

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

PRINTED: 11/04/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2008
NAME OF PROVIDER OR SUPPLIER STONE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560	
(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 312 SS=D	<p>483.25(a)(3) ACTIVITIES OF DAILY LIVING</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure urine was cleansed from all areas of the perineum to promote good hygiene for 1 (Resident #2) of 4 case mix residents who were incontinent (Residents #2, #5, #6 and #7). The failed practice had the potential to affect 51 residents who were incontinent of bladder, as documented on the Resident Census and Conditions of Residents form dated 10/22/08. The findings are:</p> <p>Resident #2 had diagnoses of Dementia with Behavior Disturbance and Failure to Thrive. The Quarterly Minimum Data Set dated 9/1/08 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on staff for transfers, toileting and personal hygiene and incontinent of bowel and bladder.</p> <p>a. The Plan of Care dated as reviewed/revised by the facility on 9/1/08 documented: "Resident is in need of assistance from staff with care modalities as evidenced by DX [diagnosis] of Dementia, Confusion, forgetfulness, unsteady gait and impaired decision-making ability... Approaches: Incontinent care of bowel and bladder to be provided by nursing staff as needed..."</p>	F 312		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

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

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F 312	Continued From page 1 b. On 10/21/08 at 12:25 p.m., Certified Nursing Assistant (CNA) #2 and Licensed Practical Nurse (LPN) #1 assisted the resident to stand from the recliner. The resident's incontinent brief was wet with urine and was removed by the staff. CNA #1 used a pre-moistened wipe to cleanse the left buttock in and up and down motion. A second wipe was used to cleanse the right buttock. The CNA wadded the 2 soiled wipes in the palm of his gloved left hand and picked up the clean incontinent brief without disposing of his soiled gloves. The CNA then placed the clean incontinent brief on the resident without cleansing the urine from the perineal area, mons pubis and groin folds.	F 312		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure the torso and lower extremities were supported to prevent potential injury during transfers or repositioning for 3 (Residents #2, #12 and #14) of 8 (Resident #2, #5 - #8 and #12 - #14) case mix residents who required assistance with transfers or repositioning. The failed practice had the potential to affect 28 residents who were dependent on staff for transfers, as documented on the Resident Census and Condition of	F 323		

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F 323	Continued From page 2 Residents form dated 10/22/08. The findings are: 1. Resident #2 had diagnoses of Dementia with Behavior Disturbance and Failure to Thrive. The Minimum Data Set (MDS) dated 9/1/08 documented the resident was severely impaired in cognitive skills for daily decision making and totally dependent on the assistance of 2 or more staff for transfers. a. The Plan of Care dated as reviewed by the facility on 9/1/08 documented: "Resident is in need of assistance from staff with care modalities as evidenced by DX [diagnosis] of Dementia, Confusion, forgetfulness, unsteady gait and impaired decision-making ability... Approaches: Encourage resident to ask staff for assistance during ambulation... Remind resident of safety precautions during transfer and ambulation..." b. On 10/21/08 at 11:35 a.m., the resident was sitting in a recliner. Certified Nursing Assistants (CNA's) #1 and #2 placed a gait belt around resident's waist. The gait belt was not cinched snugly around the resident's waist and was visibly loose. The CNA's each placed one arm under one of the resident axillae and lifted the resident up out of the recliner. The resident's knees were bent and her feet began to slide forward. The CNA's grabbed the gait belt to stop the resident from sliding further, but the loose gait belt was ineffective. The CNA's then placed their feet in front of the resident's feet to stop her from sliding. The CNA's instructed the resident to stand, but she was unable to straighten her legs to stand up properly and bear weight, causing the majority of her body weight to be supported by her shoulder joints. The CNA's lowered her back to the recliner and stated they would return later to	F 323			

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F 323	<p>Continued From page 3 provide care.</p> <p>c. On 10/21/08 at 12:10 p.m., the resident remained in the recliner. CNA's #2 and #3 placed a gait belt around the resident's upper buttock area. The CNA's each placed one arm under one of the resident's axillae. The CNA's attempted to grasp the gait belt, but it was loose so they grabbed the back of the waistband of the resident's pants. The resident was then lifted up from the recliner by her axillae and the waistband of her pants.</p> <p>2. Resident #12 had diagnoses of Cerebrovascular Accident, History of Sacrum/Coccyx Fracture and Osteoporosis. The Annual MDS dated 9/16/08 documented the resident had modified independence in cognitive skills for daily decision making and totally dependent on the assistance of 2 or more staff for transfers.</p> <p>a. The Care Plan dated as reviewed and updated by the facility on 10/8/08 documented: "Risk of pain/falls... Dx [diagnosis] OA [Osteoarthritis], Osteoporosis... May use recliner when out of bed for change in body positioning..." The Plan of Care did not address what methods should be used to transfer or reposition the resident when sitting in a wheelchair.</p> <p>b. On 10/21/08 at 12:20 p.m., the resident was sitting in a wheelchair. The resident was leaning over the left wheelchair arm. CNA #4 stood behind the resident's wheelchair, placed her arms under the resident's axillae and pulled the resident up in the wheelchair, causing the resident's weight to be supported by her shoulder joints.</p>	F 323			

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F 323	Continued From page 4 3. Resident #14 had a diagnosis of Alzheimer's Disease. The Minimum Data Set (MDS) dated 10/14/08 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent on the assistance of 2 or more staff for transfers. a. The Care Plan dated as reviewed by the facility on 10/7/08 documented the resident required assistance from staff for activities of daily living. The Care Plan did not address the level of assistance with transfers or the type of transfer that should be utilized for this resident. b. On 10/3/08 at 9:00 a.m., the resident was sitting in a wheelchair. CNA's #6 and #7 placed a gait belt around the resident's waist. The CNA's each grasped the gait belt with one hand and lifted the resident out of the wheelchair. The resident's ankles were crossed as the CNA's attempted to move the resident into the recliner. The resident did not bear weight on her lower extremities during the transfer. The CNA's stated, "She usually bears weight." When the resident was unable to stand and bear weight, the CNA's each grabbed under one of the resident's arms at the axillary area and pulled the resident over into the recliner, causing a significant portion of the resident's body weight to be supported on her shoulder joints.	F 323			
F 329 SS=E	483.25(I) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329			

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F 329	<p>Continued From page 5</p> <p>adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure gradual dose reductions/tapering of antidepressant medications were attempted in the absence of a detailed written statement from the physician, including documentation of an evaluation of the risks versus benefits of the medication and evidence to demonstrate why a dose reduction attempt would be contraindicated for 1 (Resident #6) of 5 case mix residents with physician orders for antidepressant medications (Residents #2, #4, #6, #9, #10 and #12). The failed practice had the potential to affect 42 residents with physician orders for antidepressant medications, as documented on the Resident Census and Conditions of Residents form dated 10/22/08 at 2:00 p.m. The findings are:</p>	F 329			

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F 329	Continued From page 6 Resident #6 had diagnoses of Parkinsonian/Senile Dementia with Behavioral Disturbances and Major Depressive Disorder with Anxiety. The Minimum Data Set (MDS) dated 8/2/08 documented the resident was moderately impaired in cognitive skills for daily decision making and exhibited indicators of depression, anxiety or sad mood which were easily altered. a. A physician order dated 5/18/07 documented: "Cymbalta 60 mg [milligrams] capsule, 1 by mouth every day." b. A Psychiatric Examination Record dated 2/15/08 documented: "Dementia/[behavior change]/depression/anxiety/ insomnia... [increasing] dementia, but better mood. C/O [complains of poor sleep]... Mood and affect... better than before, mood affect friendly, but blunted [secondary] to Parkinson's..." c. The Pharmacist Consultant Communication to the Physician form dated 7/21/08 documented: "This resident is currently receiving Cymbalta 60 mg QD [every day] for Depression, to manage behavior, stabilize mood, or treat a psychiatric disorder. Federal guidelines require periodic dose reduction trials in an attempt to minimize or discontinue medications that are unnecessary. Please assess resident for possible dose reduction. If the current dose maintains functional status and a reduction attempt would likely cause a return or worsening of symptoms or an increase in Depression or distressed behaviors please document in the space provided below... If recommendation is not accepted please indicate why reduction would not be Clinically Indicated for this resident in the space provided below..." The physician's response	F 329			

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F 329	Continued From page 7 dated 8/1/08 documented: "Is felt med [medication] necessary - maintains functional capacity without adverse effects." No recent symptoms, behaviors or other clinical indications for the continued use of Cymbalta were documented to justify the continued use of Cymbalta and no rationale was documented to demonstrate that a dose reduction attempt would be contraindicated. d. As of 10/23/08, there was no documentation in the Nurses' Notes or elsewhere in the clinical record of ongoing, routine monitoring of the resident's response to the Cymbalta or of monitoring for potential side effects. e. On 10/23/08 at 9:15 a.m., the Director of Nursing (DON) presented 4 Nurses Notes which documented check marks to indicate the resident was, "alert x [times] 3, confused at times, pleasant, calm/content, sleeps well, tearful/sad at x's [times], delusions at x's, anxious at x's, depressed at x's." There were no dates or Nurse signatures on these Nurses Notes. The DON was unable to provide documentation of Cymbalta dose reduction attempts or documentation to demonstrate why a dose reduction attempt would be contraindicated.	F 329			
F 441 SS=D	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	F 441			

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F 441	<p>Continued From page 8</p> <p>resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure direct care staff implemented Universal Precautions to prevent potential infection, as evidenced by failure to ensure items used for resident care were not contaminated during incontinent care for 1 (Resident #5) of 4 case mix residents who were incontinent (Residents #2, #5, #6 and #7). The failed practice had the potential to affect 43 residents who were incontinent of bowel and 51 residents who were incontinent of bladder, as documented on the Resident Census and Conditions of Residents form dated 10/21/08. The findings are:</p> <p>Resident #5 had diagnoses of Urinary Retention and Alzheimer's Disease. The Quarterly Minimum Data Set (MDS) dated 9/2/08 documented the resident was totally dependent on staff for personal hygiene and bathing and incontinent of bowel and bladder.</p> <p>a. On 10/21/08 at 3:30 p.m., Certified Nursing Assistants (CNA's) #1 and #5 entered the resident's room to provide incontinent care. The resident's anal area and buttocks were soiled with a large, incontinent bowel movement. The CNA's donned gloves and CNA #1 used pre-moistened, disposable wipes from a plastic container to cleanse the resident. The CNA soiled his gloves with the fecal material as he provided care, but continued to handle and remove additional wipes from the plastic container without changing</p>	F 441			

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F 441	Continued From page 9 gloves. After completing the incontinent care procedure, the CNA removed the container of wipes from the resident's bed and placed it on the bedside table. The container was marked by the Surveyor at this time. b. On 10/22/08 at 9:10 a.m., the marked container of pre-moistened disposable wipes remained on the resident's bedside table.	F 441			