

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

PRINTED: 01/28/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/11/2008
NAME OF PROVIDER OR SUPPLIER STONE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560		
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F 000	INITIAL COMMENTS	F 000			
F 224 SS=D	<p>Complaint #13195 was unsubstantiated.</p> <p>Complaint #13186 was unsubstantiated.</p> <p>483.13(c) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff implemented the facility's policy and procedures regarding misappropriation of resident property as evidenced by staff using the resident's personal telephones without the resident's permission for 1 (Resident #2) of 1 case mix resident whose phone was observed being used by an employee of the facility. This failed practice had the potential to effect 25 residents who had personal telephones according to the list provided by the Administrator on 1/11/08. The findings are:</p> <p>1. Resident #2 had diagnoses of Dementia and Depression. The Medicare 14 day Minimum Data Set dated 12/24/07 documented the resident was moderately impaired in cognitive skills for daily decision making.</p> <p>a. The Plan of Care dated 12/24/07 documented, "Cognitive Loss/Dementia or Alteration in Thought Processes Related to Impaired Decision Making, Short and/or Long Term Memory Loss. ...Provide a homelike, therapeutic environment.</p>	F 224			

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 224	<p>Continued From page 1</p> <p>b. On 1/8/08 at 8:30 a.m., while the surveyor was conducting an interview with the resident, Housekeeper #1 entered the resident's room without knocking, walked across the room and made a personal phone call on the resident's private phone and did not ask the resident's permission to use the phone. When finished with the call, the housekeeper left the resident's room. The resident was asked how often does that happen and the resident stated, "It happens all the time. Some ask if they can use it, and some don't." TNA (Training Nurse Aide) #3, who was working as the resident's private sitter and was in the room at the time the House Keeper used the resident's telephone without permission, stated, "If [Resident #3]'s daughter knew about this she would be very upset."</p> <p>c. On 1/10/08 at 9:45 a.m., the Administrator provided a Social Service Progress Note that documented, "I have placed a call to resident's daughter. I asked her if she has ever given any staff, namely [Name of House Keeper #1], permission to use her mother's phone. She stated it wasn't her phone to give anyone permission to use it. It was her mother's phone."</p> <p>2. The policy and procedure entitled "Reporting Suspected Abuse, Neglect, Exploitation, Incidents, Accidents, Deaths from Violence, and Misappropriation of Resident Property" documented, "Misappropriation of Resident's Property: Means the deliberate misplacement (hiding), exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Examples: Theft of monies or property, use of resident's personal phone or television, intentionally hiding personal property from the resident, taking the</p>	F 224			

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F 225 SS=D	<p>resident's personal food/snacks from them, etc."</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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.</p>	F 225			

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F 225	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to the Office of Long Term Care for 1 (Resident #2) of 1 case mix resident that had made an allegation of abuse. This failed practice had the potential to effect all 71 residents according to the census provided by the Administrator on 1/7/08. The findings are: 1. Resident #2 had diagnoses of Dementia, Depression, Fracture, and Non-Insulin Dependent Diabetes Mellitus. The Medicare 14 day Minimum Data Set dated 12/24/07 documented the resident was moderately impaired in cognitive skills for daily decision making. a. The Plan of Care dated 12/24/07 documented, "Cognitive Loss/Dementia or Alteration in Thought Processes Related to Impaired Decision Making, Short and/or Long Term Memory Loss. ... Promote dignity. Provide a homelike, therapeutic environment." b. A Nurse's Note dated 12/27/07 at 1100 (11:00 a.m.) by Licensed Practical Nurse (LPN) #4 documented, "Resident sitting at dining room table awaiting meal. Resident stated, "I need to tell the nurse my left arm and left side are killing me. Someone almost pushed me through the wall and now it is killin' me." Nurse assessed resident. [No] reddened spots or skin tears noted. Light healing bruise to dorsal of left hand noted. Resident has [no] other s/s (signs/symptoms) of acute distress noted. Resident requires assist x (times) 2 with ADLs (activities of daily living) and is a w/c (wheelchair)	F 225			

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F 225	<p>Continued From page 4</p> <p>amb. (ambulatory) with push. Family notified and RN (Registered Nurse) notified.</p> <p>c. On 1/10/08 at 9:00 a.m., the Director of Nursing (DON) was asked to provide the I & A (Incident & Accident) report, Internal Investigation or any other documentation the facility had on the incident that occurred on 12/27/07 at 11:00 a.m. related to the allegation of abuse made by the resident. The DON stated, "I will check on it."</p> <p>d. On 1/10/08 at 3:30 p.m., the Administrator stated, "No I&A report was documented on the incident and I'm not sure why." The Administrator provided Witness Statements documented on Nurse's Notes Sheets by RN #1, RN #2, and LPN #4 and stated, This is all I have." The following was documented:</p> <p>1. A Nurse's Note/Witness Statement written by RN #2 and dated 12/29/07 at 1525 (3:25 p.m.) documented, "On December 27th [at] approx. (approximately) 1100 (11:00 a.m.) a CNA (Certified Nurse Aide), (I can't remember who) came to the nurses station and reported something was wrong with [Resident #2]. She was crying. [LPN #4] was at the nurses station with me and offered to help with assessment. [Resident #2] was sitting in her wheelchair at the table she always sits at, across from 2 residents she always sits with for meals. [Resident #2] was visibly upset, sobbing almost. I asked her what had happened and she stated someone had pushed her toward the dining room but then pushed her into the wall. She c/o (complained of) pain in (L) (left) arm and side. No reddened areas or skin tears noted. I pulled up her shirt sleeve to look at her upper arm but no reddened areas noted. She [resident] denied falling out of</p>	F 225			

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F 225	Continued From page 5 chair, just reported she got pushed into the wall. [LPN #4] pointed out a puffy spot on top of [resident's] left hand, but this was an edematous area resident had for quite some time. [LPN #4] and I both concerned & (and) with our findings of no visible trauma. We returned to the nurses station where [LPN #4] charted the residents c/o and our findings. I, [RN #2] immediately phoned resident's daughter and informed her of the incident & to report her mother's status. I reported to her mine and [LPN #4's] assessment, that physically there were no s/s of trauma. I did tell the daughter that I felt it possibly startled and scared her. I told the daughter of her c/o, and that she was crying. The daughter told me she would be in around 1:00 p.m. She asked why it was that her mom was left in the wheelchair in hall and not pushed into the dining room. I told her I did not know and would try to find out. After that call, I questioned all the CNAs on West hall that day and no one admitted to bringing [Resident #2] out into the hallway. I left work that day around 1200. When I left, [Resident #2] had calmed down and the daughter hadn't made it in yet." 2. A Nurse's Note/Witness Statement written by LPN #4 and dated 12/29/07 at 1500 (3:00 p.m.) documented, "I, [LPN #4], was sitting [at] W. H. (West Hall) nurses station charting MCR (Medicare) Nurses Assessment Documentation. In the midst of charting on [Resident #2] a CNA came to nurses station and reported to W. H. Charge Nurse that resident was in W.H. Formal dining room crying and wanting to speak with a nurse. I asked [RN #2] is she would like me to assist in an assessment. Resident had [no] reddened areas or skin tears noted. Resident had [no] s/s of acute distress noted at present.	F 225			

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F 225	Continued From page 6 Resident could not tell [LPN #4 and RN #2] of who ran into the back of her wheelchair that "almost pushed me through the wall and now is is (L) arm (L) back is killing me." After incident and assessment I, [LPN #4], noted the assessment and incident in MCR Nurses Notes. After which, [RN #2 and I], questioned all CNAs on W.H. as to who took [Resident #2] to the formal dining room. Everyone stated, "Not me." [Name of RN #2] called and notified daughter and then left. 3. A Witness Statement written by RN #1 and dated 12/27/07 documented, "At 1430 (2:30 p.m.) hours resident's daughter asked to speak with me. Resident told her that someone with long dark hair pushed her toward dining room for lunch and stopped at nurse's station on West Hall. Stated someone else then came up behind her and started pushing her toward dining room. Resident stated this person (identity unknown) pushed her into iron fence while someone was opening it and hurt her arm and neck. Exam negative for injury. Staff stated later found resident sitting in door to formal dining room on west hall. [RN #2 and LPN #4] were the 2 nurses sitting at the nurses station at that time. Statements received from both nurses." e. On 1/10/08 at 3:30 p.m., the Administrator stated, "Based on the Nurse's Note and what is documented here [witness statements] I can see why you think it is an allegation of abuse." When asked why the incident was not documented on an I&A report the Administrator stated, "Not sure." When asked if the staff followed the policy and procedure for protecting, reporting and investigating the allegation the Administrator stated, "I guess not."	F 225			
F 226	483.13(c) STAFF TREATMENT OF RESIDENTS	F 226			

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F 226 SS=D	Continued From page 7 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 their abuse policy and procedure was followed for 1 (Resident #2) of 1 case mix resident that had made an allegation of abuse that was not reported to the Office of Long Term Care. This failed practice had the potential to effect all 71 residents according to the census provided by the Administrator on 1/7/08. The findings are: 1. Resident #2 had diagnoses of Dementia, Depression, Fracture and Non-Insulin Dependent Diabetes Mellitus. The Medicare 14 day Minimum Data Set dated 12/24/07 documented the resident was moderately impaired in cognitive skills for daily decision making. a. The Plan of Care dated 12/24/07 documented, "Cognitive Loss/Dementia or Alteration in Thought Processes Related to Impaired Decision Making, Short and/or Long Term Memory Loss. ... Promote dignity. Provide a homelike, therapeutic environment." b. A Nurse's Note dated 12/27/07 at 1100 (11:00 a.m.) by Licensed Practical Nurse (LPN) #4 documented, "Resident sitting at dining room table awaiting meal. Resident stated, "I need to tell the nurse my left arm and left side are killing me. Someone almost pushed me through the	F 226			

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F 226	<p>Continued From page 8</p> <p>wall and now it is killin' me." Nurse assessed resident. [No] reddened spots or skin tears noted. Light healing bruise to dorsal of left hand noted. Resident has [no] other s/s (signs/symptoms) of acute distress noted. Resident requires assist x (times) 2 with ADLs (activities of daily living) and is a w/c (wheelchair) amb. (ambulatory) with push. Family notified and RN (Registered Nurse) notified.</p> <p>c. On 1/10/08 at 9:00 a.m., the Director of Nursing (DON) was asked to provide the I & A (Incident & Accident) report, Internal Investigation or any other documentation the facility had on the incident that occurred on 12/27/07 at 11:00 a.m. related to the allegation of abuse made by the resident. The DON stated, "I will check on it."</p> <p>d. On 1/10/08 at 3:30 p.m., the Administrator stated, "No I&A report was documented on the incident and I'm not sure why." The Administrator provided Witness Statements documented on Nurse's Notes Sheets by RN #1, RN #2, and LPN #4 and stated, "This is all I have." The following was documented:</p> <p>1. A Nurse's Note/Witness Statement written by RN #2 and dated 12/29/07 at 1525 (3:25 p.m.) documented, "On December 27th [at] approx. (approximately) 1100 (11:00 a.m.) a CNA (Certified Nurse Aide), (I can't remember who) came to the nurses station and reported something was wrong with [Resident #2]. She was crying. [LPN #4] was at the nurses station with me and offered to help with assessment. [Resident #2] was sitting in her wheelchair at the table she always sits at, across from 2 residents she always sits with for meals. [Resident #2] was visibly upset, sobbing almost. I asked her what</p>	F 226			

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F 226	Continued From page 9 had happened and she stated someone had pushed her toward the dining room but then pushed her into the wall. She c/o (complained of) pain in (L) (left) arm and side. No reddened areas or skin tears noted. I pulled up her shirt sleeve to look at her upper arm but no reddened areas noted. She [resident] denied falling out of chair, just reported she got pushed into the wall. [LPN #4] pointed out a puffy spot on top of [resident's] left hand, but this was an edematous area resident had for quite some time. [LPN #4] and I both concerned & (and) with our findings of no visible trauma. We returned to the nurses station where [LPN #4] charted the residents c/o and our findings. I, [RN #2] immediately phoned resident's daughter and informed her of the incident & to report her mother's status. I reported to her mine and [LPN #4's] assessment, that physically there were no s/s of trauma. I did tell the daughter that I felt it possibly startled and scared her. I told the daughter of her c/o, and that she was crying. The daughter told me she would be in around 1:00 p.m. She asked why it was that her mom was left in the wheelchair in hall and not pushed into the dining room. I told her I did not know and would try to find out. After that call, I questioned all the CNAs on West hall that day and no one admitted to bringing [Resident #2] out into the hallway. I left work that day around 1200. When I left, [Resident #2] had calmed down and the daughter hadn't made it in yet." 2. A Nurse's Note/Witness Statement written by LPN #4 and dated 12/29/07 at 1500 (3:00 p.m.) documented, "I, [LPN #4], was sitting [at] W. H. (West Hall) nurses station charting MCR (Medicare) Nurses Assessment Documentation. In the midst of charting on [Resident #2] a CNA	F 226			

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F 226	<p>Continued From page 10</p> <p>came to nurses station and reported to W. H. Charge Nurse that resident was in W.H. Formal dining room crying and wanting to speak with a nurse. I asked [RN #2] is she would like me to assist in an assessment. Resident 0 reddened areas or skin tears noted. Resident had [no] s/s of acute distress noted at present. Resident could not tell [LPN #4 and RN #2] of who ran into the back of her wheelchair that "almost pushed me through the wall and now is is (L) arm (L) back is killing me." After incident and assessment I, [LPN #4], noted the assessment and incident in MCR Nurses Notes. After which, [RN #2 and I], questioned all CNAs on W.H. as to who took [Resident #2] to the formal dinning room. Everyone stated, "Not me." [Name of RN #2] called and notified daughter and then left."</p> <p>3. A Witness Statement written by RN #1 and dated 12/27/07 documented, "At 1430 (2:30 p.m.) hours resident's daughter asked to speak with me. Resident told her that someone with long dark hair pushed her toward dining room for lunch and stopped at nurse's station on West Hall. Stated someone else then came up behind her and started pushing her toward dinning room. Resident stated this person (identity unknown) pushed her into iron fence while someone was opening it and hurt her arm and neck. Exam negative for injury. Staff stated later found resident sitting in door to formal dining room on west hall. [RN #2 and LPN #4] were the 2 nurses sitting at the nurses station at that time. Statements received from both nurses."</p> <p>e. On 1/10/08 at 3:30 p.m., the Administrator stated, "Based on the Nurse's Note and what is documented here [witness statements] I can see why you think it is an allegation of abuse." When</p>	F 226			

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F 226	Continued From page 11 asked why the incident was not documented on an I&A report the Administrator stated, "Not sure." When asked if the staff followed the policy and procedure for protecting, reporting and investigating the allegation the Administrator stated, "I guess not." 2. The policy and procedure entitled "Reporting Suspected Abuse, Neglect, Exploitation, Incidents, Accidents, Deaths from Violence, and Misappropriation of Resident Property" documented, "The following events shall be reported to the OLTC by facsimile transmission to telephone number 501-682-8551 of the completed Incident & Accident Intake Form (Form DMS-7734) no later than 11:00 a.m. on the next business day following discovery by the facility: Any alleged, suspected, or witnessed occurrences of abuse or neglect to residents. Written reports of all incidents and accidents shall be completed within five days after discovery. The written incident and accident reports shall be comprised of all information specified in forms DMS 7734 and 762 as applicable. The facility must ensure that all alleged or suspected incidents involving resident abuse, exploitation, neglect, or misappropriation of resident property are thoroughly investigated, and must prevent further potential incidents while the investigation is in progress. The facility must immediately report the suspected, witnessed, or alleged abuse, neglect, or misappropriation of resident property to the local law enforcement agency. While there is no requirement under state law or regulations to notify the attending physician when an incident of abuse or neglect occurs to a resident, it is strongly recommended that facilities do so. The appropriate corrective action is up to the facility in accordance with the facility's policies	F 226			

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F 226	Continued From page 12 and procedures, providing said policies and procedures ensure the protection of the resident(s), identifies the problem so that it doesn't happen again, and provides subsequent training for facility staff as indicated.	F 226			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure a mattress was cleaned for 1 (Resident #7) of 1 case mix resident who required a specialty low air loss bed and was being treated for multiple pressure sores. This failed practice had the potential to affect 2 residents who required the use of the low air loss beds as provided by the Administrator on 1/11/08. The findings are: Resident #7 had diagnoses of End Stage Dementia with Percutaneous Enterogastrostomy (Peg) Tube Feedings, Contractures and Pressure Sores. The Quarterly Minimum Data Set dated 10/18/07 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent for all Activities of Daily Living (ADLs), incontinent of bowel and bladder, six Stage 2 Pressure Sores and one Stage 3 Pressure Sore. a. On 1/7/07 at 2:28 p.m. and 6:00 p.m., the resident was observed on a specialty air loss bed with many areas of dried, white substances at different areas of the bed from the top of the bed	F 253			

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F 253	Continued From page 13 to the foot of the bed. b. On 1/8/08 at 8:17 a.m., the resident was observed on a specialty air loss bed with many areas of dried, white substances at different areas of the bed from the top of the bed to the foot of the bed. c. On 1/10/08 at 3:55 p.m., the Environmental Services Supervisor (ESS) provided a Deep Cleaning Schedule that documented, "Room "302 - Monday." When asked what that meant, the ESS pointed at Monday then pointed to 302 and said, "See, her bed is to be cleaned on Monday, although, it don't look like it got cleaned this Monday for some reason."	F 253			
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure therapeutic levels of anticoagulation therapy were monitored for 1 (Resident #8) of 1 case mix resident who received Coumadin therapy. This failed practice had the potential to affect 12 residents who received Coumadin therapy according to the Director of Nursing (DON) on 1/11/08. The findings are: Resident #8 had diagnoses of Atrial Fibrillation and Flutter and Thrombocytopenia. The Annual	F 282			

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F 282	<p>Continued From page 14</p> <p>Minimum Data Set dated 10/23/07 documented the resident was severely impaired in cognitive skills for daily decision making.</p> <p>a. A Physician's Order dated 2/8/07 documented, "Coumadin tabs (tablets) 2 mg (milligram) 1 PO (by mouth) daily [at] 1800 (6:00 p.m.). PT (Prothrombin Time)/INR (International Ratio) Q (every) month Coumadin Use."</p> <p>b. The Plan of Care updated on 4/19/07 documented, "Risk of abnormal bleeding ET (and/or) bruising r/t (related to) Coumadin therapy. Coumadin 2 mg daily [at] 1800. PT/INR monthly."</p> <p>c. As of 1/8/08, the results for a PT/INR for September 2007 were not in the clinical record.</p> <p>d. On 1/9/08 at 11:50 a.m., the Assistant Director of Nurses (ADON) stated, "[Licensed Practical Nurse (LPN) #5) prints a monthly list and it's put at the Nurse's stations. It has the resident's names and what is to be drawn and done. The nurse then writes it on the big desk calendar and it's crossed off when it's done. The computer print out is usually crossed off or highlighted when they are done." When asked if the past months calendar sheets were kept on file, the ADON stated, "No, they are thrown away." When asked if the monthly computer print out lists were kept on file after they had been marked as completed, LPN #1 went to another room to check, then returned and stated that he could not find any on file.</p> <p>e. On 1/9/08 at 1:00 p.m., there was not a list of residents with ordered laboratory draws posted at the Northwest Nurse's station where the resident</p>	F 282			

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F 282	Continued From page 15 had resided for the month of January 2008. The large desk calendar present for the month of January 2008 did not document the name nor the PT/INR to be drawn for the resident for the month of January. f. On 1/9/08 at 2:50 p.m., the DON stated that she was unable to locate PT/INR results for September 2007.	F 282			
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that all areas of the perineum and buttocks were cleansed for 2 (Residents #4 and #8) of 6 (Resident #2, #4, #6, #7, #8 and #9) case mix residents who were incontinent of bowel and bladder and that oral hygiene was provided for 1 (Resident #7) of 2 (Resident #7 and #9) case mix residents who were totally dependent on staff for oral hygiene care. These failed practices had the potential to affect 43 residents who were incontinent of bowel, 49 residents who were incontinent of bladder and 21 residents who were totally dependent on staff for bathing and hygiene needs according to the Resident Census and Conditions of Residents form dated 1/7/08. The findings are: 1. Resident #8 had diagnoses of Bipolar Disorder, Dementia with Behaviors, Presenile	F 312			

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F 312	<p>Continued From page 16</p> <p>Dementia, Reactive Depressive Psychosis, Urinary Retention and Diabetes. The Annual Minimum Data Set (MDS) dated 10/23/07 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for hygiene needs and was incontinent of bowel and bladder.</p> <p>a. The Plan of Care updated on 10/23/07 documented, "Risk of skin breakdown R/T (related to) B/B (bowel and bladder) incontinence ... Keep skin clean [and] dry, peri care PRN as needed) after each incontinence episode."</p> <p>b. On 1/9/08 at 9:35 a.m., Certified Nurses Assistant (CNA) #5 provided care after an episode of bladder incontinence. The front of the scrotum was not cleansed.</p> <p>2. Resident #4 had diagnoses of Cerebral Vascular Accident (CVA), Anemia, Senile Dementia, Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Hypertension, and Osteoporosis. The MDS dated 12/19/07 documented the resident was severely impaired in cognitive skills for daily decision making, had total dependence for dressing, hygiene, bathing, toilet use and was incontinent of bowel and bladder.</p> <p>On 1/8/07 at 2:10 p.m., Training Nursing Assistant (TNA) #1 and CNA #2 assisted the resident to a standing position for incontinent care. The resident's urine soaked pants were pulled down to his ankles. As the saturated pull-up brief was being pulled down, bowel movement (BM) smeared on the resident's left lower leg. The CNA and the TNA left the brief down at his ankles with his pants. The CNA</p>	F 312			

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F 312	<p>Continued From page 17</p> <p>wiped the anal area with wet wash cloths two times. There was still BM on the wash cloth after the last wipe. The buttocks, testes, penis, or groins were not cleansed. There was a urine soaked cloth bed pad folded in the wheel chair that was under the resident. The CNA turned the pad over and sat the resident down on the pad. The CNA and the TNA then removed the wet pants and pull-up brief from around the ankles and placed the resident's feet in a clean pull-up and then pants. The TNA wet a wash cloth and wiped BM from the left ankle and handed a wet cloth to the CNA who then wiped BM that was on the resident's left lower leg. The TNA was asked if the cloths were wet with only water and the TNA and CNA both replied, "Yes, water." The CNA and TNA assisted the resident to standing position again. A moderate amount of BM was smeared on the folded bed pad in the chair. The CNA and TNA both looked behind the resident and observed the BM on the pad and then pulled up the brief and the pants without further cleansing of the anal area. The CNA picked up the urine and BM soiled pad and put them in a bag with the soiled clothing. The gel cushion in the wheelchair was not cleansed. They then assisted the resident to a recliner.</p> <p>3. Resident #7 had diagnoses of End Stage Dementia with Percutaneous Enterogastrostomy (Peg) Tube Feedings, Contractures, Pressure Sores, and Urinary Retention. The Quarterly MDS dated 10/18/07 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent for all Activities of Daily Living and incontinent of bowel and bladder.</p> <p>a. The Plan of Care updated 10/22/07</p>	F 312			

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F 312	Continued From page 18 documented, "Staff to do oral care." b. On 1/7/08 at 6:00 p.m., there were 3 wide, whitish, stringy substances hanging from the roof of the resident's mouth to the back of her tongue. c. On 1/7/08 at 6:13 p.m., CNA #1 and #6 entered the room to provide care but did not offer nor provide oral care to clean the substances out of the resident's mouth. d. On 1/8/07 at 8:26 a.m., CNA #3 and TNA #1 entered the room to provide care for the resident. Oral care was not provided. 4. The policy and procedure entitled "Oral Hygiene for the unconscious resident" documented, "Check resident's care plan for special instructions." 5. The policy and procedure entitled "Incontinence Care" documented, " ... To keep skin clean, dry free of irritation and odor ... Wash all soiled skin areas and dry very well, especially between skin folds."	F 312			
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315			

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F 315	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and record review, the facility failed to ensure a back to front motion was not used during incontinent care to prevent potential Urinary Tract Infections (UTI) for 1 (Resident #9) of 6 (Resident #2, #4, #6, #7, #8 and #9) case mix residents who were incontinent of bowel and bladder. This failed practice had the potential to affect 43 residents who were incontinent of bowel and 49 residents who were incontinent of bladder according to the Resident Census and Conditions of Residents form dated 1/07/08. The findings are:</p> <ol style="list-style-type: none"> 1. Resident #9 had diagnoses of Urosepsis, Bipolar Affective Disorder, Depression and Osteoarthritis. The Minimum Data Set dated 11/10/07 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for hygiene needs, incontinent of bowel and bladder all or almost all of the time and had a diagnosis of UTI in the last 30 days. <ol style="list-style-type: none"> a. The Plan of Care updated on 9/4/07 documented, "... Continues to experience recurrent UTI . . . Cipro 500 mg (milligram) 1 PO (by mouth) BID (two times daily) X (times) 5 days." b. The Plan of Care updated on 12/01/07 documented, "[At] risk for recurrent UTI as evidenced by hx (history) of." c. A laboratory result for Urinalysis dated 9/12/07 documented, "WBC (white blood cells) 11-30 (normal range negative), bacteria 1+ (normal range negative), clarity turbid (normal range 	F 315			

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F 315	Continued From page 20 clear), nitrates positive (normal range negative) and leukocyte esterase large (normal range negative)." d. A Physician's Order Sheet from a local hospital dated 11/4/07 documented, "Rocephin 1 gm (gram) IM (intramuscularly) ... DX (diagnosis) UTI ... Ceftin 500mg TID (3 times daily) X 4 days." e. On 1/9/08 at 8:30 a.m., Certified Nurses Assistant (CNA) #4 provided care after an episode of bladder incontinence. The vaginal area and both groin areas were cleansed using a front to back motion. 2. The policy and procedure entitled "Incontinence Care" documented, " To keep skin clean, dry free of irritation and odor ... To prevent skin breakdown ... To prevent infection."	F 315			
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure residents who smoked were assessed and quarterly reassessed for their ability to safely smoke unsupervised by staff and to keep smoking materials in their possession for 3 (Residents #1,	F 323			

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F 323	<p>Continued From page 21</p> <p>#10, and #11) of 3 case mix residents (Residents #1, #10 and #11) observed for smoking safety. The facility failed to ensure Training Nurse Aides (TNA) did not perform resident transfers with mechanical lifts without the supervision for 1 (Resident #11) of 3 case mix residents (Resident #7, #9 and #11) observed for transfers. The facility failed to ensure an employee bathroom that had no call light system was kept locked and inaccessible to independently mobile residents residing on the West Hall and hazardous chemicals were not left in resident shower areas. These failed practices had the potential to effect 8 residents who smoked and 6 residents dependent on staff for Mechanical Lift transfers according to the list provided by the Administrator on 1/11/08, 8 independently mobile residents on the East and West Hall and 8 independently mobile residents who received showers in the East 100 Hall Shower room according to the list provided by the Administrator on 1/9/08. The findings are:</p> <p>1. Resident #1 had diagnoses of Asthma, Atrial Fibrillation, Diabetes Mellitus, Benign Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease (COPD) and Osteoarthritis. The Minimum Data Set (MDS) dated 11/5/07 documented the resident was independent in cognitive skills for daily decision making, required extensive assistance with all activities of daily living.</p> <p>a. The Plan of Care dated 11/26/07 documented, "Resident is a smoker ... Resident keeps cigarettes in room. Family brings Cigarettes as needed. Resident informs staff when cigarette is desired and staff assists as needed. Spouse does leave lighter with resident.</p>	F 323			

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F 323	<p>Continued From page 22</p> <p>b. On 1/9/08 at 10:20 a.m., the clinical record was reviewed. A Smoking Assessment Form dated 10/13/06 documented the resident required supervision with smoking due to having a musculoskeletal diagnosis of Back Spasms. There were no Smoking assessments documented since that date found in the clinical record or in the Risk Assessment Book that was located at the West Hall Nurse's Station.</p> <p>c. On 1/9/08 at 11:00 a.m., the resident was observed smoking unsupervised in the resident smoking area located off of the feeder dinning room on West Hall.</p> <p>d. On 1/10/08 at 3:00 p.m., the resident was asked if someone was always with her when she smoked and she stated, "No. My husband goes with me when he's here everyday." The resident was asked if a staff member was with her when her husband was not there, and she stated, "No. Sometimes they are already out there, but sometimes no one is out there." When asked where her cigarettes and lighter were kept, the resident stated, "In my coat pocket."</p> <p>2. Resident #11 had diagnoses of Cerebral Palsy, COPD, Muscle Spasms, Paraplegia, Depression, and Schizophrenia. The MDS dated 12/2/07 documented the resident was moderately impaired in cognitive skills for daily decision making and required total assistance with activities of daily living.</p> <p>a. The Plan of Care updated 11/26/07 documented, "Needs Assist with ADLs to Meet Needs. Needs supervision with smoking. ... assist resident to smoking breaks prn (as needed). Staff to keep cigarettes and lighters at</p>	F 323			

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F 323	Continued From page 23 nurse's stations or social office. Observe resident when smoking for ashes that fall on the lap/clothes. Remind family and other visitors of smoking rules and to not leave cigarettes or lighters with the resident or in their room." The Plan of Care did not address the resident's transfer needs. b. On 1/10/08 at 9:30 a.m., TNA #2 had positioned the Hoyer Lift Sling under the resident who was resting in bed with the bedside rails up. The sling was positioned with the top of the sling above the resident's head and the bottom of sling was positioned midway of the resident's buttocks. At this time, the TNA stated, "I need help with this" and turned on the resident's call light. TNA #1 entered the room to assist TNA #2. TNA #1 moved the Hoyer Lift to the bedside and lowered the hooks so the straps of the sling could be attached to the lift hooks. TNA #2 asked TNA #1 what color of straps are used at top and bottom of sling and TNA #1 stated, "Green at top and Blue at bottom." Both TNA's attached the sling straps to the lift hooks then wrapped the remaining colored straps around the hooks of the lift. TNA #1 turned on the Hoyer Lift and raised the resident approximately 6 inches off the mattress causing the resident's head to bend forward towards her chest and the residents body to curl with one half of the resident's buttocks left hanging out of the bottom of the sling. TNA #1 stated, "This doesn't look right. I think we need some guidance. I don't do this much." TNA #2 stated, "This is only my 4th time to use the Hoyer Lift and the resident is new to me." TNA #1 stated, "I'm calling for guidance," and turned on the call light after lowering the resident back onto the bed mattress. Neither TNA removed the wrapped straps from the lift. Certified Nursing	F 323			

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F 323	<p>Continued From page 24</p> <p>Assistant (CNA) #2 entered the room and stated, "This is not done right."</p> <p>c. On 1/11/08 at 10:00 a.m., Registered Nurse (RN) #1 was asked if TNAs were allowed to work alone during patient care such as Hoyer Lift Transfers and the RN stated, "TNAs are allowed to work the floor after being checked off on a skill, but is to work with a CNA and cannot work alone."</p> <p>d. On 1/10/08 at 1:00 p.m., the "Arkansas LTCF (Long Term Care Facility) Nursing Assistant Trainee Task Performance Record" for TNA #1 and #2 was received from the DON. There was no documentation that either TNA had been checked off on the Hoyer Lift.</p> <p>e. The policy and procedure entitled "Hydraulic Lift (Hoyer Lift)" documented, "Place widest seat part under resident's buttocks and thighs, so that lower edge of seat is under knees. Place narrow part of seat just above the small of the resident's back. Attach "S" hooks of the chain to the loops on the seat hanger."</p> <p>f. On 1/10/08 at 11:30 a.m., the clinical record was reviewed. A Smoking Assessment Form dated 10/23/06 documented the resident required supervision with smoking due to Schizophrenia, Depression, Cerebral Palsy, Muscle Spasms, and Paraplegia. There were no Smoking Assessments documented since that date in the clinical record or the Risk Assessment Book kept at the West Hall Nurses Station.</p> <p>g. On 1/11/08 at 9:15 a.m., the Administrator was asked for the Resident Smoking Policy and Procedure. The Administrator stated, "The policy was on my desk 3 weeks ago and now I can't find</p>	F 323			

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F 323	Continued From page 25 it. Apparently that was the only copy." h. On 1/11/08 at 11:00 a.m., the Director of Nursing (DON) was asked how new staff were made aware of supervision needs of smokers and the DON stated, "We verbally tell them. The supervised resident's cigarettes and lighters are kept bagged and locked up and the staff has to go and get them. We try not to let the residents keep lighters but the families bring them in. There is nothing written that states they can't have it." 3. On 1/9/07 at 3:20 p.m., there was a spray bottle labeled Buckeye Sanicare Pine Quat Disinfectant Cleaner hanging on the metal glove box holder affixed to the wall next to a large dispenser of Aloe Vesta Skin Protectant in the East Hall Shower Room. Both containers were on the left at the entry into the second shower stall. The Environmental Services Supervisor stated he didn't know who put the disinfectant/cleanser there, when it was put there or why it was there. a. On 1/9/07 at 4:35 p.m., the Material Safety Data Sheet (MSDS) was received from the administrator that documented, "Corrosive-causes irreversible eye damage. Causes skin irritation. Harmful if inhaled." b. The policy and procedure on the storage of chemicals documented, "All poisons, bleaches, detergents, and disinfectants shall be kept in a safe place accessible only to employees." 4. On 1/8/08 at 4:50 p.m. the Administrator was notified that the door on employee bathroom	F 323			

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F 323	Continued From page 26 across from the Northwest Nurses Station had no means to lock the door and there was no emergency call light. 5. Resident #8 had diagnoses of Lumbar Disc Displacement with Spinal Stenosis, Bilateral Lower Extremity Radiculopathy and Cerebrovascular Accident. The Quarterly MDS dated 10/23/07 documented the resident was independent in cognitive skills for daily decision making. a. The Resident-Data Collection, Status Upon Admission form dated 7/27/07 documented, "Personal Habits: Smokes?" A check mark was inserted into the "Yes" box provided. b. The Social Service Progress Notes dated 9/7/07 documented, "R (resident) confused upon admissions. The Social Service Progress Notes dated 12/11/07 documented, "R now alert x's (times) 3." c. The Plan of Care updated on 10/23/07 documented, "... Need for activities participation as evidenced by spends most of time in television room ... Does smoke in designated smoking areas & visits with others." d. On 1/10/08 at 1:10 p.m., the resident was observed smoking on the smoking porch without staff present. e. On 1/10/08 at 2:00 p.m., the Administrator was notified that no smoking assessments could be located in the medical record or the West Hall resident assessment book for the resident. The Administrator stated, "We don't do smoking assessments. We know who is cognitively able	F 323			

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F 323	Continued From page 27 to do it by themselves. They smoke on the deck there where the glass door and windows are where we can see them." When asked how the staff were aware of a change in condition to change smoking allowances for the residents, the Administrator stated, "We watch them. We notice is there is a change in their fingers or how they move. No one is allowed to keep cigarettes or a lighter unless it is snuck in or something and we miss it." The Administrator was then asked for a copy of the smoking policy. f. On 1/10/08 at 2:10 p.m., when asked if he kept his own cigarettes and lighter in his room, the resident stated, "Yes." The Administrator was notified of the resident's statement on 1/10/08 at 6:15 p.m. g. On 1/11/08 at 9:15 a.m., when asked for the smoking policy, the Administrator stated, "It was on my desk 3 weeks ago and I can't find it now. I guess it was the only copy." h. On 1/11/08 at 11:50, the Administrator was asked how the staff knew which residents were safe to smoke unsupervised and the Administrator stated, "[Environmental Services Director] handles that. Their department staff members take the residents out to smoke that need supervision. [Environmental Services Director] tells them all about the smoker's needs and tells the new staff, too. He has weekly meetings so I'm sure is there's an issue with smoking, they discuss it. If one of them is called away from smoking the residents, whoever takes over is told specifics on each resident and what they can or can't do or need to watch for."	F 323			
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS	F 332			

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F 332	<p>Continued From page 28</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview of the 8:00 a.m. medication pass on 1/10/08, the facility failed to ensure the medication error rate was less than 5%. Physician's Orders were not followed on 2 (Resident #6 and #16) of 6 residents observed during the medication passes resulting in medication errors. Medication errors were made by 2 Licensed Practical Nurses (LPN #1 and #3) of 3 licensed nurses observed administering medications. This failed practice had the potential to affect 44 residents on the northwest hall and the east/west hall according to the initial rounds sheets on 1/07/08. The medication error rate was 5.67% based on administration of 52 medications with 3 medication errors observed. The findings are:</p> <ol style="list-style-type: none"> 1. Resident #6 had a Physician's Order dated 12/28/07 for Advair 250/50 1 puff every 12 hours. <ol style="list-style-type: none"> a. On 1/10/08 at 7:35 a.m., during the 8:00 a.m. medication pass, LPN #1 administered the Advair 250/50 and did not have the resident rinse their mouth after use. b. The manufacture package insert documented, "Rinse your mouth with water after breathing-in the medicine. Spit the water out. Do not swallow." 2. Resident #6 had a Physician's Order dated 	F 332			

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F 332	Continued From page 29 12/28/07 for Spriva 18 mcg (micrograms) handihaler 2 inhalation every day. a. On 1/10/08 at 7:37 a.m., during the 8:00 a.m. medication pass, LPN #1 administered Spiriva 1 inhalation. b. The Geriatric Dosage Handbook documented on page 1543, "... Tilt head slightly back and inhale (rapidly, steadily and deeply); the capsule vibration may be heard within the device. Hold breath as long as possible, if any powder remains in capsule, exhale and inhale again. 3. Resident #17 had a Physician's Order dated 11/12/07 for Toprol XL (time release) 25 mg (milligram) 1 by mouth (po) every day. On 1/10/08 at 8:23 a.m., during the 8:00 a.m. medication pass, LPN #3 administered Metoprolol 25 mg (short acting).	F 332		
F 333 SS=E	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Physician's Orders were followed so that residents were free of significant medication error for 1 (Resident #16) resident that received medications on the Northwest Hall. This failed practice had the potential to affect 18 residents that received medications on the Northwest Hall according to the Initial Rounds sheets on 1/7/08. The findings are:	F 333		

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F 333	Continued From page 30 1. Resident #16 had a Physician's Order dated 11/12/07 for Toprol XL (time release) 25 mg (milligram) 1 by mouth (po) every day. a. On 1/10/08 at 8:23 a.m., during the 8:00 a.m. medication pass, Licensed Practical Nurse (LPN) #3 administered Metoprolol 25 mg (short acting). b. The Medication Administration Record (MAR) dated 1/1/08 thru 1/30/08 documented, "Toprol XL 25 mg tablet SA (sustain action) 1 po every day." c. The Medication Bubble Pack documented Metoprolol 25 mg with a fill date of 12/28/07. The Bubble Pack contained an axillary label that documented, "Directions changed refer to chart and under this label the directions documented: Take one tablet by mouth three times a day." d. According to the Medication Bubble Pack 12 doses had been administered. e. On 1/10/08 at 9:35 a.m., LPN #3 was asked for blood pressures for the resident. The LPN stated, "They take vitals but don't document it." f. This was a significant error due to the frequency.	F 333			
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in	F 441			

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F 441	<p>Continued From page 31</p> <p>the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a soiled gel cushion in a wheel chair was cleaned for 1 (Resident #4) of 1 case mix resident observed with a soiled gel cushion, failed to ensure a nurse did not contaminate gloves being used for Percutaneous Enterogastrostomy (Peg) Tube site care and did not contaminate the plunger by laying it on the outside of a contaminated syringe bag when it was removed from the syringe for 1 (Resident #17) of 1 case mix resident with a feeding tube observed during med pass. The facility failed to ensure expired dressing supplies were removed from the current supply of wound dressing materials in the Central Supply. These failed practices had the potential to affect 49 residents that were incontinent of bladder, 43 residents that were incontinent of bowel, 4 residents with pressure sore and 2 residents with peg tubes according to the Resident Census and Conditions of Residents form dated 1/7/08. The findings are:</p> <p>1. Resident #4 had diagnoses of CVA (Cerebral Vascular Accident), Senile Dementia, Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, and Osteoporosis. The Annual Minimum Data Set (MDS) dated 12/19/07 documented the resident was severely impaired in cognitive skills for daily decision making, total dependence for transfers, dressing,</p>	F 441			

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F 441	<p>Continued From page 32</p> <p>hygiene/bathing, toilet use and was incontinent of bowel and bladder.</p> <p>On 1/8/07 at 2:10 p.m., Training Nursing Assistant (TNA) #1 and Certified Nursing Assistant (CNA) #2 assisted the resident to a standing position for incontinent care. The urine soaked pants were removed. There was a urine soaked cloth bed pad folded in the wheel chair on top of a gel cushion. The CNA turned it over and sat the resident down on the pad. The CNA and the TNA then removed the wet pants and brief from around the resident's ankles and placed the feet in a clean pull-up with pants. The resident was assisted to a standing position. A moderate amount of BM was smeared on the folded bed pad in the chair. The CNA picked up the urine and BM soiled pad and put it in a bag with his soiled clothing. The gel cushion in the wheelchair was not cleansed. They then assisted the resident to the recliner.</p> <p>2. On 1/9/07 at 2:50 p.m., the Central Supply storage room contained 9 boxes of 15 each, 12 ply Carrasyn Hydrogel 4x4 Dressings that had an expiration date of May 2007.</p> <p>3. On 1/8/08 at 10:02 a.m., Licensed Practical Nurse (LPN) #1 applied gloves and prepared to administer a peg tube feeding and medications for Resident #17. There was a knock at the door and the LPN stated, "Resident care." No one answered so the LPN went to the door, opened it with the gloved hand, and then returned to the resident to check placement of the feeding tube. The LPN continued with the administration of the medications and feeding and did not change gloves. After checking placement, the LPN removed the plunger from the syringe and laid the</p>	F 441			

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F 441	Continued From page 33 plunger back on the outside of the plastic bag on the bedside table.	F 441			
F 443 SS=E	483.65(b)(2) PREVENTING SPREAD OF INFECTION The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure an employee notified their supervisor of a potentially infectious illness prior to providing resident care. This failed practice had the potential to effect all 71 residents according to the census provided by the Administrator on 1/7/08. The findings are: 1. On 1/10/08 at 1:30 p.m., Licensed Practical Nurse (LPN) #1 was in the medication room assisting a surveyor with medication counts. The LPN stated, "I feel so bad. I have been sick and throwing up." When asked if it was something he ate the LPN stated, "I don't think so. My daughter was sick and throwing up last night and I cleaned up after her." 2. On 1/10/08 at 2:30 p.m., LPN #1 was at the West Hall Nurses Station and stated, "I guess I messed up. I took care of my little girl last night and she was sick and throwing up. I guess I have caught it now, because I have vomited 2 times already and I feel terrible." The LPN then left the Nurse's Station and entered a resident's room on West Hall.	F 443			

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NAME OF PROVIDER OR SUPPLIER STONE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560	
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F 443	Continued From page 34 3. On 1/10/08 at 5:10 p.m., LPN #1 was observed passing medications to the residents in the formal dining room on West Hall. 4. On 1/10/08 at 5:30 p.m., LPN #1 was coming down the West Hall and when asked if he was feeling better the LPN stated, "Not really." 5. On 1/11/08 at 11:00 a.m., the Director of Nursing (DON) was asked if she was aware that LPN #1 was sick the previous day and the DON stated, "No." When asked about a policy related to employees working sick the DON stated, "They are told to call in if they are sick with a fever, diarrhea, nausea & vomiting, or have a bad cough." When asked what happens if if they get sick after coming to work the DON stated, "They are supposed to tell us and we send them home."	F 443		
F 498 SS=E	483.75(f) PROFICIENCY OF NURSE AIDES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Training Nurse Assistants (TNA's) utilized proper technique when transferring with a Hoyer Mechanical Lift for 1 (Resident #11) of 3 (Resident #7, #9 and #11) case mix resident observed for mechanical lift transfers and failed to ensure Certified Nursing Assistants (CNA) did not operate feeding pumps for 1 (Resident #7) of 1 case mix resident with a tube feeding. These	F 498		

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F 498	Continued From page 35 failed practices had the potential to effect 6 residents dependent on staff for mechanical lift transfers according to the list provided by the Administrator on 1/11/08 and 2 residents who received tube feedings according to the Resident Census and Conditions of Residents form dated 1/7/08. The findings are: 1. Resident #11 had diagnoses of Cerebral Palsy, COPD (Chronic Obstructive Pulmonary Disease), Muscle Spasms, Paraplegia, Depression, and Schizophrenia. The Minimum Data Set (MDS) dated 12/2/07 documented the resident was moderately impaired in cognitive skills for daily decision making and required total assistance with activities of daily living. a. The Plan of Care updated 11/26/07 documented, "Needs Assist with ADLs to Meet Needs." The Plan of care did not address the resident's transfer needs. b. On 1/10/08 at 9:30 a.m., TNA #2 had positioned the Hoyer Lift Sling under the resident who was resting in bed with the bedside rails up. The sling was positioned with the top of the sling above the resident's head and the bottom of sling positioned midway at the resident's buttocks. TNA #2 stated, "I need help with this" and turned on the resident's call light. TNA #1 entered the room to assist TNA #2. TNA #1 moved the Hoyer Lift to the bedside and lowered the hooks so the straps of the sling could be attached to the lift hooks. TNA #2 asked TNA #1 what color of straps are used at top and bottom of sling and TNA #1 stated "Green at top and Blue at bottom." Both TNA's attached the sling straps to the lift hooks then wrapped the remaining colored straps around the hooks of the lift. TNA #1 turned on	F 498			

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F 498	<p>Continued From page 36</p> <p>the Hoyer Lift and raised the resident approximately 6 inches off the mattress causing the resident's head to bend forward towards her chest and the residents body to curl with one half of the resident's buttocks left hanging out of the bottom of the sling. TNA #1 stated, "This doesn't look right. I think we need some guidance. I don't do this much." TNA #2 stated, "This is only my 4th time to use the Hoyer Lift and the resident is new to me." TNA #1 stated, "I'm calling for guidance," and turned on the call light after lowering the resident back onto the bed mattress. Neither TNA removed the wrapped straps from the lift. CNA #2 entered the room and stated, "This is not done right."</p> <p>d. On 1/11/08 at 10:00 a.m., Registered Nurse (RN) #1 was asked if TNAs were allowed to work alone during patient care such as Hoyer Lift Transfers and the RN stated, "TNAs are allowed to work the floor after being checked off on a skill, but is to work with a CNA and cannot work alone."</p> <p>e. On 1/10/08 at 1:00 p.m., the "Arkansas LTCF (Long Term Care Facility) Nursing Assistant Trainee Task Performance Record" for TNA #1 and #2 was received from the DON. There was no documentation that either TNA had been checked off on the Hoyer Lift.</p> <p>2. The policy and procedure entitled "Hydraulic Lift (Hoyer Lift)" documented, "... Place widest seat part under resident's buttocks and thighs, so that lower edge of seat is under knees. Place narrow part of seat just above the small of the resident's back. Attach "S" hooks of the chain to the loops on the seat hanger. ..."</p>	F 498			

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F 498	<p>Continued From page 37</p> <p>3. Resident #7 had diagnoses of End Stage Dementia with Percutaneous Enterogastrostomy (Peg) Tube Feedings, Contractures, Pressure Sores, and Urinary Retention. The Quarterly MDS dated 10/18/07 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent for all Activities of Daily Living and incontinent of bowel and bladder.</p> <p>a. On 1/7/08 at 6:13 p.m., after completing resident care, CNA #1 restarted the resident's peg tube pump.</p> <p>b. On 1/10/08 at 9:00 a.m., the Assistant Director of Nursing (ADON) was asked for the list of employees that had been inserviced on turning the feeding tube equipment/pump on and off. The ADON stated the CNAs are allowed to turn the pumps on and off for providing care.</p> <p>c. On 1/10/08 at 10:15 a.m., the ADON provided a list with handwritten employee names. The heading on top of the paper documented "Employees instructed on GT policy when giving personal care to residents. Demonstrated and return demonstrated." The ADON was asked for the sign-in sheet that the employees had attended that inservice. The ADON stated, "Don't have that information, it was not documented." When asked where the names came from, the ADON stated, "This is actually a list of staff inserviced on incontinent care, but I also talked about residents with peg tubes." CNA #1 was not on the list. The ADON was asked for the dates those employees were inserviced with return demonstration for turning the pumps on and off. The ADON said she did not have any dates of the observed return demonstration training. The</p>	F 498			

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F 498	<p>Continued From page 38</p> <p>ADON was asked if all the employee names on that list had been inserviced on turning the pumps on and off. The ADON said, "Yes." The ADON was then asked if TNAs are allowed to turn the feeding tube pumps on and off. The ADON said, "Oh no." She was then asked why a TNA #1's name was on that list of names allowed to do so. She said, "I didn't know I put his name on there."</p> <p>f. On 1/10/08 at 3:30 p.m., the ADON was asked for their policy and procedure for allowing the TNAs/CNAs to turn the pumps on and off. The ADON stated, "We don't have a policy and procedure for TNA/CNA regarding turning on the feeding tube pump. Basically we follow the curriculum guidelines in the regulations."</p> <p>4. The policy and procedure entitled "Enteral Nutritional Therapy (tube feeding)" documented, "Basic Responsibility: Licensed Nurse ..."</p>	F 498			