

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

PRINTED: 06/07/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045181</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/26/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRESCOTT MANOR NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 MANOR DRIVE PRESCOTT, AR 71857</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 164 SS=E	<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:</p> <p>Based on observation and record review, the facility failed to ensure privacy curtains were completely pulled and/or windows blinds were closed during personal care for 4 (Resident #4, 6, 9 and 10) of 14 (Resident # 1-5, 7,8, # 11-14)</p>	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 164	<p>Continued From page 1</p> <p>case mix residents. This failed practice had the potential to affect all 72 residents. The findings are:</p> <p>1. Resident #10 had diagnoses of Cerebrovascular Accident with Paralysis, Dementia and Depressive Disorder. The Quarterly Minimum Data Set (MDS) dated 4/13/06 documented the resident was severely impaired in cognitive skill for daily decision making, incontinent of bowel and bladder and required total assistance for (ADL'S) activities of daily living.</p> <p>On 5/25/06 at 3:10 p.m., CNA (Certified Nursing Assistant) #9 and 10 provided Foley catheter care. There was no privacy curtain on this resident's side of the room.</p> <p>2. Resident #4 had a diagnosis of Dementia with Psychosis. The Annual MDS dated 3/6/06 documented the resident was severely impaired in cognitive skilled for daily decision making, incontinent of bowel, had an indwelling Foley catheter and required total assistance with ADLs.</p> <p>On 5/24/06 at 8:30 a.m., CNA #7 provided Foley catheter care. The window blinds were not closed and the privacy curtain was not pulled around the resident's bed.</p> <p>3. Resident #9 had diagnoses of Alzheimers with Psychosis, Dementia and Depressive Disorder. The Significant Change MDS dated 4/24/06 documented the resident was severely impaired in cognitive skills for daily decision making, incontinent of bowel, had an indwelling Foley catheter and required total assistance with ADLs.</p>	F 164			

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F 164	Continued From page 2 On 5/23/06 at 2:05 p.m., CNA #12 provided Foley catheter and incontinent care. The resident was in bed A next to the door and the CNA pulled the privacy curtain part way around the resident's bed leaving the section by the room door open. At 2:13 p.m., the Assistant Director of Nurses (ADON) entered the room while the resident was exposed. At 2:18 p.m., the ADON opened the room door and the resident was exposed to anyone in the hallway. At 2:20 p.m., the Director of Nurses (DON) entered the room while the CNA was dressing the resident.  4. Resident #6 had a diagnosis of Senile Dementia. The MDS dated 5/2/06 documented the resident was independent in cognitive skills for daily decision making, continent of bowel and frequently incontinent of bladder.  On 5/25/06 at 3:45 p.m., CNA #5 and 6 provided incontinent care. The CNAs did not pull the privacy curtain around the end of the resident's bed, so if the door were opened the resident would be exposed to anyone in the hallway.	F 164		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interview the facility failed to ensure a pre-restraint assessment of resident was completed for 1 (Resident #7) of 4 case mix	F 221		

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F 221	<p>Continued From page 3</p> <p>residents (Resident #1, 4, 7 and 9) who were physically restrained. This failed practice had the potential to affect 13 residents who were physically restrained according to the Resident Census and Conditions of Residents form dated 5/23/06. The findings are:</p> <p>Resident #7 had diagnoses of Schizophrenia, Mental Retardation, Aspiration Pneumonia and Weight/Swallow Disorder. The Significant Change Minimum Data Set dated 11/26/05 documented the resident was severely impaired in cognitive skills for daily decision making; had behaviors of wandering, physically abusive, socially inappropriate behavior and resisted care; required extensive assistance in activities of daily living; had a feeding tube and received 3 antipsychotics, 3 antianxiety and 3 antidepressants in the last 7 days.</p> <p>a. A Pre-Restraining Assessment done was dated 3/13/06 and documented half door and discontinue soft belt restraint.</p> <p>b. A physician order dated 5/8/06 documented pelvic restraint in wheelchair.</p> <p>c. Nurses notes dated 5/23/06, no time, documented "Res (Resident) up in w/c (wheelchair) [with] pelvic restraint in place..."</p> <p>d. On 5/23/06 at 8:20 a.m. and 10:50 a.m., the resident was in a wheelchair with a pelvic restraint in place.</p> <p>e. As of 5/23/06 there was no documentation in the clinical record of a pre-restraint assessment for a pelvic restraint.</p>	F 221			

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F 241 F 241 SS=B	Continued From page 4 483.15(a) DIGNITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by:  Based on observation and record review, the facility failed to ensure a hospital gown was properly fastened to prevent exposure of 1 (Resident #10) of 2 case mix residents (Residents #7 and 10) who were dependent on staff for dressing. The facility failed to ensure an bed was provided for 1 of 1 case mix resident (Resident #7) who had behaviors. These failed practices had the potential to affect 39 residents who were dependent on staff for dressing as identified by the Resident Census and Conditions of Residents report dated 5/22/06 and 42 residents on behavior monitoring as documented on list provided by the Administrator on 5/26/06 at 11:03 a.m. The findings are:  1. Resident #10 had diagnoses of Cerebrovascular Accident with Paralysis, Dementia and Depressive Disorder. The Quarterly Minimum Data Set dated 4/13/06 documented the resident was severely impaired in cognitive skills for daily decision making and required total assistance for Activities of Daily living.  On 5/24/06 at 2:33 p.m., the resident was setting in a geri-chair leaning forward, with both feet elevated. The resident was attending an activity in	F 241 F 241		

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F 241	<p>Continued From page 5</p> <p>the main dining room with 19 other residents and staff. The resident was dressed in a hospital gown that was not tied in the back exposing the resident's back.</p> <p>2. Resident #7 had diagnoses of Schizophrenia, Mental Retardation, Aspiration Pneumonia and Weight/Swallow Disorder. The Significant Change Minimum Data Set dated 11/26/05 documented the resident was severely impaired in cognitive skills for daily decision making; had behaviors of wandering, physically abusive, socially inappropriate behavior and resisted care; required extensive assistance in activities of daily living; had a feeding tube and received 3 antipsychotics, 3 antianxiety and 3 antidepressants in the last 7 days.</p> <p>a. The Plan of Care dated 11/26/05 and updated 3/1/06 documented a problem of "cognition deficient: High risk of complication R/T (related to) MR (mental retardation)." and approaches dated 4/26/06 of "has a child like mind. She has to be redirected as you would a child that does not understand or aware for their safety. The staff will continue to redirect as needed and continue 1 on 1 supervision when out of room. The care plan documented a problem of "Delirious/anxious/pulling out G-tube (gastrostomy); Behavior requiring 1 on 1 supervision." with approaches of "Avoid placing resident in enforced inactivity."</p> <p>b. The Immediate Plan of Care dated 4/20/06 documented, "At Risk for: Aspiration/Aspiration Pneumonia. Problem-getting into other resident's food, attempting to consume." The interventions included "prevent getting into other resident's food and consuming it, remain in room during</p>	F 241		

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F 241	<p>Continued From page 6</p> <p>meal times, may be out of room for short periods of time with 1 on 1 staff accompanying her for observation and check and release every 2 hours for exercise outside of room with 1 on 1 supervision."</p> <p>c. A physician order dated 5/22/06 documented discontinue mattress use floor mat.</p> <p>d. On 5/22/06 at 6:25 p.m., the Administrator and the Director of Nurses (DON) were asked how long the resident had blue pads only in the room and the DON stated, "About 3 weeks". The Administrator stated, "We tried a low bed but the resident would move it to door and climb over the 1/2 door that had been placed to keep the resident from obtaining food from other residents." The DON stated, "we move a mattress in to sleep on at night but move it out during the day because she rolls the mattress to the door and climbs over door."</p> <p>e. On 5/23/06 at 5:00 p.m. and 5:35 p.m., 5/24/06 at 8:00 a.m. and 10:00 a.m. and 5/26/06 at 6:00 p.m. and 8:03 p.m., the resident was lying on a 2 inch floor mat.</p> <p>f. On 5/24/06 at 2:00 p.m., the DON was asked if anyone had seen the resident climb over the door and she stated, "I'm sure it's in the nurse's notes" The DON was asked for those nurse's notes and she stated, "No it's not in the nurse's notes"</p> <p>g. As of 5/24/06, there was no documentation in the clinical record or incident and accident reports that the resident had climbed over the door by stacking furniture or using the mattress. There was no documentation in the clinical record that other interventions had been attempted to provide</p>	F 241			

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F 241	Continued From page 7 the resident with a bed.	F 241		
F 253 SS=C	483.15(h)(2) HOUSEKEEPING/MAINTENANCE  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by:  Based on observation, the facility failed to ensure walls and doors were in good repair, there no odors of urine, molding was free of scuff marks, air vents and floors were clean, and cracked/stained/chipped ceiling tiles were replaced. This failed practice had the potential to affect all 72 residents. The findings are:  1. On 5/24/06 at 10:40 a.m., the following observations were made:  a. On Wing #1:  1) The back hall exit door had bubble-like raised areas below the door knob and the bottom of the door surface was rusted.  2) In the lounge there was one 24 by 48 inch cracked ceiling tile and one 24 by 48 inch brownish stained ceiling tile. The paint on the inside wall to the immediate right of the entrance was chipped 41 inches from the floor, one inch thick and extended around the right side of the room to the window.  3) The baseboard molding throughout the wing had scuff marks along the 1/4 inch lip that touched the floor.	F 253		

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F 253	Continued From page 8  b. In the Front Lobby the air vent was covered with gray specs (dust/dirt like), the wall between the Main Office and the Visitor's Restroom and the wall to the right of the Visitor's Restroom had scuff marks 12 inches from the floor and one inch wide.  c. In the Main Dinning Room:  1) The door to the residents' smoking area had scuff marks at the bottom quarter of the door, the wallpaper to the left of the door was detached in 2 places and the wallpaper below the window on the wall next to the door to the residents' smoking area was detached.  2) There were six 24 by 48 inch chipped ceiling tiles and one 24 by 48 inch cracked ceiling tiles.  3) The door to the employees' smoking area had black and gray marks seven inches from the floor and extending across the width of the door. The wall to the left of the door had scuff marks seven inches from the floor.  4) The paint on the trellis in front of the dirty dishes return area was chipped.  5) The wall molding between the pick-up and the return window was chipped and exposed the unpainted surface underneath.  6) The door jambs to the pick-up window were scratched and the paint was chipped in several places.  7) The baseboard molding throughout the wing had scuff marks along the 1/4 inch lip that	F 253			

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F 253	Continued From page 9 touched the floor.  d. On Wing #2:  1) There were ten 12 by 12 inch cracked (spider web-like) floor tiles at the entrance (fire doors) and the paint on the doors was chipped in several places.  2) A 7 by 5 foot "L" shaped area of one inch wide ceiling T-bars at the entrance to Wing #2 was rusted.  3) The paint on the door frame below the door knob to Resident Room #206 was chipped.  4) The wall between Resident Room #208 and #210 had a brownish yellow streak (stain) 1 1/2 inches wide that extended from the ceiling to the handrail.  5) The back hall air vent was covered with gray specs (dust like) and the paint was chipped. The paint on the back Hall exit door was chipped in several places and there was one 24 by 48 inch brownish stained ceiling tile on the back hall.  6) In Resident Room #212 there were no screens on the windows. There were two 24 by 48 inch ceiling tiles above the air vent with dust-like substance and the bathroom smelled of urine.  7) The floor in front of Resident Room #213 had five 12 by 12 inch floor tiles that were cracked and stained with a brownish gray colored substance.  8) The shower room had paint chipped from the threshold plate to the shower and mold/mildew	F 253			

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F 253	Continued From page 10 build up on the wall to the right of the shower entrance 16 inches long by 5 inches wide.  9) The baseboard molding throughout the wing had scuff marks along the 1/4 inch lip that touched the floor.  e. On Wing #3:  1) The right side fire door to the entrance had scuff marks 12 inches from the floor and extended across the width of the door.  2) The dining room door paint was chipped 18 inches from the floor in several places.  3) The paint on the walls to the entrance of the lounge was chipped at the corners in several places and the right side wall in the lounge was scraped off 41 inches from the floor, 1 to 1 1/2 inches wide and extended across the width of the wall.  4) The shower floor had a 74 inch long mold-like substance in an area parallel to the threshold plate.  5) The air vent between the environment supervisor's office and the mechanical room was covered with white and grey specs and the paint was chipped in several places.  6) The paint on the back hall exit door was chipped seven inches from the floor and extended the width of the door.  7) The baseboard molding throughout the wing had scuff marks along the 1/4 inch lip that touched the floor.	F 253			

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F 253	Continued From page 11  2. On 5/23/06 at 8:30 a.m., in Resident Room #303 there were two scuff marks on the inside of the entrance door below the door knob (one mark was 7 by 1/2 inch, the other was 3 by 1 inch). There was a pink streak on the wall to the left of entrance below the door knob and extended to the head of bed "A".  3. On 5/23/06 at 8:15 a.m., in Resident Room #307 there was a strong smell of urine in the bathroom and the door jambs on the inside of the bathroom were rusted from the floor eight inches high.  4. On 5/22/06 at 2:30 p.m. the floor in Resident Room # 217 had a sticky brownish substance approximately 5 feet in diameter on the floor.  5. On 5/25/06 at 10:30 a.m., on the center of the floor in Resident Room #207 there was a sticky tan substance 1 foot from the wall approximately 3 feet in diameter.  6. On 5/23/06 at 10:10 a.m., in the bathroom in Resident Room 104 there were 3 holes in the wall. The first hole was approximately 12 inches from the top of the tub and approximately 1 inch in diameter. The second and third holes were behind the handrail on the same wall next to the commode and were approximately 1/2 inch in diameter and approximately 12 inches from floor.	F 253			
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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F 281	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview the facility failed to ensure a feeding tube was flushed with water after administration of feeding tube supplement for 1 (Resident #7) of 4 case mix residents (Resident #1, 4, 5 and 7) who had a feeding tube. This failed practice had the potential to affect 13 residents with feeding tubes according to the Resident Census and Conditions of Residents report dated 5/23/06. The findings are:</p> <p>Resident #7 had diagnoses of Aspiration Pneumonia and Weight/Swallow Disorder. The Significant Change Minimum Data Set (MDS) dated 11/26/05 documented the resident was severely impaired in cognitive skills for daily decision making, had chewing and swallowing problems and had a feeding tube.</p> <p>a. A physician order dated 5/6/06 documented Jevity 1.2, 300 cc (cubic centimeter) every 4 hours by way of feeding tube and flush feeding tube with 60 cc of water before and after medications.</p> <p>b. On 5/23/06 at 8:40 a.m., LPN (Licensed Practical Nurse) #1 did not flush the feeding tube with water after the administration of 300 cc (cubic centimeters) of Jevity 1.2 formula.</p> <p>c. On 5/26/06 at 7:30 a.m., the DON (Director of Nursing) was asked regarding feeding tube flush and she stated, "Yes, you're right that a tube needs to be flushed after feeding."</p> <p>d. On 5/26/06 at 12:05 p.m., the Administrator</p>	F 281			

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F 281	Continued From page 13 provided a Policy and Procedure titled Gastric Tube Feeding that documented, "Objective-To provide liquid nourishment through a tube into the alimentary tract. Procedure: Item 6-Follow feeding with 1-2 ozs. (ounces) (30-60 cc) of water."	F 281			
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interview the facility failed to ensure that TED (thromboembolic device) hose were available per the physician order for 1 (Resident #5) of 1 case mix resident who had a physician order for TED hose. This failed practice had the potential to affect 2 residents who had an order for TED hose as documented on listing provides by the Administrator on 5/26/06 at 11:02 a.m. The findings are:  Resident #5 had diagnoses of Cardiac Arrhythmia, Osteoarthritis, Hip Fracture and Alzheimer's Disease. The Minimum Data Set dated 4/28/06 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for all activities of daily living and had a hip fracture in the last 180 days.  a. A physician order dated 3/2/06 documented TED hose.	F 282			

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F 282	Continued From page 14  b. On 5/22/06 at 3:15 p.m., 5/23/06 at 10:00 a.m. and 3:30 p.m. and 5/24/06 at 10:00 a.m., the resident was not wearing TED hose.  c. On 5/25/06 at 10:30 a.m., LPN (Licensed Practical Nurse) #1 was about the order for TED hose and she stated, "Yes, I see there is an order. No we are not putting them on the resident. I've been here 3 months and I've never seen them on her. I'll call the doctor to see what he wants us to do now."	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.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interview, the facility failed to ensure Foley catheter tubing was not lying on the floor and catheter bags were properly hung to ensure urine did not flow back into the bladder for 1 (Resident #4, 9 and 10) of 4 (Residents #4, 9, 10 and 11) case mix residents who had Foley catheters. The facility also failed to ensure dressing removal was only performed by licensed nursing staff for 1 (Resident #1) of 1 case mix resident who required dressing changes. These failed practices had the potential to affect 9 residents who had a Foley catheter as identified on the Resident Census and	F 309			

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F 309	<p>Continued From page 15</p> <p>Conditions of Residents report dated 5/22/06 and 6 who required dressing changes according to a list provided by the Administrator on 5/26/06. The findings are:</p> <p>1. Resident #10 had diagnoses of Cerebrovascular Accident with Paralysis and Urinary Tract Infection. The Quarterly Minimum Data Set (MDS) dated 4/13/06 documented the resident was severely impaired in cognitive skill for daily decision making, was incontinent of bowel and bladder and did not have an indwelling catheter.</p> <p>a. A physician order sheet dated 4/25/06 documented a Foley catheter for genital redness dated 4/25/06.</p> <p>b. The plan of care dated 4/7/06 documented a problem of "Altered Urinary elimination-indwelling catheter/incontinent of bowel." with approaches of "Keep the collection unit below the level of the bladder at all times to prevent reflux. Secure catheter to inside of thigh, (leg band) securing bag to side of bed, allowing the resident freedom of movement."</p> <p>c. On 5/23/06 at 5:25 p.m., the resident was in a geri-chair in the dining room. The Foley catheter tubing was wrapped over the right armrest of the geri chair above the resident's bladder and the Foley bag was hanging on the second pull bar on the back of the geri-chair.</p> <p>d. On 5/24/06 at 8:05 a.m., the resident was setting in the geri-chair in the day room. The Foley catheter bag was not visible. CNA (Certified Nursing Assistant) #11 found the Foley catheter bag under the resident's right upper part</p>	F 309			

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F 309	<p>Continued From page 16 of the leg.</p> <p>e. On 5/24/06 at 12:25 p.m., the resident was setting in the dayroom in a geri-chair and the catheter tubing was on the floor.</p> <p>2. Resident #1 had diagnoses of Diabetes, Dementia, and Congestive Heart Failure. The MDS dated 4/14/06 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for activities for daily living and application of dressing to other than feet.</p> <p>a. On 5/25/06 at 8:25 a.m., CNA #1 was giving the resident a whirlpool. The CNA removed a Band-Aid dressing from the resident's right hand where there was a skin tear.</p> <p>b. On 5/25/06 at 2:00 p.m., LPN (Licensed Practical Nurse) #1 was asked who was allowed to take dressings off and she stated, "Only the nurse can put dressings on or take dressings off."</p> <p>c. The Policy and Procedure titled Dressing Change (Clean) provided by the Administrator on 5/26/06 at 11:03 a.m. documented, "Responsibility: Licensed Nurse."</p> <p>3. Resident #4 had a diagnosis Metastatic Prostate Cancer. The Annual Minimum Data Set (MDS) dated 3/6/06 documented the resident was severely impaired in cognitive skill for daily decision making, incontinent of bowel and had indwelling Foley catheter.</p> <p>a. The May 2006 Physician Order sheet documented Foley catheter.</p>	F 309		

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F 309	<p>Continued From page 17</p> <p>b. The plan of care dated 3/6/06 documented a problem of "Altered Urinary Elimination-indwelling catheter" with approaches of "Keep collection below level of the bladder at all times to prevent reflux. Secure catheter to inside of thigh, (leg band) securing bag to side of bed, allowing resident freedom of movement."</p> <p>c. On 5/23/06 at 10:33 a.m., CNA (Certified Nursing Assistant) #7 and 11 transferred the resident from the bed to the geri-chair. The catheter tubing was not secured with a leg band.</p> <p>d. On 5/24/06 at 8:30 a.m., the resident was lying in bed. CNA #7 removed the resident's gown and there was no leg band in place to secure the catheter tubing. After the CNA provided catheter and incontinent care, the CNA did not apply a leg band to secure the catheter tubing.</p> <p>e. On 5/24/06 at 10:00 a.m., the resident was setting in the geri-chair. The Foley catheter bag and tubing were on the floor to the right side of the geri-chair.</p> <p>4. Resident #9 had diagnoses of Hypertension and Urinary Tract Infection. The Significant Change MDS dated 4/24/06 documented the resident was severely impaired in cognitive skill for daily decision making, incontinent of bowel and had an indwelling Foley catheter.</p> <p>a. A physician order dated 3/21/06 documented Indwelling Foley catheter.</p> <p>b. The plan of care dated 4/24/06 documented a problem of "Altered Urinary elimination- Indwelling catheter," with an approach of "Secure catheter to inside of thigh (leg band), securing bag to side of</p>	F 309			

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F 309	Continued From page 18 bed.  c. On 5/23/06 at 12:50 p.m., the resident's Foley tubing was draining urine to collector placed in a privacy bag. The resident had no leg band on to secure the tubing.  d. On 5/23/05 at 2:05 p.m., CNA #11 provided catheter care. There was no leg band in place to secure the catheter tubing.  e. On 5/24/06 at 8:00 a.m., the resident was lying in bed on her back, dressed in a hospital gown and there was no leg strap in place.	F 309		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by:  Based on observation and record review, the facility failed to ensure the buttocks, groin, labia, pubis or upper thighs were cleaned during incontinent care for 1 (Resident #6) of 5 (Resident #1, 5, 6, 7 and 17) case mix residents who were incontinent of bowel/bladder. This failed practice had the potential to affect 37 resident who were incontinent as documented on the Roster/Sample Matrix provided received on 5/22/06. The finding are:  Resident #6 had diagnoses of Osteoarthritis and Diabetes. The MDS dated 5/2/06 documented	F 312		

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F 312	Continued From page 19 the resident was independent in cognitive skills for daily decision making, continent of bowel and frequently incontinent of bladder.	F 312		
F 315 SS=E	483.25(d) URINARY INCONTINENCE  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interview the facility failed to provide incontinent care in a manner to prevent the potential for urinary tract infection for 3 (Resident #1 and 5) of 5 (Resident #1, 5, 6, 7 and 17) case mix residents who were incontinent of bowel/bladder. This failed practice had the potential to affect 37 resident as documented on the Roster/Sample Matrix provided received on 5/22/06. The finding	F 315		

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F 315	Continued From page 20 are:  1. Resident #1 had diagnoses of Diabetes, Dementia, and Congestive Heart Failure. The MDS dated 4/14/06 documented the resident was severely impaired in cognitive skills for daily decision making and was incontinent of bowel and bladder.  a. On 5/25/06 at 8:25 a.m., CNA #2 and 1 provided incontinent care. CNA #2 poured perineal cleanser in a basin of water, used a wash cloth and cleaned the groin area front to back changing areas of cloth, spread the labia and cleaned front to back 3 times without changing areas of the cloth. The CNA dried the labia by patting with the same area of the towel. The CNAs rolled the resident onto the side and cleaned the anal area using a back and forth motion, then dried using a patting motion with the same area of towel.  b. On 5/25/06 at 2:15 p.m. CNA #1 was asked how she had been trained to provide incontinent care and she stated, "Wipe front to back cleaning the labia first, then you flip the cloth and wipe the labia again. You change the towel and gloves, wipe the groin area front to back, get a towel and dry from to back by patting. You change the water, turn the resident to wash the bottom after cleaning bowel movement with tissue, change the gloves and then clean going from the vagina up."  2. Resident #5 had diagnoses of Osteoarthritis, Hip Fracture and Alzheimer's Disease. The MDS dated 4/28/06 documented the resident was severely impaired in cognitive skills for daily decision making, dependent on staff for activities of daily living and was incontinent.	F 315			

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F 315	Continued From page 21	F 315		
F 323 SS=E	<p>483.25(h)(1) ACCIDENTS</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation the facility failed to ensure doors and walls did not have cracked and jagged edges, chairs were in good repair and there were no electrical plug-in adaptors in use. These failed practices had the potential to affect all 72 residents. The findings are:</p> <p>1. On 5/24/06 at 10:40 a.m., the following</p>	F 323		

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F 323	Continued From page 22 observations were made:  a. On Wing #1, the outside lower wall to the right of the entrance to Resident Room #116 had chipped and jagged edges.  b. On Wing #2, the door to the shower room was cracked and had jagged edges on the inside, 12 inches from the floor on the hinge side.  c. On Wing #3, there was a vinyl covered chair that had a one inch sharp tear on each arm rest.  2. On 5/22/06 at 3:25 p.m., in Resident Room 114 there was a 2 plug electrical outlet. There was a tan 3 plug adaptor inserted in one of the outlets and there were two electric fans, both were in use, and a CD (compact disc)/radio plugged into the adaptor.	F 323		
F 324 SS=E	483.25(h)(2) ACCIDENTS  The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interview the facility failed to ensure staff did not use the Marisa Lift for transporting residents for 2 (Resident #1 and 16) of 4 (Resident #1, 4, 5 and 16) case mix residents who required lift/transfer with a mechanical lift. This failed practice had the potential to affect 13 residents who required the use of a mechanical lift according to a list provided by the Administrator on 5/26/06. The findings are:	F 324		

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F 324	Continued From page 23  1. Resident #1 had diagnoses of Diabetes, Dementia and Congestive Heart Failure. The Minimum Data Set (MDS) dated 4/14/06 documented the resident was severely impaired in cognitive skills for daily decision making and was totally dependent on staff for transfers.  a. The Overall Plan of Care dated 10/18/05 and updated on 4/14/06 documented a problem of "Totally dependent for all ADLs (activities of daily living) related to cognitive status, requires bathing, dressing, transporting per 2 CNA's (Certified Nurse's Assistant)." and under approaches documented, "Provide transfer assistance of 2 CNAs with Hoyer lift for bathing. Provide supplies and oversee for safety." Another problem documented, "Mobility, impaired, physical." with an approach of "provide protection from physical harm, lift with mechanical lift to and from G/C (geri-chair), transfer resident to Geri-chair via Hoyer lift Xs (times) 2 CNA'S."  b. On 5/25/06 at 8:25 a.m., CNA (Certified Nursing Assistant) #1 and 2 put the lift pad under the resident and lifted the resident off of the bed with the mechanical lift (Marisa lift) and transported the resident 36 feet to the whirlpool room with the lift sling approximately 4 feet from the floor. The resident was in a supine position with her head forward and her feet toward the lift.  c. CNA #1 (1 month employee) stated, "I told them this was not legal but this is the way they told me to do it. We usually have one person in the whirlpool to do the bath" When asked what she would do if resident started to fall, she stated, "Just call for help".	F 324			

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F 324	<p>Continued From page 24</p> <p>d. CNA #2 (10 year employee) was asked who trained her to operate the lift and she stated, "The Restorative Aide trained on lift and transporting with lift using 2 aides to transport and after the resident is in the water and stable only 1 aide actually bathes."</p> <p>e. On 5/25/06 at 10:00 a.m., the Restorative Certified Nursing Assistant (RCNA) stated, "I trained the staff how to open the legs of the lift, brake operation, battery charge and how to put on lift sheets. I trained on how to transfer from the bed to the chair and the chair to the bed and how to transport to the whirlpool room or shower." When asked the safety measures taught to staff she stated, "To be careful, watch where you are going, always use 2 staff with the resident facing you in a reclined position. If resident starts to fall, call for help, try to ease to floor, get DON (Director of Nursing)." The RCNA was asked how low the lift would lower. The RCNA and surveyor measured at the lowest position with the bar 21 1/2 inches from the floor. When asked who trained her in the operation of the lift, she stated, "The factory representative trained me but did not go over safety measures".</p> <p>2. Resident #16 had diagnosis of Senile Dementia, Psychosis, Cerebrovascular Accident and Hypertension. The Admission Minimum Data Set (MDS) dated 11/1/05 documented the resident was severely impaired in cognitive skills for daily decision making and required total assistance of two or more for transfers and lifted manually.</p> <p>a. The Overall Plan of Care dated 5/1/06 documented a problem of "Totally: ADL (activities of daily living) deficit/dependent for bathing,</p>	F 324			

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F 324	<p>Continued From page 25</p> <p>dressing, grooming and oral hygiene" with an approach of "Provide transfer for resident using Hoyer lift or two Certified Nursing Assistance (CNAs) to stand resident and pivot to wheelchair requires staff to transport to designated place."</p> <p>b. A Lift Designation Form dated 11/1/05 and updated 5/1/06 documented, "Continue with nonlifting continue help with transfers self to chair with assistance of two CNAs."</p> <p>c. On 5/25/06 at 9:20 a.m., the resident was being transported down the hall by a mechanical lift (Marisa lift). The resident was setting in the lift sling facing the opposite direction from CNA #7 who was pushing the lift. The resident's feet were approximately 45 inches from the floor. CNA #8 was walking beside CNA #7 and not providing any support and out of reach of the resident. The two CNAs transported the resident approximately 50 feet down the hall to the resident's room.</p> <p>d. On 5/25/05 at 9:25 a.m., CNA #7 stated "We always transport the residents who can not stand in the lift. We have always done that and no resident has been hurt," The resident was not facing me and that was not right. CNA #8 stated "They trained me to hold and guide the resident. When asked if the lift had tilted could you have caught the resident: CNA # 8 responded, "No. I don't think that I could have reached him."</p> <p>3. The manufacturer's guideline for the Hoyer lift documented, "If transporting over a short distance, ensure that the resident is facing the attendant and keep the resident as low as possible so that the feet rest on the base of the lifter straddling the mast. Lower center of gravity reduces the risk of tipping over." In a box at</p>	F 324			

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F 324	Continued From page 26 bottom of the same page of the guide documented, "WARNING Lifters are primarily a transfer device, NOT a transporting device."	F 324		
F 328 SS=B	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, record review and interview the facility failed to ensure the oxygen tubing, nasal cannulas and oxygen masks were stored in a manner to prevent the potential for contamination for 3 (Resident #8, 12 and 13) of 4 case mix residents (Residents #7, 8, 12 and 13) who required oxygen therapy. This failed practices had the potential to affect 10 residents who required oxygen therapy as documented on the oxygen printout received from the Administrator on 5/26/06 at 11:10 a.m. The findings are:  1. Resident #8 has diagnoses of Asthma, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Angina and Pneumonia. The Admission Minimum Data Set (MDS) dated 3/10/06 documented the resident was	F 328		

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F 328	<p>Continued From page 27</p> <p>independent in cognitive skills for daily decision-making and required oxygen therapy.</p> <p>a. A physician order dated 2/11/06 documented, Oxygen @ (at) 2.5 LPM (liters per minute) via N/C (nasal canula).</p> <p>b. On 5/22/06 at 2:25 p.m., the O2 tubing was lying across the resident's bed uncovered and was dated 5/21/06.</p> <p>c. On 5/23/05 at 11:15 a.m., the resident was asked who puts on the oxygen and the resident stated, "I put it on when I got back." The resident was asked if there anything to put the end of the tubing in when it is not in use and the resident stated, "I dropped the bag and just never got another one."</p> <p>d. On 5/23/06 at 12:20 p.m., the oxygen tubing was not covered and was coiled around the handle of the oxygen tank in the room. The resident stated, "I use it (portable oxygen tank) when I go to activities and physical therapy."</p> <p>2. Resident #13 had diagnoses of COPD (chronic obstructive pulmonary disease) and Pulmonary Edema. The Quarterly MDS dated 5/2/06 documented the resident was independent in cognitive skills for daily decision making and did not require oxygen.</p> <p>a. A physician order dated 6/8/05 documented, Oxygen at 2 Liters PRN (as needed) via N/C (nasal canula) at resident's request for shortness of breath.</p> <p>b. On 5/22/06 at 2:32 p.m., the resident ambulated from the hall and sat down on the bed</p>	F 328			

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F 328	Continued From page 28 then picked up the oxygen cannula off of the floor and placed the nasal cannula in her nose.  c. On 5/26/06 at 7:48 a.m., the resident entered the room and picked up the oxygen tubing off the floor and placed the cannula in her nose then turned on the oxygen concentrator.  3. Resident #12 had diagnoses of COPD (Chronic Obstructive Pulmonary Disorder) and Asthma. The MDS dated 3/10/06 documented the resident was independent in cognitive skills for daily decision making and did not require oxygen.  a. A physician order dated 5/7/06 documented, "O2 (Oxygen) at 2 liters per nasal cannula PRN SOB (shortness of breath)."  b. On 5/25/06 at 8:15 p.m., the resident's O2 mask was uncovered/unbagged and hanging on the oxygen level indicator with the tubing laying on the floor and the nasal cannula was laying on the bed uncovered/unbagged.  c. On 5/26/06 at 8:15 a.m., the resident's O2 nasal cannula was hanging on the front of the concentrator unbagged and uncovered and the tubing was laying on the floor to the right of the concentrator. The O2 mask was laying on the concentrator uncovered and unbagged with the tubing on the bed.	F 328			
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	F 441			

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F 441	<p>Continued From page 29</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure staff implemented contact isolation precautions to prevent the potential for the spread of infection for 1 (Resident #14) of 1 case mix residents who was in contact isolation. The facility failed to handle linen in a manner to prevent the potential for the spread of infection. The facility failed to ensure the ice scoop was not left in the ice chest when dispensing ice to residents. These failed practices had the potential to affect all 65 residents. The findings are:</p> <p>1. The facility's policy on Isolation Precautions, Categories of documented "General Guidelines: ... B. ... c. Gloves and Handwashing: 1. Wear gloves (clean, nonsterile) when entering the room.... d. Gown: 1. Wear a gown (clean, non sterile) when entering the room if you anticipate that your clothing will have substantial contact with the patient, environmental surfaces, or items in the patient's room; if the resident is incontinent; or if the resident has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing."</p> <p>2. Resident #14 had diagnoses of Prostate Cancer and Urosepsis. The Minimum Data Set</p>	F 441			

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F 441	<p>Continued From page 30</p> <p>(MDS) dated 4/13/06 documented the resident was independent in cognitive skills for daily decision making, had pneumonia and respiratory infection and an Indwelling catheter.</p> <p>a. A physician's order dated 5/22/06 documented, "Hospice Care @ (at)NH (nursing home) and Isolation Precautions."</p> <p>b. A Hospice Care Initial Assessment and Plan of Care dated 3/10/06 documented, "Comments: Respiratory Isolation Precautions for MRSA (Methicillin Resistant Staphylococcus Aureus)."</p> <p>c. On 5/22/06 at 3:35 p.m., the DON (Director of Nursing) stated the resident was on contact isolation due to MRSA contracted while in hospital. The DON then entered the resident's room without a mask, gown or gloves on, adjusted the resident's catheter tubing, then exited the resident's room. The DON was asked if the precautions were to be used when caring for isolation residents and she stated yes. The DON was asked if gloves should have ben worn when adjusting the catheter tubing and she stated</p> <p>4. Resident #1 had diagnoses of Diabetes, Dementia, and Congestive Heart Failure. The MDS dated 4/14/06 documented the resident was severely impaired in cognitive skills for daily decision making and totally dependent on staff for activities of daily living.</p> <p>a. On 5/25/06 at 8:25 a.m., CNA (Certified Nursing Assistant) #2 was giving the resident a whirlpool bath. The CNA placed used linen in a pillowcase then placed the pillow case on the floor in the whirlpool room. After the whirlpool, CNA #1 washed and dried the resident's hair then placed</p>	F 441		

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F 441	Continued From page 31 the towel over the CNA's shoulder. After the CNA was finished she gave the towel to another CNA who placed it in a pillow case that had been laying on the floor.	F 441			
F 460 SS=B	5. On 5/25/06 at 2:55 p.m., CNA #4 passed ice and water for residents in Resident Room 201, 202, 203, 204 and 205. Each time the CNA filled a water pitcher, the CNA would place the ice scoop back down in the ice.  483.70(d)(1)(iv)-(v) RESIDENT ROOMS  Bedrooms must be designed or equipped to assure full visual privacy for each resident.  In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.  This REQUIREMENT is not met as evidenced by:  Based on observation, the facility failed to ensure privacy curtains were hung in all non-private resident rooms. This failed practice had the potential to affect 65 residents who resided in semi-private rooms according to the Administrator on 5/22/06. The findings are:  1. On 5/25/06 at 3:10 p.m., there was no privacy curtain in Resident Room #108, that was a semi-private resident room.  2. On 5/23/06 at 8:40 a.m., there was no privacy curtain in Resident Room #217 that was a semi-private room.	F 460			

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F 502 F 502 SS=D	Continued From page 32 483.75(j)(1) LABORATORY SERVICES  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by:  Based on record review and interview the facility failed to ensure a Dilantin level was drawn for for 1 (Resident #5) of 14 case mix residents (Resident #1-13 and 16). This had the potential to affect all 72 residents. The findings are:  Resident #5 had diagnoses of Cardiac Arrhythmia, Osteoarthritis, Hip Fracture, Seizures and Alzheimer's Disease. The Minimum Data Set (MDS) dated 4/28/06 documented the resident was severely impaired in cognitive skills for daily decision making.  a. A physician order dated 5/20/06 documented, Dilantin level 5/22/06 and Q (every) 3 months.  b. On 5/24/06 at 11:00 a.m., the DON (Director of Nursing) was asked to find the Dilantin level in the resident's clinical record and she stated, "No. I don't see it but maybe it's in the computer."  c. On 5/24/06 at 3:15 p.m., the DON stated, "No. The level was not done but I've called the lab to come draw."	F 502 F 502			
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS  The facility must maintain clinical records on each resident in accordance with accepted professional	F 514			

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F 514	<p>Continued From page 33</p> <p>standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview the facility failed to ensure the blood glucose level and administration of insulin was documented for 2 (Resident #2 and 8) of 4 case-mix residents (Resident #1, 2, 6 and 8) who received insulin. The facility failed to ensure tube feeding intake was documented for 2 (Resident #1 and 5) of 4 case mix residents (Resident #1, 4, 5 and 7) who had a feeding tube. The facility failed to ensure the intake was recorded for 1 (Resident #11) of 4 case mix residents (Resident #4, 9, 10 and 11) who had an indwelling catheter. These failed practices had the potential to affect 9 residents who received insulin according to a list provided by the Administrator on 5/26/06 and 13 residents who had a feeding tube and 9 residents who had an indwelling catheter according to the Resident Census and Conditions of Residents form dated 5/23/06. The findings are:</p> <p>1. Resident #2 has diagnoses of Diabetes Type II, Peripheral Neuropathy and Diabetic Retinopathy. The Quarterly Minimum Data Set documented the resident was independent in cognitive skills for</p>	F 514			

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F 514	<p>Continued From page 34 daily decision making.</p> <p>a. A physician order dated 5/1/06 documented, ACCU-CHECKS BID (two times per day).</p> <p>b. The May 2006 Medication Administration (MAR) documented Accu checks were to be done at 6:30 a.m. and 4:30 p.m. There was no documentation the Accu checks were performed at 4:30 p.m. on 5/1/06, 5/2/06, 5/3/06, 5/5/06, 5/6/06, 5/7/06, 5/11/06, 5/13/06, 5/14/06, 5/21/06, 5/22/06 and 5/23/06.</p> <p>c. The May 2006 MAR documented sliding scale insulin was to be administered at 6:30 a.m. and 4:30 p.m. There was no documentation of the amount of insulin administered on 5/1/06, 5/3/06, 5/4/06, 5/13/06, 5/21/06 and 5/23/06 at 4:30 p.m.</p> <p>d. On 5/24/06 at 10:15 a.m., LPN (Licensed Practical Nurse) #1 was asked "What is the procedure for a resident on sliding scale insulin." The LPN stated, "An Accu-check is done and insulin is given per sliding scale and it should be documented on the medication record."</p> <p>2. Resident #8 had a diagnosis of IDDM (Insulin Dependent Diabetes Mellitis). The Admission MDS dated 3/10/06 documented the resident was independent in cognitive skills for daily decision-making.</p> <p>a. A physician order dated 2/23/06 documented, "Accu CK's (checks) with s/s (sliding scale) Medium dose QID (four times per day) (follow Pre-printed MD (Medical Doctor) s/s Orders." The Sliding Scale Pre-printed Physician's Orders documented, "...5. ...BG (blood glucose) 301-400 ... Medium Dose 16 Units."</p>	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045181</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/26/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRESCOTT MANOR NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 MANOR DRIVE PRESCOTT, AR 71857</b>		
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F 514	<p>Continued From page 35</p> <p>b. The May 2006 MAR documentation on 5/23/06 at 8:00 p.m. a blood glucose level of 380 and no documentation that insulin had been given.</p> <p>c. On 5/24/06 at 10:05 a.m., LPN #2 was shown the documentation for 5/23/06 at 8:00 p.m. for his sliding scale insulin. The LPN stated, "This is a 380 blood sugar and I forgot to document the insulin. I gave it."</p> <p>3. Resident #5 had a diagnosis of Alzheimer's Disease. The MDS dated 4/28/06 documented the resident was severely impaired in cognitive skills for daily decision making, had a feeding tube and required monitoring of intake and output.</p> <p>a. The Overall Plan of Care dated 3/20/06 with an update of 4/28/06 documented a problem of "alteration in nutrition: Gastrostomy Tube." with an approach to "Monitor intake and output."</p> <p>b. The April 2006 Intake and Output Summary did not document any intake on 13 occasions. From 5/1/06 to 5/24/06 there was no documentation on the Intake and Output Summary of any intake on 45 occasions.</p> <p>4. Resident #1 had a diagnosis of Diabetes. The MDS dated 4/14/06 documented the resident was severely impaired in cognitive skills for daily decision making, had a feeding tube and required monitoring of intake and output.</p> <p>a. The Plan of Care dated 10/18/05 and last updated on 4/14/06 documented a problem of "Tube feeding Glucerna at 50 cc (cubic centimeters) per hour via auto pump cont. (continuous)." and an approach to "Monitor I &amp; O</p>	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:  <b>045181</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/26/2006</b>
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F 514	<p>Continued From page 36 (intake and output) Q (every) shift &amp; record."</p> <p>b. The April 2006 Intake and Output Summary did not document any intake on 13 occasions. From 5/1/06 to 5/24/06 there was no documentation on the Intake and Output Summary of any intake on 33 occasions.</p> <p>5. Resident #11 had diagnoses of Unspecified Disorder of the Bladder and Urinary Retention. The MDS dated 5/15/06 documented the resident was moderately impaired in cognitive skills for daily decision making and had an indwelling catheter.</p> <p>a. The Plan of Care dated 11/16/06 and updated on 5/15/06 documented a problem of "Altered Urinary Elimination-Indwelling Catheter-Supra Pubic to be changed as ordered and PRN (when necessary) malfunction' with an approach to "record accurate intake and output Q (every) 8 hours."</p> <p>b. The April 2006 Intake and Output Summary did not document any intake on 28 occasions. From 5/1/06 to 5/24/06 there was no documentation on the Intake and Output Summary of any intake on 46 occasions.</p> <p>6. On 5/26/06, the DON was informed of the concern regarding intake and output and she stated, "I didn't realize they were not putting total intake in addition to recording tube feeding and flush on the MARS (Medication Administration Record)."</p>	F 514			