

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

PRINTED: 02/09/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/30/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>SEARCY HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 SKYLINE DRIVE</b> <b>SEARCY, AR 72143</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 282 SS=E	<p>Complaint #14194 was unsubstantiated.</p> <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: Based on observation, record review and interview, the facility failed to ensure that physician orders were followed for 4 (Residents #2, 3, 11 and 17) of 14 (Residents #1 - 5, 8, 9 and 11-17) case mix residents with a physician's order for a regular and/or therapeutic diet. The failed practice had the potential to affect 122 residents on regular and/or therapeutic diets according to the Diet List dated 1/26/09. The findings are:</p> <p>1. Resident #2 had a diagnosis of Dementia and Alzheimer's Disease. The quarterly Minimum Data Set dated 1/13/09 documented the resident had moderately impaired cognitive skills for daily decision making, and required limited assistance of one person for meals.</p> <p>a. A physician's order dated 9/19/08 documented for a regular diet.</p> <p>b. On 1/26/09 at 5:40 p.m., the resident was served a mechanical altered diet that consisted of ground hamburger. The dietary tray card documented a mechanical soft diet.</p> <p>c. On 1/27/09 at 7:30 a.m., the resident was</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.

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F 282	<p>Continued From page 1</p> <p>served a breakfast tray that consisted of scrambled egg, ground ham, 1 biscuit, gravy, grape juice, milk, coffee, cornflakes, sugar, margarine, apple jelly, salt and pepper.</p> <p>d. On 1/26/09 at 2:00 p.m., after review of the clinical record, there was no documentation found in the Nurses notes, and physician orders to indicate the resident required a mechanically altered meat.</p> <p>2. Resident #3 had diagnoses of Alzheimers Disease and Hypertension. The quarterly Minimum Data Set dated 11/27/09 documented the resident had moderately impaired cognitive skills for daily decision making and required limited assistance of one person for meals.</p> <p>a. A physician's order dated 6/9/08 documented for a regular diet.</p> <p>b. On 1/26/09 at 5:25 p.m., the resident was in the dining room and was served a pureed diet of carrots, pureed potatoes, pureed ground beef, pureed bread with catsup, mustard, salt, pepper and applesauce. The dietary tray card documented a regular diet.</p> <p>c. On 1/27/09 at 7:32 a.m., the resident was served a pureed diet of pureed eggs, pureed meat, pureed bread and pureed oatmeal.</p> <p>d. As of 1/27/09 there was no documentation in the clinical record to indicate the resident required a pureed diet.</p> <p>3. Resident #11 had diagnoses of Lower Back Pain and Pressure Ulcer. The Medicare 5 day Minimum Data Set dated 1/22/08 documented the</p>	F 282			

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F 282	Continued From page 2 resident had moderately impaired cognitive skills for daily decision making, and required set up only for meals.  a. A physician's order dated 1/14/09 documented for a regular diet with no salt packet.  b. On 1/26/09 at 7:40 a.m., the resident was at the assist table and was served scrambled eggs, bacon, biscuit and gravy, cream of wheat, margarine, grape juice, milk, 2 sugar packets, pepper and salt packets.  c. On 1/27/09 at 12:30 p.m., the resident was served ham, sweet potatoes, Brussels sprouts, dinner roll, pineapple, margarine, 2 sugar packets, milk, iced tea and pepper and salt packets.  4. Resident #17 had diagnoses of Pyelonephritis and Hypertension. The Medicare 14 day Minimum Data Set dated 11/26/08 documented the resident had modified independent cognitive skills for daily decision making.  a. A physician's order dated 11/13/08 documented for a 1500 calorie diet with no salt packet.  b. The Nutrition Risk Assessment form dated 11/18/08 documented the resident's diet order as regular low concentrated sweet/no salt packet.  c. On 1/27/09 at 12:25 p.m., the resident ate in the dining room and was served a regular tray of ham, sweet potatoes, brussels sprouts, a roll, margarine and pineapple. The resident's tray ticket documented regular, low concentrated sweet/no salt packet.	F 282			

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F 282	Continued From page 3  d. On 1/27/09 at 1:15 p.m., a review of the resident's clinical record no other diet order could be found since the above diet order written on 11/13/08.  e. On 1/27/09 at 1:30 p.m., the Dietary Manager was told that the resident's tray ticket documented a regular/low concentrated sweet, no salt packet diet, and no physician's order was found in the resident's clinical record for this diet. She stated that nursing had sent a Dietary Communications form for the change. The Dietary Manager looked for Communication form but could not locate a form for a regular/low concentrated sweet, no salt packet diet. The Dietary Manager did find a Dietary Communications form for a 1500 calorie, 2 gram sodium diet dated 11/13/08 and stated that they would call the physician to clarify the orders.	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 a foley catheter was secured at the insertion site when providing catheter care to prevent trauma on the urinary meatus for 1 case mix resident (Resident #14), failed to ensure that an indwelling urinary	F 309			

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F 309	Continued From page 4 catheters were secured to prevent the potential of trauma to the urinary meatus for 2 (Resident #9 and #12) of 5 (Resident # 4, #5, #9, #12, and #14) case mix residents with indwelling urinary catheters, and failed to ensure that nail care was provided for 2 (Resident #7 and #9) of 24 (Resident #1, thru #24) case mix residents that required staff assistance for nail care. These failed practices had the potential to affect 6 residents in the facility with indwelling urinary catheters as documented on the Resident Census and Conditions of Residents form dated 1/27/09, and 165 residents in the facility that required the assistance of staff for nail care according to a list provided by the Director of Nursing on 1/30/09 at 8:50 a.m. The findings are:  1. Resident # 9 had diagnoses of Late Effect Hemiplegia and Cerebral Vascular Disease. The Quarterly Minimum Data Set (MDS) dated 1/19/09 documented the resident had modified independent cognitive skills for daily decision making and was totally dependent on staff for personal hygiene.  a. The plan of care updated 11/6/08 documented, "Problem onset 7/29/2007 Res (Resident) needs total assist with activities of daily living (ADL'S) Res is incont (incontinent) of bowel and bladder." The care plan did not address the foley catheter.  b. A Physician's Order dated 1/5/09 documented, "Check leg band placement q (every) shift."  c. On 1/26/09 at 6:10 p.m., and 1/28/09 at 9:20 a.m., the resident's fingernails were long, measuring approximately 1/4 inch past the end of the finger pads, with a dark substance encrusted	F 309			

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F 309	<p>Continued From page 5 under the nail.</p> <p>d. On 1/26/09 at 5:10 p.m., Certified Nursing Assistant (CNA) #1 and CNA#2 performed incontinent care after the resident had been incontinent of bowel. The CNA 's rolled the resident back and forth while providing incontinent care for the resident. The resident had an indwelling urinary catheter. The catheter tubing was not secured to prevent the potential of trauma to the urinary meatus.</p> <p>e. On 1/27/09 at 10:00 a.m., Licensed Practical Nurse (LPN) #1 changed the tubing and collection bag for the resident's indwelling urinary catheter. The catheter tubing was not secured in any way after the LPN had completed the care for the resident.</p> <p>2. Resident #7 had diagnoses of Late Effect Hemiplegia and Chronic Skin Ulcers. The Medicare 30 day MDS documented the resident had independent cognitive skills for daily decision making and required extensive assistance of staff for personal hygiene.</p> <p>a. On 1/27/09 at 10:20 a.m., the resident received incontinent care. The toe nails on the resident's right foot were long, pointed, sharp, and jagged.</p> <p>b. On 1/28/09 at 10:08 a.m., a treatment was performed on ulcers on the resident's right ankle and outer foot. The toe nails were long, they extended approximately 1/4 inch past the end of the toes, sharp, and jagged.</p> <p>3. Resident #12 had diagnoses of Chronic Obstructive Pulmonary Disease, Cirrhosis of</p>	F 309			

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F 309	<p>Continued From page 6</p> <p>Liver, Alcohol Abuse, Myocardial Infarct, and Psychosis. The Initial MDS dated 1/16/09 documented the resident was moderately impaired in cognitive skills for daily decision making, was bedfast, required extensive assistance for activities of daily living, and had a foley catheter.</p> <p>a. The care plan dated 1/12/09 documented, " ... resident removes leg band that secures foley cath. ... "</p> <p>b. On 1/27/09 at 9:45 a.m., CNA #5 and CNA #6 provided catheter care. The catheter was in a privacy bag hanging on the right side of the bed on the bed rail. The resident was repositioned on the left side to cleanse the buttocks and the CNA's did not lift the catheter collection bag out of the privacy bag causing the catheter to be pulled tight when the resident was repositioned. The foley catheter tubing was not secured to prevent trauma to the urinary meatus.</p> <p>c. On 1/28/09 at 11:37 a.m., LPN #2 and CNA #6 were providing a treatment to the coccyx area for a pressure sore. The catheter collection bag was hooked to the right bed rail. The resident was repositioned to the right side for care. The foley catheter bag remained on the right side of the bed causing the foley catheter tubing to be pulled tight when the resident was repositioned. The foley catheter tubing was not secured to prevent trauma to the urinary meatus. The CNA stated that the resident would not leave it [catheter leg band] on.</p> <p>4. Resident #14 had diagnoses of Congestive Heart Failure, Insulin Dependent Diabetes Mellitus and Urinary Retention. The Quarterly</p>	F 309			

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F 309	Continued From page 7 MDS dated 12/22/08 documented the resident was moderately impaired in cognitive skills for daily decision making, had an indwelling foley catheter and was totally dependent on staff for personal hygiene.  a. A physician's order dated 8/13/07 documented, "...Foley cath (catheter) care...q (every) shift..."  b. On 1/27/09 at 10:33 a.m., CNA #4 provided catheter care to the resident. CNA #4 did not secure the foley catheter tubing as the catheter tubing was cleansed from the insertion site outward. The resident stated, "...that hurts! ...that hurts..."	F 309		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure electrical wires did not protrude from the wall, a medication cart lock was not broken and the sides of the medication cart did not have sharp, jagged edges, and an oxygen tank was secured when being transported. These failed practices had the potential to affect 60 residents who routinely eat meals in the dining room, 34 cognitively impaired residents independent for ambulation on halls 9	F 323		

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F 323	Continued From page 8 and 10 where the medication cart was used and 8 residents residing on the hall where the full oxygen tank was dropped as identified by the Administrator on 1/30/09. The findings are:  1. On 1/27/09 during general observations rounds of the facility the following observations were made:  a. At 10:00 a.m., in the dining room on the south wall, wiring stripe and an outlet was hanging from the wall.  b. At 10:35 a.m., a medication cart that was used on halls 9 and 10 had a broken lock and sharp jagged edges around the side of the cart. Hall 9 and 10 where this medication cart was used was a locked unit. Residents were ambulating throughout the medication pass on both hallways.  2. On 1/27/09 at 3:01 p.m., CNA (Certified Nursing Assistant) #3 was getting a large "H" oxygen tank from the oxygen storage closet located near the rotunda of 7, 8, 9, 10, and 11 halls; after removing the tank from the closet and traveling down 7 hall with the oxygen tank mounted on the oxygen dolly, CNA #3 dropped the full tank of oxygen onto the floor. The security chain on the oxygen dolly was hanging down the side and was not secured.  3. On 1/27/09 at 3:20 p.m., the Assistant Director of Nursing stated, "They should have a chain around the tank...a chain across the tank to secure it to the dolly..."  e. On 1/27/09 at 3:24 p.m., the oxygen closet was inspected with the Assistant Director of	F 323			

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F 323	Continued From page 9	F 323			
F 363 SS=E	<p>Nursing. 6 dollies with oxygen tanks on them were found and of the 6 dollies, three dollies had broken security chains and were not secured.</p> <p>483.35(c) MENUS AND NUTRITIONAL ADEQUACY</p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure meals were prepared and served according to the planned, written menu and failed to ensure a planned diet for a 1500 calorie diet for 1 (Resident #17) of 1 case mix resident who had orders for a 1500 calorie diet. The failed practices had the potential to affect all 171 residents who took their meals from the kitchen according to the Diet List dated 1/26/09 and 1 resident who had orders for a 1500 calorie diet according to Dietary Physician Orders List dated 1/26/09. The findings are:</p> <p>1. On 1/26/09 the dinner menu documented hamburger on Bun for all diets and lettuce, French fries (Pureed potatoes with sauce for pureed diets), tomato (stewed tomatoes for pureed diets), onion, pickle for regular and low concentrated sweet diets.</p> <p>a. On 1/26/09 at the dinner meal all residents who received a hamburger were served 2 slices white bread instead of a bun. There were no</p>	F 363			

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F 363	Continued From page 10 hamburger buns present in the kitchen.  b. Pureed diets were served 1-#20 scoop of pureed bread with pureed meat instead of 2-#20 scoops to equal 1 whole bun, pureed carrots instead of pureed stewed tomatoes.  c. Pureed diets were to receive pureed potato with sauce. There was no sauce prepared for the pureed potato.  d. On 1/27/08 from 9:37 a.m., til 10:40 a.m., a group meeting was held with 5 alert and oriented residents. Three of the 5 residents in the group meeting complained of too many carrots.	F 363			
F 371 SS=F	483.35(i) SANITARY CONDITIONS  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure opened packages were dated when opened, a bag of juice that had been leaking was not used, hand washing was done between different task, and after handling their clothing or touching body	F 371			

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F 371	<p>Continued From page 11</p> <p>parts to prevent the potential transfer of food-borne organisms and cross contamination. The failed practices had the potential to affect all 171 residents who took meals from the kitchen according to the Diet List dated 1/26/09. The findings are:</p> <p>1. On 1/26/09 at 12:50 p.m. the following observations were made in the kitchen:</p> <p>a. One bag of Great Value shredded cheese in the Raetone refrigerator was twist tied with no date.</p> <p>b. One box of townhouse wheat crackers were on top of counter in the prep area opened with 1 and 1/2 sleeves of crackers inside and had no date.</p> <p>c. A pan was on floor underneath the juice dispenser with the tubing from the juice container and a red colored liquid in the pan.</p> <p>On 1/27/09 at 1:13 p.m., the Dietary Manager stated that the juice tubing in the pan on the floor was there to prevent the juice from getting on the floor because the bag of juice had been punctured.</p> <p>2. On 1/26/09 at 2:00 p.m., Dietary Employee #1 was removing the clean dishes from the dish machine. Dietary Employee #1 was asked to get a package of oreo cookies from the storeroom, he did so, and passed them to the nurse and then continued to remove the clean plates and stack them without washing his hands.</p> <p>a. On 1/26/09 at 2:24 p.m., Dietary Employee #1 replaced a full soap container in the soap</p>	F 371			

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>045140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/30/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>SEARCY HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 SKYLINE DRIVE</b> <b>SEARCY, AR 72143</b>		
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F 371	Continued From page 12 dispenser on the dirty side of the dish machine and then continued handling the clean dishes on the clean side of the dish machine without washing hands.  b. On 1/26/09 at 2:41 p.m., Dietary Employee #1 pulled his pants up and continued to handle clean bowls.  c. On 1/26/09 at 3:00 p.m. the same employee touched his nose and continued to wrap clean silverware for dinner.	F 371			