

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

PRINTED: 03/26/2009
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 03/13/2009 |
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| NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE SEARCY, AR 72143 | |
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| F 000 | INITIAL COMMENTS | F 000 | | |
| F 309 SS=E | <p>Complaint #14346 was substantiated, all or in part, with deficient practice cited at F309.</p> <p>483.25 QUALITY OF CARE</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #14346 was substantiated, all or in part, with these findings:</p> <p>Based on observation, record review and interview the facility failed to ensure residents were not placed in a locked unit without an assessment, behavioral care plans and/or behavioral monitoring were completed for 3 case mix residents (Resident's #2, #3, and #4) of 3 case mix residents who resided on the locked unit. This failed practice had the potential to affect 48 residents residing on the locked units without physician orders according to the printout of physician orders dated 3/13/09. The findings are:</p> <p>1. Resident #3 had diagnoses of Unsocial Aggression, Alzheimer's Disease, Depression, Anxiety, Psychosis and Dementia with Behaviors. The Minimum Data Set (MDS) dated 1/19/08 documented the resident had modified independent cognitive skills for daily decision making, had indicators of depression with</p> | F 309 | | |

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 309 | <p>Continued From page 1</p> <p>persistent anger with self or others, easily annoyed, anger at placement in nursing home, sad, pained worried facial expression and furrowed brows, and had antipsychotic and antianxiety medications seven of the past seven days.</p> <p>a. The Resident Assessment Protocols (RAPs) dated 1/19/09 documented short term memory problems, impaired decision-making, unhappy with residents other than roommate, expresses sadness/anger/empty feeling over lost roles/status, persistent anger with self or others, sad, pained, worried facial expressions and mood persistence.</p> <p>b. An Incident/Accident Report dated 1/22/09 at 8:55 p.m. documented, "Res [resident] was sitting near St 2 [Station 2]. Other res pulled a dinner tray off of shelf making a mess. Res started yelling at her. She was in w/c [wheelchair] and propelled over res foot. He hit her [with] his fist 3 times on the face." The recommendations/new interventions section documented "Both res are on same hall. Maybe one could be transferred to another hall. Resident admitted to [Hospital Psychiatric Unit] on 1/23/09. "</p> <p>1). A Temporary Problem List dated 1/22/09 documented, "Resident punched a female res [Resident #6] 3 [times] in face [post] altercation [verbally]" with approaches documented as "redirected, 1:1, behavior monitoring-resident transferred to [Hospital Psychiatric Unit 1/23/09]." [As of 3/13/09 at 2:30 p.m., there was no documentation of 1:1 or behavior monitoring for the month of January 2009 available for review.]</p> <p>2). Nurse's Notes dated 1/23/09 time, 12:00 noon</p> | F 309 | | |

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| F 309 | <p>Continued From page 2</p> <p>documented, "Orders received from [Attending Physician] to admit to [Hospital Psychiatric Unit] d/t (due to) recent and increasing combative behavior. [Attending Physician] states definite need for med review and adjustment under controlled environment."</p> <p>c. The Minimum Data Set (MDS) dated 2/9/09 documented the resident had modified independent cognitive skills for daily decision making, no behavioral symptoms, placement in Alzheimer's/dementia special care unit and had antipsychotic, antianxiety and hypnotic medications during seven of the past seven days.</p> <p>d. Nurse's Notes dated 2/22/09 at 9:00 a.m. documented, "[Resident] transferred to Hall 11 as per orders of Director of Nursing due to inappropriate behaviors in smoking room on Hall 1." [Hall 11 is a locked behavior unit. As of 3/13/09 at 2:30 p.m., there were no physician orders in the clinical record to transfer the resident to the locked unit and there were no interventions for this behavior documented on the Care Plan .]</p> <p>The Antecedent Behavior Monitoring Log dated 2/22/09 timed 9:00 a.m. documented, "Was reported that on 2/21/09 R (resident) was in smoking room fondling females on their breasts." The intervention was documented as "R transferred to Hall 11 [locked behavior unit]."</p> <p>e. A statement dated 3/8/09 at no time noted, Certified Nursing Assistant #1 (CNA #1) documented, "[Resident #3] was in [Resident #1's] room when I walked by her room and he was shaking her. As soon as he seen me, he wheeled his way out. Notified the nurse."</p> | F 309 | | | |

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| F 309 | Continued From page 3 [Resident #1 was not housed on the locked behavior unit.] f. On 3/13/09 at 1:20 p.m., the Director of Nursing stated, "[Resident #3] was allowed to go to the smoke room out of the locked unit until the 3/8/09 incident." 2. Resident #2 had diagnoses of Impulse Control Disorder, Anxiety, Alcohol Abuse, and Post Traumatic Stress Syndrome. The MDS dated 2/15/09 documented the resident had moderately impaired cognitive skills for daily decision-making, had no behavioral symptoms and had antidepressant medication seven of the past seven days. a. The Plan of Care dated 2/16/09 documented, "Problem: Resident exhibits inappropriate sexual behavior toward staff members has history of becoming aggressive with staff, waving cane, touching inappropriately and making sexual comments ... Approaches ... Reinforce with resident unacceptability of resident's sexually inappropriate behavior, remove resident from public area when behavior is disruptive, talk with resident in calm voice when behavior is disruptive, and redirect conversation when resident attempts to make sexual remarks." The Plan of Care was updated on 3/5/09 with the documentation "Resident placed on Hall 11 secure unit without female residents present on Hall 11." b. The Quality Assurance Behavior Monitoring Log dated 2/16/09, timed 10:30 p.m. documented, "Pulled open CNA's blouse. ... Interventions ... Tried to redirect." | F 309 | | | |

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| F 309 | <p>Continued From page 4</p> <p>c. An Incident/Accident Report dated 2/22/09, at 8:30 a.m. documented, "Resident was observed by other residents trying to steer a female resident [Resident #1] down the hall toward his room. ... Recommendations/new interventions ... Admit to [Hospital Psychiatric Unit] per [Attending Physician] orders. ..."</p> <p>d. The Quality Assurance Behavior Monitoring Log dated 2/23/09 at 9:00 a.m. documented, "Touched another R [Resident] breasts ... Interventions ... 1:1-separated." As of 3/13/09 at 2:30 p.m., there was no documentation of 1:1 monitoring available for review.</p> <p>e. The Quality Assurance Behavior Monitoring Log dated 2/23/09, [no time], documented, "R has to go to [Hospital Psychiatric Unit] for med evaluation and tx [treatment]. Had to call police r/t [related to] R using cane to try and hit staff. LPN [Licensed Practical Nurse], DON [Director of Nursing] and Police helped R to wc [wheelchair]. R was calm and police walked out with him."</p> <p>f. On 3/12/09 at 1:00 p.m., the Director of Nursing stated, "I cannot find any documentation of 1:1 monitoring [relative to the 2/23/09 incident]."</p> <p>g. Nurse's Notes dated 2/24/09 at 4:15 p.m. documented, "R [continues] to be aggressive towards staff and has made threats this a.m. with his cane. [Attending Physician] paged and gave orders to transfer R to [Hospital Psychiatric Unit] services for evaluation and tx [treatment] as indicated. R transferred via company van at 4:15 p.m."</p> <p>h. The Hospital Psychiatric Evaluation form</p> | F 309 | | | |

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| F 309 | <p>Continued From page 5</p> <p>documented Resident #2 was not admitted to the psychiatric unit until on 2/24/09.</p> <p>i. Nurses Note dated 3/4/09, [no time] documented, " [Resident] admitted [at] [4:30 p.m. via facility via [wheel chair] ... "</p> <p>j. The Quality Assurance Behavior Monitoring Log dated 3/4/09 at 7:30 p.m., documented, "Resident hugging on female resident [Resident #1]. ... Interventions ...Told to keep his hands to himself."</p> <p>k. The Quality Assurance Behavior Monitoring Log dated 3/4/09 at 10:30 p.m. documented, "Resident standing by same female resident hugging on [Resident #1]. ... Interventions ...Was told to keep his hands off."</p> <p>l. The Quality Assurance Behavior Monitoring Log dated 3/4/09 at 11:00 p.m. documented, "Walking off with same female resident [Resident #1]. ... Interventions ...Another resident alerted nurse."</p> <p>m. Nurses Notes dated 3/5/09 [no time] documented [Resident] transferred to Hall 11. Accompanied by facility staff. Transferred self-ambulation. "</p> <p>n. On 3/12/09 at 1:00 p.m., the Director of Nursing stated, "[Resident #2] was placed on Hall 11 without females on 3/5/09."</p> <p>3. Resident #4 had diagnoses of Panic Disorder, Paranoid Schizophrenia, and Anxiety State. The Quarterly MDS dated 2/13/09 documented the resident had short and long-term memory problems, had moderately impaired cognitive</p> | F 309 | | | |

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| F 309 | Continued From page 6 skills for daily decision making, demonstrated no behavioral symptoms, received antipsychotic and antianxiety medications 7 of the past 7 days, and resided on an Alzheimer's/dementia special care unit. a. The "Social Services Assessment Note" dated 2/13/09 documented, "Comments: R [resident] currently lives on locked unit. Has daughter that lives in N.H. [nursing home] that visits often. No new psycho-social changes during this review." b. On 3/112/09 at 10:00 a.m., review of the Nurses Notes from 1/14/09 thru 3/3/09, no documentation was found to indicate behavioral problems, behavioral incidents, behavioral assessments or behavioral monitoring. c. On 3/12/09 at 10:10 a.m., the Director of Nursing (DON) stated, "The resident's daughter lives in the nursing home on the 100 hall. [Resident #4] visits her daughter a lot - sometimes she gets upset and anxious. She thinks her daughter is dying. After their visit she gets more anxious at times. She wants to live in the room with her daughter. We're assessing her." d. On 3/13/09 at 9:15 a.m. the DON stated, "... She's in an assessment period to see if she can go back to the general population. She accelerates her anxiety and psychosis in a less quiet environment." The DON was asked if there were any assessments available for review relative to the residents' progress for moving out of the locked unit. The DON stated, "No, there are no assessments." e. On 3/13/09 at 12:15 p.m., the resident was | F 309 | | | |

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| F 309 | Continued From page 7 asked if she liked the (locked) unit. Resident #4 stated, " I'd like to be with my daughter. She has heart trouble and her lungs are burned up - she's dying. I'd like to be with her." f. On 3/13/09 at 12:57 p.m. the Director of Nursing stated, "There are no assessments relative to [Resident #4] wanting to be off the unit. Also, there are no behavioral monitoring sheets on her." | F 309 | | | |