

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

PRINTED: 10/22/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045239</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/09/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MONTICELLO HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1052 OLD WARREN ROAD MONTICELLO, AR 71655</b>	
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F 221 SS=E	<p><b>483.13(a) PHYSICAL RESTRAINTS</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure assessments were conducted to determine if physical restraints were medically necessary prior to initiating the restraint, failed to ensure ongoing assessments to determine if the restraint could be reduced or eliminated were conducted and failed to ensure an informed consent was signed by the resident or responsible party for 1 of 1 case mix resident with a lap buddy in use (Resident #11). The failed practice had the potential to affect only this resident (the only resident in the facility with a lap buddy in use), as identified on a list provided by the Director of Nursing (DON) on 10/9/08. The findings are:</p> <p>Resident #11 had diagnoses of Dementia with Behavior Disturbances and Debility. The Quarterly Minimum Data Set dated 9/10/08 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive assistance of staff for bed mobility, was totally dependent on staff for transfers, required extensive assistance for locomotion, had no limitations in range of motion, did not receive Physical Therapy or Nursing Rehabilitative Care in the last 7 days and had no devices or restraints in use.</p> <p>a. A physician order dated 6/6/08 documented,</p>	F 221		
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 221	<p>Continued From page 1</p> <p>"Lap buddy while up in w/c [wheelchair] to position upper body while up in wheelchair and ensure proper body alignment..."</p> <p>b. The Care Plan dated 9/10/08 documented: "Impaired thought processes... Goal: Resident will be free of injury by next review... Approaches... Evaluate the need for physical restraint use - lap buddy will be used..."</p> <p>c. On 10/6/08 at 1:20 p.m., the resident was sitting in a wheelchair with a lap buddy positioned across her mid-abdominal area.</p> <p>d. On 10/9/08 at 8:20 a.m., the resident was seated in the wheelchair with the lap buddy secured behind the arm rest bars.</p> <p>e. On 10/9/08 at 10:30 a.m., Certified Nursing Assistant (CNA) #5 placed the lap buddy on the resident and secured it behind the wheelchair arms.</p> <p>f. As of 10/9/08 at 10:30 a.m., there was no documentation in the Nurses' Notes or elsewhere in the clinical record of an assessment conducted prior to initiating the lap buddy to determine if the device was medically necessary, no documentation of ongoing assessments to determine if the lap buddy could be reduced or eliminated and no documentation of a signed, informed consent for the use of the lap buddy.</p> <p>g. On 10/9/08 at 11:55 a.m., the Director of Nursing (DON) was asked if the resident could remove the lap buddy. The DON stated, "No, the sitter said she can't take it off." The DON was asked if she had tried to see if the resident could remove the lap buddy. The DON stated, "Yes.</p>	F 221			

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F 221	Continued From page 2 Hands stayed on the lap buddy and no attempt." The DON was asked if, when a resident had a lap buddy, a pre-restraint assessment and ongoing assessments to determine if the device was appropriate and necessary were required and if a consent was to be signed by the resident or responsible party. The DON stated, "Yes."	F 221			
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure fingernail care was routinely provided to 1 (Resident #5) of 9 (Residents #1 through #9) case mix residents who were totally dependent on staff for nail care/cleaning. The failed practice had the potential to affect 70 residents who were dependent on staff for activities of daily living and required assistance for nail care, as documented by the Director of Nursing (DON) on 10/9/08. The findings are:  Resident #5 had diagnoses of Brain Hemorrhage - Deep Coma, Quadriplegia and Gastrostomy. The Initial Minimum Data Set (MDS) dated 7/26/08 documented the resident was in a comatose state, was incontinent of bowel, had an indwelling urinary catheter, had surgical wounds and was totally dependent on staff for activities of daily living.	F 312			

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F 312	Continued From page 3 a. Nurses Notes dated 9/18/08 documented: "R [resident] has abrasion to L [left] frontal lobe measuring 2 cm [centimeters] x [by] 1 cm R/T [related to] R picking @ [at] old surgical scar c [with] fingernails..." b. Nurses Notes dated 10/1/08 documented: "R has a 1 cm x .8 cm x .5 cm wound to L frontal lobe R/T R picking at old surgical site... Old scar to top of L foot R/T to R scratching..." c. On 10/6/08 at 12:50 p.m., 10/7/08 at 8:10 a.m. and 9:55 a.m. and 10/8/08 at 10:05 a.m., the resident's fingernails had a black substance visible under the tips of his fingernails, with the fingernails on the left hand appearing more soiled than those on the right hand.	F 312			
F 314 SS=D	483.25(c) PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation record review and interview, the facility failed to ensure skin barrier protectant was applied after incontinent care for 1 (Resident #6) of 4 case mix residents (Residents #1, #3, #5 and #6) who were assessed by the facility as at high risk for pressure sores. The failed practice had the potential to affect 10	F 314			

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F 314	<p>Continued From page 4</p> <p>residents who were at high risk for pressure sore development, as documented on a list provided by the Director of Nursing (DON) on 10/9/08. The findings are:</p> <p>Resident #6 had diagnoses of Quadriplegia and Joint Contractures to Multiple Joints.</p> <p>a. A Braden Scale for Predicting Pressure Sore Risk form dated 1/1/08 documented the residents pressure ulcer risk score was 11, with a score of 12 or less indicating the resident was at high risk for pressure ulcer development. The Braden Scale form dated 7/1/08 documented the pressure ulcer risk score was 15, with a score of 15 to 18 indicating the resident was at mild risk for pressure ulcer development.</p> <p>b. The Minimum Data Set (MDS) dated 7/25/08 documented the resident had modified independence in cognitive skills for daily decision making, was totally dependent on staff for activities of daily living, had functional limitation in range of motion on both sides with full loss in the arms, hands, legs and feet, was totally dependent on staff for all activities of daily living, was incontinent of bowel all or almost all of the time, had a skin ulcer that resolved in the last 90 days and received application of ointments/medications to the skin (other than the feet) in the last 7 days.</p> <p>c. The Plan of Care dated 4/28/08 documented: "At risk for skin impairment due to incontinence of bowel, impaired bed mobility, bedfast most of the time and history of pressure ulcers... Approaches... Provide incont [incontinent care] ever 2 hours and PRN [as needed]..."</p>	F 314			

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F 314	Continued From page 5 d. On 10/7/08 at 9:40 a.m., the resident was receiving incontinent care from Certified Nursing Assistants (CNA's) #3 and #4. The resident had been incontinent of a moderate amount of loose stool. The resident's scrotum was slightly reddened and the buttocks and coccyx area had pink, excoriated skin. The CNA's did not apply any type of skin protectant or barrier cream after incontinent care was completed.  e. On 10/9/08 at 9:50 a.m., the Director of Nursing was asked if it was facility protocol to use a skin protectant on the residents after doing incontinent care, particularly if the skin was reddened. The DON stated, "Yes." When asked who applied the skin protectant, the DON stated, "The CNA's."	F 314			
F 318 SS=E	483.25(e)(2) RANGE OF MOTION  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 and interview, the facility failed to ensure devices to prevent further declines in range of motion were provided to 1 (Resident #6) of 3 case mix residents (Residents #6, #9 and #12) with contractures. The failed practice had the potential to affect 12 residents with contractures, as documented on the Resident Census and Conditions of Residents form dated 10/6/08. The findings are:	F 318			

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F 318	Continued From page 6  Resident #6 had diagnoses of Quadriplegia, Joint Stiffness and Joint Contractures of Pelvis and Hands. The Minimum Data Set (MDS) dated 7/25/08 documented the resident had modified independence in cognitive skills for daily decision making, was totally dependent for activities of daily living and had functional limitation in range of motion on both sides with full loss in the arms, hands, legs and feet.  a. A physician order dated 7/18/08 documented: "Apply bilateral U/E [upper extremity] splints as tolerated."  b. On 10/6/08 at 12:40 p.m., the resident was in bed, positioned on his back. The resident's hands and fingers were severely contracted. There were 2 soft hand splints on top of the small refrigerator in the resident's room, but no devices were in place in the resident's hands to prevent worsening of the contractures.  c. On 10/6/08 at 3:30 p.m., the resident was in bed and had splints on both hands. The resident was asked if he wore the splints every day and he stated, "No, they just put them on sometimes."  d. On 10/7/08 at 8:40 a.m., the resident was in bed. There were no hand splints on either of the resident's hands. At 9:40 a.m., the resident was in bed and was receiving care from Certified Nursing Assistant (CNA) #3. No hand splints were in place and none were applied when the care was completed. At 1:00 p.m., 3:30 p.m. and 6:10 p.m., the resident remained in bed and had no hand splints in use.  e. On 10/8/08 at 7:45 a.m. and 8:45 a.m., the	F 318			

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F 318	Continued From page 7 resident was in bed with no hand splints or other devices to prevent worsening of the hand contractures.  f. On 10/8/08 at 10:00 a.m., 12:00 p.m. and 3:00 p.m., the resident was in bed with no splints on his hands.  g. As of 10/8/08, the Plan of Care available for review in the resident's clinical record was dated 4/28/08 and did not address the contractures or the use of splints.	F 318			
F 322 SS=E	483.25(g)(2) NASO-GASTRIC TUBES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a contaminated tubing was not reinserted into the resident's feeding tube and failed to ensure adequate fluids to maintain hydration were administered to 1 (Resident #5) of 2 (Residents #1 and #5) case mix residents who received tube feedings. The failed practice had the potential to affect 6 residents who received tube feedings, as documented on the Resident Census and Conditions of Residents form dated 10/6/08, including 3 residents who received hydration exclusively via feeding tube, as documented by	F 322			

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F 322	<p>Continued From page 8</p> <p>the Director of Nursing on 10/9/08. The findings are:</p> <p>Resident #5 had diagnoses of Brain Hemorrhage - Deep Coma, Quadriplegia and Gastrostomy. The Initial Minimum Data Set (MDS) dated 7/26/08 documented the resident was in a persistent vegetative comatose state and had a feeding tube through which he received 76 to 100% of the total daily caloric intake and 1501 to 2000 cubic centimeters (cc) per day of fluid.</p> <p>a. A physician order dated 10/1/08 documented: "...Pulmocare feeding via PEG [percutaneous endoscopic gastrostomy] tube @ [at] 30 cc hr [cubic centimeters per hour]..."</p> <p>1.) On 10/7/08 at 9:25 a.m., the resident's feeding tube line was disconnected from the gastrostomy tube. Certified Nursing Assistant (CNA) #1 placed the line between a folded towel and called for the nurse. At 9:50 a.m., the feeding line remained disconnected. When the resident was turned to the side during care by CNA's #1 and #2, the feeding line fell onto the floor with the tip exposed. CNA #1 picked the line up and placed it between the folded towel at the head of the bed.</p> <p>2.) On 10/7/08 at 10:07 a.m., Licensed Practical Nurse (LPN) #1 removed the feeding line from the towel and inserted the uncapped line into the gastrostomy tube. The CNA's did not inform the nurse that the feeding line had been on the floor. At 10:09 a.m., CNA #1 called the nurse back to the bedside to report that the tube had leaked. LPN #1 used the same towel to wrap the tube.</p> <p>3.) On 10/7/08 at 10:22 a.m., LPN #1 was asked</p>	F 322			

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F 322	<p>Continued From page 9</p> <p>if the CNA's had informed her that the tip of the feeding tubing had been on the floor. The LPN stated, "No." The LPN was asked if a feeding line that had been in contact with the floor should be reconnected to the gastrostomy tube. The LPN stated, "No, if I had known, I wouldn't have used a soiled one..."</p> <p>4.) On 10/9/08 at 12:05 p.m., the Director of Nursing (DON) was asked if feeding tubing should be used if the tip had been in contact with the floor. The DON stated, "No."</p> <p>b. The Care Plan dated 7/25/08 documented: "Potential for fluid volume deficit related to presence of feeding tube... Approaches... Monitor intake/output and record. Report any negative fluid trends to physician..."</p> <p>c. A physician order dated 8/15/08 documented: "Auto flushes 10 cc HR [cubic centimeters per hour] X [times] 23 hours..." A physician order dated 10/1/08 documented: "...H2O [water] flushes per policy..."</p> <p>d. On 10/7/08 at 10:45 a.m., Licensed Practical Nurse (LPN) #1 changed the resident's formula bag and hung a 500 cc bag of water on the feeding pump.</p> <p>e. On 10/7/08 at 1:00 p.m., the 500 cc of water remained in the bag and the feeding pump was infusing formula only.</p> <p>f. On 10/7/08 at 1:10 p.m., Licensed Practical Nurse (LPN) #1 was asked how much water flush the resident received. The LPN stated, "Thirty cc's before and after meds [medications]. I believe his feeding pump should flush. His</p>	F 322			

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F 322	<p>Continued From page 10</p> <p>feeding is 30 cc's an hour through the pump. His flush is 30 cc's before and after meds." LPN #1 was asked if the resident received other water flushes. The LPN stated, "I don't see anything on the MAR [Medication Administration Record]."</p> <p>g. The October 2008 MAR documented: "Flushes with H2O per PEG [percutaneous endoscopic gastrostomy] 30 ml [milliliters] before and after meds." There was no documentation of other flushes on the MAR. The scheduled administration times for the 30 cc water flushes were documented as: "7-3 [7:00 a.m. to 3:00 p.m. shift], 3-11 [3:00 p.m. to 11:00 p.m. shift] and 11-7 [11:00 p.m. to 7:00 a.m. shift]." If administered once per shift as documented on the MAR, this would represent a total of 60 cc of water per shift or 180 cc of water per day. The MAR documented the resident had medications administered once daily on the 11:00 p.m. to 7:00 a.m. shift (at 6:00 a.m.), once daily on the 7:00 a.m. to 3:00 p.m. shift (at 12:00 p.m.) and twice daily on the 3:00 p.m. to 11:00 p.m. shift (at 6:00 p.m. and 8:00 p.m.), a total of 4 opportunities for medication administration daily. If administered a 30 cc water flush before and after each medication administration opportunity, this would represent 240 cc of water per day.</p> <p>h. The 2008 Monthly Weight Log documented the resident's October 2008 weight as 106 pounds (48.18 kilograms). Based on the resident's weight, multiplied by 30 cc of fluid required per kilogram of body weight, the resident required 1445 cc of fluid per day. The resident was reweighed on 10/7/08. The weight was 99.2 pounds (45.09 kilograms) which would require a total fluid intake of 1352 cc per day. Based on a total of 60 cc of water flush with medications 4</p>	F 322			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045239</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/09/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MONTICELLO HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1052 OLD WARREN ROAD MONTICELLO, AR 71655</b>		
(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 322	Continued From page 11 times daily plus the water supplied by the formula (552 cc), the resident was receiving 792 cc of fluid per day, a deficit of 560 cc per day.  i. On 10/7/08 at 1:25 p.m., the Assistant Director of Nursing (ADON) was asked if the resident received a continuous 10 cc per hour water flush. The ADON stated, "No. Per policy - before and after meds."  j. The facility's policy titled, "Maintaining Patency of a Feeding Tube (Flushing)" was provided by the Assistant Director of Nursing (ADON) on 10/8/08 at 10:20 a.m. and documented: "...General Guidelines... Flush enteral feeding tubes every four (4) to six (6) hours with thirty (30) to sixty (60) ml, or prescribed amount, of warm water during continuous feeding and before and after intermittent feedings... Flush with thirty (30) to sixty (60) ml, or prescribed amount, of warm water after checking residual stomach content... Flush enteral feeding tubes with fifteen (15) to thirty (30) ml, or prescribed amount, of warm water before and after administration of medications..."	F 322			