

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

PRINTED: 08/20/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045239</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/06/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MONTICELLO HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1052 OLD WARREN ROAD</b> <b>MONTICELLO, AR 71655</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 000	INITIAL COMMENTS	F 000		
F 312 SS=E	<p>Complaint #13702 was substantiated (all or in part) with deficiencies cited at F 312 and F 323.</p> <p>Complaint #13623 was unsubstantiated</p> <p>483.25(a)(3) ACTIVITIES OF DAILY LIVING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13702 was substantiated (all or in part) with these findings:</p> <p>Based on observation, record review and interview, the facility failed to ensure that incontinent care was provided at least every two hours for 3 residents (Resident #2, #3, and #5) of 7 case residents (Resident #1-#7), who were incontinent, and dependent on staff for incontinent care. This failed practice had the potential to effect 43 incontinent residents in the facility who were dependent on staff for incontinent care, as documented on a list provided by the Assistant Director of Nurses on 8/6/08. The findings are:</p> <p>1. Resident #2 had a diagnosis of Dementia. The Quarterly Minimum Data Set (MDS) dated 6/24/08 documented the resident had severely impaired cognitive skills for daily decision making, was incontinent of bowel and bladder, required total staff performance for all activities of daily living, was unable to maneuver himself in bed,</p>	F 312		

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 312	<p>Continued From page 1 and was unable to express his needs.</p> <p>a. The plan of care dated 6/23/08 documented, "provide incontinent bowel/bladder every 2 hours and as needed".</p> <p>b. On 8/4/08 at 7:43 p.m., CNA (Certified Nursing Assistant), #1 and #2, were observed performing incontinent care. The resident had been incontinent of bowel and bladder. The time marked on the soiled brief was unreadable. CNA #2 was interviewed and asked when the brief was last checked, the CNA stated, "4 or 5 p.m."</p> <p>2. Resident #5 had a diagnosis of Cerebral Vascular Accident. The Quarterly MDS dated 7/21/08 documented the resident had moderately impaired cognitive skills for daily decision making, was incontinent of bowel and bladder, required total staff performance for all activities of daily living, and was rarely understood.</p> <p>a. The plan of care dated 7/22/08 documented, "Adult briefs as desired, change every 2 hours and as needed due to soiling ... pericare every 2 hours and as needed due to soiling;...".</p> <p>b. On 8/4/08 at 9:15 p.m., the resident's brief was marked and documented, "2:30 p.m. FE (initials). The resident brief wet with urine.</p> <p>c. On 8/4/08 at 10:46 p.m., CNA #3 and #4 were observed removing the resident's urine soaked brief marked "2:30 p.m. FE". CNA #4 was interviewed and asked at what time the resident was checked for incontinence, the CNA stated, "At 3:00 p.m., and between 6:30 p.m. and 7:00 p.m."</p>	F 312			

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F 312	Continued From page 2 3. On 8/6/08 at 9:40 a.m. the DON (Director of Nurses), was asked how the incontinent briefs were marked when they are checked and/or changed, the DON stated, that they were marked with a time, date, and initial.  5. On 8/6/08 the following staff were interviewed and asked the following questions:  4. Resident #3 had diagnoses of Alzheimer's Disease and Joint Contracture. The Quarterly MDS dated 6/24/08 documented the resident had severely impaired cognitive skills for daily decision-making, was totally dependent on staff for bed mobility, personal hygiene, and was incontinent of bowel and bladder.  a. The Care Plan dated 12/26/07 documented, "Problem Onset: at risk for skin irritations, breakdown, and UTI's (Urinary Tract Infections) d/t (due to) urinary incontinence related to loss of bladder muscle tone, no potential for improvement, resident is severely cognitive impaired, ...Approaches ...staff will provide incont (incontinent) care q (every) two hrs (hours) and prn (as needed) per two person total assist ...pericare after each incont episode ...change soiled clothing after each incontinent episode..."  b. On 8/4/08 at 6:45 p.m., the resident was positioned on her back with the head of the bed elevated and had a disposable brief on that had been marked, "1:21 p.m." with a single line drawn through this and written above this in red print, "2:34 p.m. YB." There were 2 blue lines visible in the upper crotch area of the incontinent brief. The blue lines indicated the incontinent brief was wet.	F 312			

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F 312	<p>Continued From page 3</p> <p>c. On 8/4/08 at 7:55 p.m., the resident remained positioned on her back and had the same incontinent brief on with the same times marked and initials, "YB." The blue lines were present to the perineum area of the brief. The resident was marked at this time with tape to the sheet aligned with the resident's upper arms/shoulders on each side. The head of the bed was elevated.</p> <p>d. On 8/4/08 at 8:40 p.m., the resident was positioned on her back and the same incontinent brief remained on the resident with the blue lines visible. The tape was still aligned with the resident shoulders and arms that marked the resident ' s position.</p> <p>e. On 8/4/08 at 9:55 p.m., the resident remained positioned on her back with the same disposable brief marked, "1:21 p.m. and 2:34 p.m." The blue lines remained visible on the brief to the perineum area at the front of the brief.</p> <p>f. On 8/4/08 at 10:45 p.m., the resident remained on her back with the tape marked at each upper arm/shoulder and had worn the same incontinent brief with blue lines on the front of the beige brief and no new markings on the brief to indicate a new time the brief was checked.</p> <p>g. On 8/4/08 at 10:47 p.m., Certified Nursing Assistant (CNA) #5 and Nursing Assistant (NA) #1 removed the brief and provided incontinent care. The resident had been incontinent of urine and a small soft bowel movement.</p> <p>h. On 8/4/08 at 10:50 p.m., the CNA's were asked when was the last time the resident had been checked for incontinence, the CNA ' s stated, "After supper." The CNA's were asked</p>	F 312			

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F 312	<p>Continued From page 4</p> <p>when were the briefs marked. CNA #5 stated, "Each time we check them if they are not wet we'll re-mark this on the diapers." The CNA's were then asked what time the resident had been turned last and CNA #5 stated, "After supper." The CNA's were asked how often was a resident who was incontinent and dependent on staff for repositioning checked and repositioned and NA #1 stated, "Every 2 hours."</p> <p>i. On 8/4/08 at 10:50 p.m., NA #1 was asked when were incontinent resident checked, the NA stated, "Every two hours." The NA was then asked when and if the resident had been changed this shift, the NA stated, "No she wasn't."</p> <p>j. On 8/4/08 at 10:55 p.m., Licensed Practical Nurse (LPN) #1 was present in the resident's room and viewed the soiled brief that was removed from the resident. The LPN was asked if the times marked on the residents brief were for the 3-11 shift. LPN #1 stated, "No she wasn't marked on this shift. It says 2:34 p.m. and 1:21 p.m.. The LPN was then asked if the resident's brief had been changed on this shift [3-11] and the LPN stated, "It hasn't been."</p> <p>k. On 8/4/08 at 11:15 p.m. NA #1 was asked if she had checked the resident prior to the incontinent provided at 10:47 p.m. and when. The NA stated, "We both split up and I think we had a miscommunication."</p> <p>5. On 8/6/08 at 10:08 a.m., CNA #10 was asked if she had worked on 8/4/08 and did incontinent care on Resident #3. The CNA stated, "I think I did." The CNA was asked if she marked the incontinent brief on the resident with the initials "YB" and the CNA stated, "Yes, mam."</p>	F 312			

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F 312	Continued From page 5	F 312			
F 323 SS=E	<p>6. On 8/6/08 at 3:00 p.m., the Director of Nursing (DON) was asked how often were dependent, incontinent residents checked and changed and the DON stated, "Every 2 hours."</p> <p>483.25(h) ACCIDENTS AND SUPERVISION</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13702 was substantiated (all or in part) with these findings:</p> <p>Based on observation and interview, the facility failed to ensure that a residents face was not positioned against the side rail when providing care to prevent the potential for injury for 2 (Residents #1 and #7) of 7 case mix residents (Residents #1-#7), who were incontinent and required the use of side rails. The failed practice had the potential to effect 39 residents in the facility who were incontinent and required the use of side rails as documented on a list provided by the Assistant Director of Nursing on 8/6/08. The findings are:</p> <p>1. Resident #1 had a diagnosis of Alzheimer's Disease, and was receiving Hospice care. The Quarterly MDS (Minimum Data Set), dated 7/22/08 documented the resident had severely impaired cognitive skills for daily decision making,</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>required total staff performance for all activities of daily living, was incontinent of bowel and bladder, and was unable to maneuver himself in bed, or express his needs.</p> <p>a. On 8/4/08 at 8:04 p.m., CNA (Certified Nursing Assistant) #1 and #2 were observed checking the resident's brief for incontinence. The resident was turned to his left side, with his face positioned against the sheepskin lined side rail.</p> <p>2. Resident #7 had a diagnosis of Quadriplegia with Upper Arm Joint Contracture. The Medicare 5 day MDS dated 7/17/08 documented the resident had modified independent cognitive skills for daily decision making, was incontinent of bowel, required total staff performance for all activities of daily living, and had varying mental function over the course of the day.</p> <p>a. On 8/4/08 at 11:00 p.m., the resident was observed lying on his left side with his face positioned against the side rail and mattress during incontinent care given by CNA #3 and #4.</p>	F 323			