

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

PRINTED: 05/21/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045184</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/27/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKE VILLAGE HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653</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
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure privacy was provided during a bed bath for 1 (Resident #2) of 9 case mix residents (Resident #1 through #9) who required assistance with bathing. This failed practice had the potential to affect 71 residents</p>	F 164		

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 164	Continued From page 1 who required assistance with bathing as documented on the Resident Census and Conditions of Residents form dated 4/24/07. The findings are:  1. Resident #2 had a diagnosis of Cerebral Vascular Accident. The MDS dated 2/28/07 documented the resident had modified independence in cognitive skills for daily decision making, required limited to extensive staff assistance for bathing and hygiene, and was incontinent of bowel and bladder.  On 4/24/07 at 9:23 a.m. , CNA (Certified Nursing Assistant) # 2 gave the resident a bed bath. The CNA did not close the blinds on the window facing the parking lot.  2. The facility's "Resident Admission Agreement" documented: "H. Privacy Every Resident Has The Right to: Considerate and respectful care. Every resident will be treated with consideration, respect and full recognition of his dignity and individuality. Privacy during treatment and care of personal needs. People not involved in the care of residents shall not be present without the consent from the resident during examinations and treatment."	F 164		
F 241 SS=C	483.15(a) DIGNITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 241		

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F 241	<p>Continued From page 2</p> <p>interview the facility failed to ensure staff knocked on doors or waited for a response after knocking on doors for 3 (resident # 1, 2 and 5) of 9 case mix residents who required assistance with activities of daily living (ad'l's). This failed practice had the potential to affect all 71 residents. The findings are:</p> <p>1. Resident #1 had a diagnosis of Dementia. The MDS (Minimum Data Set), dated 3/17/07 documented the resident had modified independence in cognitive skills for daily decision making, required total staff performance for hygiene and bathing, and was frequently incontinent of bowel and bladder.</p> <p>On 4/25/07 at 9:54 am, CNA (Certified Nursing Assistant), #3 entered the resident's room without first knocking on the door.</p> <p>2. Resident #2 had a diagnosis of Cerebral Vascular Accident. The MDS dated 2/28/07 documented the resident had modified independence in cognitive skills for daily decision making, required limited to extensive staff assistance for bathing and hygiene, and was incontinent of bowel and bladder.</p> <p>At 9:37 a.m., during the resident's bed bath, Maintenance #1 knocked on the resident's door and immediately entered the room without waiting for a reply, and stated "I need to check the lights". The CNA did not state personal care was being given.</p> <p>3. Resident #5 had a diagnosis of Psychosis. The MDS dated 4/18/07 documented the resident</p>	F 241		

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F 241	Continued From page 3 was independent in cognitive skills for daily decision making and required limited assistance of staff for bathing and hygiene.  On 4/24/07 at 9:16 am while the resident was preparing for her bath, CNA #4 entered the resident's room without first knocking on the door.  4. On 4/24/07 at 1:30 p.m. 7 of 7 residents who attended the Group Meeting stated that the staff did not always knock on doors before entering resident rooms.	F 241			
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the physician was contacted as ordered for 1 of 1 case mix resident ( Resident #3) who had orders to contact the physician if Accuchecks were below 60 or above 400. This failed practice had the potential to affect 3 residents in the facility who had orders to notify the physician if Accuchecks were below 60 or above 400 according to the documentation dated 4/26/07 submitted by the DON ( Director of Nursing).The findings are:  Resident # 3 had a diagnosis of Diabetes Mellitus 2 Uncontrolled. The Annual Minimum Data Set (MDS) dated 4/11/07 documented the resident was moderately impaired in cognitive skills for	F 282			

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F 282	Continued From page 4 daily decision making and monitored for an acute medical condition.  a. A Physician Order dated 10/6/06 documented, " Accuchecks Q. D. (every day). Contact physician if blood sugar below 60 or greater than 400-Give 10 units Regular Insulin SQ (Subcutaneous) Q (every) HR (hour) til BS (Blood Sugar) is < (less than) 300."  b. A Physician Order dated 12/8/06 documented, " Lantus 100 Units/ML (Milliliter) vial Give 30 units SQ every 12 hours."  c. A physician order dated 11/10/06 documented, "Novolog 8 units SQ 30 mins (minutes) before meals."  d. The Medication Administration Record (MAR) dated April, 2007 documented Finger Stick Blood Sugar (FSBS) results below 60 or greater than 400 on:  1) 4/2/07 at 11:30 a.m. of "Lo"  2) 4/7/07 at 6:30 a.m. of 58  3) 4/12/07 at 11:30 a.m. of 35  4) 4/16/07 at 6:30 a.m. of 57  5) 4/17/07 at 6:30 a.m. of 58  6) 4/20/07 at 6:30 a.m. of 57  7) 4/23/07 at 6"30 a.m. of 59  8) 4/11/07 at 4:30 p.m. of 452	F 282		

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F 282	<p>Continued From page 5</p> <p>The Nurses Notes dated from 4/2/07 to 4/25/07 and Nurses Medication Notes dated 4/2/07 to 4/23/07 did not document the physician was contacted for blood sugar results below 60 or above 400.</p> <p>e. The April 2007 Medication Administration Record (MAR) documented Lantus Insulin 30 units was "Held" on 4/2/07; 4/9/07; 4/16/07; 4/17/07; 4/20/07; 4/23/07, and 4/25/07.</p> <p>The Nurses Medication Notes dated 4/2/07 to 4/23/07 and the Nurses Notes dated 4/2/07 to 4/25/07 did not document the physician was notified that the regularly scheduled Lantus insulin doses were not given as ordered.</p> <p>f. The April 2007 MAR documented Novolog 8 units SQ 30 minutes before meals was "Held" on 4/1/07; 4/2/07; 4/3/07; 4/4/07; 4/5/07; 4/9/07; 4/11/07; 4/12/07; 4/13/07; 4/16/07; 4/17/07; 4/18/07; 4/19/07; 4/20/07; 4/21/07; 4/23/07.</p> <p>The Nurses Medication Notes dated 4/2/07 to 4/23/07 and the Nurses Notes dated 4/2/07 to 4/25/07 did not document the physician was notified that the regularly scheduled Novolog insulin doses were not given as ordered.</p> <p>g. The Nurses Medication Notes dated 4/7/07 at 6:15 a.m. documented, " FSBS 58-unresponsive-glucogen Intramuscular (IM) injection to right thigh." The Nurses Medication Notes and Nurse's Notes did not document that the physician was notified of the change in condition. The notes did not document the resident's outcome to the injection.</p> <p>h. On 4/25/07 at 2:30 p.m. the Director of</p>	F 282			

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F 282	Continued From page 6 Nursing (DON) was asked by the surveyor, "Was the physician contacted?" The DON stated, "It's not here-it just wasn't done if it isn't here."  i. On 4/26/07 at 10:00 a.m. the DON was asked, "Was the physician to be notified when insulin was held?" The DON stated, "Yes. We don't have anything charted 7/3 or 11/7--if it's not in the nurses notes it isn't here--only 2 places it would be written--in the nurses notes or on the MAR nurses notes."	F 282		
F 312 SS=E	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 a back and forth motion was not used during incontinent care for 3 (Resident #1, #2 and #3 ) and failed to clean the labia, buttocks and perineal area and change to a clean area of the cloth during incontinent care for 4 (Resident # 1, #2, #3 and #9) of 5 case mix residents (Resident #1, #2, #3, #8, and # 9) who required assistance with incontinent care. The facility failed to ensure nail care was provided for 3 (Resident #1, #2, and #3) of 9 case mix residents (#1 through #9) who depended on staff for nail care. The facility failed to ensure bath water was changed when the water became dirty for 2 (Resident #1 and #2) of 6 case mix residents (Resident #1, #2, #3, #7, #8 and #9) who were dependent on staff for bathing. These	F 312		

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F 312	<p>Continued From page 7</p> <p>failed practices had the potential to affect 42 residents who were dependent on staff for bathing/hygiene and 38 residents who were incontinent of bowel/bladder as documented on the Resident Census And Condition of Residents form dated 4/24/07. The findings are:</p> <p>1. The facility's policy and procedure "Giving a Bedbath" documented:</p> <p>"Change the bath water as often as necessary during the bath (i.e., whenever the water becomes soapy, dirty, or cold, before washing the legs, back and perineal area, etc.)" "Check the resident's fingernails, nail beds, and between the fingers".</p> <p>2. The facility's policy and procedure "Perineal Care" documented:</p> <p>"Wash perineal area, wiping from front to back. (1) Separate labia and wash area downward from front to back. (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. Do not reuse the same washcloth or water to clean the urethra or labia. (3) rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same washcloth or water to clean the labia."</p> <p>3. Resident #1 had a diagnosis of Dementia. The MDS (Minimum Data Set) dated 3/17/07 documented the resident had modified independence in cognitive skills for daily decision</p>	F 312		

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F 312	Continued From page 8 making, required total staff performance for hygiene and bathing, and was frequently incontinent of bowel and bladder.  a. On 4/25/07 at 9:07 a.m., the right great toe nail was thick and uneven, rising approximately 3/4 inch from the nail bed, the left great toe nail was thick and uneven, rising up from the nail bed approximately 1/4 inch, and the 1st, 2nd, 3rd, and little toe nails on both feet were curving over the tips of the toes approximately 1/4/inch.  b. On 4/25/07 at 10:10 a.m., a bed bath was given by CNA (Certified Nursing Assistant) #1. CNA #1 used a washcloth and wiped back and forth across the mons pubis, up and down both groins, vaginal area and anterior upper thighs without changing to a clean area of the washcloth. The labia was not separated for cleansing. The CNA wiped the vaginal and rectal areas, back, and posterior thighs without changing to a clean area of the washcloth. The bath water was not changed during the bath. After the bath was given, lotion/baby oil was applied to the resident's body and feet, and socks were applied. No nail care was given.  4. Resident #2 had a diagnosis of Cerebral Vascular Accident. The MDS dated 2/28/07 documented the resident had modified independence in cognitive skills for daily decision making, required limited to extensive staff assistance for bathing and hygiene, and was incontinent of bowel and bladder.  a. On 4/24/07 at 9:23 a.m., the resident was incontinent of bowel and bladder during the bed bath. CNA #2 wiped up and down the left and right groin without changing to a clean area of the	F 312		

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F 312	<p>Continued From page 9</p> <p>cloth, then separated the labia and wiped upward 2 times across the rectum with feces on the cloth. The CNA placed the soiled cloth into the bath water, then dipped a towel into the water and cleansed the left buttock and rectum. The right buttock was not cleansed during the bath. The bath water was not changed during the bath.</p> <p>b. On 4/24/07 at 9:23 a.m., during the resident's bath, the left great toenail was thick and uneven, rising approximately 1/4 inch from the bed of the Toe, and the right great Toe nail was thick and uneven, rising approximately 3/8 inch from the bed of the Toe. After the bath was completed the resident's fingernails had a dark substance underneath all 10 nails. Lotion/baby oil was applied to the resident's body and feet. Socks were applied. No nail care was given.</p> <p>5. Resident # 3 had a diagnoses of Cerebrovascular Accident, Flaccid Hemiplegia-Dominant Side, and Dementia Without Behavior Disturbance. The Annual Minimum Data Set dated 4/11/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required total dependence on staff for all activities of daily living, and was incontinent of bowel and bladder.</p> <p>On 4/24/07 at 10:10 a.m. CNA #1 provided peri-care for urinary incontinence. The CNA did not separate the labia to completely cleanse the perineal area and wiped the left buttock using back and forth motion cleansing from back to front.</p> <p>6. Resident #9 had diagnoses of Cerebrovascular Accident, Diabetic Neuropathy, Lupus and Anxiety Disorder. The Quarterly MDS dated 2/21/07 documented the resident had no</p>	F 312		

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F 312	Continued From page 10 short or long term memory problems and was independent in cognitive skills for daily decision-making and required total assistance for personal hygiene and bathing with 1 person physical assist.  a. The Plan of Care updated 2/21/07 page 1 documented, "Shampoo, shower/bath 3 x weekly. Fingernails and toenails cleaned and checked".  b. On 4/23/07 at 1:58 p.m. the resident's fingernails were dirty and had a brown substance under them.  c. On 4/26/07 at 10:15 a.m. the resident received a bed bath given by CNA #4. The resident's back was washed and the resident's rectal area was washed. The CNA used the same washcloth, and same area of washcloth, and washed the resident's back again. The resident's fingernails were dirty with a brown substance underneath them.	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 ensure that pressure relieving	F 314		

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NAME OF PROVIDER OR SUPPLIER  <b>LAKE VILLAGE HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653</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	
F 314	Continued From page 11 devices were used for 1 (Resident #1) of 1 casemix residents who were at risk for the development of pressure sores. This failed practice had the potential to affect 6 residents who had pressure sores, and 44 residents who were at risk for pressure sores as stated by the DON (Director of Nursing) on 4/26/07. The findings are:  Resident #1 had a diagnosis of Dementia. The MDS (Minimum Data Set) dated 3/17/07 documented the resident had modified independence in cognitive skills for daily decision making, required total staff performance for hygiene and bathing, was frequently incontinent of bowel and bladder, and had a stage 2 pressure sore.  a. The plan of care dated 2/28/07 documented "will have no increase in number of pressure ulcers. Provide pressure reducing device to bed/chair."  b. On 4/25/07 at 10:32 a.m., CNA (Certified Nursing Assistant) #1 and CNA #6 transferred the resident from her bed to her wheelchair. CNA #1 stated, "She doesn't like a cushion in her chair". The resident stated "I want a cushion, this chair is too hard." CNA #1 put a cushion in the resident's wheelchair after she was told by this surveyor that the resident wanted one.	F 314			
F 324 SS=E	483.25(h)(2) ACCIDENTS  The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced	F 324			

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F 324	Continued From page 12 by: Based on observation, record review and interview the facility failed to ensure adequate supervision was provided during smoking and residents were not allowed to keep smoking paraphernalia for 1 (Resident #12) of 2 casemix residents (#12 #13) who smoked. The facility failed to ensure two staff assisted when the mechanical lift was used on 1 (Resident #3) of 2 casemix residents (#3 #9) who required mechanical lift for transfers. These failed practices had the potential to affect 15 residents who smoked as per a list from the smoking assessment book last updated on 9/21/06 and 15 residents who required a mechanical lift for transfers as a per list given by the Director of Nursing (DON) on 4/26/07. The findings are:  1. Resident #12 had diagnoses of Cerebrovascular Accident, Prostate Cancer, Manic Depression, Hypertension and Renal Failure. The Minimum Data Set (MDS) dated 4/12/07 documented the resident had no short or long term memory problems and was independent in cognitive skills for daily decision making.  a. The "Resident that desire to smoke" list last updated on 9/21/06 documented the name of Resident # 12.  b. A Smoking Assessment dated 9/21/06 documented, "The resident smokes safely with minimal supervision".  c. The plan of care with a review dated of 4/13/07 page 6 documented, "Problem: Potential for injury R/T (related to) smoking. Goal: Will safely smoke in designated area with staff supervision.	F 324		

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F 324	<p>Continued From page 13</p> <p>Approaches/Discipline: Observe resident during smoking q (every) shift. Counsel on designated smoking areas. Counsel on hazards of smoking in non-designated smoking areas. Do not permit matches to be used".</p> <p>d. On 4/26/07 at 8:50 a.m. th resident was sitting outside in the smoking area smoking without a staff member present. At 9:10 a.m. the resident was still sitting outside the building smoking and no staff was present. The resident was asked if he had a light and he stated, "Yes mam", the cigarette lighter was connected to a retractable key chain to the resident's belt loop on his pants.</p> <p>e. On 4/26/07 at 9:30 a.m., the Director of Nursing was asked if the residents were allowed to keep their own lighters and cigarettes and she stated, "Their cigarettes and lighters are kept on the medication carts. The resident's are issued their cigarettes. They can take their lighters if they have been screened as independent. Sometimes the resident forgets to bring the lighters back. I'm not 100% sure but I don't think they are supposed to keep their cigarettes and lighters on their person". When asked if she knew of any resident who had their own lighters she stated, "No".</p> <p>f. On 4/26/07 at 9:37 a.m. the Social Worker was asked if the residents were allowed to keep their cigarettes and lighters on their person and she stated, "Normally they are kept in my office or the nurses station. No one is allowed to keep their lighters." When asked if she knew of any resident who had their own lighters she stated, "No I haven't seen anyone this morning".</p> <p>g. On 4/26/07 at 10:27 a.m. the resident was</p>	F 324		

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F 324	<p>Continued From page 14</p> <p>sitting in the room and there was a purple lighter attached on the end of a string that was attached to the resident's belt loop. When asked how long he had the lighter he stated, "A long time". When asked if he had any cigarettes he reached into his jacket pocket and showed a package of open 1st class menthol cigarettes.</p> <p>h. The facility's Smoking Policy And Procedure documented:</p> <p>#4. "Accommodation for Residents at Risk: "The facility will accommodate residents who desire to smoke who have been assessed as unable to safely smoke independently, i.e. supervised smoking schedules, arranging for volunteers or requiring residents to arrange personal attendant/supervision. These accommodations will be determined by the interdisciplinary team and recorded in the resident's plan of care".</p> <p>#5. Storage of Smoking Materials: "Residents who have been assessed as able to safely smoke independently will have their smoking materials kept in the lock boxes in the smoking room. Residents who have been assessed as unable to safely smoke will have their smoking materials kept at the nurses station for the safety of all residents and to comply with federal, state, and/or local fire regulations, this includes cigarettes and lighters".</p> <p>2. Resident # 3 had a diagnoses of Flaccid Hemiplegia Dominant Side, Cerebrovascular Accident (CVA), Syncope and Collapse. The Annual Minimum Data Set dated 4/11/07 documented the resident was moderately impaired in cognitive skills for daily decision making, totally dependent on staff for all activities</p>	F 324			

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F 324	Continued From page 15 of daily living, and required two person physical assist to transfer.  a. The Comprehensive Care Plan dated 4/10/07 documented,"...Problem - Impaired Mobility related to CVA - Provide assistance with transfers times 2 CNA's."  b. On 4/24/07 at 10:55 a.m., the resident was transferred from the bed to a high back wheelchair with a mechanical lift and one Certified Nursing Assistant (CNA). CNA #1 did not have the assistance of a second staff member in the room during the transfer. The CNA was asked, "Can the resident bear weight" and the CNA stated, "No, not anymore."  c. On 4/26/07 at 12:10 p.m. the Director of Nursing (DON) was asked, "How many member of the staff are required to transfer a resident with a mechanical lift?" The DON stated, "2 persons."  d. The Lifting Machine, Using a Portable Guidelines/Protocol submitted by the Administrator on 4/26/07 at 10:45 documented,"...General Guidelines The portable lift can be used by one nursing assistant if the resident can participate in the lifting procedures. If not, two (2) nursing assistants will be required to perform the procedure."	F 324		
F 441 SS=D	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	F 441		

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F 441	<p>Continued From page 16</p> <p>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 the facility failed to ensure the ice scoop was not left in the ice between filling resident water pitchers with ice. This failed practice had the potential to affect 70 residents who received ice as per a list given by the Director of Nursing on 4/26/07. The findings are:</p> <ol style="list-style-type: none"> <li>On 4/25/07 at 9:40 a.m.-10:04 a.m. Certified Nursing Assistant (CNA) #5 passed ice on the 100 hall. The ice chest was on a cart with a lid to cover it. There was a plastic container sitting on the second shelf of the cart but the ice scoop was not in it. The CNA went into the resident rooms and brought the water pitchers out 2 at a time. The water pitchers were opened 1 at a time and each pitcher was filled individually by holding the pitcher over the ice in the chest and removing the scoop from inside the ice in the chest. After each pitcher was filled, the scoop was placed inside the ice chest and the scoop handle touched the ice. The lid was closed down until the CNA rolled the cart to the next room.</li> <li>An Ice Passing Times and Procedure Policy given by the Medical Records Clerk on 4/26/07 documented, "To promote resident's hydration needs ice is to be passed at the following times: 10:00 a.m., 2:00 p.m., 4:00 p.m., 12:00 p.m. Ice should be in a covered ice container with a scoop being kept in a plastic bag...".</li> </ol>	F 441			