12:02 p.m., LPN #2 stated that there was a telephone order dated 7/1/05 that documented to "continue previous orders as were home." d. On 7/14/05 at 12:10 p.m., LPN #2 provided the list from home which documented: 1) Xanax 1 tablet (anxiety), 2) Zolof 50 mg every am, 3) Micro K 16 mg every other day, 4) Aspirin 325 mg (every am), 5) Calan (verapamil) 1/2 tablet every am (120 mg) (heart/bp (blood pressure) pill), 6) Synthroid 0.1 mg (every am), 7) Lasix 40 mg (every am),	F 514			

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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 514	Continued From page 14 8) Sinemet 25/100 - 2 pills 2 x's a day (take 2 am then 2 p.m.) (for tremors), and 9) Insulin NPH 70/30- 30 units 8:00 a.m..... & 5:00 p.m. only 15 units. d. The July 2005 Medication Administratio Record (MAR) did not match any of the 3 list of medications. The MAR documented: 1) Novolin R Sliding Scale, 2) Novolin 30 U SQ at 7:00 a.m. 70/30 insulin, 3) Novolin 15 U SQ at 5:00 p.m. 70/30 insulin, 4) Zoloft 50 mg BID, 5) Sinemet CR 25/100 tab BID, 6) Micro K 16 Meq QOD in a.m., Remeron 15 mg QD at hs, 7) Depakote 500 mg Qhs, 8) Clonazepam 0.5 mg Qhs, 9) Xanax 1 mg Q a.m., 10) Calan SR 240 mg Q a.m. take 1/2 tab, 11) Lasix 40 mg po Q day, 12) ASA 325 mg QD, and 13) Synthroid 0.1 mg QD	F 514			