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	045239	A. BUILDING ______ B. WING ______	01/26/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO HEALTHCARE CENTER	**1052 OLD WARREN ROAD** **MONTICELLO, AR 71655**

(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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting	F 156		

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 156	Continued From page 1 personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and	F 156		

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F 156	Continued From page 2 applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the names, addresses and telephone numbers of the state survey and certification agency, the state licensure office, the protection and advocacy network, the Medicaid/Medicare fraud control unit and the statement that the resident may file a complaint with the state survey and certification agency concerning Abuse Prohibition and non-compliance with Advance Directives were posted. This failed practice had the potential to affect 69 residents in the facility, as identified by the Administrator on 1/22/07. The findings are: 1. On 1/24/07 at 8:17 a.m., during the environmental tour conducted with the Maintenance Director, the names, addresses and telephone numbers of the state survey and certification agency, the state licensure office, the protection and advocacy network, the Medicaid/Medicare fraud control unit and the statement that the resident may file a complaint	F 156		

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F 156	Continued From page 3 with the state survey and certification agency concerning abuse and non-compliance with Advance directives were unavailable for the residents use. 2. On 1/24/07 at 5:32 p.m., the Administrator stated, "I don't have it [the names and numbers]. I didn't know it was supposed to be posted."	F 156		
F 176 SS=E	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure an assessment was completed, a Physician order was obtained and responsibility of storage of the medications, documentation of the administration and the location of the drug administered was determined prior to allowing self-administration of updrafts for 2 of 2 (Residents #1 and #20) case mix residents. This failed practice had the potential to affect 14 residents in the facility who received respiratory services, as identified by the Registered Nurse Consultant on 1/26/07. The findings are: 1. The facility policy on "Self Administration of Medication" documented: "General Guidelines: 1. A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing by the attending physician. 2. Should the residents's attending physician permit the resident to	F 176		

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F 176	Continued From page 4 administer his/her medications(s), the following conditions will apply. a. The physician's order must be signed and dated prior to self-administration; b. Storage of medications in the resident's room must be such that it will prevent acces by other residents; c. Only the medications permitted for self-administration shall be left at the bedside; d. The nurse supervisor must record in the resident's medical record that self-administration has been authorized and shall identify the name, strength, and quantity of each medication retained at the bedside; and e. Storage of legend drugs at the bedside must be specifically ordered by the prescriber of the drugs and be limited to sublingual or inhalation forms of emergency drugs. 6. Each resident who is permitted to administer his/her medication(s) is responsible for maintaining a record of such administration and for informing the nurse supervisor when such medication(s) were taken..." 2. Resident #1 had diagnoses of Chronic Airway Obstruction, Shortness of Breath, Asthma and Anxiety State. A Quarterly Minimum Data Set (MDS) dated 11/6/06 documented the resident was independent in cognitive skills for daily decision making, required limited assistance for activities of daily living, was unable to lie flat due to shortness of breath and required respiratory therapy 7 days per week. a. A Physician order dated 7/31/06 documented: "DuoNeb Updraft QID (four times a day)." b. On 1/23/07 at 3:52 p.m., the resident was sitting on the side of the bed self-administering an up-draft.	F 176		

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At 4:06 p.m., the up-draft treatment was complete; the resident turned off the machine and put the mouth chamber in a plastic bag and stored it in the machine's storage compartment. There was no nurse present for the treatment.

c. On 1/23/07 at 4:10 p.m., the resident's clinical record was reviewed; there was no documentation regarding self-administration of medications.

d. On 1/24/07 at 11:48 a.m., the resident was asked if she had her 11:00 a.m. updraft; she stated, "No, I haven't done it yet, but I do need to do it before I go to eat lunch or I won't be able to breath. I got to watching that soap opera and I just forgot about doing it."

The resident proceeded to take a tube of medication out of the up-draft storage compartment (the medication was underneath a paper towel), added the medication to the mouthpiece chamber, put the chamber back together, turned the machine on and proceeded with the up-draft treatment. There was no nurse present for the treatment and no one checked on the resident during the treatment.

At 12:02 p.m., the up-draft treatment was completed; the resident was asked, "Do you always do the treatment yourself?" The resident stated, "Yes, I have been doing this for years. The day nurse gives me the medication for the 11:00 a.m. and the 4:00 p.m. dose. I keep it in this compartment of the machine."

e. On 1/25/07 at 11:05 a.m., the Director of Nurses stated, "The updraft is not addressed at all on the care plan." She was unable to locate a

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F 176	Continued From page 6 Physician order for the resident to self-administer medications. f. On 1/27/07 at 11:08 a.m., the resident was sitting on the side of the bed administering the up-draft. There was no nurse present for the treatment. 3. Resident #20 had diagnoses of Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. An Annual MDS dated 1/16/07 documented the resident had moderately impaired cognitive skills for daily decision making, short/long-term memory problems, shortness of breath and received oxygen therapy. a. A Physician order dated 1/2/07 documented, "Duoneb 2.5-0.5 mg [milligrams]/3 ml [milliliters] soln [solution] give updraft four times a day." b. On 1/25/07 at 8:01 a.m., the resident's up-draft was in progress; a family member was in the room. There was no nurse in the room or in the corridor. The family member stated the nurse put the medication in the up-draft, he just watched it. c. On 1/25/07 at 11:05 a.m., the DON stated, "The facility is responsible to ensure the resident does the up-draft. Even though a family member is present, it is still the responsibility of the nurse." d. As of 1/25/07 at 1:00 p.m., there was no Physician order, assessment or care plan for self-administration in the resident's clinical record. 4. On 1/25/07 at 10:50 a.m., the Director of Nurses stated, "As far as I know, I'm not aware of anyone who does self medications. In order for a resident to self-administer medications, you have	F 176		

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F 176	Continued From page 7 to have an order [physician order], make them [resident] a MAR (Medication Administration Record) so they can sign off the med (medication), have a lock box in their room, an assessment to make sure they are cognitive enough to give meds, observation of return demonstration to ensure they can do it properly, address it on the care plan and evaluate it quarterly. All of this should be in the medical record before they [resident] can self administer."	F 176		
F 221 SS=E	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure pre-restraint assessments were completed for 3 (Residents #2, #7 and #22) and consent forms were completed for 2 (Residents #2 and #22) of 11 (Residents #5, #7, #8, #14, #19, #20, #21, #22, #25, #26 and #27) case mix residents who had Physician orders for physical restraints. This failed practice had the potential to affect 14 residents who had Physician orders for physical restraints, as identified by the Registered Nurse Consultant on 1/26/07. The findings are: 1. Resident #2 had diagnoses of Dementia with Behaviors and Psychosis. A Significant Change Minimum Data Set (MDS) dated 12/7/06 documented the resident had moderately impaired cognitive skills for daily decision making, short/long-term memory problems and used full	F 221		

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F 221	Continued From page 8 bed rails daily. a. A Physical Restraint Elimination Assessment form dated 1/10/07 documented a score of 23 with 21-35 as a good candidate. The action plan and less restrictive measures to be used sections of the form were not completed. The additional comments section documented: "SR [side rails] ^ [up] x 2 Bed and chair alarm to prevent unassisted transfer." b. A Physician order dated 1/19/07 documented: "Soft waist restraint while ^ in w/c (wheelchair), check Q (every) 30 mins (minutes) released Q 2 hrs (hours) x (times) 10 mins." c. On 1/22/07 at 5:58 p.m. and on 1/23/07 at 7:15 a.m. and 11:40 a.m., the resident was in a wheelchair with an easy-release soft belt in place. d. On 1/23/07 at 12:40 p.m., the resident was in her room in a wheelchair; the resident pulled at her easy-release soft belt restraint and stated, "Take this thing off so I can stand up." e. On 1/26/07 at 10:24 a.m., the Assistant Director of Nurses (ADON) provided a copy of a Physical/Chemical Restraints Record of Informed Consent form dated 1/19/07 that documented: "Soft waist restraint" and "1/19/07 Verbal consent from [family member] will be up here to sign soon as possible." The form was not signed by a family member. f. On 1/26/07 at 10:24 a.m., the ADON stated, the resident had an "order for a soft belt. She has on a self release. I called the [family member] to sign the consent today. We had one (consent form) at the desk and it got lost." When asked if the	F 221		

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resident had a pre-restraining assessment, the ADON stated, "No assessment for" the restraint "just an order due to" the resident "tries to transfer by her self."

2. Resident #22 had diagnoses of General Muscle Weakness and Hemiplegia. A Quarterly Minimum Data Set dated 11/14/06 documented the resident was independent in cognitive skills for daily decision making, required limited assistance for activities of daily living, had Cerebral Palsy, had fallen in the past 30 days and in the past 31 to 180 days and daily used a chair that prevented rising.

a. A Physician order dated 9/11/06 documented: "Upper Body Torso" as the physical restraint.

b. The resident's plan of care revised on 11/14/06 documented: "Problem: at risk for injury related to fall(s) AEB (as evidenced by) use of [marked out] and hx (history) of multiple falls. Resident non-compliant with requesting assistance with transfers and tilting. Interventions: 9/11/06 Upper Body Torso re-instated."

c. The Physical/Chemical Restraints Record of Informed Consent form was blank in the boxes of "Give my permission, and Refuse to give my consent" for the "Upper Body Torso to prevent unassisted transfers."

d. On 1/25/07 at 8:08 a.m. and 10:02 a.m., the resident was in a wheelchair with an upper body torso restraint in place.

e. As of 1/25/07 at 10:35 a.m., there was no "Pre-Restraining Assessment" for the resident's Upper Body Torso Restraint available for review.

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F 221	Continued From page 10 3. Resident #7 had diagnoses of Dementia with Behavioral Disturbance, Alzheimer's Disease, Anxiety State, Depressive Disorder and Lack of Coordination. An Annual Minimum Data Set dated 11/27/06 documented the resident had short/long-term memory loss, modified independence in cognitive skills for daily decision making, extensive to total dependence on staff for activities of daily living and used daily a chair that prevented rising. a. The resident's printed Physician's orders dated January 2007 documented: "12/12/06 Soft waist belt while up in wheel chair, check for placement Q (every) 30 minutes and release Q 2 hours for ROM (range of motion) and BRP (bathroom privileges)." b. The plan of care revised on 11/27/06 documented: "Problem: at risk for falls AEB (as evidenced by) hx (history) of falls, use of antidepressant/antianxiety med use, use of soft waist belt while up in wheel chair & sleeps on a low bed with mat." c. On 1/22/07 at 2:09 p.m., 4:50 p.m. and 5:18 p.m., on 1/23/07 at 7:17 a.m., 8:17 a.m., 10:06 a.m. and 11:47 a.m., the resident was in a wheelchair with a lap belt restraint on. d. As of 1/24/07 at 2:20 p.m., there was no "Pre-Restraining Assessment" for the resident's soft waist belt restraint available for review.	F 221		
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	F 241		

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F 241	Continued From page 11 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to organize meal service and eating assistance in a manner to allow meals to be consumed simultaneously by residents at the same table for 2 (Residents #12 and #13) of 18 (Residents #1 thru #18) case mix residents who received meals from the kitchen. This failed practice had the potential to affect 67 residents who received their meal trays from the kitchen, as identified by the facility diet list dated 1/22/07. The findings are: 1. Resident #12 had diagnoses of Abnormal Loss of Weight, Anorexia, Depression and Alzheimer's Disease. A Quarterly Minimum Data Set dated 11/6/06 documented the resident had modified independence in cognitive skills for daily decision making and required set up only for meal trays. a. A Physician order dated 4/27/06 documented, "Regular (Diet)." b. On 1/22/07 at 5:23 p.m., during the supper meal, there were three residents sitting at a table. Two of the three residents had received their supper trays and were eating while Resident #12 sat and waited to receive a tray. At 5:33 p.m., the resident stated, "I have not gotten any food." At 5:46 p.m., the resident stood up and was leaving the dining room when she was stopped by Certified Nursing Assistant (CNA) #1 who stated,	F 241		

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F 241	Continued From page 12 "Resident did not have her tray because she was a feeder [required assistance with feeding]." At this time, the resident was assisted back to her table by CNA #2. The resident remained sitting in her chair at the table with no food tray or beverage served to her. At 5:53 p.m., she got up and left the dining room with no attempt made by the staff to bring her back. At 6:14 p.m., the resident was brought back to the dining room and was served hamburger, fries, chocolate pudding, fruited gelatin, one packet of Mayonnaise (that was not opened) and a glass of tea. She fed herself with the supervision of License Practical Nurse (LPN) #3. The nurse stated, "They considered her a feeder." The resident, in reply, stated; "I have never heard of such a racket." 2. Resident #13 had diagnoses of Muscle Weakness, Depressive Disorder, Cerebral Vascular Accident and Congestive Heart Failure. A Minimum Data Set dated 12/15/06 documented the resident had modified independence in cognitive skills for daily decision making and required one person assistance for eating. a. A Physician order dated 9/21/06 documented, " Pureed fortified foods with honey thickened foods, no straws and no tuna or fish." b. On 1/22/07 at 5:30 p.m., during the supper meal, there were three residents sitting at a table; two of the three residents had received their supper meal trays and were eating while Resident #13 waited to receive her tray.	F 241		

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F 241	Continued From page 13 At 6:49 p.m., the resident was served pureed hamburger meat, a puree mixture which consisted of bun-lettuce-tomatoes-pickles, chocolate pudding, fries, pineapple with it's juice in it.	F 241		
F 246 SS=E	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure eating assistive devices were provided to accommodate 1 (Resident #7) of 2 (Resident #7 and #28) case mix residents who required an assistive device at meals and that nourishment was provided in a form that was tolerated and consumed for 1 (Resident #8) of 2 (Residents #6 and #8) case mix residents who were dependent on staff for dining. This failed practice had the potential to affect 5 residents who required assistive devices at meals, as identified by the Unit Manager on 1/26/07 and 13 residents who were dependent for dining, as identified by the Resident Census and Conditions of Residents form dated 1/22/07. The findings are: 1. Resident #7 had diagnoses of Anorexia, Lack of Coordination, Dementia with Behavior Disturbance, Alzheimer's Disease, Anxiety State, Depressive Disorder and Muscle Weakness. An Annual Minimum Data Set (MDS)dated 11/27/06	F 246		

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F 246	Continued From page 14 documented the resident had short/long-term memory problems, modified independence in cognitive skills for daily decision making, extensive to total dependence on staff for activities of daily living, chewing problems and required set up help with meals. a. On 1/22/07 at 5:28 p.m., the resident was in the dining room eating the supper meal. The resident was approximately 18-inches away from the table in her wheel chair. The resident was served a hamburger, lettuce, tomato, pickles, onion, fruited jello and tea. The resident was using a fork to take the tomato off the hamburger, dropping food into her lap. The jello fell to the table, off the fork, and the resident used her fingers to pick up the jello and eat it. b. On 1/23/07 at 7:17 a.m., the resident was in a wheelchair in the dining room, eating breakfast. The resident was using a fork to eat scrambled eggs, dropping egg down the front of her chest area. Using the fork, the resident pushed the egg around on the regular dining plate, leaving egg scattered on the table cloth when the meal was finished. c. On 1/23/07 at 12:42 p.m., the resident was in a wheelchair in the dining room eating lunch. The resident was served whole kernel corn on a regular dining plate. The resident pushed the corn around on the plate with her fork and when the meal ended there was corn pushed off the plate, at the top, onto the table cloth. d. On 1/23/07 at 1:12 p.m., the Registered Nurse (RN) Consultant was asked if there was something that could make the meal process easier on the resident, as she observed the	F 246		

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resident pushing the corn around and off the plate; the RN consultant stated, "She could use a divided plate." She was then asked if the resident had been assessed for assistive devices. She stated, "Not that I am aware of."

2. Resident #8 had diagnoses of Dysphagia, Muscle Weakness, General, Dehydration, Renal Failure, Congestive Heart Failure, Electrolyte/Fluid
Disorder, Anorexia, Hypertension, Blindness and Low Vision and Dementia in other diseases. A Minimum Data Set (MDS) dated 1/1/07 documented the resident had short/long-term memory problems, was severely impaired in cognitive skills for daily decision making and dependent on staff for activities of daily living.

a. The resident had a Care Plan Problem, with an onset date of 4/4/06 and notation to continue current plan of care dated 1/1/07, for "At risk for further weight loss AEB (as evidenced by) hx (history) of weight loss, at risk for weight loss related to mechanically altered diet" with approaches including "determine food preferences and offer alternate foods for those dislike or consistently left on tray."

b. On 1/23/07 at 7:34 a.m., the resident was fed by CNA #11. The resident would close his mouth when food was brought to his lips. The CNA stated the resident would drink better than he will eat. The resident consumed 1/2 of his super cereal, two 8-ounce glasses of thickened juice and 6-ounces of thickened milk.

c. On 1/23/07 10:00 a.m., CNA #10 was feeding the resident his morning supplement of chocolate pudding. The CNA stated "I don't feed him that

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F 246	Continued From page 16 much, but I know when I do, he does better with the liquids. The resident consumed 1/3 of the chocolate pudding and all of the thickened water. d. On 1/26/07, the Dietary Manager stated she was unaware the resident would consume liquids better than the pureed foods.	F 246		
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure an in-room activities program was provided for 1 (Resident #8) of 2 (Residents #6 and #8) case mix residents who required in room activities. This failed practice had the potential to affect 12 residents who received in room activities, as documented on the facility's January 2007 Individual Programming Daily Participation Log copied on 1/26/07 at 10:00 a.m. The findings are: Resident #8 had diagnoses of Dysphagia, Muscle Weakness, General Dehydration, Renal Failure, Congestive Heart Failure, Electrolyte/Fluid Disorder, Anorexia, Hypertension, Blindness and Low Vision and Dementia in other diseases. A Minimum Data Set (MDS) dated 1/1/07 documented the resident had severely impaired cognitive skills for daily decision making, could sometimes make self understood, sometimes could understand others and had an average time	F 248		

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F 248	Continued From page 17 involved in activities of none. a. An Activity Assessment dated 1/1/07 documented the resident was unable to participate in group activities, rarely initiated conversations, was unable to make needs known, used a wheelchair mobile/Geri chair, was dependent on others for wheelchair transport, had poor vision and was non-responsive. b. An Activities progress note dated 1/1/07 documented: "Quarterly- Resident is assisted to group activities at times by RSD/staff. Resident does not respond when someone talks to him and sits in activity area with eyes closed. Family prefer that resident spends time in room d/t (due to) he is non responsive. Resident's spouse visits often." c. A care plan problem dated 1/1/07, documented: "Little-less than 1/3 of time spent in activity, resident unable to participate due to dementia" with interventions of "staff will talk to resident during care; provide in room activities that do not require participation from resident: music, reading to him, etc.; introduce self to resident before each interaction; and offer reality orientation on all possible occasions and contacts, and continue to provide in room activities for stimulation." d. On 1/23/07 at 10:00 a.m., 10:48 a.m., 1:04 p.m., 1:20 p.m., 2:20 p.m. and on 1/24/07 at 10:00 a.m., there was not a television or radio present in the resident's room. e. On 1/26/07 the Individual Programming daily participation Log for January 2007 was reviewed; the resident's name did not appear on the log.	F 248		

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F 248	Continued From page 18 f. On 1/26/07 at 1:35 p.m., the Activities Director stated, "I never put him on one to one because he does not respond. Sometimes I go in and talk to him and rub his face, but that's all."	F 248		
F 253 SS=C	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure resident bathing rooms were not used for storage of equipment, the ceiling was free of stains, the hall floor tiles were free of black marks, boxes were stored off the floor, drywall was free of cracks and in good repair, door frames were free of chipped and scarred paint, the dining room serving window and dish window were free of build-up and food splatters, the exterior of the ice machine was free of water marks and debris, the trash dumpster remained covered and window mini blinds were in good working order. The facility further failed to ensure that a wheelchair arm was not torn for 1 (Resident #5) of 8 (Residents #2, #4 thru #7, #14, #19 and #20) case mix residents who used a wheelchair. These failed practices had the potential to affect all 69 residents in the facility, as identified by the Administrator on 1/22/07 and 24 residents who used a wheelchair, as identified on a list provided by the facility on 1/26/07. The findings are: 1. On 1/24/07 at 8:17 a.m., during the environmental tour, the following observations were made:	F 253		

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F 253	Continued From page 19 a. The 200 Hall Bathing room had the paint scarred on the door frame on both sides, measuring approximately 3 feet up the frame from the floor. b. The 200 Hall Bathing room contained the following items stored in the room: 1 shower chair, 1 polyvinyl chloride (PVC) Geri chair, 1 wheelchair, 1 ARJO lift, 1 five-gallon bucket biohazard container, 1 regular chair, 1 3-compartment linen container and 1 linen cart. c. The shower stall in the 200 Hall resident bathing room had a build-up of a yellowish brown substance in the grout lines, in the bottom one half of the shower. d. On 200 Hall, at the end of the hall next to the exit door, there was a circular brown stain on the ceiling approximately 1-foot by 4-inches in diameter. e. Between Rooms #208 and #210 there were 15 black marks on the floor tiles, measuring approximately 1-inch in diameter. f. The Medical Supply Storage room, located in the Day Room, had 3 cases of Ensure and 5 boxes of trash can liners stored directly on the floor. g. The Janitor's Closet, next to the smoking area, had a divider wall between the mop sink and the chemical storage in which the plaster was missing on the bottom area of the wall approximately 6-inches up from the floor and a rust colored substance on the metal; the metal was bent outward.	F 253		

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F 253	Continued From page 20 h. At the entry to the beauty parlor, there were two wall vents that were discolored with a rust colored substance. i. On 400 Hall, the Storage room door frame had chipped paint on both sides of the door frame. j. The 400 Hall Clean Linen room had a hole in the wall behind the door measuring approximately 1-inch in diameter. k. The clean side of the laundry had two ceiling vents that were discolored with a rust colored substance and the plaster was missing around the vents. l. The 400 Hall Shower/Whirlpool room had the following items stored in the room: 1 Geri chair, 2 wheelchairs, 1 ARJO lift, 2 bed side commodes, 1 stretcher lift, 1 folding screen, 1 back board and 2 wheelchair legs. m. The wall at the end of the Whirlpool (400 hall) had gouges and scrapes in the drywall, with a 2-inch gouge where the plaster was missing. n. In the middle of 400 Hall, stretching the length of the hall, were 15 black marks on the floor tiles. o. In the IV Storage room there were 4 empty boxes left on top of the stored boxes of supplies. p. In the Dining Room, the following observations were made: 1) The dirty dish window had a build-up of dried food substance on both sides of the window approximately 6-inches from the bottom of the window.	F 253		

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F 253	Continued From page 21 2) In the corner next to the window, there was a build-up of a black substance. 3) At the serving window, to the right, there was a brown substance splattered on the wall, reaching 12-feet up to the ceiling. 4) Under the coffee cart, a rug covered 15 floor tiles that were brown stained and cracked, and 13 floor tiles that had a black substance around the edges of the tiles. 5)The ice machine had brown streaks along the front and right panel of the machine that ran from the top of the machine to the bottom of the machine. 6)At the eating assistance tables, there were 9 corners that were gouged and had plaster missing that corresponded with the tops of the tables. In the middle of the room, there were 2 floor tiles cracked and both had a piece of missing tile approximately 1-inch in diameter. q. The following Resident Rooms had chipped and scarred paint on the door frames: #301, #302, #303, #309, #310, #311 and #312. r. In the 300 Hall Janitor's closet, there were 22 boxes of supplies stored directly on the floor. s. The resident bathing room on 300 Hall had the following items stored in the room: 1 ARJO walker, 1 ARJO lift, 1 therapy stairway, 1 lap buddy and 1 wheel chair. The entry wall on the left had an area, approximately 3-feet up from the floor and extending 3-feet in length, where there were gouges in the drywall.	F 253		

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F 253	Continued From page 22 t. In the Men's restroom on 300 Hall, there was a 1-inch hole in the linoleum behind the commode. The ceiling vent had a rust colored substance on the surface. u. In the middle of 300 Hall, extending the length of the hall, there were 18 black marks on the floor tiles. v. Dumpster #1 had the lid down inside the container. There were 5 items of trash on the ground around the dumpster. w. Resident Rooms #310 and #316 had bent louvers on the window's mini blinds. 2. On 1/23/07 at 1:28 p.m., there was a tear approximately 3-inch long on the left wheelchair arm of Resident #5. The tear was not sharp or jagged.	F 253		
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 that a Physician plan of care was implemented for therapeutic diets for 7 (Residents #2, #5, #6, #8, #12, #13 and #14) of 24 (Residents #1 thru #10, #12 thru #17, #19, #20, #22 and #24 thru #28) case mix residents who had Physician orders for	F 282		

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F 282	Continued From page 23 therapeutic diets, physical restraints were released as ordered by the Physician for 3 (Residents #2, #5 and #7) of 11 (Residents #2, #5 thru #8, #19, #20, #22 and #25 thru #27) case mix residents who had physical restraints and the Physician was notified for finger stick blood sugars over 350 for 1 (Resident #5) of 3 (Residents #1, #4 and #5) case mix residents who required finger stick blood sugars. This failed practice had the potential to affect 7 residents who received thickened liquids and 17 residents who received fortified foods, as identified on the diet list received from the Dietary manger on 1/22/07, 14 residents who required physical restraints, as identified by the Registered Nurse (RN) Consultant on 1/26/07 and 16 residents who were diabetic, as identified by the Director of Nursing (DON) on 1/31/07. The findings are: 1. Resident #14 had diagnoses of Altered Mental Status, Acute Renal Failure, Depressive Disorder and Reflux Esophageus. A Minimum Data Set (MDS) dated 11/16/06 documented the resident was moderately impaired in cognitive skills for daily decision making and required set up help only for eating. a. A Physician order dated 11/9/06 documented: "Diet: Regular ground with honey thickened liquid." b. A speech/language pathology progress note dated 1/22/07 documented: "Impact on burden of care/remaining functional deficits: Pt (patient) continues to have dysphagia deficits with thin liquids and will continue on honey thickened liquids at this time due to no s/s (signs/symptoms) of aspiration and no recurrent pneumonia at this time."	F 282		

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c. On 1/23/07 at 7:21 a.m., the resident took a carton of whole milk served to Resident #7, who was sitting at the same table with her, and started drinking it. When the surveyor informed Certified Nursing Assistant (CNA) #1 that the resident was drinking Resident #7's milk, the CNA went to the kitchen and brought another carton of milk to Resident #7.

There was no attempt made by the CNA to take the milk away from the resident, due to resident's order being thickened liquid.

2. Resident #2 had diagnoses of Dementia with Behavior, Alzheimer's Disease and Peripheral Vascular Disease. A Significant Change Minimum Data Set dated 12/17/06 documented the resident was moderately impaired in cognitive skills for daily decision making and required one person assistance for eating.

a. A Physician order dated 11/24/06 documented: "Diet: Pureed NSP (No Salt Packet) Diet" and a Physician order dated 12/28/06 documented: "Fortified foods."

b. On 1/23/07 at 11:40 a.m., the resident was served pureed green bean salad, apple sauce, chicken, corn, a 4-ounce carton of mighty shake, an 8-ounce glass of tea, a 6-ounce glass of water and regular prepared mashed potatoes, instead of fortified potatoes.

3. Resident #5 had diagnoses of Diabetes Mellitus and Decubitus Ulcer. A Medicare 30-Day Minimum Data Set dated 1/17/07 documented the resident had modified independence in cognitive skills for daily decision making and required one

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person assistance for eating.

a. A Physician order dated 12/19/06 documented: " Diet: Low concentrated sweet diet with fortified foods."

b. On 1/23/07 at 11:45 a.m., the resident was served 1 roll, corn, green bean salad, pineapple, an 8-ounce glass of tea, a 6-ounce glass of water and regular prepared potatoes, instead of fortified potatoes. The fortified potatoes were on the steam table, but not being served to any residents.

4. Resident #6 had diagnoses of Decubitus Ulcer and Esophageal Reflux. A Minimum Data Set dated 11/3/06 documented the resident had modified independence in cognitive skills for daily decision making and required one person assistance for eating.

a. A Physician order dated 9/21/05 documented: "Diet: No Added Salt with Fortified Foods."

b. On 1/23/07 at 11:55 a.m., the resident was served barbecue chicken, three bean salad, pineapple with cherries, corn, roll, tea and regular mashed potatoes, instead of fortified mashed potatoes.

5. Resident #8 had diagnoses of Anorexia, Dehydration, Congestive Heart Failure, Dysphagia and Renal Failure. A Quarterly Minimum Data Set dated 1/1/07 documented the resident was severely impaired in cognitive skills for daily decision making and required one person assistance for eating.

a. A Physician order dated 1/15/07 documented:

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F 282	Continued From page 26 "Add Fortified food." b. On 1/23/07 at 11:37 a.m., the resident was served pureed barbecue chicken, three bean salad, apple sauce, corn, thickened milk and regular prepared mashed potatoes, instead of fortified potatoes as per the Physician's order. 6. Resident #12 had diagnoses of Abnormal Loss of Weight, Anorexia, Depressive Disorder and Alzheimer's Disease. A Quarterly Minimum Data Set dated 11/6/06 documented the resident had modified independence in cognitive skills for daily decision making and required set up help for eating. a. A Physician order dated 1/9/07 documented the resident was to receive fortified foods three times a day. b. On 1/23/07 at 11:54 a.m., the resident was served corn, barbecue chicken, three bean salad, a roll, a carton of mighty shake and regular prepared mashed potatoes, instead of fortified mashed potatoes. 7. Resident #13 had diagnoses of Congestive Heart Failure and Nutritional Anemia. A Minimum Data Set dated 12/15/06 documented the resident had modified independence in cognitive skills for daily decision making and required one person assistance for eating. a. A Physician order dated 9/21/06 documented: "Diet: Pureed Fortified foods." b. On 1/23/07 at 11:56 a.m., the resident was served regular prepared mashed potatoes, instead of fortified potatoes.	F 282		

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8. Resident #7 had diagnoses of Dementia with behavioral disturbance, Alzheimer's Disease, Anxiety State, Depressive Disorder and Lack of Coordination. An Annual MDS dated 11/27/06 documented the resident had short/long-term memory problems, modified independence in cognitive skills for daily decision making, extensive to total dependence on staff for activities of daily living and daily required a chair that prevented rising.

a. The resident's January 2007 Physician Orders documented: "12/12/06 Soft waist belt while up in wheel chair, check for placement Q (every) 30 minutes and release Q 2 hours for ROM (range of motion) and BRP (bathroom privileges)."

b. The resident's plan of care dated 11/27/06 documented: "Problem: at risk for falls AEB (as evidenced by) hx (history) of falls, use of antidepressant/antianxiety med (medication) use, use of soft waist belt while up in wheel chair & sleeps on a low bed with mat. (mattress) Intervention: Check and release soft waist belt per facility protocol for toileting, ROM, etc."

c. On 1/22/07 at 5:18 p.m. and on 1/23/07 at 7:17 a.m., the resident was in a wheelchair in the dining room; the resident's restraint was untied in the back, while the resident was at the dining table, however, the belt remained snug around the front of the resident and was not released from the arms of the wheel chair.

9. Resident #2 had diagnoses of Dementia with Behaviors and Psychosis. A Significant Change (MDS) dated 12/7/06 documented the resident had moderately impaired cognitive skills for daily

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decision making, had short/long-term memory problems and used full bed rails daily.

a. A Physician order dated 1/19/07 documented: "Soft waist restraint while ^ (up) in w/c (wheelchair), check Q (every) 30 mins (minutes) released Q 2 hrs (hours) x (times) 10 mins."

b. On 1/22/07 at 5:58 p.m., on 1/23/07 at 7:45 a.m. and 11:40 a.m., the resident sat in a wheelchair in the dining room. The resident's easy release waist restraint straps were untied from the back kick bars of the wheelchair, but not undone or loosened from the wheelchair arms. The waist belt remained snug around the resident's waist. She was not repositioned in any way by the staff.

10. Resident #5 had diagnoses of Dementia with Behaviors and Alzheimer's Disease. A Quarterly MDS dated 12/7/06 documented the resident had modified independence in cognitive skills for daily decision making, short/long-term memory problems and a restraint.

a. A Physician order dated 12/19/06 documented: "Easy release seat belt when up in wheel chair to assist with upper body alignment. To be checked every 30 min and released every 2 hrs for ROM (range of motion) and incont (incontinent) care."

1) On 1/22/07 at 5:33 p.m. and on 1/23/07 at 7:20 a.m. and 11:45 a.m., the resident was in a wheelchair in the dining room with a waist restraint on. The straps of the restraint were not tied to the back kick bars of the wheelchair. The straps were not release from around the arms of the wheelchair and the restraint was snug on the resident's waist. The resident was not

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F 282	Continued From page 29 repositioned by staff. 2) On 1/23/07 at 12:34 p.m., Certified Nurse Assistant (CNA) #3 stated, "I don't understand why they untied this restraint in both places." b. A Physician order dated 12/19/06 documented: "Accucheck 2 hour post prandial supper call for blood sugars less than 60 or greater than 350." 1) The resident's January 2007 Medication Administration Record (MAR) documented blood sugars of 353 on 1/9/07, 352 on 1/10/07, 359 on 1/16/07, 360 on 1/18/07, 362 on 1/20/07 and 351 on 1/21/07. 2) On 1/26/07 at 10:15 a.m., when asked for documentation that the Physician had been notified, Licensed Practical Nurse (LPN) #4 stated there was none. 11. On 1/26/07 at 10:59 a.m., the ADON and DON when asked why the restraints were untied from the back kick bars of the wheelchairs at meal time, both stated, "Eating is a good time to release the restraint." When asked if the residents were repositioned during this time, both stated, "No."	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.	F 309		

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This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure necessary care and services were provided as evidenced by failure to assess for toileting needs and intervene in a timely manner for 1 (Resident #2) of 9 (Residents #2, #4, #5, #7, #6, #8, #14, #19 and #20) case mix residents who were incontinent or had incontinent episodes and that staff intervened in a timely manner by conducted assessments and contacting the Physician for 1 (Resident #4) of 10 (Residents #1, #3, #5, #6, #7, #8, #9, #14, #19, #20) case mix residents who had Physician orders for PRN (as needed) pain medication. This failed practice had the potential to affect 37 residents who were incontinent of bowel and bladder or had incontinent episodes and 58 residents who had Physician ordered PRN pain medications, as identified by a list provided by the facility on 1/26/07. The findings are:

1. Resident #2 had diagnoses of Dementia with Behaviors, Constipation/Diarrhea and Urinary Tract Infection. A Significant Change Minimum Data Set (MDS) dated 12/7/06 documented the resident had moderately impaired cognitive skills for daily decision making, short/long-term memory problems, was totally dependent on two staff persons for toilet use, incontinent of bowel and had an indwelling catheter.

a. The resident had a Physician order dated 1/19/07 that documented: "Soft waist restraint while ^ in w/c (wheelchair)..." and a Physician order dated 12/5/06 that documented: "...Foley cath (catheter)..."

b. The resident's Plan of Care dated 12/06/06

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F 309	Continued From page 31 documented: "Provide 1 person assist with toileting" and "Assist Resident to bathroom as needed." c. On 1/23/07 at 9:31 a.m., the resident wheeled herself into the bathroom in her room. The resident leaned forward and backward 4 times against the waist restraint and shut the bathroom door. When the surveyor asked the resident if she needed help, the resident stated, "I got to go to the bathroom." d. On 1/23/07 at 9:40 a.m., the resident said to a Certified Nursing Assistant (CNA), "I got to get some of these clothes off." The resident was pulling at her clothing. The surveyor informed the CNA that the resident had requested to go to the bathroom. The CNA stated, "You have a catheter and don't need to get on the commode." The CNA pushed the resident in the wheelchair out of the room and to the group activity. The resident had clear yellow urine in her Foley catheter tubing. e. On 1/23/07 at 12:40 p.m., the resident was alone in her room. She tugged at the restraint and stated, "Take this thing off so I can stand up." At 12:45 p.m. a laundry staff person entered the room. The resident stated, "Undo this" and pulled on the restraint. The laundry person left the room. The resident wheeled her wheelchair into the bathroom, leaned forward against the restraint and wheeled her self out of the bathroom. f. On 1/23/07 at 1:50 p.m., Certified Nursing Assistant (CNA) #4 and CNA #5 entered the resident's room and stated to the resident, "We are here to put you down." CNA #4 stated the resident had "been up since before I got here"	F 309		

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F 309	Continued From page 32 and "been up since before 6:00 (a.m.)." The resident refused to go to bed. The CNAs left the room. g. On 1/23/07 at 2:38 p.m., when asked if the CNA's had told her anything about this resident. LPN (Licensed Practical Nurse) #5 stated, "No, CNAs did not tell me anything." The LPN was informed by the surveyor that according to the CNA's statements, the resident had been up in the wheelchair since 6:00 a.m. LPN #5 and CNA #5 went to the resident's room; the resident stated, "I want to go to the bathroom." CNA#5 stated, "You have a catheter, go ahead and go in that." LPN #5 asked the resident if she wanted to go to bed and left the room to "get help." When asked what she would do when the resident acted this way, CNA #5 stated, "I would try to comfort her." The CNA did not mention she would tell a nurse until being prompted by surveyor. h. On 1/23/07 at 2:52 p.m., LPN #5 returned to the room and administered one pill to the resident. When asked what the pill was, the LPN stated, "Ativan." The LPN did not ask the resident any questions or examine her prior to administering the pill. i. On 1/23/07 at 3:15 p.m., when asked if she had any pain, the resident stated, "No, I just got to pee." CNA #6 and CNA #7 entered the room. The resident stated, "I want to go to the bathroom." The CNA's assisted the resident to the toilet. She had a moderate amount of formed feces. CNA #6 stated, "Her catheter must be leaking" and showed the surveyor the resident's wet brief.	F 309		

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j. The most current Nurse's Note in the resident's clinical record was dated 1/20/07.

k. The 24-Hour Nursing Report dated 1/23/07 documented: " [Resident #2] ativan @ (at) 2:45."

l. The 24-Hour Nursing Report dated 1/24/07 documented: " [Resident #2] d/c (discontinue) Foley cath (catheter) d/c tx (treatment) to G-tube D/C Zoloft & (and) Ativan/Flush peg-tube c (with) 60 cc (cubic centimeters) H2O (water) q (every) shift." There was no documentation the resident's skin or indwelling catheter had been assessed on 1/23/07.

m. On 1/24/07 at 2:10 p.m., when asked if toileting assessments had been done for incontinent residents, LPN #3 and the MDS Coordinator stated there were no assessments done. When asked if the facility had a toileting program, they stated, "No."

2. Resident #4 had diagnoses of Joint/Leg pain, Cramp in Limb, Difficulty in Walking and Colon Cancer. An Annual Minimum Data Set dated 10/4/06 documented the resident had short-term memory loss, was independent in cognitive skills for daily decision making, required limited assistance for activities of daily living and had mild joint pain.

a. The resident's Medication Administration Record dated January 2007 documented: "11/28/06 Ultram 50 mg (milligrams) tablet give 1 PO (by mouth) QID (four times a day)." The medication was documented as given four times per day on January 1 2007 thru January 3, 2007.

b. The resident's clinical record documented the

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F 309	Continued From page 34 resident was in the hospital January 4 - 8, 2007. c. The resident's Daily Skilled Nurses Notes dated 1/11/07 documented: "11-7 Res (resident) in bed not sleeping requesting a pain pill for leg pain. Advised resident she did not have a pain pill ordered, but I (LPN) would pass her request along for DR (doctor) to be called in a.m. for something PRN (per request) by nurse on next shift in a.m." d. On 1/12/07 a telephone order documented: "1/12/07 Ultram 50 mg (1 or 2) tab PO Q 4 PRN, pain." e. The resident's plan of care did not address pain as a problem nor any interventions to relieve pain. f. On 1/25/07 at 9:25 a.m. the resident stated, "There was one night I asked [for a pain med] and they [the nurse] told me I didn't have any pain meds ordered. They didn't do anything that night to relieve the pain." g. There was no pain assessment completed for January 11, 2007 and there were no alternative interventions put into place to provide the resident comfort to relieve the pain.	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	F 312		

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by:
Based on observation, record review and interview the facility failed to ensure toenail care was provided for 3 (Residents #5, #6 and #8) and fingernails were trimmed for 1 (Resident #19) of 13 (Residents #1 thru #9, #19, #20, #22 and #23) case mix residents dependent on staff for nail care. This failed practice had the potential to affect all the residents in the facility, as identified by the Unit Manager on 1/26/07. The facility further failed to ensure pericare was provided for 2 (Residents #5 and #8) of 9 (Residents #2, #4, #5, #6, #7, #8, #14, #19 and #20) case mix residents who were incontinent. This failed practice had the potential to affect the 37 residents in the facility who were incontinent, as identified by the Unit Manager on 1/26/07. The findings are:

1. Resident #8 had diagnoses of Dysphagia, Muscle Weakness, General Dehydration, Renal Failure, Congestive Heart Failure, Electrolyte/Fluid
Disorder, Anorexia, Hypertension, Blindness and Low Vision and Dementia in other diseases. A Minimum Data Set (MDS) dated 1/1/07 documented the resident had short/long-term memory problems, severely impaired cognitive skills for daily decision making and was dependent on staff for activities of daily living.

a. On 1/23/07 at 3:43 p.m., incontinent care was provided by Certified Nursing Assistant (CNA) #8 and CNA #9. CNA #8 failed to cleanse the resident's buttocks that had been in contact with urine.

b. The resident's Care Plan listed a problem dated 1/1/07 of, "Requires total care with ADLs

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F 312	Continued From page 36 (activities of daily living)" with an intervention of "nailcare weekly and as needed." c. On 1/24/07 at 2:10 p.m., the nail on the resident's right great toe was noted to be thick, dome shaped rising approximately 1/2 inch from the nail bed, with an irregular, uneven surface. 2. Resident #6 had diagnoses of Quadriplegia and Peripheral Vascular Disease. A Minimum Data Set dated 11/3/06 documented the resident had modified independence in cognitive skills for daily decision making and was totally dependent on staff for hygiene and bathing. a. The resident had a care plan problem with an onset date of 11/03/06 of, "Requires total care for all needs" with approaches "provide one person assist with personal hygiene." b. On 1/24/07 at 10:05 a.m., a body audit was done with LPN #4 in attendance. The toenail to the right great toe was growing upward approximately 1/2 inch, not growing into the nail bed which could snag on the lines and pull; the second toenail was growing upward off the nail bed and the third toe nail was growing curving over the tip of the toe. The LPN stated "We need to get you out to the [name of Podiatrist]. 3. Resident #19 had diagnoses of Dysphagia, Fracture Femur and Psychosis. An MDS dated 1/18/07 documented the resident had short/long-term memory problems, severely impaired cognitive skills for daily decision making and was dependent on staff for all activities of daily living. a. The resident had a care plan problem with	F 312		

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F 312	Continued From page 37 dated 1/18/07, "Requires total care for all ADLs" and approaches to include "nail care weekly and as needed." b. On 1/25/07 at 8:50 a.m., the resident's finger nails were long, extending past the tips of the fingers and jagged. 4. Resident #5 had diagnoses of Dementia with Behaviors and Alzheimer's Disease. A Quarterly MDS dated 12/7/06 documented the resident had modified independence in cognitive skills for daily decision making, short/long-term memory problems, was totally dependent on staff for personal hygiene, occasionally incontinent of bladder and bowel and had no scheduled toileting plan. a. The resident's Plan of Care dated 12/06/06 documented: "at risk for skin impairment due to being usually incontinent of bladder..." and "give perineal care when resident is incontinent and as needed." b. On 1/23/07 at 1:28 p.m., CNA #3 and CNA #13 assisted the resident to a standing position from a wheelchair. CNA #13 stated the resident was "wet." A clean, dry disposable brief was applied. No pericare was done. c. The resident's Plan of Care dated 12/06/06 documented: "nailcare weekly and as needed." d. On 1/24/07 at 2:27 p.m., the nail of the fourth toe on the right foot was approximately 1/8 inch long with 1/2 of the nail on the right side missing.	F 312		
F 314 SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a	F 314		

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MONTICELLO HEALTHCARE CENTER	**1052 OLD WARREN ROAD MONTICELLO, AR 71655**

(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
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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 were repositioned and/or cleansed of urine to prevent the potential for skin breakdown for 5 (Residents #2, #5, #8, #14 and #20) of 7 (Residents #2, #5, #6, #8, #14, #19 and #20) case mix residents who were at risk for pressure ulcers. This failed practice had the potential to affect 15 residents who were at high risk for pressure ulcers, as identified on a list provided by the facility on 1/26/07. The findings are:

1. Resident #2 had diagnoses of Dementia with Behaviors, Constipation/Diarrhea, Pressure Sore and Urinary Tract Infection. A Significant Change Minimum Data Set (MDS) dated 12/7/06 documented the resident had moderately impaired cognitive skills for daily decision making, short/long/-term memory problems, was totally dependent on two staff persons for toilet use, incontinent of bowel and had an indwelling catheter.

a. A Physician order dated 1/19/07 documented: "Soft waist restraint while ^ (up) in w/c (wheelchair), Check Q (every) 30 min (minutes) released Q 2 hrs (hours) x (times) 10 mins."

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b. The resident's Plan of Care dated 12/06/06 documented: "at risk for skin impairment," "assist with pericare every 2 hours and as needed" and "perform catheter care every shift and as needed."

c. On 1/22/07 at 5:58 p.m. and on 1/23/07 at 7:45 a.m. and 11:40 a.m., the resident sat in a wheelchair in the dining room. The easy release waist restraint straps were untied from the back kick bars of the wheelchair, but were not undone or loosened from the wheelchair arms. The waist belt remained snug around the resident's waist and she was not repositioned in any way by the staff.

d. On 1/23/07 at 2:38 p.m., Certified Nursing Assistant (CNA) #4 stated the resident had "been up since before I got here" and "been up since before 6:00 a.m."

e. On 1/23/07 at 3:15 p.m., CNA #6 and CNA #7 assisted the resident to the toilet. CNA #6 stated, the resident's "catheter is leaking" and held a brief with a wet area in the center. A clean disposable brief was placed on the resident. No catheter care or washing of the peri-area was completed.

2. Resident #5 had diagnoses of Dementia with Behaviors and Alzheimer's Disease. A Quarterly MDS dated 12/7/06 documented the resident had modified independence in cognitive skills for daily decision making, short/long-term memory problems and a restraint.

a. A Physician order dated 12/19/06 documented: "Easy release seat belt when up in wheel chair to assist with upper body alignment. To be checked

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every 30 min (minutes) and released every 2 hrs (hours) for ROM (range of motion) and incont (incontinent) care."

b. On 1/22/07 at 5:33 p.m. and on 1/23/07 at 7:20 a.m. and 11:45 a.m., the resident was in a wheelchair in the dining room with a waist restraint on. The straps of the restraint were not tied to the back kick bars of the wheelchair. The straps were not released from around the arms of the wheelchair, keeping the restraint snug on the resident's waist; the resident was not repositioned by staff.

c. The Plan of Care dated 12/06/06 documented: "at risk for skin impairment due to being usually incontinent of bladder..." and "give perineal care when resident is incontinent and as needed."

d. On 1/23/07 at 1:28 p.m., CNA #3 and CNA #13 assisted the resident to a standing position from a wheelchair. CNA #13 stated the resident was "wet." A clean, dry disposable brief was applied. No pericare was done.

3. Resident #14 had diagnoses of Alzheimer's Disease, Polyarthritis and Muscle Weakness. An Admission MDS dated 11/17/06 documented the resident had moderately impaired cognitive skills for daily decision making, short/long-term memory problems, was incontinent of bowel and bladder, had one Stage II pressure sore and a restraint.

a. A Physician order dated 11/24/06 documented: "Self-release belt while up in chair for resident safety."

b. The resident's Plan of Care dated 11/16/06

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documented: "at risk for skin impairment" and "turn and reposition every 2 hours and as needed."

c. On 1/25/07 at 9:25 a.m., the resident sat in a wheelchair across from the nurse's station. A self-release belt was on the resident. The resident was pushed to the dining room for Bingo at 9:40 a.m. and was not moved from the dining room until 1:17 p.m. The resident was not repositioned by staff during this time.

d. On 1/25/07 at 1:17 p.m., CNA #14 pushed the resident to the doorway of the shower room. A strong urine odor was present.

e. On 1/25/07 at 1:24 p.m. the resident stated, "I cannot undo the belt by myself. Someone's got to do it." At 1:25 p.m., CNA #15 pushed the resident into the shower room and undid the seat belt. CNA #14 and CNA #15 assisted the resident to stand. A small amount of feces was on the resident's wet, disposable brief.

4. Resident #20 had diagnoses of Cerebrovascular Accident and Incontinence without Sensory Awareness. An Annual MDS dated 1/16/07 documented the resident had moderately impaired cognitive skills for daily decision making, short/long-term memory problems, was totally dependent on staff for toileting, incontinent of bladder and bowel and had 2 Stage II pressure sores.

a. A Physician order dated 1/2/07 documented: "Turn and reposition Q (every) 2 H (hours) and PRN (as needed)" and "Soft waist belt while up in chair check Q 30 minutes and release Q 2 hours for ROM (range of motion) and BRP (bathroom

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F 314	Continued From page 42 privileges)." b. The Plan of Care dated 1/15/07 documented: "at risk for further skin impairment", "Turn and reposition Q 2 hrs and as needed" and "when up in w/c reposition q 2 hrs and as needed." c. On 1/25/07 at 9:00 a.m., the resident was placed in a lounge chair. The resident stayed in the lounge chair, feet up, until 12:00 p.m. The resident's pants were wet and the brief was saturated. 5. Resident #8 had diagnoses of Dysphagia, Muscle Weakness, General Dehydration, Renal Failure, Congestive Heart Failure, Electrolyte/Fluid Disorder, Anorexia, Hypertension, Blindness and Low Vision and Dementia in other diseases. An MDS dated 1/1/07 documented the resident had short/long-term memory problems, was severely impaired in cognitive skills for daily decision making and dependent on staff for activities of daily living. a. The resident's Care Plan Problem dated 1/1/07 documented: "at risk for pressure ulcer/skin impairment AEB: incontinent of bowel & bladder, use of incontinent briefs/pads & impaired bed mobility, and HX (history) of pressure ulcers" with approaches including "provide incontinent care every 2 hours and as needed." b. On 1/23/07 at 3:43 p.m., incontinent care was provided for the resident by CNA #8 and CNA #9. CNA #8 failed to cleanse the resident's buttocks that had been in contact with urine.	F 314		
F 315 SS=E	483.25(d) URINARY INCONTINENCE	F 315		

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Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure toileting program assessments were conducted for 2 (Residents #2 and #5) of 9 (Residents #2, #4, #5, #6, #7, #8, #14, #19 and #20) case mix residents who were incontinent. This failed practice had the potential to affect 37 residents who were incontinent, as identified on a list provided by the facility on 1/26/07. The findings are:

1. Resident #2 had diagnoses of Dementia with Behaviors, Constipation/Diarrhea and Urinary Tract Infection. A Significant Change Minimum Data Set (MDS) dated 12/7/06 documented the resident had moderately impaired cognitive skills for daily decision making, short/long-term memory problems, was totally dependent on assist of two staff persons for toilet use, incontinent of bowel, had no scheduled toileting plan and an indwelling catheter.

a. The resident's Plan of Care dated 12/6/06 documented: "potential for urinary tract infection associated with presence of indwelling catheter," "perform catheter care every shift and as

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F 315	Continued From page 44 needed," "provide 1 person assist with toileting," and "assist resident to bathroom as needed." b. On 1/23/07 at 9:31 a.m., the resident propelled her wheelchair into the bathroom in her room and shut the bathroom door. When the surveyor asked the resident if she needed help, the resident stated, "I got to go to the bathroom." At 9:40 a.m., the surveyor informed a Certified Nursing Assistant (CNA), who entered the room, that the resident had requested to go to the bathroom. The CNA stated, "You have a catheter and don't need to get on the commode." c. On 1/23/07 at 2:38 p.m., the resident stated, "I want to go to the bathroom." CNA #5 stated, "You have a catheter, go ahead and go in that." d. On 1/23/07 at 3:15 p.m., the resident stated, "... I just got to pee." CNA #6 and CNA #7 entered the room. The resident stated, "I want to go to the bathroom." The CNAs assisted the resident to the toilet. She had a moderate amount of formed feces. CNA #6 stated, "Her catheter must be leaking" and showed the surveyor the wet brief. No catheter care or cleansing of the perineal area was done. e. On 1/24/07 at 2:10 p.m., when asked if incontinent residents were assessed for a toileting program, Licensed Practical Nurse (LPN) #3 and LPN #6 stated there was no documentation of any assessments done. There was no toileting program. 2. Resident #5 had diagnoses of Dementia with Behaviors and Alzheimer's Disease. A Quarterly MDS dated 12/7/06 documented the resident had	F 315		

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F 315	Continued From page 45 modified independence in cognitive skills for daily decision making, short/long-term memory problems, was totally dependent on staff for personal hygiene, occasionally incontinent of bladder and bowel and had no scheduled toileting plan. a. The resident's Plan of Care dated 6/6/06 documented: "Provide 1 person assist with toileting" and "take resident to bathroom every 2 hours and as needed." b. On 1/23/07 at 9:58 a.m., the resident was pushed to the day room for a group activity. The resident was marked with a small piece of paper, with the date 1/23 and 10:00 a.m. documented on it, under the left thigh. c. On 1/23/07 at 10:55 a.m., the resident was pushed to her room by the Activity Director. At 11:25 CNA #13 and CNA #16 placed socks and house shoes on the resident in the resident's room. They did not ask the resident if she needed to go to the bathroom. d. On 1/23/07 at 1:28 p.m., CNA #13 and CNA #3 assisted the resident to stand. The small piece of paper dated 1/23 at 10:00 a.m. was at her left thigh. The CNAs did not ask the resident if she needed to go to the bathroom before placing her in a lounge chair. e. On 1/24/07 at 2:10 p.m., when asked if the resident had been assessed for a toileting program, the Administrator and LPN #6 stated, "No incontinence assessment for this resident. No toileting program. No form, no screening, no assessment. She's just incontinent."	F 315		
F 318	483.25(e)(2) RANGE OF MOTION	F 318		

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F 318 SS=D	Continued From page 46 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a physician ordered splint was in place for 1 (Resident #20) of 3 (Residents #5, #6 and #20) case mix residents with a Physician ordered splint. This failed practice had the potential to affect 6 residents with Physician ordered splints, as identified on a list provided by the facility on 1/26/07. The findings are: Resident #2 had diagnoses of Dementia with Behaviors, Pain in Limb and Muscle Weakness. A Significant Change Minimum Data Set (MDS) dated 12/7/06 documented the resident had moderately impaired cognitive skills for daily decision making and short/long-term memory problems. a. A Physician order dated 11/24/06 documented: "Left wrist splint applied Q (every) shift for skin." b. The resident's January 2007 Medication Administration Record (MAR) documented: with the nurse initials, that the splint had been checked on the 7:00 a.m. to 3:00 p.m. shift and on the 11:00 p.m. to 7:00 a.m. shift on 1/23/07. There was no further documentation that the	F 318		

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F 318	Continued From page 47 splint was checked. c. On 1/23/07 at 7:15 a.m., 11:40 a.m., 12:40 p.m. and 3:15 p.m., the resident had no splint on either wrist. d. On 1/24/07 at 11:11 a.m., when asked if the resident wore a wrist splint, Certified Nurse Assistant (CNA) #14 stated, "tried both splint and alarms. She takes them off..."	F 318		
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure the doors were free of splinters, the beauty parlor chair was free of sharp edges, dryers were free of lint buildup, the break room coffee maker was not available to confused residents, oxygen and helium cylinders were secured, electrical outlet covers were free of sharp corners and an unidentified cream was not left in a resident ' s room on an over bed table. This failed practice had the potential to affect 30 independently mobile residents on the 200, 300 and 400 halls, according to lists received from the Nurse Consultant on 1/26/07 at 11:42 a.m. The findings are: 1. On 1/24/07 at 8:17 a.m., during the environmental tour conducted with the Maintenance Director, the following items were observed:	F 323		

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F 323	Continued From page 48 a. The 200 Hall Shower/Whirlpool room entry door had gouges measuring 22-inches up from the floor, on the latch side of the door, which exposed a rough sharp edge. b. Resident Room #207 and Resident Room #214 had an area measuring 13-inches up from the floor, on the hinged side, that exposed gouges with splinters. c. Resident Room #211 had an area measuring 20-inches up from the floor, on the hinged side, that exposed gouges with splinters. d. The left Fire Door to the Day Room, located next to the resident's smoking area, had an area measuring 22-inches up from the floor that was gouged, exposing sharp edges. e. The Beauty Parlor had one chair located next to the washing sink that had a circular metal floor piece in which the metal had a rust colored substance on the metal base and there were pieces missing, leaving approximately 2-feet of sharp jagged edge. The entry door had an area approximately 6-inches up from the floor that was gouged and sharp on the hinged side of the door. f. In the Laundry, there were two dryers that had a lint build-up in the back corners behind the lint screens. Dryer #1 had a build-up measuring approximately 2-inches in diameter in the corner and Dryer #2 had a build-up measuring approximately 6-inches in diameter in the back right corner. g. Resident Room #412 had an area measuring	F 323		

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14-inches up from the floor, on the hinged side, that exposed gouges with splinters.

h. The left entry door to the 300 Hall Dining Room had an area, measuring 36-inches up from the floor on the hinged side, which exposed gouges with splinters.

The right entry door had an area, measuring 22-inches up from the floor on the hinged side, which exposed gouges and splinters.

Both doors on the latch side were gouged 36-inches up from the floor, exposing splinters.

i. On the wall, to the left of the entry to the dining room, there was a cover plate in which the right top corner was broken, exposing a point in the plastic.

j. Resident Room #307 and Resident Room #312 had gouges in the hinged side of the door, measuring 17-inches up from the floor that exposed splinters.

k. The 300 Hall Shower/Whirlpool room entry door had gouges, measuring 35 inches up from the floor on the latch side of the door, which exposed splinters.

l. In the IV Storage Room there were 4 small oxygen cylinders and one large helium tank behind the door that were not secured.

m. The front entry door had gouges exposing splinters, approximately 1 and 1/2 feet up from the floor on the latch side of the door.

2. On 1/22/07 at 3:00 p.m., an odorless white

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F 323	Continued From page 50 cream was in an unlabeled medication cup on the over bed table in Resident Room 411B.	F 323		
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: Based on observation, record review and interview, the facility failed to ensure that a chair alarm was in place as order by the physician for 1 (Resident #2) of 2 (Residents #2 and #5) case mix residents with a Physician ordered chair alarm, the axillae and waist band were not used to transfer for 1 (Resident #5) of 7 (Residents #2 thru #8) case mix residents requiring assistance with transfers and restraints were tied/placed correctly for 7 (Residents #5, #7, #19, #20, #25, #26 and #27) of 11 (Residents #2, #5, #6, #7, #8 #14, #19, #20, #25, #26 and #27) case mix residents who had a Physician order for a restraint. These failed practices had the potential to affect 4 residents with a chair alarm, as identified by the Unit Manager on 1/26/07, 29 residents who required assistance with transfers, as identified on the Resident Census and Condition of Residents form dated 1/22/07 and 18 residents with a restraint, as identified on a list provided by the facility on 1/26/07. The findings are: 1. Resident #2 had diagnoses of Dementia with Behaviors and Muscle Weakness. A Significant Change Minimum Data Set (MDS) dated 12/7/06 documented the resident had moderately impaired cognitive skills for daily decision making	F 324		

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and short/long-term memory problems.

a. A Physician order dated 11/24/06 documented: "W/C (Wheelchair) alarm to alert staff of unassisted transfers Check Q (every) shift to make sure unit is operational."

b. The resident's January 2007 Medication Administration Record (MAR) documented: with the nurse's initials, that the wheelchair alarm had been checked "q shift to make sure unit is operational" on the 11:00 p.m. to 7:00 a.m. shift on 1/23/07. There was no further documentation on the MAR that the wheelchair alarm had been checked.

c. On 1/23/07 at 7:36 a.m., 11:40 a.m., 12:40 p.m. and 1:50 p.m. there was no wheelchair alarm attached to the resident's wheelchair or to the resident.

2. Resident #5 had diagnoses of Dementia with Behaviors, Muscle Weakness and Alzheimer's Disease. A Quarterly MDS dated 12/7/06 documented the resident had modified independence in cognitive skills for daily decision making, short/long term-memory problems, was totally dependent on 2 persons for transfer and had a restraint.

a. The resident's Plan of Care dated 12/6/06 documented: "provide 2 person assist with all transfers."

b. The resident's ADL (activities of daily living) form to be completed by the Certified Nursing Assistants (CNA) documented: "assist with transfers" and all but 1/23/07 was documented as "3" with the code "3=two+person assist."

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F 324	Continued From page 52 c. On 1/23/07 at 1:28 p.m., CNA #3 and CNA #13 placed the resident in a wheelchair directly across from the lounge chair and assisted the resident to stand by lifting her under each armpit and holding onto the back of her pants. The resident's legs were bent and she was slid across the floor by the CNAs. The CNAs stated they did not use a mechanical lift on the resident. d. A Physician order dated 12/19/06 documented: "Easy release seat belt when up in wheelchair to assist with upper body alignment. To be checked every 30 min [minutes] and released every 2 hrs [hours] for ROM [range of motion] and incont [incontinent] care." e. The Application Instruction Sheet Posey Self-releasing Soft Lap Belt documented: "Bring the straps over the thighs at a 45 degree angle around the back post and pass them between the seat and the side of the chair." and "Cross the straps and twist behind the patient and attach them underneath the chair." f. On 1/24/07 at 11:32 a.m., the resident was in a wheelchair with a lap belt over the lower abdomen. The straps were wrapped around the arm rests and then straight down and tied to the kick spur on each side without crossing. 3. Resident #20 had a diagnosis of Late Effect Hemiplegia. An Annual MDS dated 1/16/07 documented the resident had moderately impaired cognitive skills for daily decision making, short/long-term memory problems, a restraint and received oxygen therapy. a. A Physician order dated 1/2/07 documented:	F 324		

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"Soft waist belt while up in chair Check Q 30 minutes and release Q2 hours for ROM and BRP."

b. On 1/23/07 at 8:07 a.m., the resident sat in a wheelchair with the left strap of a soft waist restraint around the oxygen cylinder and tied around the opposite kick spur.

c. On 1/23/07 at 10:12 a.m., the resident sat in a recliner that was reclined and had a lap belt around the upper abdomen under the breasts.

d. On 1/25/07 at 8:01 a.m. and 12:00 p.m., the resident was in a wheelchair with a soft belt restraint on. The straps of the restraint were tied straight down each side to the kick spurs and were not crossed in the back.

e. On 1/25/07 at 1:35 p.m., the resident was in a wheelchair with the left strap of the belt restraint tied straight down to the kick spur and the right strap crossed over the top of the oxygen cylinder.

4. Resident #25 had diagnoses of Cerebrovascular Accident and Difficulty in Walking. A Quarterly MDS dated 1/2/07 documented the resident had modified independence in cognitive skills for daily decision making, short/long-term memory problems and a restraint.

a. A Physician order dated 10/7/04 documented: "Soft-belt restraint while up in w/c (wheelchair) to prevent unassisted transfers. To be checked Q (every) 2 hours and released x (times) 10 minutes for ROM (Range of Motion) and toileting."

b. On 1/23/07 at 7:30 a.m., the resident was in a

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F 324	Continued From page 54 wheelchair with a soft belt restraint on; the straps were wrapped and tied around the back of the wheelchair arms on both sides. 5. Resident #26 had diagnoses of Dementia, Abnormality of Gait and Muscle Weakness. A Quarterly MDS dated 11/21/06 documented the resident had modified independence in cognitive skills for daily decision making, a short-term memory problem and no restraint. a. A Physician's order dated 12/20/06 documented: "Soft waist belt when up in chair Check Q 2 hours and release for 10 minutes for ROM and BRP (bathroom privileges)." b. On 1/23/07 at 10:00 a.m., the resident was in a wheelchair with a soft belt waist restraint on. The straps were straight down on each side of the wheelchair without crossing in the back. c. On 1/23/07 at 11:38 a.m., the resident was in a wheelchair with the soft belt straps looped around the back of the left arm of the wheelchair and tied around the right arm of the wheelchair and straight down the back on both sides without crossing. 6. Resident #27 had diagnoses of Paranoid Schizophrenic, Convulsions and Psychosis. A Quarterly MDS dated 1/9/07 documented the resident had moderately impaired cognitive skills for daily decision making, short/long-term memory problems and a restraint. a. A Physician order dated 10/28/05 documented: "Soft waist belt while in wheelchair to prevent unassisted transfers. Check every 2 hours, release for 10 mins for incont (incontinent) care	F 324		

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F 324	Continued From page 55 and ROM." b. On 1/23/07 at 10:00 a.m., the resident sat in a wheelchair with a soft belt waist restraint that had one strap tied on the back of the wheelchair arm on the right and both straps tied straight down both sides without crossing in the back and wrapped numerous times around the kick bars on the back of the wheelchair. c. On 1/23/07 at 12:12 p.m., the resident sat in a wheelchair with the soft waist restraint strap looped around the back of the wheelchair arm on the right. 7. Resident #7 had diagnoses of Dementia with Behavioral Disturbance, Alzheimer's Disease, Anxiety State, Depressive Disorder and Lack of Coordination. An Annual Minimum Data Set dated 11/27/06 documented the resident had short/long-term memory loss, modified independence in cognitive skills for daily decision making, extensive to total dependence on staff for activities of daily living and daily used a chair that prevented rising. a. The resident's January 2007 Physician Orders documented: "12/12/06 Soft waist belt while up in wheel chair, check for placement Q (every) 30 minutes and release Q 2 hours for ROM (range of motion) and BRP (bathroom privileges)." b. The resident's plan of care revised on 11/27/06 documented: "Problem: at risk for falls AEB (as evidenced by) hx (history) of falls, use of antidepressant/antianxiety med use, use of soft waist belt while up in wheel chair & sleeps on a low bed with mat."	F 324		

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c. On 1/22/07 at 2:09 p.m., the resident was in a wheelchair with the lap belt positioned up under the resident's arms (in the axillae area).

d. On 1/22/07 at 4:50 p.m., the resident was in a wheelchair with the lap belt positioned across the breast area.

e. On 1/23/07 at 7:17 a.m., the resident was in a wheelchair with the lap belt positioned across the upper abdominal area.

f. On 1/23/07 at 10:06 a.m., the resident was in a wheelchair with the lap belt positioned under the breast area.

g. On 1/23/07 at 11:47 a.m., the resident was in a wheelchair with the lap belt positioned under the arms (in the axillae area).

h. On 1/23/07 at 2:22 p.m. and 3:12 p.m. the resident was in a wheelchair with the lap belt positioned across the chest area.

i. On 1/24/07 at 8:10 a.m. and 10:19 a.m. the resident was in a wheelchair at the nursing station with the lap belt across the breast area, with the left side under the axillae area.

8. Resident #19 had diagnoses of Dysphagia, Fractured Femur and Psychosis. An MDS dated 1/18/07 documented the resident had short/long-term memory problems, severely impaired cognitive skills for daily decision making and was dependent on staff for all activities of daily living.

a. The resident had a Physician order dated 4/8/05 for, "Lap Buddy while up in high back

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F 324	Continued From page 57 wheelchair to prevent leaning. Check q 30 minutes and release q 2 hours and prn for repositioning and incontinent care." b. On 1/23/07 at 12:20 p.m., 1/24/07 at 5:50 p.m., 1/25/07 at 8:10 a.m. and 8:50 a.m. and 1/26/07 at 8:45 a.m., the resident was in a wheelchair with the lap buddy on wheelchair backwards, the indentation for the resident's abdomen was facing out, away from the resident. 9. The Manufacturer's Instruction sheet for the "Posey Lap Belt" documented: "Application Instructions: 1. Lay the belt across the patient's lap, foam side down. 2. Bring the strap ends with loops down over the thighs between the seat and the wheel chair skirt guard. Go around the back post and cross the straps behind the patient... #12. Hips should be held securely against the back of the chair whenever any type of restrictive product is used. The straps should be at 45 degrees over the hips and secured under the seat out of the patient's reach..."	F 324		
F 327 SS=D	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure fluid needs were calculated and how the resident would receive fluids was care planned to ensure an adequate amount of liquids would be offered/consumed for 1 (Resident #8) of 2 (Residents #8 and #13) case mix residents who	F 327		

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were on thickened liquids. This failed practice had the potential to affect the 7 residents in the facility with orders for thickened liquids, as per the a provided by the facility on 1/26/07. The findings are:

Resident #8 had diagnoses of Dysphagia, Dehydration, Renal Failure, Congestive Heart Failure, Electrolyte/Fluid Disorder, Anorexia, Hypertension, Blindness and Low Vision and Dementia in other diseases. A Significant Change Minimum Data Set (MDS) dated 4/4/06 documented the resident had a urinary tract infection in the last 30 days, a diagnosis of dehydration and had a problem condition of dehydrated - output exceeds input. An MDS dated 1/1/07 documented the resident as had short/long term memory problems, severely impaired cognitive skills for daily decision making, was dependent on staff for eating and drinking and had a swallowing problem.

a. The resident's nutritional progress notes dated 7/3/06 documented: "On a pureed diet with Large portions with honey thickened liquids due to swallowing problems..."

Following the 7/3/06 nutritional progress notes related to honey thickened liquids, there was no documentation of an assessment or calculation of fluid needs for the resident nor was there a care plan for how the resident would be offered fluids to ensure adequate intake.

The resident's fluid need, calculated by the surveyor using the resident's weight of January 2007, was 1990 cc per 24 hours.

b. The resident had a Physician's order dated

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12/07/06 for honey thickened liquids.

c. The resident had a care plan problem dated 1/1/07 of, "at risk for dehydration AEB (as evidenced by) recent dx (diagnosis) of dehydration" and "at risk for UTI (urinary tract infection) related to dehydration with approaches... offer extra fluids with meds..."

d. A 24-hour summary of the total of liquids that were sent out from the kitchen with the resident's meal trays and offers made to the resident of fluids when the hydration cart was sent around calculated the resident received 1140 cc:

1) On 1/22/07 at 5:55 p.m., the resident was served an evening meal; there was one 6-ounce glass of thickened milk on the tray.

2) On 1/23/07, during breakfast, the resident's tray came from the kitchen with 6-ounces of milk and 8-ounces of juice.

3) On 1/23/07, during lunch, the resident's tray came from the kitchen with 6-ounces of milk on the tray.

4) On 1/23/07, the resident received 6-ounces of thickened water during the morning pass of the hydration cart and 6-ounces thickened water during the afternoon hydration cart pass.

5) The resident had medication passes 6 times a day. There was no documentation of the amount of fluids offered during meal times or medication passes.

e. On 1/25/07 at 10:14 a.m., the medication nurse, Licensed Practical Nurse (LPN) #7 was

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F 327	Continued From page 60 asked how much thickened liquids she gave the resident with medications; she stated that she lets him drink until he clamps his mouth.	F 327		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that oxygen was administered at the rate ordered by the Physician for 1 (Resident #20) of 3 (Residents #1, #5 and #20) case mix residents who had respiratory treatments. This failed practice had the potential to affect 9 residents who received respiratory treatments, as identified on the Resident Census and Conditions of Residents form dated 1/22/07. The findings are: Resident #20 had diagnoses of Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. An Annual Minimum Data Set dated 1/16/07 documented the resident had moderately impaired cognitive skills for daily decision making, short/long-term memory problems, shortness of breath and received oxygen therapy.	F 328		

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F 328	Continued From page 61 a. A Physician order dated 1/02/07 documented: "O2 (oxygen) 2 LPM (liters per minute) via nasal cannula PRN (as needed) for SOB (shortness of breath)." b. The resident's Plan of Care dated 1/15/07 documented: "administer oxygen as ordered" and "check O2 machine for proper function every shift and as needed while in use." c. On 1/25/07 at 8:50 a.m., a family member placed the oxygen cannula on the resident. The oxygen rate was set at 3 liters per minute. d. On 1/25/07 at 11:30 a.m. and at 1:35 p.m., the resident had oxygen on per nasal cannula at 3 liters per minute. e. On 1/25/07 at 3:45 p.m., the resident had oxygen on per nasal cannula at 3 liters per minute.	F 328		
F 329 SS=D	483.25(l) 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. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		

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record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure condition was assessed and monitored for adequate indication of administration of an anti-anxiety medication for 1 (Resident #2) of 4 (Residents #1, #2, #7 and #20) case mix residents who had Physician ordered PRN (as needed) Ativan. This failed practice had the potential to affect 6 residents who received PRN Ativan, as identified on a list provided by the Unit Coordinator on 1/26/07. The findings are:

Resident #2 had a diagnosis of Anxiety. A Significant Change Minimum Data Set (MDS) dated 12/7/06 documented the resident had moderately impaired cognitive skills for daily decision making, short/long-term memory problems, no anxious complaints and received no antianxiety medication.

a. A Physician order dated 12/19/06 documented: "Ativan 0.5 mg (milligram) tablet Give 1 PO (by mouth) or via PEG (percutaneous endoscopic gastrostomy) Q (every) 6 hour PRN (as needed) anxiety."

b. On 1/23/07 at 9:31 a.m., the resident wheeled herself into the bathroom, leaned forward and

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backward 4 (four) times against her waist restraint and shut the bathroom door and stated, "I got to go to the bathroom."

c. On 1/23/07 at 2:38 p.m., the resident stated, "I want to go to the bathroom." Certified Nursing Assistant (CNA) #5 stated, "You have a catheter, go ahead and go in that."

Licensed Practical Nurse (LPN) #5 asked the resident if she wanted to go to bed and left the room to "get help."

d. On 1/23/07 at 2:52 p.m., LPN #5 administered one Ativan tablet to the resident. The LPN did not ask the resident a question or assess the resident.

e. The resident's January 2007 Medication Administration Record (MAR), copied 1/23/07 at 3:08 p.m., documented the dose on 1/23/07 as the only time in January the resident had received the medication. The back of the MAR documented: "1-23 - Ativan 0.5 mg for anxiety." The most current nurse's note in the resident's clinical record was dated 1/20/07.

f. The 1/23/07 24-Hour Nursing Report documented: "[Resident #2] ativan @ (at) 2:45."

g. The 1/24/07 24-Hour Nursing Report documented: "[Resident #2] d/c (discontinue) foley cath (catheter)/d/c tx (treatment) to G-tube D/C Zoloft & (and) Ativan/Flush peg-tube c (with) 60 cc (cubic centimeters) H2O (water) q (every) shift."

h. On 1/24/07 at 10:24 a.m., when asked why the resident's Ativan had been discontinued on

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F 329	Continued From page 64 1/24/07, LPN #3 stated the resident had "improved so much, doing better, gained weight." i. As of 1/26/07 at 4:15 p.m., the facility could not provide documentation that the resident had been assessed, non-pharmacological interventions utilized and the resident monitored for the use of Ativan PRN for anxiety.	F 329		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the 4:00 p.m. and 6:00 p.m. medication passes on 1/22/07 and the 8:00 a.m. medication pass on 1/23/07 and record review, the facility failed to follow physician's orders to ensure that the medication error rate was less than 5%. Physician's orders were not followed for 2 (Residents #10 and #11) of 13 residents observed during the medication pass(es). Medication errors were made by 2 (Licensed Practical Nurse [LPN] #1 and LPN #2) of 4 nurses that administered medication according to the Administrator. This failed practice had the potential to affect 69 residents receiving medication from these nurses. The medication error rate was 6.25% based on administration of 47 medications plus 1 medication ordered but not administered and observations of a total of 3 errors. The findings are: 1. Resident #10 had a Physician order dated 9/8/05 for a lubricant eye ointment for dry eye	F 332		

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F 332	Continued From page 65 syndrome, 4 times a day. On 1/22/07 at 4:26 p.m., LPN #1 administered Refresh Plus eye drops to the resident. Lubricant eye ointment was not administered. 2. Resident #11 had a Physician order dated 2/11/06 for Xalatan ophthalmic solution to administer one drop in each eye at 6:00 p.m. On 1/22/07 at 6:11 p.m., LPN #2 did not administer the Xalatan ophthalmic drops to the resident. 3. Resident #11 had a Physician order dated 1/12/07 for Vicodin 5/500 every 6 hours at 6:00 p.m., 12:00 Noon, 6:00 p.m. and 12:00 Midnight per G-Tube. a. On 1/22/07 at 6:11 p.m., after checking for tube placement, the nurse poured water into the syringe for a flush; when asked how much water she was flushing with she stated, "10 cc", which was confirmed with observation. She stated the orders did not say how much to flush with prior to the medication. b. Federal regulations state that you must flush with at least 30 cc of water before and after medication administration.	F 332		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the	F 334		

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benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:

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F 334	Continued From page 67 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure residents were offered the pneumococcal vaccine, that a system was in place to know when the residents had last received the pneumococcal vaccine and when the residents would need to have another vaccine given. This failed practice had the potential to affect 65 residents, as identified by the Unit Manager on 1/26/07. The findings are: 1. On 1/26/07 at 11:10 a.m., the Unit Manager stated none of the residents had been offered the pneumococcal vaccine at the facility. She also stated they had no way of knowing when the residents had received their last vaccine and when they would need another vaccine given. There was no system in place to monitor which	F 334		

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F 334	Continued From page 68 residents had received the pneumococcal vaccine or to know when they would need another vaccine given. There had also been no pneumococcal vaccines offered to any new admissions. She also stated there had been no education given to the residents or the family members regarding the pneumococcal vaccines. 2. The facility Pneumococcal Vaccine policy documented: "Policy Statement: All residents will be offered the pneumococcal vaccine to aid in preventing infections and pneumonia."	F 334		
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 their planned written menu was followed for 12 (Residents #1, #2, #5, #6, #7, #8, #12, #13, #15, #17, #18 and #29) of 24 (Residents #1, #2, #5 thru #10, #12 thru #19, #21, #22, #23 and #25 thru #29) case mix residents who received regular or pureed diets. This failed practice had the potential to affect 37 residents who received regular diets and 8 residents who received pureed diet, according to the facility diet list dated 1/22/07. The findings are: 1. The 1/22/07 Dinner menu for a regular diet	F 363		

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F 363	Continued From page 69 documented: Hamburger on Bun, French Fries, Lettuce/Tom (tomato)/Onion/Pickle, Fruited Gelatin, Milk and Beverage of Choice. The 1/22/07 Dinner menu for a pureed diet documented: Pur (pureed) Hamburger on Bun, Pur Potato w (with)/sauce, Vegetable Juice, Pur Canned Fruit, Milk and Beverage of Choice. a. Resident #2 had diagnoses of Dementia with Behavior, Peripheral Vascular Disease and Alzheimer's Disease. A Quarterly Minimum Data Set (MDS) dated 12/25/06 documented the resident was moderately impaired in cognitive skills for daily decision making and required one person assistance for eating. 1) A Physician order dated 12/28/06 documented: "Diet: pureed no added salt packet." 2) On 1/22/07 at 5:58 p.m., the resident was served pureed hamburger meat, bun, mashed potatoes with gravy, 6 ounce (oz.) vegetable juice, chocolate pudding and 8 oz. glass of tea. There was no milk or pureed canned fruit served to the resident, as per the written menu. b. Resident #5 had diagnoses of Diabetes Mellitus and Decubitus Ulcer. A Medicare 30-Day MDS dated 1/17/07 documented the resident had modified independence in cognitive skills for daily decision making and required one person assistance for eating. 1) A Physician order dated 12/19/06 documented: "Diet: Low concentrated sweet diet with fortified foods." 2) On 1/22/07 at 5:33 p.m., the resident was	F 363		

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served a hamburger, fries, lettuce, tomatoes, onion, pickles, pudding, tea and water. There was no milk or fruited gelatin served to the resident, as per the written menu.

c. Resident #6 had diagnoses of Decubitus Ulcer and Esophageal Reflux. An MDS dated 11/3/06 documented the resident had modified independence in cognitive skills for daily decision making and required one person assistance for eating.

1) A Physician order dated 9/21/05 documented: "Diet: No Added Salt with Fortified Foods."

2) On 1/22/07 at 5:20 p.m., the resident was served pureed hamburger meat, bun, fries, chocolate pudding, fruited gelatin and tea. There was no milk served to the resident, as per the written menu.

d. Resident #7 had diagnoses of Anorexia, Osteoporosis and Alzheimer's Disease. An MDS dated 11/27/06 documented the resident had modified independence in cognitive skills for daily decision making and required set up help for eating.

1) A Physician order dated 12/12/06 documented: "Diet: Regular."

2) On 1/22/07 at 5:30 p.m., the resident was served fries, fruited gelatin, a glass of tea, a hamburger with lettuce, tomato and pickles. There was no milk served to the resident, as per the written menu.

e. Resident #8 had diagnoses of Anorexia, Dehydration, Congestive Heart Failure,

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F 363	Continued From page 71 Dysphagia and Renal Failure. A Quarterly MDS dated 1/1/07 documented the resident was severely impaired in cognitive skills for daily decision making and required one person assistance for eating. 1) The resident's Physician orders documented: "11/29/04 Large portions each meal, 10/3/06 Pureed Diet, Milk with each meal (honey thickened liquids), 1/15/07 Add fortified food." 2) On 1/22/07 at 5:55 p.m., the resident was served pureed hamburger meat, bun, chocolate pudding, fries and 6 oz. of milk. There was no pureed canned fruit served to the resident as per the written menu. f. Resident #12 had Diagnoses of Abnormal Loss of Weight and Anorexia. A Quarterly MDS dated 11/6/06 documented the resident had modified independence in cognitive skills for daily decision making and required set up help for eating. 1) A Physician order dated 4/27/06 documented: "Diet: Regular." 2) On 1/22/07 at 6:14 p.m., the resident was served a hamburger, fries, chocolate pudding, fruited gelatin. There was no milk served to the resident, as per the written menu. g. Resident #13 had Diagnoses of Nutritional Anemia and Congestive Heart Failure. An MDS dated 12/15/06 documented the resident had modified independence in cognitive skills for daily decision making and required one person assistance for eating. 1) The resident's lab result report dated 9/20/06	F 363		

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documented an abnormal level of total protein of 5.6 g/dl and an abnormal level of Albumin 2.9 gm/dl. The normal range for Total Protein is 6.0 - 8.4 gm/dl and the normal range for Albumin is 3.5 to 5.0 gm/dl.

2) A Physician order dated 9/21/06 documented: "Diet: Pureed fortified foods with honey thickened liquids."

3) On 1/22/07 at 6:49 p.m., the resident was served pureed hamburger meat, bun pureed with tomatoes, lettuce, pickles and thickened water. There was no milk served to the resident, as per the written menu.

h. Resident #1 had diagnoses of Dehydration, Vitamin Deficiency and Constipation. A Quarterly MDS dated 11/06/06 documented the resident was independent in cognitive skills for daily decision making and required set up help for eating.

1) A Physician order dated 1/7/07 documented: "Regular Ground Meat Diet."

2) On 1/22/07 at 5:30 p.m., the resident was served fries, fruited gelatin, a glass of tea, ground hamburger with shredded lettuce, diced tomatoes and pickles and a Mighty Shake. There was no milk served to the resident, as per the written menu.

2. On 1/23/07, the menu for the lunch meal called for 3 ounces of barbecue chicken.

a. On 1/23/07 at 12:36 p.m. Residents #15, #17, #18 and #29 were served one chicken leg each. Resident #15, stated "I like chicken, this one is

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F 363	Continued From page 73 too small." b. On 1/23/07 at 12:50 p.m., one chicken leg was weighed by dietary employee #1 and it weighed one ounce.	F 363		
F 365 SS=D	483.35(d)(3) FOOD Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure food was prepared and served at the correct consistency for 1 (Resident #13) of 2 (Resident #8 and #13) case mix residents who had a Physician order for thickened liquids. This failed practice had the potential to affect 7 residents who had Physician orders for thickened liquids, according to the diet list dated 1/22/07. The findings are: 1. Resident #13 had diagnoses of Congestive Heart Failure and Anemia. A Minimum Data Set (MDS) dated 12/15/06 documented the resident had modified independence in cognitive skills for daily decision making and required one person assistance for eating. a. A Physician order dated 9/21/06 documented: "Diet: pureed fortified foods with honey thickened liquids no straws, tuna and fish." b. On 1/22/07 at 6:49 p.m., the resident was served pureed pineapple with juice in it that was not thickened. Registered Nurse #1 was feeding the resident and stated, "It was not thickened."	F 365		

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F 366 SS=D	483.35(d)(4) FOOD Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure substitutes were offered for items not eaten at meals for 1 (Resident #16) of 16 (Resident #1 thru #9 and #12 thru #18) case mix residents. This failed practice had the potential to affect 67 residents who received their meal trays from the kitchen, as identified by the facility diet list dated 1/22/07. The findings are: Resident #16 had diagnoses of Anorexia, Shortness of Breath, Alzheimer's Disease and Dementia with Behaviors. A Minimum Data Set dated 11/27/06 documented the resident had modified independence in cognitive skills for daily decision making and required set up help for eating. a. A Physician order dated 11/14/06 documented: "Diet: Regular with mighty shake three times a day." b. On 1/22/07 at 5:21 p.m., the resident was served ground hamburger meat on a bun, fries, tomatoes, onion, lettuce, a carton of whole milk, fruited gelatin and a carton of mighty shake. The resident was coughing. Registered Nurse #1 (RN) brought a bib and put it around the resident's neck and left. The resident took a bite of hamburger and started coughing. He drank some milk and some of the mighty	F 366		

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F 366	Continued From page 75 shake. At 5:32 p.m., the resident wheeled himself out of the dining room leaving the fries and gelatin; he took a bite of the hamburger, drank 1/4 of the milk and mighty shake. There was no attempt made by the staff to offer substitutes in place of food items not consumed by the resident.	F 366		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed ensure the residents were served meals in a timely manner. This failed practice had the potential to affect 67 residents who received their meal trays from the kitchen, according to the diet list dated 1/22/07. The findings are: 1. The facility employee list form dated 1/22/07	F 368		

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F 368	Continued From page 76 documented: "supper meal hour to be 5:15 p.m." a. On 1/22/07 at 5:33 p.m., Resident #12, who was sitting at a table where two other residents had been served their trays and were eating, stated; "I have not gotten any food." At 5:46 p.m., the resident was leaving the dining room when she was stopped by Certified Nursing Assistant (CNA) #1 and was assisted back to her chair by Nursing Assistant (NA) #2. There was no attempt made by the staff to serve her a tray. At 5:53 p.m., the resident left the dining room. At 6:14 p.m., the resident was directed back to the dining room and served her supper meal. b. On 1/22/07, the supper meal ended at 7:00 p.m.; 45 minutes past the normal time for the meal to end. c. On 1/23/07 at 10:00 a.m., 9 of 9 alert residents who attended the group meeting stated: "Sometimes meal was 30 to 45 minutes late."	F 368		
F 371 SS=F	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 interview the facility failed to ensure food was properly stored to prevent contamination or spoilage, food	F 371		

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preparation equipment was maintained in sanitary conditions, employees washed their hands between handling food, dirty dishes and clean dishes, the ice machine was free of debris and hot food was served at a temperature of 140 degrees Fahrenheit or above. These failed practices had the potential to affect 67 residents who received their meals from the kitchen ,according to the diet list dated 1/22/07. The findings are:

1. On 1/22/07 at 1:52 p.m., the following observations were made in the facility's kitchen.

a. A box of diced onion, stored on the shelf above the food preparation sink, was not sealed.

b. A rubber container, on the shelf in the refrigerator where slices of cheese were stored, had no lid on it.

c. A can opener, attached at the end of the food preparation counter, had shavings of metal on the blade.

d. The trash can, located in the kitchen by the wall close to the table, had no lid on it. The trash can was half full of trash and debris.

e. The lid to a rubber container of bran flakes, located on the shelf in the storage room, had a crack in the lid that could allow pest to crawl in.

f. The top panel to the ice machine, located in the dining room, had rusty, wet condensation on it that could drop on the ice.

g. The ice machine scoop holder, on the right side of the machine, had water standing in it. The

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F 371	Continued From page 78 standing water had a whitish matter that was floating on top. The tip of the ice scoop was sitting directly in the water. 2. On 1/22/07 at 4:46 p.m., Dietary Employee #1 who had long nails and nail polish on her finger nails, was observed picking up the handle to the deep fryer rack that contained fries and emptied the fries in a pan. She opened the oven door and checked on the hamburger patties. Without washing her hands, she picked up the hamburger buns to be pureed with her bare hands, and then picked up a knife and started spreading Mayonnaise on the buns. 3. On 1/22/07 at 4:46 p.m., Dietary Employee #2 who had a ring on her hand, was observed picking up a pan from the counter. She then placed it back on the counter, opened the door to the oven, took out a pan that contained hamburger patties, placed the pan on the counter, picked up a tong to transfer the Hamburger patties into another pan. She picked up another tong and used it to transfer fries to a bowl. She picked up a pot on the stove that contained milk and placed it on the counter by the mixer. Without washing her hands, while she was pouring the fries straight from the bowl to the blender she used her bare hand to push the fries down in the blender. She poured the pureed fries in a pan, washed the blender bowl and adjusted it back to it's motor. She then opened the door to the refrigerator, brought out a container of Mayonnaise, placed it on the counter and picked up a knife. Without washing her hands, she picked up the hamburger buns to be pureed with her bare hands and started spreading Mayonnaise on the buns.	F 371		

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F 371	Continued From page 79 4. On 1/23/07 at 11:35 a.m., the temperature of the ground chicken was 119 degrees Fahrenheit, when taken on the steam table by the Dietary Employee #3.	F 371		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a nurse did not blow on an alcohol prepared blood sugar testing site for 1 (Resident #29) of 3 (Residents #4, #5 and #29) case mix residents who required a finger stick and oxygen tubing not reconnected to an oxygen supply after having been wrapped around a wheelchair axle for 1 (Resident #20) of 3 (Residents #1, #5 and #20) case mix residents who received respiratory therapy. This failed practice had the potential to affect 16 residents who had Diabetes Mellitus, as identified on a list provided by the Director of Nurses on 1/31/07 and 9 residents who received respiratory therapy, as identified on the Resident Census and Condition of Residents form dated 1/22/07. The findings are:	F 441		

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1. Resident #28 had a diagnosis of Diabetes Mellitus. A Quarterly Minimum Data Set (MDS) dated 11/14/06 documented the resident had moderately impaired cognitive skills for daily decision making.

a. A Physician order dated 4/11/06 documented: "Accuchecks Q (every) 4 (4:00) p.m. (If blood sugars are less than 60 or greater than 300 notify MD)."

b. The facility policy, Obtaining a Fingerstick Glucose Level, provided 1/26/07 by the Unit Manager documented: "Maintain clean technique...as indicated." and "If alcohol is used to clean the fingertip, allow it to dry completely because the alcohol may alter the reading."

c. On 1/22/07 at 4:08 p.m., Licensed Practical Nurse (LPN) #1, after applying alcohol to the resident's finger, blew on the resident's finger before sticking the finger for an Accuchecks.

2. Resident #20 had diagnoses of Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. An Annual MDS dated 1/16/07 documented the resident had moderately impaired cognitive skills for daily decision making, short/long-term memory problems, shortness of breath and received oxygen therapy.

a. A Physician order dated 1/02/07 documented: "O2 (oxygen) 2 LPM (liters per minute) via nasal cannula PRN (as needed) for SOB (shortness of breath)."

b. On 1/23/07 at 8:07 a.m., the resident's oxygen tubing was loose as the resident was pushed in a

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F 441	Continued From page 81 wheelchair, with an oxygen cylinder, from the dining room. The oxygen tubing was wrapped around the axle of the wheelchair. Certified Nursing Assistant (CNA) #3 handled the oxygen tubing, unwrapped it from the axle, touching it on the floor, before it was reconnected to the cylinder.	F 441		
F 498 SS=E	483.75(f) PROFICIENCY OF NURSE AIDES The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that Certified Nursing Assistants demonstrated competency in positioning residents in a chair for 1 (Residents #7) of 8 (Residents #2, #5, #6, #7 #8, #14, #19 and #20) case mix residents who required positioning assistance, applying restraints and/or releasing restraints for repositioning for 8 (Residents #2, #5, #14, #19, #20, #25, #26 and #27) of 11 (Residents #5, #7, #8, #14, #19, #20, #21, #22, #25, #26 and #27) case mix residents who had Physician orders for physical restraints, applying chair alarms for 1 (Resident #2) of (Residents #2 and #5) case mix residents with chair alarms, performing transfers for 1 (Resident #5) of 7 (Residents #2 thru #8) case mix residents requiring assistance with transfers and providing correct and timely incontinent care for 4 (Residents #2, #5, #14 and #20) of 9 (Residents #2, #4, #5, #6, #7, #8, #14, #19 and #20) case mix residents who were incontinent. These failed	F 498		

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practices had the potential to affect 30 residents who required positioning by staff, as identified on a list provided by the Director of Nurses on 1/31/07, 18 residents with a restraint, according to a list provided by the Registered Nurse Consultant on 1/26/07 at 11:45 a.m., 29 residents who required assistance with transfers, as identified on the Resident Census and Condition of Residents form dated 1/22/07 and 4 residents with a chair alarm, as identified on a list provided by Licensed Practical Nurse #4 on 1/26/07 at 2:00 p.m. The findings are:

1. Resident #2 had diagnoses of Dementia with Behaviors and Psychosis. A Significant Change Minimum Data Set (MDS) dated 12/7/06 documented the resident had moderately impaired cognitive skills for daily decision making and short/long-term memory problems.

a. A Physician order dated 1/19/07 documented: "Soft waist restraint while ^ (up) in w/c (wheelchair), Check Q (every) 30 min (minutes) released Q 2 hrs (hours) x (times) 10 mins."

b. The resident's Plan of Care dated 12/6/06 documented: "at risk for skin impairment," "assist with pericare every 2 hours and as needed" and "perform catheter care every shift and as needed."

c. On 1/22/07 at 5:58 p.m., on 1/23/07 at 7:45 a.m. and 11:40 a.m., the resident sat in a wheelchair in the dining room. The resident's easy release waist restraint straps were untied from the back kick-bars of the wheelchair, but were not undone or loosened from the wheelchair arms. The waist belt remained snug around the resident's waist. She was not repositioned in any

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way by the staff.

d. On 1/23/07 at 2:38 p.m., Certified Nursing Assistant (CNA) #4 stated the resident had "been up since before I got here" and "been up since before 6:00 a.m."

e. On 1/23/07 at 3:15 p.m., CNA #6 and CNA #7 assisted the resident to the toilet. CNA #6 stated, the resident's "catheter is leaking" and held a brief with a wet area in the center. A clean disposable brief was placed on the resident. No catheter care or washing of the peri-area was completed.

f. A Physician order dated 11/24/06 documented: "W/C alarm to alert staff of unassisted transfers Check Q (every) shift to make sure unit is operational."

g. On 1/23/07 at 7:36 a.m., 11:40 a.m., 12:40 p.m. and 1:50 p.m., there was no wheelchair alarm attached to the wheelchair or the resident.

2. Resident #5 had diagnoses of Dementia with Behaviors and Alzheimer's Disease. A Quarterly MDS dated 12/7/06 documented the resident had modified independence in cognitive skills for daily decision making, short/long-term memory problems and a restraint.

a. A Physician order dated 12/19/06 documented: "Easy release seat belt when up in wheel chair to assist with upper body alignment. To be checked every 30 min and released every 2 hrs for ROM (range of motion) and incont (incontinent) care."

b. On 1/22/07 at 5:33 p.m. and on 1/23/07 at 7:20 a.m. and at 11:45 a.m., the resident was in a wheelchair in the dining room with a waist

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F 498	Continued From page 84 restraint on. The straps of the restraint were not tied to the back kick-bars of the wheelchair. The straps were not released from around the arms of the wheelchair and the restraint remained snug on the resident's waist. The resident was not repositioned by staff. c. On 1/23/07 at 12:34 p.m., Certified Nurse Assistant (CNA) #3 stated, "I don't understand why they untied this restraint in both places." d. The resident's Plan of Care dated 12/6/06 documented: "at risk for skin impairment due to being usually incontinent of bladder..." and "give perineal care when resident is incontinent and as needed." e. On 1/23/07 at 1:28 p.m., CNA #3 and CNA #13 assisted the resident to a standing position from a wheelchair. CNA #13 stated the resident was "wet." A clean, dry disposable brief was applied. No pericare was provided for the resident. f. The Plan of Care dated 12/6/06 documented "provide 2 person assist with all transfers." g. The ADL (activities of daily living) form completed by the Certified Nursing Assistants documented: "assist with transfers" and all but 1/23/07 was documented as "3" with the code "3=two+person assist." h. On 1/23/07 at 1:28 p.m., CNA #3 and CNA #13 placed the resident in a wheelchair directly across from a lounge chair and assisted the resident to stand by lifting her under each armpit and holding onto the back of her pants. The resident's legs were bent and she was slid across the floor by the CNAs. The CNAs stated they did not use a	F 498		

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F 498	Continued From page 85 mechanical lift on the resident. i. On 1/24/07 at 11:32 a.m., the resident was in a wheelchair with a lap belt over the lower abdomen. The straps were wrapped around the arm rests and then straight down and tied to the kick spur on each side, without crossing. 3. Resident #14 had diagnoses of Alzheimer's Disease, Polyarthritis and Muscle Weakness. An Admission MDS dated 11/17/06 documented the resident had moderately impaired cognitive skills for daily decision making, had short/long-term memory problems, one Stage II pressure sore and a restraint. a. A Physician order dated 11/24/06 documented: "Self-release belt while up in chair for resident safety." b. The resident ' s Plan of Care dated 11/16/06 documented: "at risk for skin impairment" and "turn and reposition every 2 hours and as needed." c. On 1/25/07 at 9:25 a.m., the resident sat in a wheelchair across from the nurse's station. A self-release belt was on the resident. The resident was pushed to the dining room for Bingo at 9:40 a.m. and was not moved from the dining room until 1:17 p.m. The resident was not repositioned by staff during this time. d. On 1/25/07 at 1:17 p.m., CNA #14 pushed the resident to the doorway of the shower room. A strong urine odor was present. e. On 1/25/07 at 1:24 p.m., the resident stated, "I cannot undo the belt by myself. Someone's got to	F 498		

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do it." At 1:25 p.m., CNA #15 pushed the resident into the shower room and undid the seat belt. CNA #14 and #15 assisted the resident to stand. Small amount of feces noted on wet disposable brief.

4. Resident #20 had a diagnosis of Late Effect Hemiplegia. An Annual MDS dated 1/16/07 documented the resident had moderately impaired cognitive skills for daily decision making, had short/long-term memory problems and a restraint.

a. A Physician order dated 1/2/07 documented:, "Turn and reposition Q (every) 2 H (hours) and PRN (as needed)" and "Soft waist belt while up in chair check Q 30 minutes and release Q 2 hours for ROM (range of motion) and BRP (bathroom privileges)."

b. The resident ' s Plan of Care dated 1/15/07 documented: "at risk for further skin impairment," "Turn and reposition Q(every) 2 hrs (hours) and as needed" and "when up in w/c (wheelchair) reposition q 2 hrs and as needed."

c. On 1/25/07 at 9:00 a.m., the resident was placed in a lounge chair. The resident remained in the lounge chair, feet up, until 12:00 p.m. The resident's pants were wet and the brief was saturated.

d. A Physician order dated 1/2/07 documented: "Soft waist belt while up in chair Check Q 30 minutes and release Q2 hours for ROM and BRP (bathroom privileges)."

e. On 1/23/07 at 8:07 a.m., the resident sat in a wheelchair with the left-strap of a soft waist

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F 498	Continued From page 87 restraint around the resident ' s oxygen cylinder; it was then tied around the opposite kick spur. f. On 1/23/07 at 10:12 a.m., the resident sat in a recliner that was reclined and had a lap belt around the upper abdomen, under the breasts. g. On 1/25/07 at 8:01 a.m. and at 12:00 p.m., the resident was in a wheelchair with a soft belt restraint on. The straps of the restraint were tied straight down each side, to the kick spurs, and not crossed in the back. h. On 1/25/07 at 1:35 p.m., the resident was in a wheelchair with the left-strap of the belt restraint tied straight down to the kick spur and the right strap crossed over the top of the oxygen cylinder. 5. Resident #25 had diagnoses of Cerebrovascular Accident and Difficulty in Walking. A Quarterly MDS dated 1/2/07 documented the resident had modified independence in cognitive skills for daily decision making, short/long-term memory problems and a restraint. a. A Physician order dated 10/7/04 documented: "Soft-belt restraint while up in w/c to prevent unassisted transfers. To be checked Q 2 hours and released x 10 minutes for ROM and toileting." b. On 1/23/07 at 7:30 a.m., the resident was in a wheelchair with a soft belt restraint on; the straps were wrapped and tied around the back of the wheelchair arms on both sides. 6. Resident #26 had diagnoses of Dementia, Abnormality of Gait and Muscle Weakness. A Quarterly MDS dated 11/21/06 documented the	F 498		

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F 498	Continued From page 88 resident had modified independence in cognitive skills for daily decision making, a short-term memory problem and no restraint. a. A Physician order dated 12/20/06 documented: "Soft waist belt when up in chair Check Q 2 hours and release for 10 minutes for ROM and BRP." b. On 1/23/07 at 10:00 a.m., the resident was in a wheelchair with a soft belt waist restraint on. The straps were straight down on each side of the wheelchair, without crossing in the back. c. On 1/23/07 at 11:38 a.m., the resident was in a wheelchair with the soft belt straps looped around the back of the left arm of the wheelchair and tied around the right arm of the wheelchair and straight down the back on both sides, without crossing. 7. Resident #27 had diagnoses of Paranoid Schizophrenic, Convulsions and Psychosis. A Quarterly MDS dated 1/9/07 documented the resident had moderately impaired cognitive skills for daily decision making, short/long-term memory problems and a restraint. a. A Physician order dated 10/28/05 documented: "Soft waist belt while in wheelchair to prevent unassisted transfers. Check every 2 hours, release for 10 mins for incont care and ROM." b. On 1/23/07 at 10:00 a.m., the resident sat in a wheelchair with a soft belt waist restraint on that had one strap tied on the back of the wheelchair arm on the right, and both straps tied straight down both sides without crossing in the back and wrapped numerous times around the kick-bars on the back of the wheelchair.	F 498		

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MONTICELLO HEALTHCARE CENTER	**1052 OLD WARREN ROAD MONTICELLO, AR 71655**

(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
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c. On 1/23/07 at 12:12 p.m., the resident sat in a wheelchair with the soft waist restraint strap looped around the back of the wheelchair arm on the right.

8. The Application Instruction Sheet Posey Self-releasing Soft Lap Belt documented: "Bring the straps over the thighs at a 45 degree angle around the back post and pass them between the seat and the side of the chair." and "Cross the straps and twist behind the patient and attach them underneath the chair."

9. On 1/26/07 at 10:59 a.m., the ADON and DON when asked why the restraints were untied from the back kick bars of the wheelchairs at meal time, both stated, "eating is a good time to release the restraint." When asked if the residents were repositioned during this time, both stated, "No."

10. Resident #19 had diagnoses of Dysphagia, Fracture Femur and Psychosis. An MDS dated 1/18/07 documented the resident had short/long-term memory problems, was severely impaired in cognitive skills for daily decision making and dependent on staff for all activities of daily living.

a. The resident had a care plan problem dated 4/4/06 that documented: "At risk for skin impairment due to impaired bed mobility...and approaches which included "pillows may be used for support, positioning, and comfort as needed."

b. On 1/23/07 at 12:10 p.m., the resident was in a high-back wheelchair with a lap buddy in use. The resident was leaning to the right arm of the

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	045239	A. BUILDING ______ B. WING ______	01/26/2007

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wheelchair, with her right elbow on the lap buddy and her shoulder up against the metal arm rest; the resident was without support under the right arm and side area.

c. On 1/26/07 at 8:45 a.m., the resident was seated in her wheelchair in her room with her lap buddy in place backwards, leaning to the right side with the right mid upper arm against the wheelchair arm; no padding to prevent pressure was present.

d. On 1/23/07 at 12:20 p.m., 1/24/07 at 5:50 p.m., 1/25/07 at 8:10 a.m., 1/25/07 at 8:50 a.m., and 1/26/07 at 8:45 a.m. the resident was in a wheelchair with a lap buddy on the wheelchair backwards; the indentation for the resident ' s abdomen was facing out away from the resident.

11. Resident #7 had diagnoses of Dementia with behavioral disturbance, Alzheimer's Disease, Anxiety State, Depressive Disorder and Lack of Coordination. An Annual MDS dated 11/27/06 documented the resident had short/long-term memory loss, modified independence in cognitive skills for daily decision making, extensive to total dependence on staff for activities of daily living and used daily a chair that prevented rising.

a. On 1/23/07 at 8:17 a.m., the resident was in a wheelchair, leaning to the right side with her rib area on the arm of the wheelchair.

b. On 1/23/07 at 12:17 p.m., the resident was up in a wheelchair, moving herself to the dining room in the hall. CNA #3 approached the resident to assist her to the dining room and noticed the resident holding a rolled up blanket on top of her right thigh. CNA #3 stated, "I don't know why this

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F 498	Continued From page 91 [blanket] is here." The CNA removed the blanket and took it with her on down the hall, leaving the resident leaning to the right-side of the wheel chair.	F 498		