

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

PRINTED: 06/05/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045375	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/23/2008
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NAME OF PROVIDER OR SUPPLIER PARKVIEW REHABILITATION & HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 BARROW ROAD LITTLE ROCK, AR 72204
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F 000	INITIAL COMMENTS	F 000		
F 201 SS=E	<p>Complaint #13513 was substantiated (all or in part) with deficiencies cited at F202 and F323.</p> <p>Complaint #13528 was unsubstantiated.</p> <p>483.12(a)(2) TRANSFER AND DISCHARGE REQUIREMENTS</p> <p>The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;</p> <p>The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;</p> <p>The safety of individuals in the facility is endangered;</p> <p>The health of individuals in the facility would otherwise be endangered;</p> <p>The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or</p> <p>The facility ceases to operate.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 201		

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 201	<p>Continued From page 1</p> <p>Based on closed record review and interview, the facility failed to ensure that residents were not discharged without documented evidence of the facility's inability to meet that resident's need for 1 (Resident #1) of 2 case- mix residents (Residents #1 and #6) who were discharged from the facility. The failed practice had the potential to affect 7 residents with behavioral symptoms, as documented on the Resident Census and Conditions of Residents form dated 5/21/08. The findings are:</p> <p>Resident #1 had diagnoses of Chronic Pain, Rheumatoid Arthritis and Anemia. The Minimum Data Set dated 2/15/08 documented the resident was independent in cognitive skills for daily decision making, had no short or long term memory problems, exhibited indicators of depression anxiety or sad mood which were not easily altered (including negative verbal statements, persistent anger with self or others, repetitive health complaints, repetitive anxious complaints/concerns and unpleasant mood in morning), exhibited verbally abusive behaviors and resisted care, required limited to extensive assistance with bed mobility, transfers, dressing, toilet use, personal hygiene and bathing and had limited range of motion in one arm, both hands and both legs.</p> <p>a. Social Service Notes dated 2/8/08 documented the resident's problems included hoarding items in room, verbal aggression toward staff and refusing to bathe. The next Social Service Note was dated 5/20/08 and documented the resident was transferred to another facility.</p> <p>b. The Care Plan dated 4/8/08 documented: "Self care deficit r/t [related to] decreased mobility,</p>	F 201			

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F 201	<p>Continued From page 2</p> <p>Noncompliance r/t Dementia/Poor cognition (refusing weights, refusing to participate in safety drills), Noncompliance r/t Dementia/Poor cognition (refusal to wear arm band), Noncompliance r/t Dementia/Poor cognition (refusing showers), Noncompliance r/t Dementia/Poor cognition (refuses to let staff cut nails), Disruptive behavior r/t state of constant complaints, Feelings of Anxiety Nervousness restlessness, Need to feel in control r/t loss of independence (verbal abuse, mood changes, refuses care at times, refuses to be weighed, refuses to let certain CNA's [Certified Nursing Assistants] care for her, wants meds [medications] at a certain time and refuses to get up for breakfast), Potential for pain r/t Arthritis, Potential for Hypothyroidism r/t Hypothyroidism, Hearing loss and Potential of adverse medication side effects, excessive medication use r/t taking 9 or more medications."</p> <p>c. A Physician Order Sheet dated 4/17/08 documented the following medications: Norvasc 10 milligrams (mg), Senakot, Lasix 40 mg, Ultracet 37.5 mg Levothyroxine 0.15 mg, Diovan 160 mg, Claritin 10 mg, Enbrel 25 mg (injection), Pepcid 20 mg, Os-cal D 500 mg, Vitamin C 500 mg, Centrum Silver, Iron 325 mg, Refresh eye lubricant, Lacrilube ointment and Restasis 0.05% with Cyclosporine 0.05% emulsion. Telephone Orders dated 5/1/08 documented the following medications were added to the resident's medication regimen: Depakote sprinkles 250 mg and Zyprexa 5 mg.</p> <p>d. A Psychiatric Evaluation dated 5/1/08 and performed by Advanced Practice Nurse (APN) #1 documented: "Plan ... [Resident] needs Geropsych [geriatric-psychiatry] tour to TX [treat]</p>	F 201			

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F 201	<p>Continued From page 3</p> <p>mood DO [disorder] and Paranoid delusions. She is harmful to herself by refusing RX [prescribed medications], bathing. She would be combative if pushed... Has no POA [Power of Attorney] - doubtful if Psych inpat [Psychiatric Inpatient] would take her. Recommend getting court order for Geropsych inpat. tour ... VPA [Valproic Acid] 250 mg p.o. [by mouth] q [every] a.m., 1700 [5:00 p.m.] and hs [bedtime]. If she refuses a.m. [morning] dose, give at noon ... Zyprexa 5 mg hs - If refuses p.o. VPA or Zyprexa, give IM [intramuscular] injection Zyprexa 5 mg ..." There was no physician's signature on the evaluation.</p> <p>e. Nurses' Notes dated 5/2/08 at 7:07 a.m. documented the resident refused to have an electrocardiogram (EKG) and chest x-ray done when informed that the tests were ordered by the APN. The resident stated she was not going to do any test or take any new medication unless her physician approved.</p> <p>f. Physician's Progress Notes dated 5/2/08 at 11:15 a.m. documented: "Input from psychiatry appreciated (Zyprexa, Depakote sprinkles ordered) ... sour mood this a.m. - Number 1 complaint is inability to sleep, which she blames on her roommate's frequent verbalizations and mumbling. Patient also upset at having additional blood draws (extensive bruise on arm from earlier phlebotomy) - (I can understand this) - Staff also notes that patient refuses medications at times. Patient has tended to have similar transient mood swings over the years."</p> <p>g. Nurses' Notes dated 5/3/08 through 5/13/08 documented the resident refused the Depakote and/or Zyprexa on 20 occasions and refused the eye lubricant and iron tablet on one occasion.</p>	F 201			

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F 201	Continued From page 4 There was no documentation that the physician was notified of these refusals or that any other interventions were implemented to address the resident's behavior. There was no documentation in the Nurses' Notes, Care Plan or elsewhere in the clinical record that the facility attempted through care planning to address the resident's needs through a multi-disciplinary approach, in an effort to address her refusal of physician-ordered medications, laboratory tests, treatments or procedures. h. A Letter of Discharge dated 5/5/08 from the facility to the resident documented: "...This is a thirty (30) day notice that the facility is discharging you due to the inability to meet your needs. This inability is caused by your refusal to take Physician order medications, refusal to allow drawing of Physician ordered labs, refusal of Physician ordered treatments, refusal of Physician Ordered procedures and refusal to allow staff to perform ADL's [activities of daily living]." i. On 5/23/08 at 9:50 a.m., the Administrator was asked for documentation from the resident's physician that the resident's needs could not be met in the facility. He stated, "You're not going to find it. He [the physician] didn't write one. [Physician] did not agree that she needed to go to Geri-psych or that we needed to go to court. So we were following through on the Psychological consult."	F 201			
F 323 SS=K	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323			

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F 323	Continued From page 5 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure mechanical lift transfers were conducted in accordance with the manufacturer's instructions to prevent potential accidents/injuries for 2 (Residents #5 and #2) of 5 case mix residents who required transfers via mechanical lift (Residents #2, #3, #4, #5 and #7). The facility also failed to ensure safety clips were present on 2 of 7 Vander-Lift II mechanical lifts and that rubber grommets were not damaged or missing on 7 of 7 Vander-Lift II mechanical lifts. The facility failed to ensure mechanical lift slings were routinely inspected for signs of damage, loose or missing stitching, tears and excessive wear. The failed practices resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury or death to Resident #5, who was left unattended while up in a mechanical lift sling, and Resident #2, who experienced a fall from an improperly applied mechanical lift sling. The failed practices also had the potential to cause more than minimal harm to 26 residents who required mechanical lift transfers, as documented on a form provided by the Administrator on 5/21/08. The facility was informed of the Immediate Jeopardy condition on 5/20/08 at 3:21 p.m. The findings are: 1. Resident #5 had diagnoses of Dementia and Seizure Disorder. The Annual Minimum Data Set (MDS) dated 3/10/08 documented the resident was severely impaired in cognitive skills for daily	F 323			

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F 323	Continued From page 6 decision making, had short-term memory problems, resisted care, was totally dependent on staff for transfers, was lifted mechanically and had no functional limitation in range of motion. a. The Plan of Care dated 2/5/08 documented, "Problem: Self Care Deficit Related to: Visual deficit, Decreased mobility Confusion... Assist with transferring... Problem: Potential for Violence (maladaptive behavior with anger): Need to monitor behavior... Report episodes of violence to the nurse. Provide close supervision. Watch for signs of increasing anxiety... Problem: Potential for Seizures Related to: Seizure disorder. Goal: Safety maintained, falls without injury... Maintain safety..." b. A Nursing document titled, "Transfers" and dated 5/7/08 documented, "Requires two aides assist [assistance] to transfer to lift the resident during transfers; Transfer/ambulation devices: lifted mechanically ..." c. On 5/20/08 at 1:17 p.m., the resident was alone in his room in a Vander-Lift II mechanical lift sling. The resident's buttocks were approximately 2 feet from the mattress, the left foot was touching the mattress and the right foot was dangling in the air. Certified Nursing Assistant (CNA) #1 was standing in the hallway one door down and followed the Surveyor into the room. The CNA then left the room again, leaving the resident suspended 2 feet above the bed in the lift sling, and went out into the corridor to call for assistance from CNA #3. d. On 5/20/08 at 1:19 p.m., CNA #2 replaced the battery on the mechanical lift and lowered the resident to the bed. CNA #2 stated, "[Lift] has	F 323		

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F 323	<p>Continued From page 7</p> <p>emergency button to lower," and pointed to the button. CNA #1 stated, "I didn't know about the emergency button."</p> <p>e. On 5/20/08 at 1:24 p.m., when asked if a resident was to be left up in a lift unattended, CNA #1 stated, "No. I went to get help. I thought the battery was out."</p> <p>f. On 5/20/08 at 1:36 p.m., when informed of the resident being left unattended in the mechanical lift sling, Licensed Practical Nurse (LPN) #1 stated, "There is no reason to ever leave a resident up in a lift unattended."</p> <p>g. On 5/21/08 at 2:35 p.m., CNA #1's personnel record was reviewed and contained an Employee Warning Notice dated 10/26/07 which documented the CNA, "...used lift without assistants [assistance] to transfer resident from w/c [wheelchair] to bed and caught resident's L [left] leg on leg rest causing a large skin tear... Corrective action... Always have another aide assisting when you use a lift for any transfer..."</p> <p>h. The staff sign-in sheets for an inservice dated 3/27/08 and titled, "Vanderlift II" did not include CNA #1's signature to indicate the CNA was present at the inservice.</p> <p>i. A Vander-Lift inservice check-off sheet dated 3/31/08 and signed by CNA #1 documented, "...Always have the help from another person when using..." There was no documentation on this form regarding the emergency release button or that a resident should not be left in the lift unattended.</p> <p>j. A Vander-Lift inservice check-off sheet dated</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>4/29/08 and signed by CNA #1 documented, "2nd [second] retraining... Always have the help from another person when using..." There was no documentation on this form regarding the emergency release button or that a resident should not be left unattended in the lift.</p> <p>k. On 5/20/08 at 3:40 p.m., CNA #4 was asked, "Where is the emergency button on the Vander-Lift II?" The CNA stated, "I haven't the faintest idea."</p> <p>2. Resident #2 had diagnoses of Diabetes Mellitus, Seizures and Cerebrovascular Accident. The Minimum Data Set dated 4/14/08 documented the resident was moderately impaired in cognitive skills for daily decision making, had short and long term memory problems, required total assistance of 2 or more staff for transfers and had limited range of motion in the arm and leg.</p> <p>a. An Incident Report dated 5/5/08 documented the resident sustained a fall with injury involving a Hoyer lift while being transferred by 2 CNA's. The report documented: "Comments: This nurse was called to Resident room at 13:30 [1:30 p.m.] by CNA. Resident was lying on the floor with legs still in sling. I looked at the sling and it was criss-crossed at the head and feet. Resident alert and oriented to her name. Large Hematoma about the size of a baseball on the back of her head. Resident removed from the sling. Hoyer lift pad replaced under resident and 6 person lift used to put resident into the bed. Red unopened area about 5 cm [centimeters] in length noted on left upper back."</p> <p>b. Nurses' Notes dated 5/5/08 regarding the</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>above incident documented the Hoyer lift pad was applied incorrectly by CNA's #5 and #6 and the resident fell from the lift and sustained a baseball-sized hematoma to the back of the head and a red area to the left upper back. When the nurse got to the resident's room, the resident was on the floor with her legs still in the sling. The sling was crossed at the feet and head. The resident was sent to the hospital for evaluation and computed tomography (CT) scan of the head. CNA's #5 and #6 were counseled on safety during transfers and watched a video on the use of the Vander-Lift II.</p> <p>c. On 5/21/08 at 3:00 p.m., CNA #6's personnel file was reviewed. The file documented the CNA was hired on 5/1/08. There was no documentation in the file that the CNA had received training on the Vander-Lift II prior to the incident on 5/5/08.</p> <p>d. A timecard report documented CNA #5 worked in the facility on 3/27/08 when a Vander-Lift II inservice was provided to the CNA's. The inservice sign-in sheet did not include CNA #5's name to indicate that the CNA was present for the inservice.</p> <p>e. On 5/21/08 at 3:00 p.m., CNA #5's personnel file was reviewed. The file documented the CNA was hired on 3/24/08. A CNA Proficiency sheet dated 4/9/08 documented the CNA was checked off on proper demonstration of lift use.</p> <p>f. Vander-Lift check off sheets dated 5/5/08 for CNA's #5 and #6 documented: "Inservice done via video tape 5/5/08."</p> <p>g. The Vander-Lift II operating manual</p>	F 323			

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F 323	Continued From page 10 documented on page 7 under Staff Training: "Watching the DVD [digital video disc] without hands on training does not qualify as training." 3. The facility's Mechanical Lift policy, revised 3/9/06 documented, "The Mechanical Lift will be operated in a manner consistent with the Manufacturer's Guidelines and the Training that is current at the date in question." 4. The Vander-Lift II product information from the Vanderlift II website documented the following: a. Page 1: "Manual lowering device can be used in case of emergencies." b. Page 2: "Manual lowering device can safely be used in case of emergencies." 5. The Vander-Lift II operating manual documented the following: a. Page 3: "...Emergency lowering switch (on bottom of mobilette control)." An illustration next to this statement depicted the location of the emergency lowering switch. b. Page 6: 1.) "Warning. Before each patient transfer, it is important for staff to inspect the Vander-Lift II to make sure no parts are missing or overly worn and that all parts work correctly. If a problem is noted, the lift should not be used until qualified maintenance staff has made repairs." 2.) "Warning. Before each patient transfer, the sling must also be inspected for signs of damage, for loose and missing stitching, and for tears and	F 323			

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F 323	Continued From page 11 excessive wear that might cause it to fail... It is important that qualified maintenance staff inspect all Vander-Lift II's." 3.) "It is also required that a nurse or professional rehabilitation staff member inspects all Vander-Lift II slings for the above types of damage at least monthly. A permanent record of each of these inspections and action taken should be kept by the facility..." 4.) "Warning. It is important that a nurse or professional rehabilitation staff member inspects all Vander-Lift II slings monthly." c. Page 7: "A DVD demonstrating transfer techniques and Vander-Lift II care was sent to the facility with the lift. This video can be used, along with hands on training led by a nurse or professional rehabilitation staff member who has been designated as your facility's mechanical lift trainer... Warning. Watching the DVD without hands on training DOES NOT QUALIFY AS TRAINING. Staff members who have seen the video but who have not had hands on training described above may not use the Vander-Lift II." d. Page 8: "Warning. Although one person can perform patient transfers, certain patients or situations may require the help of one or more additional staff members. For example, patients with unpredictable behavior due to dementia may require additional help if their behavior poses risk of injury to themselves or to staff members..." e. Page 10: "Two methods of connecting the Uni-fit sling to the Vander-Lift II: 1.) Method One: Crossed Loop Connection.	F 323			

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F 323	<p>Continued From page 12</p> <p>Cross the leg loops for one leg support through the leg loop closest to the leg support on the other side of the sling..."</p> <p>2.) Method Two: Crossed Leg Support Connection. Cross one leg support under both of the patient's legs then cross the other leg support under both of the patient's legs..."</p> <p>f. Page 25: "Emergency Lowering Switch. Warning. If the pendant switch fails, use the emergency lowering switch located on the bottom of the mobilette control. To use it, press the yellow button to lower the lift. This switch should only be used in emergency situations when the pendent switch fails."</p> <p>5. On 5/20/07 at 4:15 p.m., the facility's Vander-Lift II mechanical lifts were inspected with the following findings:</p> <p>a. Vander-Lift II #L04269373 was missing 4 safety pins and the rubber grommets were very worn.</p> <p>b. Vander-Lift II #L03938026 had one missing rubber grommet.</p> <p>c. Vander-Lift II's #L03938018 and #L03938028 had two missing rubber grommets.</p> <p>d. Vander-Lift II #L03938029 had very worn rubber grommets and was missing 2 safety pins.</p> <p>e. Vander-Lift II #03938023 had one very worn rubber grommet.</p> <p>f. Vander-Lift II #03938024 had two very worn rubber grommets.</p>	F 323			

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

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F 323	Continued From page 13 6. On 5/21/08 at 9:05 a.m., the Administrator was asked for the mechanical lift sling inspection records. At 11:00 a.m., Assistant Director of Nursing (ADON) #1 brought a, "Plan of Correction for Vander lift" dated 5/20/08 which documented that the slings on 100, 200, 300, and 400 Halls had been inspected on 5/20/08. No other documentation of lift sling inspections were provided by the facility. 7. On 5/21/08 at 1:15 p.m., the Administrator stated, "They scavenged parts to make 4 working lifts." 8. An e-mail from the medical supply company to the Administrator and dated 5/21/08 at 12:23 p.m. documented, "Lifts may be used without grommets or safety clips as long as the caregiver is paying proper attention to the proper operation of the lift. The lifts were designed to have the grommets and safety clips as extra safety precaution." 9. On 5/21/08 at 1:20 p.m., a phone call was placed to the Vander-Lift company. A company spokesman was asked if the rubber grommets were a safety factor. He stated, "They prevent metal on metal wear of the hanger assembly." When asked if the missing safety clips were a factor, the spokesman stated, "The clips are on there to prevent the sling from sliding off. If they are not on, they have to be awful careful. It all comes back to training." 10. The Immediate Jeopardy was removed and the scope/severity reduced to "E" on 5/21/08 at 8:00 a.m. when the facility implemented the following Plan of Removal:	F 323			

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F 323	Continued From page 14 a. All Vander lifts will be removed from halls and locked in therapy room until in-service of lift is performed on all CNA's and on all shifts. b. Vander lifts that were deemed unsafe were removed from floors to prevent use. c. The rubber grommets have been ordered and will be replaced upon receipt. Product distributor states they are not a safety factor. d. After In-service is completed, the CNA will be checked off for accuracy with return demonstration. e. Only those who complete the in-service and post-test, and have been checked off, will be able to use the Vander lifts. f. All in-services/check offs and return demonstration will be competed by the resident care coordinators/CNA trainers. g. DON or designee will observe 3 lifts daily on all shifts and halls that use the Vander lift 7 days a week x [times] 2 weeks, then 3 x a week for 2 weeks. h. Random monthly checks will be completed on all shifts and halls that use the Vander lift. i. Any negative findings will be immediately addressed. j. All new staff will be in-serviced on proper use of Vander lift use during orientation period and this will be documented with returned demonstration.	F 323			

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F 323	Continued From page 15 k. All CNA's will be re-inserviced on a quarterly basis x 1 year and re-evaluation of effectiveness of system. l. Maintenance will check all lifts monthly for use of missing parts or excessive wear, negative findings will immediately be addressed. m. Nursing staff will check Vander Lift slings weekly for excessive wear/tears, any negative findings will immediately be addressed.	F 323			