

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

PRINTED: 01/20/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04E116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/12/2006
NAME OF PROVIDER OR SUPPLIER SUMMIT HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 618 ROBINSON TAYLOR, AR 71861	
(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 226 SS=C	<p>483.13(c) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to implement their abuse policy and procedure by not conducting and/or not conducting in the required time frame a Criminal Record Check (CRC) for 4 of 5 newly hired employees and the Employment Clearance Registry (ECR) check for 3 of 5 employees newly hired employees. This failed practice had the potential to affect all 33 residents. The findings are:</p> <p>1. The facility's Abuse Policy and Procedure documented:</p> <p>a. XXX healthcare company screens all prospective applicants prior to offering any position. All pertinent job references are checked by the department head of the department with the job opening. According to Law, the (OLTC) Office of Long Term Care Employment Clearing Registry is contacted and the results of the contact documented. If all references are satisfactory, an offer of employment may be extended.</p> <p>b. All employees (Under Arkansas State Law) must be willing to undergo a Criminal Background Check consisting of State and FBI (Federal Bureau of Investigation) Fingerprint checks. Anyone refusing this will not be employed by the</p>	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.

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F 226	Continued From page 1 facility. The background check will be submitted to Arkansas State Police by the 5th day of employment. 2. On 1/11/06 at 3:00 p.m., the following personnel files were reviewed: a. Housekeeping/Laundry Employee #1 had a hire date of 1/3/06. There was no documentation a CRC had been completed. The Administrator stated the employee is currently working. "I am waiting for a check from the corporate office to mail in the request for the criminal record check." b. Certified Nursing Assistant (CNA) #5 had a hire date of 10/20/05. The ECR check was dated 1/11/06 and the CRC was dated 1/5/06. c. CNA #6 had a hire date of 11/2/05 and the ECR check was dated 1/11/06 and the CRC had not been completed. d. CNA #7 had a hire date of 10/12/05 and the Criminal Record Check was dated 1/5/06.	F 226		
F 253 SS=C	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure window sills, floors, walls and	F 253		

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F 253	Continued From page 2 doorways were clean, floor tiles were not cracked and the glass window in an exit door was not cracked. These failed practices had the potential to affect all 33 residents. The findings are: 1. On 1/10/06 at 2:00 p.m. the following observations were made: a. The floors in the front lobby had a thick blackish-brown substance around the entire perimeter of the room at the baseboards. b. On both sides of the front entrance door was a thick blackish-brown substance along the threshold and at the bottom of the door jambs. c. The following observation was made of the dividing doorways in the lobby: 1) The right side of the door facing East had a thick blackish-brown substance along the threshold and at the bottom of the door jambs. 2) The left side of the doorway had yellowish-brown stains along the threshold and at the bottom of the door jambs. d. The lobby floor had approximately 69 floor tiles that were cracked and stained. e. The two entry doors from the lobby closest to the nurses station, had thick dirty build-up along the threshold and at the bottom of the door jambs. There was a brown build-up of dirt at the base board around the perimeter of the area. Along the room divider there were approximately 8 cracked floor tiles. 2. On 1/11/06 at 2:20 p.m. the following	F 253			

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F 253	Continued From page 3 observations were made on the South Hall: a. In the Omens' Bath Room, sterilizer room and the utility room there was a dirty black build-up along all of the thresholds and at the bottom of the door jambs. b. The baseboard along the floor had a dirty black build-up that extended the full length of the hallway on both sides. c. The walls extending from the floors upward approximately 36 inches had dried yellow colored stains and smears extending the full length of the hallway on both sides. d. Resident Room #2, 3, 4, 5, 6, 7, 8, and 9 had a dirty black build-up at the door jamb on the threshold on both sides of the entry doors. e. There was dirt and debris in the window sill below the glass in the exit door at the end of the hall. 3. On 01/11/06 at 2:30 p.m., the following observations were made on the East Hall: a. On both sides of the doorway to the nurses station there was a dirty black build-up along the threshold and at the bottom of the door jambs. b. The entry to the Beauty Shop and the Janitors Closet across from the nurses station, a storage closet close to the dining room and the Rest Room had dirty black build-up along the threshold and at the bottom of the door jambs. c. Resident Room #1 had stained floor tiles across the threshold and a dirty black build-up	F 253			

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F 253	Continued From page 4 along the threshold and at the bottom of the door jambs. d. The fire doors had a thick black dirty build-up on the hinge side of both doors at the threshold that extended behind the doors approximately 36 inches along the base board. e. In the dining area there was a dirty brown build-up on the floor around the coke machine, a refrigerator and the ice machine. f. The dining room floor had approximately 8 tiles across that were stained. g. Resident Rooms #18, 19, 20 and 21 had a dirty black build-up at the door jamb on the threshold at both sides of the doorways. h. The glass in the exit door at the end of the hallway had spider-web cracks. On both sides of the exit door was a dirty black build-up at the door jamb on the threshold. i. There was a dirty black build-up that extended the entire length of the hallway on both sides along the baseboard on the floor. 4. On 1/11/06 at 2:45 p.m., the following observations were made on the North Hall: a. The entryway at the beginning of the hall had 8 stained cracked tiles across the threshold. b. On both sides of the door to the Linen Closet and Resident Bathroom there was a dirty black build-up at the door jamb on the threshold. c. There was a dirty black build-up along the	F 253		

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F 253	Continued From page 5 floors at the baseboard that extended the entire length of the hallway on both sides. d. Resident Rooms #10, 11, 12, 13, 14, 15 and 20 had a dirty black build along the threshold and at the bottom of the door jambs. e. In Resident Room #15 there were 5 broken mix-matched tiles in the center of the room and on the lower wall along the right lower side of the Air Conditioning/Heat unit on the right lower side were black stains. 5. On 1/11/06 at 1:45 p.m., in Resident #7's room there was an area of stained floor tiles approximately 24 inches in circumference in the center of the room.	F 253		
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure incontinent care was provided in a manner to maintain personal hygiene for 2 (Resident #1 and 3) of 4 case-mix residents (Resident 1, 3, 4 and 8) who required assistance with incontinent care. This failed practice had the potential to affect 17 residents who were frequently or occasionally incontinent of bowel and bladder according to the Resident	F 312		

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F 312	Continued From page 6 Census and Conditions of Residents report dated 1/9/06. The findings are: 1. Resident #1 had diagnoses of Alzheimer's Disease, Cerebrovascular Accident, Hypertension, Depression and Psychosis. The MDS (Minimum Data Set) dated 10/17/05 documented, the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for personal hygiene and incontinent of bowel and bladder. On 1/10/06 at 1:25 p.m., CNA (Certified Nursing Assistant) #1 and 2 provided incontinent care. The labia was not separated and washed. 2. Resident #3 had diagnoses of Cerebrovascular Accident, Adult Onset Diabetes Mellitus, Hypothyroidism, and Personality Disorder. The MDS dated 10/18/05 documented, the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for personal hygiene and incontinent of bowel and bladder. On 1/11/06 at 10:00 a.m., CNA #3 and 4 provided incontinent care. The labia was not separated and washed.	F 312		
F 315 SS=E	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		

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F 315	Continued From page 7 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure incontinent care was provided in a manner to prevent the potential for urinary tract infections for 2 (Resident #1 and 3) of 4 case-mix residents (Resident 1, 3, 4 and 8) who were incontinent of bowel and bladder. This failed practice had the potential to affect 17 residents who were frequently or occasionally incontinent of bowel and bladder according to the Resident Census and Conditions of Residents report dated 1/9/06. The findings are: 1. Resident #1 had diagnoses of Alzheimer's Disease, Cerebrovascular Accident, Hypertension, Depression and Psychosis. The MDS (Minimum Data Set) dated 10/17/05 documented, the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for personal hygiene and incontinent of bowel and bladder. On 1/10/06 at 1:25 p.m., CNA (Certified Nursing Assistant) #1 and 2 provided incontinent care. The resident was wiped in the right groin with an upward then downward motion. The left groin area was wiped with several upward and downward motions and the middle frontal genitalia was washed. All areas were washed without changing areas of the washcloth. 2. Resident #3 had diagnoses of Cerebrovascular Accident, Adult Onset Diabetes Mellitus, Hypothyroidism, and Personality	F 315		

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F 315	Continued From page 8 Disorder. The MDS dated 10/18/05 documented, the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for personal hygiene and incontinent of bowel and bladder. On 1/11/06 at 10:00 a.m., CNA #3 and 4 provided incontinent care. The resident was washed with a downward stroke and then back up in the right groin. The left groin was washed with downward and upward strokes and then over the mons pubis area without changing areas of the washcloth.	F 315		
F 371 SS=F	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was stored in a manner to prevent cross contamination, cold food was served at 41 degrees Fahrenheit (F) or below, the refrigerator floor shelf and vent hoods were free of spillage and grease, milk was properly thawed and cooking equipment and pans were cleaned after each use. This failed practice had the potential to affect 30 residents who received meal trays from the kitchen according to the Resident Census and Conditions of Resident form dated 1/9/06. The findings are: 1. On 1/11/06 at 9:30 a.m., the following observations were made:	F 371		

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F 371	Continued From page 9 a. A half gallon of frozen milk was thawing at room temperature on the counter by the window opposite the food preparation sink. b. The blender on top of the food preparation counter by the hand washing sink had dried yellow food on the inside, edges and the blade that rotated the food. At 11:40 a.m., Dietary Employee #1 started to pour green bean casserole into the blender she was stopped and shown what was inside the blender by a surveyor. The employee stated, "I used the blender to crumble corn flake." c. A bowl and hand mixer whisks used to prepare diabetic chocolate pudding were left on food preparation counter uncovered. At 9:45 a.m., Dietary Employee #1 picked up a half gallon of milk that had been thawing in the sink and poured the half gallon of milk into the same pan used to prepare diabetic chocolate pudding. While she was pouring the milk into the pan, water from the body of milk gallon was dripping into the bowl. She then added a bag of chocolate pudding mixture and used the same whisk attached to the hand mixer that was covered with left over diabetic chocolate pudding, to mix chocolate pudding to be served to residents on a regular diet at the lunch meal. 1) At 9:45 a.m., the frozen gallon of milk by the window was placed in the sink at room temperature without cold running water over it to thaw it. The half gallon of milk remained in the sink until 11:15 a.m., when Dietary Employee #1 picked up the half gallon of milk from the sink, took out prepared chocolate pudding from the refrigerator and poured the remaining milk into	F 371			

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F 371	<p>Continued From page 10</p> <p>the pudding. She then mixed it up again and placed it back in the refrigerator.</p> <p>d. There was a fly in the kitchen.</p> <p>e. There was sliced ham in an original packet and sliced ham stored in a zip lock bag inside the refrigerator that were open exposing them to cross contamination.</p> <p>f. In the bottom of the refrigerator were plastic storage containers that had a yellow/brownish liquid mixed with black substance. One of the containers had loose onion leaves in it and there was a loose molded tomato on top of the onion leaves.</p> <p>g. A bag of frozen chicken stored in the freezer in the storage room was torn open exposing the chicken to freezer burn.</p> <p>h. The vent hood over the stove had a thick accumulation of greasy lint hanging down. The oven metal attachment had spilled dried foods, grease and black substance on it. The grease trap had an accumulation of dried food items and oil in it. The gas line metal boards located at the bottom front of the oven had thick accumulation of lint and food crumbs. Dietary Employee #1 stated it was cleaned two months ago by maintenance. The facings were missing on both ovens.</p> <p>i. In a green pitcher located on top of the ice machine in the dining room, where the ice scoop was stored, there was standing water that contained a strand of hair.</p> <p>2. On 1/11/06 at 4:40 p.m., the temperature of</p>	F 371		

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F 371	Continued From page 11 food stored on ice to be served was taken by Dietary Employee #2: a. Macaroni salad with mayonnaise was 90 degrees F. b. Pureed chicken salad was 62 degrees F. c. Pureed Macaroni salad was 78 degrees F. d. Chicken salad was 62 degrees F.	F 371		