STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ______ B. WING ______	02/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS PLACE	3501 COLLEGE AVENUE CONWAY, AR 72032

(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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 1	F 225		

by:
Based on record review and interview the facility failed to ensure all allegations of misappropriation of property were investigated, reported to the Office of Long Term Care (OLTC) and local law enforcement. This failed practice had the potential to affect all 87 residents in the facility according to the Resident Census and Conditions of Resident form dated 2/9/09. The findings are:

1. On 2/9/09 at 1:30 p.m. during the group interview, [Resident #19] alleged that she had $35.00 missing from her room about two week ago. The resident stated that she had told a CNA (Certified Nursing Assistant) and the Day Nurse and no one had ever looked for the money or replaced it.

2. On 2/10/09 at 1:05 p.m., the Director of Nursing (DON) was informed of the allegation made by [Resident #19] and that the allegation had been reported to a CNA and the Day Nurse. The DON was asked if the allegation had been reported to the Office of Long Term Care (OLTC). The DON stated that she did not know if it had been reported to OLTC but that she did know about the missing $35.00.

3. On 2/10/09 at 2:50 p.m., the Administrator was asked for allegations that had been reported to OLTC within the last year. The Assistant Director of Nursing (ADON) brought in one allegation that had been reported to the OLTC. The ADON stated that the allegation for [Resident #19] had not been reported.

4. On 2/12/09 at 9:20 a.m., the Administrator stated, that he did not investigate or report the incident to law enforcement because the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ____ B. WING ____	02/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS PLACE	**3501 COLLEGE AVENUE CONWAY, AR 72032**

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F 225	Continued From page 2 would complain often and when the facility investigated the allegation they would discover the family had taken whatever had been missing home. The Administrator was asked if the problem that was identified had been care planned, the Administrator stated no.	F 225		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the facility's Abuse Prohibition Policy and Procedure was implemented to ensure that an allegation of misappropriation of property was investigated, reported to the Office of Long Term Care and local law enforcement. The failed practice had the potential to affect all 87 residents according to the Resident Census and Conditions of Residents form dated 2/9/09. The findings are: 1. The facility's Abuse and Neglect Policy and Procedures documented, " ... 5. Investigation Protocols ... G. The results of the investigations of abuse and neglect will be maintained and monitored by the staff in start-up meetings in order to provide frequent opportunities for trending of any occurrences. H. The Administrator will submit or cause to be submitted to the Office of Long Term Care and other authorities or agencies, all reports as required. 2. On 2/9/09 at 1:30 p.m. during the group	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ______ B. WING ______	02/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS PLACE	3501 COLLEGE AVENUE CONWAY, AR 72032

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F 226	Continued From page 3 interview, [Resident #19] alleged that she had $35.00 missing from her room about two week ago. The resident stated that she had told a CNA (Certified Nursing Assistant) and the Day Nurse and no one had ever looked for the money or replaced it. 3. On 2/10/09 at 1:05 p.m., the Director of Nursing (DON) was informed of the allegation made by [Resident #19] and that the allegation had been reported to a CNA and the Day Nurse. The DON was asked if the allegation had been reported to the Office of Long Term Care (OLTC). The DON stated that she did not know if it had been reported to OLTC but that she did know about the missing $35.00. 4. On 2/10/09 at 2:50 p.m., the Administrator was asked for allegations that had been reported to OLTC within the last year. The Assistant Director of Nursing (ADON) brought in one allegation that had been reported to the OLTC. The ADON stated that the allegation for [Resident #19] had not been reported. 5. On 2/12/09 at 9:20 a.m., the Administrator stated, that he did not investigate or report the incident to law enforcement because the resident would complain often and when the facility investigated the allegation they would discover the family had taken whatever had been missing home. The Administrator was asked if the problem that was identified had been care planned, the Administrator stated no.	F 226		
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ______ B. WING ______	02/12/2009

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F 318	Continued From page 4 appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that Physical Therapy discharge instructions were planned, scheduled and implemented by staff to prevent the potential for further decline in range of motion for 1(Resident # 1) of 3 (Resident #1, #4, and #14) case mix residents who received physical therapy. The failed practice had the potential to affect 9 residents in the facility with orders for Physical Therapy as documented by a list provided by the Corporate Physician Consultant on 2/12/09 at 8:10 a.m. The findings are: 1. Resident #1 had a diagnosis of Fracture (FX) of Femur, Shaft Closed. The significant change Minimum Data Set dated 1/19/09 documented the resident had moderately impaired cognitive skills for daily decision making and had partial loss of range of motion of the leg on one side including the hip or knee. a. A Physician's Telephone Order dated 1/12/09 documented, "Physical Therapy [PT] evaluation [eval] for strength increase, activity of daily living (ADL) training 2-3 weekly (wkly) X 4 -6 wks [weeks]." b. A Physical Therapy Discharge Summary dated 1/30/09 documented, " ... Reasons for Discharge: Maximum Level reached ... Additional Discharge Information:	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ______ B. WING ______	02/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 318	Continued From page 5	F 318		

Functional Measures

Transfers to/from bed
Initial level: Wheelchair - Extensive - Maximal assistance of two. Final Level: Wheelchair-extensive- maximal assistance with cueing.

Transfers to/from chair Initial level: Wheelchair - Extensive - Maximal assistance of two.
Final Level: Wheelchair-extensive- maximal assistance with curing.

Ambulation: Even Terrain:
Initial level: Not Applicable. ...
Final Level: Total dependence on two. Patient is unable to assist.

Tolerance to IADLs [Independent Activities of Daily Living].
Initial level: Severe pain and limitation during and/or after a specific IADL affecting performance. ...
Final level: Sever limitation in a specific IADL affecting performance.

Tolerance to recreation Activities.
Initial level: Unable to perform specific recreational activity to pain or limitation. ... Final level: Unable to perform specific recreational activity secondary to pain or limitation.
Functional characteristics and analysis: [Patient] still unable to ambulate due to fear of falling and being reluctant to WB [weight bearing] on the [left lower extremity]. Impairment goal; Short term: Transfers improved. Functional goals; Long Term: Transfers are improved.
Strength/endurance improved to functional level.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ___ B. WING ___	02/12/2009

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F 318	Continued From page 6	F 318		

Gait improved to independent on rolling walker by discharge. ...

Final Instructions to Patient/Caregiver: Patient and family were given a written 2 times daily program to maintain current level of function."

c. On 2/11/09 at 12:05 p.m., Physical Therapist #1 was asked why the discharge instructions were not given to restorative nursing. The Physical Therapist stated, "I don't think they have a restorative aide yet."

d. On 2/11/09 at 12:40 p.m., Physical Therapist #1 was asked if there was documentation of the instructions given to the family. The Physical Therapist stated, "Don't have any documentation of the stretching exercises. I met with the husband and showed him some stretching for lower extremities ... to straighten out extension to the knee." The Physical Therapist also stated, "She has contractures of the knees, trying to see if she could get some flexibility back."

e. On 2/11/09 at 2:15 p.m., the resident's husband was asked if he was given instructions from the Physical Therapist. The resident's husband stated," Within the last 2 months [Physical Therapist #1] showed me how to do some stretching. Friday I had stints put in at the hospital. Before that I had a stroke. As far as I know I'm the only one that ' s been doing the stretching."

f. On 2/11/09 at 2:15 p.m., Certified Nursing Assistant (CNA) #2 was asked if she was caring for the resident. The CNA stated, "Yes." The CNA was asked if she ever received special instructions for stretching exercises for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ____ B. WING ____	02/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 318	Continued From page 7 resident. The CNA stated, "I was never told anything in particular for stretching exercises." g. On 2/11/09 at 2:35 p.m., the Director of Nursing was asked how the instructions from physical therapy was reported to the staff. The Director of Nursing stated, "When they are on therapy they fill out a sheet. We put it in the cardex or tell staff." The Director of Nursing was then asked about discharge instructions from physical therapy for the resident. The Director of Nursing looked at the Physical Therapy Discharge Summary for the resident and the cardex and stated, "There is not any documentation on the progress note for us to know about stretching exercises. " The Director of Nursing was asked how the facility documented when instructions from therapy were carried out, like a restorative book. The Director of Nursing stated, "We don't have a restorative program." h. On 2/11/09 at 2:10 p.m., after record review of the Physician's Orders, PT Discharge Summary, care plan and cardex there was no documentation found that indicated staff was to perform stretching exercises or range of motion for the resident.	F 318		
F 323 SS=K	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ______ B. WING ______	02/12/2009

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ST ANDREWS PLACE	**3501 COLLEGE AVENUE** **CONWAY, AR 72032**

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F 323	Continued From page 8 This REQUIREMENT is not met as evidenced by: A. Based on observation, record review and interview the facility failed to ensure staff received training prior to the use of a mechanical lift for 1 (Resident #13) of 6 case mix residents (Residents #1, #6, #7, #8, #13 and #14) who were transferred with a mechanical lift and failed to ensure interventions were developed and implemented to prevent the potential for continued falls for 1 (Resident #5) of 15 case mix residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15) who sustained multiple falls. These failed practices resulted in Immediate Jeopardy which resulted in or could have resulted in serious injury, harm, impairment or death for Resident #13 who sustained a fracture when falling from an improperly secured lift sling and Resident # 5 who sustained multiple falls. These failed practices had the potential to affect 22 facility residents who were transferred with a mechanical lift and 62 facility residents who had the potential for falls as documented on a list provided by the Administrator on 2/19/09. The facility was informed of the Immediate Jeopardy on 2/10/09 at 2:46 p.m. The findings are: 1. Resident #13 had diagnoses of Multiple Sclerosis, Parkinson's Disease and Anxiety State. A Minimum Data Set dated 10/13/08 documented the resident was moderately impaired in cognitive skills for daily decision making, was totally dependent on staff for all Activities of Daily Living (ADL's), did not ambulate, was lifted mechanically and was unable to attempt balance test for sitting or standing. a. A Nurses Note dated 2/9/09 timed 5:15 a.m.,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ______ B. WING ______	02/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS PLACE	3501 COLLEGE AVENUE CONWAY, AR 72032

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F 323	Continued From page 9 documented, "This nurse was outside [resident] room - CNA [Certified Nursing Assistant] called for help- CNA x 2 were transferring [resident] when CNA pulled up on lift sheet to get [resident] in proper alignment [with] chair. [Resident] slid from lift sling - when nurse entered room [resident] mid-back was over rail and CNA x2 were easing [resident] the rest of the way to the floor. Resident did not hit head [resident] slid from left feet first [with] upper body eased to floor CNA x2. On first assessment [resident] [complained] of pain all over. [Resident] had no bruising or edema or lacerations noted- Neuro [checks within normal limits at 5:20 a.m.] DON (Director of Nursing) notified [at] [5:22 a.m.] Ambulance called at [5:30 a.m.]. [Resident] daughter [name] notified. [Resident then reassessed. [Resident] pain in [left] leg intensified. [Resident] had edema noted above and below knee and in foot [resident] pedal pulse present. ... [Resident] pain 10 on pain scale. [Resident] also started [complaint of] mid-back pain. Paramedics present. Splint applied to leg by paramedics [at] [5:45 a.m.] [Resident] left facility to [hospital emergency room] ... " b. The DMS 7734 Incident and Accident Report dated 2/9/09 documented "Staff was getting resident up with a Vanderlift. The lift sheet was not crossed between the resident's legs and the resident slipped from the lift sheet when the lift raised her up off the bed. The wheelchair and lift were positioned correctly. Lift sheet was attached to the lift but was positioned wrong. Resident slid from lift sheet feet first. No head injury reported. CNAs assisted resident to floor to avoid fall. Resident first complained of pain all over. Neuro checks within normal limits. Resident began complaining of left leg pain and lower back pain.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ______ B. WING ______	02/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS PLACE	3501 COLLEGE AVENUE CONWAY, AR 72032

(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 323	Continued From page 10	F 323		

Edema was noted above and below the resident's left knee...Order received to transfer resident to [hospital] for evaluation and treatment."

c. A hospital Discharge Summary dated 2/12/09 documented a diagnosis of "Left femur fracture ... Procedures Performed: Surgery for left femur fracture."

d. The facility's Policy and Procedure for use of the Mechanical lift titled "Basic Procedures" documented: "These basic fundamentals are to be used during procedures discussed in each of the individual applications in the next section in this document. Before proceeding, please refer to the diagram of the Uni-Fit Sling illustrated below and familiarize yourself with the various components of the sling. . . Step Two - Connecting the Leg loops - For this procedure you will be using the hanger bar opposite the one you have just connected the shoulder loops to. Cross leg support loops and connect them to the hanger bar. When this procedure is completed the leg loops will be crossed in front of the patient."

e. On 2/10/09 at 2:00 p.m. the acting ADON stated, "[CNAs #4 and #5] were getting the resident up in the lift. [CNA #4] has been here a week and I did not do his training. I asked [CNA #5] what she was doing. She said she was operating the lift handle and did not look at the way the resident was secured. [CNA #4] did the lift sling. [CNA #4] did not cross the leg straps and the resident slid out."

f. On 2/10/09 at 2:00 p.m., the ADON provided copies of Vanderlift training for CNA # 4 and #5. The in-service sheet for CNA #4 was dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ____ B. WING ____	02/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS PLACE	**3501 COLLEGE AVENUE** **CONWAY, AR 72032**

(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 323	Continued From page 11	F 323		

9/20/08. The Inservice training sheet for CNA #5 was dated 2/9/09. The ADON stated she had done the inservice for CNA #5 after the resident fell.

2. Resident #5 had diagnoses of Alzheimer's Dementia with Agitation and Arthritis. A significant change MDS dated 1/14/09 documented the resident was severely impaired in cognitive skills for daily decision making, required limited assistance with transfers, supervision for ambulation, was unable to attempt balance test without physical help and had fallen in the past 30 days and in the past 31 to 180 days.

a. An Incident and Accident Report, dated 10/18/08 at 2:00 a.m., documented the resident was found on floor at 100 hall nurses station with rolling chair on top of [resident], tenderness, swelling noted to [left] lower ribs. The section titled "Recommended steps to prevent recurrence" documented: "Closely observe nighttime wandering."

b. An Incident and Accident Report dated 11/3/08 at 7:25 p.m. documented, "Heard another resident say this [resident] had fallen. Went to day room. Resident was lying on floor" No injuries were documented. The section of the form titled "Recommended steps to prevent recurrence" documented: "Observe [Resident] more closely."

c. A handwritten entry in the plan of care dated 11/3/08 (no time) documented, "Fall in day room unobserved. 11/3/08 - Spoke with family re: missing glasses. Continue to observe closely when ambulatory."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ______ B. WING ______	02/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS PLACE	3501 COLLEGE AVENUE CONWAY, AR 72032

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F 323	Continued From page 12 d. A Nurses Note dated 12/17/09 at 7:00 p.m. documented, "Called to 100 hall. Resident sitting on floor in front of couch." e. A plan of care dated 12/17/09 documented, "R [resident] found in floor...R will have appt [appointment] with MD [physician] for behaviors, weight loss and recent fall." As of 2/12/09 there was no documentation in the Nurses Notes or physician orders to indicate the resident was seen by the physician. f. A handwritten entry in the plan of care dated 12/28/08 documented, "R found sitting on floor [no] injury. 12/28/08 Contact SW [social worker] re finding R's glasses or obtaining a new pair. MD consult for [multiple]-falls scheduled 1/12/09." g. A handwritten entry in the plan of care dated 1/2/08 (no time) documented, "R found sitting on floor [no] injury. 1/2/09 MD to assess R's mds/condition 1/12/09. [Question] of behavior [sitting on floor]." As of 2/12/09 there was no documentation in the Nurses Notes or physician orders to indicate the resident went to the physician on 1/12/09. h. A Nurses note dated 1/13/09 at 10:55 a.m. documented, "[Resident] out to see Dr [name] for [check] up. No ill effects from drinking cologne." i. A physician's "Physical Exam Sheet" dated 1/13/09 documented, "1) DON sent letter of complaints [check] PT/INR [prothrombin time/International Normalized Ratio] [Laboratory] Results and respond to any [medication] changes. 2) Weight loss. . .3) Swallow Brut Aftershave over the weekend. Poison control	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ____ B. WING ____	02/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS PLACE	3501 COLLEGE AVENUE CONWAY, AR 72032

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F 323	Continued From page 13	F 323		

called per note. 4) Cough Productive yellow phegm X 3 -4 [days]. " The physician's assessment documented, " ... 1) Advanced Dementia. 2) A. Fib [Atrial Fibrillation]. " The physician's plan documented, "1) [Continue] Coumadin as is. 2) Ensure 1 can [three times a day] as tolerated. 3) [Increase] Risperdal to 1 mg [milligram] bid (twice a day). " There was no documentation that indicated the physician was made aware of or addressed the falls.

j. An "Event Report dated 1/13/09 at 10:30 p.m. documented, "Called to lobby by CNA. R was observed on floor . . . ROM [range of motion] checked - WNL [within normal limits] R assisted to chair - checked skin - no redness or breakage noted. R assisted to room and into bed."

k. A handwritten entry in the plan of care dated 1/13/09 documented, "Found sitting on the floor. 1/13/09 - R frequently sits on floor when tired - behavior related."

l. An Event Reporting form dated 1/18/09 at 3:00 p.m. documented, "R was in his room at 1500 [3:00 p.m.] et [and] decided to sit on his recliner et wasn't close enough. R sat on floor. ...denies pain. R [right] side of back noted to be pink color. [No] injuries noted. Dr [name] on call for [name of attending physician]. Called back [no] N.O. [New Order]."

m. A handwritten entry in the plan of care dated 1/20/09 documented, "[Resident] noted to sit down in floor on several occasions, not falling. Monitor behavior and document prn [as needed]. Check on status of new glasses."

n. A Nurses note dated 1/22/09 at 1:20 p.m.

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	045313	A. BUILDING ______ B. WING ______	02/12/2009

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F 323	Continued From page 14	F 323		

documented, "R was sitting in W/C [wheelchair] facing [station?] when he attempted to stand up. Loop on side of left pant leg caught on W/C causing R to fall down. R fell to floor landing on bottom. R hit middle of back on W/C arm causing red area, [with] small bruise and abrasion. R assisted to feet. ROM [checked] and WNL [within normal limits]. R escorted to room and placed in bed. "

o. A weekly summary nurses note dated 1/24/09 documented, "R has unsteady gait. R has had more falls recently. R thinks a chair is there but there isn't. Then he sits on the floor."

p. A weekly summary nurses note dated 1/31/09 documented, "R has unsteady gait, more falls recently."

q. A Nurses Note dated 2/7/09 at 1:45 p.m. documented, "Res [Resident] in floor in room. Slid from W/C. [No] apparent injury noted. Res sits very close to edge of WC and attempts self-transfer. Left message for son [name] for permission to use lap buddy. Personal alarm to be used while in bed or W/C to alert staff to res attempts self transfer."

r. A plan of care dated 2/7/09 documented, "On floor in room. Approach - Apply personal alarm in bed and W/C to alert staff to res. attempts to self transfer."

s. On 2/9/09 at 8:35 a.m., the resident was in bed with side rails up. There was no bed alarm visible on the resident's bed.

t. On 2/9/09 at 11:10 a.m., a loud yell for help was heard at the nurse's station. Three staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ______ B. WING ______	02/12/2009

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ST ANDREWS PLACE	**3501 COLLEGE AVENUE** **CONWAY, AR 72032**

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F 323	Continued From page 15 members and the Administrator responded. The resident was lying on his back on the floor just inside the door to the activity room. The resident was assessed by LPN (Licensed Practical Nurse) #1 as having a small hematoma to the back of the head and a red area on his back. The LPN stated the resident had been in the wheelchair and he decided to get up and walk. There was no chair alarm in the wheelchair. u. A plan of care intervention dated 2/9/09 documented, "Pommel cushion in W/C." v. On 2 /9/09 at 5:45 p.m., the resident was sitting in a wheelchair in the dining room. There was no alarm on the chair or attached to the resident. w. On 2/10/09 at 9:35 a.m., the resident was being dressed by CNA's #3 and #6. CNA #3 was asked is there an alarm under the resident's mattress. She stated, "Oh, no, he doesn't have any kind of alarm." The resident was placed in a wheelchair with a pommel cushion. There was no alarm attached to the chair. x. On 2/10/09 at 10:50 p.m., the resident was in the day room self propelling in a wheelchair. There was no alarm on the wheel chair. 3. The Immediate Jeopardy was removed on 2/10/09 at 6:48 p.m. and the scope and severity reduced to an "G"after the facility implemented the following Plan of Removal: On 2/9/09 Resident #8 received injury related to fall during lift transfer. CNAs involved in incident were re-trained immediately on 2/9/09 by charge nurse using manufacturers guidelines and return	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ______ B. WING ______	02/12/2009

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F 323	Continued From page 16	F 323		

demonstration. Starting 2/9/09 all CNA staff have been trained using manufacturers guidelines and return demonstration as they report to work prior to assignments by DON/designee.

All resident's at risk for falls were identified and interventions were reviewed for appropriateness and implementation on 2/10/09 by IDT (Interdisciplinary team). All care plans for residents with falls were audited and verified to be current with falling star. All CNA will be trained on fall interventions prior to reporting to assignment by DON/designee.

All residents using bed and chair alarms were identified on 2/10/09 at 18:30. Resident care plans were reviewed and updated to ensure the use of the bed/chair alarm on 2/10/09 by 1900 by IDT. All staff will be inserviced on bed and chair alarm use prior to reporting to assignment by DON/designee as staff reports to work.

Administrator, DON, and ADON were inserviced on 2/10/09 at 1830 by nurse consultant for implementation of interventions related to Incidents and Accidents.

B. Based on observation the facility failed to ensure that shower drains had covers over them and that an oxygen tank was secured. This failed practice had the potential to affect 39 residents in the facility who took showers in the 200 Hall shower room and 30 residents in the facility who resided on the Hunan Hall where the oxygen was stored as documented on a list provided by the Corporate Physician Consultant on 2/12/09 at 8:10 a.m. The findings are:

1. On 2/10/09 at 1:10 p.m., during general

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	045313	A. BUILDING ____ B. WING ____	02/12/2009

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F 323	Continued From page 17 observations, 2 showers in the 200 Hall shower room did not have covers over the floor drains. The missing drain covers exposed a hole approximately 3 inches in diameter in the floor of each of these showers. 2. On 2/10/09 at 1:15 p.m., during general observations, an unsecured oxygen tank was in the oxygen storage room. The tank was sitting upright on the floor in the room.	F 323		
F 366 SS=D	483.35(d)(4) FOOD Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure dislikes were honored or substitutes of similar nutritive value were offered to residents who refused food served for one of one case mix (Resident #12) who did not eat pork meat due to her religious belief. The failed practice had the potential to affect 82 resident residents who received their meal trays from the kitchen as identified on the diet list dated 2/5/09. The findings are: 1. Resident #12 had diagnoses of Esophageal Reflux, Hypertension, Coronary Artery Disease, and Hypolipidemia. The Minimum Data Set dated 2/2/09 documented the resident was independent in cognitive skills for daily decision making and required set up help only for eating. a. A physician order dated 7/21/08 documented for the resident to receive a Low Concentrated	F 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. BUILDING ____ B. WING ____	02/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS PLACE	3501 COLLEGE AVENUE CONWAY, AR 72032

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F 366	Continued From page 18 Sweet diet. b. The resident tray card documented under dislikes, " No Pork, No Shrimp, No Scavenger Fish, No Bacon and No Citrus." c. The facility ' s recipe #8814 for Baked Beans documented, "Canned pork and beans bake for 45 minutes. ... " d. On 2/9/09 at 12:20 p.m., the resident was served rancher's chicken, broccoli with cheese sauce, chocolate pudding and baked beans with pork. The resident ate some baked beans and stated, "I was hungry, I hope God forgives me." e. On 2/9/09 at 12:30 p.m., Dietary Employees #1 and 2 stated that nothing different was prepared to substitute for the baked beans. f. On 2/11/09 at 12:26 p.m., the resident was served one roll, garden blend rice, beef steak with gravy, seasoned greens, and pear halves in water. The resident looked at the greens and stated, " I don't eat greens here, because they cook it with pork." There was no substitutes offered to the resident by the staff members. g. On 2/11/09 at 5:11 p.m., Dietary Employee #2 stated, "The resident should not be getting any thing with pork."	F 366		
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	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 19	F 371		

Continued From page 19

This REQUIREMENT is not met as evidenced by:
Based on observation and interview the facility failed to ensure hot food items were maintained at 135 degrees Fahrenheit (F) or above, employees washed their hands or changed gloves between handling food items, dirty towel, and equipment and the kitchen was free of pest. These failed practices had the potential to affect 82 residents who received their meal trays from the kitchen according to the diet list dated 2/5/09. The findings are:

1. On 2/11/09 at 11:00 a.m., the following observations were made:

a. Dietary Employee #1, was in the kitchen area wearing a pair of disposable gloves. The employee pulled her pant up, then went into the storage room and brought out a box containing bread crumbs and placed the box on the counter. With out changing gloves, the employee picked up a spoon and mixed the bread crumbs. Without changing gloves the employee tore off a piece of saran wrap to line the bottom of a pan and sprayed the lined pan with a non stick coating. The employee then transferred the bread mixture into the pan and pressed the mixture into the rectangular shape of the pan. At no time did the employee wash her hands or change gloves.

2. On 2/11/09 at 3:11 p.m., Dietary Employee #2 was in the kitchen wearing a pair of disposable gloves. The employee picked up a measuring

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	045313	A. BUILDING ____ B. WING ____	02/12/2009

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F 371	Continued From page 20 cup, then opened the door to the storage room and brought out a box of bread crumbs and placed it on the counter. She turned on the faucet at the sink and obtained water in a container and poured the water over the bread crumbs. With out changing gloves, the employee mixed the bread crumbs with her gloved hands. She then used a paper towels to wipe the counter. The employee then tore off a piece of saran wrap to line the bottom of a pan and sprayed the lined pan with a non stick coating. The employee then transferred the bread mixture into the lined pan and began to press the mixture into the rectangular shape of the pan. At no time did the employee wash her hands or change gloves. . 3. On 2/11/09 at 4:43 p.m., Dietary Employee #3 scratched her face. With out washing her hands, she picked up a serving spoon to be used in serving the supper meal from the area that goes in the food. 2. On 2/11/09 at 4:50 p.m., the temperature of the food items on the steam table when taken by Dietary Employee #3 were as follows: a. The mashed potatoes were 118 degrees F. b. The low fat mashed potatoes were 122 degrees F. c. The pureed turkey meat registered 119 degrees F. 3. On 2/11/09 at 4:56 p.m., there was a roach crawling on the shelf by the steam table where clean dishes were kept. There was another roach crawling on the board on the wall where	F 371		

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F 371	Continued From page 21 information was posted. This board was located by the door leading to the dish room. 4. On 2/11/09 at 5:20 p.m., Dietary Employee #4 was on the line serving supper meal had gloves on both hands. The employee left the line and went to the walk in refrigerator. The employee took out a carton of magic cup to be served at the 5:00 p.m. meal service. The employee picked up spoons, forks, and knives by the tip that is used to hold food and placed them on resident trays. The employee handled tray cards, serving spoons, and plates during the meal service. The employee wiped her gloved hands with a dirty wet towel that had been used to wipe spilled food. With out changing gloves, she removed slices of bread from a bag and placed them on the resident's meal trays. At no time during the observation did the employee wash her hands or change gloves. 5. On 2/11/09 at 6:15 p.m., Dietary Employee #4 was asked what is done when food is not hot enough. The employee stated, "I suppose to reheat it. Dietary Employee #4 was asked what is suppose to be done when you handle different object before or during handling food. The employee stated, "Take the gloves off and wash my hands."	F 371		