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BEVERLY HEALTHCARE MONTICELLO	1194 N CHESTER ST MONTICELLO, AR 71655

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F 000	INITIAL COMMENTS Complaint #10380 was substantiated (all or in part) with deficiencies cited at F312, F314 and F315.	F 000		
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Complaint #10380 was substantiated (all or in part) in these findings. Based on observation, interview and record review the facility failed to ensure that incontinent care was provided in a manner to maintain good hygiene for 3 (Residents #4, #15 and #13) of 11 (Residents #1, #4, #5, #7, #9 and #11 thru #16) case-mix residents who were incontinent and dependent on staff for Activities of Daily Living. This failed practice had the potential to affect 45 incontinent residents in the facility, according to the Director of Nursing on 10/7/05. The findings are: 1. Resident #4 had diagnoses of Alzheimer's Disease, Psychosis, Hypertension, Hypertensive Heart Disease, Diabetes Mellitus and Chronic Urinary Tract Infections. The Annual Minimum Data Set (MDS) dated 7/7/05 documented that the resident had severely impaired cognitive skills	F 312		11/6/05

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 312	Continued From page 1 for daily decision-making, was totally dependent on the assistance of two staff persons for toileting and personal hygiene and was incontinent of bowel and bladder. a. The Resident Plan of Care dated 10/4/05 documented: Requires extensive to total assistance to meet her activity of daily living needs with no potential for improvement due to Alzheimer's Disease and resident is at risk for skin breakdown, and UTI's (Urinary Tract Infections) due to urinary incontinence. Interventions included: incontinent care every 2 hours and as needed. Staff will observe for signs and symptoms of UTI's. Resident will be as clean and dry as possible. b. A Physician Order dated 9/8/05 documented: "AZO-Cranberry 450 mg. (milligrams) 2 tablets by mouth three times per day." c. On 10/3/05 at 2:00 p.m. during the provision of incontinent care, after a large bowel movement, Certified Nurse Aide (CNA) #1 failed to wash the resident's vulva, labia, urinary meatus and buttocks. The CNA did not rinse the resident's skin after cleansing the rectal area with soap and water. 2. Resident #15 had diagnoses of Incontinence, Diabetes, Hypertension and Renal Failure. An Annual MDS dated 8/9/05 documented that the resident was incontinent of bowel and bladder and was totally dependent on staff for bathing and personal hygiene. a. On 10/5/05 the resident was sitting in a	F 312		

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recliner, at the bedside, from 9:18 a.m. until 1:34 p.m. (4 hours and 16 minutes) in an incontinent diaper and pants that were thoroughly saturated in urine. A very strong urine odor permeated the room.

b. On 10/5/05 at 1:34 p.m., Certified Nursing Assistant (CNA) #3 and CNA #7 transferred the resident to the bed with a mechanical lift. CNA #3 provided incontinent care to the resident's peri area and CNA #7 provided incontinent care to the resident's rectal area. Neither of the CNAs cleaned the resident's thighs or upper or lower abdomen, which was saturated in urine, when the incontinent care was provided. The Director of Nurses (DON) was present during the incontinent care.

c. On 10/5/05 at 4:05 p.m., the DON acknowledged that the incontinent care provided was inadequate.

3. Resident #13 had diagnoses of Diarrhea, Bladder Disorder and Irritable Colon. A Quarterly MDS dated 9/30/05 documented that the resident had moderately impaired cognitive skills for daily decision-making, required extensive assistance with toileting and hygiene and was incontinent of bowel and bladder.

a. A Care Plan dated 9/15/05 documented: "Check [resident] at least Q 2 hours for any incontinent episodes."

b. On 10/4/05 at 3:24 p.m., the resident was lying in bed with the incontinent pad, top and bottom sheets and bed spread saturated with urine. There were several dried feces smears present on the under side of the top sheet. There were

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F 312	Continued From page 3 dried feces smears on the resident's upper thighs and buttocks. A very strong urine odor permeated the room. c. On 10/4/05 at 4:09 p.m., a CNA stripped the resident's bed. The resident had been removed from his bed. It was noted the resident's incontinent pad, top and bottom sheet and bedspread were saturated with urine. Dried feces smears were noted on the top sheet. A strong urine odor was noted in the room.	F 312		
F 314 SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Complaint #10380 was substantiated (all or in part) in these findings. Based on observation, interview, and record review the facility failed to ensure that residents who were incontinent and had a Pressure Ulcer or were at risk for Pressure Ulcers, received treatments and/or services in a manner to prevent possible infections, promote healing, and prevent development of pressure ulcers for 3 (Residents #1, #15 and #12) of 13 (Residents#1 thru #5, #7,	F 314		11/6/05

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#9, #11 and #12 thru #16) case-mix residents reviewed for Pressure Ulcers. This failed practice had the potential to affect 64 residents in the facility that required services for the treatment of or prevention of pressure ulcers, according to the Director of Nurses on 10/7/05. The findings are:

1. Resident #1 had diagnoses of Decubitus Ulcer, Alzheimer's Disease, Hypertension, Depressive Disorders and Vitamin Deficiency. The Quarterly Minimum Data Set (MDS) dated 8/4/05 documented that the resident had moderately impaired cognitive skills for daily decision-making, required extensive assistance with all activities of daily living, was incontinent of bowel and bladder, had one Stage IV Pressure Ulcer and required preventive skin care and ulcer treatments.

a. The Resident Plan of Care dated 9/21/05 documented that the resident was at risk for skin breakdown and had an open area to the coccyx. Interventions included Xenaderm everyday until healed, staff will observe for skin irritations and will use a barrier care product as needed for irritation.

b. The Physician Orders signed 9/7/05 did not address the open Pressure Ulcer located on the resident's coccyx.

c. On 10/5/05 at 10:50 a.m., Certified Nurse Aide (CNA) #3 applied Laniseptic Ointment to the resident's Stage III open Pressure Ulcer, using the same dirty, contaminated gloves worn while cleaning feces off of the resident during incontinent care.

2. Resident #12 had diagnoses of Pineal Gland Neoplasm, Convulsions, Cerebral Vascular

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F 314	Continued From page 5 Accident, Embolis, Senile Dementia, Urinary Incontinence, Anorexia, Peptic Ulcer Disease, Gastrointestinal Reflux Disease and Nutritional Deficiency. The Quarterly MDS dated 9/20/05 documented that the resident had severely impaired cognitive skills for daily decision-making, required extensive assistance of staff for toileting needs and personal hygiene and was incontinent of bowel and bladder. a. The Resident Care Plan dated 3/8/05 documented: "Problems/Strengths: Resident is at risk for developing UTIs [Urinary Tract Infections] and skin breakdown D/T [due to] she is incont [incontinent] of urine. She has no potential for improvement D/T old CVA [Cerebral Vascular Accident] and Brain Tumor. Interventions: Staff will observe for S/S [signs and symptoms] of UTIs, Decreased urine output, odor appearance, c/o [complaint of] pain on voiding, frequent voiding, elevated temp [temperature] etc. Resident will have prompt incont care ..." b. On 10/4/05 at 2:50 p.m., a family member stated, "[Resident #12] has a shunt in the head that drains into the urinary tract causing frequent urination. I find [resident] wet and smelling of old urine all the time. I have complained and complained to the nursing staff about this and they still leave [resident] wet. [Resident] is laying in a saturated, smelly bed right now." c. On 10/4/05 at 2:58 p.m., the resident's clothing, bed linens and top covers were saturated with urine and had a strong, foul, stale urine odor present. d. On 10/5/05 at 1:35 p.m., the resident was lying in the bed in a supine position. The resident did	F 314		

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not have on an adult brief and was lying on an incontinent pad. The incontinent pad was wet and had no odor. The pad was marked, with a blue ink pen, by the surveyor.

e. On 10/5/05 at 1:45 p.m., CNA #2 put on latex exam gloves and felt of the resident's incontinent pad for wetness. When asked by the surveyor if the resident was wet, the CNA stated, "No, she is not." The CNA then positioned the resident for comfort and exited the room. The surveyor's blue ink mark was still visible on the resident's incontinent pad.

f. On 10/5/05 at 1:55 p.m., the resident's incontinent pad was observed by two surveyors and verified to be marked with the same blue mark and was wet underneath the resident.

g. On 10/5/05 at 2:05 p.m., CNA #6 entered the resident's room, followed by the surveyor at 2:10 p.m., at which time CNA #6 stated, "I just changed her bed pad. It wasn't wet, but someone put a blue mark on it." When asked by the surveyor, are you sure the resident was not wet, the CNA removed the marked incontinent pad from the linen disposal bag and checked the pad with bare hands and agreed with surveyor that the pad was wet. The CNA stated, "I guess I will have to do her again." The incontinent skin care was performed by the CNA at 2:15 p.m.

3. Resident #15 had diagnoses Incontinence and Diabetes. An Annual MDS dated 8/9/05 documented that the resident was incontinent of bowel and bladder and totally dependent on staff for toileting, personal hygiene and bathing.

a. The resident's Care Plan dated 8/9/05

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F 314	Continued From page 7 documented: "Problems/Strengths: At risk for Pressure Ulcers D/T [due to] bowel & bladder incontinence and dependent for bed mobility. Interventions: Reposition every two hours and prn [as needed]. Problems/Strengths: Resident is at risk for skin breakdown and UTIs [Urinary Tract Infections] D/T she is incont of urine. Resident requires one-person assistance to prevent skin breakdown. Interventions: Staff will provide one person assist with incontinent care every two hours and prn. Problems/Strengths: Resident is a tube feeder who is at risk for dehydration, weight loss and aspiration. Interventions: Observe for S/S of infection to G/T site, drainage, odor and skin irriation [irritation]." b. On 10/5/05 the resident was observed sitting in a recliner at the bedside from 9:18 am until 1:34 pm (4 hours and 16 minutes). The resident was incontinent of urine & BM & sat in an incontinent brief that was saturated with urine and was not repositioned for the 4 hours and 16 minutes. 4. The facility's policy and procedure titled, Pressure Ulcer, documented, under the pressure reduction guidelines, Change position in bed or chair at least every 2 hours.	F 314		
F 315 SS=E	483.25(d) URINARY INCONTINENCE 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	F 315		11/6/05

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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:

Complaint #10380 was substantiated (all or in part) in these findings.

Based on observation, record review and interview the facility failed to ensure incontinent care was provided in a manner to prevent the potential for Urinary Tract Infections for 2 (Residents #12 and #15) of 11 (Residents #1, #4, #5, #7, #9, and #11 thru #16) case-mix residents that were incontinent of bowel and bladder. This failed practice had the potential to affect 45 residents that were totally dependent on staff for toileting, according to the Director of Nurses on 10/7/05. The findings are:

1. Resident #12 had diagnoses of Pineal Gland Neoplasm, Convulsions, CVA (Cerebral Vascular Accident), Embolis, Senile Dementia, Urinary Incontinence, Anorexia, Peptic Ulcer Disease, Gastrointestinal Reflux Disease and Nutritional Deficiency. The Quarterly Minimum Data Set (MDS) dated 9/6/05 documented that resident had severally impaired cognitive skills for daily decision-making, was incontinent of bowel and bladder and dependent on staff for all toileting needs.

a. The Resident Care Plan dated 3/8/05 documented: "Problems/Strengths: Resident at risk for developing UTIs (Urinary Tract Infections)

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and skin breakdown d/t [due to] she is incont [incontinent] of urine. She has no potential for improvement d/t old CVA [Cerebrovascular Accident] and Brain Tumor. Interventions: Staff will observe for s/s [signs and symptoms] of UTIs: Decreased urine output, odor appearance, c/o [complaint of] pain on voiding, frequent voiding, and elevated temp [temperature] etc. Resident will have prompt incont care."

b. On 10/5/05 at 12:15 p.m., Certified Nurse Aide [CNA] #5 cleansed from the resident's groin, labia and urinary meatus repeatedly with a wet wash cloth sprayed with Peri-wash in a front to back motion without folding the wash cloth between each wipe.

2. Resident #15 had diagnoses of Incontinence and Diabetes. An Annual MDS dated 8/9/05 documented that the resident was incontinent of bowel and bladder and was totally dependent on staff for toileting, hygiene and bathing.

a. The resident's Care Plan dated 8/9/05 documented: "At risk for Pressure Ulcers D/T [due to] bowel & bladder incontinence & dependent for bed mobility...Resident is at risk for skin breakdown and UTI's D/T she is incontinent of Urine. Resident requires one person assistance to prevent skin breakdown...Staff will provide one person assist with Incontinent Care every two hours and PRN [as needed]..."

b. On 10/5/05 at 1:34 p.m., CNA #3 and CNA #7 were transferred the resident from a recliner to the bed by a mechanical lift. CNA #3 removed the resident's incontinent brief and pants that were completely saturated with urine; the incontinent pad under the resident was also saturated with

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F 315	Continued From page 10 urine. The resident had been sitting in the recliner for 4 hours and 16 minutes without receiving any incontinent care. The resident had urine on her inner and outer thighs, abdomen, lower back and buttocks. The Director of Nurses [DON] was present and agreed the resident's incontinent brief, pants and incontinent pad were completely saturated with urine. c. CNA #3 cleaned the resident's peri-area from the vulva toward the rectal area with the wet corner of a towel. The CNA cleansed the area with 9 swipes of the towel, without turning the towel between swipes. After the first swipe of the towel it was noted that feces smears were present on the towel. The resident was then turned to her left side; the resident had been incontinent of bowel and diarrhea was present. CNA #7 cleansed the rectal area with the wet corner of a towel with 10 swipes of the towel. The towel was only turned the towel 5 times between swipes. The resident's inner and outer thighs, abdomen, buttocks and lower back were not cleansed. d. During the interview with the Director of Nurses on 10/5/05 at 4:05 p.m. she stated that the incontinent care was not adequate. It was not acceptable nursing practice. e. The Policy and Procedure for Incontinent Care provided by the facility that was Amended on 12/13/04 documented, "...Step 12, Woman Changes, Note: ... wash perineal area wiping front to back. Wash legs or any part of body that has been exposed to urine or feces, and dry skin with towel..."	F 315		
F 322	483.25(g)(2) NASO-GASTRIC TUBES	F 322		11/6/05

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Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and interview, the facility failed to ensure that a feeding pump was not turned off for an extended period of time and was turned off when the head of the bed was in a flat position for 1 (Resident #12) and failed to ensure a Gastrostomy Tube dressing was maintained in a manner to prevent the possibility of infection for 1 (Resident #15) of 4 (Residents #12 thru #15) case-mix residents that received tube feedings. This failed practice had the potential to affect 9 residents in the facility who received tube feedings, as identified by the Director of Nursing on 10/7/05. The findings are:

Resident #12 had diagnoses of Pineal Gland Neoplasm, Convulsions, Cerebral Vascular Accident (CVA), Embolis, Senile Dementia, Urinary Incontinence, Anorexia, Peptic Ulcer Disease, Gastrointestinal Reflux Disease and Nutritional Deficiency. The Quarterly Minimum Data Set dated 9/6/05 documented that the resident had severely impaired cognitive skills for daily decision-making, required a tube feeding and was totally dependent on staff for calorie and hydration needs.

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a. The resident Plan of Care dated 3/8/05 documented that the resident was a tube feeder who was at risk for dehydration, weight loss, and aspiration. Interventions included Novasource Pulmonary at 35 cc's (cubic centimeters) with auto flushing every 59 minutes to equal 1207 kcal/805 cc's every 24 hours. Medications may be crushed and mixed with liquids to give via G-Tube [Gastric Tube]. Observe for s/s [signs/symptoms] of dehydration, dry mucous membranes, decrease in urine output, confusion, and abnormal labs. Bed elevated for G-Tube feedings. Quantum Pump for feeding as ordered with auto flush of water 25 cc's/hour.

b. The resident Plan of Care dated 3/8/05 documented: "Problems/Strengths: Resident is totally dependent on others to meet her care ADL [activities of daily living] needs daily and prn [as needed]. No potential for improvement d/t [due to] brain tumor, old CVA with lt. [left] side weakness. At risk for poor hygiene, episodes of dehydration, social isolation, and dental care. Interventions: Resident will be up in g/c [Geri-chair] daily and out of room for short periods..."

c. The Physician Orders dated 8/7/05 documented: "Check G-Tube placement via aspiration and auscultation before administering medications every eight hours. Pulmocare at 35 cc's/hour via G-Tube, via Quantum Pump to provide 1207 kcal/805 cc's/23 hours. May turn Tube Feeding off when up in Geri-Chair. Flush G-Tube before and after medications with 30 cc's water--for total of 60 cc's each flush. G-Tube intake each shift."

d. The resident's Weight Record documented that

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the resident had a 2.12% (2.6 pounds) weight loss in one month from August 10, 2005 to September 12, 2005.

e. The resident's Lab Work and Physician's Orders revealed that the resident had a Urinary Tract Infection and was treated with Ampicillin 500 mg. (milligrams) two times a day for 7 days (9/28/05-10/5/05).

f. On 10/5/05, from the hours of 9:05 a.m. to 12:05 p.m. and 12:15 p.m. to 2:13 p.m. (total of 4 hours and 53 minutes), the resident's feeding tube was disconnected and the feeding pump turned off. There was a bottle containing 850 cc's of Novasource Pulmonary hanging above the pump in the resident's room during this period of time.

g. On 10/5/05 at 2:13 p.m., Licensed Practical Nurse (LPN) #1 entered the resident's room, checked the resident's G-Tube placement via 30 cc's auscultation of air, attached the feeding tube to the resident's G-Tube and restarted the Feeding pump to infuse the remaining 850 cc Novasource Pulmonary at 35 cc per hour. During this procedure, the LPN was informed by Certified Nurse Assistant (CNA) #5 that incontinent care was going to be done for the resident. The LPN continued with the procedure and left the room with the feeding pump infusing at 35 cc per hour.

h. On 10/5/05 at 2:15 p.m., CNA #6 lowered the head of the resident's bed to a flat position to perform incontinent care on the resident; the resident's feeding pump was infusing at 35 cc's per hour. The formula continued to infuse with the head of the resident's bed in a flat position for a period of 10 minutes, until the Director of Nursing

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(DON) passed by the resident's room; CNA #5 asked the DON to raise the head of the resident's bed back to a 45-degree angle.

i. On 10/5/05 at 2:25 p.m., after raising the resident's head to a 45-degree angle, the DON was asked, Is it acceptable nursing practice to do incontinent skin care with the head of bed in a flat position for a resident with a tube feeding infusing per pump at 35 cc's per hour. The DON stated, "No ma'am, it is not." When told that the resident was left flat for 10 minutes during care with the feeding pump running, the DON stated, "I can see I need to do more training."

2. Resident #15 had diagnoses of Incontinence and Diabetes. An Annual MDS dated 8/9/05 documented that the resident was incontinent of bowel and bladder and totally dependent on staff for toileting, hygiene and bathing.

a. The resident's Care Plan dated 8/9/05 documented: "At risk for Pressure Ulcers D/T [due to] bowel & bladder incontinence & dependent for bed mobility...Observe for S/S (sign & symptoms) of infection to G/T [Gastrostomy Tube] site, drainage, odor and skin irritation..."

b. On 10/5/05, the resident was sitting in a recliner at the bedside. The resident had been incontinent of bowel and bladder. The resident sat in a urine soaked brief and pants from 9:18 a.m. until 1:34 p.m. (4 hours and 16 minutes); the resident's Gastrostomy Tube dressing was saturated with urine during that time.

c. On 10/5/04 at 1:28 p.m., the Director of Nurses (DON) and the Administrator accompanied the surveyor to the resident's room; after examining

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F 322	Continued From page 15 the resident's Gastrostomy Tube dressing, the DON stated the resident was wet with urine. The DON also stated that the resident's Gastrostomy Tube dressing was saturated with urine.	F 322		
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 and record review, the facility failed to ensure the menu was followed for 16 residents on a pureed diet. This had the potential to affect 81 residents who ate meals in the facility. The findings are: 1. On 10/6/05, the lunch menu for the pureed diet documented "Tater Tots;" instead, Mashed Potatoes were prepared for 16 residents that were on pureed diets. 2. On 10/6/05, the menu for the evening meal documented "Harvard beets;" the residents were served beets from the can, cooked on the stove, without any seasoning.	F 363		11/6/05
F 366 SS=B	483.35(d)(4) FOOD Each resident receives and the facility provides substitutes offered of similar nutritive value to	F 366		11/6/05

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F 366	Continued From page 16 residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure that residents were offered a substitute for foods that they refused to eat. This failed practice had the potential to affect 47 residents who ate their meals in the main dining room. The findings are: 1. On 10/6/05, the menu documented "Liver and Onion with Gravy" and "Harvard Beets." At 5:46 p.m., 21 of 47 residents refused to eat their beets and liver. No substitutions were offered by staff in the dining room, although substitutes of green beans and sweet potatoes were available.	F 366		
F 441 SS=E	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, interview and record review the facility failed to ensure interventions for	F 441		11/6/05

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F 441	Continued From page 17 the prevention of possible infections were implemented for 2 (Residents #4 and #12) of 11 (Residents #1, #4, #5, #7, #9 and #11 thru #16) case-mix residents reviewed for urinary incontinence. This failed practice had the potential to affect 45 residents that were totally dependent on staff for incontinent care, according to the Director of Nurses on 10/7/05. The findings are: 1. Resident #12 had diagnoses of Pineal Gland Neoplasm, Convulsions, Cerebral Vascular Accident, Embolis, Senile Dementia, Urinary Incontinence, Anorexia, Peptic Ulcer Disease, Gastrointestinal Reflux Disease and Nutritional Deficiency. The quarterly Minimum Data Set (MDS) dated 9/6/05 documented that the resident had severely impaired cognitive skills for daily decision-making, required extensive assistance with all activities of daily living, was dependent on staff for all toileting needs and incontinent of bowel and bladder. a. The Resident Care Plan dated 3/8/05 documented that the resident at risk for developing UTIs [Urinary Tract Infections]. b. The Physician Orders dated 5/1/05 documented: AZO-Cranberry 450 mg. (milligrams) tabs 2 by mouth three times per day for urinary incontinence. c. On 10/5/05 at 12:15 p.m., Certified Nurse Aide (CNA) #5, after performing incontinent care on the resident, failed to change her gloves. With the same contaminated gloves, the CNA opened the resident's bedside table drawer, obtained a bottle of Johnson's Baby Lotion and applied the baby lotion to the resident's buttocks and both legs.	F 441		

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F 441	Continued From page 18 2. Resident #4 had diagnoses of Alzheimer's Disease, Psychosis, Hypertension, Hypertensive Heart Disease, Diabetes Mellitus and Chronic Urinary Tract Infections. The annual MDS dated 7/7/05 documented that the resident had severely impaired cognitive skills for daily decision-making, was totally dependent on staff for all activities of daily living and incontinent of bowel and bladder. a. The Resident Plan of Care dated 10/4/05 documented: Requires extensive to total assistance to meet her activity of daily living needs with no potential for improvement due to Alzheimer's Disease. b. The Physician's Orders dated 9/8/05 documented: AZO-Cranberry 450 mg. (milligrams) 2 tablets by mouth three times per day. c. On 10/3/05 at 2:00 p.m., after the resident had a large bowel movement CNA #1 provided incontinent care. The CNA placed the feces soiled brief, incontinent bed pad, wash cloths and towel onto the resident's gel pad located in the resident's Geri-chair, while performing the incontinent care. When finished with the incontinent care, the CNA failed to change her dirty contaminated gloves, opened the resident's dresser drawer, obtained a clean night gown and with the same contaminated gloves on, assisted CNA #2 in dressing the resident. CNA #1 then gathered all the dirty supplies into a trash bag and exited the room. The CNA failed to cleanse/disinfect the resident's gel pad.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM	F 463		11/6/05

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F 463	Continued From page 19 The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to maintain a functional call light system in a shower room and a whirlpool room. This failed practice had the potential to affect 22 residents who use these rooms for showers and baths. The findings are: 1. During environmental rounds on 10/3/05 at 10:00 a.m., the shower room and the whirlpool room on North hall near the Nurses Station had call lights that were not working.	F 463		
F 498 SS=D	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 and record review the facility failed to ensure Certified Nursing Assistants (CNA) demonstrated competency in 2 person manual transfers for 1 (Resident #12) of 5 (Residents #5, #7, #8, #9 and #11) case-mix residents observed for transfers. This failed practice had the potential to affect 38 residents	F 498		11/6/05

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F 498	Continued From page 20 that were totally dependent on staff for transfers, according to the Director of Nurses on 10/7/05. The findings are: Resident #12 had diagnoses of Pineal Gland Neoplasm, Convulsions, Cerebral Vascular Accident, Senile Dementia, Urinary Incontinence and Anorexia. The quarterly Minimum Data Set dated 9/6/05 documented that the resident had severally impaired cognitive skills for daily decision-making, was totally dependent on staff for transfers and lifted manually. a. The Resident Care Plan dated 3/8/05 documented that the resident was totally dependent on others to meet activities of daily living care everyday and as needed due to Brain Tumor and old CVA with left side weakness with an intervention for staff to provide two person total assist with transfers to and from the wheelchair, bed, or bath. b. On 10/5/05 at 12:15 p.m., the resident was transferred from the Geri-chair to the bed. CNA #5 and Licensed Practical Nurse (LPN) # 1 placed their forearms under the resident's arms, at the arm pits, then lifted and pivoted the resident into the bed. The resident was non-weight bearing, resulting in a full body weight of 120 pounds being supported by the armpits during the transfer. c. The facility's policy and procedure titled, Transfer Activities, did not address how to perform a manual 2-person transfer on a resident that was non-weight bearing.	F 498		