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F 000	INITIAL COMMENTS Complaints #11110, #11264, #11322 and #11347 were unsubstantiated. Complaint #11302 was substantiated (all or in part) with deficiencies cited at F324, F444 and F445.	F 000		
F 241 SS=D	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, record review and interview, the facility failed to ensure the contents of a bedside commode were emptied prior to in-room meal service for 1 of 1 case mix resident who used a bedside commode (Resident #10). The facility also failed to ensure a resident was dry and free of urine odors during a meal for 1 (Resident #8) of 4 case mix residents who were incontinent and ate meals in their rooms (Residents #7, #8, #11 and #12). The failed practices had the potential to affect 61 residents who routinely ate meals in their rooms, as identified by the Registered Nurse Coordinator on 1/19/06 at 2:04 p.m. The findings are: 1. Resident #8 had diagnoses of Cerebrovascular Accident (CVA) and Osteoarthrosis. The Quarterly Minimum Data Set dated 11/15/05 documented the resident was	F 241		

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 241	Continued From page 1 severely impaired in cognitive skills for daily decision-making, required extensive assistance of one person for eating, was totally dependent on staff for toilet use, was incontinent of bowel all or most of the time and had multiple daily episodes of bladder incontinence. a. The Care Plan dated as reviewed/revised on 11/14/05 documented: "Problem - Resident had decline in ADL [activities of daily living] functional ability related to Vascular Dementia... Approaches - Resident requires total assistance and care with all ADL functions including bed mobility and eating... She is incontinent of B & B [bowel and bladder]... Provide toileting before and/or after meals and activities, upon rising, and prior to going to bed." b. On 1/18/06 at 6:45 a.m., a urine odor was present and noted immediately upon entering the resident's room. The incontinent pad under the resident was wet. The Surveyor marked the incontinent pad with a pen at this time. c. On 1/18/06 at 7:35 a.m., Certified Nursing Assistant (CNA) #3 entered the resident's room with a breakfast tray. The CNA raised the head of the bed and started feeding the resident. The strong urine odor was still present in the room at this time. The CNA finished feeding the resident at 7:52 a.m. At 8:05 a.m., incontinent care was provided to the resident and the same wet, marked incontinent pad was removed from under the resident's hips at that time. d. On 1/18/06 at 1:05 p.m., CNA #3 was asked what services were provided when preparing a resident for meal service. The CNA stated, "Knock on the door, tell the resident who you are	F 241		

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and what I'm doing. Ask if it's okay if I check them to see if they are wet. Straighten them up to eat and then feed them." The CNA was asked how Resident #8 was checked. The CNA stated, "Well, I was in a hurry and I just stuck my hand under her sheet and she was dry." When asked if she had pulled the sheet back to observe the resident's incontinent pad, the CNA stated, "No." The CNA was asked if she was aware that the resident's incontinent pad had been wet since 6:45 a.m. The CNA stated, "No, I was in a hurry and didn't pull the covers back. I just put my hand on the incontinent pad and it was dry where I touched so I fed her."

2. Resident #10 had diagnoses of Diabetes Mellitus Type II and Senile Delusions. The Quarterly Minimum Data Set dated 10/29/05 documented the resident had modified independence in cognitive skills for daily decision-making, short and long-term memory problems, required supervision for eating, had no limitations in functional range of motion and was continent of bowel and bladder.

a. On 1/18/06 at 6:52 a.m., the resident's bedside commode (BSC) was sitting between the resident's bed and the bedside chair. The resident was in bed with the siderails down. There was approximately 1 inch or greater of clear yellow urine in the bottom of the BSC. The resident stated she had been up to the BSC two times during the night. As of 8:00 a.m., the contents of the BSC had not been emptied.

b. On 1/18/06 at 8:15 a.m., the facility's Office Manager served the resident's breakfast tray with the resident sitting up in the bedside chair. The contents of the BSC had not been emptied at this

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time and were within 6 inches of the left side of the chair during the resident's meal. The resident finished her meal at 8:38 a.m.

c. On 1/18/06 at 9:14 a.m., the resident remained in the bedside chair and the BSC had not been emptied. CNA #4 entered the resident's room and was asked what she did at the beginning of her shift for residents who were more independent, as this resident was. She stated, "I'd bring a washcloth and towel before meals, check the pot to see if it needed emptying." When asked about checking the BSC before a resident had their meal, the CNA stated, "Yes, you wouldn't want them eating with that next to them."

F 280 SS=B — 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS — F 280

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

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F 280	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the nursing plan of care was revised to include newly developed interventions to prevent falls for 1 (Resident #9) of 8 case mix residents with a history of falls/injuries (Residents #1 through #6, #8 and #13). The failed practice had the potential to affect 132 residents who were at risk for falls, as documented on a list provided by the Director of Nursing (DON) on 1/12/06. The findings are: Resident #9 had diagnoses of Subdural Hematoma, Ischemic Heart Disease and Congestive Heart Failure. The Significant Change Minimum Data Set (MDS) dated 11/23/05 documented the resident was moderately impaired in cognitive skills for daily decision-making, required extensive assistance of 2 or more persons for transfers and ambulation in room, fell in the past 30 days and past 31 to 180 days and used "other" type of side rails daily. a. A physician order dated 8/4/05 documented: "May use self re-leasable seat belt with alarm check q [every] 30 minutes." b. Change of Condition Reports dated 9/14/05 through 12/27/05 documented the resident experienced 5 falls during this time period, including a fall on 12/27/05 which resulted in a laceration to her forehead. c. The Care Plan dated as revised by the facility on 12/27/05 documented: "Problem/Need: Resident at risk for falls due to unsteady gait and history of falls. She refuses to allow anyone to	F 280		

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F 280	Continued From page 5 assist her... Approaches - Ensure bed and chair alarm is in place and functioning properly..." d. On 1/19/06 at 3:00 p.m., the Director of Nursing (DON) was asked what the most recent intervention was to reduce the risk of falls for Resident #9. The DON stated, "Getting the resident up in the wheelchair in view of staff anytime the resident is restless." When asked if this intervention had been added to the Nursing Care Plan or the Daily Care Guide used by the Certified Nursing Assistants, the DON stated, "No."	F 280		
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the physician's plan of care and/or the nursing plan of care was implemented for 1 (Resident #10) of 8 case mix residents with physician orders for therapeutic diets (Residents #2, #4, #5, #7, #8, #9, #10 and #11), for medication administration for 1 (Resident #4) of 13 case mix residents with physician orders for medication (Residents #1 through #13), for a skin treatment for 1 (Resident #2) of 3 case mix residents with orders for non-decubitus skin treatments (Residents #1 through #3) and for assessments of lung	F 282		

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F 282	Continued From page 6 sounds/respiratory status for 1 (Resident #13) of 2 case mix residents with respiratory disorders (Residents #7 and #13). The failed practice had the potential to affect all 179 residents, as documented on the Roster/Sample Matrix provided by the Director of Nursing on 1/10/06. The findings are: 1. Resident #10 had diagnoses of Diabetes Mellitus Type II and Senile Delusions. The Quarterly Minimum Data Set dated 10/29/05 documented the resident had short and long-term memory problems and required supervision for eating. a. The January 2006 Physician Orders sheet documented a diet order dated 2/25/05 for a regular, no concentrated sweets diet. b. The facility's menu for 1/18/06 documented the residents on low concentrated sweets diets were to receive unsweetened beverages and diet jelly. c. On 1/18/06 at 8:17 a.m., the facility's Office Manager served a breakfast tray to the resident in her room. The Office Manager set the tray up after removing the plate cover and tray card, then left the room. The tray card documented: "Regular NCS." The resident's tray contained two regular sugar packets and one package of regular strawberry jam that had been opened for the resident. The resident's roommate had a regular diet and had been served artificial sweeteners and asked Resident #10 to exchange those for the resident's sugar packets. d. On 1/18/06 at 8:38 a.m., the Office Manager was asked if she was a Certified Nursing	F 282		

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Assistant or had received training in meal tray service. She stated the administrative staff took turns passing meal trays and, "we just learn over the years. No, no special training."

e. On 1/18/06 at 8:38 a.m., the resident had finished her breakfast and consumed the entire package of regular strawberry jam.

2. Resident #4 had diagnoses of Heart Failure, Gastrostomy Tube and Decubitus Ulcer.

a. The December 2005 MAR documented a physician order dated 10/17/05 for: "Lortab elixir 2.5 mg/5 ml [milliliters], give 15 ml (7.5 mg) every four hours prn."

b. Nurses' Notes dated 12/20/05 at 4:00 p.m. documented the resident's family had requested that Extra Strength Tylenol be administered to the resident for pain, then to administer Lortab if the Extra Strength Tylenol was not effective, due to increased sedation of the resident. The December 2005 MAR documented a physician order to: "Give Tylenol ES [extra strength] elixir 500 mg/15 ml, give 30 ml (1000 mg) every four hours prn pain or temp [temperature]... Give first before giving Lortab Elixir."

c. The facility's narcotic records documented administration of Lortab elixir on 12/22/05, 12/23/05, 12/25/05 (two separate doses), 12/29/05, 12/31/05 (two separate doses) and 1/9/06 (two separate doses), for a total of 9 doses administered after the most recent order dated 12/20/05. There was no documentation in Nurses' Notes or MAR's from December 2005 and January 2006 that Tylenol ES 1000 mg was administered prior to the Lortab on 12/25/05 (both

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doses), 12/29/05, 12/31/05 (both doses) and 1/9/06 (one dose at 11:30 a.m.). The physician order to administer Extra Strength Tylenol first was not followed on 6 of 9 occasions.

3. Resident #2 was admitted on 12/9/05 with diagnoses of Congestive Heart Failure, Shortness of Breath and Weakness. The Initial MDS dated 12/20/05 documented the resident had short and long-term memory problems, was moderately impaired in cognitive skills for daily decision-making, required limited assistance of one person for transfers and had an unsteady gait.

a. The Immediate Plan of Care dated 12/9/05 documented: "Risk of falls related [to] weakness... 1/4/06 - Resident attempted to get out of chair, stood up, sat in floor, hit arm on rail, received skin tear."

b. A physician order dated 1/4/06 documented the treatment of the skin tears to the resident's right arm as: "Cleaning with normal saline, apply triple antibiotic ointment, cover with 4x4's and wrap with roll gauze daily until healed."

c. On 1/10/06 at 1:14 p.m., the dressing on the resident's right forearm was dated 1/9/06.

d. On 1/11/06 at 11:29 a.m., the dressing dated 1/9/06 remained on the resident's right forearm, which demonstrated the dressing change had not been done daily as ordered.

4. Resident #13 was admitted on 1/11/06 with a diagnosis of Congestive Heart Failure (CHF). The Immediate Plan of Care dated 1/11/06 documented: "At risk for Respiratory Failure...

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F 282	Continued From page 9 Pulse Ox prn [as needed], O2 [Oxygen] at 2 LPM [liters per minute] per NC [nasal cannula] prn and Lung Sounds q [every] shift and prn." a. The January 2006 MAR documented an order dated 1/11/06 for Oxygen at 2 liters per minute via NC as needed for shortness of breath. The MAR documented the use of oxygen on all 11:00 p.m. to 7:00 a.m. shifts from 1/11/06 through 1/16/06, on the 3:00 p.m. to 11:00 p.m. shift on 1/13/06 and on the 7:00 a.m. to 3:00 p.m. shift on 1/16/06. b. Nurses' Notes dated 1/11/06 through 1/16/06 were reviewed and there was no documentation of auscultation of the resident's lung sounds as care planned. There was no documentation in Nurses' Notes of the oxygen use, its effectiveness or of pulse oximetry readings from 1/11/06 through 1/15/06.	F 282		
F 324 SS=E	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #11302 was substantiated (all or in part) with these findings. Based on observation, record review and interview, the facility failed to ensure planned interventions to prevent falls/injuries were implemented for 2 (Residents #2 and #9) of 8 case mix residents with a history of falls/injuries	F 324		

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(Residents #1 through #6, #8 and #13). The facility also failed to ensure interventions were developed and implemented to prevent repeated injuries to 1 of 1 case mix resident who exhibited uncontrolled, spastic movements and had unpadded side rails in use (Resident #1). The failed practice had the potential to affect 84 residents at risk for bruising, 8 residents at risk for skin tears and 132 residents at risk for falls, as documented on a list provided by the Director of Nursing (DON) on 1/12/06. The findings are:

1. Resident #1 had diagnoses of Cerebral Palsy, Gastrostomy Tube and Neurotic Disorders. The Quarterly Minimum Data Set (MDS) dated 7/11/05 documented the resident had short and long-term memory problems, was severely impaired in cognitive skills for daily decision-making, required total assistance for transfers and bed mobility, had limitations in functional range of motion on both sides with partial loss of voluntary movement of one arm, hand, leg and foot, had no abrasions, bruises or skin tears, no accidents and did not use siderails of any kind.

a. A physician's telephone order dated 9/21/05 documented: "Siderails up times 2 while in bed d/t [due to] attempts to self transfer and ambulate."

b. The Care Plan dated 10/7/05 documented: "Problem - Resident is at risk for complications due to the use of side rails up times 2 to prevent resident from falling... Goal - Resident will have no side effects from use of side rails... Interventions - Observe for and report any complications such as muscle atrophy, skin problems, contractures, etc... Unable to pad side rails due to resident hx [history] of picking at side

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rail padding and putting in his mouth... 1/7/06 - Old bruising noted to arm - consistent with frailing [sic] about in bed and hitting rails." There was no documentation on the Care Plan of any new interventions planned after the initial date of 10/7/05.

c. Weekly Skin Audit sheets documented the following:

1.) 11/15/05 - Abrasion left abdomen.

2.) 12/20/05 - Bruise and bite marks to left hand.

3.) 1/3/06 - Bruises to both anterior arms, scabbed areas to both feet.

d. An Incident and Accident Report dated 1/7/06 at 4:10 p.m. documented: "Bruising to Left arm - due to bumping bed rails." The report also documented the bed rails were up at the time of the incident. The Investigation Follow-Up dated 1/7/06 documented: "Summary of investigation - Resident moves about in bed almost constantly. Often gets to foot of bed. Shakes BSR's [bed side rails]. His BSR with arms and legs... Past interventions attempted - Unable to pad BSR due to history of picking at padding and putting into his mouth... Recommendations/New Interventions - Areas appear consistent with bumping on BSR, unable to pad BSR due to resident has history of trying to eat anything in or on bed with him." There was no documentation of any interventions planned to prevent further injury to the resident.

e. On 1/10/06 at 12:35 p.m., the Assistant Director of Nursing (ADON) was in attendance in the resident's room. The resident was in bed and the ADON stated the resident had recent bruising

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and abrasions. The ADON also stated, "...can't pad the side rails cause he eats it." The resident was lying across the mattress at the foot of the bed, his head was against the left metal side rail. Both full side rails were up and unpadded. The resident was very active and moving all extremities in jerking motions, flailing his arms and legs. Licensed Practical Nurse (LPN) #3 was also in the room and was asked if she had noticed any recent injuries to the resident. LPN #3 stated, "No, but he was thrashing pretty bad one day last week." A skin audit was performed at this time and the resident had the following injuries:

1.) Inner left wrist - reddened, abraded area that measured approximately 5 by 3.5 centimeters (cm).

2.) Right outer wrist - an approximately 1 cm open area with surrounding redness which measured approximately 6 by 3 cm.

3.) Bilateral feet/toes - open scabbed areas on the toes and on the top of each foot. The ADON stated these injuries were from, "bumping his feet on the footboard."

f. On 1/10/06 at 12:47 p.m., Certified Nursing Assistants (CNA's) #9 and #10 repositioned the resident in bed. The resident jerked his entire body and turned completely sideways in the bed and hit the left side of his head on the left side rail. The CNA's repositioned the resident again and at 12:48 p.m., the resident jerked his entire body sideways again. The resident's right foot hit the right siderail, then his feet went through the opening in the rail. The CNA's provided incontinent care with the resident moving at all

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times. The resident's feet were curled and pressed into the wooden, unpadded footboard of the bed.

g. On 1/11/06 at 8:56 a.m., the resident was calm, lying sideways at the foot of the bed. His head was resting against the left side rail and his right foot was through the right side rail. CNA #11 was in the room and stated about 1 week ago the resident was very agitated. When asked about the bruises/abrasions on the resident's body, CNA #11 stated, "It's from him banging on the siderails and bed." When asked if the resident got sideways in the bed a lot, CNA #11 stated, "All the time."

h. On 1/11/06 at 11:20 a.m., the resident was sideways at the foot of the bed. Both of the resident's feet/ankles were between the end of the right side rail and the footboard, a space that measured approximately 5 inches. CNA #11 came into the room and repositioned the resident in bed.

i. On 1/11/06 at 4:12 p.m. during an end-of-day meeting with the Administrator, Director of Nursing (DON), Assistant Administrator and Assistant DON, a request was made for documentation of interventions attempted to prevent further injuries for this resident after each of the injuries described on Weekly Skin Audit sheets dated 9/6/05, 10/4/05, 12/20/05 and 1/3/06. As of 1/19/06, the facility had not provided documentation of interventions to prevent injury for this resident.

2. Resident #2 was admitted on 12/9/05 with diagnoses of Congestive Heart Failure, Shortness of Breath and Weakness. The Initial MDS dated

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12/20/05 documented the resident had short and long-term memory problems, was moderately impaired in cognitive skills for daily decision-making, required limited assistance of one person for transfers, had an unsteady gait, was occasionally incontinent of bladder and received Occupational and Physical Therapy services. The Medicare 14-Day MDS dated 12/29/05 documented the same information and in addition, the use of full siderails.

a. A Fall Risk Assessment dated 12/9/05 documented the resident's fall risk score as, "10" with a score of 10 or greater indicating a high risk for falls.

b. A Daily Care Guide (the Certified Nursing Assistants' Care Plan) documented the resident was to be assisted with transfers and side rails were to be used on his bed.

c. An Immediate Plan of Care dated 12/9/05 documented: "Problem - risk of falls related to weakness... 1/4/06 - Resident attempted to get out of chair, stood up, sat in floor, hit arm on rail, received skin tear... Interventions: 1/4/06 - chair alarm..."

d. An Incident and Accident Investigation Follow-Up dated 1/4/06 documented: "Recommendations/New Interventions: Chair alarm."

e. On 1/11/06 at 8:49 a.m. and 10:51 a.m., the resident was in bed with the right side rail up and the left side rail down. At 11:29 a.m., the resident's side rails remained in the same position and the resident was sitting up on the side of the bed. The resident stated he needed to go to the

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bathroom and attempted to stand on his own. The resident was very unsteady. The Surveyor pushed the resident's call light to obtain assistance for the resident.

f. On 1/11/06 at 2:37 p.m., a therapist brought the resident to his room in his wheelchair. No chair alarm was on the chair. At 2:49 p.m., CNA #8 was in the resident's room. The CNA was asked if the resident's siderails should be up or down and she stated, "I put them up since he's been sick." The CNA was also asked if the resident used a chair or bed alarm and she stated, "No."

3. Resident #9 had diagnoses of Subdural Hematoma, Ischemic Heart Disease and Congestive Heart Failure. The Significant Change Minimum Data Set (MDS) dated 11/23/05 documented the resident had short-term memory, no problems with long-term memory, was moderately impaired in cognitive skills for daily decision-making, required extensive assistance of 2 or more persons for transfers and ambulation in room, fell in the past 30 days and past 31 to 180 days and used "other type" of side rails daily.

a. A physician order dated 8/4/05 documented: "May use self re-leasable seat belt with alarm check q [every] 30 minutes..."

b. Change of Condition Reports dated 9/14/05 through 12/27/05 documented the resident experienced falls during that period, including 2 falls that resulted in lacerations.

c. The Care Plan dated as revised by the facility on 12/27/05 documented: "Problem/Need: Resident at risk for falls due to unsteady gait and

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history of falls. She refuses to allow anyone to assist her... Approaches - Ensure bed and chair alarm is in place and functioning properly..."

d. On 1/19/06 at 8:30 a.m., the resident was sitting in her wheelchair, self-propelling through the Nurses' Station with no restraint or alarm in use. The resident's room was observed by the Surveyor at 8:32 a.m. and the pressure alarm pad was lying on the recliner seat and the alarm box was on the head of the bed frame.

e. On 1/19/06 at 8:35 a.m., Certified Nursing Assistant (CNA) #1 was asked if the pressure pad alarm was on the resident's chair. The CNA stated, "No, there's no alarm on her wheelchair. Whoever got her up left it on the recliner."

f. On 1/19/06 at 9:05 a.m., CNA's #1 and #2 were asked if they knew who had gotten the resident up out of bed this morning. Both CNA's stated, "The night shift."

g. On 1/19/06 at 2:25 p.m., Licensed Practical Nurse (LPN) #1 was asked to describe the facility's process to ensure residents were not left wet, soiled or in need of other care at the beginning of the shift. The LPN stated, "The CNAs round together and check residents to see if they are dry, if the call lights are in reach and alarms are on." The LPN was asked if anyone was assigned to check the residents in the dining room and the hall during the CNA rounds. The LPN stated, "Someone should be. The Aides in the dining room are monitoring the residents, but they wouldn't know if the resident needs an alarm or restraints." When asked if she had noticed that this resident's alarm was not in place this morning at the Nurses' Station, the LPN stated,

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F 324	Continued From page 17 "No, I didn't notice [resident's] alarm."	F 324		
F 329 SS=E	483.25(l)(1) UNNECESSARY DRUGS 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a hypnotic medication was not given on a daily basis for longer than 10 consecutive days without an attempted dosage reduction for 1 (Resident #10) of 2 case mix residents with physician orders for Ambien (Residents #5 and #10). The failed practice had the potential to affect 14 residents with physician orders for Ambien, as documented on a list provided by the Administrator on 1/19/06 at 12:25 p.m. The findings are: Resident #10 had diagnoses of Insomnia, Anxiety, Difficulty in Walking and Senile Delusions. The Quarterly Minimum Data Set (MDS) dated 10/29/05 documented the resident had short and long-term memory problems, had fallen in the last 31 to 180 days and received Hypnotic medications 7 days per week. a. A physician order dated 11/4/04 documented:	F 329		

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F 329	Continued From page 18 "Ambien tabs [tablets], 5 mg [milligrams] 1/2 tab to equal 2.5 mg po [by mouth] PRN [as needed] at hs [bedtime]." b. A Psychiatric Evaluation dated 8/5/05 documented the psychiatrist's orders to: "Change Ambien 2.5 mg to q [every] hs, not prn... Monitor for ADE [adverse drug effects] lethargy, falls in AM [morning]." The August 2005 MAR documented the resident received Ambien 2.5 mg on a nightly basis from 8/5/05 through 8/31/05. c. A Consultant Pharmacist Communication sheet dated 8/31/05 documented the administration of Ambien 2.5 mg at bedtime for more than 10 days and a recommendation to reduce the dose to an as-needed basis, "no more than 5 doses per week." The Communication sheet also documented the physician's written response to this recommendation was to change the Ambien order to PRN. The sheet also documented a note dated 9/12/05 and signed by the Assistant Director of Nursing (ADON) which documented: "order already prn at hs." On 1/18/06 at 3:50 p.m., the ADON stated she thought at the time that the Ambien was already ordered as a PRN medication because the order had never been changed in the computer. d. The September 2005 MAR documented the PRN Ambien order from 11/4/04. The 8/5/05 order to change the Ambien to a scheduled nightly medication and the physician order from the 8/31/05 Consultant Pharmacist Communication Sheet were not transcribed to this MAR. e. A physician order dated 9/27/05 documented: "Ambien 2.5 mg should be PRN, not scheduled at	F 329		

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hs." The telephone order was signed by the physician on 9/27/05. This order was not transcribed to the September 2005 MAR.

f. The October, November and December 2005 and January 2006 MAR's documented the Ambien order as: "Ambien 2.5 mg by mouth at night." There was no documentation on these MAR's to indicate that this medication was to be given only as needed, rather than on a scheduled nightly basis. The current January 2006 Physician Orders sheet documented the Ambien as a scheduled nightly medication with a scheduled administration time of 9:00 p.m., instead of a PRN medication as ordered by the physician on 9/27/05.

g. As of 1/18/06, the facility's narcotic records documented the resident received Ambien 2.5 mg nightly from 10/1/05 through 10/31/05, 11/1/05 through 11/11/05, 11/14/05 through 11/18/05 (when the supply count was zero), 11/25/05 (documented receipt of 30 tablets) through 11/30/05, 12/1/05 through 12/24/05, 1/2/06 through 1/7/06, 1/9/06 through 1/12/06 and 1/14/06 through 1/17/06.

h. There was no documentation in the Nurse's Notes from October 2005 to January 2006 of the resident having requested sleeping medication or that the Ambien was administered on a PRN basis for insomnia. On 1/18/06 at 4:55 p.m. the DON was asked for any documentation that supported the continued use of the Ambien on an "as needed" basis as ordered since 9/27/05. As of 1/19/06 at 6:20 p.m., the facility had not provided any documentation to that effect.

i. The Centers for Medicare and Medicaid

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F 329	Continued From page 20 Services (CMS) Interpretive Guidelines at F329 documented: "Drugs used for sleep induction should only be used if: ...Daily use of the drug is less than ten continuous days unless an attempt at a gradual dose reduction is unsuccessful... For drugs in this category, a gradual dose reduction should be attempted at least three times within six months before one can conclude that a gradual dose reduction is clinically contraindicated.	F 329		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Complaint #11302 was substantiated (all or in part) with these findings. Based on observation, record review and interview, the facility failed to ensure Certified Nursing Assistants (CNA's) washed their hands after incontinent care, prior to passing ice and between direct contact with each resident to prevent the potential spread of infection. The failed practice had the potential to affect 53 residents who resided on Halls 3, 8 and 9, as documented on the facility's Roster/Sample Matrix dated 1/10/06. The findings are: 1. Resident #8 had diagnoses of Cerebrovascular Accident (CVA) and Osteoarthrosis. The Quarterly Minimum Data Set	F 444		

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F 444	Continued From page 21 dated 11/15/05 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for toilet use, incontinent of bowel all or most of the time and had multiple daily episodes of bladder incontinence. a. On 1/18/06 at 8:02 a.m., CNA #1 provided incontinent care to the resident, whose incontinent pad was wet with urine. The soiled linens were placed in a plastic bag at the foot of the bed. The CNA tied this bag with her soiled gloves on, then removed the gloves and placed them in the other plastic trash bag. The CNA left the room carrying the linen and trash bags with her bare hands and holding the bags by the ties. The CNA went to the soiled utility room, lifted the linen lid with her left hand and placed the bag into the hamper with her right hand. The CNA then pushed down on the linen bags in the hamper. The CNA left the soiled utility room at 8:19 a.m. without washing her hands. There was no sink present in the soiled utility room. b. On 1/18/06 at 8:20 a.m., CNA #1, who had still not washed her hands, entered Room #87, came out of the room with a water pitcher in her hand, picked up the ice scoop, opened the lid and filled the water pitcher with ice. The CNA then closed the lid, placed the scoop back inside a plastic bag and returned the water pitcher to the room. c. On 1/18/06 at 8:21 a.m., CNA #1, who had still not washed her hands, entered Room #90 after pushing the ice chest cart down the hall. The CNA returned to the ice cart without a water pitcher and pushed the ice cart to the doorway of Room #91.	F 444		

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d. On 1/18/06 at 8:22 a.m., CNA #1, who had still not washed her hands, entered Room #91, came back out with a water pitcher, picked up the ice scoop, opened the lid and filled the water pitcher with ice. The CNA then closed the lid, placed the scoop back inside a plastic bag and returned the water pitcher to the room.

e. On 1/18/06 at 8:24 a.m., after pushing the ice chest cart down the hall, CNA #1 placed the ice chest cart inside the storage room on Hall 7. The CNA still had not washed her hands at this time.

f. On 1/18/06 at 8:25 a.m., CNA #1 went to the linen closet on Hall 10 and obtained clean washcloths and a clean towel. At 8:27 a.m., the CNA pushed Resident #15 in a wheelchair down Hall 8 into the resident's room while still holding the clean linens from the linen closet. The CNA released the resident's seat belt, donned gloves, turned off the chair alarm and attempted to assist the resident to stand for transfer to the commode. The resident was unable to stand and the CNA reapplied the seat belt, removed the gloves and left the room without washing her hands.

g. On 1/18/06 at 8:44 a.m., CNA #1, who had still not washed her hands, went to the linen closet on Hall 10 and obtained clean washcloths and towels. At 8:45 a.m., the CNA put the washcloths and towels on the hand rail outside Room #81. The CNA then entered the room and assisted another CNA to get Resident #14 off the shower chair and into the bed. CNA #1 spread a sheet on the bed, assisted with placement of the lift pad to the resident's back, hooked the lift pad to the lift frame and guided the resident over the bed using the lift pad. CNA #1 then helped to position the resident and moved the lift. The CNA left the

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F 444	Continued From page 23 room without washing her hands. 2. Resident #7 had diagnoses of Psychosis,Osteoarthritis and Hypertension. The Minimum Data Set (MDS) dated 12/7/06 documented the resident was severely impaired in cognitive skills for daily decision-making, required extensive assistance of 1 person for hygiene and was incontinent of bowel and bladder. On 1/19/06 at 9:25 a.m., CNA's #5 and #6 provided incontinent care to the resident. CNA #6 then rolled out a length of paper towels, turned the water on, washed her hands with soap and water then turned the water off with her bare, wet hands before drying her hands with a paper towel. CNA #6 then placed a hat on the resident's head and adjusted the resident's shirt.	F 444		
F 445 SS=E	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure soiled linens were handled in a manner to prevent the potential spread of infection. The failed practice had the potential to affect 132 residents who resided on Halls #1, #2, #3, #4, #5, #8 and #9, as documented on the Roster/Sample Matrix provided by the Director of Nursing on 1/10/06. The findings are:	F 445		

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1. Resident #12 had diagnoses of Bone/Cartilage Disease, Congestive Heart Failure and Retention of Urine. The Minimum Data Set dated 12/26/05 documented the resident had modified independence in cognitive skills for daily decision-making and was totally dependent on staff for personal hygiene.

a. On 1/18/06 at 7:05 a.m., Certified Nursing Assistant (CNA) #7 provided incontinent care to the resident. The CNA placed the feces-soiled incontinent pad on the floor, unbagged, to roll the pad up for removal from the resident's room.

b. On 1/18/06 at 2:45 p.m., CNA #7 was asked how soiled linens should be handled. She stated, "You always bag."

2. Resident #8 had diagnoses of Cerebrovascular Accident (CVA) and Osteoarthrosis. The Quarterly Minimum Data Set dated 11/15/05 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for toilet use, incontinent of bowel all or most of the time and had multiple daily episodes of bladder incontinence.

a. On 1/18/06 at 8:02 a.m., CNA #1 provided incontinent care to the resident, whose incontinent pad was wet with urine. The soiled linens were placed in a plastic bag at the foot of the bed. The CNA tied the bag with soiled gloves, removed the gloves and placed them in the trash bag. The CNA left the room carrying the linen and trash bags with her bare hands and holding the bags by the ties. The CNA went to the soiled utility room, lifted the linen lid with her left hand

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SEARCY HEALTHCARE CENTER	1205 SKYLINE DRIVE SEARCY, AR 72143

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F 445	Continued From page 25	F 445		

and placed the bag into the hamper with her right hand. The CNA then pushed down on the linen bags in the hamper. The CNA left the soiled utility room at 8:19 a.m. and did not wash her hands before passing ice to several other residents.

b. On 1/18/06 at 8:25 a.m., CNA #1, who had still not washed her hands, went to the linen closet on Hall 10 and obtained clean washcloths and a clean towel. At 8:27 a.m., the CNA pushed Resident #15 in a wheelchair down Hall 8 into the resident's room while still holding the clean linens from the linen closet. The CNA released the resident's seat belt, donned gloves, turned off the chair alarm and attempted to assist the resident to stand for transfer to the commode. The resident was unable to stand and the CNA reapplied the seat belt, removed the gloves and left the room without washing her hands.

c. On 1/18/06 at 8:44 a.m., CNA #1, who had still not washed her hands, went to the linen closet on Hall 10 and obtained clean washcloths and towels. At 8:45 a.m., the CNA put the washcloths and towels on the hand rail outside Room #81. The CNA then entered the room and assisted another CNA to get Resident #14 off the shower chair and into the bed. CNA #1 spread a sheet on the bed, assisted with placement of the lift pad to the resident's back, hooked the lift pad to the lift frame and guided the resident over the bed using the lift pad. CNA #1 then helped to position the resident and moved the lift. The CNA left the room without washing her hands.

3. Resident #7 had diagnoses of Psychosis,Osteoarthritis and Hypertension. The Minimum Data Set (MDS) dated 12/7/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045140	A. BUILDING ___ B. WING ___	C 01/19/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEARCY HEALTHCARE CENTER	1205 SKYLINE DRIVE SEARCY, AR 72143

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F 445	Continued From page 26 documented the resident was severely impaired in cognitive skills for daily decision-making, required extensive assistance of 1 person for hygiene and was incontinent of bowel and bladder. On 1/19/06 at 9:25 a.m., CNA's #5 and #6 provided incontinent care to the resident. CNA #6 then rolled out a length of paper towels, turned water on, washed her hands with soap and water, turned the water off with her wet hands, then dried her hands with a paper towel. CNA #6 then placed a hat on the resident's head and adjusted the resident's shirt, using her bare hands that had been contaminated by touching the control knobs of the faucet.	F 445		