

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

PRINTED: 11/16/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045176</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/01/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - MONTICELLO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1194 N CHESTER ST MONTICELLO, AR 71655</b>	
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F 312 SS=E	<p><b>483.25(a)(3) ACTIVITIES OF DAILY LIVING</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure all areas were cleansed of urine and feces during incontinent care for 2 (Residents #3 and #4) of 12 (Residents #1 through #5, #7 through #10 and #11 through #13) case mix residents who were incontinent. This failed practice had the potential to affect 59 residents in the facility who were incontinent, according to a list provided by the Administrator on 11/1/07. The findings are:</p> <p>1. Resident #3 had diagnoses of Alzheimer's Disease and Urinary Incontinence. The Minimum Data Set (MDS) dated 8/18/07 documented the resident had short/long-term memory problems, was moderately impaired in cognitive skills for daily decision making, was incontinent of bowel and bladder and was totally dependent on the physical assistance of 2 staff persons for toileting.</p> <p>On 10/29/07 at 10:15 a.m., Certified Nursing Assistant (CNA) #2 provided incontinent care for the resident, with CNA #1 assisting. The resident was wiped down each groin area using the same area of the washcloth, then swiped across the mons pubis and once more down the right groin area using same area of washcloth. The resident was turned to the left side, rectal area was washed. The buttocks were not washed on either</p>	F 312		

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 side. The resident's brief was wet prior to incontinent care.  2. Resident #4 had diagnoses of Cerebrovascular Accident and Urinary Incontinence. The MDS dated 9/30/07 documented the resident had short/long-term memory problems, was severely impaired in cognitive skills for daily decision making, was incontinent of bowel and bladder and was totally dependent on the physical assistance of 2 staff persons for toileting and transfers.  On 10/30/07 at 10:45 a.m., CNA #4 provided incontinent care for the resident, with CNA #5 assisting. The resident had voided and had been incontinent of a moderate amount of feces. The resident's buttocks were not washed on either side.	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 and record review, the facility failed to provide incontinent care in a timely manner to prevent skin irritation and skin breakdown for 1 (Resident #1) of 8 (Residents #1 through #4, #8, #11, #12 and #13) case mix	F 314		

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F 314	Continued From page 2 residents who were at risk for pressure ulcers. This failed practice had the potential to affect 22 residents who are at risk for pressure ulcers, as identified by the Director of Nursing on 11/1/07. The findings are:  1. Resident #1 had diagnoses of Dysphasia, Bi-polar Disorder, Hypertension, Parkinson's, Depression and Anxiety. The Minimum Data Set dated 8/31/07 documented the resident was moderately impaired in cognitive skills for daily decision making, had mental function that varied over the course of the day, had episodes of disorganized speech, required extensive assistance with activities of daily living, was incontinent of bowel and bladder and had a feeding tube.  a. The Pressure Ulcer Risk Assessment form, dated 8/19/07, documented a total score of "13" for the resident. The form documented, "Total score of 8 or above represents high risk."  b. The Care plan dated 8/31/07 documented, "[Resident #1] is at risk for skin breakdown d/t (due to) incont (incontinent) of urine & she requires limited assistance with bed mobility & transfers... Interventions... Staff will provide one person assist with incontinent care every two hours and prn (as needed). Staff will observe for skin irritations and will use a barri (barrier) care product as needed for irritation... Will be as clean and dry as possible."  c. The resident's Weekly Evaluation dated 10/24/07, on the Skin Evaluation form, received from the DON on 10/30/07 at 5:15 p.m., documented only that there was bruising to the resident's left hand.	F 314			

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F 314	Continued From page 3  d. On 10/30/07 at 8:30 a.m., 9:30 a.m., 10:30 a.m. and 11:20 a.m., the resident was sitting in a wheelchair in her room. The surveyor maintained constant observation of the resident's room and no staff entered. The resident remained in the same sitting position until 11:35 a.m., 3 hours and 5 minutes.  e. The Nurse's note dated 10/30/07 at 10:15 a.m. documented, "...Req (Requires) assist with adl's (activities of daily living), incont. (incontinent) care of b/b (bowel/bladder) & transfers... Skin w/d (warm/dry)..."  f. On 10/30/07 at 11:35 a.m., Certified Nursing Assistant (CNA) #1 and CNA #2 entered the resident's room to provide incontinent care for the resident. CNA #1 removed the resident's brief, with the assistance of CNA #2; the skin in the peri area and between the legs, down almost to the resident's knees, was bloody red and excoriated. The brief was saturated with urine and had a strong urine odor. When the resident was turned on her side, the skin on the buttocks and the back of her legs to her knees was also bloody red and excoriated.	F 314			
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 8:00 a.m. medication pass on 11/1/07, record review and interview, the facility failed to ensure the medication error rate	F 332			

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F 332	<p>Continued From page 4</p> <p>was less than 5%. Physician orders were not followed on 2 (Residents #18 and #19) of 7 residents observed during the medication pass resulting in medication errors. Medication errors were made by 2 Licensed Practical Nurses (LPN) [LPN #3 and LPN #4] of 3 licensed nurses observed administering medications in the facility. This failed practice had the potential to affect 51 residents on the North and South Hall, according to the Nurse Consultant on 11/1/07. The medication error rate was 9.43% based on administration of 49 medications with 4 omissions for a total of 53 medications with 5 medication errors observed. The findings are:</p> <ol style="list-style-type: none"> <li>1. Resident #18 had a physician order dated 6/7/07 for Iron 325 milligrams (mg) 1 by mouth (po) three times a day. *Give with food* <ol style="list-style-type: none"> <li>a. On 11/1/07 at 7:36 a.m., during the 8:00 a.m. medication pass, LPN #3 administered Ferrous Sulfate 325 mg to the resident with water. The resident was in the Dining Room and no meal trays were being served.</li> <li>b. On 11/1/07 at 7:52 a.m., there were still no meal trays being served.</li> </ol> </li> <li>2. Resident #19 had physician orders for the following: 10/13/06 - Aricept 10 mg tablet Donepezil Hydrochloride po everyday. 6/1/07 - Razadyne 4 mg tablet (Galantamine Hydrobromide) Give 1 tablet oral two times a day. 8/28/07 - Lasix 20 mg tablet Furosemide po every day for edema. 8/28/07 - Potassium CL ER (extended release) 10 mEq (milliEquivalent) 1 capsule po twice a day. <ol style="list-style-type: none"> <li>a. On 11/1/07 at 7:45 a.m., during the 8:00 a.m.</li> </ol> </li> </ol>	F 332			

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F 332	Continued From page 5 medication pass, LPN #4 did not administered Lasix 20 mg, Potassium CL 10 mEq, Razadyne 4 mg, or Aricept 10 mg to the resident, with all the resident's other scheduled 8:00 a.m. medications.  b. On 11/1/07 at 9:30 a.m., the surveyor reviewed the resident's Medication Administration Record (MAR) dated 11/1/07 thru 11/30/07; the MAR did not have page number 1 with pages 2 through 5.  Page 1 of the resident's November 2007 MAR, provided by the Administrator on 11/1/07 at 11:45 a.m., documented the following medications scheduled for 8:00 a.m.: Lasix 20 mg, Potassium CL ER 10 mEq, Razadyne 4 mg and Aricept 10 mg  c. This resulted in 4 medication errors.	F 332			
F 371 SS=E	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 raw meats were thawed correctly, employees washed their hands between handling food, clean dishes and picking up objects and hot food was maintained at 140 degrees Fahrenheit (F) or above. These failed practices had the potential to affect 75 residents who received their meal trays from the kitchen, as identified on the facility's Diet List dated 10/29/07. The findings	F 371			

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F 371	<p>Continued From page 6</p> <p>are:</p> <ol style="list-style-type: none"> <li>On 10/31/07 at 10:20 a.m., approximately 5-pounds of turkey breast and a packet of pureed turkey, to be used in making shape and serve for the residents on pureed diets, were in the sink thawing at room temperature.</li> </ol> <p>On 10/31/07 at 10:56 a.m., Dietary Employee #1 stated, "I took them out 10 minutes before you came in the kitchen. They have been in the refrigerator."</p> <p>Dietary Employee #2 picked up the turkey breast, labeled it, and placed it back in the refrigerator. The employee stated, "That was an extra meat."</p> <ol style="list-style-type: none"> <li>On 10/31/07 at 10:25 a.m., Dietary Employee #3 was drying pans with a towel before stacking them up.</li> <li>On 10/31/07 at 10:27 a.m., Dietary Employee #2 lifted up a trash can lid and threw away pie covers. Then, without washing her hands, she proceeded to pick up pie shells with her fingers on the shells.</li> <li>On 10/31/07 at 12:41 a.m., Dietary Employee #2 picked up papers from the floor and saran wrap from the counter. She lifted the trash can lid and threw the items away. Than, without washing her hands, she went to the clean area in the dish room and picked up clean bowls, touching her fingers to the inside of the bowls.</li> <li>On 10/31/07 at 12:46 p.m., the temperature of the mashed potatoes on the grill by the stove, when tested by the Dietary Employee #1, was 116 degrees F.</li> </ol>	F 371			

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F 441 SS=E	<p><b>483.65(a) INFECTION CONTROL</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure oral medication was maintained in a sanitary condition for 1 (Resident #18) resident on the North Hall and a syringe/plunger was maintained in a sanitary condition for 1 (Resident #1) of 3 (Residents #1, #4 and #11) case mix residents. This failed practice had the potential to affect 26 residents on North Hall and 8 residents in the facility who received nutrition via enteral feedings, according to the Nurse Consultant on 11/1/07 at 11:35 a.m. and the Resident Census and Conditions of Residents form dated 10/29/07. The findings are:</p> <p>1. Resident #18 had a physician order dated 10/26/07 for Lamisil 250 milligrams (mg) 1 tablet oral daily for fungus to right great toe for 90 days.</p> <p>a. On 11/1/07 at 7:36 a.m., during the 8:00 a.m. medication pass, Licensed Practical Nurse (LPN) #3 dropped the resident's Lamisil 250 mg tablet on the top of the medication cart. The LPN</p>	F 441			

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F 441	<p>Continued From page 8</p> <p>gloved and stated, "...I'm going to go ahead and give it.</p> <p>The LPN put the Lamisil tablet back into the cup with the rest of the medications and administered it to the resident.</p> <p>2. Resident #1 had a diagnosis of Dysphagia. The Minimum Data Set (MDS) dated 8/31/07 documented the resident was moderately impaired in cognitive skills and had a feeding tube.</p> <p>On 11/1/07 at 8:52 a.m., the resident's feeding tube was disconnected and LPN #4 prepared for medication administration and pulled the syringe out of the plastic bag. The LPN then placed the plastic bag on the bedside table. The LPN then placed the plunger, from the syringe, on the plastic bag 2 times and 1 time on the bedside table, not on the bag. The syringe and plunger were not cleansed or replaced, but were placed into the existing clear plastic bag.</p>	F 441			