

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/19/2007
NAME OF PROVIDER OR SUPPLIER SUMMIT HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 506 NORTH LONG AVENUE 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 281} SS=D	<p>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure supra pubic catheter care was performed by licensed nursing staff only for 1 of 1 case mix residents (Resident #7) who had supra pubic catheter. This failed practice had the potential to affect only 1 resident who had a suprapubic catheter according to the ADON (Assistant Director of Nursing) on 1/19/07 at 11:30 a.m. The findings are:</p> <p>1. The Facility policy for Suprapubic Catheter Care documented that Suprapubic Catheter Care was the, "Basic Responsibility: (of)Licensed Nurse."</p> <p>2. Resident #7 had diagnoses of Non-Insulin Dependent Diabetes Mellitus and Urethral Blockage. The Significant Change Minimum Data Set dated 11/1/06 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with personal hygiene and had an indwelling catheter.</p> <p>a. A physician order dated 1/3/07 documented, "Clarification order: Change S/P (suprapubic catheter) monthly [with] 26 french [with] 30 cc (cubic centimeter) bulb. Change S/P cath (catheter) PRN (as needed) occlusion/accidental removal. Send to ER for replacement on the 29th & PRN."</p>	{F 281}		
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 281}	Continued From page 1 b. On 1/18/07 at 3:55 p.m., CNA (Certified Nursing Assistant) #1 provided supra-pubic catheter care. The suprapubic catheter had a small amount of old dried blood on it approximately 1/3 to 1/2 inch from the abdomen. The CNA grasped the catheter with one hand and wiped the tube from about 2 inches out wiping toward the abdomen. The CNA put on a clean incontinence brief and the resident's trousers. c. On 1/18/07 at 5:55 p.m., RN (Registered Nurse) #1 asked how the care went. When the care was described to RN #1 she stated, "CNAs are not supposed to give supra pubic catheter care. It is only done by nurses in this facility."	{F 281}			
{F 282} SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure Lantiseptic cream was applies to the buttocks after an incontinent episode for 1 of 1 case mix resident (Resident #5) who had a physician order to apply Lantiseptic cream to the buttocks after an incontinent episode. This failed practice had the potential to affect 4 residents who had orders for preventive skin care, according to a list provided by the Nurse Consultant on 1/19/07 at 12:09 p.m. The findings are: Resident #5 had diagnoses of Alzheimer's	{F 282}			

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{F 282}	Continued From page 2 Disease, Osteoporosis and Seizures. The Quarterly Minimum Data Set dated 12/22/06 documented the resident was severely impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and had a stage 1 skin ulcer. a. The January 2007 Physician Order sheet documented, "Lantiseptic to buttocks after each incontinence episode." b. On 1/17/07 at 9:55 a.m., CNA (Certified Nursing Assistant) #2 and 3 performed incontinent care but did not apply Lantiseptic cream to the buttocks. c. On 1/18/07 at 10:10 a.m., CNA #5 and 4 performed incontinent care but did not apply Lantiseptic cream to the buttocks.	{F 282}			
{F 309} SS=D	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 ensure the entire supra pubic catheter was cleaned completely and the urinary drainage bag was not lying on the floor for 1 of 1 case mix residents (Resident #7) who had supra pubic catheter. This failed practice had the potential to affect only 1 resident who had a	{F 309}			

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{F 309}	Continued From page 3 suprapubic catheter according to the ADON (Assistant Director of Nursing) on 1/19/07 at 11:30 a.m. The findings are: Resident #7 had diagnoses of Non-Insulin Dependent Diabetes Mellitus and Urethral Blockage. The Significant Change Minimum Data Set dated 11/1/06 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with personal hygiene and had an indwelling catheter. a. A physician order dated 1/3/07 documented, "Clarification order: Change S/P (suprapubic catheter) monthly [with] 26 french [with] 30 cc (cubic centimeter) bulb. Change S/P cath (catheter) PRN (as needed) occulusion/accidental removal. Send to ER for replacement on the 29th & PRN." b. On 1/18/07 at 3:55 p.m., CNA (Certified Nursing Assistant) #1 provided supra-pubic catheter care. The CNA assembled a small stack of peri wipes which she stated were moistened with peri wash. She removed the incontinence brief. The suprapubic catheter had a small amount of old dried blood on it approximately 1/3 to 1/2 inch from the abdomen. The CNA grasped the catheter with one hand and wiped the tube from about 2 inches out wiping toward the abdomen. She wiped, then turned the 'wipe' to a fresh surface before each wipe. She discarded the 'wipe' and repeated the procedure with several more wipes. The CNA put on a clean incontinence brief the resident's trousers. The resident was transferred back to the wheelchair. During incontinent care the urine collection bag was not in the privacy bag and was laying on the	{F 309}			

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{F 309}	Continued From page 4 floor. After the resident was placed in the wheel chair the CNA started to reposition the resident, The urine collection bag was on the floor under the wheelchair. The surveyor pointed this out to the CNA and the CNA picked up the bag and put it into the privacy bag.	{F 309}			
{F 314} SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure Lantiseptic cream was applied to the buttocks after an incontinent episode for 1 of 1 case mix resident (Resident #5) who was at risk for developing pressure sores. This failed practice had the potential to affect 10 resident who had pressure sores according to the Resident Census and Conditions of Residents form dated 1/16/06. The findings are: Resident #5 had diagnoses of Alzheimer's Disease, Osteoporosis and Seizures. The Quarterly Minimum Data Set dated 12/22/06 documented the resident was severely impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and had a stage 1 skin ulcer.	{F 314}			

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{F 314}	Continued From page 5 a. The January 2007 Physician Order sheet documented, "Lantiseptic to buttocks after each incontinence episode." b. On 1/17/07 at 9:55 a.m., CNA (Certified Nursing Assistant) #2 and 3 performed incontinent care but did not apply Lantiseptic cream to the buttocks. c. On 1/18/07 at 10:10 a.m., CNA #5 and 4 performed incontinent care but did not apply Lantiseptic cream to the buttocks.	{F 314}			
{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 resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Surveyor: Ford, Pat A Based on observation and record review, the facility failed to ensure clean peri wipes were not placed on a unclean surface and dirty peri wipes were not placed on the same surface next to clean peri wipes after providing suprapubic catheter care. This failed practice had the potential to affect only 1 resident who had a suprapubic catheter according to the ADON (Assistant Director of Nursing) on 1/19/07 at	{F 441}			

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{F 441}	<p>Continued From page 6 11:30 a.m. The findings are:</p> <p>Resident #7 had diagnoses of Non-Insulin Dependent Diabetes Mellitus and Urethral Blockage. The Significant Change Minimum Data Set dated 11/1/06 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with personal hygiene and had an indwelling catheter.</p> <p>a. A physician order dated 1/3/07 documented, "Clarification order: Change S/P (suprapubic catheter) monthly [with] 26 french [with] 30 cc (cubic centimeter) bulb. Change S/P cath (catheter) PRN (as needed) occlusion/accidental removal. Send to ER for replacement on the 29th & PRN."</p> <p>b. On 1/18/07 at 3:55 p.m., CNA (Certified Nursing Assistant) #1 performed supra-pubic catheter care. The CNA assembled a small stack of peri wipes which she stated were moistened with peri wash. These were placed in a stack on the bed side table on the wood surface. The surface of the table was not cleaned beforehand by CNA #1. After she cleaned the catheter the CNA piled the soiled wipes up on the top of the bedside table next to the clean wipes. She did not have a bag or receptacle for contaminated items.</p>	{F 441}			