

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

PRINTED: 04/18/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04A145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/11/2008
NAME OF PROVIDER OR SUPPLIER YELL COUNTY NURSING HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 502 WEST PENNINGTON OLA, AR 72853		
(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 221} SS=E	<p>483.13(a) PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a physician order and an informed consent were obtained and a pre-restraint assessment was completed to determine the medical necessity and the least restrictive restraint device prior to the use of a restraint for 2 (Resident #6 and 9) of 5 case-mix residents (Resident #1, 4, 6, 7 and 9) who used a restraint/or geri-chair with a tray. These failed practices had the potential to 10 affect residents who used a restraint according to a list provided the Assistant Director of Nurses (ADON) on 4/11/08. The findings are:</p> <p>1. Resident #9 had diagnoses of Osteoporosis of Left Knee Cap and History of Ankle Fracture. The Quarterly MDS (Minimum Data Set) dated 1/14/08 documented the resident was moderately impaired in cognitive skills for daily decision making, totally dependent on staff for transfers and did not require the use of a restraint.</p> <p>a. As of 4/8/08, there was no documentation in the clinical record of a physician order for the use of a restraint.</p> <p>b. On 4/8/08 at 8:55 a.m., 10:50 a.m. and 2:48 p.m.; and 4/9/08 at 8:53 a.m. and 3:18 p.m., the resident was in a wheel chair with a self release seat belt in place. On 4/8/08 at 2:48 p.m. and</p>	{F 221}			

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 221}	<p>Continued From page 1</p> <p>4/9/08 at 8:53 a.m., the resident was asked to release the self release seat belt, but was unable to do so.</p> <p>c. As of 4/9/08, there was no documentation in the clinical record of pre-restraint assessment to determine the least restrictive restraint device or an informed consent for the use of a self release soft belt restraint.</p> <p>c. On 4/9/08 at 1:30 p.m., the Social Service/Activity Director was asked to provide an informed consent and a pre-restraint assessment for the use of a self release soft belt restraint. She was unable to provide the requested documentation.</p> <p>d. On 4/9/08 at 3:18 p.m., this surveyor and the Social Service/Activity Director entered the resident's room. The resident was sitting in a wheelchair with a self release belt restraint in place. The Social Service/Activity Director asked the resident to release the self-release soft belt. The resident struggled with the belt for approximately 3 minutes and was unable to release the belt. The Social Service/Activity Director again asked the resident to release the belt. The resident stated, "I can't."</p> <p>2. Resident #6 had diagnoses of Pelvic Fracture History, Diabetes, Hypertension and Depression. The Quarterly MDS dated 2/11/08 documented the resident had modified independence in cognitive skills for daily decision making, required extensive assistance of two staff members for transfers and mobility, maintained her position while sitting with trunk control, had functional limitation in range of motion in one leg only, and did not require the use of a restraint.</p>	{F 221}			

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{F 221}	Continued From page 2 a. On 4/7/08 at 2:18 p.m. and 4:13 p.m., 4/8/08 at 10:05 a.m. and 3:58 p.m. the resident was in a geri chair with a tray attached. b. A Social Progress Notes dated 2/11/08 documented, "...She continues to be up daily in personal recliner, ambulates with assist of two daily." c. As of 4/8/08, there was no documentation in the clinical record of a physician order, pre-restraint assessment or informed consent prior to the use of the geri-chair with a tray. d. On 4/8/08 at 4:25 p.m., when was asked for the restraint information for this resident, the MDS Director stated, "The geri chair is used as an enabler because her recliner wouldn't work any more so we use the geri chair for her." The Director was not able to present a physician order, pre-restraining assessment or consent for the use of the geri chair.	{F 221}			
{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 and record review, the facility failed to ensure the urinary catheter was secured during incontinent care to prevent	{F 309}			

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{F 309}	Continued From page 3 potential trauma to the urinary meatus for 1 (Resident #2) of 2 case mix residents (Resident #2 and 3) who had a urinary catheter. This failed practice had the potential to affect 6 residents who had a Foley catheter according to the list provided by the ADON (Assistant Director of Nursing) on 4/11/08. The findings are: Resident #2 had diagnoses of Retention of Urine and Decubitus. The Quarterly Minimum Data Set dated 4/8/08 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent of bowel, had an indwelling catheter and required total assistance of staff for personal hygiene and bathing. a. On 4/10/08 at 2:50 p.m., CNA (Certified Nursing Assistant) #1 provided Foley catheter care. CNA #1 cleaned the Foley Catheter from the point of insertion outward. CNA #1 did not secure the catheter at the point of insertion 4 out of 5 times resulting in the catheter being pulled taunt causing possible trauma to the urinary meatus.	{F 309}			
{F 322} SS=E	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 and record review, the	{F 322}			

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{F 322}	Continued From page 4 facility failed to ensure infection control procedures were followed during administration of flushes and medications for 2 (Resident #2 and #3) of 2 case mix residents who had a feeding tube. This failed practice had the potential to affect 5 residents who had a feeding tube as identified by the Assistant Director of Nurses on 4/11/08. The findings are: 1. Resident #3 was admitted on 4/7/08 and had diagnoses of Malnutrition, Anorexia and Gastroesophageal Reflux Disease. a. A physician order dated 4/7/08 documented, "240 cc (cubic centimeter) H2O (water) per tube QID (4 times a day) Flush 30 cc before and after meds Formula: Fibersource 45 cc hr (per hour)..." b. On 4/9/08 at 3:10 p.m., Licensed Practical Nurse (LPN) #1 turned back the sheet to expose the feeding tube insertion site, disconnected the feeding tube from the insertion site and placed the uncovered tip inside the opened clear plastic bag used to hold the syringe that was placed on top of the turned back sheet. The uncapped syringe was placed on top of the sheet without a protective barrier and the syringe plunger was removed and placed directly on the sheet. The LPN infused 240 cc of water into the feeding tube, then placed the plunger in the syringe. The uncapped syringe was again placed directly on top of the turned back sheet. The uncapped feeding tube tip was reconnected to the tubing and the uncapped syringe returned to the clear plastic bag. c. On 4/10/08 at 8:45 a.m., LPN #1 administered medications via the feeding tube. The LPN laid the stethoscope's bell on the bed and picked it up	{F 322}			

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{F 322}	Continued From page 5 to check the resident's tube placement. The LPN laid the syringe on the pulled back sheet while working with the insertion tube. The plunger from the syringe was laid on the pulled back sheet and the resident's incontinent brief. The LPN placed the plunger back into the syringe and hung the syringe back up on the tube pole to be used for the next administration. 2. Resident #2 had diagnoses of Esophageal Reflux, Dysphagia, Organic Mental Syndrome, Depression and Alzheimer's Disease. The Quarterly Minimum Data Set dated 1/11/08 documented the resident was moderately impaired in cognitive skills for daily decision making, totally dependant on staff for eating and received 75-100% and 2001 cc daily from a feeding tube. a. A physician order dated 4/7/08 documented, "240 cc H2O (water) per tube QID Flush 30 cc before and after meds Flush 60cc H2O per tube BID (twice a day) Formula: Fibersource 50 cc hr (per hour)..." b. On 4/10/08 at 8:05 a.m., LPN #2 administered medications via the tube feeding. The LPN laid the plunger on the outside of the plastic bag, administered Arginaid, picked up the plunger, replaced the plunger into the syringe and hung it back up on the tube pole to be used for the next administration. 3. The Policy for PEG (Percutaneous Endoscopic Gastrostomy)/NG (Nasogastric) Tube Irrigation provided by the Assistant Director of Nurses on 4/11/08 documented, "Infection Control: 1. Observe Universal Precautions."	{F 322}			
{F 329}	483.25(l) UNNECESSARY DRUGS	{F 329}			

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{F 329} SS=D	Continued From page 6 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 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. 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. This REQUIREMENT is not met as evidenced by: Based record review the facility failed to ensure there was clinical rationale for the continued use for Proton Pump Inhibiting drug (Pepcid) for 1 Residents (Residents #2) of 4 case mix residents (Resident # 2, 5, 7 and 9) who received Pepcid. This failed practice had the potential to affect 15 residents who received Pepcid according to a list provided by the Assistant Director of Nursing on 4/11/08. The findings are:	{F 329}			

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{F 329}	Continued From page 7 Resident #2 had a diagnosis of Esophageal Reflux. The Quarterly MDS (Minimum Data Set) dated 4/8/08 documented the resident was moderately impaired in cognitive skills for daily decision making. a. A physician order dated 10/23/05 documented Pepcid 20 mg (milligrams) 1 tablet per feeding tube. b. As of 4/10/08, there was no documentation in the clinical record for the clinical justification for the continued use Pepcid 20 mg.	{F 329}		
{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 and record review, the facility failed to follow physician's orders to ensure that residents were free of significant medication error for 1 of 1 case mix resident (Resident #10) who received sliding scale insulin. This failed practice had the potential to affect 8 residents receiving sliding scale insulin medication according to the Assistant Director of Nursing (ADON) on 4/10/08. The findings are: Resident #10 had a diagnosis of Insulin Dependent Diabetes Mellitus. a. A physician telephone order dated 4/8/08 documented, "Increase Insulin Novolin N 100 units to 10 units every morning 5 units every p.m. Start pt (patient) on sliding scale." The order documented Sliding Scale Insulin as follows:	{F 333}		

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F 428	<p>Continued From page 9</p> <p>Based on record review, the facility failed to ensure the pharmacy consultants recommendations were acted upon for 2 (Resident #2 and 9) of 8 (Residents #2 through 9) case-mix residents who received medications. These failed practices had the potential to affect 39 residents who were on antidepressant medications according to a list provided by the Assistant Director of Nursing on 4/11/08. The findings are:</p> <p>1. Resident #2 had a diagnosis of Esophageal Reflux. The Quarterly MDS (Minimum Data Set) dated 4/8/08 documented the resident was moderately impaired in cognitive skills for daily decision making.</p> <p>a. A physician order dated 5/4/05 documented Paxil 20 mg 1 per tube and an order dated 5/19/05 documented Trazodone 50 mg tablet per tube at bedtime.</p> <p>b. The Consultant Pharmacist Monthly QA (Quality Assurance) Report dated 3/27/08 documented, "...Paxil 20 mg Qday (everyday) since 5/4/05 and Trazodone 50mg HS (at bedtime) since 9/19/05 diagnosis depression, need current Geriatric Depression scale and documentation by nursing staff and social services of depressive episodes to justify continuation of these meds." The report was signed by the pharmacy consultant, but not by any of the facility staff to acknowledge the recommendations.</p> <p>c. As of 4/10/08, there was no documentation in the clinical record that the physician was notified of these recommendations.</p>	F 428			

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F 428	Continued From page 10 2. Resident #9 had diagnoses of PUD (Peptic Ulcer Disease), Gastrostomy and Colitis. The Quarterly MDS dated 1/14/08 documented the resident was moderately impaired in cognitive skills for daily decision making. a. A physician order dated 1/17/06 documented Trazodone 50 mg give 1/2 tablet (25mg) at bedtime and an order dated 2/23/07 documented Paxil 20 mg 1 tablet daily. b. The Consultant Pharmacist Monthly QA Report dated 3/27/08 documented, "...Paxil 20 mg Q Day since 2/23/07, resident recently on 3/24/08 had Trazodone 25 mg HS DC'ed (discontinued) diagnosis of depression; need current Geriatric Depression scale and documentation by nursing staff and social services of depressive episodes to justify continuation the these meds." The report was signed by the pharmacy consultant, but not by any of the facility staff to acknowledge the recommendations. c. As of 4/10/08, there was no documentation in the clinical record that the physician was notified of these recommendations.	F 428			
{F 441} SS=F	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.	{F 441}			

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{F 441}	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the infection control program identified correct onset dates, sites of infection, whether cultures were obtained, identified organisms, and dates the infections were resolved or the antibiotics ordered were completed to provide information for trending and investigative purposes. This failed practice had the potential to affect all 57 residents as identified by the Director of Nurses (DON) on 4/7/08. The findings are: 1. The Infection Control Log dated 3/1/08 through 4/8/08 was provided by the Assistant Director of Nursing on 4/9/08 at 2:15 p.m. The log documented that on 3/17/08 Resident #8 had an onset date for a recent infection. The nurses notes dated 3/13/08 documented Resident #8 was transferred to hospital and returned on 3/17/08. The infection control log documented in the "Site" column, "from (local hospital)." 2. On 4/9/08 at 3:45 p.m., the Assistant Director of Nurses (ADON) was asked what "SC" meant under the heading of "admit date", and she stated, "I don't know, you would have to ask Licensed Practical Nurse (LPN) #2 that. She fills out the form. On the second page I see room numbers and north or south hall." The ADON was asked what the entry "from (local hospital)" meant under the site and infection related diagnosis column, the ADON stated, "That	{F 441}			

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{F 441}	<p>Continued From page 12</p> <p>just means they came back from the hospital and had antibiotics ordered. The infection started here usually."</p> <p>The ADON was asked about the onset date column for Resident #8 listed as 3/17/08 and a check mark under the column of "Culture, No", the ADON stated, "I assume he went to the hospital because of infection and 3/17 is when he came back to us. How would I know what the organism was or if a culture was done? I guess I would have to call the hospital."</p> <p>The ADON was asked if the hospital sent copies of hospital records upon the resident's return to the facility, such as physician notes and labs, the ADON stated, "Yes. I guess we could look at that and if it's not there, call the hospital."</p> <p>The ADON was asked if she could tell if the facility might have an infection control problem that needs investigation and interventions by looking at the Infection Control Log, the ADON stated, "I can't (tell)."</p> <p>3. The Infection Control Log documented 25 resident entries from 3/1/08 through 4/8/08. In the "Site and Infection Related Dx (diagnosis)" column, 8 of these entries documented, "from (local hospital)", 9 entries were blank under "Site", 4 entries documented "RTF (return to facility)", 22 were checked for "No" under the column "Culture" with 2 other entries left blank, antibiotic medications were written for all 25 residents under the column "Antibiotic", 24 of the entries under the column "date resolved" documented "completed" with no specific date and all 25 entries had no documentation in the column of "Organism."</p>	{F 441}			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04A145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/11/2008
NAME OF PROVIDER OR SUPPLIER YELL COUNTY NURSING HOME, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 502 WEST PENNINGTON OLA, AR 72853		
(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 441}	Continued From page 13 4. The Infection Control Log Guidelines provided by the ADON on 4/10/08 at 8:50 a.m. documented, "Document onset of infection as evident by antibiotic order. Address symptoms if present. Culture as per physician's order. If culture is done, then document identified organism when culture returns... chart the date the antibiotic is completed or changed."	{F 441}		