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	04A145	A. BUILDING ______ B. WING ______	R 06/01/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELL COUNTY NURSING HOME, INC	**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 164} SS=E	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the residents' personal information including diagnoses, treatment, medication and ordered laboratory test were protected from view of others who did not require knowledge of this information. This failed	{F 164}		

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 164}	Continued From page 1 practice had the potential to affect 23 residents who resided on the south hall according to the listing provided by the Assistant Director of Nursing on 5/31/07. The findings are: 1. The facility's "Resident Rights" documented "... (e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. (1) Personal privacy includes accomodation, medical treatment, ..." 2. On 5/30/07 at 9:25 a.m., on the south hall in the alcove next to the nursing station on the bulletin board there was a listing dated 2/4/07that identified residents residing on the south hall who were Diabetics; who required pro-times and specified the medication which required the routine pro-time; and residents with Foley catheters. 3. On 5/30/07 at 3:20 p.m., the Administrator was informed of the above listing found at the south nursing station. The Administrator stated "This should not be posted, it is a violation of our privacy policy".	{F 164}		
{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 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure that residents' private space was respected as evidenced by staff not knocking on	{F 241}		

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{F 241}	Continued From page 2 resident doors and requesting permission to enter the resident's room for 2 of 3 (Resident # 2, # 3, and # 8) case mix residents and two non case mix residents rooms who resided on the south hall. This failed practice had the potential to affect 23 residents who resided on the south hall according to the listing provided by the Assistant Director of Nursing on 5/31/07. The findings are: 1. The facility's Resident Rights documented, "... Quality of Life, A facility must care for its residents in a manner and an environment that promotes maintenance or enhancement of each resident's quality of life. (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 full recognition of his or her individuality. 2. Resident # 3 had diagnoses of Cerebral Vascular Accident (CVA), Chronic Obstructive Pulmonary Disease (COPD), and Alzheimer's Disease. The Quarterly Minimum Data Set (MDS) dated 3/12/07 documented the resident had moderately impaired cognitive skills for daily decision making and the resident had no problems making self understood or understanding others. a. On 5/30/07 at 1:50 p.m., Nursing Assistant's (NA) # 1 and # 2 entered the resident's room without knocking or announcing their entrance into the resident's room. The resident was in bed in her room on the South hall. b. On 5/30/07 at 2:00 p.m., NA # 1 and # 2 entered the resident's room without knocking or announcing their entrance into the resident's room.	{F 241}		

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{F 241}	Continued From page 3 3. Resident # 8 had a diagnoses of Postural Deformity, CVA, Intermittent Explosive Disorder, and Paralytic Polio. The Quarterly Minimum Data Set dated 3/19/07 documented the resident was moderately impaired in cognitive skills for daily decision making and that the resident had no problems making self understood or understanding others. a. On 5/30/07 at 1:55 p.m., NA # 2 entered the resident's room without knocking or announcing her entrance into the room. The resident was in bed in his room on the South hall. b. On 5/30/07 at 1:58 p.m., NA # 1 entered the resident's room without knocking or announcing her entrance into the resident's room. The resident was in his room. 4. On 5/30/07 at 1:52 p.m., NA # 1 entered South room # 14 without knocking or announcing entrance. The resident was present in the bed. 5. On 5/30/07 at 1:52 p.m. NA # 2 entered South room # 9 without knocking or announcing entrance. The resident was present in the room. 6. On 5/30/07 at 2:10 p.m., NA # 2 was asked what were you taught concerning procedures for privacy and dignity. NA # 2 stated "Before we enter a room, knock on the door ..." 7. On 6/1/07 at 10:05 a.m., the Assistant Director of Nursing (ADON) stated, "They know they are supposed to knock - we have gone over that."	{F 241}		
{F 281} SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility	{F 281}		

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{F 281}	Continued From page 4 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that Novolin 70/30 and Regular insulin was drawn up according to acceptable standards of practice for 1 resident (Resident #9) of 1 case mix residents that had orders for insulin administration. The failed practice had the potential to affect 5 residents on the South Hall who had physician orders for Regular Insulin (floor stock) as identified by the Director of Nurses on 5/30/07 at 9:35 a.m.. The findings are: Resident #9 had physician orders dated 12/13/04 for Novolin 70/30 Insulin 100 units(u)/milliliter (ml) give 14 units Subq (subcutaneous) q (every) evening and orders dated 12/12/06 for Sliding Scale Regular Insulin as follows: 250-299 give 5U SQ (subcutaneous) 300-399 give 8U SQ 400-450 give 10U SQ 450 and above give 15 U SQ and call MD a. On 5/29/07 at 3:44 p.m. during the 4:00 p.m. medication pass, LPN #1 performed a fingerstick blood sugar on the resident with a reading of 366. b. On 5/29/07 at 3:44 p.m., LPN #1 drew up 14 units of Novolin 70/30 (cloudy) Insulin first, then drew up 8 units of Regular insulin (clear) second using the same syringe. c. On 5/29/07 at 5:10 p.m., a surveyor asked the Assistant Director of Nursing (ADON) for "any policy on insulin administration, drawing up insulin	{F 281}		

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{F 281}	Continued From page 5 or mixing insulin". The ADON stated "I'll have to check". d. On 5/29/07 at 5:32 p.m., the ADON stated, "there is no policy on drawing up insulin, not that I can find". The surveyor asked if a resident gets Novolin 70/30 and regular insulin, what should be drawn up first? The ADON responded, "Novolin". The surveyor asked do you have any concerns with Regular Insulin being drawn up in the same syringe last. The ADON responded, "No, most of my nurses don't mix, they draw up in 2 syringes". The surveyor asked if the ADON could check the drug books to see if there was anything there about the order for drawing up insulin. The ADON responded "OK, but I'm not sure I'll find anything." e. On 5/29/07 at 6:05 p.m., the ADON stated "We do have a policy, I found it on our pharmacy web site. It says to draw up clear to cloudy." The surveyor asked the ADON for a copy of the policy. The ADON stated "I'll have to call them in the morning. Remind me in the morning. I've taken care of the Regular Insulin bottle on the South Hall". [The ADON disposed of the bottle]. f. The 2004 Lippincott's Nursing Drug Guide, on page 632, documented, "Use caution when mixing two types of insulin; always draw the regular insulin into the syringe first." g. On 5/30/07 at 10:55 a.m., the ADON provided the online facts and comparisons printed information on Insulin mixtures: When mixing 2 types of insulin, always draw clear regular insulin into the syringe first.	{F 281}		
{F 282} SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS	{F 282}		

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{F 282}	Continued From page 6	{F 282}		

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, record review and interview, the facility failed to ensure the Physician's plan of care was implemented for 1(Resident #4) of 2 (Residents #4 and #8) case-mix resident's who had Physician Orders for a Regular LCS (Low Concentrated Sweet) Blended diet. This failed practice had the potential to affect 19 residents who had Physician Orders for a Blended diet as documented on the diet roster dated 5/29/07. The findings are:

1. Resident #4 had diagnoses of Cerebral Vascular Accident and Dementia with Behavioral Disturbances. The Minimum Data Set dated 3/12/07 documented the resident had moderately impaired cognitive skills for daily decision making and was dependent on staff for eating.

a. A Physician Order dated 5/10/07 documented Regular Blended with Low Concentrated Sweets.

b. The Menu for the 5/29/07 dinner meal documented for a regular diet: Sausage/gravy, fried potatoes, biscuit, margarine, plums, rice krispie treat, milk, coffee, apple juice and graham crackers. The menu for blended diet documented: blended sausage/gravy, mashed potatoes, blended biscuit, blended plums.

c. On 5/29/07 at 5:20 p.m., the resident received

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{F 282}	Continued From page 7 and the daughter in law was feeding the resident sausage (cut up), gravy, a whole biscuit, graham crackers, a grilled cheese sandwich and fruit cocktail. d. On 5/31/07 at 2:25 p.m., the dietary manager stated, "He is on a blended diet. ... He should have received a blended diet, that was a mistake.	{F 282}		
{F 309} SS=E	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 Foley catheter tubing was secured to prevent potential trauma to the urinary meatus for 1 (Resident #8), the foley catheter was not raised above bladder level to decrease the risk of infections for 2 (Residents #3 and 8), the foley catheter drainage bag was not positioned on the floor for 1 (Resident #3) and that the foley catheter tubing was not occluded by the resident foot rest when up in a geri chair for 1 (Residents #2) of 3 case mix residents with Foley catheters (Residents # 2, 3, and 8). This failed practice had the potential to affect 8 residents with Foley catheters according to the listing provided by the Assistant Director of Nursing on 5/31/07. The findings are: 1. On 6/1/07 at 10:40 a.m., the Assistant Director	{F 309}		

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of Nursing (ADON) provided the following information, that was covered during inservice on Foley catheters, from "How to be a Nurse Assistant Career Training in Long Term Care Student Textbook" published by the American Health Care Association. The resource documented "Special Intervention or Skills for Care: ... When you help residents with urinary catheter change position, follow these guidelines: The external part of the catheter tube is secured to a resident's inner thigh with tape to prevent pulling of the catheter when he or she moves. ... Check tubing for kinks and leaks. The urinary drainage bag is secured to the bed or chair below the resident's bladder, so that the urine flows from the bladder into the bag by gravity. Note: Never let the drainage bag touch the floor, which is considered an "unclean" area. Never lift the drainage bag above a resident, as urine could flow back into the bladder, increasing the risk of infection. ...". The inservice was given by the ADON but was unable to give the date of the inservice.

2. Resident # 8 had a diagnosis of Urinary Retention. A physician order dated 6/8/06 documented, "Foley catheter". The Quarterly Minimum Data Set (MDS) dated 3/19/07 documented the resident had moderately impaired cognitive skills for daily decision making, required total dependence for staff support for activities for daily living, and had an indwelling catheter.

a. On 5/30/07 at 10:25 a.m., Nursing Assistant's (NA) # 1 and # 2 transferred the resident from the wheelchair into an empty bathtub without the catheter tubing being secured with a leg strap, stretching the catheter tubing and causing tension

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on the urinary meatus. NA # 1 hung the urinary drainage bag on her right top uniform pocket during the transfer. After the resident was sitting in the empty bathtub, both NA # 1 and 2 hooked the urinary drainage bag on the left wheelchair arm rest. The urinary drainage bag was above the level of the resident's bladder. The NA's were asked by surveyor if the resident had a leg strap to secure the catheter. NA # 2 stated, "He has one and I just took it off for his bath."

b. On 6/1/07 at 9:00 a.m., NA # 2 was asked what were the measures for preventing trauma with catheters. NA # 2 stated, "Catheter bag covers - if they drag the floor change them. Never put the bag above the resident." NA # 2 was asked what she was taught about securing a catheter. NA # 2 stated, "Use a leg band".

3. Resident # 3 had a diagnoses of Retention of Urine and Decubitus. A physician order dated 4/30/05 documented, "# 24/30 fr [French] Foley catheter Dx [diagnosis] UA [urinary] Retention." The Quarterly Minimum Data Set (MDS) dated 3/12/07 documented the resident had moderately impaired cognitive skills for daily decision making, had an indwelling catheter, had a decubitus and was totally dependent on staff for activities of daily living.

a. On 5/31/07 at 8:32 a.m., the resident's catheter bag was in the privacy bag and lying on the floor directly below the left bed rail.

b. On 5/31/07 at 8:54 a.m., Certified Nurses Assistant (CNA) # 3 picked the resident's catheter bag up from the floor and held the bag above the level of the resident and bed during catheter and incontinent care. Urine in the catheter bag flowed

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{F 309}	Continued From page 10 back up the tubing and toward the bladder. 4. Resident # 2 had diagnoses of Urinary Incontinence, Renal Failure with Retention and Urinary Sphincter Deficiency. A physician order dated 3/1/05 documented "#26/30 fr [french] Foley catheter Dx [diagnosis] Renal Failure with Retention." The quarterly Minimum Data Set (MDS) dated 5/28/07 documented that the resident had moderately impaired cognitive skills for daily decision making and had an indwelling catheter. a. The Care Plan reviewed on 5/28/07 documented, "Resident requires Foley catheter ... Approach: ... 2. Catheter care per nursing home protocol..." b. On 5/30/07 at 11:55 a.m., the resident was in a geri-chair with the foot rest in the down position. The urinary drainage bag was not seen and tubing was occluded by the lowered foot rest. Certified Nurses Assistant (CNA) # 1 who feeding the resident lunch was asked where the Foley drainage bag was. CNA # 1 stated, "Under the chair. I'll have to fix that I thought it was hung on the side of the chair not underneath. I'm glad you asked where it was - I usually pay more attention to it than that." 5. On 6/1/07 at 10:05 a.m., the Assistant Director of Nursing (ADON) was asked should catheter bags be held above the level of the resident's bladder. The ADON stated, "No, we teach them not to hold them above the resident. We just went over that. The ADON was asked should leg bands be used to secure the catheter during care. The ADON stated, "Absolutely, they need leg bands during care especially - that's when they	{F 309}		

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{F 309}	Continued From page 11 are vulnerable." The ADON was asked when a resident is in a geri chair where should the catheter and tubing be placed. The ADON stated, "Actually they should move that Foley catheter and make sure it's properly aligned, put the footrest down and make sure they then reposition the catheter."	{F 309}		
{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 manner to promote good personal hygiene for 3 (Residents # 3, 6, and 8) of 7 case mix residents (Residents # 2 - 8) who were incontinent of bowel or bladder. This failed practice had the potential to affect 37 residents who were incontinent of bowel or bladder according to the listing provided by the Assistant Director of Nursing on 5/31/07. The findings are: 1. The facility's policy entitled "Incontinent Care" documented, "Purpose: 1. To keep skin clean, dry, free of irritation and odor. ... Procedure: ... 3. Wash all soiled skin areas and water, or peri-care wash. Rinse very well dry, especially between skin folds. ..." 2. Resident # 3 had diagnoses of Cerebral Vascular Disease (CVA), Retention of Urine, and Decubitus. The Quarterly Minimum Data Set	{F 312}		

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{F 312}	Continued From page 12 (MDS) dated 3/12/07 documented the resident had moderately impaired cognitive skills for daily decision making, had an indwelling catheter, had bowel incontinence and was totally dependent on staff for toilet use. a. The Care Plan dated 3/12/07 documented, "Problem: ... 18. At risk for problems r/t [related to] Dx [diagnosis] UA [Urinary] Retention; resident has Foley catheter ... Approach, ... 2. Foley care per nursing home protocol. ..." b. On 5/31/07 at 8:54 a.m., Certified Nursing Assistant (CNA) # 2 provided incontinent care and cleansed bowel movement from the rectal area only. CNA # 2 did not cleanse the urinary meatus, mons pubis, labia, and front genitalia area. 3. Resident # 8 had a diagnoses of CVA, Paralytic Polio, and Urine Retention. The Quarterly MDS dated 3/19/07 documented the resident had moderately impaired cognitive skills for daily decision making, had an indwelling catheter, and was totally dependent on staff for toilet use. a. On 5/31/07 at 9:30 a.m., CNA # 2 provided catheter care cleansing only the scrotum, groin areas, and wiped the catheter outward away from the meatus once. CNA # 2 did not cleanse the urinary meatus and penis. 4. Resident #6 had a diagnosis of Senile Dementia. The Minimum Data Set dated 4/16/07 documented the resident had moderately impaired cognitive skills for daily decision making, was incontinent of bowel and bladder and was totally dependent on staff for toilet use.	{F 312}		

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{F 312}	Continued From page 13 a. On 5/31/07 at 2:03 p.m., Certified Nurse Assistant # 4 performed incontinent care. The resident was incontinent of bowel and bladder. She cleansed the left and right groin area then mid labia. The resident turned to her left side. The CNA cleansed and dried the buttocks and rectal area. She did not cleanse the mons pubis and did not dry the groin or labia.	{F 312}		
{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, record review, and interview, the facility failed to ensure residents at risk or with actual pressure sores were dried following incontinent care for 3 (Residents # 3, 6, and 8) of 7 case mix residents Residents # 2 - 8) who were incontinent of bowel or bladder and at risk for the development of pressure sores. The facility failed to ensure clean technique was maintained during wound care to prevent possible cross contamination for 2 of 2 case mix residents (Resident # 3 and 4) who received wound care. These failed practices had the potential to affect 37 residents who were incontinent of bowel or bladder and 3 residents who received wound care per the listing provided by the Assistant Director	{F 314}		

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Continued From page 14
of Nursing on 5/31/07. The findings are:

1. The facility's policy entitled "Incontinent Care" documented "Purpose: 1. To keep skin clean, dry, free of irritation and odor. ... Procedure: ... 3. Wash all soiled skin areas and water, or peri-care wash. Rinse very well dry, especially between skin folds. ...".

2. The DermaCen Perineal Wash bottle documented "Directions for Use: Spray DermaCen Perineal Wash directly to where urine, feces, or emesis has soiled skin. ... Spray additional product on warm, wet cloth and gently wipe skin of all remaining residue. ... Pat dry. ...".

3. Resident # 3 had diagnoses of Cerebral Vascular Accident (CVA), Chronic Obstructive Pulmonary Disease (COPD), and Decubitus. The Quarterly Minimum Data Set dated 3/12/07 documented the resident had moderately impaired cognitive skills for daily decision making, had a Stage II pressure ulcer, and was incontinent of bowel.

a. A physician order dated 3/21/07 documented, "Clean area on coccyx with pHisoHex, rinse with water. Apply Dermagran gauze, cover with telfa and pad with 4 x 4 sponges for protection, change q [every] three days and prn [as needed] until healed."

b. On 5/31/07 at 8:54 a.m., Certified Nursing Assistant (CNA) # 2 provided incontinent care following an episode of bowel incontinence and did not dry the skin after applying DermaCen Perineal Wash.

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{F 314}	Continued From page 15 c. On 5/31/07 at 9:03 a.m., Registered Nurse (RN) # 1 provided decubitus wound care to the coccyx by cleansing the wound side to side inside the wound with a back and forth motion. RN # 1 then cleaned outside the decubitus crater using the same motion and then used the same area of the 4 x 4 to clean the inside of the wound again. RN # 1 rinsed the wound with water on a new 4 x 4 cleaning the inside, outside and then inside again using a back and forth motion with the same area of the 4 x 4. d. On 5/31/07 at 12:15 p.m., RN # 1 was asked how were you taught to cleanse wounds. RN # 1 stated "From the center out in a circle motion." 4. Resident # 8 had diagnoses of Cerebrovascular Disease, Postural Deformity and Paralytic Polio. The Quarterly Minimum Data Set (MDS) dated 3/19/07 documented that the resident had moderately impaired cognitive skills for daily decision making, was incontinent of bowel and received other preventative or protective skin care. a. The Care Plan reviewed on 3/19/07 documented, "At risk for skin breakdown r/t [related to] inability to reposition self, B&B [bowel and bladder] incontinence and poor skin integrity. ... Approach: ... 2. Keep resident as clean and dry as possible. ..." b. On 5/31/07 at 9:30 a.m. CNA # 2 provided catheter care and failed to dry after applying DermaCen Perineal Wash. 5. Resident #6 had a diagnosis of Senile Dementia. The Minimum Data Set dated 4/16/07 documented the resident had moderately	{F 314}		

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{F 314}	Continued From page 16 impaired cognitive skills for daily decision making, was incontinent of bowel and bladder and was totally dependent on staff for toilet use. a. On 5/31/07 at 2:03 p.m., Certified Nurse Assistant # 4 performed incontinent care. The resident was incontinent of bowel and bladder. CNA #4 did not dry the groin or labia area. The resident's groin area was excoriated. b. On 5/31/07 at 2:03 p.m., after completing the incontinent care, CNA #4 stated, "Yes you should dry the resident, I do."	{F 314}		
{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, record review, and interview, the facility failed to ensure Physicians orders were followed for the flow rate of a tube feeding for 1 resident (Resident #7) of 2 case mix residents (Resident #5 and #7) who received tube feedings. The failed practice had the potential to affect 3 residents who received tube feedings, as documented on a list provided by the Assistant Director of Nurses on 5/31/07. The findings are: 1. Resident #7 had diagnoses of Dysphagia,	{F 322}		

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{F 322}	Continued From page 17 Dementia, and Cerebral Vascular Accident (CVA). The Minimum Data Set (MS) dated 4/16/07 documented the resident had severely impaired cognitive skills for daily decision-making and had a feeding tube. a. A hand written physician order dated 4/20/07 documented: "Start tube feeding at 20cc per hour then protocol to 40cc (cubic centimeter) per hour." The printed Physician Orders for May 1 thru May 31, 2007 documented: "Tube Feeder." The flow rate of the tube feeding was not documented. b. On 5/29/07 at 2:31 p.m. and at 4:30 p.m., the resident was sitting in a Geri chair in his room. Fibersource was running via gastrostomy feeding tube at 50cc per hour via pump. c. On 5/30/07 at 8:50 a.m., 10:00 a.m., 11:30 a.m., and 2:07 p.m. Fibersource was running via gastrostomy feeding tube at 50cc per hour via pump. d. On 5/31/07 at 10:40 a.m., Licensed Practical Nurse (LPN) # 2 stated, "The last order was for 40cc per hour. Somebody probably thought it should have been 50, but it was supposed to be 40. They probably thought it was 50 because that is what it was before he went to the hospital. " e. On 5/31/07 at 9:12 a.m., the Medical Records Nurse stated, "I just put tube feeder on the printed May orders because it (the flow rate) was changing so frequently."	{F 322}		
{F 324} SS=J	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance	{F 324}		

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devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to ensure a resident at risk of elopement and with a history of elopement was adequately supervised as care planned to prevent elopement for 1 of 1 (Resident # 1) case mix resident who eloped from the facility at approximately 12:45 a.m. on 4/16/07 and was not returned to the facility until 8:30 a.m. This failed practice resulted in an immediate jeopardy, which caused or could have caused serious harm, injury or death to Resident # 1 and had the potential to affect only the 1 resident at risk for elopement according to the listing provided by the Assistant Director of Nursing on 6/1/07. The facility removed the Immediate Jeopardy on 4/19/07 reducing the scope/severity to "G" actual harm for Resident #1 who required hospitalization, however, the underlying deficient practices that resulted in the Immediate Jeopardy were not corrected. The facility was informed of the Immediate Jeopardy removed on 6/1/07 at 9:10 a.m. The findings are:

1. The facility's policy entitled "Resident Behavior and Facility Practices Policy" documented "... Adequate staff will be provided to meet needs of residents that will be identified through staff reports every shift in addition to care plans."

2. Resident # 1 was admitted to the facility on 1/24/07 with diagnoses of Cerebrovascular Accident (CVA), Dementia with Depressive Features and Suicide Ideation. The Quarterly Minimum Data Set (MDS) dated 5/7/07 documented the resident had no short or long

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term memory problems and had modified independence in cognitive skills for daily decision making.

a. A physician order dated 1/24/07 documented, "May leave premises with responsible party." The Doctor's Orders and Progress Notes dated 1/24/07 documented, "64 yo [year old] WM [white male] presents to facility from home. ... At risk for elopement. ..." The Doctor's Orders and Progress Notes dated 1/30/07 documented, "... Adjusting to facility. Requires close monitoring by staff. ...".

b. The Care Plan dated 2/5/07 documented, "Problem: 1. Requires assist with ADL's [activities of daily living] r/t [related to] confusion, ... resident requires one on one attendance at all time r/t elopement risk. [Goal]: Will be assisted by one with all ADLs and will have one on one as needed thru out qtr. [quarter]. [Approach]: ... 2. One on one in attendance at all times ... Problem: 2. At risk for elopement r/t confusion - resident requires one on one attendance at all times. [Goal]: Will have one on one supervision thru out qtr. [Approach]: 1. Monitor resident whereabouts. 2. One on one attendance ...".

c. The Nurses Progress Notes from 2/27/07 at 2:00 p.m. to 3/22/07 at 4:30 p.m. did not document one on one supervision. The Nurses Progress Notes on 3/22/07 at 4:30 p.m. was the only Nurses Progress Notes from 2/27/07 until 4/19/07 at 2:00 p.m. that documented one on one supervision.

The Nurses Progress Notes dated 3/22/07 at 4:30 p.m. documented, "Pt [patient] found outside by CNAs [Certified Nurses Assistants] trying to walk

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{F 324}	Continued From page 20 down the hill. Brought back [and] CNA assigned 1:1 [one to one] to prevent eloping. ...". d. The Nurses Progress Notes dated 3/24/07 at 2:15 p.m. documented, "Res [resident] went outside without assist - seen by CNA - out to talk to res - res becoming agitated - cursing - tried to explain to res he had to wait until someone was free to go out with him for his safety - res unable to understand - tearful and agitated - found another CNA that had time to stay outside [with]." The Nurses Progress Notes dated 3/24/07 at 8:00 p.m. documented: "South side LPN [Licensed Practical Nurse] reported to me res was walking back up stairs outside - res now back inside - sat res down to explain importance of him not walking outside [without] assist and especially not after dark - res very agitated but stated 'all right' - will continue to monitor closely." The Nurses Progress Notes dated 3/24/07 at 9:00 p.m. documented, "Res attempting to get in the room of the DON [Director of Nursing] ... DON now in room [with] res ..." The Nurses Progress Notes dated 3/24/07 at 9:30 p.m. documented, "Res in bed resting quitely - CNAs aware to monitor res - report to oncoming nurse." The Nurses Progress Notes dated 3/25/07 at 2:00 a.m. documented, "... pt [patient] upset to be in here. wants to go home ... Explained to him the importance of ... not going outside by himself ..." The Nurses Progress Notes dated 3/25/07 at 3:00 a.m. documented, "... Will continue to monitor and watch carefully for elopement."	{F 324}		

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{F 324}	Continued From page 21 e. The Nurses Progress Notes dated 4/3/07 at 1:50 p.m. documented, "CNA informed nurse that res was found standing outside [and] was brought back into building ...". The Nurses Progress Notes dated 4/3/07 documented, "Res had no further wandering episodes this shift ...". f. The Nurses Progress Notes dated 4/6/07 at 8:05 p.m. documented, "Went to res room - was not in there - had given res med at 7:45 p.m., the CNAs helped res to bed - between then and 8:05 p.m. res had gotten outside [without] assist - upon searching for res he was found outside by garbage area - confused of where to go - res directed back to facility to his room." The Nurses Progress Notes dated 4/6/07 at 8:15 p.m. documented, "... spoke [with] about importance of asking someone to go [with] him and not wandering outside especially [after] dark ...". g. The Nurses Progress Notes dated 4/15/07 at 11:35 p.m. documented: "Called down to the south end of the building. Res had gone there and aids were having a little trouble getting him to come back to his room. ... Pt [patient] became combative trying to get out the back door - shoving me through the back door. CNA pulled him into the wheelchair while I was able to give him Valium 5 mg [milligram] IM [intramuscular]." The Nurses Progress Notes dated 4/16/07at 12:00 a.m. documented: "CNAs sitting [with] pt watching National Geographic channel while he was calming down."	{F 324}		

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The Nurses Progress Notes dated 4/16/07 at 12:15 a.m. documented, " ...took patient to bed and talked with him ...".

The Nurses Progress Notes dated 4/16/07 at 12:30 a.m. documented, " ...Went down to South wing to give Tylenol - pt still in bed. CNA still report pt still in bed at 12:45 [a.m.]".

The Nurses Progress Notes dated 4/16/07 at 12:50 a.m. documented, "CNAs ... came running down and reported him pt [patient] missing. Searched whole building. Checked pts [patients] room first. Window was open, but this nurse didn't think anything about it since he has had a stroke. Searched outside. woke up DON around 1:15 a.m. Wife ... said he climbed out through window at home. ..."

The Nurses Progress Notes dated 4/16/07 1:00 - 8:30 [a.m.] documented "Pt was last seen 12:45 a.m. CNA had seen pt in bed. 12:50 CNAs reported pt was not in room and window was open. A search of building was done. Family called, Adm [administrator] called, DON here, police called. [Physician] called, Office of Long Term Care called. Search and rescue looking, 2 more dogs dispatched from Hot springs. Search continued until Sheriff dept [department] found patient on Hwy [highway] 7. ... pt arrived at facility at 8:30 a.m."

h. The Nurses Progress Notes dated 4/16/07 at 8:30 a.m. documented, "[Physician] called pt had scratches, clothes wet hand and face scratched and bruised ... pt cold and wet asst [assisted] to bed ... Blankets applied to get pt warm [after] were removed. ... EMS [Emergency Medical

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Services] called and pt sent to hospital for exam. ...".

The Doctor's Orders and Progress Notes dated 4/16/07 documented "Pt had wandered away from facility and sustained multiple lacerations [and] contusions. Pt was hypothermic and hypotensive. Admitted to [hospital] for warming and cont'd [continued] observation."

The Nurses Progress Notes dated 4/16/07 at 10:40 a.m. documented, "Notified pt being admitted overnight for observation."

i. The [hospital] Physician Progress Record dated 4/16/07 documented, "64 yo WM presents from [nursing home] ... wandering outside. Cold [with] multiple lacerations. Admit observation. Imp [impression]; 1) Multiple skin abrasions/contusions with skin infection 2) Hypothermic ... 4) Hypotension ..."

The [hospital] Physician Progress Record dated 4/17/07 documented, "Made acute care for further IV [intravenous] fluids and warming. Feet cool and discolored. Multiple lacerations to upper ext [extremity] [right] > [greater than] [left]. [Right] sl. [slightly] edematous. ... B/P [blood pressure] 87/52 ..."

j. The Nurses Progress Notes dated 4/19/07 at 11:45 a.m. documented, "Returned to [nursing facility] ...".

k. The immediate jeopardy was removed on 4/19/07 and the scope and severity was reduced to "G" when on return from the hospital the facility implemented one to one supervision until a wander guard alert system and window circuit

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alarm was installed in the residents room on 4/24/07.

l. On 5/30/07 at 2:55 p.m., the Social Service Director/MDS and Care Plan Coordinator was asked what does one on one on the Care Plan initialed on 2/5/07 mean. The Social Service Director/MDS and Care Plan Coordinator stated "Someone with resident sitting with him 24/7 [24 hours a day/7 days a week] even had one on one for 1 week after alarm put on resident. There wasn't one on one all the time before the elopement - only when he was upset, crying until he calmed down."

m. On 5/31/07 at 2:05 p.m. the Administrator, Director of Nursing (DON)and Assistant Director of Nursing (ADON) were asked to review the Nurses Notes dated 3/22/07 at 4:30 p.m.. They were asked how long did the one on one last on 3/22/07. The Administrator stated, "We knew he had a history of elopement when he was at home. We had no reason to believe he would do something here." The DON stated, "Everyone was made aware when he was first admitted. We watched him pretty close then. We only stayed with him if he was upset until he calmed down." The Administrator, DON and ADON were asked if there was any documentation of one on one monitoring anywhere other than the Nurses Notes. The DON stated, "No". The Administrator, DON and ADON were asked what was done different after 3/22/07. The Administrator stated, "Nothing, we all knew he was at risk - that's how we found him outside every time." The Administrator, DON and ADON were asked was anything different done anytime you found him outside unattended. The DON stated "No. ... We didn't do anything until after

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YELL COUNTY NURSING HOME, INC	**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 324}	Continued From page 25 he got back from the hospital on 4/19/07. Then we sat with him around the clock until the alarm systems were installed and for about 1 week even after that". n. On 5/29/07 at 4:13 p.m., the Administrator was asked what features of the environment prevented elopement. The Administrator stated, "Magnetic door locks are on all doors but they are not currently activated. Alarms on door of [Resident # 1] room ... both the window and the door are wired." The Administrator stated that the alarms were only installed about one month ago.	{F 324}		
{F 363} SS=E	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 the planned menu was followed as written, to ensure that residents on pureed diets were served proper portions of protein and to ensure that the menu met basic nutritional needs by providing a balance of nutritional food in the groups of the food pyramid system. This failed practice had the potential to affect all 52 residents who received meals from the kitchen according to the Diet List dated 5/29/07. The findings are: 1. On 5/29/07 at 2:00 p.m., the supper menu	{F 363}		

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{F 363}	Continued From page 26 documented sausage gravy, fried potatoes, biscuit, margarine, plums, rice krispies treats and milk. a. On 5/29/07 at 2:00 p.m. when surveyors entered the kitchen, a paper towel taped to the half door of the kitchen had a handwritten menu of vegetable soup, fried spam sandwich, chips, cottage cheese, fruit cocktail. The p.m. cook #1 was asked what the menu on the paper towel was. The cook removed the paper towel from the door, tore it up and stated, "We were going to have this, but we're not going to serve this now. We were, but not now." b. On 5/29/07 at 2:00 p.m., the evening cook took out sausage patties and made biscuits for supper. c. On 5/29/07 no margarine was served with any diets, no rice krispie treats were prepared. The p.m. cook stated that the residents didn't like them, "They can't chew them." Prepackaged hard oatmeal cookies and hard graham crackers were taken from wrappers and served instead of rice krispie treats. d. On 5/29/07 at 4:15 p.m., 14 sausage patties were pureed and added to white gravy for sausage gravy for 19 blended (pureed) diets. e. On 5/29/07 at 4:15 p.m., cranberry juice was substituted for apple juice that had been handwritten on the supper menu. Employee #2 stated that there was no apple juice in stock. Fruit cocktail was substituted for plums as there were no plums in the storeroom. f. Resident #4 received grilled cheese	{F 363}		

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{F 363}	Continued From page 27	{F 363}		

sandwiches at lunch and supper meals daily. The grilled cheese sandwich consisted of 2 slices of bread and one slice of cheese.

1) On 5/31/07 at 1:07 p.m. the evening cook weighed a slice of cheese at 1/2 ounce.

2) On 5/31/07 at 1:50 p.m., a review of 4 months menus documented that all sandwiches (bologna and cheese, hamburger, meat salad sandwiches) required 2 ounces of protein.

2. On 5/30/07 at 12:15 p.m., after all trays were served with no margarine, the Dietary Manager was asked why no margarine was served on any trays, she stated that they had been out of margarine patties for a while, but it had been ordered that morning.

3. On 5/31/07 at 11:15 a.m., the Dietary Manager stated that the delivery truck had just left the facility and they now had margarine patties.

a. Residents were served no margarine patties from supper on 5/29/07 until lunch on 5/31/07 (7 meals).

b. On 5/31/07 at the noon meal, pureed diets were served no bread when the menu documented 1/4 cup of blended bread.

4. On 5/31/07 a review of the planned menu for 3 of 7 days for the week of 5/27/07-6/2/07 for nutritional adequacy and variety according to the 5-A-day food pyramid guidelines documented the following:

a. On 5/29/07 the menu for 3 meals per day documented fruit cocktail and a combination

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{F 363}	Continued From page 28 salad. b. On 5/30/07 the menu for 3 meals daily documented pear halves only and coleslaw and lettuce and tomato for a hamburger. c. On 5/31/07 the menu for 3 meals daily documented okra and tomatoes for lunch and peach halves with grated cheese for supper. d. The Food Guide Pyramid from Tufts Nutrition, Fall, 1999 documented ...for persons over age 70..."We suggest eating dark, leafy greens like spinach, orange and yellow vegetables like sweet potatoes and squash, and colorful fruit like strawberries and mangos that are more rich in vitamins A and C and in folic acid"...Potatoes are not pictured in the pyramid because they are filling but less nutritious...Other nutrient-dense choices include romaine lettuce rather than iceberg, and peaches, apricots, or nectarines rather than apples, celery, or cucumbers." e. The Food Guide Pyramid recommends 5-A-Day servings of 2-4 fruits and 3-5 vegetables daily.	{F 363}		
{F 371} SS=C	483.35(i)(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 record review, the facility failed to ensure that staff used proper	{F 371}		

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{F 371}	Continued From page 29	{F 371}		

handwashing technique and that staff entering the kitchen wore proper hair restraints. This failed practice had the potential to affect 52 residents who received meals from the kitchen according to the Diet List dated 5/29/07. The findings are:

1. The facility's kitchen policy for handwashing documented "To thoroughly dry hands ... use a new paper towel for each stroke; discard paper towels in the waste container. Turn off hand controlled faucets with a clean, dry paper towel and discard it in the waste container."

2. On 5/29/07 at 3:07 p.m., Employee #1 washed her hands with soap and water, rinsed in clear water, turned the water off by touching the faucet handles, then pulled a paper towel and dried her hands. Then she passed a clean glass of iced water through the window to staff for a resident.

a. On 5/29/07 at 3:08 p.m., Employee #2 took a clean cup away from a resident who reached from outside the window and picked up the cup, then gave the cup back to the resident. The Employee then began gathering napkins to wrap clean silverware for supper without washing his/her hands.

b. On 5/29/07 at 3:20 p.m., Employee #1 lifted the trash from the trash can, tied the bag of trash, then washed her hands by using soap and water, rinsing, turning water off by touching faucet handles, pulled paper towel and then dried his/her hands.

c. On 5/29/07 at 3:40 p.m., Employee #1 touched the trash can lid to discard trash, then took a wet towel and wiped the counter. The employee did not was her/his hands.

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{F 371}	Continued From page 30 3. On 5/30/07 at 11:40 a.m. during meal service, a housekeeper went into the kitchen without proper hair restraint and put paper towels in the dispenser and stocked the storeroom with rubber gloves while food was uncovered and exposed.	{F 371}		
{F 490} SS=J	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Nursing Administration failed to ensure a resident at risk of elopement and with a history of elopement was adequately supervised as care planned to prevent elopement for 1 of 1 (Resident # 1) case mix resident who eloped from the facility at approximately 12:45 a.m. on 4/16/07 and was not returned to the facility until 8:30 a.m. This failed practice resulted in an immediate jeopardy, which caused or could have caused serious harm, injury or death to Resident # 1 and had the potential to affect only the 1 resident at risk for elopement according to the listing provided by the Assistant Director of Nursing on 6/1/07. The facility removed the Immediate Jeopardy on 4/19/07 reducing the scope/severity to "G" actual harm for Resident #1 who required hospitalization, however, the underlying deficient practices that resulted in the Immediate Jeopardy were not corrected. The facility was informed of the Immediate Jeopardy removed on 6/1/07 at 9:10 a.m. The findings are:	{F 490}		

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{F 490}	Continued From page 31 1. The facility's policy entitled "Resident Behavior and Facility Practices Policy" documented "... Adequate staff will be provided to meet needs of residents that will be identified through staff reports every shift in addition to care plans." 2. Resident # 1 was admitted to the facility on 1/24/07 with diagnoses of Cerebrovascular Accident (CVA), Dementia with Depressive Features and Suicide Ideation. The Quarterly Minimum Data Set (MDS) dated 5/7/07 documented the resident had no short or long term memory problems and had modified independence in cognitive skills for daily decision making. a. A physician order dated 1/24/07 documented, "May leave premises with responsible party." The Doctor's Orders and Progress Notes dated 1/24/07 documented, "64 yo [year old] WM [white male] presents to facility from home. ... At risk for elopement. ..." The Doctor's Orders and Progress Notes dated 1/30/07 documented, "... Adjusting to facility. Requires close monitoring by staff. ...". b. The Care Plan dated 2/5/07 documented, "Problem: 1. Requires assist with ADL's [activities of daily living] r/t [related to] confusion, ... resident requires one on one attendance at all time r/t elopement risk. [Goal]: Will be assisted by one with all ADLs and will have one on one as needed thru out qtr. [quarter]. [Approach]: ... 2. One on one in attendance at all times ... Problem: 2. At risk for elopement r/t confusion - resident requires one on one attendance at all times. [Goal]: Will have one on one supervision thru out qtr. [Approach]: 1. Monitor resident	{F 490}		

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{F 490}	Continued From page 32 whereabouts. 2. One on one attendance ...". c. The Nurses Progress Notes from 2/27/07 at 2:00 p.m. to 3/22/07 at 4:30 p.m. did not document one on one supervision. The Nurses Progress Notes on 3/22/07 at 4:30 p.m. was the only Nurses Progress Notes from 2/27/07 until 4/19/07 at 2:00 p.m. that documented one on one supervision. The Nurses Progress Notes dated 3/22/07 at 4:30 p.m. documented, "Pt [patient] found outside by CNAs [Certified Nurses Assistants] trying to walk down the hill. Brought back [and] CNA assigned 1:1 [one to one] to prevent eloping. ...". d. The Nurses Progress Notes dated 3/24/07 at 2:15 p.m. documented, "Res [resident] went outside without assist - seen by CNA - out to talk to res - res becoming agitated - cursing - tried to explain to res he had to wait until someone was free to go out with him for his safety - res unable to understand - tearful and agitated - found another CNA that had time to stay outside [with]." The Nurses Progress Notes dated 3/24/07 at 8:00 p.m. documented: "South side LPN [Licensed Practical Nurse] reported to me res was walking back up stairs outside - res now back inside - sat res down to explain importance of him not walking outside [without] assist and especially not after dark - res very agitated but stated 'all right' - will continue to monitor closely." The Nurses Progress Notes dated 3/24/07 at 9:00 p.m. documented, "Res attempting to get in the room of the DON [Director of Nursing] ... DON now in room [with] res ..."	{F 490}		

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{F 490}	Continued From page 33 The Nurses Progress Notes dated 3/24/07 at 9:30 p.m. documented, "Res in bed resting quitely - CNAs aware to monitor res - report to oncoming nurse." The Nurses Progress Notes dated 3/25/07 at 2:00 a.m. documented, "... pt [patient] upset to be in here. wants to go home ... Explained to him the importance of ... not going outside by himself ..." The Nurses Progress Notes dated 3/25/07 at 3:00 a.m. documented, "... Will continue to monitor and watch carefully for elopement." e. The Nurses Progress Notes dated 4/3/07 at 1:50 p.m. documented, "CNA informed nurse that res was found standing outside [and] was brought back into building ...". The Nurses Progress Notes dated 4/3/07 documented, "Res had no further wandering episodes this shift ...". f. The Nurses Progress Notes dated 4/6/07 at 8:05 p.m. documented, "Went to res room - was not in there - had given res med at 7:45 p.m., the CNAs helped res to bed - between then and 8:05 p.m. res had gotten outside [without] assist - upon searching for res he was found outside by garbage area - confused of where to go - res directed back to facility to his room." The Nurses Progress Notes dated 4/6/07 at 8:15 p.m. documented, "... spoke [with] about importance of asking someone to go [with] him and not wandering outside especially [after] dark ...". g. The Nurses Progress Notes dated 4/15/07 at	{F 490}		

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{F 490}	Continued From page 34 11:35 p.m. documented: "Called down to the south end of the building. Res had gone there and aids were having a little trouble getting him to come back to his room. ... Pt [patient] became combative trying to get out the back door - shoving me through the back door. CNA pulled him into the wheelchair while I was able to give him Valium 5 mg [milligram] IM [intramuscular]." The Nurses Progress Notes dated 4/16/07at 12:00 a.m. documented: "CNAs sitting [with] pt watching National Geographic channel while he was calming down." The Nurses Progress Notes dated 4/16/07 at 12:15 a.m. documented, " ...took patient to bed and talked with him ...". The Nurses Progress Notes dated 4/16/07 at 12:30 a.m. documented, " ...Went down to South wing to give Tylenol - pt still in bed. CNA still report pt still in bed at 12:45 [a.m.]". The Nurses Progress Notes dated 4/16/07 at 12:50 a.m. documented, "CNAs ... came running down and reported him pt [patient] missing. Searched whole building. Checked pts [patients] room first. Window was open, but this nurse didn't think anything about it since he has had a stroke. Searched outside. woke up DON around 1:15 a.m. Wife ... said he climbed out through window at home. ..." The Nurses Progress Notes dated 4/16/07 1:00 - 8:30 [a.m.] documented "Pt was last seen 12:45 a.m. CNA had seen pt in bed. 12:50 CNAs reported pt was not in room and window was open. A search of building was done. Family called, Adm [administrator] called, DON here,	{F 490}		

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{F 490}	Continued From page 35 police called. [Physician] called, Office of Long Term Care called. Search and rescue looking, 2 more dogs dispatched from Hot springs. Search continued until Sheriff dept [department] found patient on Hwy [highway] 7. ... pt arrived at facility at 8:30 a.m." h. The Nurses Progress Notes dated 4/16/07 at 8:30 a.m. documented, "[Physician] called pt had scratches, clothes wet hand and face scratched and bruised ... pt cold and wet asst [assisted] to bed ... Blankets applied to get pt warm [after] were removed. ... EMS [Emergency Medical Services] called and pt sent to hospital for exam. ...". The Doctor's Orders and Progress Notes dated 4/16/07 documented "Pt had wandered away from facility and sustained multiple lacerations [and] contusions. Pt was hypothermic and hypotensive. Admitted to [hospital] for warming and cont'd [continued] observation." The Nurses Progress Notes dated 4/16/07 at 10:40 a.m. documented, "Notified pt being admitted overnight for observation." i. The [hospital] Physician Progress Record dated 4/16/07 documented, "64 yo WM presents from [nursing home] ... wandering outside. Cold [with] multiple lacerations. Admit observation. Imp [impression]; 1) Multiple skin abrasions/contusions with skin infection 2) Hypothermic ... 4) Hypotension ..." The [hospital] Physician Progress Record dated 4/17/07 documented, "Made acute care for further IV [intravenous] fluids and warming. Feet cool and discolored. Multiple lacerations to upper ext	{F 490}		

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{F 490}	Continued From page 36 [extremity] [right] > [greater than] [left]. [Right] sl. [slightly] edematous. ... B/P [blood pressure] 87/52 ..." j. The Nurses Progress Notes dated 4/19/07 at 11:45 a.m. documented, "Returned to [nursing facility] ...". k. The immediate jeopardy was removed on 4/19/07 and the scope and severity was reduced to "G" when on return from the hospital the facility implemented one to one supervision until a wander guard alert system and window circuit alarm was installed in the residents room on 4/24/07. l. On 5/30/07 at 2:55 p.m., the Social Service Director/MDS and Care Plan Coordinator was asked what does one on one on the Care Plan initialed on 2/5/07 mean. The Social Service Director/MDS and Care Plan Coordinator stated "Someone with resident sitting with him 24/7 [24 hours a day/7 days a week] even had one on one for 1 week after alarm put on resident. There wasn't one on one all the time before the elopement - only when he was upset, crying until he calmed down." m. On 5/31/07 at 2:05 p.m. the Administrator, Director of Nursing (DON)and Assistant Director of Nursing (ADON) were asked to review the Nurses Notes dated 3/22/07 at 4:30 p.m.. They were asked how long did the one on one last on 3/22/07. The Administrator stated, "We knew he had a history of elopement when he was at home. We had no reason to believe he would do something here." The DON stated, "Everyone was made aware when he was first admitted. We watched him pretty close then. We only stayed	{F 490}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELL COUNTY NURSING HOME, INC	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 490}	Continued From page 37 with him if he was upset until he calmed down." The Administrator, DON and ADON were asked if there was any documentation of one on one monitoring anywhere other than the Nurses Notes. The DON stated, "No". The Administrator, DON and ADON were asked what was done different after 3/22/07. The Administrator stated, "Nothing, we all knew he was at risk - that's how we found him outside every time." The Administrator, DON and ADON were asked was anything different done anytime you found him outside unattended. The DON stated "No. ... We didn't do anything until after he got back from the hospital on 4/19/07. Then we sat with him around the clock until the alarm systems were installed and for about 1 week even after that". n. On 5/29/07 at 4:13 p.m., the Administrator was asked what features of the environment prevented elopement. The Administrator stated, "Magnetic door locks are on all doors but they are not currently activated. Alarms on door of [Resident # 1] room ... both the window and the door are wired." The Administrator stated that the alarms were only installed about one month ago.	{F 490}		