

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

PRINTED: 02/28/2007  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>045209</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>02/15/2007</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BYRD HAVEN NURSING HOME</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>105 SO COLLEGE</b><br><b>SEARCY, AR 72143</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 |
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| F 000         | INITIAL COMMENTS  | F 000 |  |  |
| F 253<br>SS=C | <p>Complaint # 12238 unsubstantiated.</p> <p>483.15(h)(2) HOUSEKEEPING/MAINTENANCE</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, the facility failed to ensure that the walls were free of scuff marked, missing moldings/tiles were replaced, ripped awnings was repaired, chipped tiles were replaced and doors were in good repair. This failed practice had the potential to affect 78 residents in the facility, according to a list provided by the Administrator on 2/14/07. The findings are:</p> <p>On 2/12/07 at 9:00 a.m., the following observations were made:</p> <p>1. On Hall #2:</p> <p>a. The Rest Room had 6 (4 inch by 4 inch) ceramic tiles missing below the paper towel dispenser.</p> <p>b. The hall entrance had detached moldings approximately 4 inches from the floor on both sides and 1 molding had an approximately 6 inch by 2 inch that was water stained and a chipped ceiling tile.</p> <p>2. On Hall #3:</p> <p>a. The wall under the BUG Zapper at Station #2 had scuff marks approximately 12 inches from</p> | F 253 |  |  |

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| 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 253  | Continued From page 1<br>the floor.<br><br>3. On Hall #4:<br><br>a. Room #24 had a 4-inch by 4-inch piece of rubber molding missing from the bottom left side of the entrance.<br><br>b. The door marked "Carol George Activity Director" had tape partially detached from the hinge side edges.<br><br>4. The Main Entrance had 1 (24 inch by 24 inch) chipped ceiling tile.<br><br>5. Building Exterior:<br><br>a. The blue, dome shaped awning, in front of the building labeled "BYRD HAVEN" had a tear at the top of the "Y", approximately 18 inches long which exposed the covered area underneath.  | F 253   |   |   |
| F 315<br>SS=D  | 483.25(d) URINARY INCONTINENCE<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and interview the facility failed to ensure that a back to | F 315   |   |   |

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| F 315  | Continued From page 2<br>front motion was not used when performing incontinent care for 1 (Resident #9) of 3(Resident #4, #9, and #10) case mix residents, residing on the middle hall, that require incontinent care. This failed practice had the potential to affect 15 residents in the facility that resided on the middle hall and required incontinent care as documented on the list provided by the Administrator on 2/14/07 at 2:00 p.m. The findings are:<br><br>1. Resident # 9 had diagnoses of Senile Dementia With Delirium and Parkinson's Disease. A quarterly Minimum Data set dated 12/8/06 documented the resident had severely impaired cognitive skills for daily decision-making, total dependence for toilet use and bowel and bladder incontinence.<br><br>a. On 2/12/07 at 11:45 a.m., Certified Nursing Assistant (CNA) #1 performed incontinent care for Resident # 9. The CNA used wipes for the incontinent care. The CNA cleansed the groin and the perineum by using back to front motions that started from the rectal area, up the front to the mons pubis area.<br><br>b. The Perineal Care policy received from the Administrator documented, " Wash perineal area, wiping from front to back. Separate labia and wash area downward from front to back". | F 315   |   |                      |   |
| F 322<br>SS=E  | 483.25(g)(2) NASO-GASTRIC TUBES<br><br>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   | F 322   |   |                      |   |

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| F 322  | Continued From page 3<br>possible, normal eating skills.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and interview the facility failed to ensure PEG (Percutaneous Enteral Gastrostomy) tube placement was checked prior to administering medications and/or flushing with water for 2 (Residents #4 and #9) of 2 casemix resident's with PEG tubes. This failed practice had the potential to affect only these 2 residents in the facility whose PEG tubes were accessed by LPN #1. The findings are:<br><br>1. Resident # 9 had a diagnosis of Dysphagia. A quarterly Minimum Data Set dated 12/8/06 documented the resident had severely impaired cognitive skills for daily decision-making, total dependence for eating and a feeding tube.<br><br>a. The Plan of Care dated 6/15/06 documented, "Nothing by mouth (NPO); fed by peg tube related to (R/T) dysphagia" and "check placement of tube prior to flushes."<br><br>b. The Physician ' s Order sheet for February 2007 documented to check placement, verify placement before administration of medications or flushes via peg tube.<br><br>c. On 2/12/07 at 11:45 a.m., Licensed Practical Nurse (LPN) #1 flushed the resident's feeding tube with 120cubic centimeters (cc) of water. The LPN did not check the feeding tube placement prior to flushing the tube with 120 cc ' s of water.<br><br>2. Resident #4 had diagnoses of Gastrostomy | F 322   |   |                      |   |

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| F 322  | Continued From page 4<br>and Gastritis. The Quarterly Minimum Data Set (MDS) dated 1/12/07 documented the resident was severely impaired in cognitive skills for daily decision making, was dependent on staff for all activities of daily living and had a feeding tube.<br><br>a. Physician's orders dated 2/1/07 documented, "PEG tube check placement before giving any medication and flushes".<br><br>b. On 2/12/07 at 2:19 p.m., LPN #1 accessed the PEG tube of Resident #4 and administered a medication without checking for tube placement.<br><br>3. The facility's Policy and Procedure for Administering Medications through a Feeding Tube was obtained from the Administrator on 2/12/07 at 2:35 P.M. The Policy documented, "... #17. Check placement in the stomach by one of the following modalities: a. Listen for breath sounds at end of tube or place end of tube in a glass of water. OR b. Check length of tube for proper position. OR c. Place stethoscope over stomach and instill a small amount of air into feeding tube. Listen for air to enter stomach. #19. Place syringe into tube #20. Flush the feeding tube with the water if ordered - may use total flush amount divided before and after meds". | F 322   |   |                      |   |
| F 323<br>SS=E  | 483.25(h)(1) ACCIDENTS<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, the facility failed to ensure that the environment was free of hazards as   | F 323   |   |                      |   |

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| F 323  | Continued From page 5<br>evidenced by cracked/jagged doors. This failed practice had the potential to affect 45 residents who ambulate with or without assistive devices, according a list provided by the Administrator on 2/14/07. The findings are:<br><br>On 2/12/07 at 9:00 a.m., the following observations were made:<br><br>1. On Hall #2:<br><br>a. The wall to the left of the Dinning Room door to the kitchen had cracked/jagged edges on the formica to the bottom left side of the entrance approximately 6 inches from the floor.<br><br>b. Room #5 had cracked/jagged edges on the hinge side door edges.<br><br>2. On Hall #3:<br><br>a. Room #17 and Room #19 had cracked/jagged edges on the hinge side door edges. | F 323   |   |   |
| F 328<br>SS=B  | 483.25(k) SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced   | F 328   |   |   |

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| F 328  | Continued From page 6<br>by:<br>Based on observation the facility failed to ensure that the filters on oxygen concentrators were clean for 2 (Resident# 9 and Resident #11) of 4 (Resident #4, # 9, # 11, and# 12) case mix residents that received oxygen therapy by means of an oxygen concentrator. This failed practice had the potential to affect 7 residents in the facility that received oxygen therapy by means of an oxygen concentrator as documented by the list provided by the Administrator on 2/14/07 at 9:55 a.m. The findings are:<br><br>1. Resident # 9 had a diagnosis of Congestive Heart Failure. A quarterly Minimum Data Set (MDS) dated 12/8/06 documented the resident had severely impaired cognitive skills for daily decision-making and had oxygen therapy.<br><br>a. The Physician Order sheet for February 2007 documented, " Oxygen; clean filter on concentrator weekly on Sundays. Check both sides " .<br><br>b. On 2/12/07 at 8:00 a.m., 2/12/07 at 3:30 p.m., and on 2/13/07 at 2:50 p.m., the filter on the right side of the concentrator being used by Resident #9 had a light grayish/white dust like substance on it.<br><br>2. Resident #11 had diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and Shortness of Breath. A quarterly Minimum Data Set (MDS) dated 12/22/06 documented the resident had modified independent cognitive skills for daily decision-making, and received oxygen therapy.<br><br>a. The Physician Order sheet for February 2007 | F 328   |   |                      |   |

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| F 328  | Continued From page 7<br>documented, " Oxygen; clean filter on concentrator weekly on Sundays. Check both sides " .   | F 328   |   |                      |   |
| F 458<br>SS=B  | <p>b. On 2/11/07 at 4:20 p.m. and at 2/13/07 at 2:50 p.m., the filter on the oxygen concentrator had a light gray colored dust matted on the filter.</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:<br/>Based on observation, the facility failed to ensure multiple-bed resident rooms provided at least 80 square feet of usable living space per resident. The failed practice had the potential to affect 7 residents who resided in the affected rooms, as documented on the facility's Roster Sample Matrix dated 2/11/07. The findings are:</p> <p>On 2/11/07 at 4:30 p.m., 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> <p>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</p> | F 458   |   |                      |   |

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| F 458  | Continued From page 8<br>from the room size, only 154.7 square feet (or 77.35 square feet per resident) remained.      | F 458   |   |                      |   |