

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

PRINTED: 06/29/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045181	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/15/2007
NAME OF PROVIDER OR SUPPLIER PRESCOTT MANOR NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MANOR DRIVE PRESCOTT, AR 71857	
(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 226 SS=B	<p>Complaint #12579 substantiated (all or in part) with deficiencies cited at F241, F312, F314 and F315.</p> <p>483.13(c) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that all staff were trained through orientation and on-going sessions on issues related to abuse prohibition practices for 4 employees hired for the facility and screen potential employees for a history of abuse, neglect or mistreating of residents by attempting to obtain information from previous employers and/or current employees and checking with the appropriate licensing boards and registries for 1 of 5 new employees hired. This failed practice had the potential to affect all 57 residents according to the Resident Census and Conditions of Residents form dated 6/11/07. The findings are:</p> <p>1. On 6/14/07 at 3:40 p.m. after review of the facility employee record for new hires for the past 4 months, 5 sampled records 4 of the new hires, date of hire for 2 of the new hires were 5/25/07, and the date of hire for the other 2 new hires were 6/5/07, did not have abuse training before starting employment. One of the new hires, date of hire 3/8/07, did not have a reference check before starting employment.</p>	F 226		

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 226	Continued From page 1 2. On 6/14/07 at 4:35 p.m. RN #1 stated, "New employees only get abuse training if they come out of the CNA (Certified Nursing Assistant) class. They get it there. They don't get it here as part of their orientation." 3. On 6/14/07 at 4:45 p.m., the Administrator stated, "The CNA instructor does the reference checks on all the CNA's in her class. We don't have that here. She does the Abuse Training for all the CNA's in her class. So we don't do it here. Any new employee hired past March 20, 07 (Inservice on Abuse and Neglect) it is up to the area supervisor to do the Abuse training. They are to go over the facility policy and procedure book which has abuse training and it should go in their files. I have done some reference checks since I've been here, only on some. I know it's a problem. I just haven't gotten to this yet." 4. An Inservice Training, entitled Abuse and Neglect, dated March 20, 2007 given by (RN) Registered Nurse #1 on Abuse and Neglect provided by the Administrator on 6/14/07 at 4:45. The Administrator stated that there had been no other inservice on Abuse and Neglect since that time and all new hires past that date had not had abuse and neglect training. 5. The Facility Policy and Procedure, entitled " Abuse and Neglect " received from Administration on 6/11/07 documented, " ... Screening: Verifying reference checks from previous/current employees and/or Personal references. We will document date, whom we talked with and ask if they are eligible for rehire... Training: This facility will train all employees through orientation and on-going inservices on	F 226			

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F 226	Continued From page 2 issues related to this policy. On going training with annual inservices. What do abuse, neglect and misappropriation of resident's property mean? Identification: This facility will train staff, residents and families to recognize occurrences of abuse... "	F 226			
F 241 SS=E	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: Complaint #12579 substantiated (all or in part) with these findings: Based on observation and record review the facility failed to ensure that residents were positioned in a manner to enhance meal service for 2 (Resident #5 and 11) of 4 (Resident #4, 5, 6, 11 and 12) case mix residents that required assistance with meals and positioning. The facility failed to ensure incontinent care was provided before meals to enhance 1 (Residents) of 4 (Residents #4, 5, 6, 11 and 12) case mix residents dignity who required staff assistance with incontinent care and eating. The failed practice had the potential to affect 13 residents that require assistance from staff for meals and positioning and/or personal hygiene according to a list provided by the Administrator on 6/14/07. The findings are: 1. Resident # 5 had a diagnosis of Cerebral Vascular Accident and Diabetes. The Quarterly Minimum Data Set dated 6/11/07 documented the	F 241			

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F 241	<p>Continued From page 3</p> <p>resident had severely impaired cognitive skills for daily decision making was totally dependent of staff for all activities of daily living and was incontinent of bowel.</p> <p>a. The Care Plan dated 6/11/07 documented, "Problem. . . Self Care Deficit: feeding. . . Goal. . . [Resident #5] will be fed by staff at each meal. . . Approaches. . . 1. Elevate head of bed or place in a sitting position for feeding ... Problem ... Dependent for proper bathing, dressing, grooming and oral hygiene ... Incontinent care Q (even 2 hrs (hours) and PRN (as needed). ... "</p> <p>b. On 6/11/07 at 5:15 p.m. the resident was lying on her back in bed. The left side of her head was pushing against the side rail. She was incontinent of a large amount of liquid stool. The incontinent pad under her buttock was saturated and stained that extended approximately 6 inches from her hips. The outer edge of the stain was marked with a ink-pen. The room had a foul odor. The door to her room was open and the odor could be identified from the hall outside of her room.</p> <p>c. On 6/11/07 at 5:30 p.m., Certified Nurse Assistant (CNA) #1 was feeding the resident. The right side of her head remained pushed up against the side rails. The CNA made no attempt of re-position the resident. The odor from the liquid stool was still present.</p> <p>e. On 6/11/07 the resident remained on the incontinent pad that was saturated with the liquid stool from 5:15p.m. until 8:15 p.m.</p> <p>f. On 6/11/07 at 8:10 p.m. CNA's #1, #3 and #6 provided incontinent care and a fly crawled across the residents face, down her abdomen,</p>	F 241			

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F 241	<p>Continued From page 4</p> <p>onto her peri area into the liquid stool then made its way back up to the resident's face. Neither staff attempted to shoo the fly away.</p> <p>2. The facilities Policy and Procedure for "Respect and Dignity," provided by the Administrator on 6/14/07 documented," . . . Treating residents with dignity and respect means that you are meeting their needs and supporting the quality of life. In addition, you enhance resident's. . . considerate of their needs, wants and rights, treats them the way they want to be treated. . ."</p> <p>3. On 6/14/07 at 2:35 p.m. Registered Nurse #1 (RN) When asked are residents to be positioned appropriately and checked for incontinent care before they are feed?" She answered, "They are supposed to be."</p> <p>4. Resident #11 had a diagnosis of Alzheimers Disease and Dementia. The Annual Minimum Data Set (MDS) dated 3/6/07 documented the residents cognitive skills for daily decision making are severely impaired, is totally dependant of staff to perform all activities of daily living including eating, and is incontinent of bowel and bladder.</p> <p>a. The physician's order dated 1/12/2007 documented, " May use g chair for proper positioning and comfort."</p> <p>b. On 6/11/07 at 5:15 p.m. the resident was at the feeder table in a geri chair. The geri chair was layed back to a 40 degree angle. The resident was almost laying down. Pureed food was on her face around her mouth and chin. A fly was crawling on her face, nose, chin and mouth on the pureed food. A CNA walked over and</p>	F 241			

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F 241	Continued From page 5 repositioned her in the geri chair. The chair was repositioned to a 75 degree angle and then the resident was repositioned in the geri chair.	F 241			
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: Complaint #12579 substantiated (all or in part) with these findings: Based on observation, record review and interview the facility failed to ensure incontinent care was provided after an incontinent episode to prevent the potential for skin breakdown for 1 (Resident #11) of 7 (Residents #1, 2, 4, 5, 6, 11, and 12) incontinent and require the assistance of staff for personal care. This failed practice had the potential to affect 24 residents that were incontinent of bowel/bladder according to a list by the Administrator on 6/14/07 at 9:30 a.m. The findings are: 1. Resident #11 had a diagnosis of Alzheimers Disease and Dementia. The Annual Minimum Data Set (MDS) dated 3/6/07 documented the resident had severely impaired cognitive skills for daily decision making, was totally dependent of staff to preform all activities of daily living including eating, and was incontinent of bowel and bladder. a. The Care Plan dated 3/6/07 documented,	F 312			

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F 312	<p>Continued From page 6</p> <p>"Problem. . . Bowel/urinary elimination: alteration in incontinent. . . Goal . . . Keep resident clean, dry, free from odor. . . approaches. . . 1. Wash resident after each urinary incontinence and change clothing. . . 3. Maintain consistent perineal hygiene. . ."</p> <p>b. On 6/11/07 at 7:00 p.m. Certified Nurse Assistance (CNA) #1 and #6 returned the resident to her room in a geri-chair. They stated they were going to put the resident to bed. After the resident was placed in bed by the use of a lift, CNA #6 removed the brief and handed it to CNA #1. When asked if the brief was soiled, CNA #1 took it out of CNA #6 hand and opened it and stated, "Yes, it was wet." CNA #1 pulled the resident night gown down over her peri area, then CNA #6 covered the resident with the sheet and blanket. CNA #6 pulled up the resident's side rails and both CNA's left the resident's room. No incontinent care was provided to the resident.</p> <p>3. The facilities Policy and Procedure for Perineal Care provided by the Administrator on 6/14/07 documented, "Purpose- To cleanse perineum, to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident skin condition. Perineal care is given as needed after incontinent episodes of urination and/or defecation. . . 6. If bowel movement present wipe feces from resident's skin with edge of adult brief. . . Cleanse perineum using soap and water or incontinence preparation Using downward stroke from front-to-back, separate labia and wash."</p> <p>4. On 6/15/07 at 9:10 a.m. Registered Nurse #1stated, "Any time a resident is incontinent of urine or bowel, incontinent care should be given.</p>	F 312			

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F 312	Continued From page 7 They should always wipe from front to back to prevent infection and make sure all stool is washed off.	F 312			
F 314 SS=D	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: Complaint #12579 substantiated (all or in part) with these findings: Based on observation, interview and record review, the facility failed to ensure incontinent care was provided in a timely manner for 1(Resident #5) of 7 (Residents #1, 2, 4, 5, 6, 11, and 12) case mix residents at risk for skin breakdown and/or pressure ulcers. This failed practice had the potential to affect 24 residents that were incontinent of bowel/bladder and at risk for skin breakdown according to a list d by the Administrator on 6/14/07 at 9:00 a.m. The findings are: 1. Resident # 5 had a diagnosis of Cerebral Vascular Accident, Diabetes, and Urinary Tract Infections. The Quarterly Minimum Data Set dated 6/11/07 documented her cognitive skills for daily decision making were severely impaired, requires full dependence on staff for all activities	F 314			

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F 314	<p>Continued From page 8</p> <p>of daily living, was incontinent of bowel and bladder and had a urinary tract infection in the past 30 days.</p> <p>a. The Care Plan dated 6/11/07 documented, ". . . Problem. . . Dependent for proper bathing, dressing, grooming and oral hygiene. . . Goal. . . Will have bathing and oral/all hygiene needs met by staff on a daily basis. . . Approaches. . . 3. Incontinent care [every 2 hours and as needed.] . . . Problem. . . Bladder and Bowel Elimination. . . Incontinent. . . Goal. . . Keep resident clean, dry, free from odor . . . Approaches. . . 1. Wash resident after each incontinent episode and change clothing [as needed]. . . 2. Change bed as needed to keep resident dry and prevent skin breakdown. . . 3. Maintain consistent perineal hygiene . . ."</p> <p>b. The Weekly Pressure Ulcer Skin Report dated 4/18/07 documented that the resident had a history of Pressure Ulcers.</p> <p>c. On 6/11/07 the following observations were made:</p> <p>At 5:15 p.m. the resident was lying on her back in bed. The left side of her head was pushing against the side rail. The resident had been incontinent of a large amount of liquid stool. The incontinent pad that was under her buttocks was saturated and stained and the stain extended approximately 6 inches from her hips. The outer edge of the stain was marked with a ink-pen. The room had a foul odor. The door to her room was open and the odor could be identified from the hallway outside of the residents room.</p> <p>At 5:30 p.m., Certified Nurse Assistant (CNA) #1</p>	F 314			

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F 314	<p>Continued From page 9</p> <p>was feeding the resident. The right side of her head remained pushed up against the side rails. The CNA made no attempt of re-position the resident. The odor from the liquid stool was present.</p> <p>At 6:00 p.m. Licensed Practical Nurse (LPN) #1 was leaving the resident's room. The resident had been repositioned with her head away from the side-rail and the resident was aligned in bed. The ink mark remained and the watery stool stain had extended beyond the pen mark that was made at 5:15 p.m.. The odor in the room and hallway was still present.</p> <p>At 6:40 p.m. the resident was still lying on the stool soaked pad. The first ink mark remained and a second ink mark was made on the outer edge of the stain which was now approximately 9 inches from the residents hips. The foul odor remained.</p> <p>At 6:50 p.m. CNA (Certified Nursing Assistant) #1 and CNA #6 entered the room pushing the resident's room-mate in a wheel chair. They left the room, then returned at 7:00 p.m with a lift. The CNA's transferred the room-mate into the bed next to the door. The foul odor was present from the hallway and in the room. The CNA's did not check resident #5 and left the room.</p> <p>At 7:15 p.m. CNA's #1 and #6 walked down the hallway past the resident's room and continued down the hall. The foul odor was still present in the hallway.</p> <p>At 7:45 p.m. LPN#1 entered the room to give the room-mate medication. The foul odor was still present in the room. The LPN did not check</p>	F 314			

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F 314	Continued From page 10 resident #5. At 7:55 p.m. Registered Nurse (RN) #1 entered the room, then turned around and left. At 7:57 p.m. R.N. #1 returned to the resident's room "Oh, my goodness," then left the resident's room. At 8:10 p.m., CNA's #1 and #6 returned to provide incontinent care. CNA #3 entered room to assist at 8:15 p.m. When the resident's sheet was removed, the ink marks remained on the incontinent pad and the outer edges of the stain was now dry and a brown ring was present. At 8:35 p.m after CNA #3 completed the incontinent care of the petri area CNA # 1 patted the resident dry with a white towel between her legs. When the towel was lifted from between her legs and yellow stool was present. The CNA's did not clean the Perineum again. The resident was then turned on her side and the CNA's cleaned the stool from the resident's buttock. Areas on the residents inner buttocks were lighter in colored and elongated. CNA #3 stated that the resident had a history of pressure sores and the areas noted were the scars. The resident's buttock had no further break in the skin.	F 314			
F 315 SS=D	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.	F 315			

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F 315	Continued From page 11 This REQUIREMENT is not met as evidenced by: Complaint #12579 substantiated (all or in part) with these findings: Based on observation, interview and record review, the facility failed to ensure that a clean area of the wash cloth and a front to back motion was used when cleansing multiple areas while providing incontinent care to prevent the potential for urinary tract infection for 1 case-mix resident (Resident #5) of 9 case-mix residents (Residents #3, #4, #5, #6, #7, #8, #11, #12 and #13) who are incontinent of bowel and/or bladder and required assistance with personal care. This failed practice had the potential to affect 24 residents that were incontinent of bowel/bladder and required the assistance with personal care according to a list provided by the Administrator on 6/14/07. The findings are: 1. Resident # 5 had a diagnosis of Cerebral Vascular Accident, Diabetes and Urinary Tract Infections. The Quarterly Minimum Data Set dated 6/11/07 documented the resident had severely impaired cognitive skills for daily decision making, was fully dependent on staff for all activities of daily living, was incontinent of bowel and bladder and had a urinary tract infection in the past 30 days. a. A form entitled " Weekly Pressure Ulcer Skin Report," dated 4/18/07 documented that the resident had a history of Pressure Ulcers according to the facilities, b. The [Lab name] Services report dated 3/8/07 documented, "Urine Culture," test positive for	F 315			

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F 315	<p>Continued From page 12</p> <p>Escheria - Coli. {stool}"</p> <p>c. The [Lab name] Services report dated 3/22/07 documented, "Urine Culture test positive for Escheria-Coli, [stool]."</p> <p>d. The Care Plan dated 6/11/07 documented, ". . . Problem. . . Dependent for proper bathing, dressing, grooming and oral hygiene. . . Goal. . . Will have bathing and oral/all hygiene needs met by staff on a daily basis. . .Approaches. . . 3. Incontinent care [every 2 hours and as needed.] ... Problem. . . Bladder and Bowel Elimination. . . Incontinent. . .Goal. . . Keep resident clean, dry, free from odor . . . Approaches. . . 1. Wash resident after each incontinent episode and change clothing [as needed]. . . 2. Change bed as needed to keep resident dry and prevent skin breakdown. . . 3. Maintain consistent perineal hygiene. . ."</p> <p>e. On 6/11/07 at 8:15 p.m. the resident was incontinent of a large amount of liquid brown stool extending between her legs and out to the incontinent pad approximately 9 inches from her hips. Certified Nurse Assistant (CNA) #5 wet a wash cloth and sprayed the wet cloth with Peri Wash. The CNA then began wiping the resident up and down the left upper inner thigh and the mounds pubis several times without changing the areas of the cloth</p> <p>2. The facilities Policy and Procedure for Perineal Care provided by the Administrator on 6/14/07 documented, "Purpose- To cleanse perineum, to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident skin condition. Perineal care is given as needed after incontinent episodes of</p>	F 315			

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F 315	Continued From page 13 urination and/or defecation. . . 6. If bowel movement present wipe feces from resident's skin with edge of adult brief. . . Cleanse perineum using soap and water or incontinence preparation Using downward stroke from front-to-back, separate labia and wash."	F 315			
F 324 SS=D	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 supervise or assess the ability of 1 (Resident #8) to carry a cigarette lighter, of 2 case mix (Residents #8 and 14) who were smokers and independent in ambulation/locomotion. This failed practice had the potential to affect 11 residents identified as smokers who smoke in the smoking yard and gazebo, as identified by the Director of Nursing (DON) on 6/14/07 at 9:30 a.m. The findings are: 1. Resident #8 had diagnoses of Dementia and Mild Manic Bipolar Affective Disorder. The Minimum Data Set (MDS) dated 3/26/07 documented the resident had modified independent cognitive skills for daily decision making and had been evaluated by a licensed	F 324			

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F 324	Continued From page 14 mental health specialist in the last 90 days. a. On 6/11/07 at 12:55 p.m., the resident was outside, sitting on a sofa in front of the laundry building, smoking. The resident showed his cigarette lighter that he carried in his pocket. There were 2 large Oxygen tanks secured to the outside of the laundry building wall approximately 20 feet away from the smoking resident. The resident stated, "When I want a cigarette I want a cigarette." b. On 6/11/07 at 1:05 p.m., the surveyor told the Activity Director that a resident was outside smoking in front of the laundry building and that he had a cigarette lighter in his possession. The Activity Director immediately went outside and retrieved the lighter. c. On 6/11/07 at 1:58 p.m., the Director of Nursing stated the resident had not been assessed for carrying a cigarette lighter. d. The Smoking Policy for the facility documented, "...Staff members are responsible for giving out cigarettes and supervise residents @ [at] smoking times..." e. The Safe Practices for Handling and Operating Oxygen Equipment Policy for the facility documented, "Do not allow smoking around oxygen. Store oxygen in clean, dry locations away from direct sunlight..."	F 324			
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization,	F 334			

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F 334	<p>Continued From page 15</p> <p>each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes</p>	F 334			

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F 334	<p>Continued From page 16</p> <p>documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure an effective immunization program was in place, residents were offered the Influenza and/or Pneumococcal vaccines to prevent potential outbreaks of Influenza and/or Pneumonia infection for 4 case mix (Residents #4, 5, 7 and 8) and an informed consent regarding the benefits and potential side effects of the immunization for 1 (Resident #5) of 14 case mix (Residents #1 - 14) case mix residents eligible for vaccine administration. This failed practice had the potential to affect 47 residents who are at risk for Pneumonia and 1(Resident 8) who was admitted during the Flu season as identified by the Administrator on 6/15/07 at 10:35 a.m. The findings are:</p>	F 334			

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F 334	Continued From page 17 1. Resident # 5, date of birth 12/8/1946, had a diagnosis of Cerebral Vascular Accident, Diabetes and Urinary Tract Infections. The Quarterly Minimum Data Set dated 6/11/07 documented the resident had severely impaired cognitive skills for daily decision making and was dependent on staff for all activities of daily living. a. On 6/13/07 at 9:00 a.m. the MDS (Minimum Data Set) Coordinator stated, "[Residents name] received her flu vaccine 12/1/06. We just started giving the pneumonia vaccine last fall. We are calling the family, her doctor did not know or have a record of it." 2. On 6/13/07 at 12:05 p.m., the MDS Coordinator stated, " I can't find any consents for the flu/pneumonia vaccine. You know we just started giving pneumonia last fall." The last consent for the flu vaccine in the residents chart dated 10/15/2001. 3. Resident #4, date of birth 8/14/1943, was admitted on 8/11/04, had diagnoses of Chronic Obstructive Pulmonary Disease and Dementia with Huntington's. The MDS dated 5/10/07 documented the resident had modified independent cognitive skills for daily decision making. a. The list of Pneumococcal vaccinations received from the Administrator on 6/11/07 did not document that the resident had received the PPV. b. On 6/12/07 at 9:47 a.m. Licensed Practical Nurse (LPN) #3 stated, "She [Resident #4] has not received the Pneumococcal vaccine [PPV]"	F 334			

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F 334	<p>Continued From page 18</p> <p>from us. We don't know when her last PPV was."</p> <p>4. Resident #7, date of birth 9/28/1932, was admitted on 12/18/06, had diagnoses of Pneumonia, Sepsis and End Stage Renal Disease. The MDS dated 4/2/07 documented the resident was independent in cognitive skills for daily decision making.</p> <p>a. The list of Pneumococcal vaccinations received from the Administrator on 6/11/07 did not document that the resident had received the PPV.</p> <p>b. On 6/12/07 at 10:57 a.m. LPN #3 stated, "She [resident #7] didn't get it [PPV]. I don't know when her last one was." LPN #3 stated she had sent a letter to the resident's doctor in March (2007) concerning the date of the last PPV, but had not received any information and had not followed up.</p> <p>5. Resident #8, birth date 11/17/1930, was admitted on 3/14/07, had diagnoses of Chronic Obstructive Pulmonary Disease and Seizure Disorder. The MDS dated 3/26/07 documented the resident had modified independent cognitive skills for daily decision making.</p> <p>a. The list of Pneumococcal vaccinations received from the Administrator on 6/11/07 did not document that the resident had received the PPV or the Influenza vaccine.</p> <p>b. On 6/12/07 at 10:44 a.m. LPN #3 stated, "I don't know about [Resident's name] PPV. I didn't give him the Flu vaccine because he was admitted on 3/14/07."</p>	F 334			

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F 334	Continued From page 19 6. On 6/12/07 at 4:25 p.m., the Director of Nursing stated she was aware that not all PPV's had been administered and that letters had been sent to the physicians in March (2007), "But it has not been followed up on." 7. On 6/15/07 a facility Policy for Vaccination/Immunization documented, "It is the policy of this facility that all patients/residents receive, if not contraindicated, appropriate vaccinations/immunizations as determined by physician's order, Centers for Disease Control guidelines and patient/family consent.	F 334			
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that food was properly stored in the refrigerator, freezer, and storage area to prevent potential for cross-contamination and freezer burn. Failed to maintain cold food at 41 degrees or below and failed to ensure that employees wash their hands between handling dirty equipment and the food. These failed practices had the potential to effect 46 residents who received their meal trays from the kitchen. Dated 6/11/07 according to the Resident Census and Condition of the Residents. The findings are: 1. On 6/11/07 at 11:20 a.m., the following observations were made:	F 371			

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F 371	Continued From page 20 a. There were nine bowls of apple cobbler on the food preparation counter that were covered with a thin-tissue paper that was saturated with the contents inside the apple cobbler bowls that were to be served to the residents at the lunch meal. There was a fly at the edge of the bowl. b. There was a box of baking soda and a box of corn starch on the shelf in the storage room that were not sealed. c. There was a gallon of lemon juice-more than half used- on the shelf in the storage room. More than half of the juice had been used. Instructions on the bottle documented, "Refrigerate after Opening." d. There was one package of ground hamburger meat at the bottom of the refrigerator that was opened and not placed in a sealed bag. e. There was one packaged of beef hot dogs that was on the second shelf of the refrigerator that was not sealed or sealed. f. A box that contained sausage was in the refrigerator on the second shelf and was not sealed. 2. On 6/11/07 at 11:40 a..m., Dietary Employee #1 who had gloves on both hands, went to the storage room, picked up a loaf of bread, turned on the sink faucet, rinsed her hands and then opened the bread bag. She placed the wet hand inside the bread bag and removed seven slices of bread and placed them in a pan then placed the pan in the oven.	F 371			

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F 371	<p>Continued From page 21</p> <p>3. On 6/11/07 at 4:54 PM., Dietary Employee #1 had a glove on her right hand, picked up a measuring cup and scooped up cold green beans into the blender, then picked up bread bag turned on the sink faucet, rinsed her hands and placed the wet gloved hand inside the bread bag and removed slices of bread and placed them on top of the cut green beans already in the mixer and pureed them to be served to the residents for the supper meal.</p> <p>4. On 6/11/07 at 5:06 p.m., when the food temperature was taken by Dietary Employee #2, on ice, the macaroni salad temperature registered 60 degrees F.</p> <p>5. On 6/12/07 at 9:15 a.m., the following observations were made:</p> <p>a. There were two packages of meat, one package of ham and one package of salami, placed on the second shelf of the refrigerator, both packages were sealed.</p> <p>b. The same package of hot dog from 6/11/07 was still not sealed.</p> <p>c. There was approximately 5lb of Roast Beef in a clear bag that was in the dining room freezer that was not sealed exposing it to freezer burn.</p> <p>d. There was a bag of green peas in the dining room freezer that was not covered exposing it to freezer burn.</p> <p>e. There was a bag of chicken in the dining room freezer that was not sealed exposing it to freezer burn.</p>	F 371			

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F 371	Continued From page 22	F 371			
F 428 SS=D	<p>f. There was approximately 5lbs of Roast Beef that was stored in a clear bag. The bag was torn on the side and bottom. The meat was touching a box that contained breaded chicken strips.</p> <p>483.60(c) DRUG REGIMEN REVIEW</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure the Consultant Pharmacist Monthly Reports were acted upon for 1 of 1 case mix (Resident #4). This failed practice had the potential to affect all 57 residents according to the Resident Census And Conditions Of Residents report dated 6/11/07. The findings are:</p> <p>1. Resident #4 had diagnoses of Gastritis, Anemia, Chronic Obstructive Pulmonary Disease and Dementia with Huntington's. The Minimum Data Set dated 5/10/07 documented the resident had modified independent cognitive skills for daily decision making.</p> <p>a. The consultant pharmacist dated documented, "In order for nursing homes to comply with State and Federal regulations, consultant pharmacists are required to make recommendations</p>	F 428			

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F 428	Continued From page 23 concerning drug therapy for our residents. These regulations also require that we notify you of these findings, and record your response to the recommendations. We hope you will assist us by responding and returning this letter. Finding: [Resident name] has been on Prevacid 15 mg [milligrams] PO BID [by mouth twice daily] since 8-06. It is recommended that the patient be re-evaluated after 8 weeks of Anti-Ulcer medication to determine if the dosage could be reduced to a maintenance level (or discontinued altogether). Please evaluate per new Federal regulations that require a re-evaluation of therapy to determine if the resident can use maintenance only dose of QDAY [every day]. If the current dose maintains the residents function, please indicate on the sheet..."	F 428			
F 441 SS=F	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	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045181	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/15/2007
NAME OF PROVIDER OR SUPPLIER PRESCOTT MANOR NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MANOR DRIVE PRESCOTT, AR 71857		
(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 441	<p>Continued From page 24</p> <p>to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure an effective infection control program was maintained by not investigating, tracking and analyzing trends or potential causes of infections, and failed to ensure an effective immunization program was implemented. This failed practice had the potential to affect all residents who currently reside in the facility as provided by the Administrator on 6/11/07. The findings are:</p> <ol style="list-style-type: none"> On 6/12/07 at 3:45 p.m., the facility's Infection Control Log was received from the Director of Nursing (DON). The log did not document and identify the causative agent of infections (when indicated), analyze clusters, changes in prevalent organisms or describe where the infection was acquired (nosocomial or community-acquired). The DON stated, "We haven't been tracking and trending. The Lab does some tracking for us but we have been using that information for our QA every 3 months. I'll get them for you." On 6/12/07 at 4:05 p.m., the DON stated, "I'm having the Lab fax them to me." On 6/12/07 at 4:25 p.m., the DON stated, after 	F 441			

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F 441	Continued From page 25	F 441		
F 445 SS=C	<p>receiving the fax of Microbiology from the Lab, "We have no tracking and trending." 483.65(c) INFECTION CONTROL - LINENS</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure soiled linens were handled in a way to prevent possible contamination of staff's clothing. This failed practice had the potential to affect all 57 residents who currently reside in the facility as provided by the Administrator on 6/11/07. The findings are:</p> <ol style="list-style-type: none"> On 6/11/07 at 7:15 p.m. Certified Nurse Assistant (CNA#1) carried bundle of linen to the soiled linen barrel on the 200 hall. The CNA was holding the dirty linen up against her chest contaminating her uniform. The CNA removed her gloves and washed her hands and entered into a residents room. At 7:22 p.m., the CNA came out of the room, with gloved hands and took clean linen off the clean linen cart in the hall way and re-entered the residents room. The facilities "Handling Soiled Linen," Policy and Procedure provided by the Administrator on 6/14/07 at 9:30 a.m. documented, "It is a policy of [Name of Facility] to handle soiled linen in such a way to prevent spread or contamination to any and all residents. After linens will be folded with soiled side turned in. Linen will be carried to the linen barrel held away from employee to prevent contamination and spread of possible organisms. 	F 445		

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F 445	Continued From page 26 .."	F 445			
F 469 SS=E	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that the dining room, kitchen, and residents' rooms were free of pests. The failed practice had the potential to effect all 57 residents that reside in the facility according to the Resident Census and Condition of Residents form dated 6/11/07. These findings are: 1. Resident #4 had diagnosis of Chronic Obstructive Pulmonary Disease and Dementia with Huntington's. The MDS dated 5/10/07 documented the resident had modified independent cognitive skills for daily decision making. a. On 6/11/07 at 1:09 p.m., the resident was served a carton of whole milk, a carton of health shake, cooked apple, cut green beans, carrots, barbecue ribs, and corn bread. There was a fly on the corn bread. There were two flies on the resident's bed. Two flies were on the resident's bed-side table, where the resident was eating. There was a fly on the right side of the tea glass. A gnat was crawling around the opening/mouth area of the health shake. The resident was drinking out of the health shake which had no straw.	F 469			

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F 469	Continued From page 27 b. On 6/11/07 at 5:37 p.m., the resident was sitting in a chair in her room. She was served ham, cut green beans, carton of whole milk, mandarin orange, carton of health shake, water, Italian Beans, and lettuce. There was a fly on the striped towel on the bedside table by her meal tray. Three flies were on the resident's bed sheet. One fly on the bedspread. 2. Resident #xxxxxx had diagnosis of xxxxx. The Quarterly Assessment dated 6/04/07 documented the resident was severely impaired in cognitive skills for daily decision making. a. On 6/11/07 at 5:50 p.m., the resident was served 1 slice of buttered toast, macaroni casserole, cut green beans, and tea. There was a fly on the resident's toast. The fly was crawling on the resident's head, upper arm, finger, and one on her macaroni casserole. b. On 6/11/07 at 6:00 p.m., a fly was on her mandarin orange desert and another fly was on her hair. At 6:05 p.m., the resident threw up her food back into her plate. There were two flies on her upper arm. c. There were a total of 12 flies on the table and no attempt made by the staff members to remove the flies from the residents or to chase flies away from the residents' or their food items. 3. Resident #11 had a diagnosis of Alzheimers Disease and Dementia. The Annual Minimum Data Set (MDS) dated 3/6/07 documented the residents cognitive skills for daily decision making are severely impaired, is totally dependent of staff to preform all activities of daily living including	F 469			

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F 469	Continued From page 28 eating, and is incontinent of bowel and bladder. a. On 6/11/07 at 5:15 p.m. the resident was at the feeder table in a geri chair. The geri chair was layed back to a 40 degree angle. The resident was almost laying down. Pureed food was on her face around her mouth and chin. A fly was crawling on her face, nose, chin and mouth on the pureed food. A CNA walked over and repositioned her in the geri chair. 4. Resident #9 stated, "The flies are bad here." 5. Resident #10 stated, "Yea, the flies are bad. No, I don't like them on my food." 6. On 6/11/07 and 6/12/07 when interviewed, 4 of 4 alert and oriented residents who had flies on their food items stated, "We don't like flies in our food." One resident stated, "All you have to do is kill the flies with a fly swatter." "We have not seen staff chase no flies away." One resident stated, " Those flies come in when they open the door." The resident pointed to the outside door of the dining room when explained.	F 469			