

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

PRINTED: 06/04/2007
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 05/18/2007
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 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 and record review the facility failed to ensure privacy was provided during toileting for 1 (Resident #12) of 15 (Residents #1 thru #5, #7 thru #10, #12 thru #16 and #25) case-mix residents who required assistance with toileting. This failed practice had</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 the potential to affect 105 residents in the facility who required assistance with toileting, according to a list received from the Administrator on 5/17/07 at 2:05 p.m. The findings are: 1. Resident #12 had diagnosis of Alzheimer's Dementia. The Minimum Data Set dated 5/8/07 documented the resident had severely impaired cognitive skills for daily decision-making, was incontinent of bowel and bladder and required staff assistance with toileting and personal hygiene. On 5/15/07 at 5:45 p.m., the resident was observed, from the corridor, sitting on the toilet with the bathroom door open. Certified Nursing Assistant (CNA) #17 and CNA #18 were present in the bathroom.	F 164		
F 241 SS=D	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 and record review the facility failed to ensure assistance was provided during meals to preserve dignity for 1 (Resident #7) of 10 (Residents #1, #2, #6 thru #9, #13, #14, #16 and #19) case-mix residents who required assistance with eating. This failed practice had the potential to affect 73 residents in the facility who had been assessed to require assistance with eating, according to a Census List dated 5/18/07 at 8:14 a.m. The findings are:	F 241		

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F 241	Continued From page 2 1. Resident #7 had diagnoses of Vascular Dementia and Glaucoma. The Significant Change Minimum Data Set dated 4/27/07 documented the resident had short/long-term memory problems, was moderately impaired in cognitive skills for daily decision making, required set-up help only for eating and had a weight loss of 5% or more in the last 30 days or 10% or more in the last 180 days, . a. The care plan dated 4/27/07 documented: "Problem/Need: Resident with further decline in ADL (activities of daily living) functional abilities... Approach: Need supervision with eating." b. On 5/15/07 at 12:27 p.m., during the noon meal the resident was observed eating his meal, which included bar-b-que chicken and corn, with his fingers. The resident's tray card documented: "Assist Tray." c. On 5/15/07 at 5:28 p.m., the resident was again eating his meal with his fingers, including the ice cream. No one was at the table where the resident was sitting to assist him.	F 241		
F 309 SS=E	483.25 QUALITY OF CARE 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 309		

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F 309	Continued From page 3 interview, the facility failed to ensure catheters were positioned in a manner to prevent the potential for urinary tract infections for 1 (Resident #18), catheters were secured to prevent the potential for trauma to the urinary meatus for 3 (Residents #16, #18 and #19) and catheter care was provided during incontinent care for 2 (Residents #13 and #16) of 7 (Residents #3, #4, #13, #16, #18, #19 and #21) case-mix residents with catheters. These failed practices had the potential to affect 14 residents with catheters, as identified by a list provided by the Administrator on 5/17/07. The findings are: 1. Best Practices - A Guide to Excellence in Nursing Care, copyright 2003 by Lippincott Williams & Wilkins, pages 437, 438 documented: "Hang the collection bag below bladder level to prevent urine reflux into the bladder, which can cause infection. Explain the basic principles of gravity drainage so the patient realizes the importance of keeping the drainage tubing and the collection bag lower than his bladder at all times. Tape the catheter to the female patient's thigh to prevent possible tension on the urogenital trigone." 2. Resident #18 had diagnoses of Neurogenic Bladder and Renal Failure. The Temporary Plan of Care documented the resident was a recent admission on 5/9/07 and required the use of a Foley Catheter due to Neurogenic Bladder. a. The Physician order dated 5/9/07 documented, Foley Catheter 16 Fr. (French) 10 cc (cubic centimeters) Dx (Diagnosis): Neurogenic Bladder. b. On 5/14/07 at 3:00 p.m., during initial rounds, the resident's catheter tubing was not secured.	F 309			

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F 309	Continued From page 4 c. On 5/17/07 at 9:45 a.m., the resident was lying in bed with both side rails in the up position. The resident's catheter tubing was positioned over the side rail, which placed the catheter and the proximal tubing higher than the level of the resident's bladder and prevented urine from flowing by gravity out of the bladder, thru the catheter tubing and into the urine collection bag. 3. Resident #19 had diagnoses of Urinary Tract Infection and Urinary Retention. The Minimum Data Set dated 4/5/07 documented the resident had severely impaired cognitive skills for daily decision-making, required the use of an indwelling catheter and had a urinary tract infection in the past 30 days. a. The Physician order dated 2/27/07 documented, "Foley Leg Strap in place at all times." b. On 5/14/07 at 3:12 p.m., during initial rounds, the resident's catheter was not secured with a leg strap. 4. Resident #16 had diagnoses of Decubitus Ulcer and Urinary Tract Infection. A Quarterly Minimum Data Set dated 4/26/07 documented short and long term memory problems, moderately impaired cognitive skills for daily decision making, and total dependence for toilet use. On 5/14/07 at 11:50 a.m., after a loose incontinent bowel movement, Certified Nursing Assistant (CNA) #15 and CNA #16 performed incontinent care for the resident. There was not a catheter strap or any other means to secure the	F 309			

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F 309	Continued From page 5 catheter. The catheter bag was in a privacy bag on the left side of the bed. When the resident was rolled to the right side there was a pulling tension observed on the catheter. The catheter came in contact with the resident's soiled incontinent pad, but the penis and catheter were not cleansed during the procedure. 5. Resident #13 had diagnoses of Cerebral Vascular Accident and Decubitus Ulcer. An Admission MDS dated 3/21/07 documented the resident had modified independence in cognitive skills for daily decision making, was totally dependent on staff for bed mobility, was frequently incontinent of bowel and had an indwelling catheter. On 5/15/07 at 8:55 a.m., after the resident had a loose incontinent bowel movement, CNA #15 performed incontinent care for the resident. The resident had an indwelling urinary catheter which had come in contact with the soiled incontinent pad. The penis and catheter were not cleansed during the procedure.	F 309		
F 312 SS=D	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 all areas of the perineum were cleansing during incontinent care to maintain hygiene for 1 (Resident #6) of 16	F 312		

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F 312	Continued From page 6 (Residents #1 thru #10, #12 thru #16 and #25) case-mix residents who required incontinent care. This failed practice had the potential to affect 105 residents in the facility, as documented by a list provided by the Administrator on 5/17/07 at 2:05 p.m. The findings are: Resident #6 had diagnoses of Malaise and Fatigue and General Muscle Weakness. A Quarterly Minimum Data Set dated 4/13/07 documented the resident had moderately impaired cognitive skills for daily decision making and required extensive assistance of staff for personal hygiene. a. The Plan of Care documented, "Problem onset: 1/10/07 At risk for decline in Activities of Daily Living function" and "approaches 4/3/07 incontinent care after each episode." b. On 5/14/07 at 12:10 p.m., Certified Nursing Assistant (CNA) #14 performed incontinent care for the resident. The CNA stated that the gown the resident was wearing was wet with urine. The CNA cleansed the resident in the front with 1 quick wipe front to back, and cleansed the right groin with 1 quick wipe front to back. The CNA then cleansed the buttock and rectal areas. The CNA did not separate the labia to cleanse, or cleanse the left groin area, during the procedure. c. The policy for perineal care received from the Administrator on 3/18/07 at 8:35 a.m. documented, "Separate labia and wash area downward from front to back"	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	F 314			

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F 314	<p>Continued From page 7</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure residents were turned and repositioned to prevent the potential for skin breakdown and promote healing for 1 (Resident #4) of 8 (Residents #1, #2, #4, #5, #13, #14, #16 and #18) case mix residents with pressure sores. This failed practice had the potential to affect 15 residents with pressure sores, according to the Resident Census and Conditions of Residents form dated 5/14/07. The findings are:</p> <p>Resident #4 had diagnoses of Decubitus Ulcer and Bilateral Above the Knee Amputee. The Significant Change Minimum Data Set dated 4/12/07 documented the resident was moderately impaired in cognitive skills for daily decision making, was totally dependent on the assistance of 2 persons for bed mobility, had a urinary catheter and was incontinent of bowel.</p> <p>a. The care plan dated 4/13/ 07 documented under Problem/Need: Admitted with pressure ulcer to left buttock stage 2, and stage 2 to right buttock. Under approached it was documented "Turn and reposition every 2 hours when in bed".</p> <p>b. On 5/15/07 at 9:07 a.m., the resident's draw sheet was marked on the right and left side to</p>	F 314			

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F 314	Continued From page 8 check for turning and repositioning. c. On 5/15/07 at 10:42 a.m., the resident was checked for repositioning; the resident had not been turned and repositioned. d. On 5/15/07 at 12:15 p.m., resident was checked again and the resident had not been turned and repositioned.	F 314		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that incontinent care was provided in a manner to prevent the potential for Urinary Tract Infections for 1 (Resident #9) of 15 (Residents #1 thru #5, #7 thru #10, #12 thru #16 and #25) case-mix residents who were dependent on staff for incontinent care and failed to discontinue a catheter per Physician orders for 1 (Resident #16) of 7 (Residents #3, #4, #13, #16, #18, #19 and #21) case mix residents with catheters. This failed practice had the potential to affect 105 residents dependent on staff for incontinent care and 14 residents with catheters, as identified by	F 315		

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F 315	Continued From page 9 lists provided by the Administrator on 5/17/07. The findings are: 1. Resident #9 had diagnoses of Alzheimer's Disease and Incontinence. The Minimum Data Set (MDS) dated 4/20/07 documented the resident had severely impaired cognitive skills for daily decision-making, was incontinent of bowel and bladder and was dependent on staff for toileting and personal hygiene. a. The Plan of Care dated 1/24/07 documented, "Keep clean and dry. Incontinent care q (every) 2 hours and PRN (as needed)". b. On 5/16/07 at 10:15 a.m., the resident had been incontinent of a large amount of loose yellow feces. Certified Nursing Assistant (CNA) #1 wiped the anterior pubis area, but did not spread the labia and cleanse between the folds. The CNA applied a new incontinent brief, but prior to fastening it was asked by the surveyor to wipe down the middle in the labia fold with a clean washcloth. The CNA wiped the area with a clean cloth and obtained a large amount of yellow fecal material. 2. Resident #16 had diagnoses of Decubitus Ulcer and Urinary Tract Infection. A Quarterly MDS dated 4/26/07 documented the resident had moderately impaired cognitive skills for daily decision making and was totally dependent on staff for toilet use. a. A Physician Order dated 5/4/07 documented: # 16 FR (french) Foley catheter to contained drainage system (CDS). Discontinue (DC) 5/5. Reinsert if unable to void.	F 315			

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F 315	Continued From page 10 b. On 5/18/07 at 8:45 a.m., the Director of Nursing looked through the resident's Nurse's Notes and stated, "I didn't see where they tried to take it [Foley catheter] out." There was no documentation found in the Nurse's Notes concerning any attempt to discontinue the resident's catheter. The indwelling catheter was not addressed in the Plan of Care.	F 315		
F 318 SS=E	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that positioning devices were consistently utilized to prevent the potential for further decline in range of motion for 3 (Residents #3, #9 and #14) of 4 (Residents #3, #9, #14 and #15) case-mix residents with contractures. This failed practice had the potential to affect 30 residents with contractures, as identified by a list provided by the Administrator on 5/17/07. The findings are: 1. Resident #9 had diagnoses of Alzheimer's Disease and Contractures. The Minimum Data Set (MDS) dated 4/20/07 documented the resident had severely impaired cognitive skills for daily decision-making and had functional limitation in range of motion in both hands.	F 318		

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F 318	<p>Continued From page 11</p> <p>a. The Occupational Therapy Plan of Care for Rehabilitation dated 1/26/07 documented, "Orthotic splint of R (right) hand for decreased (arrow down) risk of further contractures. R hand splint with finger separators and thumb roll in place. Staff + c (with) FMP (functional maintenance program) & demo (demonstrates) good understanding c splint wearing & schedule for 6 hours daily".</p> <p>b. The facility staff inservice sheet dated 1/26/07 documented, "Splint Program. Splint for right hand. Wear 6 hours per day."</p> <p>c. On 5/14/07 at 3:10 p.m., on 5/15/07 at 9 a.m., 10:45 a.m., 12:15 p.m., 3:55 p.m. and 6:25 p.m. and on 5/16/07 at 10:15 a.m. and 11 a.m., the resident was observed with bilateral hand contractures. There were no positioning devices in place.</p> <p>d. On 5/16/07 at 11:00 a.m., Certified Nursing Assistant (CNA) #2 stated that the resident was unable to extend the fingers of either hand due to her contractures. The CNA was asked if the resident had a splint or handrolls and she stated, "Not that I know of."</p> <p>e. On 5/16/07 at 11:15 a.m., CNA #3, who was assigned to this resident, was asked if the resident had a hand splint. The CNA stated she thinks she used to, but not now. The CNA looked in the resident's bedside drawers, dresser and closet and stated, "I don't see one but Restorative is the ones that does the splints so maybe they keep them somewhere else."</p> <p>f. On 5/16/07 at 11:30 a.m., Restorative CNA #4 and CNA #5 stated that the resident was not on</p>	F 318		

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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 05/18/2007
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 318	<p>Continued From page 12</p> <p>their list to do, so the floor CNAs were responsible for doing that splint.</p> <p>2. Resident #3 had diagnoses of Cerebrovascular Accident with Hemiplegia. The Quarterly MDS dated 5/5/07 documented the resident had moderately impaired cognitive skills for daily decision-making, was totally dependent on others for activities of daily living and had limited range of motion with partial loss of voluntary movement of the arm, hand, leg and foot and limitation of range of motion on both sides with partial loss of voluntary movement of the neck.</p> <p>On 5/14/07 at 2:18 p.m., during initial facility rounds, the resident was lying in bed with the left hand contracted; there no positioning device in place to prevent further decline.</p> <p>3. Resident #14 had diagnoses of Cerebrovascular Accident, Osteoporosis and Dementia. The Annual MDS dated 3/31/07 documented the resident had moderately impaired cognitive skills for daily decision-making, required total assistance with all activities of daily living, had functional limitation in range of motion of both arms and feet and functional limitation in range of motion of one hand and one leg with partial loss of voluntary movement and was receiving Hospice care.</p> <p>a. On 5/14/07 at 3:55 p.m., during the initial facility tour, the resident was lying in bed with bilateral upper extremity contractures. A sign on the wall at the head of the resident's bed said "splint on 4 hours off 2 hours hand roll when the splint is off." CNA #8 stated "...never seen a splint in the room."</p>	F 318			

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F 318	Continued From page 13 b. 5/15/07 at 8:45 a.m., the resident was lying in bed with the left hand contracted; there was no positioning device in place.	F 318		
F 322 SS=E	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the head of the bed was elevated to decrease the potential for aspiration for 2 (Residents #3 and #13) of 3 (Residents #3, #13 and #15) case mix residents with feeding tubes. This failed practice had the potential to affect 7 residents with feeding tubes, as identified by a list provided by the Administrator on 5/17/07. The findings are: 1. Resident #3 had diagnoses of Cerebrovascular Accident with Hemiplegia/Hemiparesis and History of Aspiration Pneumonia. A Quarterly Minimum Data Set (MDS) dated 5/5/07 documented the resident had moderately impaired cognitive skills for daily decision making and 76% to 100% total calories received were via a feeding tube. a. The Physician Orders for 5/1/07 documented, elevate HOB (head of bed).	F 322		

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F 322	<p>Continued From page 14</p> <p>b. On 5/16/07 at 4:00 p.m., Licensed Practical Nurse #2 administered a bolus tube feeding to the resident.</p> <p>c. On 5/16/07 at 4:11 p.m., Certified Nursing Assistant (CNA) #9 and CNA #10 transferred the resident from a wheel chair into the bed. The resident was placed on her back with the head of the bed flat. The resident remained with her head flat on the bed while the CNAs provided care. The head of the residents bed was elevated at 4:27 p.m.</p> <p>2. Resident #13 had diagnoses of Cerebral Vascular Accident and Decubitus Ulcer. An Admission MDS dated 3/21/07 documented the resident had modified independence in cognitive skills for daily decision making, had total dependence on staff for bed mobility, had one stage II and one stage IV pressure ulcer.</p> <p>a. A Physician order dated 4/23/07 documented, elevate HOB (head of bed) 30-45 degrees.</p> <p>b. The Plan of Care documented, Problem onset: 4/6/07 Resident is at risk for complications d/t (due to) the use of PEG (percutaneous endogastrostomy) tube and feeding and HOB elevated 30 degrees and assess lung sounds for aspiration.</p> <p>c. On 5/16/07 at 12:04 p.m., the head of the resident's bed was lowered until it was almost flat by the treatment Licensed Practical Nurse (LPN). The PEG tube feeding was infusing per pump at 40 cubic centimeters an hour during the procedure. A treatment was done on the resident's heel, coccyx and sacrum by the LPN; the procedure was completed and the head of the</p>	F 322			

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F 322	Continued From page 15	F 322		
F 323	bed was raised back up at 12:50 p.m.			
SS=E	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 that the environment was maintained hazard free as evidenced by the doors and walls in disrepair which resulted in exposed splinters and chemicals left accessible to confused, independently mobile residents. These failed practices had the potential to affect 124 ambulatory residents and 65 residents who were independently mobile and confused, according to lists provided by the Administrator on 5/18/07. The findings are: 1. On 5/16/07, during Environmental Rounds with the Administrator, Assistant Administrator, Housekeeping Supervisor and Maintenance Man, the following observations were made: a. On Hall #9, the whirlpool door had a piece, that was approximately 1/8-inch by 1-inch, partially detached approximately 1-inch from the lower portion of the door surface. b. On Hall #7, the corner molding, that was directly across from the maintenance room, was splintered 24-inches from the floor. c. On Hall #4, the fire doors at the hall entrance had a piece that was approximately 1/8-inch by 1-inch, partially detached from the lower right side	F 323		

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F 323	Continued From page 16 of the door surface. 2. On 5/15/07 at 5:10 p.m. on Hall 200, the personal item storage cabinet attached to the wall was unlocked. The storage cabinet contained 2 razors in a opened package and 6 razors in another package that were open and accessible to staff and residents. The cabinet had 6 bottles of aloe vista ointment and 2 containers of derm cen skin cleanser. The labels of these items documented external use only. 3. On 5/15/07 at 5:17 p.m. on Hall 300, a storage container was positioned on the wall approximately 40-inches from the floor, in full view and reach. The storage unit contained 3 complete packs of razors and 2 packs that contained 4 razors each. The labels on 4 bottles of derm cen skin cleanser read: External use only. 4. On 5/15/07 at 5:20 p.m., a wall storage unit was unlocked and opened on Hall 9 and contained 3 bottles of aloe vesta skin conditioner, 1 bottle of antimicrobial-T hand soap, 3 bottles of aloe vesta protective ointment, and 1 bottle of derma cen instant hand sanitizer. The labels on these bottles documented if swallowed to call a poison control center.	F 323		
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 by: Based on observation, record review and interview the facility failed to ensure that	F 324		

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F 324	<p>Continued From page 17</p> <p>non-weight bearing residents were not transferred using the underarms to prevent the potential for injury for 3 (Residents #3, #10 and #14) of 10 (Residents #3, #5, #7, #8, #10, #14, #18 thru #20 and #22) case mix residents who required two person assistance for transfers. This failed practice had the potential to affect 53 residents who required two person transfer assistance, as documented by the Administrator on 5/17/07. The findings are:</p> <p>1. Resident #3 had diagnoses of Cerebrovascular Accident with Hemiplegia. The Quarterly Minimum Data Set (MDS) dated 5/5/07 documented the resident had moderately impaired cognitive decision-making skills, required total assistance of two plus persons for transfers, was unable to attempt the standing balance test without physical support and had functional limitations on both sides with partial loss of voluntary movement of the neck, arm, hand, leg and foot.</p> <p>On 5/16/07 at 4:05 p.m., Certified Nursing Assistant (CNA)# 9 and CNA #10 prepared to transfer the resident from a wheelchair to the bed. The CNAs stood at the resident's side and placed one arm each under the resident's arms. The CNAs then manually lifted the resident up and out of the wheelchair, dragging her feet across the floor.</p> <p>2. Resident #14 had diagnoses of Cerebrovascular Accident Osteoporosis and Dementia. The Annual MDS dated 3/31/07 documented the resident had moderately impaired cognitive skills for daily decision-making, required total assistance of two plus persons for transfers, had modes of transfer of mechanically</p>	F 324			

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F 324	Continued From page 18 lifted and transfer aid slide board, was unable to attempt the standing balance test without physical support and had functional limitation in range of motion on both sides with partial loss of voluntary movement of the arm, hand, leg and foot. On 5/15/07 at 11:55 a.m., CNA #11 and CNA #12 had provided a.m. care for the resident and the resident was sitting in a shower chair beside the bed. CNA #11 placed a gait belt around the resident's waist and secured the belt. With one CNA standing on each side of the resident, the CNAs placed an arm under the resident's arm. The CNAs lifted the resident from the chair with her legs hanging down, but never touching the floor. The resident was transferred to the bed. The CNAs never touched the gait belt. 3. Resident #10 had diagnoses of Disc Degeneration, Arthropathy, Osteoporosis, Muscle Weakness and Musculoskeletal Symptomatic Limb Disease. The Quarterly MDS dated 3/16/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance for transfers and was incontinent of bowel and bladder. On 5/15/07 at 10:12 a.m., CNA #6 and CNA #7 sat the resident up in bed; with one CNA under each arm, they lifted the resident from the bed and sat the resident on a shower chair. All of the resident's weight was supported by the resident under the arms. She did not bear any of her own weight on her feet and legs.	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	F 328		

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F 328	<p>Continued From page 19</p> <p>special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure oxygen concentrator filters were clean, oxygen tubing and nasal cannulas were covered when not in use and/or oxygen tubing was not on the floor for 5 (Residents #1, #3, #6, #20 and #21) of 13 (Residents #1, #3 thru #6, #9, #14, #16 thru #18, #20, #21 and #23) case mix residents. This failed practice had the potential to affect 47 residents with Physician orders for oxygen as needed and/or continuous, as identified by the Director of Nurses on 5/17/07. The findings are:</p> <p>1. Resident #1 had a diagnosis of Chronic Airway Obstruction. An Annual Minimum Data Set (MDS) dated 3/16/07 documented the resident had moderately impaired cognitive skills for daily decision making and received oxygen therapy.</p> <p>a. The Physician order dated 11/27/06 documented, "Oxygen 2 LPM (liters per minute) per nasal canula for shortness of breath."</p> <p>b. On 5/14/07 at 2:26 p.m., during initial facility rounds, the resident had an oxygen concentrator on the floor beside the bed. The resident was</p>	F 328		

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F 328	<p>Continued From page 20</p> <p>receiving oxygen at 2 liters per minute by nasal canula. The concentrator had no humidifier bottle in place.</p> <p>c. On 5/16/07 at 10:48 a.m., the resident was lying in bed receiving oxygen per nasal canula at 2 liters per minute. The oxygen concentrator was in the floor beside the bed, without a humidifier bottle. The resident's oxygen tubing was laying on the floor.</p> <p>2. Resident #3 had diagnoses of Cerebrovascular Accident, Hemiplegia/Hemiparesis and Hypertension. The Quarterly Minimum Data Set (MDS) dated 5/5/07 documented the resident had moderately impaired cognitive skills for daily decision making, was totally dependent for activities of daily living and received oxygen therapy.</p> <p>a. The Physician order dated 4/12/07 documented, "Oxygen at 2 lpm (liters per minute) per nasal canula continuous.</p> <p>b. The plan of care for the resident, dated 4/12/07, documented: "At risk for complications due to use of O2 (oxygen) prn (as needed). Approaches: Clean filters on concentrators weekly and prn."</p> <p>c. On 5/14/07 at 2:32 p.m., during initial facility rounds, the resident had an oxygen concentrator on the floor beside the bed. The resident was receiving oxygen at 2 and 1/2 liters per minute via nasal canula. The concentrator had two black filters that were covered with a white lint-type substance.</p> <p>3. Resident #20 had diagnoses of Chronic Airway</p>	F 328			

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F 328	<p>Continued From page 21</p> <p>Obstruction and Hypertension. The Quarterly MDS dated 4/25/07 documented the resident had moderately impaired cognitive skills for daily decision making and received oxygen therapy.</p> <p>a. The Physician order dated 10/26/06 documented, "Oxygen 2 lpm (liters per minute) for shortness of breath.</p> <p>b. On 5/14/07 at 2:06 p.m., the resident was lying in bed receiving oxygen per nasal canula at 2 liters per minute; the resident's oxygen tubing was not dated and was laying on the floor. The concentrator had a black filter that was covered with a white lint-type substance.</p> <p>4. Resident #21 had diagnoses of Congestive Heart Failure, Hypertension, Diabetes and History of Acute Bronchitis. The Admission MDS dated 4/26/07 documented the resident had modified independence in cognitive skills for daily decision making and received oxygen therapy.</p> <p>a. The Physician order dated 4/23/07 documented, "Oxygen at 3 lpm (liters per minute) continuous."</p> <p>b. On 5/14/07 at 2:32 p.m., during initial facility rounds, the resident had an oxygen concentrator beside the bed and was receiving oxygen at 3 liters per minute via nasal cannula. The oxygen concentrator had one black filter covered with a white lint-type substance and the oxygen tubing, from the concentrator to the bed, was on the floor. In a container was an oxygen E-tank with the tubing attached to nasal cannula that was uncovered and open to air.</p> <p>c. On 5/17/07 at 9:30 a.m., the resident was lying</p>	F 328			

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F 328	Continued From page 22 in bed on her left side with the head of the bed elevated. Setting in a container was an oxygen E-tank with the tubing attached to nasal cannula that was uncovered and open to air. 5. Resident #6 had diagnoses of Congestive Heart Failure and Bronchitis. A Quarterly MDS dated 4/13/07 documented the resident was moderately impaired in cognitive skills for daily decision making, had shortness of breath and received oxygen therapy. a. A Physician Order dated 3/23/07 documented, O2 (oxygen) @ (at) 2 LPM/NC (liters per minute per nasal cannula) PRN (as needed) shortness of breath. b. On 5/16/07 at 9:30 a.m., the resident's oxygen concentrator was running at 2 liters per minute, but the nasal cannula was not on the resident. The nasal cannula was laying in the bed next to the resident, not stored in a bag and open to air. The nasal cannula was marked at this time with a pen where the cannula tubing connected to the oxygen concentrator. c. On 5/16/07 at 11:20 a.m., the resident had the same marked nasal cannula on, receiving oxygen at 2 liters per minute. d. On 5/16/07 at 2:55 p.m., the resident had the same marked nasal cannula on, receiving oxygen at 2 liter per minute.	F 328		
F 333 SS=E	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		

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F 333	<p>Continued From page 23</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation of the 4:00 p.m. medication pass on 5/14/07, the 8:00 a.m. medication pass on 5/15/07, and record review, the facility failed to follow Physician orders to ensure that residents were free of significant medication errors. One (Resident #17) of 10 residents observed during the medication pass was found to have a significant medication error. A significant medication error was made by 1 (Licensed Practical Nurse #1) of 7 nurses that administered medication. This failed practice had the potential to affect 175 residents in the facility, according to the Resident Census and Conditions of Residents form dated 5/14/07. The findings are:</p> <p>1. Resident #17 had diagnoses of Cough, Malaise and Fatigue. A Physician order dated 7/23/06 was for, Advair 100/50 to use one puff twice a day.</p> <p>a. On 5/15/07 at 7:58 a.m., Licensed Practical Nurse (LPN) #1 administered one puff of Advair 250/50 to the resident.</p> <p>b. On 5/15/07 at 10:30 a.m., the provider pharmacy stated that Advair 100/50 had been dispensed from 1/06 until 5/7/07, when a new order was received from the facility for 250/50.</p> <p>c. On 5/15/07 at 11:05 am, the resident's physician stated that he had not changed the resident's medication to Advair 250/50 and no order was found to change the medication.</p> <p>d. The Advair dispenser documented that 16 doses of Advair 250/50 had been administered since 5/7/07.</p>	F 333			

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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 333	Continued From page 24	F 333			
F 364 SS=B	<p>e. This was a significant medication error due to the resident's condition (Cough, History of Pneumonia) and frequency of the error.</p> <p>483.35(d)(1)-(2) FOOD</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the food served was palatable and served at the correct temperature. This failed practice had the potential to affect 133 residents who received a mechanical and solid tray from dietary, according to the Diet Roster dated 5/15/07. The findings are:</p> <p>a. On 5/15/07 at 5:40 p.m., the residents were in the main dining room for the supper meal. An alert resident was served a well-done pizza with dark edges and bottom area. 2 residents were observed trying to cut the pizza with a knife, then picking it up and separating the pizza with their hands. The resident took a bite and attempted to chew, then placed the pizza on the plate and shook their head. One resident said, "It is hard."</p> <p>b. On 5/16/07 at 12:50 p.m., a test tray for the menu including glazed ham, blackeyed peas and seasoned greens was checked for serving temperatures. The seasoned greens registered 102 degrees Fahrenheit, they were cool when sampled and would not melt butter. The foods on the plate retained a hot temperature. The greens</p>	F 364			

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F 364	Continued From page 25	F 364		
F 371 SS=F	<p>were in an individual bowl with a lid that did not fit the bowl.</p> <p>483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE</p> <p>The facility must store, prepare, distribute, and serve food under sanitary conditions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure food was stored in a manner to prevent food borne illness and failed to maintain the kitchen in a manner to prevent potential food contamination. These failed practices had the potential to affect 171 residents in the facility who received meals from the kitchen, according to the Diet Roster dated 5/15/07. The findings are:</p> <p>1. On 5/14/07 at 2:00 p.m., during the initial kitchen observation, a 5-gallon container of mixed fruit with juice was stored in the refrigerator with the lid to the container unsealed and off-set, causing risk of contamination from the unwashed celery stored on the refrigerator shelf directly above the mixed fruit.</p> <p>2. On 5/16/07 at 10:45 a.m., the following conditions were observed in the kitchen:</p> <p>a. Paint was flaking on a ceiling vent over the clean dishes waiting near the food line.</p> <p>b. An open ceiling penetration with lint hanging down was identified over the dishwasher where clean dishes were air drying.</p>	F 371		

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F 371	Continued From page 26 c. An open ceiling penetration with broken tile was located over the food service line. d. Flaking paint was peeling from a vent located above the ice machine where staff was filling glasses with ice. e. A 46-ounce can of tomato juice was dented at the top rim seal and stored on the shelf with other cans of tomato juice to be used for resident meals. f. A 96-ounce can of jalapeno peppers was dented at the top rim seal and stored on the shelf with other cans of jalapeno peppers to be used for resident meals.	F 371		
F 441 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure that a sign was posted outside the door for a resident in isolation, that contaminated dressings were discarded properly, that staff hands were cleansed before touching	F 441		

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F 441	Continued From page 27 items outside of an isolation room and that staff wore isolation gowns to prevent the potential for contamination of their clothing for 1 (Resident #13) of 2 (Residents #13 and #18) case mix residents in isolation. This failed practice had the potential to affect 2 residents in the facility who required isolation, according to initial rounds on 5/14/07. The findings are: 1. The facility policy and procedure for Pressure Ulcers and the facility policy and procedure for Perineal Care documented: "Purpose: Infection Control Protocol and Safety... 1. Wash your hands thoroughly with soap and water at the following intervals: ...d. when changing/removing gloves or any personal protective equipment; e. whenever in doubt; and f. upon completion of your task or procedure. 2. Wear appropriate personal protective equipment (e.g., gloves, gown, mask, eyewear, etc., as necessary to prevent exposure to spills or splashes of blood or other potentially infectious materials. 3. Maintain clean technique and isolation precautions as indicated." 2. Resident #13 had diagnoses of Cerebral Vascular Accident and Decubitus Ulcer. An Admission Minimum Data Set dated 3/21/07 documented the resident had modified independence in cognitive skills for daily decision making, had total dependence on staff for bed mobility and had a stage II and a stage IV pressure ulcer. a. The Physician Order dated 4/23/07 documented, Contact Isolation MRSA (Methicillin Resistant Staphylococcus Aureus). b. The Plan of Care documented Contact	F 441		

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F 441	Continued From page 28 Isolation D/T (due to) MRSA in coccyx wound. c. On 5/14/07 at 3:15 p.m., Licensed Practical Nurse (LPN) #3 stated that the resident was in isolation for MRSA. There was not a sign on the door to the resident's room indicating any isolation or precautions to take at this time. d. On 5/15/07 at 8:55 a.m., LPN #3 performed wound treatment on the resident's coccyx and sacral areas. The resident had been incontinent of bowel. Certified Nursing Assistant (CNA) #15 was in the room and placed the resident's soiled incontinent pad on the foot of the resident's bed. The LPN placed a red bag on the foot of the bed. The soiled dressing, gauze squares used for cleaning the wound and gloves used during the procedure were placed in to the red bag. After the treatment, the LPN picked up the red bag off of the resident's bed, without wearing any gloves. The LPN then took the red bag into the hallway and placed it into a plastic bag on the treatment cart. The LPN initialed the treatment book and then entered another resident's room. The LPN's hands were not washed prior to initialing the treatment book or entering the other resident's room. Certified Nursing Assistant (CNA) #15 then performed incontinent care for the resident. The CNA did not wear an isolation gown during the procedure. The CNA's scrub top was observed touching the resident's hospital gown during the procedure.	F 441		
F 502 SS=E	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The	F 502		

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F 502	Continued From page 29 facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a laboratory specimen was obtained in a timely manner per Physician orders which resulted in delayed initiation of medication change for 1 (Resident #9) of 25 (Residents #1 thru #25) case mix residents with lab orders. This failed practice had the potential to affect 148 residents with orders for lab, as identified by a list provided by the Administrator on 5/17/07. The findings are: Resident #9 had diagnoses of Alzheimer's Disease and Hypothyroidism. The Minimum Data Set dated 4/20/07 documented the resident had severely impaired cognitive skills for daily decision-making and was dependent on staff for all activities of daily living. a. The Physician order dated 11/29/06 documented, "Levothroid 0.075 mg. one PO (by mouth) Q (every) day." b. The Physician order dated 4/27/07 documented, "TSH (Thyroid Stimulating Hormone) Level Now then yearly." c. On 5/15/07, the most current TSH level available for review was dated 1/31/07 and documented an abnormal high reading of 4.750 (0.465 - 4.680). d. On 5/16/07 at 10:0 a.m., Licensed Practical Nurse (LPN) #1 stated the lab test was drawn	F 502			

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F 502	Continued From page 30 yesterday [5/15/07]. She stated it was on the list to do, but must have gotten missed. LPN #1 called the lab and asked that the lab results be faxed. The lab results documented an abnormal high TSH reading of 6.030 (0.465 - 4.680). e. The Lab Sheet dated 5/15/07 documented, "Call to Dr. [name of physician] c (with) order to increase (arrow up) Levothroid 0.088 and repeat TSH in 2 months."	F 502			