STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ____ B. WING ____	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	**706 OAK GROVE STREET** **MOUNTAIN VIEW, AR 72560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 Complaint #10030, unsubstantiated.	F 000		
F 226 SS=C	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to implement their Abuse Prevention policies and procedures by not completing reference checks for 4 newly hired employees and for obtaining results of a Criminal Record Check (CRC) for 1 newly hired employee. This failed practice had the potential to affect all 76 residents. The findings are: 1. The Abuse Prevention Policy and Procedures provided by the Administrator on 8/18/05 documented, "All potential employees will be screened for History of abuse, Neglect or mistreating residents. This includes attempting to obtain information from previous employers and/or current employers. All potential employees will be checked with the appropriate licensing board and registries which include criminal background checks per state requirement..." 2. On 8/18/05 at 1:00 p.m., there were 2 incomplete reference check forms in the	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	**706 OAK GROVE STREET** **MOUNTAIN VIEW, AR 72560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 226	Continued From page 1 personnel file of Housekeeper #1 who had a hire date of 7/18/05. 3. On 8/18/05 at 1:10 p.m., there were 2 incomplete reference check forms in the personnel file of CNA (Certified Nursing Assistant) #4 who had a hire date of 6/23/05. 4. On 8/18/05 at 1:20 p.m., there were 2 incomplete reference check forms in the personnel file of LPN #4 who had a hire date of 4/25/05. 5. On 8/18/05 at 1:30 p.m., there was 1 incomplete reference check and 1 reference check form that documented, "No record of employment" from a facility that Dietary #4 had listed on the employment application as a prior employer. Dietary #4 had a hire date of 7/14/05. 6. On 8/18/05 at 1:40 p.m., there was documentation a CRC had been completed for CNA #1 who had a hire date of 5/31/05, but there was no documentation of the results of the CRC. On 8/19/05 at 10:45 a.m., the Business Office Manager (BOM) provided the CRC request and the money order that was submitted on 5/31/05 for CNA #1. The BOM stated that she could not find the results of the CRC and that she did not have a system in place to track when the facility received the results of the CRC's that had been submitted.	F 226		
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 241	Continued From page 2	F 241		

full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on observation the facility failed to ensure dignity was maintained by not serving residents at the same table at the same time and not serving residents in a timely manner for 9 of 9 case mix residents (Residents #24 -32) who received their meals in the dining room. This failed practice had the potential to affect 39 residents who ate their meals in the main and feeder dining room according to the Dietary Manager on 8/19/05.
The findings are:

1. On 8/17/05 at 5:10 p.m., in the feeder dining room, Resident #24 received her tray and was assisted with eating by the staff. Resident #25 was seated at the same table and did not receive her tray until 5:30 p.m. The third table mate, Resident #26, did not receive her tray until the other 2 had finished eating at 5:45 p.m.

2. On 8/17/05 at 4:45 p.m., Resident #27 and #28 were already in the dining room. At 5:45 p.m., the resident's supper trays were setting in the serving window. From the time the residents were brought to the dining room and until the resident's were served their meals , the residents removed their clothes protectors, rolled away from the table and slept at times. At 5:50 p.m. Certified Nursing Assistant (CNA) #9 served their trays and the residents fed themselves. The CNA stated that the residents could feed themselves most of the time.

3. On 8/18/05 at 7:32 a.m., in the main dining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	**706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 241	Continued From page 3 room Resident #25 was seated at a table with 2 table companions. Resident #29 sat and watched Resident #25 eat her meal. She yelled to the person at the tray line at 7:45 a.m.," Hey, I'm hungry too". At this time her tray was served. At 8:00 a.m., Resident # 30's tray was served. 4. On 8/18/05 at 11:45 a.m., Resident #31 and #32 were brought to dining room. They were put at tables and fed at 12:45 p.m. In the hour between being brought to the dining room and being fed, they watched their tablemates being fed, wandered around the dining room and moved the feeder tables back and forth. At 12:20 p.m., Resident #32 left the dining room and had to be brought back. At 12:35 p.m., Resident #31 tried to leave the dining room and had to be brought back.	F 241		
F 309 SS=H	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to monitor urine for color, odor, cloudiness, to monitor intake and output every shift to ensure sufficient fluid for hydration needs were provided to prevent Urinary Tract Infections (UTI's) for 1 (Resident #4) of 2	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	**706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309	Continued From page 4	F 309		

(Residents #4 and #12) with indwelling Foley catheters. The facility failed to ensure that catheter care was provided after an incontinent episode of bowel for 2 of 2 case-mix residents (Residents #4 and #12) who had indwelling Foley catheters. The failed practices resulted in a pattern of actual harm for Resident #4 who experienced multiple urinary tract infections and had the potential to cause more than minimal harm to Resident #12. There were only the 2 residents with indwelling Foley catheters as documented by the Director of Nursing on 8/19/05. The findings are:

1. The Handbook of Geriatric Nursing Care, Second Edition , published by Lippincott, Williams & Wilkins, page 409 documents under the section of Preventing Dehydration: " Monitor Intake and Output. Ensure an intake of at least 1500 ml of oral fluids and output of 1,000 ml per 24 hours. Less than 1,000 ml per day may lead to more concentrated urine which predisposes the patient to urinary tract infections.

2. Resident #4 had diagnoses of Polynephritis and Urosepsis. The facility "SNF (Skilled Nursing Facility) Admission History and Physical [H&P]" documented the resident was re-admitted to the facility on 4/4/05 with diagnoses of Polynephritis, Sepsis, VRE [Vancomycin Resistant Enterococcus, Dehydration and UTI [Urinary Tract Infection]. The H&P further documented the plan of treatment to "monitor fluid intake D/T dehydration and report any decline."

The resident was re-admitted to the hospital on 4/9/05. The hospital History and Physical documented the "Laboratory and X-Ray" admission "UA shows 10-20 white cells, 10-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309	Continued From page 5	F 309		

red cells, and 2+ leukocytes. The patient does have a moderate yeast. The patient does have a Foley catheter in place." Nurses notes dated 4/11/05 at 4:30 p.m. documented the resident was re-admitted to the facility.

The Significant Change Minimum Data Set (MDS) dated 4/15/05 documented the resident had short/long-term memory problems, was severely impaired in cognitive skills for daily decision making, dependent for Activities of Daily Living (ADL), had an indwelling urinary catheter, vomiting, and two stage 2 pressure sores.

a. The Resident Assessment Protocol (RAPs) worksheet dated 4/15/05 for the problem area of dehydration/fluid maintenance status documented the resident had dehydration risk factors of diarrhea, vomiting, presence of infection, and frequent laxatives/enema/diuretic use. The worksheet documented, "resident's mental status and physical status has declined. Has had problems with vomiting and diarrhea. Important to provide fluids and monitor I&O closely."

b. As of 8/17/05, the Plan of Care which was updated 4/15/05 identified a problem of "Potential for fluid volume deficit evidenced by use of Lasix 40 mg. [milligrams] on T/TH/SA/SU [Tuesday/Thursday/Saturday] and 80 mg. on M/W/F [Monday/Wednesday/Friday] and 40 mg. q [every] pm and diagnosis of CHF [Congestive Heart Failure]" with interventions "assess for dehydration (dry mucous membranes, poor skin turgor, concentrated urine) and ascertain basis for dehydration (fever, meds, decision making ability, refusal to eat, etc.)." There was no documentation on the Plan of Care, Dietary Notes, or Nurse's Notes to indicate the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309	Continued From page 6	F 309		

assessed the resident's fluid needs and planned specific interventions to prevent the re-occurrence of dehydration and urinary tract infections.

c. A Physician's Progress Note dated 5/15/05 documented the resident had a UTI with a "Plan" to "Encourage oral intake" and Cipro 250 mg. x 7 days." A Urine Analysis drawn on 5/15/05 documented the color as amber, appearance cloudy, specific gravity of >1.030 [indicating dehydration], trace blood, positive for nitrates, WBCs of TNTC (too numerous to count), 2-5 RBCs, and many bacteria. The Urine Culture completed on 5/18/05 documented the resident had >100,000 colonies/ml of Klebsiella pneumoniae.

d. A hospital "History and Physical" dated 5/30/05 documented the Chief Complaint as lethargy and fever. The "Laboratory and X-Ray" section documented "urinalysis is nitrate positive with 20-50 white blood cell and 20-50 red cells. Specific gravity is >1.030 reflecting dehydration. Bacteria revealed few and many yeast are noted. White blood count ***18,100 with 82% granulocytes reflecting a profound leukocytosis with a left shift. Hemoglobin 15.3, hematocrit 47.1 in this fluid contracted lady." The Initial Assessment diagnoses included Urosepsis, Pyelonephritis, Dehydration, and Leukocytosis with left shift.

e. The facility "SNF Admission History and Physical" dated 6/7/05 documented the resident was re-admitted from the hospital with diagnoses of Urosepsis, Staph Aureus, Enterococcus Faecalis, and Polynephritis with a documented plan of treatment to "monitor urine for color, odor,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ____ B. WING ____	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309	Continued From page 7	F 309		

cloudiness and to monitor intake and output q shift".

f. A 5-Day Medicare MDS dated 6/11/05 documented the resident had antibiotic resistant infection (e.g. Methicillin resistant staph), Pneumonia, and Urinary tract infection in last 30 days. There was no documentation on the April 2005, May 2005, or the June 2005 MARs, Meal consumption records or nurses notes that the intake for this resident was monitored as per the plan of treatment.

g. The July Medication Administration record [MAR] documented the resident received Lasix 40 mg every Tue/Thur/Sat/Sun, 80 mg every Mon/Wed/Fri and 40 mg daily at 4:00 p.m.. The MAR also documented the resident's urinary output as follows:

1. July 1 - 550 cc [22.9 cc/hr]
2. July 2 - 500 cc [20.8 cc/hr]
3. July 3 - 600 cc [25 cc/hr]
4. July 4 - 350 cc [14.58 cc/hr]
5. July 5 - 625 cc [26 cc/hr]
6. July 6 - 625 cc [26 cc/hr]
7. July 7 - 450 cc [22.5 cc/hr]
8. July 8 - 500 [20.8 cc/hr]

h. Nurses notes dated 7/9/05 at 9:05 p.m. documented, "R c/o [resident complained of] lower abdominal pain. Resident also c/o frequent urges to urinate even though she has a Foley cath. F/C [Foley catheter] draining amber colored urine with sediment." The notes documented the physician was notified and orders received to obtain catheter UA. At 10:15 p.m. the nurse notes documented, "Attempt to obtain UA from port of cath. Obtained 12 cc. clamped cath.: At

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309	Continued From page 8	F 309		

10:45 p.m. "Obtained 12 cc urine at this time." At 11:15 p.m. "Obtained 10 cc urine at this time. Will attempt again later." At 2435 obtained enough urine for specimen , r (resident) cath unclamped at this time, urine amber with sediment noted."

i. A Urine sample collected 7/10/05 documented the urine was cloudy with a pH of 8.0, positive for nitrates, 2+ leukocytes, 20-50 WBCs, and many bacteria. The urine culture documented > [greater than] 100,000 colonies/ml Pseudomonas Aeruginosa. A Physician's Order dated 7/10/05 documented for the resident to receive Cipro 250 mg. bid [twice daily] times 10 days for a UTI.

j. The July 2005 MAR documented the resident's urinary output:

7/11/05- 700 cc/hr [29 cc/hr]
7/12/05- 400 cc/hr [16.6 cc/hr]
7/13/05- 500 cc/hr [21 cc/hr]
7/14/05 - 750 cc/hr [31.25 cc/hr]
7/17/05 - 300 cc/hr [12.5 cc/hr]
7/18/05 - 350 cc/hr 14.58 cc/hr]
7/19/05 - 700 cc/hr[29 cc/hr]

k. There was no documentation in the July 2005 and August 2005 nurses notes, plan of care, dietary notes or meal consumption sheet that the resident received extra fluids or that fluid were calculated to ensure the resident received sufficient fluids to prevent dehydration and urinary tract infections.

l. A document faxed to the primary physician dated 8/11/05 documented, " Resident's daughter [name] told me that resident is been complaining to her of lower abdominal pain & frequent urges

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	**706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309	Continued From page 9	F 309		

to urinate, even though the resident has a Foley cath. Daughter made a request to have UA done to check if her mother has a UTI. May we have an order for UA?" An order was obtained for a CBC [complete blood count] & urine culture. A Urine sample collected 8/13/05 documented the urine was cloudy, positive for nitrates, 2+ leukocytes, TNTC [Too numerous to count] WBCs [White Blood Cells], RBCs [Red Blood Cells] of 2-5, bacteria many, and yeast many. The urine culture documented the urine contained greater than [>] 100,000 colonies/ml Enterobacter Cloacae Pseudomonas Aeruginosa.

m. On 8/15/05 at 11:45 a.m. the resident was in bed, a Foley catheter intact, with a large amount of sediment in the entire length of the catheter tubing. At 2:10 p.m., the resident was in bed, the catheter was under the right buttocks and the right upper thigh, and there was no leg strap or mechanism used to secure the catheter. The urine in the catheter bag appeared to be a dark straw colored and was extremely cloudy.

n. A Physician's Order dated 8/15/05 at 6:00 p.m. documented, "Start IV of Lactated Ringers at 50 cc per hour". Additionally there was an order for "Tobramycin IVPB 100 mg. q 12 hours x 5 days."

o. On 8/16/05 at 9:15 a.m. the IV was initiated. At 10:30 a.m. the water pitcher at the bedside was empty and the water level in the sippy cup was marked by the surveyor. At 12:00 noon the water pitcher remained empty and the level of water in the sippy cup remained in the same position. It was also noted that the urine in the catheter tubing contained sedimentation to the degree that the color of the urine could not be determined. There was a leg strap on the resident's thigh but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ____ B. WING ____	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	**706 OAK GROVE STREET** **MOUNTAIN VIEW, AR 72560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309	Continued From page 10 the catheter tubing was not secured with the leg strap or any other mechanism to secure the catheter tubing. At 12:45 p.m. the resident consumed one carton of milk from her lunch tray. The water pitcher remained empty and the level of water in the sippy cup remained in the same position. At 3:00 p.m. the water pitcher remained empty and the level of water in the sippy cup remained in the same position and the resident's catheter remained without the tubing secured to prevent trauma by the leg strap or any other mechanism. At 4:55 p.m. the resident was sitting up in bed with the catheter tubing under the right leg. LPN #1 lifted the resident's leg and pulled the catheter tubing tautly around the resident's foot to secure the tubing to the leg strap. The resident yelled, "Oh, that hurt." The LPN attached the catheter tubing to the leg strap, washed her hands, left the room, and did not offer the resident any fluids. p. On 8/17/05 at 8:30 a.m. the resident was in bed, the water pitcher was marked by the surveyor, and the sippy cup was empty. At 10:10 a.m. CNA #2 brought 10 a.m. snacks and placed the snacks in the refrigerator on the nursing unit. At 10:20 a.m. the LPN asked CNA #1 if the resident took her snack. CNA #2 stated, "No, the resident is still asleep." At 10:27 a.m. the consumption record for the a.m. meal was reviewed. The record documented the resident had zero consumption for her breakfast meal. At 10:30 a.m. the water pitcher remained in the same marked position and the sippy remained empty. At 10:45 a.m. CNA #2 and #3 entered the room to turn the resident. The resident had a moderate formed bowel movement (BM). The staff cleansed the BM from the resident but did not do catheter care. At 11:15 a.m. CNA #2 filled	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ____ B. WING ____	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	**706 OAK GROVE STREET** **MOUNTAIN VIEW, AR 72560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309	Continued From page 11 the sippy cup with cold water, offered the resident fluids from the sippy cup, and the resident consumed approximately 1/3 of the sippy cup of water. 3. Resident #12 had diagnoses of Persistent Vegetative State, Brain Injury, and Gastrostomy. The Annual MDS dated 7/27/05 documented the resident was totally dependent for personal hygiene and toilet use, bedfast, had an indwelling catheter and a feeding tube. a. A Care Plan dated 7/27/05 documented a problem, "the resident has an indwelling catheter due to diagnosis of bladder disorder," with an intervention, "Periurethral care as ordered." b. A physician order dated 8/1/03 documented, "Foley catheter care with soap and water qd (daily) and prn (as needed)." c. On 8/18/05 at 10:37 a.m., the resident was incontinent of a large, loose bowel movement. CNA #6 and 7 cleansed the groin area, but did not clean the Foley catheter at the urethral opening. The CNAs completed the incontinent care, positioned the resident with pillows and covered the resident. At 10:48 a.m., CNA #6 was asked what she had been instructed about Foley catheter care. She stated, "with soap and water," and done "once a shift and as needed." When asked for examples of "as needed', the CNA stated, "if there's discharge or something." When asked about catheter care after bowel incontinence, CNA #6 stated, "Well, I guess that would have been a good time since you're down there."	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309	Continued From page 12 4. A policy and procedure for, "Catheter Care (Indwelling Catheter)," was received from the Director of Nursing on 8/18/05 at 12:08 p.m. and documented, "5. NOTE: Do not contaminate area with feces. If resident has had an involuntary bowel movement, clean this area first."	F 309		
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure the head of the bed was elevated for 1 (Resident #12) of 2 (Residents #12 and 13) case mix residents who had a feeding tube. This failed practice had the potential to affect 2 residents who had a feeding tube as documented by the Director of Nursing (DON) on 8/19/05. The findings are: 1. Resident #12 had diagnoses of Persistent Vegetative State, Brain Injury, and Gastrostomy. An Annual Minimum Data Set dated 7/27/05 documented the resident was bedfast and had a feeding tube. a. A Care Plan dated 7/27/05 documented a	F 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 322	Continued From page 13 problem, "Feeding tube as evidenced by physical findings and MD (physician) orders," with an intervention to, "Keep HOB (head of bed) elevated @ (at) 45 degrees @ all times." b. On 8/18/05 at 10:37 a.m., Certified Nursing Assistant (CNA) #6 and 7 provided incontinent care. The head of the bed was flat and a tube feeding was infusing at a rate of 25 cc (cubic centimeters) per hour per enteral pump. The pump had not been turned off. The resident was turned to the right side and began to cough with audible congestion. The head of bed was elevated at 10:48 a.m., 11 minutes after being lowered. c. On 8/18/05 at 1:03 p.m., CNA #7 was asked about the position of the head of the bed while caring for this resident and she stated, "I don't know if we're allowed to, but the pump should be on hold when he's flat." When asked, "Is that what you normally do?" CNA #7 stated, "Yes." 2. On 8/18/05 at 2:00 p.m., the DON and RN (Registered Nurse) #1 were asked what the facility had instructed their nursing staff to do in reference to positioning of residents with tube feedings. RN #1 stated, "elevated at all times." The DON stated, "I don't know that I've told them one way or the other." When asked about positioning during incontinent care, RN #1 stated, "They should ask a nurse to turn it [pump] off."	F 322		
F 327 SS=H	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 327	Continued From page 14	F 327		

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and interview the facility failed to ensure sufficient fluid intake to maintain proper hydration was provided, assessments were conducted to determine hydration needs, reassessments were conducted if infections, fever, or diarrhea occurred, care plans were developed to include specific interventions to meet hydration needs, and a system of recording fluid intake was developed for 1 (Resident #4) of 7 (Residents #1, #2, #3, #4, #6, #10, and #11) case mix residents at risk for dehydration. The failed practices resulted in a pattern of actual harm for Resident #4 who experienced dehydration and multiple urinary tract infections. The failed practices had the potential to cause more than minimal harm to 33 residents identified at risk for dehydration as documented by the Director of Nursing on 8/19/05 at 9:05 a.m. The findings are:

1. The OBRA federal interpretive guidelines at F327 - Hydration, document, "Sufficient fluid means the amount of fluid needed to prevent dehydration (output of fluids far exceeds fluid intake) and maintain health. The amount needed is specific for each resident, and fluctuates as the resident's condition fluctuates (e.g., increase fluids if resident has fever or diarrhea)." The guidelines also document;

"A general guideline for determining baseline daily fluids needs is to multiply the resident's body weight in kg times 30cc (2.2 lbs = 1kg)," and,

(signs and symptoms of dehydration) "abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium, chloride, sodium, albumin,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ____ B. WING ____	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	**706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 327	Continued From page 15	F 327		

transferrin, blood urea nitrogen (BUN), or urine specific gravity.

2. The Handbook of Geriatric Nursing Care, Second Edition , published by Lippincott, Williams & Wilkins, page 409 documents under the section of Preventing Dehydration: " Monitor Intake and Output. Ensure an intake of at least 1500 ml of oral fluids and output of 1,000 ml per 24 hours. Less than 1,000 ml per day may lead to more concentrated urine which predisposes the patient to urinary tract infections.

3. Resident #4 had diagnoses of Polynephritis and Urosepsis. The facility "SNF (Skilled Nursing Facility) Admission History and Physical" documented the resident was re-admitted to the facility on 4/4/05 with diagnoses of Polynephritis, Sepsis, VRE, Dehydration and UTI. The H&P further documented the plan of treatment to "monitor fluid intake D/T dehydration and report any decline."
The resident was re-admitted to the hospital on 4/9/05. The hospital History and Physical documented the "Laboratory and X-Ray" admission "UA shows 10-20 white cells, 10-20 red cells, and 2+ leukocytes. The patient does have a moderate yeast. The patient does have a Foley catheter in place." Nurses notes dated 4/11/05 at 4:30 p.m. documented the resident was re-admitted to the facility.

The Significant Change Minimum Data Set (MDS) dated 4/15/05 documented the resident had short/long-term memory problems, was severely impaired in cognitive skills for daily decision making, dependent for Activities of Daily Living (ADL), had an indwelling urinary catheter, vomiting, and two stage 2 pressure sores.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 327	Continued From page 16	F 327		

a. The Resident Assessment Protocol (RAPs) worksheet dated 4/15/05 for the problem area of dehydration/fluid maintenance status documented the resident had dehydration risk factors of diarrhea, vomiting, presence of infection, and frequent laxatives/enema/diuretic use. The worksheet documented: "resident's mental status and physical status has declined. Has had problems with vomiting and diarrhea. Important to provide fluids and monitor I&O closely."

b. As of 8/17/05, the Plan of Care which was updated 4/15/05 identified a problem of "Potential for fluid volume deficit evidenced by use of Lasix 40 mg. [milligrams] on T/TH/SA/SU [Tuesday/Thursday/Saturday] and 80 mg. on M/W/F [Monday/Wednesday/Friday] and 40 mg. q [every] pm and diagnosis of CHF [Congestive Heart Failure]" with interventions "assess for dehydration (dry mucous membranes, poor skin turgor, concentrated urine) and ascertain basis for dehydration (fever, meds, decision making ability, refusal to eat, etc.)." There was no documentation on the Plan of Care, Dietary Notes, or Nurse's Notes to indicate the facility assessed the resident's fluid needs and planned specific interventions to prevent the re-occurrence of dehydration.

c. A monthly weight review form dated 4/20/05 and signed by the Dietary Manager and the Registered Dietitian did not document the resident ' s baseline fluids needs had been determined to prevent dehydration and to ensure sufficient fluids to meet the resident ' s needs.

d. A Physician's Progress Note dated 5/15/05 documented the resident had a UTI with a "Plan"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ____ B. WING ____	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 327	Continued From page 17	F 327		

to "Encourage oral intake" and Cipro 250 mg. x 7 days." A Urine Analysis drawn on 5/15/05 documented the color as amber, appearance cloudy, specific gravity of >1.030 [indicating dehydration], trace blood, positive for nitrates, WBCs of TNTC (too numerous to count), 2-5 RBCs, and many bacteria. The Urine Culture completed on 5/18/05 documented the resident had >100,000 colonies/ml of Klebsiella pneumoniae.

e. A hospital "History and Physical" dated 5/30/05 documented the Chief Complaint as lethargy and fever. The "Laboratory and X-Ray" section documented "urinalysis is nitrate positive with 20-50 white blood cell and 20-50 red cells. Specific gravity is >1.030 reflecting dehydration. Bacteria revealed few and many yeast are noted. White blood count ***18,100 with 82% granulocytes reflecting a profound leukocytosis with a left shift. Hemoglobin 15.3, hematocrit 47.1 in this fluid contracted lady." The Initial Assessment diagnoses included Urosepsis, Pyelonephritis, Dehydration, and Leukocytosis with left shift.

f. The facility "SNF Admission History and Physical" dated 6/7/05 documented the resident was re-admitted from the hospital with diagnoses of Urosepsis, Staph Aureus, Enterococcus Faecalis, and Polynephritis with a documented plan of treatment to "monitor urine for color, odor, cloudiness and to monitor intake and output q shift".

g. A 5-Day Medicare MDS dated 6/11/05 documented the resident had antibiotic resistant infection (e.g. Methicillin resistant staph), Pneumonia, and Urinary tract infection in last 30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 327		F 327		

Continued From page 18

days. .

h. A monthly weight review form for June signed by the Dietary Manager on 6/18/05 and the Registered Dietitian on 6/22/05 did not document the resident ' s baseline fluids needs had been determined to prevent dehydration and to ensure sufficient fluids to meet the resident ' s needs.

i. There was no documentation on the April 2005, May 2005, or the June 2005 MARs, Meal consumption records or nurses notes that the fluid intake for this resident was monitored as per the plan of treatment

j. The July Medication Administration record [MAR] documented the resident received Lasix 40 mg every Tue/Thur/Sat/Sun, 80 mg every Mon/Wed/Fri and 40 mg daily at 4:00 p.m.. The MAR also documented the resident's urinary output as follows:

1. July 1 - 550 cc [22.9 cc/hr]
2. July 2 - 500 cc [20.8 cc/hr]
3. July 3 - 600 cc [25 cc/hr]
4. July 4 - 350 cc [14.58 cc/hr]
5. July 5 - 625 cc [26 cc/hr]
6. July 6 - 625 cc [26 cc/hr]
7. July 7 - 450 cc [22.5 cc/hr]
8. July 8 - 500 [20.8 cc/hr]

k. Nurses notes dated 7/9/05 at 9:05 p.m. documented, "R c/o [resident complained of] lower abdominal pain. Resident also c/o frequent urges to urinate even though she has a Foley cath. F/C [Foley catheter] draining amber colored urine with sediment." The notes documented the physician was notified and orders received to obtain catheter UA. At 10:15 p.m. the nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	**706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 327	Continued From page 19	F 327		

notes documented, "Attempt to obtain UA from port of cath. Obtained 12 cc. clamped cath.: At 10:45 p.m. "Obtained 12 cc urine at this time." At 11:15 p.m. "Obtained 10 cc urine at this time. Will attempt again later." At 2435 obtained enough urine for specimen , r cath unclamped at this time, urine amber with sediment noted."

l. The July 2005 MAR documented the resident's urinary output:

7/11/05- 700 cc/hr [29 cc/hr]
7/12/05- 400 cc/hr [16.6 cc/hr]
7/13/05- 500 cc/hr [21 cc/hr]
7/14/05 - 750 cc/hr [31.25 cc/hr]
7/17/05 - 300 cc/hr [12.5 cc/hr]
7/18/05 - 350 cc/hr 14.58 cc/hr]
7/19/05 - 700 cc/hr[29 cc/hr]

m. There was no documentation in the July 2005 and August 2005 nurses notes, plan of care, dietary notes or meal consumption sheet that the resident received extra fluids, the amount of fluid intake or that fluids were calculated to ensure the resident received sufficient fluids to prevent dehydration and urinary tract infections.

n. A document faxed to the primary physician dated 8/11/05 documented, " Resident's daughter [name] told me that resident is been complaining to her of lower abdominal pain & frequent urges to urinate, even though the resident has a Foley cath. Daughter made a request to have UA done to check if her mother has a UTI. May we have an order for UA?" An order was obtained for a CBC [complete blood count] & urine culture. A Urine sample collected 8/13/05 documented the urine was cloudy, positive for nitrates, 2+ leukocytes, TNTC [Too numerous to count]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ____ B. WING ____	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 327	Continued From page 20	F 327		

WBCs [White Blood Cells], RBCs [Red Blood Cells] of 2-5, bacteria many, and yeast many. The urine culture documented the urine contained greater than [>] 100,000 colonies/ml Enterobacter Cloacae Pseudomonas Aeruginosa.

o. On 8/15/05 at 11:45 a.m. the resident was in bed, a Foley catheter intact with a large amount of sediment in the entire length of the catheter tubing. The urine in the catheter bag appeared to be a dark straw colored and was extremely cloudy.

p. A Physician's Order dated 8/15/05 at 6:00 p.m. documented, "Start IV of Lactated Ringers at 50 cc per hour". Additionally there was an order for "Tobramycin IVPB 100 mg. q 12 hours x 5 days."

q. On 8/16/05 at 9:15 a.m. the IV was initiated. At 10:30 a.m. the water pitcher at the bedside was empty and the water level in the sippy cup was marked by the surveyor. At 12:00 noon the water pitcher remained empty and the level of water in the sippy cup remained in the same position. It was also noted that the urine in the catheter tubing contained sedimentation to the degree that the color of the urine could not be determined. At 12:45 p.m. the resident consumed one carton of milk from her lunch tray. The water pitcher remained empty and the level of water in the sippy cup remained in the same position. At 3:00 p.m. the water pitcher remained empty and the level of water in the sippy cup remained in the same. At 4:55 p.m. the resident was sitting up in bed LPN #1 lifted the resident's leg and pulled the catheter tubing tautly around the resident's foot to secure the tubing to the leg strap. The LPN attached the catheter tubing to the leg strap, washed her hands, left the room, and did not offer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	**706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 327	Continued From page 21 the resident any fluids. r. On 8/17/05 at 8:30 a.m. the resident was in bed, the water pitcher was marked by the surveyor, and the sippy cup was empty. At 10:10 a.m. CNA #2 brought 10 a.m. snacks and placed the snacks in the refrigerator on the nursing unit. At 10:20 a.m. the LPN asked CNA #1 if the resident took her snack. CNA #2 stated, "No, the resident is still asleep." At 10:27 a.m. the consumption record for the a.m. meal was reviewed. The record documented the resident had zero consumption for her breakfast meal. At 10:30 a.m. the water pitcher remained in the same marked position and the sippy remained empty. At 10:45 a.m. CNA #2 and #3 entered the room to turn the resident. At 11:15 a.m. CNA #2 filled the sippy cup with cold water, offered the resident fluids from the sippy cup, and the resident consumed approximately 1/3 of the sippy cup of water. s. On 8/18/05 at 9:15 a.m. during an interview, the Director of Nurses stated the physician and nursing staff assessed the residents ' fluid needs, fluid consumption was monitored and documented on the meal consumption log, and that she had no other way of determining how much fluid the resident needed or received.	F 327		
F 328 SS=E	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;	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 22	F 328		

Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and interview the facility failed to ensure oxygen was administered at the correct flow rate for 2 (Resident #4 and 16) of 10 (Residents #1, 4, 5, 7, 9, 10, 11, 12, 13 and 16) case mix residents who required oxygen therapy. This failed practice had the potential to affect 25 residents who received oxygen therapy as documented by the Director of Nursing (DON) on 8/19/05. The findings are:

1. Resident #4 had diagnoses of Dementia and Congestive Heart Failure (CHF). The Quarterly Minimum Data Set (MDS) dated 7/5/05 documented the resident had short/long term memory problems, was dependent on staff for Activities of Daily Living and had received Oxygen Therapy in the past 14 days.

a. The August 2005 physician orders documented a order dated 6/14/05 for "Oxygen @ (at) 4 L (Liters)/M (minute) VIA (by way of) N/C (nasal canula), PRN (as needed), SOB (shortness of breath)."

b. On 8/15/05 at 11:45 a.m. and 2:10 a.m. and 8/16/05 at 9:15 a.m. and 3:00 p.m. the resident received oxygen at 2 liters per minute by nasal cannula.

c. On 8/17/05 at 10:30 a.m. the resident received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 23 oxygen at 5 liters or greater per minute by nasal cannula. (The Oxygen concentrator was turned up as high as it would go.) 2. Resident #16 had a diagnosis of Left Lower Lobe Pneumonia. The Quarterly MDS dated 6/30/05 documented the resident had short/long term memory problems, was severely impaired in cognitive skills for daily decision making, dependent of staff for all Activities of Daily Living and received oxygen in the past 14 days. a. The plan of care updated 8/4/05 documented a problem of "Decline in Resp (Respiratory) status r/t (related to) aspiration pneumonia" with interventions that included "Resident receives Oxygen @ 2L/Min by nasal cannula and check pulse ox (oxygen) q (every) shift & (and) document." b. On 8/15/05 at 10:40 a.m., the resident was up in the geri chair. The resident had a nasal cannula in her nose however the oxygen concentrator was set on zero.	F 328		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the medication error rate was less than 5%. Physician orders were not followed for 6 (Resident #17, #5, #18, #19, #20, and #21) out 28	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	**706 OAK GROVE STREET** **MOUNTAIN VIEW, AR 72560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 332	Continued From page 24	F 332		

residents observed during medication passes. Medication errors were made by 2 Licensed Practical Nurses (LPN) (LPN #1 and #2) of 3 Licensed Nurses who administered medications. The medication error rate was 16.27% based on administration of 43 medications and 2 medications ordered but not given with a total of 7 errors detected. The failed practice had the potential to affect 52 residents, as identified by the Assistant Director of Nursing (ADON) on 7/16/05 at 11:05 a.m. The findings are:

1. Resident #17 had a physician order dated 2/7/05 for ACCU checks before meals (AC) & (and) bedtime (HS) and a physician order dated 6/29/05 for Sliding Scale Insulin: Humulin R Insulin: if Blood Sugar is 251 - 300 Give 4 units SQ.

a. On 8/15/05 at 12:17 p.m., the resident was eating lunch. LPN #1 did not do an ACCU before the meal.

b. On 8/15/05 at 2:45 p.m., LPN #1 was asked about the ACCU check and she stated, "The blood sugar was 268 and I gave it [insulin] while they ate."

2. Resident #5 had a hand written physician order dated 5/17/05 for Bidex 400 milligrams (mg) po (by mouth) three times a day (tid).

On 8/15/05 at 12:23 p.m., LPN #1 did not administer Bidex 400 mg.

3. Resident #18 had a physician order dated 11/22/04 for Starlix 120 mg 1 by mouth tid ac.

a. On 8/15/05 at 12:42 p.m., LPN #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	**706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 332	Continued From page 25 administered Starlix while the resident was eating. b. The 2004 Lippincott's Nursing Drug Guide documented Starlix was to be taken 30 minutes before meals. 4. Resident #19 had a physician order dated 7/29/05 for Over-the-Counter (OTC) Motrin 1 po every 6 hours. a. On 8/15/05 at 1:02 p.m., LPN #1 did not administered Motrin. b. LPN #1 stated they did not know if they were using Ibuprofen for Motrin. The Ibuprofen was in the medication cart. c. The LPN #1 placed her initials and circled them and wrote on the back on the Medication Administration Record (MAR) Motrin not given unavailable at this time. 5. Resident #20 had a physician order dated 2/10/05 for Glucosamine/Chondroitin 500-400 mg 1 po twice a day (bid) with food. On 8/15/05 at 3:47 p.m., LPN #2 administered Glucosamine/Chondroitin 1500-1200 mg maximum strength. 6. Resident #21 had a physician order dated 12/8/04 for Dilantin capsules 100 mg 1 po bid. a. On 8/15/05 at 4:48 p.m., LPN #2 crushed the Dilantin after opening the capsule. The LPN stated, "I know you are not to crush Dilantin, but the resident came from another floor and they said the Physician said it was OK."	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 332	Continued From page 26 b. According to Medication Guides for the Long-Term Care Nurse sixth edition Dilantin 100 mg should not be crushed due to it is a Time release formulation. 7. Resident #23 had a physician order dated 5/17/05 to "Please crush meds." On 8/15/05 at 4:22 p.m., LPN #2 did not crush Ditropan 5mg, Risperdal 0.5 mg or Chlorophyll 1 mg before administering the medications.	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 residents were free of significant medication errors for 1 (Resident #5) of 28 residents observed during the medication passes. This failed practice had the potential to affect all 76 residents. The findings are: Resident #5 had a diagnosis of Chronic Obstructed Pulmonary Disease (COPD) with exacerbation. a. A fax sent to the physician by Licensed Practical Nurse (LPN) #5 dated 5/13/05 documented, "Resident has order for Bidex 600 mg (milligrams) i (1) Bid (twice a day), out stock we now have is 400 mg Guaifenesin.... Can we	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ____ B. WING ____	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 333	Continued From page 27 [change] from 600 mg to 400 mg PO Bid?" A hand written physician order dated 5/17/05 and signed by the physician documented, "[Change] Bidex to 400 mg TID (three times a day); congestion." a. On 8/15/05 at 12:23 p.m., the Bidex 400 mg was not administered. b. The August 2005 Medication Administration Record (MAR) documented the Bidex was to be administered PRN (as needed). The MAR did not document the resident received Bidex during the month of August. c. This was a significant medication error due to the frequency of the error.	F 333		
F 363 SS=B	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, record review and interview the facility failed to ensure that 22 residents received a planned menu item and were offered foods from the salad bar. This failed practice had the potential to affect 75 residents who received a tray from the kitchen as	F 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ____ B. WING ____	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 28 documented on the Diet Roster dated 8/15/05. The findings are: 1. On 8/16/05 at 12:30 p.m. the Dietary Manager stated that the salad bar food items were offered at the time a tray was served to a resident. 2. On 8/16/05, the menu for the evening meal documented green pea salad. 3. On 8/16/05 at 6:20 p.m., in the main dining room, 22 residents did not receive the green pea salad and were not offered any of the salads from the salad bar.	F 363		
F 364 SS=B	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was served at a palatable temperature. This failed practice had the potential to affect the 75 residents who received a tray from Dietary according to the Diet Roster dated 8/15/05. The findings are: 1. On 8/15/05 at 10:45 a.m., all of the food for the noon meal was placed on the steam table. CMS (Centers for Medicare/Medicaid Services)	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ___ B. WING ___	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 364	Continued From page 29 guidelines documented resident food was not to be on the tray line for more than 30 minutes before service. 2. On 8/16/05 at 5:00 p.m., Resident #6 was served the supper tray in the resident's room and staff left the room. At 5:45 p.m. and at 6:00 p.m., the resident's food remained on the over-bed table. At 6:15 p.m., the resident was served a fresh tray and fed by staff. 3. On 8/16/05 at 5:00 p.m., Resident #7 was served the supper tray in the resident's room. a. At 5:45 p.m. and 6:00 p.m., the tray remained on the over-bed table. b. At 6:05 the temperature of the food registered; Meat-80 degrees F. (Farenheit), Vegetables 78 degrees F., Yogurt 70 degrees F., Dessert 66 degrees F, milk 64 degrees F. The resident was served a fresh tray and fed by staff. 4. On 8/17/05 at 10:30 a.m., in the Group Meeting, 2 of 6 residents stated that sometimes the food was served cold in the dining room. 5. On 8/18/05 at 12:00 p.m., in the feeder dining room, Resident #16's tray was served on the table. At 12:45 p.m., the resident had not been fed. The temperature of the meat registered 90 degrees F. and the vegetables registered 89 degrees F. The food would not melt butter.	F 364		
F 371 SS=E	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 30 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure stored food was covered, sealed and dated; food was handled in a manner to prevent food borne illness and employees' hair was completely covered. These failed practices had the potential to affect 75 residents who received a tray from Dietary documented on the Diet Roster dated 8/15/05. The findings are: 1. On 8/15/05 at 10:45 a.m., the following observations were made: a. In the walk-in refrigerator there was a green plastic bowl of ham dated 8/14/05, a bowl of grated cheese and a bowl of black olives that were not covered. b. In the walk-in freezer there were 2 one-gallon ziplock bags of broccoli, 1 one-gallon ziplock bag of corn on the cob, 2 one-gallon ziplock bags of Normandy blend vegetables and 2 one-gallon ziplock bags of meatballs that were not dated. 2. On 8/17/05 at 5:10 p.m., Dietary Employee #1 had on disposable gloves and was putting dinner rolls on the residents' trays. She left the tray line and went across the room and handled the kitchen copy of the menu sheets. Without changing her gloves or washing her hands, she returned to the line and served rolls on 10 resident trays. 3. On 8/18/05 at 7:10 a.m., Dietary Employee #2 had on disposable gloves and was putting biscuits onto the residents' trays. At 7:10 a.m., she went to the stove and brought a menu item to	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 31 the tray line. She reached into her pockets and pulled out paper and pen to write down the temperature. She then used kitchen utensils and took the temperature and put the pens and paper back in her pocket with her gloved hands. She continued to serve the biscuits on all the residents' trays without changing her gloves. 4. At 7:10 a.m., Dietary Employee #2 and #3 were serving the tray line. Both employees had on baseball caps with disposable hair restraints pulled over the caps. The hair around the face was completely uncovered. a. At 7:30 p.m., in the North Dining Room, Dietary Employee #2 removed the baseball cap. She had the hair restraint positioned on the back of her hair. The hair around the face was completely uncovered. b. CMS (Centers for Medicare/Medicaid Services) guidelines documented the appearance of dietary staff should include appropriate attire and hair restraints. 5. On 8/18/05 at 11:45 a.m., Dietary Employee #3 had on disposable gloves and placed dinner rolls onto the residents' trays. While filling the North and West Hall trays the employee used his gloved hands to fill the coffee cups and returned to the line to serve the residents' rolls without changing his gloves.	F 371		
F 427 SS=D	483.60(b)(1)-(3) PHARMACY SERVICES - SERVICE CONSULTATION The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy	F 427		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 427	Continued From page 32	F 427		

Continued From page 32

services in the facility; establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

This REQUIREMENT is not met as evidenced by:
Based observation and record review, the facility failed to ensure that the physical inventory of all controlled drugs was counted for and documented by two nurses at each shift change. This failed practice has the potential to affect 23 residents who received controlled drugs on West Hall as identified by Licensed Practical Nurse (LPN #3) on 8/16/05 at 5:30 p.m. The findings are:

1. On 8/16/05 at 10:45 a.m., the Narcotic Record Audit book revealed that on the West Hall 6 signatures were missing.

a. The Narcotic Record Audit book was missing two signatures by two licensed nurses on 7/14/05 at 4:45 p.m., 7/20/05 at 12:45 a.m., 7/24/05 at 10:30 p.m., 8/10/05 at 6:45 a.m. and 7:40 p.m., and 8/2/05 at 6:30 p.m.

2. On 8/16/05 at 11:22 a.m., LPN #2 was asked if there were any narcotics in the narcotic box in the refrigerator and she stated she did not know, but she would open the box. There were 6 Lorazepam 2 milligrams/1 milliliter in the refrigerator narcotic box and the narcotic box was not secured to the inside of the refrigerator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ____ B. WING ____	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 441	Continued From page 33	F 441		
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 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure the Infection Control log accurately reflected the use of Antibiotic Therapy in order to track and trend Urinary Tract Infections for 1 of 1 case mix resident (Resident #4) who had a history Urinary Tract Infections. The facility also failed to ensure staff washed there hands after providing incontinent care and before providing further care to another resident. This failed practice had the potential to affect 41 residents who were incontinent according to the Resident Census and Conditions of Residents form dated 8/17/05. The findings are: 1. Resident #4 had diagnoses of Polynephritis and Urosepsis. The Significant Change Minimum Data Set (MDS) dated 4/15/05 documented the resident was severely impaired cognitively for daily decision making skills, dependent for	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ____ B. WING ____	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	**706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 441	Continued From page 34 Activities of Daily Living (ADL) skills and had an indwelling catheter. a. The Plan of Care updated 4/15/05 identified a problem of "Potential for fluid volume deficit evidenced by use of Lasix 40 mg. on T/TH/SA/SU and 80 mg. on M/W/F and 40 mg. q pm and diagnosis of CHF" with interventions that included "assess for dehydration (dry mucous membranes, poor skin turgor, concentrated urine) and ascertain basis for dehydration (fever, meds, decision making ability, refusal to eat, etc.)". b. On 3/24/05 the resident was admitted to the hospital with diagnoses of VRE of the urine, Polynephritis and significant dehydration. The resident returned to the facility on 4/4/05. c. On 4/9/05 the resident was admitted to the hospital again with diagnoses of Urinary Tract Infection. d. On 5/15/05 the resident received antibiotic therapy in the facility for a UTI that was cultured Klebsiella. e. On 5/30/05 the resident was admitted to the hospital with Urosepsis and Dehydration. She was readmitted to the facility on 6/7/05. f. On 7/10/05 the resident received Cipro for a Urinary tract infection that was cultured Pseudomonas. g. On 8/13/05 the resident received Tobramycin for a Urinary Tract Infection that cultured Pseudomonas. h. On 8/16/05 the resident was admitted to the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ____ B. WING ____	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 441	Continued From page 35 hospital for Hydration and Antibiotic therapy for a Urinary Tract Infection. i. On 8/18/05 the facility's Infection Surveillance Report was reviewed. The resident was not on the surveillance report for the following antibiotic therapies and infections. 1) 3/24/05 VRE of urine and Polynephritis 2) 5/15/05 Klebsiella of the urine 3) 6/7/05 for Urosepsis, Polynephritis j. On 8/19/05 at 11:30 a.m. the Director of Nursing was asked to review the Infection Surveillance Report for the missing entries. She reviewed the report and stated they were not on there. The Director of Nursing was also asked " Do you have any other methods for tracking and trending infections?" She replied "NO." k. The Director of Nursing was asked " How can you track or trend infections, if it's not on the logs?" If it's not on the log, we can't." 2. Resident #12 had diagnoses of Persistent Vegetative State, Brain Injury, and Gastrostomy. An Annual Minimum Data Set dated 7/27/05 documented the resident was totally dependent for personal hygiene and toilet use, bedfast, and had a feeding tube. a. On 8/18/05 at 10:37 a.m., the resident was incontinent of a large, loose bowel movement. CNA (Certified Nursing Assistant) #7 wore gloves and cleansed stool from the resident's thighs and buttocks. The CNA did not change gloves before assisting CNA #6 to reposition the resident,	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 441	Continued From page 36 touching the resident's shirt, abdomen, and clean bed linens with the soiled gloves. CNA #7 also placed a pillows at the resident's back and a clean sheet over the resident with the same soiled gloves.	F 441		
F 445 SS=D	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure soiled linen was stored in a manner to ensure residents did not have access. This failed practice had the potential to affect 8 confused, mobile residents as identified by Registered Nurse (RN) #1 on 8/19/05. The findings are: 1. On 8/16/05 at 3:20 p.m., a resident in a wheelchair with a lap buddy and a personal alarm was observed pulling soiled linens out of a laundry barrel that was located inside the Hall 200 Ladies rest room. The resident was pulling linens out of the barrel, attempting to fold them and then stacking them on the lap buddy. There were 2 wet/soiled sheets and a wet incontinent pad on the lap buddy. There was a soiled sheet in [his/her] hands. The rest room door was open to the hallway. The Administrator was informed of this incident and assisted in removing the resident from the area. 2. On 08/17/05 at 8:30 a.m., the Hall 200 Ladies rest room door was open to the hallway. There	F 445		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 445	Continued From page 37 was a laundry barrel containing soiled linens in this room. The lid was not fastened down and was slightly ajar. There was an odor of urine present.	F 445		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure emergency call light systems in the shower rooms were in working order. This failed practice had the potential to affect 14 female residents who utilized the shower room on Hall 200 and 19 residents who utilized the Hall 100 shower room according to a list provided by the facility. The findings are: 1. On 8/17/05 at 8:30 a.m., the call light system in the Ladies shower room on Hall 200 was tested. There were 2 shower stalls with a pull switch in each. Neither of the pull switches activated the alert light above the hall door. 2. On 8/17/05 at 10:30 a.m., there was no call light system in the shower room on Hall 100. There were no pull cords in the 2 shower stalls. There was no indicator light above the hall door. The Maintenance Supervisor stated, "I guess I just didn't notice there wasn't one."	F 463		
F 502 SS=E	483.75(j)(1) LABORATORY SERVICES	F 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 502	Continued From page 38 The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Accu Checks were completed in a timely manner for 2 of 2 case mix residents (Resident #17 and 2) who required Accu Checks. This failed practice had the potential to affect 12 residents who required Accu Checks according to the Administrator on 9/2/05. The findings are: 1. Resident #17 had a physician orders dated 2/7/05 for ACCU checks before meals (AC) & bedtime (HS). a. On 8/15/05 at 12:17 p.m., the resident was eating. LPN (Licensed Practical Nurse) #1 had not done the ACCU check prior to the meal. 2. Resident #22 had a physician order dated 7/20/05 for ACCU checks ac and hs. a. On 8/15/05 at 12:14 p.m., LPN #1 stated the resident had an ACCU check due, but they would have to go to the room, so they would come back to him. b. On 8/15/05 at 12:46 p.m., the LPN #1 stated the resident has already started eating, the resident was asked to stop eating so the LPN #1 could take them to their room to do the ACCU check.	F 502		