

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

PRINTED: 03/08/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/28/2007
NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE 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 000	INITIAL COMMENTS	F 000		
F 225 SS=E	<p>Complaint # 12338 was substantiated (all or in part) with deficiencies cited at F225 and F226</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225		

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: 03/08/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2007
NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE 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 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Compliant # 12338 was substantiated (all or in part) with these findings: Based on record review, and interview the facility failed to ensure an allegation of neglect was thoroughly investigated, interviews were conducted with staff, other residents and/or family members, protection of the resident from further potential abuse, staff was knowlegable of what to report and when to report allegation of abuse and failed to report allegations of abuse to the Office of Long Term Care and/or any other agencies as required by law for 1 (Resident #1) of 2 (Residents #1 and 2) casemix residents with a Gastrostomy tubes on the 800 hall. These failed practices had the potential to affect 2 residents with Gastrostomy tubes that reside in the facility on the 800 hall where LPN #1 worked as per the resident Roster/Sample Matrix dated 2/26/07. The findings are: Resident #1 had diagnoses of Alzheimer and Paralysis Agitans. The Quarterly Minimum Data Set dated 12/19/06 documented the resident had severely impaired cognitive skills for daily decision making, was dependent of staff for all activities of daily living, had full loss in range of motion involving both hands and arms, received nutrition via Gastrostomy tube and was under the care of hospice. a. The plan of care dated 8/22/06 documented, " Problem ... Resident at risk for malnutrition and dehydration d/t (due to) dysphagia and poor oral	F 225			

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

PRINTED: 03/08/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2007
NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE 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 225	<p>Continued From page 2 intake. ... Interventions:</p> <ol style="list-style-type: none"> 1. 10/3/06: Fibersource HN 50cc/hr. 2. 12/29/06: Nova Source 2.0, 237 cc bolus Q (every) 8 hours per PEG (Percutaneous endoscopic gastrostomy). 3. 1/11/06: Nova source 2.0, 237 cc per peg 2 x day bolus then 40cc/hr cont (continue) from 7p-7a 4. 1/30/07 : Change cont. feeding from 6p-6a". <p>b. The plan of care dated 2/8/06 documented, " Problem ... At risk for uncontrolled pain due to contractures and Parkinson disease. Due to cognitive impairment [name] cannot express her need for pain medications ... Interventions: ... Lortab as ordered and Monitor for restlessness, facial grimacing or moaning and medicate as needed".</p> <p>c. A telephone order dated 1/10/07 documented to discontinue Lexapro, Miralax & Melatonin and change the times of Bacofen to 8a and 5p. There was also a order to change the tube feeding to " Novasource 2.0 give 237cc bolus per peg 2 x 1day @ 11a and 3p and to have continuous feeding of Novasource 2..0 at 40cc/hr from 7p-7a".</p> <p>d. A Problem/Grievance/Complaint form dated 1/10/07 documented, " ... Dtr (Daughter) stated that her mother did not get her 8pm meds or bolus feeding on 1/8/07. Dtr stated that Peg tube had not been used all NOC (night)". The action taken documented, " Spoke with LPN (Licensed Practical Nurse) on duty on 1/8/07 and CNA's (Certified Nurses Assistants) on duty. LPN stated all meds were give and CNAs stated that nurse was in rm (room) several x's (times) during noc Narc (Narcotic) medication signed off as given</p>	F 225			

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

PRINTED: 03/08/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2007
NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE 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 225	<p>Continued From page 3</p> <p>and Narc count was correct. No (zero with a line through it) evidence that nurse failed to give meds". The resolution documented, "Med changes done and feedings changed to cont (continuos) feeding instead of bolus feedings".</p> <p>e. A witness statement dated 1/10/07 from LPN #1 documented, " Never in my nursing/health career have I every been accused of neglecting or knowingly omitting medication or treatment for a resident".</p> <p>f. A hand written note reported by daughter of the resident dated 1/12/07 at 9:35-9:45 a.m., documented by the Assistant Administrator documented, " ... Monday p.m. 1/8/ from 8-9 pm documented " LPN #1 never came to the room, put little blue plug in feeding tube - LPN #1 probably did not feed or give meds to her that night ...Tuesday 1/9 - Next night LPN #1 had not fed ... " . Across the bottom of the note a started entry was made that documented, " Mentioned to (administrator) that (daughter) has called about LPN #1 incident [with] (name of resident)".</p> <p>g. On 2/27/07 at 11:30 a.m., the Administrator stated that the daughter had concerns with LPN #1 - not giving medications or bolus feedings. She further stated that the daughter told her that she (daughter) had put something in the tube on 1/9/07 and it was still there on 1/10/07. The DON stated that they had changed the tube feeding to continuos and had changed the medication times and thought the problem was taken care of until 1/30/07 when a plan of care meeting was done.</p> <p>h. A care plan conference summary sheet dated 1/30/07 documented, " Concern about PEG feedings and medications ...".</p>	F 225			

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

PRINTED: 03/08/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2007
NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE 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 225	Continued From page 4 i. On 2/27/07 at 11:45 a.m., the DON stated that she had talked with LPN#1 again & informed him that he was to have a witness to sign the narcotic book with him- " It was in his best interest. The DON was asked, " Do you know if he is having someone to sign the narcotic book with him?" She replied, " I don't know." j. As of 2/27/07 there was no documentation in the Narcotic Log that a nurse had signed the form with LPN #1 when he administered the medication on the following days: January 31 and February 1,2,5,6,7,9,10,11,12,13,14,19,20,21,24,25,and 26th. k. On 2/27/07 at 2:35 p.m., LPN #1 was interviewed. The LPN stated that the DON told him that the daughter had alleged that he had neglected her mother because she was not getting her feedings or her medications. He further stated that he saw the blue top on the end of the tube, took it out, fed the resident and administered medications and replaced the blue top. l. On 2/27/07 at 2:55 p.m., CNA #1 was interviewed. The CNA stated that she remembered the incident around the first part of January. She stated that the daughter told her that CNA #2 had called her and accused LPN #1 of not feeding or giving her mother medications on his shift and what did she think. The CNA stated she told the daughter that she did not know but would keep her eyes open. This CNA was asked, " Did you report this to anyone in the facility?" She replied, " No, because I thought it was already reported, she (daughter) told me that	F 225			

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

PRINTED: 03/08/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2007
NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE 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 225	Continued From page 5 she had talked with the Administrator". m. On 2/27/07 at 3:09 p.m., the Administrator was asked " Has any allegation of neglect been reported as per the state law for this resident to the appropriate agency/ies?" She replied, "No, around the first of February the DON said we should have reported it after the care plan meeting on 1/30/07". n. On 2/27/07 at 3:15 p.m., the DON was asked, "Since LPN#1 did not have anyone sign the narcotic book or witness the administration of any of the narcotic medication, has there been any other form of protection provided for this resident?" She replied "No." o. On 2/28/07 at 10:35 a.m., CNA #2 stated that the she did not call the daughter but the daughter told her that she didn't think LPN #1 was feeding her mother or giving her medications on his shift. CNA #2 was asked, " Did you tell anyone about this?" She replied, "No, I didn't because I didn't know if it was true." She was then asked " What have you been trained to report?" She stated, "Abuse and stuff like that, I guess I should have reported it".	F 225			
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Compliant # 12338 was substantiated (all or in part) with these findings:	F 226			

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

PRINTED: 03/08/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/28/2007
NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE 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 226	Continued From page 6 Based on record review, and interview the facility failed to ensure that their policy and procedure was implemented that an allegation of neglect was thoroughly investigated, interviews were conducted with staff, other residents and/or family members, protection of the resident from further potential abuse, staff was knowledgeable of what to report and when to report allegation of abuse and failed to report allegations of abuse to the Office of Long Term Care and/or any other agencies as required by law for 1 (Resident #1) of 2 (Residents #1 and 2) casemix residents with a Gastrostomy tubes on the 800 hall. These failed practices had the potential to affect 2 residents with Gastrostomy tubes that reside in the facility on the 800 hall where LPN #1 worked as per the resident Roster/Sample Matrix dated 2/26/07. The findings are: Resident #1 had diagnoses of Alzheimer and Paralysis Agitans. The Quarterly Minimum Data Set dated 12/19/06 documented the resident had severely impaired cognitive skills for daily decision making, was dependent of staff for all activities of daily living, had full loss in range of motion involving both hands and arms, received nutrition via Gastrostomy tube and was under the care of hospice. a. The plan of care dated 8/22/06 documented, " Problem ... Resident at risk for malnutrition and dehydration d/t (due to) dysphagia and poor oral intake. ... Interventions: 1. 10/3/06: Fibersource HN 50cc/hr. 2. 12/29/06: Nova Source 2.0, 237 cc bolus Q (every) 8 hours per PEG (Percutaneous endoscopic gastrostomy).	F 226		

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

PRINTED: 03/08/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2007
NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE 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 226	<p>Continued From page 7</p> <p>3. 1/11/06: Nova source 2.0, 237 cc per peg 2 x day bolus then 40cc/hr cont (continue) from 7p-7a</p> <p>4. 1/30/07 : Change cont. feeding from 6p-6a".</p> <p>b. The plan of care dated 2/8/06 documented, " Problem ... At risk for uncontrolled pain due to contractures and Parkinson disease. Due to cognitive impairment [name] cannot express her need for pain medications ... Interventions: ... Lortab as ordered and Monitor for restlessness, facial grimacing or moaning and medicate as needed".</p> <p>c. A telephone order dated 1/10/07 documented to discontinue Lexapro, Miralax & Melatonin and change the times of Bacolfen to 8a and 5p. There was also a order to change the tube feeding to " Novasource 2.0 give 237cc bolus per peg 2 x 1day @ 11a and 3p and to have continuos feeding of Novasource 2..0 at 40cc/hr from 7p-7a."</p> <p>d. A Problem/Grievance/Complaint form dated 1/10/07 documented, " ... Dtr (Daughter) stated that her mother did not get her 8pm meds or bolus feeding on 1/8/07. Dtr stated that Peg tube had not been used all NOC (night)". The action taken documented, " Spoke with LPN (Licensed Practical Nurse) on duty on 1/8/07 and CNA's (Certified Nurses Assistants) on duty. LPN stated all meds were give and CNAs stated that nurse was in rm (room) several x's (times) during noc Narc (Narcotic) medication signed off as given and Narc count was correct. No (zero with a line through it) evidence that nurse failed to give meds". The resolution documented, "Med changes done and feedings changed to cont (continuos) feeding instead of bolus feedings".</p>	F 226			

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

PRINTED: 03/08/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2007
NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE 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 226	<p>Continued From page 8</p> <p>e. A witness statement dated 1/10/07 from LPN #1 documented, " Never in my nursing/health career have I every been accused of neglecting or knowingly omitting medication or treatment for a resident".</p> <p>f. A hand written note reported by daughter of the resident dated 1/12/07 at 9:35-9:45 a.m., documented by the Assistant Administrator documented, " ... Monday p.m. 1/8/ from 8-9 pm documented " LPN #1 never came to the room, put little blue plug in feeding tube - LPN #1 probably did not feed or give meds to her that night ...Tuesday 1/9 - Next night LPN #1 had not fed ... " . Across the bottom of the note a started entry was made that documented, " Mentioned to (administrator) that (daughter) has called about LPN #1 incident [with] (name of resident)".</p> <p>g. On 2/27/07 at 11:30 a.m., the Administrator stated that the daughter had concerns with LPN #1 - not giving medications or bolus feedings. She further stated that the daughter told her that she (daughter) had put something in the tube on 1/9/07 and it was still there on 1/10/07. The DON stated that they had changed the tube feeding to continuos and had changed the medication times and thought the problem was taken care of until 1/30/07 when a plan of care meeting was done.</p> <p>h. A care plan conference summary sheet dated 1/30/07 documented, " Concern about PEG feedings and medications ...".</p> <p>i. On 2/27/07 at 11:45 a.m., the DON stated that she had talked with LPN#1 again & informed him that he was to have a witness to sign the narcotic book with him- " It was in his best interest. The DON was asked, " Do you know if he is having</p>	F 226			

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

PRINTED: 03/08/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2007
NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE 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 226	Continued From page 9 someone to sign the narcotic book with him?" She replied, " I don't know." j. As of 2/27/07 there was no documentation in the Narcotic Log that a nurse had signed the form with LPN #1 when he administered the medication on the following days: January 31 and February 1,2,5,6,7,9,10,11,12,13,14,19,20,21,24,25,and 26th. k. On 2/27/07 at 2:35 p.m., LPN #1 was interviewed. The LPN stated that the DON told him that the daughter had alleged that he had neglected her mother because she was not getting her feedings or her medications. He further stated that he saw the blue top on the end of the tube, took it out, fed the resident and administered medications and replaced the blue top. l. On 2/27/07 at 2:55 p.m., CNA #1 was interviewed. The CNA stated that she remembered the incident around the first part of January. She stated that the daughter told her that CNA #2 had called her and accused LPN #1 of not feeding or giving her mother medications on his shift and what did she think. The CNA stated she told the daughter that she did not know but would keep her eyes open. This CNA was asked, " Did you report this to anyone in the facility?" She replied, " No, because I thought it was already reported, she (daughter) told me that she had talked with the Administrator". m. On 2/27/07 at 3:09 p.m., the Administrator was asked " Has any allegation of neglect been reported as per the state law for this resident to the appropriate agency/ies?" She replied, "No,	F 226			

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

PRINTED: 03/08/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2007
NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE 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 226	<p>Continued From page 10</p> <p>around the first of February the DON said we should have reported it after the care plan meeting on 1/30/07".</p> <p>n. On 2/27/07 at 3:15 p.m., the DON was asked, "Since LPN#1 did not have anyone sign the narcotic book or witness the administration of any of the narcotic medication, has there been any other form of protection provided for this resident?" She replied "No."</p> <p>o. On 2/28/07 at 10:35 a.m., CNA #2 stated that the she did not call the daughter but the daughter told her that she didn't think LPN #1 was feeding her mother or giving her medications on his shift. CNA #2 was asked, " Did you tell anyone about this?" She replied, "No, I didn't because I didn't know if it was true." She was then asked " What have you been trained to report?" She stated, "Abuse and stuff like that, I guess I should have reported it".</p> <p>p. The facilities policy and procedure on Abuse documented, " Policy: It is policy of Searcy Healthcare, LLC to take appropriate steps to prevent the occurrence of abuse, neglect ... to ensure that all alleged violations of Federal or State laws which involve mistreatment, neglect, abuse, ... are reported to State agencies in accordance with existing State law. The facility will investigate each alleged violation thoroughly and report the results of all investigations to Executive Director or his/her designee, as well as to State agencies as required by State and Federal law.</p> <p>Investigation ...</p> <p>B. The investigation shall include interviews of</p>	F 226			

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

PRINTED: 03/08/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2007
NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE 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 226	Continued From page 11 staff members, visitors, or residents who may have knowledge of the alleged incident. ... Protection ... b. If the suspected perpetrator is a staff member, the Executive Director shall place the staff member on immediate investigatory suspension while completing the investigation. Reporting A. Any staff member who suspects an alleged violation shall immediately notify the Executive Director or his/her designee. The Executive Director or his/her designee shall also notify the appropriate State agency in accordance with the State agency and in accordance with State law. ... " .	F 226			