STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045239	A. BUILDING ___ B. WING ___	C 02/17/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO HEALTHCARE CENTER	**1052 OLD WARREN ROAD** **MONTICELLO, AR 71655**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 000	INITIAL COMMENTS Complaint #11431, substantiated (all or in part) with a deficiency cited at F426.	F 000		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure floor tiles were in good repair, walls were clean and in good repair, doors in were in good repair and unknown objects were not nailed to the walls. These failed practices had the potential to affect all 63 residents. The findings are: On 2/15/06 the following observations were made: a. At 9:07 a.m., in the shower room on the 400 Hall there was one 2" (inch) x 2" tile that was loose and sunk below the surrounding tile floor. There was approximately 18 inches of grout missing at the base of the right wall. 1) There were multiple chips and grey-brown discolorations on the door to the kitchen. 2) The paint was scratched on the bathroom walls in Resident Room 214, 410 and 406. b. At 10:12 a.m., part of the wall surface was	F 253		

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 pulled away for about 6 inches along the baseboard in the bathroom of Resident Room 310. 1) On the wall across from the bathroom door was a thick rectangular pad or pillow-type object nailed to the wall. The Maintenance man stated he did not know why the object was there. 2) There was a 3 foot by 3 foot black mark from the floor up on the wall in the 200 Hall shower. 3) The wall covering, approximately 4 x 5 inches in size, was torn away under the sink in the bathroom in Resident Room 207.	F 253		
F 312 SS=B	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 and record review, the facility failed to ensure facial hairs were removed for 2 (Resident #6 and 5) of 13 case mix residents (Resident #1-13) who were totally dependent on staff for personal grooming. This failed practice had the potential to affect 31 residents who were dependent on staff for personal hygiene according to the Resident Census and Conditions of Residents form dated 2/17/06. The findings are:	F 312		

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F 312	Continued From page 2 1. Resident #6 had diagnoses of Alzheimer Disease, Dysphagia, Anorexia, Depressive Disorder and Renal Insufficiency. The Significant Change Minimum Data Set (MDS) dated 11/22/05 documented the resident was severely impaired in cognitive skills for daily decision making and totally dependent on staff for personal hygiene. a. On 2/15/06 at 8:40 a.m., the resident's chin was covered with multiple facial hairs approximately 1/2 inch long. 2. Resident #5 had diagnoses of Glaucoma, Alzheimers and Chest Pain. The Annual MDS dated 12/28/05 documented the resident was severely impaired in cognitive skills for daily assistance and totally dependent on staff for personal hygiene. On 2/13/05 at 2:25 p.m., the resident had numerous curly facial hairs on her chin.	F 312		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure the environment was free of hazards by not ensuring chemical wipes were removed from a resident room. This failed practice had the potential to affect the 2 residents who resided in Resident Room 403 based on observation by the surveyor on 2/13/06. The findings are:	F 323		

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F 323	Continued From page 3	F 323		

On 2/13/06 at 4:35 p.m., 2/14/06 at 8:50 a.m., 11:10 a.m., 2:30 p.m., and 5:45 p.m., and 2/15/06 at 9:20 a.m., a box of Chlorox wipes was on the window sill of Resident Room 403. The label on the Chlorox wipes documented, "CAUTION: Causes moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling."

F 324 SS=E — 483.25(h)(2) ACCIDENTS — F 324

The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and interview, the facility failed to ensure new interventions were put into place to prevent further falls for 1 (Resident #2) of 11 (Resident #2, 3, 4, 5, 7, 8, 9, 10, 11, 12 and 13) case mix residents who were at risk for falls. This failed practice had the potential to affect 48 residents who were at risk for falls as identified by the Administrator on 2/17/06. The findings are:

Resident #2 had diagnoses of Cancer of the Prostate, Depressive Disorder, Diabetes Type II. The Significant Change Minimum Data Set (MDS) dated 10/17/05 documented the resident had short and long term memory problems, modified independence in cognitive skills for daily decision making, required limited assistance with ambulation, extensive assistance with transfers and had a fall in the past 31-180 days.

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F 324	Continued From page 4	F 324		

a. An Incident and Accident Report dated 10/15/05 at 10:40 p.m. documented the resident was found on the floor with an intervention to call for help.

b. The care plan dated 10/17/05 documented a problem of "At risk for falls AEB (as evidenced by) decline in ADLs (activity of daily living) function, use of anti-depressant" with approaches of "...Keep call light in reach while in room or in bed, encourage resident to use call light to summon assistance, answer call light promptly, post reminders in resident's room to call for assistance, encourage resident to adhere to reminders..."

c. An Incident and Accident report dated 10/21/05 documented, "Slid out of wheelchair" with an intervention of "Caution resident to call for help by using call light when needed."

d. The Physical Therapy Functional Needs worksheet dated 10/24/05 documented, "Type of Screen: other Fall, Physical therapy not indicated at this time secondary to Resident has always been non-compliant with safety, precs (precautions). All kinds of reminders and restraints have been tried with him like alarm, soft belt, environment, but resident takes them off. A pommel was also tried but there's not much of a space between his middle part and the w/c (wheelchair) seat so the pommel is left hanging."

e. An Incident and Accident report dated 12/27/05 documented, "Rolled off bed" with an intervention of "Observe frequently and remind to call for assistance before attempting to rise from bed."

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F 324	Continued From page 5	F 324		

f. A physician order dated 1/6/06 documented, "Low bed with 1/2 side rails for mobility."

g. An Incident and Accident Report dated 1/24/06 documented the resident was found sitting on the floor beside the bed" with an intervention of "Con't (continue) to enc (encourage) resident to use Call light, visual reminders to call for assistance still visible, keep bed @ (at) lowest position, fall assessment re-evaluated." There was no documentation in the clinical record of a fall risk assessment after 1/6/06.

h. An Incident and Accident Report dated 1/30/06 documented the resident fell to the floor. The Past Interventions Attempted documented, "Encourage resident to use call light to summon for assistance. Call light at Reach... Reminder in room to call for assistance."

Under Recommendations/New Interventions documented, "Remind resident to call for assistance. Reminders cont (continue) to be posted to call for assistance. Remind resident to use call light."

i. An Incident and Accident Report dated 2/13/06 documented the resident was found on the floor. The Past Interventions Attempted documented, "Remind resident to use call light to call for assistance. Reminders posted on wall to use call light..."

Under Recommendations/New Interventions documented, "Continue to remind resident to use call light to call for assistance. Keep reminders up on wall for assistance..."

j. On 2/15/06 at 9:25 a.m. and 10:10 a.m., the

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F 324	Continued From page 6 resident was sitting in a wheelchair that was next to the closet door at the foot of the bed. The call light was attached to the bottom of the half rail that was in the down position approximately 6 feet away from the resident. k. On 2/15/06 at 10:35 and 11:12 a.m., 11:25 a.m., and 2:05 p.m. the resident was pushed closer to the foot of the bed. The call light remained attached to the bottom of the half rail that was in the down position approximately 6 feet away from the resident. l. As of 2/15/06, there was no documentation in the clinical record of any new interventions since the implementation of the low bed and 1/2 rail on 1/6/06. m. On 2/15/06 at 2:15 p.m., the Administrator stated, "...He had been in a low bed for several months. We have tried everything under the sun when we went to the low bed."	F 324		
F 328 SS=E	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced	F 328		

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F 328		F 328		

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by:

Based on observation and interview the facility failed to ensure oxygen equipment was stored in a manner to prevent potential contamination for 2 of 2 case mix residents (Resident #4 and 2) who received respiratory therapy. This failed practice had the potential to affect 8 residents who received oxygen therapy as identified by the Administrator on 2/17/06. The findings are:

1. Resident #4 had diagnoses of Asthma, Cardiac Dysrhythmias, Atrial Fibrillation and Cerebral Vascular Accident. The Significant Change Minimum Data Set dated 1/23/06 documented the resident was moderately impaired in cognitive skills for daily decision making and required oxygen therapy.

a. On 2/13/06 at 2:45 p.m., there was an unbagged nasal cannula lying on the fall mat on the floor beside the low bed and the updraft machine with unbagged tubing and mouth piece was lying on the fall mat beside the low bed.

b. On 2/13/06 at 2:50 p.m., Certified Nursing Assistant (CNA #1) entered the resident's room, picked up the nasal cannula that had been lying unbagged on the fall mat on the floor beside the low bed and placed the cannula into the resident's nostrils without cleansing or replacing the nasal cannula.

c. On 2/13/06 at 4:35 p.m., the updraft machine was sitting on the fall mat on the floor, the updraft tubing and mouth piece was disconnected from the updraft machine and was lying unbagged on the floor in the resident's room.

d. On 2/14/06 at 10:45 a.m., the Director of

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F 328	Continued From page 8 Nurses placed the unbagged nasal cannula that was draped over the oxygen concentrator into the resident's nostrils. e. On 2/14/06 at 5:40 p.m., the unbagged nasal cannula was lying on the floor. f. On 2/15/06 at 9:25 a.m., the unbagged nasal cannula was draped over the oxygen concentrator. 2. Resident #2 had diagnoses of Congestive Heart Failure and Cancer of the Prostate. The Quarterly MDS dated 1/16/06 documented the resident had modified independence in cognitive skills for daily decision making and required oxygen therapy. a. A physician order dated 10/23/05 documented oxygen at 2 L/M (liters per minutes) via nasal cannula for shortness of breath as needed. b. On 2/14/05 at 9:25 a.m., the oxygen flow rate was at 2.5 l/m and the nasal cannula was draped over the top of the concentrator.	F 328		
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 2/14/06, record review and interview, the facility failed to follow physicians orders to ensure	F 332		

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the medication error rate was less than 5%. Physician orders were not followed on 1 (Resident #13) of 13 residents observed during the medication pass. Medication errors were made by 1 (LPN [Licensed Practical Nurse] #1) of 2 nurses observed administering medications. The medication error rate was 5.26 % based on the administration of 57 medications plus 1 sliding scale insulin dosage that was ordered but not administered and observation of a total of 3 errors. This failed practice had the potential to affect 32 residents who received medications from LPN # 1 according to the Director of Nursing (DON) on 2/15/06. The findings are:

Resident #13 had diagnoses of Diabetes, Left Above the Knee Amputation, Esophageal Reflux, Hypothyroidism, Osteoporosis and Depressive Disorder.

a. A physician order dated 2/4/06 documented Sliding Scale Insulin Accu-check blood sugar levels of:

1) 50-70 give no Insulin,

2) 70-100 give 3 Units of Humalog Insulin,

3) 101-150 give 4 Units of Humalog Insulin,

4) 151-200 give 6 Units of Humalog Insulin,

5) 201-250 give 8 Units of Humalog Insulin,

6) 251-300 give 10 Units of Humalog Insulin,

7) 301-350 give 12 Units of Humalog Insulin,

8) and blood sugar level greater than 350 call the

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F 332	Continued From page 10 physician. b. On 2/14/06 at 8:40 a.m., the resident's blood sugar was 131. LPN #1 did not administer any insulin. The LPN stated the sliding scale had been changed and the resident wasn't suppose to receive any insulin. c. A physician order dated 3/14/05 documented Starlix 120 mg (milligrams) give one 3 times a day with meals. On 2/14/06 at 8:40 a.m., LPN #1 did not give the resident any food with the Starlix. d. A physician order dated 5/4/05 documented Zelnorm 6 mg give 3 times a day with food. On 2/14/06 at 8:40 a.m., LPN #1 did not give the resident any food with the Zelnorm.	F 332		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure residents were free of significant medication errors for 1 (Resident # 13) of 1 case mix resident who received insulin. This failed practice had the potential to affect 11 who received insulin according to the Director of Nursing on 3/2/06. The findings are: Resident #13 had diagnoses of Diabetes, Left Above the Knee Amputation, Esophageal Reflux, Hypothyroidism, Osteoporosis and Depressive	F 333		

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F 333	Continued From page 11 Disorder. a. A physician order dated 2/4/06 documented Sliding Scale Insulin Accu-check blood sugar levels of: 1) 50-70 give no Insulin, 2) 70-100 give 3 Units of Humalog Insulin, 3) 101-150 give 4 Units of Humalog Insulin, 4) 151-200 give 6 Units of Humalog Insulin, 5) 201-250 give 8 Units of Humalog Insulin, 6) 251-300 give 10 Units of Humalog Insulin, 7) 301-350 give 12 Units of Humalog Insulin, 8) and blood sugar level greater than 350 call the physician. b. On 2/14/06 at 8:40 a.m., the resident's blood sugar was 131. LPN #1 did not administer any insulin. The LPN stated the sliding scale had been changed and the resident wasn't suppose to receive any insulin. c. On 2/14/06 at 9:20 a.m., LPN #1 was asked about the sliding scale insulin order dated 2/4/06 and she stated, "I just overlooked the new sliding scale insulin order. I'll give it right now." d. This was a significant medication error due to the classification (antidiabetic) of the medication.	F 333		
F 426 SS=E	483.60(a) PHARMACY SERVICES - PROCEDURES	F 426		

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A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to ensure that medications ordered by a physician were acquired, received, and administered in a timely manner for 1 (Resident #1) of 13 (Resident #1-13) case mix residents who had new orders for medications. This failed practice had the potential to affect all 66 residents. The findings are:

Resident #1 had diagnoses of Alzheimer's Disease, Urinary Tract Infection and Bronchitis. The Minimum Data Set (MDS) dated 11/25/05 documented the resident had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making.

a. A Physician Telephone order dated 1/19/06 documented, "1) Robitussin DM 1-2 tsp (teaspoon) p.o. (by mouth) q (every) 6 h (hours) prn (as needed) 2) Avelox 400 mg 1 p.o. qd x (times) 5 days... 4) Duoneb updraft q 6h & (and) prn x 5 days 5) Steropred--7d."

b. The January 2006 Medication Administration Record (MAR) documented Avelox 400 mg 1 p.o. qd x 5 days was started on 1/20/06 at 8:00 a.m., 16 hours after the medication order was received.

c. Nurses notes 1/20/06 on the 3:00 p.m. to

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MONTICELLO HEALTHCARE CENTER	**1052 OLD WARREN ROAD** **MONTICELLO, AR 71655**

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F 426	Continued From page 13 11:00 p.m. shift documented, "(blood pressure) 136/76, (temperature) 101.8, (pulse) 101, (respirations) 16." d. Nurses notes 1/21/06 on the 3:00 p.m. to 11:00 p.m. shift documented, "1600 (4 p.m.) ii (2) APAP (Tylenol) given for ^ (increased) temp 100.3 ax (axillary) given... [decreased] @ (at) 1800 to 99.2... R (resident) medicated again @ 2100 (9 p.m.) [with] APAP ^ 100.5." e. Nurses notes dated 1/22/06 at 9:00 a.m. documented, "Tylenol 500 mg ii (2) adm. (administered) ^ temp... 135/42- 102.9, 97, 40." and at 6:00 p.m. ^ temp at this time 103.0." f. The January 2006 MAR documented the Steropred x 7 days ordered on 1/19/06 was not started until 1/24/06 at 8:00 a.m., 5 days after being ordered. The shipping Manifest from the XXX pharmacy dated 1/23/06 documented that 21 tablets of Prednisone 10 mg tablet was delivered and received by the nursing home on 1/23/06 at 11:40 p.m. g. A Physician Telephone Orders dated 1/23/06 documented, "Augmentin 875 mg. 1 p.o. BID (twice a day). The January 2006 MAR documented the dosages for 1/24/06 were circled as not given. The Shipping Manifest from XXX pharmacy documented "Amox TR-K CLV 875/125 mg" was delivered and received by the facility on 1/24/06 at 9:38 p.m., 2 days after the order for the medication was given. h. Nurses notes dated 1/30/06 at 10:45 a.m. documented, "res daughter reported yeast to groin area. Raised reddened area noted to perineal area. Called MD (doctor) awaiting new	F 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045239	A. BUILDING ____ B. WING ____	C 02/17/2006

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F 426	Continued From page 14 order. 1315 (1:15 p.m.) N.O. (new order) Nystatin top (topical) cream- apply top to rash BID x 7 days. (daughter) notified, ordered from [pharmacy]. Will start when arrives. 3-11 Continue to wait for new med - Nystatin to arrive. Will start when rec'd (received) for yeast appearing rash to peri- area." i. The January 2006 MAR documented the Nystatin was started on 1/31/06 on the 7:00 a.m. - 3:00 p.m. shift. The shipping manifest from XXX pharmacy dated 1/30/06 documented Nystatin 100,000 unit/gm (grams) was received by the facility on 1/30/06 at 11:20 p.m. j. On 2/16/06 at 2:30 p.m., the Administrator stated all residents except one changed to XXX pharmacy on 1/1/06 due to Medicare Part D. She further stated the facility would be able to obtain emergency medications by faxing the XXX pharmacy. "They contact a local pharmacy, who provides the medications." When asked about an "initial dose" for medications the Director of Nurses stated normally if the medication comes in the middle of the night we give it the next day.	F 426		
F 441 SS=B	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.	F 441		

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F 441	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure the ice scoop was not left in the ice container to prevent the potential for contamination. This failed practice had the potential to affect 20 residents on the 200 hall and 23 residents on the 300 hall according to the Roster Sample Matrix received on 2/13/06. The findings are: 1. On 2/16/06 at 4:45 p.m. the policy on Ice Machines and Ice Storage Chests documented to "Keep the ice scoop on a clean, hard surface (e.g., uncovered stainless steel, plastic or fiberglass tray) when not in use." 2. On 2/16/06 at 9:55 a.m., the ice chest lid was wide open and a large clear plastic ice scoop lay inside the ice chest on top of the ice. a. On 2/16/06 at 10:33 a.m., the lid was closed on the ice chest on 300 hall and the ice scoop was lying inside on top of the ice. b. On 2/16/06 at 3:10 p.m., CNA (Certified Nursing Assistant) #2 held a large clear plastic ice scoop in her hand, then placed the bag on top of the ice chest lid and laid the ice scoop on top of the zip lock bag. c. On 2/17/06 at 8:00 a.m., the ice chest on 300 hall sat in the hall unattended with the ice scoop lying on top of a zip lock bag on top of the ice chest lid.	F 441		