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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A145	A. BUILDING ____ B. WING ____	C 08/14/2007

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 000	INITIAL COMMENTS Complaint #12786 was unsubstantiated. Complaint #12800 was unsubstantiated.	F 000		
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 Physician's orders were followed for feeding tube flushes and feedings for 3 (Residents #1, #2 and #3) and the head of bed was maintained at 30 degrees to prevent the potential for aspiration for 2 (Residents #1 and #2) of 3 (Residents #1, #2 and #3) case mix residents with tube feedings. This failed practice had the potential to affect 5 residents in the facility with feeding tubes, according to the facility's Roster Sample Matrix dated 8/13/07. The findings are: 1. The facility policy on Enteral Nutritional Supplements documented "...Implementation: ...2. during shift assessment, the nurse will check tube placement and patency, followed by a flush. 3. Feeding tube will be flushed following medications and PRN (as needed)..." 2. Resident #1 had diagnoses of Cerebrovascular	F 322		

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 322	Continued From page 1 Accident, Alzheimer's Disease, Hiatal Hernia and Gastroesophageal Reflux Disease. The Quarterly Minimum Data Set (MDS) dated 6/5/07 documented the resident had severely impaired cognitive skills for daily decision making and had a feeding tube. a. A Physician order dated 10/21/04 documented, "Jevity 1.2 cal (calorie) 40 cc (cubic centimeters) per hr (hour)." b. A Physician order dated 2/15/06 documented, "Flush PEG (Percutaneous Endogastrostomy) tube with 30 cc warm H2O (water) before and after meds (medications)." c. A Physician order dated 1/1/07 documented, "Per Tube: 120 cc H2O q (every) 2 hours per tube." d. On 8/13/07 at 11:40 a.m., the resident's feeding pump was turned off. The resident's spouse stated, "Every now and then we have to turn off the [feeding] pump when she gets too full. We leave it off for about 30 minutes." e. On 8/14/07 at 8:29 a.m., Licensed Practical Nurse (LPN) #3 pushed the medication cart past the resident's room. The August 2007 Medication Administration Records (MAR) were checked, and the 8:00 a.m. entry for the 120 cc water flush was blank. Then at 9:15 a.m., the LPN pushed the medication cart past the resident's room to the Nurse's desk. The resident's room had been under constant observation since 6:55 a.m. and no nurse had entered the resident's room. The MARs were checked, and LPN #3 had documented initials into the 8:00 a.m. and 10:00 a.m. flushes, indicating that the flushes had been	F 322		

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F 322	Continued From page 2 delivered to the resident. f. On 8/14/07 at 9:15 a.m., LPN #3 stated "I guess I initialed the 10:00 [a.m.] dose too early." When asked about the 8:00 a.m. flush, the LPN stated, "I guess I initialed the 8:00 a.m. flush too early and then missed it." When asked if the 8:00 a.m. flush had been given, the LPN answered, "No." As of 8/14/07, there was no Physician order located in the clinical record to hold or stop the feeding pump, as needed for comfort or at the husband's request. 3. Resident #2 had diagnoses of Parkinson, Congestive Heart Failure and Insulin Dependent Diabetes Mellitus. The Quarterly MDS dated 6/25/07 documented the resident was moderately impaired in cognitive skills for daily decision making. a. A Physician order dated 7/30/07 documented, "NPO (nothing by mouth) p (after) midnight 8/1/07 for PEG tube placement." b. A verbal Physician order, taken by the Director of Nursing, dated 8/2/07 documented, "Diabetasource 1/2 strength 20 cc/hr (cubic centimeters per hour) - feeding and H2O per protocol." c. Verbal Physician orders dated 8/2/07 documented, "Diabetasource c increase to 40 cc per protocol" and "Flush PEG tube c 30 cc warm H2O before and after meds." d. The Nurse's Progress Notes, documented by LPN #2, dated 8/2/07 at 4:00 a.m., 8/4/07 at 12 m/n (midnight) and 4:00 a.m., 8/6/07 [untimed	F 322		

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F 322	Continued From page 3 entry] and 8:00 p.m. and 8/9/07 at 12 m/n and 4:00 a.m. documented, "...Tube placement checked and irrigated q (every) 2 [hours] c 120 [cc] H2O..." LPN #2 was not available for interview during the survey. e. The Nurses Progress Notes documented by LPN #2, dated 8/12/07 at 4:00 p.m. and 8:00 p.m. and on 8/13/07 at 8:00 p.m. documented, "...Tube placement checked and irrigated q 4 [hours] c 240 [cc] H2O..." LPN #2 was not available for interview during the survey. f. On 8/13/07 at 3:06 p.m., LPN #1 reviewed the resident's August 2007 MAR and administered the scheduled 4:00 p.m. medication, with a 30 cc flush before and after medication administration, via PEG tube. When asked, "Is that all the resident gets?" The LPN stated, "Yes." When asked if the resident received any other flushes, the LPN stated "No, not at this time." LPN #1 showed the resident's MAR to the surveyor and stated, "Only flush is 30 cc before and after meds." g. On 8/14/07 at 1:15 p.m., the Assistant Director of Nursing (ADON) was asked to find the order for flushes for the resident. The ADON stated there was an order for tube feeding protocol dated 8/2/07 and that the resident should get flushes of 240 cc four times a day at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. and flushes of 60 cc at 12:00 a.m. and 4:00 a.m. The ADON was asked to find the protocol in the resident's chart, and was unable to locate the protocol. The ADON stated that all of the protocol flushes, before and after meds and those on the	F 322		

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F 322	Continued From page 4	F 322		

protocol, should be on the MAR. The ADON presented a blank protocol entitled "Routine PEG Orders." The protocol documented "... H2O 240 cc qid [four times a day] - 8a, 12n, 4p, 8p. H2O 60 cc to flush tube - 12am, 4a ..."

4. Resident #3 had diagnoses of Gastric Ulcer, Peptic Ulcer Disease and Poor Appetite. The Quarterly MDS dated 6/18/07 documented the resident had modified independence in cognitive skills for daily decision making.

a. A Physician order dated 8/11/07 at 1:15 p.m. documented, "Return to facility. Continue previous orders. Add: HOB (head of bed) ^ (elevated) 50 degrees at all x's (times)... Jevity 1.2 cal (calorie) at 35 cc/hr/pump (cubic centimeters per hour per pump) 800 cc H2O qd (every day) po (by mouth) or per tube..."

b. A Physician order dated 8/11/07 at 2:00 p.m. documented, "Add liquid diet."

c. On 8/13/07 at 12:05 p.m., the resident's tube feeding pump was off and unplugged. The resident was provided a liquid lunch tray while the surveyor was in the room.

d. On 8/13/07 at 1:13 p.m., a family member informed Registered Nurse (RN) #1 that the tube feeding pump was still off and unplugged. The RN plugged the pump in and started the pump, without checking placement or flushing the PEG tube .

e. On 8/13/07 at 1:55 p.m., RN #1 was asked how long the pump had been off. The RN stated, "Maybe half and hour or so, because feeding the resident, I think it got unplugged. The resident

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F 322	Continued From page 5 gets a liquid tray and meds by mouth." When asked if there was any order to turn the pump off while the resident ate, the RN stated, "No." f. On 8/14/07 at 9:45 a.m., LPN #1 administered 60 cc water by gravity flush per tube. After administration, the LPN signed the flush off on the August 2007 MAR. The August 2007 MAR documented "60 cc H2O PT (per tube) q 2 hours - 8/13/07" The flush was initialed as first given on 8/14/07 at 6:00 a.m. The 8:00 a.m. dose was also initialed as given. g. On 8/14/07 at 10:45 a.m. when the surveyor entered the resident's room the ADON was present changing the dressing on the tube site. The tube feeding pump was running at 35 cc/hr and the head of the bed was flat. The ADON completed the tube dressing change and removed the dressings from the resident's right leg. The ADON stated she had already changed the dressing on the residents arms, coccyx and other leg. The ADON completed the dressing change of the right leg at 10:53 a.m., then examined the resident's right shoulder area and applied a dressing. At 10:59 a.m., the ADON turned on the call light "for the CNA" then left the room with the dressing cart, leaving the head of the bed flat. The DON then entered the resident's room and attempted to remove the resident's call light from the over bed light. At 11:00 a.m., a CNA entered the room and the DON instructed to the CNA to get another hand bell for the resident. The DON then began instructing the resident on how to use the hand bell. At 11:06 a.m. the DON left the	F 322		

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F 322	Continued From page 6 room without raising the head of the resident's bed. The tube feeding pump was still running at 35 cc/hr. At 11:08 a.m., Certified Nursing Assistant (CNA) #1 and CNA #2 entered the resident's room. The CNAs left the head of the bed flat while moving the resident to the left side of the bed. The resident's pillow was removed from under the resident's head. At 11:17 a.m., the head of the resident's bed was raised, after the CNAs changed the resident's linens. The CNAs were asked what position the head of the resident's bed was in when they entered the room. CNA #1 stated, "Flat." h. On 8/14/07 at 11:19 a.m., the DON was asked, Did you notice the residents HOB and tube feeding pump when you were in the room? The DON stated, "No." When asked if it was a problem that the head of the bed was flat and the tube feeding pump was running, the DON stated "Of course." i. On 8/14/07 at 11:20 a.m. when asked how long was the head of the resident's bed had been down, the ADON stated "It was flat when she was turned so I could do other leg." When asked, Did you notice the tube feeding pump was still running? The ADON stated "No." j. On 8/14/07 at 1:05 p.m., LPN #1 was asked if she could find the order for the every two hour tube feeding flush for the resident; the LPN stated, "No - [ADON] told me there was an order, so I put it on the MARs (Medication Administration Record)."	F 322		

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F 322	Continued From page 7 k. On 8/14/07 at 1:15 p.m., when asked if she could find the order for the 60 cc flushes for the resident, the ADON stated "I got the order yesterday from the physician for 800 cc of fluids by mouth or per tube and to watch for overload. I told [RN #1], but I don't think I stopped and wrote the order."	F 322		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Physician orders for flushes of Percutaneous Endogastrostomy (PEG) tubes were transcribed to the Medication Administration Record (MAR) and the Enteral Feeding Record for 2 (Residents #2 and #3) of 3 (Residents #1, #2 and #3) case mix residents with orders for hydration flushes. This failed practice had the potential to affect 5 residents in the facility with tube feedings, according to the facility's Roster/Sample Matrix dated 8/13/07. The findings are: 1. The facility's policy entitled "Physician's Orders"	F 514		

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documented, "Purpose: To assure that all licensed Nursing Personnel are fully informed and capable of transcribing physician's orders to the appropriate places with the resident's chart and Medication Administration Record, (MAR). ...5. the charge nurse on duty at the time the order is received, or the licensed nurse receiving the order, is responsible for ALL of the following: a. Faxing or telephoning the new order into the pharmacy exactly as prescribed as soon as possible after receiving and noting it on the physician's order sheet. ...c. Entering newly prescribed medication on the patient's current medication administration record. ...6. All physician's orders will be written on the Physician Order Sheet, then transcribed appropriately to the MAR."

2. Resident #2 had diagnoses of Parkinson, Congestive Heart Failure and Insulin Dependent Diabetes Mellitus. The Quarterly Minimum Data Set (MDS) dated 6/25/07 documented the resident was moderately impaired in cognitive skills for daily decision making.

a. A Physician order dated 7/30/07 documented, "NPO (nothing by mouth) p (after) midnight 8/1/07 for PEG tube placement."

b. A verbal Physician order, taken by the Director of Nursing and dated 8/2/07 documented, "Diabetasource 1/2 strength 20 cc/hr (cubic centimeters per hour) - feeding and H2O (water) per protocol."

c. Verbal Physician orders dated 8/2/07 documented, "Diabetasource c (with) increase to 40 cc per protocol" and "Flush PEG tube c 30 cc warm H2O before and after meds (medications)."

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d. The Nurse's Progress Notes documented by Licensed Practical Nurse (LPN) #2, dated 8/2/07 at 4:00 a.m., 8/4/07 at 12 m/n (midnight) and 4:00 a.m., 8/6/07 [untimed entry] and at 8:00 p.m. and 8/9/07 at 12 m/n and 4:00 a.m. documented "...Tube placement checked and irrigated q (every) 2 [hours] c 120 [cc] H2O..." LPN #2 was not available for interview during the survey.

e. The Nurse's Progress Notes by LPN #2, dated 8/12/07 at 4:00 p.m. and 8:00 p.m. and 8/13/07 at 8:00 p.m., documented "...Tube placement checked and irrigated q 4 [hours] c 240 [cc] H2O..." LPN #2 was not available for interview during the survey.

f. On 8/13/07 at 3:06 p.m., LPN #1 reviewed the resident's August 2007 Medication Administration Record and administered the resident's scheduled 4:00 p.m. medication with a 30 cc flush, before and after medication administration via the resident's PEG tube. When asked, "Is that all the resident gets?" The LPN stated, "Yes."

When asked if the resident received any other flushes, the LPN stated, "No, not at this time." LPN #1 showed the resident's MAR to the surveyor and stated, "Only flush is 30 cc before and after meds."

g. On 8/14/07 at 1:15 p.m., the Assistant Director of Nursing (ADON) was asked to find the order for flushes for the resident. The ADON stated there was an order for tube feeding protocol dated 8/2/07 and that the resident should get flushes of 240 cc four times a day at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. and flushes of 60 cc at 12:00 a.m. and 4:00 a.m.

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The ADON was asked to find the protocol in the resident's chart and was unable to locate the protocol. The ADON stated that all of the protocol flushes, before and after meds and those on the protocol, should be on the MAR. The ADON was asked which nurse was supposed to put the Physician order taken on 8/2/07 on the MAR. The ADON stated, "The nurse who took the verbal orders."

The ADON present a blank protocol entitled "Routine PEG Orders". The protocol documented "... H2O 240 cc qid [four times a day] - 8a, 12n, 4p, 8p. H2O 60 cc to flush tube - 12am, 4a..."

h. On 8/14/07 at 1:45 p.m., LPN #3 was asked have you given the resident any flushes today. LPN #3 stated, "With her med (medication), yes and 240 cc -- gave with meds at 8:00 a.m. and 12 noon. Gave per protocol - he [physician] always orders the same protocol so I know what to give even if it's not on the MAR." When asked if it was documented, the LPN stated "It should be on the enteral feeding sheet. Oh, I see. No one put in any fluid amounts."

i. On 8/14/07 at 2:20 p.m., when asked if documentation of flush amounts were documented on the enteral feeding record, the ADON stated "They should have the amount next to the time it's given and then they should initial after it's given."

4. Resident #3 had diagnoses of Gastric Ulcer, Peptic Ulcer Disease and Poor Appetite. The Quarterly MDS dated 6/18/07 documented the resident had modified independence in cognitive skills for daily decision making.

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a. A Physician order dated 8/11/07 at 1:15 p.m. documented, "Return to facility. Continue previous orders. Add: HOB (head of bed) ^ (elevated) 50 degrees at all x's (times)... Jevity 1.2 cal (calorie) at 35 cc/hr/pump (cubic centimeters per hour per pump) 800 cc H2O qd (every day) po (by mouth) or per tube..."

b. A Physician order dated 8/11/07 at 2:00 p.m. documented, "Add liquid diet."

c. On 8/14/07 at 9:45 a.m., LPN #1 administered 60 cc water by gravity flush per tube. After administration, the LPN signed the flush off on the August 2007 MAR.

The MAR documented, "60 cc H2O PT (per tube) q 2 hours - 8/13/07" The flush was initialed as first given on 8/14/07 at 6:00 a.m. The 8:00 a.m. dose was also initialed as given.

d. The resident's enteral feeding record documented that only one flush of 400 cc was administered on the 3 - 11 (3:00 p.m. to 11:00 p.m.) shift on 8/13/07.

e. On 8/14/07 at 1:05 p.m., LPN #1 was asked if she could find the order for the every two hour tube feeding flush for the resident; the LPN stated, "No - [ADON] told me there was an order so I put it on MARs (Medication Administration Record)."

f. On 8/14/07 at 1:15 p.m., when asked if she could find the order for the 60 cc flushes for the resident, the ADON stated "I got the order yesterday from the physician for 800 cc of fluids by mouth or per tube and to watch for overload. I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A145	A. BUILDING ______ B. WING ______	C 08/14/2007

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 514	Continued From page 12 told [RN #1], but I don't think I stopped and wrote the order."	F 514		