

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

PRINTED: 10/07/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MONTICELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1194 N CHESTER ST MONTICELLO, AR 71655	
(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 253 SS=D	<p>483.15(h)(2) HOUSEKEEPING/MAINTENANCE</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure an exit door was free of holes. This failed practice had the potential to effect 27 residents who resided on the North hall, according to the Director of Nursing on 9/25/08 at 9:05 a.m. The findings are:</p> <ol style="list-style-type: none"> On 9/23/08 at 9:10 a.m., there was a rotted-looking area on the lower left bottom corner of the north hall exit door; it had an approximate quarter-sized hole open to the outside. On 9/23/08 at 9:12 a.m., a maintenance staff member walked to the door and used a kick-like motion with his foot into the soft, rotted-looking area in the lower left bottom corner of the door; he leaned against the door before opening it. 	F 253		
F 312 SS=E	<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: Based on observation, record review and interview, the facility failed to ensure residents</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	Continued From page 1 were free of facial hair for 2 (Residents #2 and #10) of 15 (Residents #1 through #10 and #15 through #18 and #22) case mix residents who required assistance with bathing and grooming. This failed practice had the potential to affect 32 residents who required assistance with bathing/grooming and 56 residents in the facility who were dependent for bathing/grooming, according to the Resident Census and Conditions of Residents form dated 9/22/08. The findings are: 1. Resident #2 had diagnoses of Congestive Heart Failure, Alzheimer's Disease, Chronic Ischemic Heart Disease, Cardiac Dysrhythmias, Psychosis and Atherosclerosis. The Medicare 14-Day Minimum Data Set (MDS) dated 9/4/08 documented the resident had moderately impaired cognitive skills for daily decision making, was incontinent of bowel and bladder and required extensive assistance from staff for personal hygiene. a. The resident's care plan dated 8/25/08 documented, "[Resident #2] ...is at risk for self care defect ...in bathing, dressing, personal hygiene and oral care ...staff will provide one person to assist with ...grooming." b. On 9/22/08 at 3:15 p.m., on 9/23/08 at 8:10 a.m., 8:55 a.m., 11:25 a.m. and 2:15 p.m. and on 9/24/08 at 7:40 a.m., the resident had facial hair, approximately 1-centimeter (cm) in length, covering the entire chin area. 2. Resident #10 had diagnoses of Epilepsy, Mental Retardation, Gastrostomy Tube Feeding and Aphagia. The Quarterly MDS dated 8/22/08 documented the resident had severely impaired	F 312		

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F 312	Continued From page 2 cognitive skills for daily decision-making, was totally dependent of staff for all activities of daily living, was aphagic and was incontinent of bowel and bladder. a. The resident's care plan dated 9/8/08 documented, "...staff will provide one person to dress and do personal hygiene and grooming daily and prn (as needed)." b. On 9/22/08 at 3:25 p.m. and on 9/23/08 at 8:20 a.m., 9:20 a.m. and 2:15 p.m. and on 9/24/08 at 7:45 a.m., the resident had facial hair above the upper lip that was approximately 1-cm in length. 3. The Facility policy titled, "Shaving the Resident" was received on 9/25/08 and documented, "...Purpose: To remove facial hair and improve the resident's appearance and morale."	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, record review and interview, the facility failed to ensure soap was rinsed from all areas during incontinent care to	F 314			

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F 314	Continued From page 3 prevent the potential for skin irritation for 1 (Resident #7) of 9 (Residents #1 through #5 and #7 through #10) case mix residents who received incontinent care. This failed practice had the potential to affect 57 residents who required perineal care for bowel and/or bladder incontinence, as documented on the Resident Census and Conditions of Residents form dated 9/22/08. The findings are: 1. Resident #7 had diagnoses of Hypertension, Depressive Disorder and Glaucoma. The Quarterly Minimum Data Set (MDS) dated 9/11/08 documented the resident had moderately impaired cognitive skills for daily decision making, had total dependence on staff for personal hygiene and was incontinent of bowel and bladder. a. On 9/24/08 at 12:10 p.m., Certified Nursing Assistant (CNA) #7 provided incontinent care for the resident after an episode of urinary incontinence. The CNA prepared a bath basin of warm soapy water; no basin of rinse water was prepared. The CNA wiped the resident's pelvis, groin areas, labia, separated the labia and cleansed and cleansed the rectal area and buttocks with the soapy water. The CNA did not rinse the resident's skin before drying. When asked what was in the basin and the CNA stated, "Warm water, light soap and a little bit of periwash." b. On 9/24/08 at 12:25 p.m., CNA #7 was asked what type soap was used for the resident's pericare. The CNA pointed to the soap dispenser on the wall in the resident's bathroom and stated, "This soap right here." When asked if it was Provon, the CNA stated, "Yes."	F 314		

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F 314	Continued From page 4	F 314			
F 315 SS=D	<p>2. The manufacturer's recommendations for Provon Antimicrobial Foaming Soap, received from the Administrator on 9/25/08 at 8:55 a.m., documented, "Provon Antimicrobial Foaming Soap has to be rinsed with water."</p> <p>483.25(d) URINARY INCONTINENCE</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Base on observation and record review, the facility failed to ensure front to back wiping motions with a clean area of a cloth were used for each cleansing stroke to prevent the potential for urinary tract infections for 1 (Resident #8) of 13 (Residents #1 through #5, #7 through #10, #15, #16, #18 and #22) case mix residents who were incontinent of bowel and/or bladder. This failed practice had the potential to affect 57 residents who were occasionally or frequently incontinent of bladder and 40 residents who were occasionally or frequently incontinent of bowel, according to the Resident Census and Conditions of Residents form dated 9/22/08. The findings are:</p> <p>1. The facility's policy and procedure "Incontinence Care" documented "Procedure...5.</p>	F 315			

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F 315	Continued From page 5 Wash all soiled skin areas, washing from front to back, rinse and dry very well..." 2. Resident #8 had diagnoses of Dementia and Left Above the Knee Amputation. The Significant Change Minimum Data Set (MDS) dated 9/10/08 documented the resident had severely impaired cognitive skills for daily decision making, required total staff performance for hygiene and bathing and was incontinent of bowel and bladder. a. The resident's plan of care dated 9/9/08 documented, "... will be as clean and dry as possible." b. On 9/23/08 at 10:00 a.m., during the resident's bed bath, CNA #5 wiped down the vagina 3 times without turning to a clean area of the cloth; the CNA did not separate the labia for cleansing, wiped up the groin areas 2 times without changing to a clean area of the cloth, and wiped down the rectum 2 times towards the vagina without changing to a clean area of the cloth.	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 and interview, the facility failed to ensure positioning devices were provided to decrease the potential for further decline in	F 318			

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F 318	Continued From page 6 range of motion for 1 (Resident #4) of 6 (Residents #3, #4, #7, #9, #16 and #18) case mix residents with contractures. This failed practice had the potential to affect 20 residents in the facility with contractures, as per the Resident Census and Conditions of Residents form dated 9/22/08. The findings are: Resident #4 had diagnoses of Mental Retardation, Seizure Disorder and Nutritional Deficiency. The Minimum Data Set (MDS) dated 8/27/08 documented the resident had both short/long-term memory problems, was severely impaired in cognitive skills for daily decision making, was totally dependent for activities of daily living and had limitation in range of motion with partial loss of voluntary movement in both arms, hands, legs and feet. a. The Plan of Care dated 9/10/08 documented, "Self Care Deficit: ...Does have limited ROM (range of motion) due to contractures." b. On 9/22/08 at 2:20 p.m., the resident was observed with contractures of both hands. The resident's fingers closed over the thumb on the right hand and the fingers were closed down onto the hand, on the left. There were no positioning devices in place in the resident's contracted hands. c. On 9/22/08, at 5:50 p.m. the resident was sitting in a Geri-chair in the dining room; there were no positioning devices in the resident's contracted hands. d. On 9/24/08 at 7:45 a.m. the resident was sitting in a Geri-chair; there were no positioning devices in the resident's contracted hands to	F 318		

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F 318	Continued From page 7	F 318			
F 322	prevent further contractures.				
SS=D	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 and record review, the facility failed to ensure Physician orders were followed to maintain the head of the bed at 30 degrees to decrease the potential for aspiration for 1 (Resident #3) of 5 (Residents #3, #4, #5, #9 and #10) case mix residents who received tube feedings. This failed practice had the potential to affect 11 residents who received tube feedings, as documented on the Residents Census and Conditions of Residents form dated 9/22/08. The findings are: Resident #3 had diagnoses of Pneumonitis due to Solids/Liquids, Essential Hypertension and Bipolar Affective Disorder. The Medicare 5-Day Minimum Data Set (MDS) dated 9/4/08 documented the resident had severely impaired cognitive skills for daily decision making and had a feeding tube. a. The Physician order dated 4/24/08 documented, "HOB (head of bed) elevated at 30 degrees at all times."	F 322			

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F 322	Continued From page 8 b. The Plan of Care dated 8/17/08 documented on page 2, "Problems/strengths... has a G (gastrostomy)-tube and is at risk for... aspiration. Has dysphagia. Has chronic issues with aspiration. ...Interventions ...HOB elevated at 30 degrees at all times. ...Interventions ...HOB to be elevated 30 degrees due to high risk for aspiration..." c. On 9/23/08 at 6:20 p.m., Certified Nursing Assistant (CNA) #6 and Registered Nurse (RN) #2 were on each side of the resident's bed. CNA #6 lowered the head of the resident's bed flat, while the tube feeding infused. The resident coughed twice.	F 322		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION 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. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure a multi-outlet extension plug was not in use and a call light was without exposed wires for 1 (Resident #7) of 14 (Residents #1 through #11, #15, #16 and #18) case mix residents with room reviews conducted and portable oxygen cylinders were securely stored. This failed practice had the potential to affect all 90 residents in the facility, according to the Resident Census and Conditions of Residents form dated 9/22/08. The findings are:	F 323		

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F 323	Continued From page 9 1. Resident #7 had diagnoses of Hypertension, Depressive Disorder and Glaucoma. The Quarterly Minimum Data Set (MDS) dated 9/11/08 documented the resident had moderately impaired cognitive skills for daily decision making and had total dependence on staff for activities of daily living. a. On 9/22/08 at 3:30 p.m., there was a 6-outlet extension plug in the 2-plug wall outlet located over the dresser; a mini-refrigerator was plugged into the outlet. b. On 9/24/08 at 12:40 p.m., a call-light was clipped to the left shoulder of the resident's shirt. The call-light had an area of exposed wires that was approximately 1/2-inch in length. 2. On 9/23/08 at 2:30 p.m., during environmental rounds on the South Hall, the crash cart was in the storage room. The cart contained 2 unsecured portable (full) oxygen cylinders positioned on their side on the second shelf.	F 323			
F 328 SS=E	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328			

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F 328	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure oxygen cannula nasal prongs were in nares, non-licensed staff did not apply oxygen cannula and contaminated tubing/nasal cannula were not used for 1 (Resident #3) of 4 (Resident #2, #3, #4 and #5) case-mix residents who had oxygen. This failed practice had the potential to affect 7 residents in the facility who had orders for oxygen, as documented by the Director of Nursing on 9/25/08. The findings are:</p> <p>1. Resident #3 had diagnoses of Pneumonitis due to Solids/Liquids, Essential Hypertension and Bipolar Affective Disorder. The Medicare 5-Day Minimum Data Set (MDS) dated 9/4/08 documented the resident had severely impaired cognitive skills for daily decision making and received oxygen therapy.</p> <p>a. The Physician order dated 4/24/08 documented, "...O2 (oxygen) via N/C (nasal cannula) @ (at) 2 L/M (liters per minute) PRN (as needed) to be checked every 2 hours for rate..."</p> <p>b. The Plan of Care dated 8/17/08 documented on page 16, "Problems/strengths ...at risk for oxygen depletion D/T (due to) decreased air exchange R/T (related to) repeated history of aspiration pneumonia.... Interventions... Staff will check oxygen concentrator every shift for proper functioning. ...oxygen via n/c @ 2 L/M to be checked every 2 hours for rate..."</p> <p>c. On 9/22/08 at 12:05 p.m., during initial rounds, the resident had oxygen on at 2 liters per minute</p>	F 328			

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F 328	<p>Continued From page 11</p> <p>by nasal cannula. The cannula nasal prong was in the right nostril only; the other nasal prong was located outside of the resident's nose and against the right side of the resident's face. Registered Nurse (RN) #3 checked the resident's ears, but did not move the oxygen cannula into the resident's nose before leaving the room.</p> <p>d. On 9/22/08 at 3:05 p.m., the resident's oxygen cannula continued to infuse with only one nasal prong in the nose.</p> <p>e. On 9/22/08 at 5:50 p.m., the resident's oxygen nasal cannula was out of the nostrils and on the right side of the face.</p> <p>f. On 9/22/08 at 6:15 p.m., the nasal prongs were on the right side of the resident's face, not in the resident's nose.</p> <p>g. On 9/22/08 at 6:20 p.m., the nasal cannula was out of the resident's nose and were on the right side of the resident's face.</p> <p>h. On 9/24/08 at 7:40 a.m., Certified Nursing Assistant (CNA) #7 and CNA #8 provided care at the resident's bedside. The oxygen cannula was lying on the floor with the oxygen concentrator on at 2 liters per minute.</p> <p>i. On 9/24/08 at 7:50 a.m., CNA #7 picked up the oxygen cannula from the floor and handed it to CNA #8. CNA #8 then placed the oxygen cannula into each of the resident's nostrils. The oxygen tubing and cannula were not changed, prior to being placed in the resident's nose.</p> <p>j. On 9/24/08 at 11:35 a.m., CNA #8 was asked if Certified Nursing Assistants could apply oxygen</p>	F 328			

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F 328	Continued From page 12 to a resident's nose. The CNA stated, "I'm assuming yes, as long as it's not initial set up. We do change their gowns and they may have a cannula and we put it on and off." k. On 9/24/08 at 10:42 a.m., CNA #7 was asked what the facility policy was for oxygen administration by Certified Nursing Assistants; the CNA replied, "Not really sure." l. On 9/25/08 at 11:40 a.m. Licensed Practical Nurse (LPN) #2 was asked if Certified Nursing Assistants could put oxygen cannula on a resident; the LPN stated, "No..." When asked if oxygen cannulas could be used on a resident after the cannula had been on the floor, the LPN stated, "No, they need to be replaced." m. On 9/25/08 at 12:00 p.m., RN #2 was asked if oxygen can be put on residents by the CNA's and the RN stated, "No, I don't think so. They've got to get the nurse." 2. The facility policy for oxygen administration received from the Administrator on 9/24/08 documented, "Basic Responsibility Licensed Nurse..."	F 328			
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the 8:00 a.m. medication pass on 9/23/08 and record review, the facility failed to follow physician's orders to ensure the	F 332			

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F 332	Continued From page 13 medication error rate was less than 5%. Physician orders were not followed for 3 (Residents #12, #13 and #14) of 7 residents observed during the medication pass. Medication errors were made by 2 Licensed Practical Nurses (LPN) (LPN #1 and LPN #2) of 3 nurses who administered medication. This failed practice had the potential to affect 65 residents receiving medications from these nurses, according to Registered Nurse (RN) #1 on 9/23/08. The medication error rate was 5.77% based on administration of 52 medications with observation of a total of 3 errors. The findings are: 1. Resident #12 had a physician order dated 9/16/08 for Gevracon liquid to administer 15 cc (cubic centimeters) three times a day. On 9/23/08 at 8:35 a.m., LPN #1 administered 5 cc Gevracon liquid to the resident. 2. Resident #13 had a physician order dated 10/29/07 for potassium chloride 20 meq (milliEquivalents) to administer 2 tablets daily. On 9/23/08 at 9:00 a.m., LPN #1 administered only 1 potassium chloride tablet to the resident. 3. Resident #14 had a physician order dated 9/5/08 for aspirin 81 mg (milligram) enteric coated. On 9/23/08 at 9:16 a.m., aspirin 81 mg chewable was administered to the resident by LPN #2.	F 332			
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371			

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F 371	<p>Continued From page 14 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food stored in the refrigerator and freezer was sealed or covered to prevent cross contamination or freezer burn, kitchen equipment were clean, meat was thawed in a manner to prevent spoilage, raw peeled vegetables were not thawed in the water with meat to prevent cross contamination, the ice machine was free of debris and the kitchen and dining room were free of pests. This failed practice had the potential to affect 79 residents who received their meal trays from the kitchen, according to the Resident Census and Conditions of Residents form dated 9/22/08. The findings are:</p> <p>1. On 9/22/08 at 11:20 a.m., the following observations made were:</p> <p>a. A bag of diced ham was sitting in cold water, in the food preparation sink, thawing. There were peeled cucumbers to be used in making creamy cucumber salad to be served to the residents at the lunch meal in the same water where the bag of diced ham was left to thaw. Dietary employee #1 was picking up the cucumbers and slicing them in to a pan without washing them out, after they sat in the same water with the bag of ham.</p> <p>b. The can opener, attached at the end of the</p>	F 371			

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F 371	<p>Continued From page 15</p> <p>food preparation counter, had a blackish substance and metal shavings around the blade.</p> <p>c. A pan in the refrigerator contained left over fruit jello; there was foil at the edges of the pan, but the center had no cover on it, exposing the contents to cross contamination.</p> <p>d. A box of shredded coconut was on a shelf in the refrigerator and had been opened and not resealed, exposing the contents. The coconut had yellow food particles in it. When the coconut box was taken out and placed on the utility cart by the steam table, there were three flies crawling at the edges on the box.</p> <p>e. The ice machine panel had slimy, yellowish substance on it. The ice scoop holder had grayish matter at the bottom of it; the ice scoop was resting on the grayish matter.</p> <p>f. A pan that contained bread sticks was in the refrigerator with waxed paper on top of it; the waxed paper did not provide a seal to protect the bread sticks.</p> <p>g. A box of mix vegetables in the freezer had been opened and not covered or resealed.</p> <p>h. There were flies on the serving spoons, tong and inside the sauce pan hanging on the rack above the food preparation counter by the steam table.</p> <p>i. There were gnats crawling on the wall and flying around in the kitchen closet.</p> <p>2. On 9/22/08 at 12:30 p.m., there was a fly crawling at the edge of a pan that contained</p>	F 371			

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F 371	Continued From page 16 cooked broccoli, to be served at the lunch meal. 3. On 9/22/08 at 4:49 p.m., two napkins used to wrap utensils for the residents to be used during meals, had two flies crawling on them. There were three flies crawling on a pole at the end of the steam table. 4. On 9/23/08 at 8:20 a.m., there were two roaches crawling on the floor around the base board in the dining room. 5. On 9/23/08 at 8:24 a.m., there was a roach crawling on the wall in the kitchen closet.	F 371		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure employees washed their hands before and after resident contact to decrease the potential for the spread of infection for 2 (Residents #3 and #10) of 11 (Residents #1 through #11) case-mix residents who received care from facility staff. This failed practice had the potential to affect all 90 residents in the facility, as identified on the Resident Census and Conditions of Residents form dated 9/22/08. The findings are: 1. Resident #3 had diagnoses of Pneumonitis	F 444		

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F 444	<p>Continued From page 17</p> <p>due to Solids/Liquids, Essential Hypertension and Bipolar Affective Disorder. The Medicare 5-Day Minimum Data Set (MDS) dated 9/4/08 documented the resident had severely impaired cognitive skills for daily decision making, had total dependence on staff for activities of daily living and was incontinent of bowel and bladder.</p> <p>a. On 9/22/08 at 6:25 p.m., Certified Nursing Assistant (CNA) #6 and Registered Nurse (RN) #2 provided pericare for the resident, after the resident been incontinent of bowel and bladder. The CNA cleansed the front of the resident's perineum, front to back, changed gloves and turned the resident to the right side, assisted by the RN. The CNA wiped front to back across the rectum to remove soft to liquid bowel movement using periwash on clean cloths and used a clean cloth with each wipe.</p> <p>b. On 9/22/08 at 6:32 p.m., CNA #6 removed the glove from the right hand and placed it in a plastic bag and went into the bathroom and put water on clean washcloths. The CNA then removed a bottle of periwash from the left pocket of her uniform top and sprayed periwash on the cloth. The CNA then stated that she was out of gloves and removed the glove from her left hand, placed it in a plastic bag. She left the resident's room at 6:34 p.m., without washing her hands.</p> <p>c. On 9/22/08 at 6:34 p.m., CNA #6 walked from the resident's room to the clean linen cart, lifted the cart cover and removed a box of gloves; she then returned to the resident's room and placed the glove box on the dresser.</p> <p>d. On 9/22/08 at 6:35 p.m., CNA #6 regloved; the CNA had not washed her hands before putting</p>	F 444			

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F 444	<p>Continued From page 18</p> <p>clean gloves on. She then continued to cleanse bowel movement from the resident's right buttock and rectal area. The CNA dried the resident's skin, changed gloves, dried the resident and then placed a clean brief on, without washing her hands, before regloving. The CNA and RN then placed a clean draw sheet on the resident's bed, repositioned the resident and covered the resident with a sheet. The CNA then removed the soiled linen bag from the room, placed it in a linen hamper, returned to the resident's room, picked up the box of gloves and took them to the nurse's station desk, without washing her hands.</p> <p>2. Resident #10 had diagnoses of Epilepsy, Mental Retardation, Gastrostomy Tube Feeding and Aphagia. The Quarterly Minimum Data Set (MDS) dated 8/22/08 documented the resident had severely impaired cognitive skills for daily decision-making, was totally dependent of staff for all activities of daily living and was incontinent of bowel and bladder.</p> <p>a. On 9/23/08 at 8:40 a.m., after assisting with the mechanical transfer of the resident following an episode of bowel and bladder incontinence from the bed into a shower chair, CNA #1 removed her gloves, left the resident and pushed the Arjo mechanical lift down the hall.</p> <p>b. On 9/23/08 at 8:45 a.m., CNA #1 entered the dining room, pushed another resident, who had been sitting in the hall in a wheel chair, into Resident Room #17, patted the resident's right shoulder and placed the call light around the arm of the resident's wheelchair. The CNA then entered Resident Room #11, came out of the room and went down the hall into the clean linen closet on the South Hall, where the CNA removed</p>	F 444			

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F 444	Continued From page 19 2 clean towels and 2 clean wash cloths from the clean linen supply. The CNA then entered Resident Room #13 and removed clean clothing from the resident's closet, left room and then obtained a clean mechanical lift sling from down the hall. c. On 9/23/08 at 8:55 a.m., CNA #1 pushed the Arjo mechanical lift into Resident Room #17, without washing hands after the removal of gloves. 3. The facility policy titled, "Hand Washing" received on 9/24/08 at 3:30 p.m. documented, "...wash hands before and after resident contact... wash hands when soiled..."	F 444			
F 445 SS=E	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure soiled linens were not placed on the floor and pillows were not used or on resident furniture after being on the floor to decrease the potential for cross contamination for 2 (Residents #3 and #10) of 11 (Residents #1 through #11) case mix residents who received linen changes. This failed practice had the potential to affect all 90 residents in the facility, as documented on the facility's Resident Census and Conditions of Residents form dated 9/22/08. The findings are: 1. Resident #3 had diagnoses of Essential	F 445			

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F 445	<p>Continued From page 20</p> <p>Hypertension, Bipolar Affective Disorder and Glaucoma. The Medicare 5-Day Minimum Data Set (MDS) dated 9/4/08 documented the resident had severely impaired cognitive skills for daily decision-making and was dependent for activities of daily living.</p> <p>a. On 9/22/08 at 6:37 p.m., Certified Nursing Assistant (CNA) #6 and Registered Nurse (RN) #2 had provided personal care to the resident, when 2 pillows fell to the floor on the left side of the resident's bed. The CNA picked up the pillows and placed them in a chair. One pillow had a pillowcase on it and one did not have a cover.</p> <p>b. On 9/22/08 at 6:45 p.m., a pillow fell onto the floor on the right side of the resident's bed. RN #2 picked up the pillow and handed it to the CNA. The RN stated, "This pillow [uncovered pillow] you'll have to take it to the laundry and the other pillow we'll have to get a pillowcase."</p> <p>c. On 9/22/08 at 6:50 p.m., RN #2 reentered the resident's room, picked up the pillows in the chair, put clean pillowcases on the pillows and then placed the pillows under each of the resident's feet. The resident had a gauze dressing on the left foot.</p> <p>d. On 9/23/08 at 8:25 a.m., CNA #9 picked up two pillows covered with pillowcases from the floor and placed the pillows onto the overbed table at the resident's bedside.</p> <p>e. On 9/23/08 at 8:31 a.m., CNA #9 picked the pillows up from the table and placed 1 pillow to the resident's right hip area and then placed the other pillow to the resident's left hip and upper</p>	F 445		

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F 445	<p>Continued From page 21</p> <p>leg. The CNA did not change pillows or pillowcases prior to placing the pillows with the soiled cases next to the resident.</p> <p>f. On 9/24/08 at 7:40 a.m., there was soiled linen on the floor next to the resident's bed, in front of the oxygen concentrator; the linen was not in a plastic bag</p> <p>2. Resident #10 had diagnoses of Epilepsy, Mental Retardation, Gastrostomy Tube Feeding and Aphagia. The Quarterly Minimum Data Set dated 8/22/08 documented the resident had severely impaired cognitive skills for daily decision-making, was totally dependent for all activities of daily living and was incontinent of bowel and bladder.</p> <p>On 9/23/08 at 9:00 a.m., CNA #2 was observed gathering up linens (1 bed sheet and 1 towel) that was on the floor in the resident's room. The CNA placed the soiled linen into a plastic bag.</p> <p>3. On 9/25/08 at 12:00 p.m., RN #2 was asked how soiled linen should be handled and the RN stated, "The linen should be bagged before you leave the room. They should not put the linen on the floor." The RN was asked if pillows and linen that had fallen on the floor should be used on the resident. RN #2 stated, "No. They need to be sent to the laundry and the pillows replaced with clean ones."</p> <p>4. A facility guideline for Laundry and Linen received from the Administrator on 9/24/08 at 3:40 p.m. documented, "The purpose of this procedure is to provide a process for the safe and aseptic handling ...of linen. ...General guidelines ...1. Separate soiled and clean linen at all times.</p>	F 445			

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F 445	Continued From page 22 2. Wash hands after handling soiled linen and before handling clean linen. 3. Consider all soiled linen to be potentially infectious. ...6. Handle soiled linen as little as possible to prevent agitation. ...In Resident Rooms ...2. Handle all soiled linen as though it is potentially infectious. 3. Deposit soiled briefs or underpads in specially designated laundry hampers or waste containers... 6. Wash and dry hands thoroughly after contact with soiled linen..."	F 445		
F 469 SS=E	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the environment was free of pests for 3 (Residents #1, #4 and #7) of 14 (Residents #1 through #11, #15, #16 and #18) case mix residents. This failed practice had the potential to affect all 90 residents, as identified on the Resident Census and Conditions of Residents form dated 9/22/08. The findings are: 1. Resident #1 had diagnoses of Alzheimer's Disease, Benign Hypertensive Heart Disease, Diabetes, Anemia and Chronic Urinary Tract Infections. The Medicare 30-Day Minimum Data Set (MDS) dated 6/28/08 documented the resident had moderately impaired cognitive skills for daily decision-making, required extensive assistance with activities of daily living and was incontinent of bowel and bladder.	F 469		

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

PRINTED: 10/07/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MONTICELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1194 N CHESTER ST MONTICELLO, AR 71655		
(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 469	Continued From page 23 On 9/22/08 at 11:30 a.m., the resident was lying in bed; one fly was observed crawling on the right side of the resident's face and on the resident's bed linen and pillow. The resident did not attempt to swat the fly away. 2. Resident #4 had diagnoses of Mental Retardation, Seizure Disorder and Nutritional Deficiency. The Minimum Data Set (MDS) dated 8/27/08 documented the resident was severely impaired in cognitive skills for daily decision making and was totally dependent for activities for daily living. a. On 9/22/08 at 12:20 p.m., the resident was lying in bed with her eyes closed; there were two flies swarming around the resident's head. b. On 9/22/08 at 5:50 p.m., the resident was in the dining room for supper, being fed per staff. While the resident was eating, there was a fly crawling around in the resident's fruit dessert. There were also flies swarming around in the dining room. c. On 9/23/08 at 12:50 p.m., there were flies on the resident's legs while in the dining room. d. On 9/23/08 at 1:05 p.m., the resident was in the dining room eating; there were flies on the resident's legs and also flying around in the dining room. 3. Resident #7 had diagnoses of Hypertension, Depressive Disorder and Glaucoma. The Quarterly Minimum Data Set (MDS) dated 9/11/08 documented the resident had moderately impaired cognitive skills for daily decision making	F 469			

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F 469	Continued From page 24 and had total dependence on staff for activities of daily living. a. On 9/22/08 at 11:45 a.m., during initial rounds there were flies on the resident's arms and legs and in the resident's room. The resident was wheelchair dependent and had a splint on the left forearm. b. On 9/24/08 at 10:30 a.m., during a resident interview, the resident was asked if the flies had bothered her and she stated, "Yes, they do bother me."	F 469		