

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

PRINTED: 11/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143		
(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 282 SS=E	<p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a Physician order for thickened liquids was followed for 1 (Resident #3) of 4 (Residents #3, #13, #14 and #15) case mix residents with Physician orders for thickened liquids. This failed practice had the potential to affect 8 residents with orders for thickened liquids, as identified on the resident diet list provided by the Administrator on 10/27/08. The findings are:</p> <p>Resident #3 had diagnoses of Aspiration Pneumonia and Cerebrovascular Accident. The Significant Change Minimum Data Set dated 10/2/08 documented that the resident had moderately impaired cognitive skills for daily decision making, was totally dependent on staff for eating and had a chewing and swallowing problem.</p> <p>a. A Physician Order dated 10/6/08 documented, "d/c (discontinue) honey thick liqs (liquids) change to pudding thick liqs."</p> <p>b. The Resident Plan of Care dated 10/3/08 documented, "At risk for poor nutritional status related to: dysphagia with hx (history) of aspiration pneumonia ...Approach: 10/7/08 diet as order by physician NAS (no added salt) pureed,</p>	F 282			

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.

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

PRINTED: 11/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143		
(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 282	<p>Continued From page 1</p> <p>pudding thick liquids ...10/8/08 restorative to feed meals."</p> <p>c. On 10/27/08 at 3:35 p.m., an open carton of honey consistency water was on the resident's overbed table.</p> <p>d. On 10/28/08 at 12:30 p.m., Certified Nursing Assistant (CNA) #3 mixed a thickening agent with the contents of an 8 ounce (oz) carton of whole milk, using a lidded cup to shake the contents. The mixed contents resembled a honey thickened consistency that fell easily from a fork when tested. Without further thickening, the liquid was given to the resident to drink unassisted. The CNA stated, "She likes to be independent. We just stay and make sure she doesn't choke."</p> <p>e. On 10/28/08 at 5:35 p.m., CNA #3 prepared to thicken an 8 oz carton of milk for the resident. The resident's supper tray contained 4 packages of a thickening product labeled, "Simply Thick - Honey" gel and 4 packages of a thickening product labeled, "Simply Thick - Nectar" gel. When asked to identify the packages, the CNA did so and stated, "I used this one [picked up the honey thickener] at lunch, I guess I'll use it again. I used 4 of these at lunch. Maybe I should mix the two together [honey and nectar]. No, maybe I should ask for sure."</p> <p>The Assistant Director of Nurses (ADON) was called into the room by the CNA to clarify the thickening issue. The ADON returned from the dietary department and said, "Mix one and one half packages of each (honey and nectar) to 6 ounces of milk, but the main thing is to get it to pudding consistency." When asked to describe pudding consistency, the ADON stated, "It should</p>	F 282			

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

PRINTED: 11/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143		
(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 282	<p>Continued From page 2</p> <p>stick to the spoon." After mixing, the liquid result resembled a honey consistency and fell from a fork when lifted from the cup. The liquid did not stick to the fork. The ADON stated, "That should do it." Without further thickening, the liquid was given to the resident to drink. The resident's tray card documented, "NAS (no added salt), pureed, pudding, thickened."</p> <p>f. On 10/28/08 at 6:55 p.m., CNA #5 was asked how the CNAs knew if a resident had an order for thickened liquids. She stated that the nurse told them and a yellow dot was placed on a card at the head of the bed with a letter to show consistency ordered, an N for nectar, H for honey and P for pudding thick. When asked who instructed the CNAs in mixing the thickened liquids, the CNA stated, "I do." When asked to describe the appearance of the pudding thickened liquid, the CNA stated, "It should stick to the spoon."</p> <p>The resident had a yellow dot, with a 'P' written inside the dot, attached to a card on the head of the bed.</p> <p>g. On 10/29/08 at 12:27 p.m., CNA #4 delivered a lunch tray for the resident that included 3 packages of Simply Thick - Honey and an 8 oz carton of milk.</p> <p>The tray card documented the same information as the previous day, "NAS (no added salt), pureed, pudding, thickened" with added handwritten documentation of, "4 oz. thin liq. (liquid). Add 3 pkg. (packages) Honey Simply Thick to make pudd. (pudding). Honey cons. (consistency) juices add 1 pkg. Honey Simply Thick to make pudd."</p>	F 282			

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

PRINTED: 11/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143		
(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 282	<p>Continued From page 3</p> <p>CNA #4 mixed 3 packages of Simply Thick-Honey and an 8 oz. carton of milk, that were provided on the resident's lunch tray. The CNA stated, "They told me to mix 3 packs of this to 8 ounces." When asked who "they" were, the CNA stated, "The Dietary Manager... [CNA #3] must not have done it right yesterday because I had a note to do it this way." The mixed liquid was given to the resident to drink, without checking the consistency. The milk flowed easily down the side of the cup as it was turned up.</p> <p>The CNA was asked to check the consistency of the milk and it dripped off the fork, as a nectar consistency. The CNA stated, "That's not right, is it?" The CNA read the tray card again and stated, "They only sent me 3 packs, I have to get 3 more from the kitchen."</p> <p>h. On 10/29/08 at 3:35 p.m., when asked if printed instructions for mixing pudding thickened liquids were available in the facility, the Dietary Manager stated, "No."</p> <p>i. On 10/29/08 at 4:00 p.m., when asked if she had instructed the staff in thickened liquids, the Speech Therapist stated that she had done that perhaps 6 months ago, that she had brought in samples of the nectar and the honey consistency, but could not remember if she had covered pudding consistency.</p> <p>j. A copy of an inservice, provided on 10/30/08 by the Director of Nurses, that was conducted by the Speech Therapist on 7/18/08 documented, "Speech Therapist discussed the difference between nectar and honey thickened liquids. Discussed the use of the shaker cup for thick</p>	F 282			

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

PRINTED: 11/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143	
(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 282	Continued From page 4 liquid. Also discussed proper way to mix both types of thickener." k. A list and description of diets available at the facility provided by the Administrator on 10/30/08 documented, " pudding thickened liq: for residents with significantly increased difficulty. Swallowing: all liquids and supplements must be thickened to the correct consistency."	F 282		
F 309 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure the foreskin was retracted for cleansing, the penis and the scrotum were cleansed and Foley catheter tubing was cleansed from the insertion site outward during bowel incontinence and catheter care for 1 of 1 (Resident #8) case mix resident who had an indwelling catheter. This failed practice had the potential to affect 1 resident who had an indwelling catheter, according to the Resident Census and Conditions of Residents form dated 10/28/08. The findings are: 1. Resident #8 had diagnoses of Chronic Kidney Disease, Benign Prostatic Hypertrophy and Urinary Retention. The Annual Minimum Data Set dated 10/6/08 documented the resident had	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143		
(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 309	Continued From page 5 moderately impaired cognitive skills for daily decision making, required extensive physical assistance of staff for personal hygiene and had an indwelling catheter. a. A Physician Order dated 7/29/08 documented, "Cranberry tabs (tablets) 1 PO (by mouth) Q (every) day (recurrent UTI'S)." The resident's October 2008 Physician Orders documented, "Foley Catheter care Q (every) shift/PRN (as needed)." b. The Resident Plan of Care dated 10/9/08 documented, "At risk for complications related to indwelling catheter ...Approach: foley catheter care Q shift." c. On 10/29/08 at 8:17 a.m., the resident had been incontinent of bowel. Certified Nursing Assistant (CNA) #2 and CNA #6 transferred the resident from a wheelchair into bed; CNA #2 provided Foley catheter care for the resident. The CNA cleansed the meatus and the catheter insertion site, but did not cleanse any further down the Foley catheter. The foreskin of the resident's penis was not retracted for cleansing and the penis and the scrotum were not cleansed. 2. A Policy and Procedure for Catheter Care, Urinary provided by the Administrator on 10/30/08 documented, "Steps in the Procedure: for the male: Use a clean washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return the foreskin to normal position... use a clean washcloth with warm water	F 309			

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

PRINTED: 11/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143	
(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 309	Continued From page 6 and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward."	F 309		
F 314 SS=D	3. The Peri Care Policy and Procedure provided by the Administrator on 10/30/08 documented, "Steps in the Procedure: For the male resident: retract the foreskin of the uncircumcised male, wash and rinse urethral area using a circular motion. Continue to wash the perineal area including the penis, scrotum and inner thighs." 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 all areas of the skin were cleansed of feces during incontinent care to decrease the potential for skin breakdown for 1 (Resident #4) of 6 (Residents #2 through #5, #7 and #9) case mix residents who were incontinent. This failed practice had the potential to affect 50 residents who were incontinent of bowel, according to the Resident Census and Conditions of Residents form dated 10/28/08. The findings are: 1. Resident #4 had diagnoses of Clostridium	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143	
(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 314	<p>Continued From page 7</p> <p>Difficile, Decubitus Ulcer to Sacrum and Urinary Tract Infection (UTI). The Quarterly Minimum Data Set dated 8/13/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance for bed mobility, transfers, dressing, bathing and hygiene, was totally dependent for toilet use, was incontinent of bowel and bladder and had one Stage IV pressure ulcer.</p> <p>a. The resident's care plan dated 8/8/08 documented, "Incontinence of bowel and bladder... Provide incontinent care following each episode, keeping [Resident #4] clean, dry and odor free... Skin breakdown Stage 4 to sacrum... Provide incontinent care following each episode, keeping [Resident #4] clean, dry and odor free... "</p> <p>b. On 10/28/08 at 10:55 a.m., the resident had been incontinent of bowel and bladder. During incontinent care, Certified Nursing Assistant (CNA) #1 wiped feces from the resident's anus using the soiled brief. The CNA did not use peri-wipes or soap and water to cleanse the resident's perineum, anus, or her buttocks. When the CNA placed a clean brief under the resident's buttocks and started to place the front of the brief into place between her legs, she was asked by the surveyor if they were through with the incontinent care. The CNA said, "Not yet, barrier cream."</p> <p>The CNA squeezed barrier cream into her hand and started to apply the barrier cream to the resident. She was asked to get a clean wet wipe/cloth and wipe the resident's perineum and anus. When CNA #1 did as asked, brown feces was on the wipe. The CNA got another wipe and feces was on the second wipe.</p>	F 314		

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

PRINTED: 11/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143		
(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 314	Continued From page 8	F 314			
F 315 SS=D	<p>2. The Peri Care Policy and Procedure provided by the Administrator on 10/30/08 documented, "Steps in the Procedure: for a female resident: (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes... wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks..."</p> <p>483.25(d) URINARY INCONTINENCE</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all areas of the skin were cleansed during incontinent care to decrease the potential for skin breakdown for 1 (Resident #4) of 6 (Residents #2 through #5, #7 and #9) case mix residents who were incontinent. This failed practice had the potential to affect 60 residents who were incontinent of bladder and 50 residents who were incontinent of bowel, according to the Resident Census and Conditions of Residents form dated 10/28/08. The findings are:</p>	F 315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143		
(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 315	<p>Continued From page 9</p> <p>1. Resident #4 had diagnoses of Clostridium Difficile, Decubitus Ulcer to Sacrum and Urinary Tract Infection (UTI). The Quarterly Minimum Data Set dated 8/13/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance for bed mobility, transfers, dressing, bathing and hygiene, was totally dependent for toilet use, was incontinent of bowel and bladder and had one Stage IV pressure ulcer.</p> <p>a. The resident's care plan dated 8/8/08 documented, "Incontinence of bowel and bladder; Hx (history) of UTI's... Provide incontinent care following each episode, keeping [Resident #4] clean, dry and odor free... Skin breakdown Stage 4 to sacrum... Provide incontinent care following each episode, keeping [Resident #4] clean, dry and odor free... "</p> <p>b. On 10/28/08 at 10:55 a.m., the resident had been incontinent of bowel and bladder. During incontinent care, Certified Nursing Assistant (CNA) #1 wiped feces from the resident's anus using the soiled brief. The CNA did not use peri-wipes or soap and water to cleanse the resident's perineum, anus, or her buttocks. When the CNA placed a clean brief under the resident's buttocks and started to place the front of the brief into place between her legs, she was asked by the surveyor if they were through with the incontinent care. The CNA said, "Not yet, barrier cream."</p> <p>The CNA squeezed barrier cream into her hand and started to apply the barrier cream to the resident. She was asked to get a clean wet wipe/cloth and wipe the resident's perineum and anus. When CNA #1 did as asked, brown feces</p>	F 315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143		
(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 315	Continued From page 10 was on the wipe. The CNA got another wipe and feces was on the second wipe. 2. The Peri Care Policy and Procedure provided by the Administrator on 10/30/08 documented, "Steps in the Procedure: for a female resident: (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes... wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks..."	F 315			
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 08:00 a.m. medication pass on 10/29/08, record review and interview, the facility failed to ensure the medication error rate was less than 5%. Physician orders were not followed for 4 (Residents #5, #10, #11 and #12) of 7 residents observed during medication pass, resulting in medication errors. Medication errors were made by 2 Licensed Practical Nurses (LPN) (LPN #1 and LPN #2) of 3 nurses who administered medications in the facility. This failed practice had the potential to affect 45 residents in the facility, according to initial rounds on 10/27/08. The medication error rate was 11.36% based on administration of 44 medications with 5 medication errors observed. The findings are: 1. Resident #5 had diagnoses of Vision	F 332			

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

PRINTED: 11/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143		
(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 332	<p>Continued From page 11</p> <p>Impairment, Gastroesophageal Reflux Disease, Hiatal Hernia and Cancer of Esophagus.</p> <p>a. A physician order dated 03/13/08 documented, Naprosyn 500 mg (milligrams) 1 po (by mouth) bid (twice a day).</p> <p>b. On 10/29/08 at 8:03 a.m., during the 8:00 a.m. medication pass, LPN #1 administered Naprosyn 500 mg with water to the resident, but did not offer the resident any food.</p> <p>The resident's meal tray was on the bedside table and the resident had not eaten any of it; when asked, "Did you not like the breakfast?" The resident stated, "I don't eat breakfast."</p> <p>c. On 10/29/08 at 11:15 a.m., when asked "Does the resident eat breakfast?" LPN #1 stated, "They [Resident #5] eat through out the day, they sometimes eat breakfast."</p> <p>d. According to Centers for Medicare and Medicaid Services (CMS): Medications that Must be Taken with Food or Antacids: The administration of medications without food or antacids when the manufacturer specifies that food or antacids be taken with or before the medication is considered a medication error. The most commonly used drugs that should be taken with food or antacids are the Nonsteroidal Anti-Inflammatory Drugs (NSAID's). There is evidence that elderly, debilitated persons are at greater risk of gastritis and GI bleeds, including silent GI bleeds. Determine if the time of administration was selected to take into account the need to give the medication with food. Examples of commonly used NSAIDS are as follows: GENERIC NAME: ...Naproxen. BRAND</p>	F 332			

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

PRINTED: 11/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143	
(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 332	<p>Continued From page 12 NAME: Naprosyn, Aleve.</p> <p>2. Resident #10 had a diagnosis of Gastritis and a physician order dated 9/30/08 for KCL (Potassium Chloride) 10 mEq (MilliEquivalent) 1 po daily. *Give with breakfast* and Coreg 3.125 mg 1 po bid *Give with food.*</p> <p>a. On 10/29/08 at 9:22 a.m., during the 8:00 a.m. medication pass, LPN #2 administered KCL 10 mEq and Coreg 3.125 mg with water to the resident, in physical therapy.</p> <p>b. On 10/29/08, the Director of Nursing (DON) stated that the resident food cart was delivered to the dining room at 6:45 a.m. [on 10/29/08].</p> <p>c. This resulted in 2 (two) errors.</p> <p>3. Resident #11 had a physician order dated 7/20/07 for Maxitrol Ophthalmic solution 1 drop both eyes bid.</p> <p>a. On 10/29/08 at 9:25 a.m., during the 8:00 a.m. medication pass, LPN #2 did not shake the Maxitrol Ophthalmic Suspension before administration.</p> <p>b. The manufacturer's bottle documented, "Shake well before using."</p> <p>4. Resident #12 had a physician order dated 10/7/08 for Spiriva Inhaler 1 puff every day at 10:00 a.m.</p> <p>a. On 10/29/08 at 10:02 a.m., LPN #1 handed the surveyor an Advair 250/50 Diskus and stated, "Spiriva."</p>	F 332		

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

PRINTED: 11/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143	
(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 332	Continued From page 13	F 332		
F 458 SS=B	<p>b. On 10/29/08 at 11:15 a.m., when asked, "Which was the resident to receive at 10:00 a.m. Advair or Spiriva?" LPN #1 stated, "the Diskus [Advair]." The LPN looked at the physician orders and stated, "It should have been the Spiriva."</p> <p>483.70(d)(1)(ii) RESIDENT ROOMS</p> <p>Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure multiple-bed resident rooms provided at least 80 square feet of usable living space per resident. This failed practice had the potential to affect 8 residents who resided in the affected rooms, as identified by the Roster Matrix provided by the Administrator on 10/27/08. The findings are:</p> <p>1. On 10/27/08 at 2:35 p.m., during the survey entrance conference, the Administrator stated that Resident Rooms #5 through #9, previously identified during surveys, had not changed in size to provide adequate usable living space for multiple residents.</p> <p>2. On 10/27/08, the following observations were made:</p> <p>a. Semi-private Resident Rooms #5, #6, #7 and #9 measured 161-square feet each. The rooms contained a portable closet which measured 10.6-square feet. When the space consumed by the closet was subtracted from the room size, only 150.4-square feet (or 75.20-square feet per resident) remained.</p>	F 458		

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

PRINTED: 11/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2008
NAME OF PROVIDER OR SUPPLIER BYRD HAVEN NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 105 SO COLLEGE SEARCY, AR 72143		
(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 458	Continued From page 14 b. Semi-private Resident Room #8 measured 161-square feet. The room contained 1 portable closet that measured 6.3-square feet. When the space consumed by the closet was subtracted from the room size, only 154.7-square feet (or 77.35-square feet per resident) remained.	F 458		