

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 253 SS=B	<p>483.15(h)(2) HOUSEKEEPING/MAINTENANCE</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview the facility failed to ensure doors were free of gouges, walls were free of cracks and areas of missing paint, commode bases were free of build up, articles were not stored on the linen closet and hopper room floors, the hopper room was free of odor and without substances on the sink and commode, the dining table did not have uneven legs, there was no build up on floor around base boards, vent covers were free of dust, tiles were intact in the shower, the ceiling was not wet in the shower room and furniture was not torn. This failed practice had the potential to affect 67 residents in the facility, according to the Resident Census and Conditions of Residents form dated 6/14/06. The findings are:</p> <p>a. On 6/14/06 at 9:42 a.m., both sides of the 100-hallway had long cracks down the upper portion of the walls. The maintenance supervisor stated the cracks were caused by settling of the building.</p> <p>b. On 6/14/06 at 9:47 a.m., the ladies bathroom on 100-hall had a gray gummie substance around the base of both commodes that could easily be</p>	F 253			

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

TITLE

(X6) DATE

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

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 253	<p>Continued From page 1 scraped off using the end of an ink pen.</p> <p>c. On 6/14/06 at 9:50 a.m., the linen closet on the 100-hall had a net bag filled with supplies, 2 blankets and 3 bed spreads stored on the floor.</p> <p>d. 6/14/06 at 9:52 a.m., the wall just outside the ladies bathroom on 100-hall had an approximate 5-inch by 18-inch dark area where the paint was marred and discolored.</p> <p>e. On 6/14/06 at 9:55 a.m., the 100-hall hopper room had a bag of pads stored on the floor.</p> <p>The 100 hall hopper room had a strong foul odor in it and the sink had multiple areas of different colored substances adhering to the sides and bottom of it. The commode had a yellow ring and areas with a brown looking substance adhering to the inside.</p> <p>f. On 6/14/06 at 9:59 a.m., the two commodes in the men's bathroom on 100-hall had gummie substances on the floor around the base of the commodes, extending out 1 to 2 inches from the commode.</p> <p>g. On 6/14/06 at 10:03 a.m., in the east/west dining room, just outside the dirty window of the kitchen, there was a square dining table with uneven legs that would tip back and forth if touched.</p> <p>h. On 6/14/06 at 10:09 a.m., in the hall just outside the formal dining room, there was a build up of a dark substance around the base board.</p> <p>i. On 6/14/06 at 10:10 a.m., a vent behind the door in the formal dining room had a layer of dust</p>	F 253			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 253	Continued From page 2 on it.  j. On 6/14/06 at 10:20 a.m., the 200-hall shower room had a 4-inch by 4-inch area of small tile missing from the floor in first stall.  k. On 6/14/06 at 10:23 a.m., the women's rest room door on the 200-hall had a gouge out of the door.  l. On 6/14/06 at 10:25 a.m., the biohazard room on the 200-hall had a build up of dust and dirt, approximately 1/4-inch deep, in the corners of the room.  m. On 6/14/06 at 10:30 a.m., the 200-hall hopper room had a bag of incontinent pads stored on the floor.  n. On 6/14/06 at 10:43 a.m., the mens/womens restroom on 300-hall had an 8-inch by 10-inch area of wall behind the soap dispenser where the paint and wall covering had been torn away.  o. On 6/14/06 at 10:49 a.m., the ceiling of the 300-hall shower room, directly over the shower, had a dark mold-like appearance.  p. On 6/14/06 at 10:55 a.m., there was a love seat in the day room at end of north-hall that had 2 approximate 3-inch tears on the seat and lower front portion of the seat.  q. On 6/14/06 at 10:56 a.m., the door to Resident Room 500 had a large gouge out of it.	F 253			
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS	F 282			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 3</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician orders for thickened liquids were followed for 1 (Resident #7) of 2 (Residents #2 and #7) case mix residents and for type of restraint for 1 (Resident #6) of 6 (Residents #2, #6, #8 thru #10 and #13) case mix residents. This failed practice had the potential to affect 9 residents with Physician orders for thickened liquids and 17 residents with Physician orders for restraints, according to lists provided by the Administrator on 6/16/06 at 12:45 p.m. The findings are:</p> <p>1. Resident #7 had diagnoses of Urinary Tract Infection and Dementia. The Minimum Data Set (MDS) dated 4/2/06 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on the physical assistance of one staff person for eating, had chewing and swallowing problems and had nutritional approaches of a mechanically altered diet, a therapeutic diet and dietary supplements between meals.</p> <p>a. The Physician order sheet dated June 2006 documented a diet order dated 10/16/05 for "all liquids to nectar consistency - due to choking."</p> <p>A diet order dated 12/12/05 documented juice (Honey Consistency) @ 10:00 a.m., 2:00 p.m.</p>	F 282			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 4 and an hour before sleep.</p> <p>b. On 6/13/06 at 12:25 p.m., the resident received a lunch tray that contained a pureed diet with 1 can of Ensure supplement, 4-oz (ounce) Honey consistency Cranberry juice, 1/2 cup of ice cream in a Styrofoam carton with lid and nectar thickened milk in a carton.</p> <p>The resident ate 1/2 of the ice cream, drank 1/2 of the Ensure and none of the milk. Certified Nursing Assistant (CNA) #1 did not add thickening agent to the Ensure or ice cream prior to feeding the resident.</p> <p>c. On 6/15/06, the Assistant Director of Nursing (ADON) was asked what the facility's policy was, or their way of making sure residents got correct thickened liquid. The ADON stated that first a therapist recommends thickened liquids, second the Doctor writes an order for the thickener, then a "milkshake" is put on the door or over the resident's bed; this determines the thickness.</p> <p>The ADON was also asked about the thickening of supplements and stated, "It is thickened in the kitchen and will be on the tray. If it isn't, then the nursing staff can thicken it on the floor; we keep thickener out there."</p> <p>When asked if anyone with thickened liquids could have ice cream out of the little carton and she stated, "Yes, I think they can." After the surveyor explained that ice cream in its melted form was a thin liquid, the Administrator said it would be on the diet order if the resident could have unthickened ice cream. Resident #7 did not have a diet order for ice cream.</p>	F 282			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 5 2. Resident #6 had diagnosis of Muscle Spasm-Back, Impaired Circulation, Depression, Psychosis and Dementia with Behavior Changes. The Quarterly MDS dated 3/22/06 documented the resident was moderately impaired in cognitive skills for daily decision making and had a trunk restraint.  a. A Physician order dated 7/2/05 documented "d/c (discontinue) lap buddy. Reverse torso support when up in wheelchair due to severe confusion, unsteady gait, unable to stand alone."  b. On 6/13/06 at 12:08 p.m., the resident was brought to the Dining room in a wheelchair with a lap buddy restraint in place.  c. On 6/13/06 at 5:45 p.m., the resident was sitting in her room in a wheelchair and had a lap buddy restraint in place.	F 282			
F 318 SS=D	483.25(e)(2) RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interview the facility failed to ensure assessment for therapy services and positioning devices was provided to prevent the potential for a decline in range of motion (ROM) for 1 (Resident #6) of 4	F 318			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 318	<p>Continued From page 6</p> <p>(Residents #6, #9, #10 and #12) case mix residents. This failed practice had the potential to affect 11 residents with contractures, according to a list provided by the Administrator on 6/16/06 at 12:45 p.m. The findings are:</p> <p>Resident #6 had diagnosis of Back Muscle Spasm, Impaired Circulation, Depression, Psychosis and Dementia with Behavior Changes. The Quarterly Minimum Data Set dated 3/22/06 documented the resident was moderately impaired in cognitive skills for daily decision making, had limitation in range of motion with partial loss of voluntary movement of one arm, one hand and bilateral feet and legs.</p> <p>a. On 6/12/06 at 3:02 p.m., the resident was sitting in a recliner chair with her head and neck tilted to the left side; there was no support or positioning device in place.</p> <p>b. On 6/13/06 at 10:20 a.m., the resident was sitting in the recliner chair with her head and neck tilted to the left side.</p> <p>c. On 6/13/06 at 10:30 a.m. and 11:45 a.m., the resident was in the recliner chair with a bed pillow positioned against the left side of her body; the pillow was positioned low and did not support the resident's head and neck.</p> <p>d. On 6/13/06 at 12:08 p.m., the resident was taken to the Dining Room in a wheelchair. The resident's head was tilted to the left side; there was no support or positioning device in place.</p> <p>e. On 6/13/06 at 3:20 p.m., the resident was in her room sitting in the recliner chair with her head slumped to the left side; there was no support or</p>	F 318			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 318	Continued From page 7 positioning device in place.  f. On 6/14/06 at 8:20 a.m., the resident was sitting in a wheelchair in her room; the resident's head and neck were tilted to the left side with no support or positioning device in place.  g. On 6/14/06 at 10:40 a.m., when asked if she was able to move her head, the resident's speech was unclear and she was unable to lift her head.  h. On 6/14/06, review of the clinical record did not reveal an evaluation by therapy or Physician orders for treatment and/or a positioning device for the resident.  i. On 6/14/06 at 11:45 a.m., the Director of Nursing was asked about ROM, therapy or a positioning device for the resident; she stated it had been that way since she came here [to the facility]. It hurts her if someone tries to straighten it. She also stated that the resident has never received ROM, therapy or had a positioning device that she knew of.	F 318			
F 323 SS=E	483.25(h)(1) ACCIDENTS  The facility must ensure that the resident environment remains as free of accident hazards as is possible.  This REQUIREMENT is not met as evidenced by:  Based on observation the facility failed to ensure doors were without splintered, sharp edges. This failed practice had the potential to affect 25 residents living on the 100 and 200 halls, according to the Roster/Sample Matrix provided	F 323			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 8 by the Administrator on 6/12/06 at 4:40 p.m. The findings are:  a. On 6/14/06 at 9:35 a.m., the door to Resident Room #111 had two gouges out of the wood that resulted in sharp edges.  b. On 6/14/06 at 9:43 a.m., the door to Resident Room #108 had an approximate 1-inch gouge in it that had sharp edges.  c. On 6/14/06 at 10:04 a.m., the door to the formal dining room, between the east and west halls, had a 1-inch gouged area in it that had sharp edges.  d. On 6/14/06 at 10:13 a.m., the fire door between the 100 and 200 halls had a large broken area 6 to 8 inches up from the floor; it had sharp splintering edges.  e. On 6/14/06 at 10:14 a.m., the door of Resident Room #206 had a broken area with sharp edges.  f. On 6/14/06 at 10:40 a.m., the door to Resident Room #208 had a large broken area at the bottom of door that had sharp edges.	F 323			
F 324 SS=E	483.25(h)(2) ACCIDENTS  The facility must ensure that 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 that planned	F 324			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 324	<p>Continued From page 9</p> <p>use of safety alarms were implemented for 3 (Residents #4, #6 and # 8) of 5 (Residents #4, #6, #8, #10 and #13) case mix residents who had a history and/or were at risk for falls. This failed practice had the potential to affect 30 residents who were at moderate to high risk for falls, as identified by a list received from the Administrator on 6/16//06 at 12:45 p.m. The findings are:</p> <p>1. Resident #4 had diagnoses of Cerebral Infarct, Syncope and Collapse, Leukocytosis, Hypoalbuminemia, Hypertension, Dementia and Delirium with Psychosis. The Quarterly Minimum Data Set dated 3/17/06 documented the resident had moderately impaired cognitive skills for daily decision making and required limited physical assistance of two staff persons for transfer.</p> <p>a. A Physician Order dated 2/24/06 documented, "May use safety alarm /c [with] bed and chair to alert staff of attempts to self transfer."</p> <p>The order had been hand-transcribed to the printed March 2006 orders, however, the order was not included in the printed or hand-entered orders for the months of April 2006, May 2006 or June 2006.</p> <p>(1) The "Specific Incident Documentation" dated 2/18/06 documented, "Resident attempted to use her bedside commode (toilet) by herself without using the call light. /R [resident] sat down and missed commode. /R was found on floor. 0 [no] bruising, 0 [no] pain. 0 [no]redness, swelling. /R [resident] states she feels fine."</p> <p>The "Interventions to Prevent Further Occurrences" documented, "Resident to be assisted to bathroom by staff prn [as needed]."</p>	F 324			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 324	<p>Continued From page 10</p> <p>Resident to have bed/chair alarm. Have tried and will retry bed/chair alarm. Staff to monitor for removal."</p> <p>(2) The "Fall Assessment - Physical Restraint Elimination" form documented, "Fall - 2/18/06. The "Action Plan" segment of the form documented, "Order to place bed/chair alarm back on pt. [patient]. Staff to assist to B/R [bathroom] prn [as needed]."</p> <p>b. The "Specific Incident Documentation" dated 3/11/06 documented, "CNA heard alarm going off and went to Res [resident] room. Res [resident] had put bed rail down and had gotten up to go to bedside commode and fell to floor. 0 apparent injuries noted." The "Interventions to Prevent Further Occurrences" documented, "Resident diagnosed with R [right] side CVA (Cerebral Vascular Accident." Bed sensor pad placed on bed."</p> <p>The "Fall Assessment - Physical Restraint Elimination" form on 3/13/06 documented, "Action Plan" segment of the form documented, "Bed sensor pad placed on bed. Encouraged to not get up alone."</p> <p>c. On 6/13/06 at 10:07 a.m., the resident was in the recliner with the body alarm box attached to the back of the recliner, however, the pull-cord was not attached to the resident.</p> <p>d. On 6/13/06 at 11:40 a.m., 12:30 p.m. and 1:10 p.m., the resident was in a wheelchair in the dining room without a body alarm.</p> <p>The resident's room was observed at 11:40 a.m., 12:30 p.m. and 1:10 p.m., and the body alarm</p>	F 324			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 324	<p>Continued From page 11 was in the resident's recliner.</p> <p>e. On 6/13/06 at 1:35 p.m. and 3:30 p.m. and on 6/14/06 at 9:00 a.m. and 9:30 a.m., the resident was sitting in her recliner with the pull-cord attached to the left posterior shoulder, however, the box of the alarm was lying in the seat of the recliner beside the resident and was unsecured/unattached.</p> <p>f. On 6/14/06 at 11:30 a.m. and 2:00 p.m., the resident was sitting in her recliner with the pull-cord unattached to the resident and the box of the alarm was lying in the seat of the recliner, beside the resident, and was unsecured/unattached.</p> <p>g. The "Care Plan" for the "Problem Onset" documented, "Potential to fall evidenced by history of falls noted." A hand entry dated 2/24/06 documented, "Bed/chair alarm at all times. Assist her to B/R [bathroom] prn." A second hand entry dated 3/11/06 documented, "Bed sensor pad placed on bed. Encourage to not get up alone."</p> <p>h. On 6/14/06 at 5:00 p.m., the Assistant Administrator was asked to review the resident's clinical record for orders pertinent to use of the alarms. The Assistant Administrator reviewed the clinical record and stated, "I cannot find an order to DC [discontinue] the order written on 2/24/06 or the order on 3/14/06. It just wasn't carried forward." The Assistant Administrator stated that she would get an order clarification from the physician.</p> <p>i. On 6/14/06, the Physician's Orders documented, "Clarification order R/T [related to] devices. 1.) Safety alarm with bed/recliner and</p>	F 324			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 324	<p>Continued From page 12</p> <p>chair. 2.) Sensor pad with bed/chair/recliner."</p> <p>j. On 6/15/06 at 8:38 a.m., the resident was sitting in her recliner. LPN #1 checked the resident and stated the sensor pad was not under the resident - it was on the bed. The sensor pad box was on the overbed table and was unattached to the sensor pad. The LPN removed the sensor pad from the bed and stated, "I need to check her orders to see if the pad is to be in her chair."</p> <p>2. Resident #6 had diagnosis of Back Muscle Spasm, Impaired Circulation, Depression, Psychosis and Dementia with Behavior Changes. The Quarterly Minimum Data Set dated 3/22/06 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent on the physical assistance of two staff persons for transfer.</p> <p>a. A Physician order dated 6/16/05 documented a safety alarm with bed and chair at all times to alert staff of self transfers.</p> <p>b. On 6/14/06 at 10:40 a.m., the resident was sitting in the recliner chair with no alarm in place.</p> <p>c. On 6/14/06 at 12:03 p.m. and 5:15 p.m., the resident was in the Dining Room in a wheelchair; no chair alarm was in place.</p> <p>3. Resident #8 had diagnosis of Dementia, Bone and Cartilage Disease and Osteoarthritis. The Quarterly MDS dated 4/4/06 documented the resident had modified independence in cognitive skills for daily decision making, was independent for locomotion via wheelchair and required supervision with transfers.</p>	F 324			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 324	Continued From page 13 a. A Physician order dated 7/16/04 documented a bed/chair alarm at all times to alert staff of self transfers.  b. On 6/13/06 at 11:52 a.m., the resident was in the dining room in a wheelchair with no chair alarm in place.  c. On 6/13/06 at 3:15 p.m., the resident was in the Day Room in a wheelchair with no chair alarm in place.  d. On 6/14/06 at 10:55 a.m. and 3:10 p.m., the resident was in his room sitting in the wheel chair. The chair alarm box was attached to the back of the wheelchair; the pull-cord was not attached to the resident.  e. On 6/14/06 at 6:00 p.m., the resident was in the Dining Room in a wheelchair. The chair alarm box was attached to the back of the wheelchair; the pull-cord was not attached to the resident.	F 324			
F 328 SS=D	483.25(k) SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced	F 328			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 328	<p>Continued From page 14</p> <p>by:</p> <p>Based on observation, record review and interview the facility failed to ensure contaminated oxygen tubing and nasal cannula were not used in administration of oxygen for 1 (Resident #4) of 6 (Residents #1, #2, #4, #7, #12 and #13) case mix residents who received oxygen therapy. This failed practice had the potential to affect 31 residents who received oxygen therapy, as identified by a list received from the Administrator on 6/16//06 at 12:45 p.m. The findings are:</p> <p>Resident #4 had diagnoses of Cerebral Infarct, Syncope and Collapse, Leukocytosis, Hypoalbuminemia, Hypertension, Dementia and Delirium with Psychosis. The Quarterly Minimum Data Set dated 3/17/06 documented the resident had moderately impaired cognitive skills for daily decision making, required limited to total assistance with the performance of activities of daily living and received oxygen therapy.</p> <p>a. A Physician Order dated 3/14/06 documented, "Oxygen @ [at] 2L/M [2 liters per minute] via N/C [nasal cannula], PRN, [as needed], pulse ox [oximetry] below 92."</p> <p>A second Physician order dated 3/14/06 documented, "Change O2 [oxygen] tubing and humidifier Q [every] 3 days and PRN - when in use."</p> <p>b. On 6/15/06 at 8:32 a.m., the oxygen administration nasal cannula tubing dated as changed on 6/15/06 was lying on the floor in front of the resident's recliner with the nasal prongs touching the floor. The resident asked for her</p>	F 328			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 328	Continued From page 15 oxygen and turned on the call light. At 8:36 a.m. LPN #1 was observed adjusting the oxygen administration nasal cannula in the resident's nostrils; the oxygen tubing was still dated 6/15/06. The resident was receiving humidified oxygen at 2 liters per minute.  c. On 6/16/06 at 12:10 p.m., the Assistant Administrator was interviewed and asked what she expected the nursing staff to do if the resident's nasal cannula was on the floor; the Assistant Administrator stated, "I would expect them to discard it and get a new one."	F 328			
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY  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.  This REQUIREMENT is not met as evidenced by:  Based on observation and interview the facility failed to ensure foods were prepared by methods that conserved nutritive value, flavor and consistency. This failed practice had the potential to affect 16 residents in the facility who received pureed diets from the kitchen, according to the Diet List dated 6/14/06. The findings are:  1. On 6/13/06 at 10:20 a.m., during meal service preparation, Dietary Staff (DS) #1 was observed preparing pureed cabbage; he had the cooked head of cabbage in a pan and then put it into the	F 363			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 363	<p>Continued From page 16</p> <p>food processor. He processed it until it was smooth, took the lid off, looked at it and added some liquid from the pan to the processor, returned the lid and processed it some more.</p> <p>The DS stopped the processor, walked to another table and got a can of Thickener, took the lid off, sprinkled thickener over the cabbage, processed it again, stopped it and removed the lid, looked into the container, then poured the contents into a pan. He then covered the pan and put it into the oven. The cabbage was served with a #10 ladle. There was no recipe for cooked cabbage.</p> <p>2. After frying chicken breast, DS #1 put 6 pieces chicken in the food processor, processed until the meat was very chopped up, removed the lid and put in six slices of light bread and processed the mixture again.</p> <p>There was approximately 2-inches of food in the processor and he added enough water to cover the meat by 2-inches. The food was then processed until it was very thinly pureed at which time he added thickener. The pureed chicken was poured up and was very thin. No measurements were made during this time.</p> <p>3. During the pureeing of the cabbage, the DS was asked how many residents he pureed food for; he stated 16 or 17. When asked what serving utensil would he use to serve the cabbage, he stated, "Number 10 ladle." Staff was asked how much does a #10 ladle hold, he nor the Dietary Manager knew. The Dietary Manager said she could find out and measured out 3 oz.</p> <p>Each chicken piece was 3 oz. The chicken was served with a #10 ladle. The recipe states if bread</p>	F 363			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 363	Continued From page 17 is added to pureed meat to change the serving size to #8 scoop for 3 oz protein or #10 for 2 oz protein. The recipe documented 1-pound plus 14-ounces for 10 servings. They were preparing for 16 to 17 servings. The Menu did not designate ounces per serving.  4. On 6/14/06, while observing supper meal preparation, DS #2 was asked how much will residents get of pureed the tuna salad. He and the Dietary Manager both said, "One #10 scoop."  The recipe documented two #10 scoops per serving.	F 363			
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE  The facility must store, prepare, distribute, and serve food under sanitary conditions.  This REQUIREMENT is not met as evidenced by:  Based on observation the facility failed to ensure dietary staff washed their hands when going from the dirty end of the dish machine to the clean end and that the fan in the kitchen had clean blades and guards to prevent the potential for contamination of the food. This failed practice had the potential to affect 70 resident who ate meals from the kitchen according to the Resident Census and Conditions of Residents form dated 6/14/06. The findings are:  1. On 6/13/06 at 11:30 a.m., the dishwashing person washed her hands in the dish room where	F 371			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 18 there was a soap dispenser and a paper towel dispenser. The staff had to use the spray nozzle with a squeeze handle, that was used to rinse dirty dishes, to access the water.  The staff would turn around from the dirty dish end to the soap dispenser, get soap, rub their hands together and then grab the squeeze-handle on the spray nozzle to rinse their hands, thus recontaminating their hands. The staff then would get a paper towel, dry their hands and go to the clean dish end to get the clean dishes out of the washer and put up clean, dried dishes.  2. On 6/14/06 at 4:00 p.m., the Dietary Manager was asked to look at the fan in the kitchen. When it was turned off, one half of each fan blade had a black substance on it and there was brown fluffy strings on the front and back guard of the fan box. When asked if she had a cleaning schedule for the fan, she stated no.	F 371			
F 442 SS=D	483.65(b)(1) PREVENTING SPREAD OF INFECTION  When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interview the facility failed to ensure infection control procedures were implemented to prevent the potential for the spread of infection for 1 of 1 (Resident #11) case mix resident with Physician	F 442			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 442	<p>Continued From page 19</p> <p>orders for isolation. This failed practice had the potential to affect 71 residents in the facility, according to the Resident Census and Conditions of Residents form dated 6/14/06. The findings are:</p> <p>1. Resident #11 had diagnoses of Quadriplegia C5-C7, L4 Fracture with Spinal Cord Injury, Bladder Spasm, Muscle Spasm-Back and Methicillin Resistant Staphylococcus Aureus of the Urinary Tract.</p> <p>a. A Physician order dated 6/9/06 documented, "Please place in isolation - MRSA."</p> <p>b. On 6/12/06 at 3:45 p.m., during initial rounds of the resident's room, two isolation containers were noted to the right side of the resident's room. One had a yellow plastic bag and one had a red bag with an infectious waste symbol. Linens had been placed on the lid of the container that contained the yellow bag.</p> <p>c. On 6/15/06 at 3:05 p.m., a florist basket with flowers and a balloon had been placed on top of the lid of the container that contained the red infectious waste bag.</p> <p>A soiled white wash cloth was on top of the lid of the container that contained the yellow bag.</p> <p>At 3:40 p.m., CNA #2 was asked to demonstrate how isolation bags are disposed of. CNA #3 entered the Northwest Hall rolling two carts labeled linen. Cart #1 was labeled Northwest Personals. Cart #2 was labeled Northwest Linen.</p> <p>CNA #2 was asked how she had taken the resident's dirty linen to laundry; she stated, "Both</p>	F 442			

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 442	<p>Continued From page 20</p> <p>bags tied and placed in one of these barrels, I don't know which one." She was then asked if clear bag in barrels had been replaced. She stated, "Yes." There was no Isolation sign posted on the resident's door.</p> <p>3) At 3:45 p.m., CNA #2 came into the room to dispose of the red isolation bag. She put on gloves, then placed both hands on the underside of the lid and raised the lid. She removed the bag and used her hands to hold the end of the bag closed.</p> <p>She then carried the bag to the open door of resident's room. CNA #3 stood just outside of the door and held open a clean red isolation bag. The clean bag was held just inside the door and on the floor of the resident's room. CNA #2 placed the red isolation bag, that contained infectious waste, inside the empty clean bag held by CNA #3.</p> <p>CNA #3 then took both bags and tied the inner bag closed, pushed down the contents with her gloved hands and tied the outer bag which was now contaminated.</p> <p>CNA #3 instructed CNA #32 to change her gloves. CNA #2 placed the dirty gloves in the resident's trash can that did not contain a red isolation bag.</p> <p>CNA #2 then took the bags from CNA #3 and held the contaminated bags in her left hand. She opened the double door at the end of Northwest Hall with her right hand and carried the bags through the Day Room and down the West Hallway toward the Bio-hazard Waste Room that was midway up West Hall.</p>	F 442		

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/16/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONE COUNTY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 OAK GROVE STREET</b> <b>MOUNTAIN VIEW, AR 72560</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 442	Continued From page 21  CNA #2 switched hands 3 times as she walked up the hall due to the heaviness of the bags. When she arrived at the Bio-hazard Waste Room, she switched the bag to her left hand and reached with her right hand to take the metal key attached to a plastic cord over the the door and unlocked the door. She then let go of the key and grabbed the contaminated bag with both hands and hefted the bag into the large Bio-hazard container with her left knee. She then removed her gloves and went into the Employee's Wash Room at the East/West Nurse's Station to wash hands and dispose of gloves.  g. On 6/16/06 at 10:10 a.m., there was no isolation sign on the resident's door or door frame.  h. On 6/16/06 at 12:45 p.m., the Administrator stated the resident was still on isolation.	F 442			