

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

PRINTED: 09/25/2007  
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>09/08/2007</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>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 312 SS=E	<p>Complaint #12857 was substantiated, all or in part, with deficiencies cited at F312 and F314.</p> <p>483.25(a)(3) ACTIVITIES OF DAILY LIVING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure urine and feces were removed from all areas of the resident's skin during incontinent care for 7 ( Resident #1, #2, #3, #4, #5, #6, and #7) of 7 case mix residents who required assistance with incontinent care. This failed practice had the potential to affect 52 residents that were incontinent as identified by the Administrator on 9/8/07. The findings are:</p> <p>1. Resident #5 had diagnoses of Mental Retardation, Monoplegia, Convulsions, Abnormal Posture and Spinal Cord Injury. The Minimum Data Set (MDS) dated 6/29/07 documented the resident had modified independence in cognitive skills for daily decision making and was incontinent of bowel and bladder.</p> <p>On 9/7/07 at 12:00 p.m., CNA #3 provided incontinent care after an episode of urinary incontinence. The CNA sprayed a washcloth with periwash, wiped both groin areas and applied an incontinent brief. The CNA was asked why she had not washed the remaining areas of the resident's skin that had come in contact with the</p>	F 312		

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.

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

PRINTED: 09/25/2007  
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>09/08/2007</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>		
(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 312	<p>Continued From page 1</p> <p>urine soaked incontinent brief. The CNA stated, "I just got nervous." The perineal area and buttocks were not cleansed.</p> <p>2. Resident #2 had diagnoses of Alzheimer Disease, Lack of Coordination and Musculoskeletal Symptoms The MDS dated 7/30/07 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive assistance with personal hygiene and was incontinent of bowel and bladder.</p> <p>a. The Care Plan dated 1/12/07 documented, "Cleanse perineal area with soap and water following urination."</p> <p>b. On 9/7/07 at 11:37 a.m., CNA #1 provided incontinent care after an episode of urinary incontinence. The penis, inner thighs and the anterior portion of the scrotum were not cleansed</p> <p>3. Resident #3 had diagnoses of Schizophrenia and Alzheimer Disease. The MDS dated 6/19/07 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive assistance with personal hygiene and was frequently incontinent of bladder and incontinent of bowel .</p> <p>On 9/07/07 at 2:10 p.m., CNA #1 provided incontinent care after an episode of urinary incontinence. The resident's shirt and pants were wet with urine. The CNA did not wash the perineal area or the inner thighs.</p> <p>4. Resident #6 had diagnoses of Dementia and Difficulty Walking. The MDS dated 7/12/07 documented the resident was severely impaired</p>	F 312			

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

PRINTED: 09/25/2007  
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>09/08/2007</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>		
(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 312	<p>Continued From page 2</p> <p>in cognitive skills for daily decision making and was usually continent of bowel and bladder.</p> <p>a. The Care Plan dated 4/13/07 documented, "...Cleanse the perineal area with soap and water following each urination..."</p> <p>b. On 9/07/07 at 1:33 p.m., Licensed Practical Nurse (LPN) #1 assisted the resident to the bath room and onto the commode. CNA #1 entered the room to assist with care. The resident's underwear had a smear of bowel movement (BM). The LPN stated the underwear was not wet. The CNA assisted the resident to a standing position, cleansed the rectal area and flushed the commode. The vaginal area was not cleansed.</p> <p>5. Resident #7 had diagnoses of Alzheimer Disease, Difficulty Walking and Alcohol Persist Dementia. The MDS dated 8/8/07 documented the resident was severely impaired in cognitive skills for daily decision making and required total dependence with toilet use and personal hygiene.</p> <p>On 9/07/07 at 2:25 p.m., CNA #2 provided incontinent care after an episode of urinary incontinence. The CNA did not wash the buttocks or the inner thighs.</p> <p>6. Resident #1 had diagnoses of Alzheimer's Disease, Anxiety, Hypertensive Heart Disease, Blindness, Incontinence, Depression and Dementia with Delusions. The MDS dated 5/28/07 documented that the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance of one person for toilet use, required limited</p>	F 312			

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>09/08/2007</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>		
(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 312	<p>Continued From page 3</p> <p>assistance of one person for personal hygiene and was incontinent of bowel and bladder.</p> <p>On 9/7/07 at 2:30 p.m., CNA #1 assisted the resident from the wheelchair to the bed to provide incontinent care after an episode of urinary incontinence. The incontinent brief was saturated with urine and the pressure relieving cushion in the wheelchair had pooled urine on it. The gluteal folds were cleansed. The perineal area, inner thighs and buttocks were not cleansed.</p> <p>7. Resident #4 had diagnoses of Alzheimer's Disease and Chronic Cystitis. The Quarterly MDS dated 8/16/07 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive assistance for personal hygiene and was incontinent of bowel and bladder.</p> <p>On 9/7/07 at 1:30 p.m., CNA #2 provided incontinent care after an episode of urinary incontinence. The incontinent brief was saturated with urine. The buttocks were not cleansed.</p> <p>8. The Policy and Procedure entitled, "Perineal Care" documented, "...The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition... Steps in the procedure....for a FEMALE resident: wet washcloth and apply soap or a cleansing agent...Wash perineal area, wiping from front to back...Separate labia and wash area downward from front to back...continue to wash the perineum moving from inside outward to and including the thighs, alternating from side to side, and using downward strokes...Do not reuse the same washcloth or water to clean the urethra</p>	F 312			

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

PRINTED: 09/25/2007  
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>09/08/2007</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>		
(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 312	Continued From page 4 or labia...Rinse perineum thoroughly in the same direction, using fresh water and a clean washcloth...wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not use the same washcloth or water to clean the labia...MALE resident: wet washcloth and apply soap or skin cleaning agent...Wash perineal area starting with urethra and working outward...retract the foreskin of the uncircumcised male...wash and rinse urethral area using a circular motion...continue to wash the perineal area including the penis, scrotum, the anus, and the buttocks."	F 312			
F 314 SS=E	483.25(c) PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure resident's skin was kept clean and dry and residents were repositioned every 2 hours to prevent the development of pressure sores or to promote the healing of pressure sores for 5 ( Resident #1, #2, #3, #6 and #7 ) of 7 (Resident #1, #2, #3, #4, #5, #6 and #7) case mix residents that were incontinent of urine, at risk for developing a pressure sore or had an existing pressure sore. This failed practice had the potential to affect 65	F 314			

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

PRINTED: 09/25/2007  
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>09/08/2007</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>	
(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 314	Continued From page 5 residents at risk for pressure ulcers as identified by the Administrator on 9/8/07. The findings are:  1. Resident #1 had diagnoses of Alzheimer's Disease, Anxiety, Hypertensive Heart Disease, Blindness, Incontinence, Depression and Dementia with Delusions. The Minimum Data Set (MDS) dated 5/28/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance of one person for toilet use, required limited assistance of one person for personal hygiene and was incontinent of bowel and bladder.  a. The Care Plan updated 6/20/07 documented, "At risk for complications r/t (related to) incont. (incontinence) ... toileted q 2 hr's (hours) and PRN (as needed) by staff."  b. The Weekly Skin Report dated 9/7/07 documented, "... In-House Stage 2 . . L buttock 0.3 x 0.3 . . treatment Santyl . . date identified: 8-10-07."  c. On 9/7/07 at 10:00 a.m., the resident was in a wheelchair. The resident remained in the wheelchair, without being toileted, until 2:30 p.m. At 2:30 p.m., Certified Nursing Assistant (CNA) #1 assisted the resident from the wheelchair to the bed. The incontinent brief was saturated with urine and the time written on the brief was 10:00 a.m. The pressure relieving cushion in the wheelchair was noted to have pooled urine on it. Incontinent care was provided. The perineal area, inner thighs and buttocks were not cleansed. The CNA stated, "She's a heavy wetter. I asked her earlier if she needed to go and she said no. She waits, I think, till just before we	F 314		

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

PRINTED: 09/25/2007  
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>09/08/2007</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>		
(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 314	<p>Continued From page 6</p> <p>put her to bed and saves it up and then goes. She knows she has to lay down after lunch for an hour to give her bottom a rest."</p> <p>2. Resident #2 had diagnoses of Alzheimer Disease, Lack of Coordination and Musculoskeletal Symptoms The MDS dated 7/30/07 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive assistance with transfer and personal hygiene and was incontinent of bowel and bladder.</p> <p>a. The Care Plan dated 1/12/07 documented, "At risk for skin breakdown d/t (do to) number of risk factors ... Cleanse perineal area with soap and water following each urination/bowel movement ..."</p> <p>b. The Pressure Ulcer Healing Record dated 8/6/07 documented a stage I decubitus on the left trochanter that was resolved on 8/10/07.</p> <p>c. Nurses Notes dated 8/9/07 documented a stage I decubitus on the scrotum.</p> <p>d. On 9/7/07 at 11:37 a.m., CNA #1 provided incontinent care on Resident # 2, the CNA failed to clean the front of the scrotum, the penis, the front of the perineal area and the inner thighs.</p> <p>3. Resident #3 had diagnoses of Schizophrenia and Alzheimer Disease. The MDS dated 6/19/07 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistance with transfers and extensive assistance with personal hygiene and was frequently incontinent of bladder and bowel .</p>	F 314			

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>09/08/2007</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>	
(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 314	Continued From page 7  a. A Physician's Order dated 9/21/06 documented, "non releasable seatbelt when up in w/c (wheelchair), check q (every) 30 minutes and release q 2 hours x 10 min (minutes) for exercises, toileting, or amb (ambulation)."  b. The Care Plan dated 3/29/07 documented, "Monitor Resident q 30 mins when up in wc and using nonrelease seatbelt. Release seatbelt q 2 hours for 10 mins and reposition resident."  c. On 9/07/07 at 9:35 a.m., the resident was sitting up in a wheelchair with a non releasable seat belt applied. The resident was in the locked unit and continuously monitored by a surveyor. The resident remained in the wheelchair, without being toileted, for 4 hours and 35 minutes. At 2:10 p.m., Licensed Practical Nurse (LPN) # 1 took the resident to the bathroom and CNA #1 entered the room to assist with care. The resident's clothing and the pressure relieving device in the wheelchair were saturated with urine and the resident had a foul urine odor. The CNA removed the incontinent brief and provided incontinent care. The perineal area and inner thighs were not washed. The incontinent brief had been marked with a date/time of 9/07/07 and 6:50 a.m. The CNA stated she had changed the resident around 8 a.m. When the time on the incontinent brief was brought to the CNA's attention, the CNA stated, "Well, I guess I didn't." During the care, the CNA stated the resident had a tiny open area on the coccyx. The LPN said he/she would notify treatment nurse.  d. On 9/7/07 at 4:50 p.m., the treatment nurse stated she had checked the resident, found a pin-point open area on the coccyx area and had	F 314		

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

PRINTED: 09/25/2007  
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>09/08/2007</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>	
(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 314	Continued From page 8 obtained a order for xenaderm until healed.  4. Resident #6 had diagnoses of Dementia and Difficulty Walking. The MDS dated 7/12/07 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive assistance with transfers and was usually continent of bowel and bladder.  a. The Care Plan dated 4/13/07 documented, "At risk for skin break down ... Cleanse the perineal area with soap and water following each urination."  b. A Physician's Order dated 6/29/07 documented, "Non releasable seatbelt when up in w/c, check q 30 minutes and release q 2 hours for ROM (range of motion)."  c. On 9/07/07 at 9:35 a.m., the resident was sitting up in a wheelchair with a non releasable seat belt applied. The resident was in the locked unit and continuously monitored by a surveyor. The resident remained in the wheelchair, without being toileted, for 3 hours and 58 minutes. At 1:33 p.m., LPN #1 took the resident to the bath room. CNA #1 entered the room and provided incontinent care. The vaginal area was not cleansed. The resident's underwear had a smear of bowel movement (BM). The LPN stated that the underwear was not wet. The resident stated, "It hurts where I go."  5. Resident #7 had diagnoses of Alzheimer, Difficulty walking and Alcohol Persist Dementia. The MDS dated for 8/8/07 documented the resident was severely impaired in cognitive skills for daily decision making and required total assistance with transfers, toilet use and personal	F 314		

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

PRINTED: 09/25/2007  
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>09/08/2007</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>		
(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 314	Continued From page 9 hygiene. and had a trunk restraint.  a. A Physicians's Order dated 7/18/07 documented, "Lap Tray to prevent unassisted transfers, check q 30 min and rel(release) q 2 hr x 10 min for ROM.  b. On 9/07/07 at 9:35 a.m., the resident was sitting up in a wheelchair with a lap tray applied. The resident was in the locked unit and continuously monitored by a surveyor. The resident remained in the wheelchair, without being toileted, for 4 hours and 50 minutes. At 2:25 p.m., CNA #2 took the resident to her room. The CNA stated she was going to lay the resident down because "her bottom was burning." The CNA provided incontinent care. The buttocks and inner thighs were not cleansed. The resident was scratching her buttocks during the care and complained her buttocks were hurting. The rectal area and inner thighs were red in appearance.  6. The Policy and Procedure entitled "Prevention of Pressure Ulcers" documented, " ... pressure ulcers are often made worse by continual pressure, heat, moisture irritating substances on the resident's skin (i.e. perspiration, feces, urine...) ... Persons confined to chairs should be repositioned at least every two hours ... Clean skin as soon as soiled..."	F 314			
F 318 SS=E	483.25(e)(2) RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318			

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

PRINTED: 09/25/2007  
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>09/08/2007</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>		
(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 318	Continued From page 10  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure physical restraints were released every 2 hours for range of motion for 3 (Resident #3, #6 and #7) of 3 case mix residents that had a Physician's Order for physical restraints. This failed practice had the potential to affect 21 residents that had Physician's Orders for physical restraints according to a list received from the Administrator on 9/08/07. The findings are:  1. Resident #3 had diagnoses of Schizophrenia and Alzheimer Disease. The MDS dated 6/19/07 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistance with transfers and extensive assistance with personal hygiene and was frequently incontinent of bladder and bowel .  a. A Physician's Order dated 9/21/06 documented, "non releasable seatbelt when up in w/c (wheelchair), check q (every) 30 minutes and release q 2 hours x 10 min (minutes) for exercises, toileting, or amb (ambulation)."  b. The Care Plan dated 3/29/07 documented, "Monitor Resident q 30 mins when up in wc and using nonrelease seatbelt. Release seatbelt q 2 hours for 10 mins and reposition resident."  c. On 9/07/07 at 9:35 a.m., the resident was in the locked unit, sitting up in a wheelchair, with a non releasable seat belt applied. The resident was continuously monitored by a surveyor. The	F 318			

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>09/08/2007</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>		
(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 318	<p>Continued From page 11</p> <p>resident remained in the wheelchair, without being toileted, for 4 hours and 35 minutes. At 2:10 p.m., Licensed Practical Nurse (LPN) #1 took the resident to the bathroom.</p> <p>2. Resident #6 had diagnoses of Dementia and Difficulty Walking. The MDS dated 7/12/07 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive assistance with transfers and was usually continent of bowel and bladder.</p> <p>a. A Physician's Order dated 6/29/07 documented, "Non releasable seatbelt when up in w/c, check q 30 minutes and release q 2 hours for ROM (range of motion)."</p> <p>b. On 9/07/07 at 9:35 a.m., the resident was sitting up in a wheelchair, in the locked unit, with a non releasable seat belt applied. The resident was continuously monitored by a surveyor. The resident remained in the wheelchair, without being toileted, for 3 hours and 58 minutes. At 1:33 p.m., LPN #1 took the resident to the bath room.</p> <p>3. Resident #7 had diagnoses of Alzheimer, Difficulty walking and Alcohol Persist Dementia. The MDS dated for 8/8/07 documented the resident was severely impaired in cognitive skills for daily decision making and required total assistance with transfers, toilet use and personal hygiene. and had a trunk restraint.</p> <p>a. A Physicians's Order dated 7/18/07 documented, "Lap Tray to prevent unassisted transfers, check q 30 min and rel(release) q 2 hr x 10 min for ROM.</p>	F 318			

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

PRINTED: 09/25/2007  
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>09/08/2007</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>		
(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 318	<p>Continued From page 12</p> <p>b. On 9/07/07 at 9:35 a.m., the resident was sitting up in a wheelchair, in the locked unit, with a lap tray applied. The resident was continuously monitored by a surveyor. The resident remained in the wheelchair, without being toileted, for 4 hours and 50 minutes. At 2:25 p.m., CNA #2 took the resident to her room. The CNA stated she was going to lay the resident down because "her bottom was burning." The CNA provided incontinent care. The resident was scratching her buttocks during the care and complained her buttocks were hurting. The rectal area and inner thighs were red in appearance.</p> <p>4. The Policy and Procedure entitled "The General Guidelines for the Use of Physical Restraint" documented, "Physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual can not remove easily which restricts freedom of movement or normal access to one's body. The practices that meet the definition of a restraint include, but are not limited to, tray tables, bars or belts that the resident can not remove easily and that prevent the resident from rising when used in conjunction with a chair. A resident placed in a restraint will be observed at least every 30 minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record. The opportunity for motion and exercise is provided for a period of not less than ten minutes during each two hours in which restraints are employed. Restrained residents must be repositioned at least every two hours on all shifts."</p>	F 318			