

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

PRINTED: 07/11/2006
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 06/28/2006
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 282 SS=D	<p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure a physician order to increase the amount of ProMod administered and Zinc 200 mg (milligrams) was implemented for 1 of 1 (Resident #1) case mix resident who had an order for Promod powder and Zinc 220 mg. These failed practices had the potential to affect all 70 residents. The findings are:</p> <p>Resident #1 had diagnoses of Skin Disorders, Vitamin Deficiency and Constipation. The Medicare 5 day Minimum Data Set (MDS) dated 4/24/06 documented the resident was moderately impaired in cognitive skills for daily decision making, totally dependent on staff for activities of daily living and had 1 Stage III pressure ulcer. The Medicare 60 day MDS dated 6/16/06 documented the resident had 2 Stage III ulcers.</p> <p>a. A Physician Order dated 4/3/06 documented, "Promod with medication pass, 1 scoop tid (three times daily) with meds (medications)."</p>	F 282			

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

TITLE

(X6) DATE

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

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

PRINTED: 07/11/2006
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 06/28/2006
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 282	Continued From page 1 b. A Physician Order dated 4/20/06 documented, "Promod powder, 1 scoop, mix with 4 ounces of water QID (four times daily) via PEG (percutaneous endoscopic gastrostomy). Zinc 220 mg (milligrams) 1 via PEG every day." c. The Plan of Care dated 5/4/06 documented in the problem section, "Stage III left heel." The approach section documented, "Protein supplement as ordered." d. The May and June 2006 Medication Administration Record (MAR) documented, "Promod Powder 1 scoop with med (medication) pass TID for wound healing 4/20/06." There was no documentation the Promod powder, 1 scoop with 4 ounces of water QID was initiated. e. The May and June 2006 Medication Administration Record did not document the order for the Zinc 220 mg. There was no documentation in the clinical record to indicate that Zinc 220 mg had been administered in May or June 2006. f. On 6/27/06 at 12:00 p.m., the Director of Nursing was asked why the Promod was not being administered as ordered and she stated she did not know. The Director of Nursing was also asked why the Zinc was not being administered as ordered and she stated she didn't know and "I know we have problems with the orders. We'll just have to fix it."	F 282			
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309			

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

PRINTED: 07/11/2006
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 06/28/2006
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 309	<p>Continued From page 2</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #11803, substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure pain medication was administered prior to performing a pressure sore treatment to kept the resident's discomfort at a minimum during a for 1 of 4 (Residents #1 through #4) case mix residents who required a skin treatment. The facility failed to ensure staff did not use a back and forth motion to clean and that the labia and catheter tubing were cleaned during incontinent care for 1 (Resident #1) of 3 (Residents #1, 3 and 4) case mix residents who had an indwelling catheter. This failed practice had the potential to affect 40 residents who required skin treatments and 8 residents who had an indwelling catheter according to a list provided by the Administrator on 6/28/06. The findings are:</p> <p>Resident #1 had diagnoses of Skin Disorders, Vitamin Deficiency and Constipation. The Medicare 60 day MDS (Minimum Data Set) dated 6/16/06 documented the resident was moderately impaired in cognitive skills for daily decision making, had 2 Stage III pressure ulcers and no pain.</p> <p>a. A physician order dated 4/20/06 documented,</p>	F 309			

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

PRINTED: 07/11/2006
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 06/28/2006
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 309	<p>Continued From page 3</p> <p>"Darvocet N 100 1 via PEG (percutaneous endoscopic gastrostomy) 1 hour prior to wound care."</p> <p>b. A physician order dated 4/20/06 documented, "Dressing wound care to left ischial, clean area with ns (normal saline), apply thin layer of Accuzyme & (and) pk (pack) [with] 0.25% Dakins sol (solution), wet to dry, secure [with] tape Q (every) day." The April 2006 MAR documented the treatments were to be conducted at 10:00 a.m.</p> <p>c. A physician order dated 6/12/06 documented, dressing change to right heel with 10% Betadine right heel and left ischium daily and cover with 4X (by) 4's. The June 2006 MAR documented the treatments were to be conducted at 10:00 a.m.</p> <p>d. The May and June 2006 Medication Administration Record (MAR) documented, "Darvocet -N 100 tablet via PEG TBE (tube) prior to dressing change."</p> <p>e. The May 2006 MAR documented the Darvocet N-100 was not administered prior to the dressing change on 5/5/06, 5/17/06, 5/20/06, 5/21/06, 5/25/06, 5/26/06, 5/29/06, 5/30/06 and 5/31/06.</p> <p>f. The June 2006 MAR documented the Darvocet N-100 was only administered on 6/1/06 at 8:00 a.m. for generalized pain and on 6/10/06 and 6/12/06, no time noted.</p> <p>g. On 6/27/06 at 11:25 a.m., the resident was lying in bed smiling. Licensed Practical Nurse (LPN) #1 entered the room to do the resident's pressure sore treatments. The resident's left heel had a crusty blackened area that measured 4 cm</p>	F 309			

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

PRINTED: 07/11/2006
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 06/28/2006
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 309	<p>Continued From page 4</p> <p>(centimeters) x 3 cm and had a small amount of serosanguinous drainage. LPN #1 took a 4 x 4 with the Betadine solution and wiped the area and the resident started crying. LPN stated, "It burns." The left heel was covered with a 4 x 4 and tape. The surveyor told the LPN that the treatment order was for the right heel and that there was no order to treat the left heel. LPN #1 then pulled the dressing off of the left heel. The surveyor asked LPN #1 if the resident had received a Darvocet prior to the dressing change and she stated, "No, but I'll give her one now since she was hurting."</p> <p>h. On 6/27/06 at 11:40 a.m., Certified Nursing Assistant (CNA) #1, who was helping hold the resident during the treatment, was asked if the resident usually cried and she stated the resident cried during treatments.</p> <p>i. On 6/27/06 at 12:00 p.m., the Director of Nursing was asked why the Darvocet N-100 was not being administered as ordered and she stated she did not know the order had changed and didn't know why it wasn't being given as ordered.</p> <p>j. The Plan of Care dated 5/4/06 documented in the problem section, "Altered urinary elimination - indwelling catheter." The approach section documented, "Change catheter every 30 days and PRN (as needed) malfunction; Instruct staff on proper catheter care and proper infection control techniques."</p> <p>k. On 6/26/06 at 10:10 p.m., Licensed Practical Nurse (LPN) #3 and the Assistant Director of Nursing rolled the resident to the left side to view a dressing on the resident's buttocks area. While rolling the resident, the urinary catheter tubing</p>	F 309			

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

PRINTED: 07/11/2006
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 06/28/2006
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 309	Continued From page 5 became disconnected by the port portion of the tube spilling a small amount of urine on the bed linens. Both ends of the tubing touched the bed linens, therefore contaminating the closed drainage system. The tubing was reconnected by the ADON. It was noted that the resident had a small bowel movement. CNA #4 and 5 were called into the room to provide incontinent care for the resident. CNA #4 prepared a basin with soapy water. CNA #5 held the resident's legs and CNA #4 took a wash cloth and washed with a back and forth motion from the anal area up on to the urinary catheter tubing. The labia was not separated and washed and the tubing was not cleansed. The resident was rolled to the left side and the anal area was washed with a back and forth motion going down onto the vaginal area. I. The facility's policy and procedure on urinary catheter care dated August 2002 documented, "Never disconnect the catheter drainage system... Ensure that there is no disconnection or leaking of urine from the system (except into the drainage bag)... With nondominant hand separate the labia of the female resident or retract the foreskin of the uncircumcised male resident. Maintain the position of this hand throughout the procedure. Assess the urethral meatus. Use a washcloth with warm water and soap to cleanse the labia... Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward."	F 309			
F 314 SS=G	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	F 314			

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

PRINTED: 07/11/2006
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 06/28/2006
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 314	<p>Continued From page 6</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #11803, substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure supplements were ordered as recommended and interventions were developed and implemented in a timely manner to prevent development of pressure sores for 1 (Resident #4) of 4 case mix residents (Resident #1, 2 and 3) who had a history pressure ulcers. This failed practice resulted in actual harm for Resident #4 who developed multiple Stage II pressure sores and had the potential to affect 70 residents who were assessed as being at risk for developing pressure sores according to the Administrator on 6/28/06. The findings are:</p> <p>Resident #4 had diagnoses of Arteriosclerotic Vascular Disease (ASCVD), Cerebral Vascular Accident (CVA), Peripheral Vascular Disease (PVD) and Insulin Dependent Diabetes Mellitus (IDDM). The Quarterly Minimum Data Set (MDS) dated 4/12/06 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistance with all activities of daily living (ADLs), was incontinent of bowel, had a Foley catheter, 1 Stage II pressure ulcer and a gastrostomy tube.</p>	F 314			

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

PRINTED: 07/11/2006
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 06/28/2006
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 314	Continued From page 7 a. The Care Plan revised 4/12/06 documented, "...Problem: Pressure Ulcer at risk for skin breakdown due to incontinence of bowel, requires TNC (total nursing care) and immobility. Has catheter for decub on buttock to heal - Approaches: Report all changes in skin, e.g. (such as) redness, breaks in skin to charge nurses. Turn and reposition every 2 hours times 2 CNAs (Certified Nursing Assistant) and apply lotion to body for prevention of dry skin during am care and PRN (as necessary)." b. The Dietary Progress Note dated 4/12/06 documented, "RD (Registered Dietician) note-wt. 143 # (pounds) stable. Skin - stage II decub to coccyx 1 x (by) 1.2 cm (centimeter) healing per DON (Director of Nursing). MVI (multivitamin), Vit. (vitamin) C, Zinc all d/c'd (discontinued). Diet Mech. (mechanical) soft. intake 25% TF (tube feeding): Glucerna Select at 50 cc (cubic centimeters)/hr (hour) Flushes recently increased to 500cc QS (every shift) secondary to dehydration... Current diet meets est.(estimated) needs but not at intake. Diet and TF providing sufficient Kcal as evidenced by stable weight... Recommend (1) Begin Arginaid or Juven protein supplement secondary to low Albumin and wounds... Goal: wound healing..." c. As of 6/27/06, there was no documentation in the clinical record of a physician order for Arginaid or Juven protein supplement or that the supplement had been administered. d. The Weekly Skin Assessment dated 6/6/06, 6/13/06 and 6/20/06 did not document any breakdown in the skin.	F 314			

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

PRINTED: 07/11/2006
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 06/28/2006
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 314	<p>Continued From page 8</p> <p>e. The June 2006 Treatment Administration Record (TAR) documented Xenaderm Ointment to reddened areas as needed. The TAR documented that the ointment was administered only once during the month of June on 6/24/06.</p> <p>f. Nurses notes dated 6/21/06, no time noted, documented, "Res. (Resident) has large area to coccyx approximately hand print size. The area is pink with no drainage but very foul odor. Will con't (continue) to monitor."</p> <p>g. A physician telephone order dated 6/22/06 documented, "Dietary Consult". As of 6/27/06, there was no documentation in the clinical record that a dietary consultation had been conducted.</p> <p>h. On 6/27/06 at 4:15 p.m., the Dietary Manager was asked if she could locate the dietary consult ordered on 6/22/06 and she stated she had called the RD (Registered Dietician) and requested the consult. She stated it was faxed but did not go through and had to call the RD back to have her fax it again.</p> <p>i. On 6/27/06 at 4:48 p.m., the dietary consult was faxed to the facility (5 days after the order was written) and documented, "6/22/06 RD note-wt decreased 10 # after month... decub healed... Diet NPO (nothing by mouth) Tube feeding Glucerna Select at 50 cc/hr... Current TF only providing 1200 kcal, 60 gm (grams) protein not meeting estimated needs placing her at risk for further weight loss and skin breakdowns. Recommend (1) increase TF to Glucerna Select at 70 cc/hr to meet 100% needs (2) continue current flushes Goal: Resident will tolerate TF at goal rate maintain and/or gain weight.</p>	F 314			

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

PRINTED: 07/11/2006
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 06/28/2006
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 314	<p>Continued From page 9</p> <p>j. On 6/27/06 at 4:48 p.m., the Dietary Manager was asked why the RD documented the resident's decub was healed and she stated the reason the RD thought the wound was healed was because, "I sent her my most recent skin sheet and 6/7/06 was the most recent I had. I don't get one every week. I think the ADON (Assistant Director of Nursing) does these... I'll be honest with you, I don't get one every week."</p> <p>k. On 6/28/06 at 8:50 a.m., the DON was asked what was the procedure for communicating concerns such as skin issues to other departments and she stated, "Normally we go through the QA (Quality Assurance) process and meet every week and discuss the problems. We make interventions and notify the doctor, family and nurses." She was asked when the Dietary consultant makes recommendation when should it be initiated and she stated, "...within a few days." She stated she did not know why the dietary manager did not receive the skin reports for 6/14/06 and 6/21/06. She also stated, "I was on vacation." and that the ADON does the weekly skin reports and was suppose to give dietary a copy every week.</p> <p>l. A physician telephone order dated 6/24/06 documented, "...Xenaderm to coccyx area until healed TID" The TAR documented Xenaderm to coccyx every shift. There was no documentation the treatment was administered on the 3:00 p.m. - 11:00 p.m. shift from 6/24/06 through 6/28/06 and on the 11:00 p.m. to 7:00 a.m. shift on 6/24/06 and 6/25/06.</p> <p>m. The Weekly Skin Assessment dated 6/27/06, no time noted, documented by LPN #2, "skin w/d (warm and dry) to touch color turgor WNL (within</p>	F 314			

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

PRINTED: 07/11/2006
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 06/28/2006
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 314	<p>Continued From page 10</p> <p>normal limits). Excoriation noted to buttock. Xenaderm applied tid..."</p> <p>n. On 6/27/06 at 4:15 p.m., a body audit was conducted by the surveyor and LPN #4. The resident's sacral and buttocks area had a large pink discoloration with the appearance of scar tissue approximately 10 x 7 cm. Interspersed within the large pink area were several Stage II open areas of all different sizes, length and width. The areas had pieces of tissue that were brown, yellow and grayish in color. There was a small amount of bloody drainage on the bed linen where the resident had been lying and also in the open areas. Just above the coccyx area, there was an open split in the skin that was gray in color. The area was not covered and during the observation there was no odor.</p> <p>o. On 6/27/06 at 4:15 p.m., CNA #2 was present during the body audit and asked if the area looked like that yesterday (6/26/06) and she stated, "Yes, I've told'em it needed more than Lantiseptic and it needed to be covered."</p> <p>p. On 6/27/06 at 4:19 p.m., LPN #2 was asked if she saw the area last night (6/26/06) and she stated, "Yes." She was asked what she thought about the area. She stated, "I was thinking it probably needed a little more than Xenaderm." At this time the Director of Nursing (DON) walked up and she was asked when she last saw the area. She stated, "about a week ago." She was asked if the area was open or just pink. She stated, "it was just pink." LPN #2 was asked when she saw the area last night, if the area was open or just pink. She stated, "It was just pink."</p> <p>q. The facility's "Wound/Skin Care Protocol" (no</p>	F 314			

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

PRINTED: 07/11/2006
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 06/28/2006
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 314	Continued From page 11 effective date given) documented, "...Once a problem has been identified and the Dietician has been consulted, the primary nurse should work with the Dietician, Dietary Manager and resident in setting realistic goals and identify approaches to be used. ...Key points: Timely assessment and implementation of a plan of care is crucial in caring for the nutritionally at risk resident. Elderly residents are quick to experience a change in condition with a negative outcome but very slow to recover..."	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. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure used clean areas of a wash cloth during incontinent care and rinsed off the soap after providing incontinent care for 1 (Resident #5) of 6 (Residents #1 - 6) case mix residents who were incontinent. This failed practice had the potential to affect 37 who were incontinent according to a list provided by the Administrator on 6/28/06. The findings are: Resident #5 had diagnoses of Dementia and	F 315			

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

PRINTED: 07/11/2006
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 06/28/2006
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 315	Continued From page 12 Prostate Hypertrophy. The Quarterly Minimum Data Set (MDS) dated 5/16/06 documented the resident was severely impaired in cognitive skills for daily decision making, incontinent of bladder, totally dependent on staff for personal hygiene and had not had a urinary tract infection in the past 30 days. a. On 6/26/06 at 9:43 p.m., Certified Nursing Assistant (CNA) #3 provided incontinent care. The CNA used a wet wash cloth with liquid soap to wash the groin and scrotal area. The CNA retracted the foreskin and with the same wash cloth washed around the urinary meatus. The CNA dried the areas, but did not rinse the areas of soap. b. The Directions for Use on the soap bottle documented, "Dispense a small amount of product onto wet washcloth or hand. Work into a rich lather. Rinse and repeat if necessary."	F 315			
F 325 SS=G	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Complaint #11803, substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure dietary	F 325			

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

PRINTED: 07/11/2006
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 06/28/2006
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 325	<p>Continued From page 13</p> <p>recommendation for a supplement was ordered and recommendation for a dietary consult was requested in a timely manner to prevent further weight loss for 1 (Resident #4) of 4 (Resident #1, 2 and 3) case mix residents who were assessed as being at risk for weight loss. This failed practice resulted in actual harm for Resident #4 who sustained an 8.1% % weight loss in 37 days and had the potential to affect 35 residents who were at risk for weight loss according to the Administrator on 6/28/06. The findings are:</p> <p>Resident #4 had diagnoses of Arteriosclerotic Vascular Disease (ASCVD), Cerebral Vascular Accident (CVA), Alzheimer's Disease and Peripheral Vascular Disease (PVD) and Insulin Dependent Diabetes Mellitus (IDDM). The Quarterly Minimum Data Set (MDS) dated 4/12/06 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistance with eating, had swallowing problems, a gastrostomy tube, and had no weight loss.</p> <p>a. A physician order dated 1/12/06 documented, "Glucerna Select 50cc (centimeters)/hr (per hour)... Wednesday weekly weights."</p> <p>b. The Dietary Progress Note dated 4/12/06 documented, "RD (Registered Dietician) note-wt. 143 # (pounds) stable. Diet Mech. (mechanical) soft. intake 25% TF (tube feeding): Glucerna Select at 50 cc (cubic centimeters)/hr (hour) Flushes recently increased to 500cc QS (every shift) secondary to dehydration... Current diet meets est.(estimated) needs but not at intake. Diet and TF providing sufficient Kcal as evidenced by stable weight... Recommend (1) Begin Arginaid or Juven protein supplement</p>	F 325			

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

PRINTED: 07/11/2006
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 06/28/2006
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 325	<p>Continued From page 14</p> <p>secondary to low Albumin and wounds... Goal: wound healing..." As of 6/27/06, there was no documentation in the clinical record of a physician order for Arginaid or Juven protein supplement or that the supplement had been administered.</p> <p>c. The Admission Nursing Assessment documented the resident returned from the hospital on 5/23/06. The Weight Record documented:</p> <p>1) 5/23/06 - 148 lbs.</p> <p>2) 6/6/06 - 144 lbs.</p> <p>3) 6/13/06 - 142 lbs.</p> <p>4) 6/20/06 - 138 lbs.</p> <p>A 6.8% weight loss in one month.</p> <p>d. The care plan revised 6/22/06 documented, "wt. (weight) loss of 6 lbs. (pounds) x (times) 2 wks (weeks) with feeding of Glucerna Select at 50 cc (centimeter)/hr (hour)... - Interventions: dietary consult to evaluate the need for increase in T (tube)-feeding,... Intake and output every shift,... Dietary manager and/or RD (Registered Dietician) will monitor resident's diet and G (gastrostomy)-tube consumption for adequate nutritional need, report to MD (medical doctor) PRN (as necessary),... monitor weekly wts..."</p> <p>e. A physician telephone order dated 6/22/06 documented, "Dietary Consult". As of 6/27/06, there was no documentation in the clinical record that a dietary consultation had been conducted.</p> <p>f. On 6/27/06 at 4:15 p.m., the Dietary Manager</p>	F 325			

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

PRINTED: 07/11/2006
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 06/28/2006
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 325	Continued From page 15 was asked if she could locate the dietary consult ordered on 6/22/06 and she stated she had called the RD (Registered Dietician) and requested the consult. She stated it was faxed but did not go through and had to call the RD back to have her fax it again. g. On 6/27/06 at 4:48 p.m., the dietary consult was faxed to the facility (5 days after the order was written) and documented, "6/22/06 RD note-wt decreased 10 # after month... decub healed... Diet NPO (nothing by mouth) Tube feeding Glucerna Select at 50 cc/hr... Current TF only providing 1200 kcal, 60 gm (grams) protein not meeting estimated needs placing her at risk for further weight loss and skin breakdowns. Recommend (1) increase TF to Glucerna Select at 70 cc/hr to meet 100% needs (2) continue current flushes Goal: Resident will tolerate TF at goal rate maintain and/or gain weight. h. On 6/26/06 at 9:10 a.m. and 6/27/06 at 9:00 a.m., 11:10 a.m. and 3:30 p.m., the resident received Glucerna Select at 50 cc/hr. i. On 6/28/06 at 10:05 a.m., the facility weighed the resident. The resident's weigh was 136 pounds. This was a weight loss of 2 pounds since 6/20/06 and was a total of 12 pounds (8.1%) in 37 days. i. On 6/28/06 at 8:50 a.m., the DON was asked when the Dietary consultant makes recommendation when should it be initiated and she stated, "...within a few days."	F 325			
F 463 SS=C	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive	F 463			

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

PRINTED: 07/11/2006
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 06/28/2006
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 463	<p>Continued From page 16</p> <p>resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #11803, substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure the call light system was in working order for 2 (Resident #7 and #8) of 11 case mix residents (Resident #1-11). This failed practice had the potential to affect all 70 residents. The findings are:</p> <ol style="list-style-type: none"> 1. On 6/26/06 at 9:22 p.m., the surveyor checked the the call light located in Resident Room #111B. The call light did not work over the resident's door and there was no alarm sounding when the call light was activated. 2. On 6/26/06 at 9:25 p.m., the surveyor checked the the call light located in Resident Room #112A. The call light did not work over the resident's door and there was no alarm sounding when the call light was activated 3. On 6/26/06 at 9:55 p.m., CNA (Certified Nursing Assistant) #2 and 6 were asked if they knew the call lights were not working in Resident Room #111B and #112A. They both stated, "No." CNA #2 was asked what do they do when they find a call light not working and she stated, "We first check to see if it is the cord not working. we switch them out from another room that no one is in, then we write it down in the maintenance book 	F 463			

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

PRINTED: 07/11/2006
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 06/28/2006
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 463	<p>Continued From page 17</p> <p>so he will fix it." She stated, "We have to call the Maintenance man if the call light didn't work or couldn't switch the cord out."</p> <p>4. On 6/27/06 at 9:30 a.m., the Maintenance man was asked how he ensured the call light system was working properly and he stated, "We usually check the call lights once a month." He was asked if he new the call lights in Resident Room #111A and 112B were not working and he stated he found out about them this morning. He stated, "I made a new monitoring log this past weekend." He also stated he had not implemented the log yet. He added he had some problems with the call light system in which the call lights in a few of the rooms would be alarming, but either would not light up over the door of the resident's room or would not light up or alarm on the panel at the nurse's station. He stated he had been attempting to contact the company who would provide maintenance for the system since April 2006. He indicated he had been unsuccessful with the company coming out to the home.</p> <p>5. On 6/27/06 at 2:10 p.m., the Administrator was asked if the facility had a policy regarding the maintenance and monitoring of the call light system and how to ensure they are working properly. As the Administrator provided a policy, she stated, "This policy doesn't specify when the call lights would be checked, but now he has developed a new monitoring system. He use to check every month, now it's every week."</p>	F 463			