

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

PRINTED: 05/15/2006  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>045313</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>04/18/2006</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ST. ANDREWS PLACE</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3501 COLLEGE AVENUE</b><br><b>CONWAY, AR 72032</b>                  |   |
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| F 000  | INITIAL COMMENTS  | F 000   |   |   |
| F 166<br>SS=C  | <p>483.10(f)(2) GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure a grievance of missing personal property was tracked and resolved for 1 (Resident #23) of 6 case mix residents (Residents #18-#23) who were interviewed regarding grievances during the Group Meeting. The failed practices had the potential to affect all 102 residents as documented on the Resident Census and Condition of Residents form dated 4/4/06. The findings are:</p> <p>1. Resident #23 had a diagnosis of Urinary Retention. The Annual Minimum Data Set (MDS) dated 3/14/06 documented the resident was independent in cognitive skills for daily decision making and had no short term or long term memory problem.</p> <p>a. On 4/5/06 at 9:00 a.m., the resident stated that two of her bed pillows were lost and further stated, "They are looking for them."</p> | F 166   |   |   |

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 166  | <p>Continued From page 1</p> <p>b. On 4/6/06 at 4:20 p.m., the resident stated, "I have two pillows missing and I've told everybody that has come to my room, but no one has told me anything. They've been lost since the first of the week."</p> <p>2. On 4/6/06 at 5:45 p.m., the Assistant Director of Nursing (ADON) when asked what the procedure was for residents' complaints of missing items, stated, "Tell the Social Director, talk with the resident and ask them if they would like to file a grievance and if the resident says no, then none is filed. If the resident says yes, we do file. The social director tries to tack the item for the resident with help of the staff."</p> <p>3. On 4/7/06 at 9:35 a.m., the Activity Director, when asked the procedure followed by the facility when a resident complained of items missing, stated, "I write it down and put a note at the nurse's station and tell the Social Director and then begin searching. I go to the laundry if clothing is missing and check there. If dentures are missing I call the family and let them know and continue to search the facility. When or if the items are found, we don't keep the note that was written regarding the missing items."</p> <p>When asked the procedure that the facility followed for a filed grievance, the Activity Director stated, "I don't know what a grievance is." When informed of what a grievance was, the Activity Director stated, "We tell (owner of facility) or (owners wife) and they replace the resident's items if they weren't found."</p> <p>When asked if the Social Director kept any complaints written down, the Activity Director stated, "I don't know, but I don't think so." The</p> | F 166   |   |                      |   |

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| F 166  | <p>Continued From page 2</p> <p>Activity Director further stated that she covered for the Social Director when the Social Director was not present.</p> <p>4. On 4/7/06 at 10:45 a.m., when asked about the facility's grievance policy, the Administrator stated, "Well, they tell me sometimes about missing stuff, and I usually get one of the employees over to the side and tell them if they can find out anything I'll give them \$500.00. Things will usually turn up after that."</p> <p>5. On 4/7/06 at 11:45 a.m., when asked about grievance forms, Registered Nurse (RN) #1 stated, "If anyone complains, we send them to (Social Director's name)." RN #1 could find no grievance/complaint forms at the nurse's station. When asked, what would she do if a grievance or complaint was made when the social director was not present, RN #1 stated that a grievance form would be "a good idea".</p> <p>6. On 4/7/06 at 3:00 p.m., Certified Nurse Assistant (CNA) #7 who worked on the hall where Resident #23 lived, when asked what procedure was followed if a resident reported a missing item, stated, "tell my supervisor and help look for it. No one has reported anything missing this week."</p> <p>7. On 4/7/06 at 4:47 p.m., the Director of Nurses was asked to provide any other documentation of grievances filed and acted upon. No documentation was provided as of 4/10/06 at 1:45 p.m.</p> <p>8. The facility admission packet provided by the Director of Nurses included Resident Rights that documented: "Grievances - You may expect</p> | F 166   |   |                      |   |

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| F 166  | Continued From page 3<br>prompt efforts for the resolution of grievances."<br><br>9. The Policy for Grievance and Complaint Processing copied 4/6/06 documented: . . .Complaint registration and disposition forms are kept in the Administrative offices as well as at each nursing station. . . Each staff member is instructed to receive recommendations or complaints from residents in a courteous manner and report the suggestions promptly to his/her immediate supervisor and to the Administrator in writing. . . All complaints and recommendations by residents or designated representatives will be responded to as soon as possible. . . The complaint/recommendation process will be constantly monitored and evaluated to ensure the process is effective."     | F 166   |   |   |
| F 176<br>SS=D  | 483.10(n) SELF ADMINISTRATION OF DRUGS<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and interview, the facility failed to ensure that a self-administered medication was ordered by the physician, and stored properly for 1 (Resident #21) of 3 case mix residents (Residents #20,#21 and #22) who were assessed to self-administer medications. The failed practice had the potential to affect 9 residents who were assessed to self-administer medications as identified on a list provided by the Director of Nurses (DON) on 4/6/06. The findings are: | F 176   |   |   |

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| F 176  | Continued From page 4<br><br>1. Resident #21 had a diagnosis of Dementia. The Quarterly Minimum Data Set dated 2/21/06 documented the resident had modified independent cognitive skills for daily decision making and a short term memory problem.<br><br>a. On 4/6/06 at 4:20 p.m., an unlabeled container of thick Mentholatum odored salve for lips was sitting next to the resident's bed. The resident applied the salve to her lips.<br><br>b. On 4/6/06 at 5:20 p.m., the DON (Director of Nurses) was asked to identify the unlabeled blue container of ointment. The DON stated, "It smells like that Vicks stuff." The Resident was asked by the DON what she used the ointment for. The resident placed a small amount of the ointment into her left nostril.<br><br>c. As of 4/6/06 there was no physician's order in the clinical record the resident had an order for the ointment to the lips or nares.<br><br>2. The Policy and Procedure for Self Administration of Drugs provided by the DON on 4/6/06 documented "all medications kept in residents room must be locked up to prevent other residents from having access to this medication." | F 176   |   |                      |   |
| F 253<br>SS=B  | 483.15(h)(2) HOUSEKEEPING/MAINTENANCE<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced   | F 253   |   |                      |   |

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| F 253  | Continued From page 5<br>by:<br>Based on observation, the facility failed to ensure that shower rooms and whirlpool rooms were free of a dirty, dark substance in the corners and the handrail supports were free of dust and debris. These failed practices had the potential to affect 53 residents who were ambulatory per self as identified on a list provided by the Director of Nurses on 4/7/06. The findings are:<br><br>On 4/5/06 at 2:25 p.m., during general observations, the following was noted:<br><br>1. The Shower Room near the 200 hall had 2 shower stalls that had a dark substance in the corners of the stalls.<br><br>2. The floor in the Whirlpool Room near the 100 Hall Nurses Station had a dark substance in all of the corners.<br><br>3. The handrail supports were dusty throughout the facility. A comb was found on the hand rail support upon entering the South 100 Hall on the right hand side.<br><br>4. The exit sign on the South 200 Hall was held together with grey duct tape. | F 253   |   |                      |   |
| F 282<br>SS=E  | 483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced  | F 282   |   |                      |   |

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| F 282  | Continued From page 6<br>by:<br><br>Based on observation, record review and interview, the facility failed to ensure physician and nursing plans of care were implemented, as evidenced by failure to provide the correct dietary orders for 3 (Residents #4, #11, and #17) of 5 (Residents #1, #4, #8, #11, and #17) case mix residents with physician orders for thickened liquids. The facility also failed to ensure transfer techniques were implemented per the plan of care to prevent the possibility of injury for 1 (Residents #4) of 9 case mix residents (Residents #1-#4, #6-#8, #13, and #17) who required staff assistance with transfers. These failed practices had the potential to affect 24 residents who required staff assistance with transfers as documented on the Resident Census and Condition of residents form dated 4/4/06 and 14 residents who had physician orders for thickened liquid diets as documented on the Diet Roster dated 4/7/06. The findings are:<br><br>1. Resident #4 had diagnoses of Ischemic Stroke and Vascular Dementia. The Annual Minimum Data Set (MDS) dated 3/1/06 documented the resident had bilateral limitations or range of motion with partial loss of voluntary movement of the neck, legs, and feet, and required a mechanical lift for the mode of transfer.<br><br>a. A physician order dated 5/30/04 documented: Diet: Regular with nectar thickened liquids."<br><br>b. The "Resident Notes" completed by the interdisciplinary team during the Plan of Care Meeting dated 3/8/06 documented: "She [Resident #4] is transferred via mechanical lift with all transfers. . . . Resident is on a regular diet | F 282   |   |                      |   |

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| F 282  | <p>Continued From page 7 with nectar thickened liquids."</p> <p>c. The Plan of Care dated 3/8/06 documented, "Problem; Resident requires assistance with ADL's [Activities of Daily Living] D/T [due to]Cognitive/Mental Status, CVA [Cerebral Vascular Accident] and Other (Seizures). . .Approaches-Transfers: Max [maximum] of 2 with Lift." The plan of care further documented: "Problem; At risk for aspiration D/T (due to) swallowing problems. Resident requires mechanically altered diet and altered fluids. Nectar thick. . . Approaches-Diet and fluids as ordered."</p> <p>d. A Speech Pathology Oropharyngeal Videofluoroscopy Report dated 3/28/06 documented: "Recommendation: Regular. All liquids thicken to Nectar. . . exhibits a moderate oropharyngeal dysphagia characterized by premature spillage and delayed swallow reflex with all consistencies. Pt. had laryngeal penetration (silent) with thin liquids with continuous sips."</p> <p>e. On 4/3/05 at 5:20 p.m., RN #1 stated the resident ate "in the dining room without assistance" and that her diet was "Regular with nectar thick liquids." A pitcher of unthickened ice water containing a corrugated straw was on the over bed table. There was no thickening agent observed in the room. RN #1 checked the water in the pitcher and stated, "it's not thickened."</p> <p>f. On 4/3/06 at 5:32 p.m., the resident was in the dining room. The resident was served thickened liquids, ate, and drank without assistance.</p> <p>g. On 4/4/06 at 12:20 p.m. a pitcher of</p> | F 282   |   |                      |   |

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| F 282  | <p>Continued From page 8</p> <p>unthickened ice water containing a corrugated straw was on the over bed table. There was no thickening agent observed in the room. At 1:00 p.m. the resident was observed in the dining room and was offered assistance by the staff. The resident stated, "I can do it myself." The resident fed herself and drank without assistance.</p> <p>h. On 4/4/06 at 1:30 p.m., the resident's pitcher of unthickened ice water containing a corrugated straw was on the over bed table. The resident was asked if she ever drank her water. The resident stated, "Not as much as I ought to." The resident was asked if the staff thickened her water. The resident stated, "I don't want it thick."</p> <p>i. On 4/4/06 at 5:35 p.m., the resident was again observed in the dining room feeding herself without assistance.</p> <p>j. On 4/5/06 at 10:38 a.m., 2:30 p.m., and 4:40 p.m., the resident had unthickened ice water in a pitcher that contained a corrugated straw on the over bed table. At 4:40 p.m., the resident was asked if she ever drank any of her water. The resident stated, "I drink from the pitcher with the straw in it - I don't use the glass." The resident was asked if she had the CNA's thicken the water for her. The resident stated, "No - I don't like it thick so I don't ask them to."</p> <p>k. On 4/6/06 at 10:00 a.m., there was no water pitcher in the resident's room. CNA #3 was asked, "where is the resident's water?" CNA #3 stated, "She doesn't get any water because she's on thickened liquids." The surveyor stated that there was water in the resident's room on the three previous days. The CNA stated, "They took it out of her room this morning."</p> | F 282   |   |                      |   |

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| F 282  | Continued From page 9<br><br>l. On 4/5/06 at 4:20 p.m., the resident was sitting in her wheelchair. CNA [Certified Nursing Assistant] #1 and CNA #2 entered the room to provide incontinent care. CNA #2 left the room to acquire a mechanical lift. When the mechanical lift was brought to the room the resident stated, "What is that thing?" CNA #1 stated, "The is the lift to get you out of bed." The surveyor asked the resident, "Do they usually use the lift to get you out of bed?" The resident stated, "No, I guess I'm getting too heavy - they had to have some help with lifting me."<br><br>m. On 4/5/06 at 4:50 p.m., CNA #2 was interviewed and was asked if the mechanical lift was normally used to lift the resident. The CNA stated, "We usually sit her up on the bedside, lift her under her arms and transfer her to the wheelchair."<br><br>n. On 4/5/06 at 4:55 p.m., CNA #1 was interviewed and was asked if the mechanical lift was normally used to lift the resident. The CNA stated, "Usually we use a gait belt at her waist, and lift under her arms. Sometimes she can stand a little. On her bad days we use the lift."<br><br>o. On 4/6/06 at 9:40 a.m., CNA #3 and CNA #4 entered the resident room to provide incontinent care. The resident was sitting in the wheelchair. The CNA's transferred the resident from the wheelchair to the bedside by lifting the resident under her arms and holding onto the elastic waistband of the resident slacks with the residents full body weight being placed on the residents underarms. The resident was unable to bear weight or to pivot during the procedure. At 9:47 a.m. the resident was transferred back to the | F 282   |   |                      |   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>045313</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>04/18/2006</b> |
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| F 282  | <p>Continued From page 10</p> <p>wheelchair by lifting the resident under her arms and holding onto the elastic waistband of the resident slacks with the residents full body weight being placed on the residents underarms. Again, the resident was unable to bear weight or to pivot during the procedure. The weight record for the month of March, 2006 documented the resident's weight to be 196.8 pounds. The mechanical lift was not in the room and no gait belt was used for the procedure.</p> <p>p. On 4/6/06 at 9:55 a.m. CNA #3 and CNA #4 were asked if the mechanical lift was to be used for this resident. CNA #3 stated, "Sometimes we do." CNA #4 stated, "Sometimes we use the Hoyer lift but not this morning. We didn't use it today. We use it if its available. It wasn't available today."</p> <p>2. Resident #17 had diagnoses of Alzheimer's and Gastritis. The Quarterly Minimum Data Set dated 2/10/06 documented the resident required staff supervision only with set up help in eating and had a swallowing problem.</p> <p>a. A physician order dated 7/18/05 1/30/06 documented, "Low fat, NAS [no added salt], NCS [No concentrated sweets], mechanical soft with honey thickened liquids."</p> <p>b. The "Resident Notes" completed by the interdisciplinary team during the Plan of Care Meeting dated 3/1/06 documented: "Resident's weight is 178 pounds and stable. Diet is low fat, NAS, NCS, mechanical soft with nectar thickened liquids, which she tolerates well."</p> <p>c. The Plan of Care dated 3/8/06 documented: "Problem/Need; At risk for aspiration D/T [due to]</p> | F 282   |   |                      |   |

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| F 282  | <p>Continued From page 11</p> <p>swallowing problems. Resident requires mechanically altered diet and altered fluids. Honey thick" The "Approaches" documented: "Diet and fluids as ordered."</p> <p>d. On 4/3/06 at 5:13 p.m., on 4/4/06 at 12:25 p.m., and 4:20 p.m., and on 4/5/06 at 10:35 a.m. the resident had a pitcher of unthickened ice water at bedside. There was no thickener observed in the room.</p> <p>e. On 4/5/06 at 4:00 p.m., LPN [Licensed Practical Nurse] #5 administered medications to the resident. The medications were crushed and given in applesauce. The Metamucil was mixed with cranberry juice. LPN #5 stated, She's on thickened liquids but the metamucil thickens the cranberry juice. At dinner she gets thickened liquids. We usually leave ice water in the pitcher then I go get the thickener for the CNA's as they need it."</p> <p>f. On 4/6/06 at 8:30 a.m., there was no water pitcher in the resident's room. At 10:05 a.m., CNA #3 was asked, "where is the resident's water today?" CNA #3 stated, "She doesn't get any in the room because she's on thickened liquids." The surveyor stated that there was water in the resident's room on the three previous days. The CNA stated, "They took it out of her room this morning."</p> <p>3. Resident #11 had diagnoses of Dementia with Delirium and Seizures. The Annual MDS dated 3/22/06 documented the resident had chewing and swallowing problems.</p> <p>a. A physician's order, dated 1/11/05 and continued on 2/20/06, documented: "Diet:</p> | F 282   |   |                      |   |

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| F 282  | <p>Continued From page 12</p> <p>Regular mechanical soft &amp; pudding consistency liquids."</p> <p>b. The Plan of Care dated 3/29/06 documented: "Problem . . . At risk for aspiration D/T [due to] swallowing problems. Resident requires mechanically altered diet and altered fluids: Pudding Thick. . . . Intervention-Diet and fluids as ordered."</p> <p>c. On 4/4/06 at 1:35 p.m., the resident's water pitcher was approximately 25% full and located on the over-bed table. The water did not contain any thickener.</p> <p>d. On 4/4/06 at 4:23 p.m., the water pitcher was observed in the same location on the over-bed table but now contained approximately 25% of ice cubes with a small amount of water with no thickener. The resident stated, "They came in and poured out the water and put in a little bit of ice water."</p> <p>e. On 4/5/06 at 9:40 a.m., the resident's water pitcher was on the bedside table with a small amount of water with no thickener.</p> <p>f. On 4/5/06 at 4:05 a.m., CNA #8 was asked if Resident #11 was suppose to have her liquids thickened. She stated yes, I believe it's suppose to be nectar thick. When asked how she would know if a resident needed thickened liquids she stated that it would be in their Care Book at the Nurse's Station.</p> <p>g. On 4/6/06 at 5:00 p.m., review of the sheet for Resident #11 located in the Care Book at the Nurse's Station documented that the resident required thickened liquids to honey consistency.</p> | F 282   |   |                      |   |

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| F 282  | Continued From page 13  | F 282   |   |                      |   |
| F 312<br>SS=B  | <p>f. The facility's "Policy and Procedure for Thickened Liquids", provided by the Director of Nursing on 4/6/06 at 3:00 p.m., documented "No water pitcher will be placed in the resident's room."</p> <p>483.25(a)(3) ACTIVITIES OF DAILY LIVING</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #11585 was substantiated (all or in part) in these findings.</p> <p>Based on observation, and record review, the facility failed to ensure residents were shaved of facial hair for 3 (Residents #2, #3, and #7) of 5 case mix residents (Residents #2, #3, #6, #7, and #8) who were dependent on staff for shaving. These failed practices had the potential to affect 55 residents who were incontinent of bowel and bladder and 19 residents who were dependent on staff for shaving as identified on Lists provided by the Director of Nurses on 4/7/06. The findings are:</p> <p>1. Resident # 2 had a diagnosis of Dementia. The Quarterly MDS dated 2/13/06 documented the resident required total staff assistance for personal grooming.</p> <p>a. On 4/4/06 at 12:50 p.m., 3:15 p.m., and at</p> | F 312   |   |                      |   |

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| F 312  | <p>Continued From page 14</p> <p>5:20 p.m., the resident had not been shaved and had a visible growth of beard.</p> <p>2. Resident # 3 had diagnoses of Brain Tumor with Shunt Placement and Alzheimer's Disease. The Admission MDS dated 3/17/06 documented the resident had severely impaired cognitive skills for daily decision making and required extensive staff assistance with Activities of Daily Living.</p> <p>a. On 4/4/06 at 3:20 p.m., 5:15 p.m., and at 6:00 p.m., the resident had not been shaved and a visible growth of beard present.</p> <p>3. Resident #7 had diagnoses of Congestive Heart Failure and Left Sided Hemiparesis. The Quarterly Minimum Data Set dated 1/25/06 documented the resident had severely impaired cognitive skills for daily decision making and required total staff assistance with Activities of Daily Living.</p> <p>a. On 4/4/06 at 12:45 p.m., 3:20 p.m. and at 5:25 p.m., the resident had not been shaved and had a visible growth of a beard present.</p> <p>b. On 4/7/06 at 9:20 a.m., a family member stated that on Saturday (4/1/06) the resident had not been shaven and had been put to bed on a dirty sheet.</p> <p>4. On 4/7/06 at 2:45 p.m., when asked how often male residents were shaved, CNA #9 stated, "Every day or when needed." CNA #10 stated, "On shower days and when they need it." As of 4/7/06 there was no documentation the the Activity of Daily Living forms/sheets that had shaving documented for the residents.</p> | F 312   |   |                      |   |

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| F 314<br>F 314<br>SS=D                                       | Continued From page 15<br>483.25(c) PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review, and interview, the facility failed to ensure that the physician and family were notified and a treatment order was obtained after the discovery of a new pressure sore for 1 (Resident #3) of 3 case mix residents (Residents #1 - #3) who had a pressure sore. This failed practice had the potential to affect 6 residents with pressure sores as documented on the Resident Census and Condition of Residents form dated 4/4/06. The findings are:<br><br>1. Resident #3 had a diagnosis of Alzheimer's Dementia with Behavior Disturbances. The admission Minimum Data Set assessment dated 3/17/06 documented the resident had severely impaired cognitive skills for daily decision making, was totally dependent on 2 plus persons for all activities of daily living, and had no pressure sores.<br><br>a. The Pressure Sore Record dated 3/15/06 documented a Stage II pressure sore (1 cm | F 314<br>F 314  |   |                      |   |

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| F 314  | <p>Continued From page 16</p> <p>[centimeter] by 0.5 cm) to right upper buttock, (first observed on 3/15/06). On 3/21/06 Stage II was measured at 1 cm by 0.4 cm. On 3/31/06 the record documented the Stage II was measured at 0.75 cm by 0.2 cm. No other pressure sores were documented on the Pressure Sore Record.</p> <p>b. On 4/5/06 at 2:35 p.m., 2 small open areas of skin breakdown were noted, one open area at the Coccyx approximately .5 cm (centimeters) by .5 cm and one small open area approximately .5 cm by .5 cm at the right upper thigh under the right gluteal fold. Certified Nurse Assistant (CNA) #11 stated, "I did not know those were there."</p> <p>c. On 4/5/06 at 2:40 p.m., Licensed Practical Nurse (LPN) #7 entered the resident's room and observed the resident's skin.</p> <p>d. As of 4/6/06 at 8:50 a.m., there was no documentation the facility had obtained a physician order for treatment of the skin breakdown on the right upper side of the resident's thigh.</p> <p>e. On 4/6/06 at 9:00 a.m., LPN #8 was asked if she had been informed about the new skin breakdown and the LPN stated, "I thought she (LPN #7) would take care of it, so I did not do anything."</p> <p>f. On 4/6/06 at 9:20 a.m., LPN #7 stated (regarding the pressure sore), "I told the 3 to 11 Nurse and the ADON (Assistant Director of Nurses)."</p> <p>g. On 4/6/06 at 10:05 a.m., the Director of Nurses (DON) was informed that a new skin</p> | F 314   |   |                      |   |

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| F 314  | Continued From page 17<br>breakdown on the resident had not been treated, and the DON stated, "On 3/15/06 a treatment was ordered to the right crack of the buttocks. As of the last pressure sore audit on 3/31/06, that was the area that was being treated."<br><br>h. On 4/6/06 at 10:50 a.m., the DON and LPN #8 assessed the resident's skin. LPN #8 measured the coccyx area as 0.4 cm by 0.4 cm healing Stage II. The open area on the left gluteal fold was measured at 0.2 cm by 0.2 cm.  | F 314   |   |                      |   |
| F 322<br>SS=E  | 483.25(g)(2) NASO-GASTRIC TUBES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and interview the facility failed to ensure that Percutaneous Enteral Gastrostomy (PEG) tube placement was checked before the administration of flushed/liquids for 2 (Residents #6 and #16) of 3 case mix residents (Residents #2, #6, and #16). The facility failed to ensure the sanitation of PEG tubing was maintained for 1 (Resident #6) of 3 (Residents #2, #6, and #16) residents, and failed to ensure that equipment required to provide nutrition via PEG was maintained in a safe manner for 1 (Residents #2) of 3 (Residents #2, #6, and #16) case mix residents who had a | F 322   |   |                      |   |

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| F 322  | <p>Continued From page 18</p> <p>gastrostomy tube for the administration of enteral feedings. This failed practice had the potential to affect 6 residents who had gastrostomy tubes as documented on the Resident Census and Conditions of Residents form dated 4/4/06. The findings are:</p> <p>1. Resident #6 had diagnoses of Neurodevelopmental Retardation, and Gastroesophageal Reflux. The Quarterly Minimum Data Set (MDS) dated 2/7/06 documented the resident had a feeding tube.</p> <p>a. A Physician Order dated 12/18/05 documented: "Start Complete Formula Via Peg, Pump 75 cc/hr [cubic centimeters/per hour] at 0600 [6:00 a.m.], stop Complete Formula at 2000 [8:00 p.m.]." An order dated 4/18/05 documented: "Flush with 60 cc H2O [water] every hour."</p> <p>b. On 4/5/06 at 9:55 a.m., the resident was to receive incontinent care by CNA's [Certified Nursing Assistants] #3 and #4. The CNA's asked LPN [Licensed Practical Nurse] #3 to disconnect the resident's tube feeding so the resident could be transferred into the bed for the care. LPN #3 disconnected the tube feeding from the resident and did not cap the end of the tubing. The LPN draped the tubing over the back of the resident's wheelchair with the uncovered tip of the tubing resting on the gel-like cushion in the wheelchair that had a yellowish-brown stain. During the incontinent care the resident flailed his arms and legs repeatedly and vigorously during the procedure with near continual motion.</p> <p>c. On 4/5/06 at 10:30 a.m., LPN #3 removed the tubing from the wheelchair and noted the</p> | F 322   |   |                      |   |

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| F 322  | <p>Continued From page 19</p> <p>yellowish-brown stain on the wheelchair pad. The LPN had the CNA's wash the gel-like pad before the resident was transferred back to the wheelchair. At 10:32 a.m., after the pad was washed and the CNA's transferred the resident to the wheelchair, the LPN reconnected the resident to the tube feeding, and resumed the tube feeding per the tube feeding pump at 75 cc/hr. The LPN did not check for tube placement prior to re-initiating the tube feeding.</p> <p>d. On 4/5/06 at 10:35 a.m., LPN #3 was asked when tube feeding placement was to be checked. The LPN stated, "Not when its been a short time like this. We check before meds at 8 am and 12 noon and the other shift checks it at 4 pm. If he's disconnected for a shower we check placement when we re-connect it."</p> <p>e. 4/6/06 at 10:40 a.m., the resident was returned to his room via wheelchair after receiving a hair cut. The CNA asked LPN #6 to reconnect the tube feeding. The LPN checked the resident's tube for placement then removed the cap that have been covering the end of the feeding tube and place the cap on the tip of the hook of the metal tube feeding pump pole. The LPN then decided to flush the tube feeding with water. The LPN retrieved the cap from the tip of the hook of the tube feeding pump pole and placed it back on the end of the feeding tube. The LPN obtained 2 plastic glasses of water from the bathroom faucet, removed the cap from the tube feeding tip, placed the cap back on the hook of the tube feeding pump pole, reconnected the tubing and turned the pump on at 75 cc/hr. LPN #6 was asked if the tube feeding pump pole was where she normally stored the tube feeding end cap. LPN #6 stated, "The tube feeding pump pole is</p> | F 322   |   |                      |   |

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| F 322  | <p>Continued From page 20</p> <p>sanitized from top to bottom every shift. I always sanitize it at the end of my shift so it's clean for the next shift." The surveyor showed the LPN a dried yellowish substance on the surfaces of the right and left hooks of the metal tube feeding pole. LPN #6 stated, "I don't know what that is - it looks kind of like dried tube feeding solution but I can't say for sure." The LPN scraped the dried matter from the metal pole and stated, "I think I had better throw this cap away and get a new one."</p> <p>2. Resident #16 had a diagnosis of IDDM [Insulin Dependent Diabetes Mellitus]. A physician order dated 12/5/05 documented: "Check G-Tube placement QSH [Every shift] and Flush with 50 cc [cubic centimeters] of H2O [water] before and after med pas [medication pass]."</p> <p>a. During the 4:00 p.m. medication pass, LPN #4 administered Glipizide 10 mg [milligram], Haldol 5 mg., Ativan 0.5 mg, and Risperdol 1 mg/ml via the PEG tube. LPN #4 did not check for tube placement before administering the medication.</p> <p>b. The Medication Guide for the Long-Term Care Nurse, Sixth Edition documented: "Administration Medication Via Feeding Tube; Guidelines: Check for correct placement of feeding tube prior to administration of medication."</p> <p>c. The facility Policy and Procedure for GASTRIC TUBE FEEDING: When medications are administered with enteral nutrition formulas, the following steps should be followed: - Check the placement of the tube.</p> <p>3. Resident # 2 had a diagnosis of Gastrostomy Tube Placement. The Annual Minimum Data Set dated 2/13/06 documented the resident had a</p> | F 322   |   |                      |   |

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| F 322  | Continued From page 21<br>feeding tube.<br><br>a. A physician order dated 11/12/05 documented: "Jevity 1/5 Cal [calorie] at 60 cc/hr via peg tube with 30cc/hr [hour] H2O flush."<br><br>b. On 4/3/06 at 4:30 p.m., Jevity 1.5 feeding was infusing via enteral pump, into the Percutaneous Enteral Gastrostomy (PEG ) tube. The feeding pole was unstable, the base, rocking easily and freely back and forth when touched and would lean to the side.<br><br>c. On 4/4/06 at 12:50 p.m., 3:15 p.m. and at 5:20 p.m., the feeding pole was loose, unstable and observed to be leaning to the right.<br><br>d. On 4/5/06 at 9:10 a.m., the feeding pole was unstable on its base. | F 322   |   |                      |   |
| F 323<br>SS=E  | 483.25(h)(1) ACCIDENTS<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>l. On 4/5/06 at 10:30 a.m., Resident #6 had a wheelchair that had bilateral axillary braces. The bracing was of a firm texture and was covered with black vinyl-like material. The right axillary brace had a tear in the vinyl approximately 3 inches long and 1 inch wide that had rough edges. The tear exposed the wood construction of the brace that also had rough edges. This torn area created the potential for skin tears for the resident.                        | F 323   |   |                      |   |



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| F 323  | Continued From page 23<br><br>a. The doorway guards had sharp torn areas in the following rooms:<br><br>1) Room 219 had 2 small sharp areas on the lower right side of the doorway guard.<br><br>2) Room 224 had a sharp area on the lower left side of the entry doorway guard.<br><br>3) Room 218 had 3 torn and jagged areas on the lower right side of the doorway guard.<br><br>4) Room 203 had a sharp area on the upper right side of the doorway guard.<br><br>5) Room 205 had a bent and sharp area of the right side of the doorway guard.<br><br>6) Room 211 had a bent and sharp area on the left side of the doorway guard.<br><br>7) Room 117 had a very sharp and jagged area on right side of the doorway guard.<br><br>8) Room 122 had a rough and jagged area on the left side of the doorway guard.<br><br>9) Room 114 had a sharp and jagged area to left side of the doorway guard.<br><br>10) The Whirlpool Room located by the 100 Hall Nurses Station had a doorway guard that had a very sharp tear on the lower left side.<br><br>b. The water fountain on the 200 hall had a broken sharp edge on the left side.<br><br>c. The North 200 hall sitting area had sharp, | F 323   |   |                      |   |

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| F 323  | Continued From page 24<br>gouged out sheetrock on the walls of the entryway.<br><br>d. The carpet in the hallway across from the executive assistant office had a large bubbled area approximately 1 1/2 feet by 1 foot. The Maintenance Supervisor stated the carpet, "does this when it rains."<br><br>e. The wooden hand rails between Room 211 and the nurse's station, beside the oxygen room between the 100 and 200 hall, opposite room 103, near room 113, between the physical therapy department doors and near the "Hall of Fame" entryway had a sharp and jagged areas that created the potential for skin tears. The handrail outside of Room #30 had a sharp area where the end of the handrails met.<br><br>f. The wooden hand rails beside the DON's [Director of Nurses] office had 2 nails sticking out at the end of the rail. The hand rail at the end of the 100 hall had a nail end that was exposed. The wood handrail by Room #121 was separated. The handrails across from the Physical Therapy Department had sharp edges where nails were exposed. Handrails in the "feeder" dining room had sharp nail ends exposed. A handrail behind the right fire door of Hulan Hall had a sharp nail protruding from the wood. All of these areas created the potential for skin tears.<br><br>g. The trash can in the whirlpool room near the 100 hall nurse station had a large piece of the edge broken off that created a sharp area.<br><br>h. The fire door on the right near room 104 had a large chunk of wood missing. | F 323   |   |                      |   |

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| F 323  | Continued From page 25<br>i. The corner of the hallway wall opposite of Room #104 had a sharp and jagged edge where the walls met.<br><br>j. The exit sign attached to the ceiling of Hulan Hall had a loose cover.<br><br>k. On 4/5/06 at 5:00 p.m., Resident #18 had sharp nail scissors and a small pair of sharp scissors in a cup at the bedside.   | F 323   |   |                      |   |
| F 328<br>SS=D  | 483.25(k) SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and interview, the facility failed to ensure that the flow rate on the oxygen concentrator was set at the correct rate per physician order, and that oxygen tubing was maintained and stored in a manner that was sanitary for 1 (Resident #7) of 3 case mix residents (Residents #7, #19 and #20) who required oxygen/updraft therapy. The facility also failed to ensure a used suction machine was properly cleaned after use and stored in a sanitary manner. These failed practices had the | F 328   |   |                      |   |

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| F 328  | <p>Continued From page 26</p> <p>potential to affect 4 residents who had physician orders for continuous or PRN (as needed) Oxygen/Respiratory therapy as documented on the Roster Matrix dated 4/4/06. The findings are:</p> <p>Resident #7 had a diagnosis of Congestive Heart Failure.</p> <p>a. A physician order dated 6/19/03 documented: "O2 [oxygen] @ [at] 2 L/M [liters/minute] via NC [nasal cannula] PRN for SOB [shortness of breath] and O2 sats [saturation] &lt; [less than] 90 % [percent]. A physician order dated 5/28/04 documented: "Albuterol Updrafts Q [every] 4-6 hr [hour] PRN for SOB."</p> <p>b. On 4/3/06 at 4:05 p.m., the flow meter on the resident's oxygen concentrator was set at 3 LPM [liters per minute]. The resident was being administered the oxygen via nasal cannula tubing. An updraft machine was on the bedside table. The end of the updraft connection tubing was not completely in the plastic storage bag and was lying directly on the resident's bedside table.</p> <p>c. On 4/4/06 at 12:45 p.m., 3:20 p.m. and at 5:25 p.m., and on 4/5/06 at 8:45 a.m., the resident was being administered 3 liters of oxygen per minute via a nasal cannula.</p> <p>d. On 4/5/06 at 2:10 p.m., Licensed Practical Nurse (LPN) # 7 entered the resident's room, and was asked by the surveyor, "What is the flow rate of the oxygen concentrator set on?" LPN # 7 stated, "The flow rate is on 3 liters a minute." At 2:15 p.m., LPN #7 stated, (after checking the resident's physician orders) ". . .2 liters is what it is supposed to be." LPN # 7 removed the oxygen cannula after the oxygen saturation of the</p> | F 328   |   |                      |   |

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| F 328  | Continued From page 27<br>resident's blood was measured at 94%. The LPN left the concentrator turned on and draped the oxygen tubing (unbagged) over the top of the tube feeding pole.   | F 328   |   |                      |   |
| F 332<br>SS=E  | 2. On 4/5/06 at 2:25 p.m., a used suction machine was stored in the main Oxygen Storage Room. The suction machine tubing contained 100 ccs (Cubic Centimeters) of an unidentified fluid.<br><br>483.25(m)(1) MEDICATION ERRORS<br><br>The facility must ensure that it is free of medication error rates of five percent or greater.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation of the 4:00 p.m. medication pass on 4/3/06, the 8:00 a.m. medication pass on 4/4/06, record review and interview, the facility failed to ensure that the medication error rate was less than 5%. Physicians orders were not followed on 4 residents (#14, #15, #9 and #10) of 8 residents observed during medication passes resulting in medication errors. Medication errors were made by 3 LPNs (Licensed Practical Nurse) (LPN #1, LPN #2, and LPN #3) of 6 nurses who administered medications in the facility. This practice has the potential to affect all 102 residents in the facility according to the Administrator on 4/3/06 at 3:00 p.m. The medication error rate was 7.14% based on administration of 55 medications and 1 omitted medication and 4 medication errors observed.<br>The findings are: | F 332   |   |                      |   |

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| F 332  | <p>Continued From page 28</p> <p>1. Resident #14 had a physician order dated 1/20/06 for Potassium Chloride (KCL) 20 mEq (Milliequivalent) po (by mouth) qid (four times a day).</p> <p>a. During the 4:00 p.m., medication pass on 4/3/06 at 4:25 p.m. the LPN #1 gave the resident KCL 20 mEq diluted in juice and water.</p> <p>b. According to the Centers of Medicare and Medicaid (CMS) guidelines, Potassium supplements should be administered with or after meals with a full glass or juice. This will minimize the possibility of gastrointestinal irritation and saline cathartic effect.</p> <p>c. On 4/3/06 at 5:10 p.m. the resident had not received the evening meal yet.</p> <p>2. Resident #15 had a physician order dated 6/8/05 for Cosopt 1 drop in right eye two times a day (bid).</p> <p>a. During the 4:00 p.m., medication pass on 4/3/06 at 4:35 p.m., LPN #1 administered two drops in the right eye.</p> <p>b. The Resident stated, "you got 2 drops in there."</p> <p>3. Resident #9 had a physician order dated 10/15/03 for Ocuvite 1 eyes bid.</p> <p>a. During the 8:00 a.m. medication pass on 4/4/06 at 8:35 a.m., LPN #2 administered Ocuvite with Lutein.</p> <p>b. On 4/4/06 at 12:35 p.m., the Director of Nursing stated, "the pharmacy provider stated</p> | F 332   |   |                      |   |

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| F 332  | Continued From page 29<br>that is what they send for Ocuвите."   | F 332   |   |   |
| F 333<br>SS=D  | 483.25(m)(2) MEDICATION ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation of the 8:00 a.m. medication pass on 4/4/06, record review and interview, the facility failed to follow physician's orders to ensure that residents were free of significant medication errors. One residents (#10) of 8 residents observed during the medication pass was found to have a significant medication error. A significant medication error was made by 1 LPN (Licensed Practical Nurse) of 6 LPNs that administered medications. This failed practice had the potential to affect 42 residents who received medications from LPN #1 who resided on the 200 Hall as documented on the Resident Census Summary dated 3/27/06. The findings are: | F 333   |   |   |

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| F 333  | Continued From page 30<br>Resident #10 had a physician order dated 3/31/06 for Maxitrol ophthalmic ointment apply to left eye lid bid for 1 week.<br><br>a. During the 8:00 a.m. medication pass on 4/4/06 at 8:50 a.m., all medication were administered except the Maxitrol ophthalmic ointment which was omitted.<br><br>b. On 4/4/06 at 12:15 p.m., the Director of Nurses stated, "it (order for Maxitrol Ophthalmic ointment) did not get added to the Medication Administration Record."<br><br>c. Due to the frequency of the error this was a significant error.   | F 333   |   |                      |   |
| F 363<br>SS=E  | 483.35(c) MENUS AND NUTRITIONAL ADEQUACY<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and interview, the facility failed to ensure menus and recipes were followed for proper portion control to ensure residents received proper nutrition. The facility also failed to ensure food items were not placed on the steamtable too far in advance of meal service which had the potential to compromise the nutritional value of the foods. These failed practices had the potential to affect | F 363   |   |                      |   |

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| F 363  | <p>Continued From page 31</p> <p>90 residents who received their meal from the Kitchen as documented on the Diet Roster dated 4/4/06. The findings are:</p> <p>1. On 4/4/06 the menu for the noon meal documented for 3 ounces of Salisbury steak per resident and the supper menu documented the residents were to receive 2 chocolate chip cookies.</p> <p>a. On 4/4/06 at 10:15 a.m., no Salisbury steak was prepared. Six inch unseasoned ground beef strips were baked and served instead of the Salisbury steak. The recipe for the Salisbury steak documented the following food items were to be used: (for 100 residents) 22 lbs. Lean ground beef for 100 residents, bread crumbs, liquid scrambled eggs, diced onions, salt, black pepper, milk. The menu documented to mix all ingredients together on low speed until well mixed. Portion meat into patties using a #10 scoop.</p> <p>b. On 4/4/06 at 11:00 a.m., all of the food for the noon meal was already on the steam table including 1 pan of corn bread (2 pans on stove), great northern beans, stewed tomatoes, Salisbury steak, and pureed food for the scheduled 12:00 noon meal service. Cook #1 stated the food was placed on the steamtable as the Kitchen served the staff at 11:15 a.m., and the other half of the staff after the residents were fed at 12:00 p.m."</p> <p>c. On 4/4/06 at 12:50 p.m., toward the end of the meal service the Kitchen ran out of the beef strips used as Salisbury steak and substituted with meat balls due to the facility having served the employees prior to meal service for the residents. The residents who were to be served No</p> | F 363   |   |                      |   |

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| F 363  | Continued From page 32<br>Concentrated Sweet diets received the meatballs.<br><br>d. On 4/4/06 the menu for the supper meal documented 2 chocolate chip cookies were to be served for all of the residents except for residents who should receive Low concentrated Sweet Diets. At 5:00 p.m., the residents were only served 1 cookie each.   | F 363   |   |                      |   |
| F 371<br>SS=E  | 483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE<br><br>The facility must store, prepare, distribute, and serve food under sanitary conditions.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, the facility failed to ensure food was properly stored/coded to maintain first in-first out stock rotation, failed to ensure foods were stored in a manner to prevent the potential for cross contamination, failed to ensure the ice machine and vent a hood were clean, and failed to ensure residents did not eat in the kitchen or cough without washing their hands to prevent the potential for cross contamination. These failed practices had the potential to affect 96 residents who receive their meals from the Kitchen as documented on the Diet Roster dated 4/3/06. The findings are:<br><br>1. The following observations were noted during the initial kitchen tour on 4/3/06 beginning at 3:15 p.m.:<br><br>a. The inside of the lid on the ice machine had a dark brown substance on it. | F 371   |   |                      |   |

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| F 371  | <p>Continued From page 33</p> <p>b. The filters inside of the vent-a-hood over the stove had a build up of grease of them.</p> <p>c. Cans stored in the shelves in the storage room were not arranged in first in first out rotation as follows:</p> <p>1) 5- 46 ounce cans of chicken noodle soup were stored on the shelf with the following delivery date orders first-3/7/06, second in line-2/14/06 and last in line-3/21/06.)</p> <p>2) Applesauce in #10 cans were arranged as follows 3/17/06, second-3/7/06, third-3/7/06, forth-3/7/06 and fifth- 3/17/06.</p> <p>d. Thirty six packages of graham crackers, 35 packages Ritz crackers, 36 packages saltines and packages of club crackers were not coded for first in first our stock rotation.</p> <p>e. There were 20-chocolate chip cookies on a tray in the storage room. The tray was not tightly sealed and the contents were exposed to the open air.</p> <p>2. The following observations were noted during the kitchen sanitation tour on 4/4/06 at 10:00 a.m.:</p> <p>a. Five gallon plastic cases of milk were stored directly on the floor of the walk in cooler.</p> <p>b. A plastic container of bulk corn meal was stored directly on the floor in the storage room.</p> <p>c. A tray that contained 12-chocolate chip cookies was loosely wrapped and in the storage room. This exposed the contents to the open air</p> | F 371   |   |                      |   |

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| F 371  | Continued From page 34 and the potential for cross contamination.<br><br>d. Hushpuppy mix stored on a storage room shelf was partially sealed. This exposed the contents to the open air and the potential for cross contamination.<br><br>e. A 50 # bag of bulk powdered sugar was stored directly on the floor. The bag was torn across the top and not tightly sealed exposing the contents to the open air and the potential for cross contamination.<br><br>3. On 4/4/06 at 5:55 p.m., the evening cook (Cook #2) was eating in the kitchen from the steam table at the end of the meal service after residents had been served.<br><br>4. On 4/5/06 at 8:45 a.m., the morning cook (Cook #1) coughed in her hand twice while looking for a recipe in the recipe . | F 371   |   |                      |   |
| F 463<br>SS=E  | 483.70(f) RESIDENT CALL SYSTEM<br><br>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, the facility failed to ensure that the emergency call light system was operational for 1 (Resident #7) of 20 case mix residents (Residents #1-#13, #18 - #22, #27 and #29) who had emergency call lights in their rooms. The facility also failed to ensure a call light was functioning in the Whirlpool/Shower on  | F 463   |   |                      |   |

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| F 463  | <p>Continued From page 35</p> <p>the 100 hall and failed to ensure 2 resident accessible bathrooms had emergency call lights installed. These failed practices had the potential to affect 15 residents who were bathed in the 100 hall shower/whirlpool room according to the Director of Nurses on 4/7/06 and 58 residents who ambulate per self or per assistive devices as documented on the Resident Census and Condition of Residents form dated 4/4/06. The findings are:</p> <ol style="list-style-type: none"> <li>1. On 4/5/06 at 2:25 p.m., the call light in the whirlpool room near 100 Hall did not light up or make a noise at the door of the whirlpool room nor at the nurse's station.</li> <li>2. On 4/5/06 at 2:30 p.m., the Visitor's Mens Restroom door was unlocked. The room did not contain an emergency call system and was open and accessible to residents. The bathroom in the "feeder" dining room was unlocked, accessible to residents and had no emergency call light system.</li> <li>3. Resident #7 had diagnosis of Seizure Disorder. The Quarterly Minimum Data Set dated 1/25/06 documented the resident required total staff assistance with all activities of daily living. <ol style="list-style-type: none"> <li>a. On 4/5/06 at 8:45 a.m., the call light would not function either by sound or the indication of a light at the Nurses Station when activated from the room.</li> </ol> </li> <li>4. On 4/5/06 at 10:00 a.m., CNA (Certified Nursing Assistant) #6 stated the call light was not working and further stated, ". . . I will make a work request."</li> </ol> | F 463   |   |                      |   |

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| F 468<br>F 468<br>SS=B                                       | Continued From page 36<br>483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS<br><br>The facility must equip corridors with firmly secured handrails on each side.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, the facility failed to ensure that handrails were firmly secured to the wall. This had the potential to affect 53 residents who ambulated per self as identified by the Director of Nurses 4/7/06. The findings are:<br><br>On 4/5/06 at 2:25 p.m., the wooden handrails were not fastened securely to the walls by Room 221, between Room 211 and the Nurse's Station, by Room 121, and between Rooms 120 and 122.            | F 468<br>F 468  |   |   |
| F 498<br>SS=E  | 483.75(f) PROFICIENCY OF NURSE AIDES<br><br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and interview, the facility failed to ensure that CNA's used transferring techniques that prevented the potential for injury for 2 (Residents #4 and #6) of 9 case mix residents (Residents #1-#4, #6-#8, #13, and #17) who required staff assistance for transfers. This failed practice had the potential to | F 498   |   |   |

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| F 498  | <p>Continued From page 37</p> <p>affect 24 residents who were dependent on staff for transfers as documented on the Resident Census and Conditions of Residents form dated 4/4/06. The findings are:</p> <p>1. Resident #4 had diagnoses of Ischemic Stroke and Vascular Dementia. The Annual Minimum Data Set (MDS) dated 3/1/06 documented the resident had bilateral limitations or range of motion with partial loss of voluntary movement of the neck, legs, and feet, and required a mechanical lift for the mode of transfer.</p> <p>a. The "Resident Notes" completed by the interdisciplinary team during the Plan of Care Meeting dated 3/8/06 documented: "She [Resident #4] is transferred via mechanical lift with all transfers."</p> <p>b. The Plan of Care dated 3/8/06 documented, "Problem; Resident requires assistance with ADL's [Activities of Daily Living] D/T [due to]Cognitive/Mental Status, CVA [Cerebral Vascular Accident] and Other (Seizures). . .Approaches-Transfers: Max [maximum] of 2 with Lift."</p> <p>c. On 4/5/06 at 4:20 p.m., the resident was sitting in her wheelchair. CNA [Certified Nursing Assistant] #1 and CNA #2 entered the room to provide incontinent care. CNA #2 left the room to acquire a mechanical lift.</p> <p>d. On 4/5/06 at 4:30 p.m. during the lifting of the resident via the mechanical lift the resident was transferred from the wheelchair to the bed for incontinent care. After the incontinent care the resident was assisted to the sitting position on the side of the bed and the lift pad was fastened to</p> | F 498   |   |                      |   |

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| F 498  | <p>Continued From page 38</p> <p>the mechanical lift frame. The wheelchair was facing the bed. The lift pad was raised and, with the resident suspended, the resident was turned 180 degrees to also face the bed. The lift was maneuvered to lower the resident into the wheelchair with the wheelchair being in a lateral position rather than a head-on position. The mechanical lift also contained a weight scale electronic box. When the resident was lowered into the wheelchair the weight scale box was pressing into the resident's forehead.</p> <p>e. On 4/6/06 at 9:40 a.m., CNA #3 and CNA #4 entered the resident room to provide incontinent care. The resident was sitting in the wheelchair. The CNA's transferred the resident from the wheelchair to the bedside by lifting the resident under her arms and holding onto the elastic waistband of the resident slacks with the residents full body weight being placed on the residents underarms. The resident was unable to bear weight or to pivot during the procedure. At 9:47 a.m. the resident was transferred back to the wheelchair by lifting the resident under her arms and holding onto the elastic waistband of the resident slacks with the residents full body weight being placed on the residents underarms. Again, the resident was unable to bear weight or to pivot during the procedure. The weight record for the month of March, 2006 documented the resident's weight to be 196.8 pounds. The mechanical lift was not in the room and no gait belt was used for the procedure.</p> <p>f. On 4/6/06 at 9:55 a.m. CNA #3 and CNA #4 were asked if the mechanical lift was to be used for this resident. CNA #3 stated, "Sometimes we do." CNA #4 stated, "Sometimes we use the Hoyer lift but not this morning. We didn't use it</p> | F 498   |   |                      |   |

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| F 498  | <p>Continued From page 39</p> <p>today. We use it if its available. It wasn't available today."</p> <p>2. Resident #6 had diagnoses of Neurodevelopmental Retardation, and Microcephalous. The Quarterly Minimum Data Set (MDS) dated 2/7/06 documented the resident had bilateral limitations of range of motion with partial loss of voluntary movement of the arms, hands, legs, feet, and other limitations, and required manual lifting.</p> <p>a. On 4/5/06 at 9:55 a.m., CNA #3 and CNA #5 entered the resident room to provide incontinent care. The resident was sitting in the wheelchair. The CNA's transferred the resident from the wheelchair to the bed by lifting the resident under his arms and holding onto the elastic waistband of the resident slacks with the residents full body weight being placed on the residents underarms. The resident was unable to bear weight or to pivot during the procedure. At 10:32 a.m. the resident was transferred back to the wheelchair by lifting the resident under his arms and holding onto the elastic waistband of the resident slacks with the residents full body weight being placed on the residents underarms. The resident was unable to bear weight or to pivot during the procedure. The weight record for the month of March, 2006 documented the resident's weight to be 123 pounds. No gait belt was used for the procedure.</p> <p>b. On 4/6/06 at 10:35 a.m., CNA #3 was asked if gait belts were used for this resident. CNA #3 stated, "Sometimes we do." Neither CNA #3 or CNA #5 had a gait belt.</p> <p>3. The Policy and Procedure for "Procedures For Specific Lift/Transfer Application" documented:</p> | F 498   |   |                      |   |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ST. ANDREWS PLACE</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3501 COLLEGE AVENUE</b><br><b>CONWAY, AR 72032</b>                  |                      |   |
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| F 498  | Continued From page 40<br>"Lowering Into A Sitting Position: Item 1: With the patient facing the lift column, position the Vander-Lift directly in front of the chair." | F 498   |   |                      |   |