

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

PRINTED: 10/12/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045176</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/29/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - MONTICELLO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1194 N CHESTER ST 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 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:</p> <p>Based on observation and record review, the facility failed to ensure privacy was provided during incontinent care for 2 (Resident #2 and 13) of 7 case mix residents (Resident #2, 3, 5, 8, 9, 10 and 13) who were incontinent. This failed</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	<p>Continued From page 1</p> <p>practice had the potential to affect 44 residents who were incontinent according to the Resident Census and Conditions of Residents form dated 9/26/06. The findings are:</p> <p>1. Resident #2 had diagnoses of Stomach Function Disorder, Epilepsy and Aphasia. The MDS (Minimum Data Set) dated 8/23/06 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent for activities of daily living and incontinent.</p> <p>On 9/26/06 at 8:50 a.m., CNA (Certified Nursing Assistant) #4 provided incontinent care. The privacy curtain was pulled loose from 4 pegs that caused the curtain to hang downward from the top and prevented the curtain from closing completely, leaving a 24 inch opening in the curtain next to the door. The resident's bed was next to the door and would have been exposed to anyone who entered the room.</p> <p>2. Resident #13 had a diagnosis of Alzheimer Disease. The MDS dated 8/22/06 documented the resident was severely impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and totally dependent on two persons for personal hygiene.</p> <p>a. On 9/26/06 at 3:25 p.m., CNA #2 and 3 provided incontinent care and did not close the curtain.</p> <p>b. On 9/26/06 at 3:40 p.m., LPN (Licensed Practical Nurse) #2 flushed the resident's feeding tube before and after administering medications. The privacy curtain was not pulled closed.</p>	F 164			

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F 164	Continued From page 2 c. This was a semi-private room and the resident would have been exposed to anyone who entered the room.	F 164		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by:  Based on observation and interview, the facility failed to ensure the floors were clean; window facing was not missing; wall tiles were not missing; paint was not peeling from the walls; the commodes were free of rust and feces and were in good repair; ceiling tiles were free of stains, did not have holes and were properly aligned; the bathroom faucet was not loose; the Sharp container plate was not rusted; bathroom sinks drained properly; linoleum flooring was in good repair; ceiling tile frame was free of rust; smoke detectors were properly secured to the wall,; air vents were not loose; window screens were not torn and soffits were secured to the fascia. These failed practices had the potential to affect all 87 residents. The findings are:  1. On 9/26/06 at 8:30 a.m., the following observations were made:  a. The guest bathroom on the Dementia Unit had a dirt build up approximately 2 to 3 inches on the floor between the sink and the wall.  b. The window by the guest bathroom had a 12 inch strip of window facing missing.	F 253		

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F 253	Continued From page 3  c. The tub room wall on the Dementia Unit was missing 12 small tiles.  d. In Resident Room #43 there was a rust build up approximately 2 inches from the base of the commode, a 1/2 inch build up of dirt around the base board and peeling paint on the blocks in the corner.  e. In Resident Room #39 there was a dirt build up around the door frame in the bathroom and rust approximately 2 inches on the base of the door frame. The commode tank top had chipped areas and peeling paint.  f. On the outside of Resident Room #43 there was a large darkened area approximately 24 inches by 12 inches on the ceiling tile and one tile had 1/2 circle darkened area. The Director of Nursing (DON) stated, "They have had to replace the tile when it comes a hard rain."  g. In Resident Room #52 there was a rust build up approximately 3 to 4 inches on the base of the door frame. There was rust at the base of the commode approximately 1 to 2 inches outward.  i. In Resident Room #42 bathroom the hot water handle was loose and there was a small stream of hot water from this faucet. The maintenance man stated that the hot water was partially turned off. There was a rust build up around the commode approximately 1 to 2 inches.  2. On 9/26/06 at 9:15 a.m., the following observations were made:  a. The East hall handicapped women's bathroom	F 253			

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F 253	<p>Continued From page 4</p> <p>commode lid was loose and had a broken area approximately 5-6 inches with jagged edges on the right corner. There was a dirt build up approximately 1 inch wide around the baseboards.</p> <p>b. The East hall tub/shower room had a build up of dirt on the outer edge of the shower. There was a Sharp container holder with a rusted back plate and a shower chair with a missing wheel laying in the shower stall.</p> <p>c. In the bathroom in Resident Room #58 there was a 2 to 3 inch build up of rust on the base of the door facing, dirt build up around the door facing and base boards approximately 1 to 2 inches and the elevated commode seat had feces on the rim.</p> <p>d. On the outside of Resident Room #58 the ceiling tile was loose and misaligned leaving a one inch gap.</p> <p>e. On the East hall the bed pan room had peeling paint on approximately 10 blocks.</p> <p>3. On 9/26/06 at 9:30 a.m., the following observations were made:</p> <p>a. The bathroom in Resident Room #2 had a 1 inch rust build up around the commode. The sink did not drain properly.</p> <p>b. The ceiling tile outside of Resident Room #7 had a 2 inch hole in the corner.</p> <p>c. The East Hall shower room had approximately 18 inches area of chipped linoleum by the door. There was a 2 to 3 inch rust build up around the</p>	F 253			

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F 253	<p>Continued From page 5</p> <p>base of the door facing and the hinged side of the door had a 3 feet of chipped and jagged area.</p> <p>4. On 9/26/06 at 10:00 a.m., the following observations were made:</p> <p>a. The East Hall in front of the Nursing Station had one grayish colored ceiling tile, one ceiling tile with a cracked area in the corner and one tile with a one inch hole.</p> <p>b. In Resident Room #11 there were 13 cracked floor tiles.</p> <p>c. In the main dining room there was a ceiling tile that was misaligned leaving a gap of one inch and 2 ceiling tiles that had 2 one inch holes.</p> <p>d. Across from the North Hall nursing station the ceiling tiles were cracked, the frame holding the ceiling tile was loose and had rusted areas.</p> <p>e. The North Nursing Station was missing approximately 6 inches of facing around the desk.</p> <p>f. The North Hall smoke detector was loose and hanging down on the left side.</p> <p>g. The North Hall Clean linen room had a plastic bag and 2 plastic bins on the floor. The ceiling tile in the right corner and the air vent was loose. There was ceiling tile debris on the clean linen.</p> <p>5. On 9/26/06 at 10:30 a.m., the following observations were made:</p> <p>a. In an office on the South Hall there was a window screen with a tear approximately 1 1/2 feet in length. The window screen in Resident</p>	F 253			

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F 253	Continued From page 6 Room #52 had 2 holes approximately 4 to 6 inches in diameter.	F 253		
F 312 SS=E	<p>b. The exterior soffitt on the South Hall had fallen off and was laying on the ground.</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:</p> <p>Based on observation and record review, the facility failed to ensure the mons pubis, groin area and buttocks were cleaned and dried for 2 (Residents #2 and 5) of 6 case mix residents (Resident #2, 3, 5, 8, 9 and 10) who were incontinent. The facility failed to ensure nail and hair care was provided for 3 (Residents #2, 4 and #5) of 14 case mix residents (Resident #1 - 10 and 12 - 15) who required assistance with nail care and bathing. These failed practices had the potential to affect 44 residents who were incontinent and 86 residents who were dependent on staff for for bathing according to the Resident Census and Conditions of Residents report dated 9/26/06. The findings are:</p> <p>1. Resident #4 had diagnosis of Diabetes Mellitus. The MDS dated 9/18/06 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent on staff for personal hygiene.</p>	F 312		

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F 312	<p>Continued From page 7</p> <p>On 9/26/06 at 10:45 a.m., 9/27/06 at 9:15 a.m. and 9/28/06 at 1:00 p.m. the resident's fingernails were uneven and were 1/2 centimeter to 1 centimeter in length with jagged sharp edges.</p> <p>2. Resident #2 had diagnoses of Stomach Function Disorder, Epilepsy and Aphasia. The MDS dated 8/23/06 documented the resident was severely impaired in cognitive skills for daily decision making and totally dependent for activities of daily living.</p> <p>a. On 9/26/06 at 8:50 a.m., CNA #1 provided incontinent care. The resident was washed with a wet wash cloth down each groin area and the labia. The mons pubis was not washed. The resident's hair was oily and dirty with a caked-on crusty and flaky substance on the scalp. The resident's hairline near the right ear and around the hairline was red in color.</p> <p>b. On 9/27/06 at 8:15 a.m., the resident's hair was oily and had a caked-on crusty and flaky substance on the scalp. The hairline around the resident's right ear was red in color.</p> <p>3. Resident #5 had diagnoses of Schizophrenic Disorder, Psychosis, Bilateral Leg Amputee, and Cerebrovascular Accident. The MDS dated 8/2/06 documented the resident was severely impaired in cognitive skills for daily decision making and totally dependent for bathing and personal hygiene.</p> <p>a. The Plan of Care updated on 6/19/06 documented, "Resident will be as clean and dry as possible. Resident will receive fingernail care weekly per Lic. (Licensed Nurse).</p>	F 312			

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F 312	Continued From page 8 b. On 9/26/06 at 3:25 p.m., CNA #2 provided incontinent care and did not wash, rinse, or dry the inner groins and the outer buttocks.  c. On 9/25/06 at 1:00 p.m., 3:12 p.m., and 6:00 p.m., the resident's fingernails on the left hand were jagged and had a brown substance under each nail.	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 the facility failed to ensure a pressure relieving device was place in the wheelchair for 1 of 1 case-mix residents (Resident #15) who required a pressure relieving device. This failed practice had the potential to affect 16 residents who required pressure relieving devices in the wheelchairs according to a list provided by the Director of Nurses on 9/29/06. The findings are:  Resident #15 had diagnoses of Alzheimer's Disease, Dementia, and Congestive Heart Failure. The Minimal Data Set (MDS) dated 9/18/06 documented the resident was moderately impaired in cognitive skills for daily decision	F 314			

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F 314	Continued From page 9 making, required pressure relieving device in chair and did not have any pressure ulcers.  a. The Plan of Care updated on 9/18/06 documented resident was at risk for pressure ulcers and to have a cushion pad in w/c (wheelchair) when up.  b. On 9/26/06 at 9:25 a.m. and 9/28/06 at 10:40 a.m., the resident was sitting in the wheelchair and there was no pressure relieving device in place.  c. On 9/29/06 at 8:25 a.m., the Director of Nurses was asked if the resident required a pressure relieving device in the wheelchair and she stated, "Yes".	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 and record review, the facility failed to ensure a back and forth motion and dirty wash cloth were not used during incontinent care for 1 ( Resident #13) of 7 case mix residents (Resident #2, 3, 5, 8, 9 10 and 13)	F 315		

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F 315	Continued From page 10 who were incontinent. This failed practice had the potential to affect 44 residents who were incontinent according to the Resident Census and Conditions of Residents form dated 9/26/06. The findings are:  Resident #13 had a diagnosis of Alzheimer Disease. The Minimum Data Set dated 8/22/06 documented the resident was severely impaired in cognitive skills for daily decision making, incontinent and totally dependent for personal hygiene.  a. On 9/27/06 at 2:45 p.m., Hospice CNA (Certified Nursing Assistant) # 5 performed incontinent care. The CNA cleaned the peri-area with a wash cloth in a back and forth motion and placed the wash cloth back in basin of water. The CNA, using the same wash cloth, cleaned resident's rectal area and bilateral buttocks using a back and forth motion. The CNA rinsed the wash cloth and washed the resident's back.	F 315		
F 323 SS=D	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 cable wiring did not impede ambulation around a commode and screws were flush with the door frames. This failed practice had the potential to affect 14 residents who ambulated and used the safety rails to assist with ambulating on the North hall and 2 resident who resided in Resident Room	F 323		

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F 323	Continued From page 11 #2 according to Director of Nursing on 9/28/06 at 3:30 p.m. The findings are:  1. On 9/26/06 at 9:30 a.m., in the bathroom in Resident Room #2 there was approximately 2 to 2 1/2 feet of television cable coiled in a loop 12 inches above the floor and extending out from the wall on the right side of the commode.  2. On 9/26/06 at 9:40 a.m., the following observations were made:  a. Outside of Resident Room #20 there were 2 screws on each side of the door frame approximately 10 inches above the safety rail. The screws were not flush with the door frame.  b. Outside of Resident Room #26 there were 2 screws on the right side of the door frame approximately 10 inches above the safety rail. The screws were not flush with the door frame.  c. The right side door frame of Resident Room #32 had one screw approximately 16 inches from the safety rail protruding approximately 1/4 inch and 2 screws on the left side of the door approximately 10 inches from the safety rail that protruded from the wall approximately 1/4 inch.  d. On the outside of Resident Room #36 there were 2 screws on the right side of the door frame and one on the left side of the door approximately 10 inches from the safety rail. The screws were rusted and had sharp edges.	F 323			
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE  The facility must store, prepare, distribute, and	F 371			

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F 371	Continued From page 12 serve food under sanitary conditions.  This REQUIREMENT is not met as evidenced by:  Based on observation and interview, the facility failed to ensure food stored in the refrigerator and storage area was sealed to prevent potential cross contamination, the ice machine was free of debris, staff washed hands between tasks, dishes were handled in a sanitary manner and the kitchen was free of pest. These failed practices 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 9/26/06. The findings are:  1. On 9/26/06 at 1:15 p.m., the following observation made were:  a. A box of sausage in the refrigerator was not sealed.  b. A bag of gravy mix in the basket on the shelf in the storage room was not sealed.  c. A box of sugar on the utility cart by the refrigerator was not sealed.  d. The ice machine located in the dining room had wet yellow, dried yellow and whitish substance on the panel. There was a black substance on the panel where the ice shoots down.	F 371			

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F 371	Continued From page 13 2. On 9/27/06 at 9:36 a.m., the following observations made were:  a. There were three roaches crawling on the wall in the janitors's closet. The janitor's closet had strong odor permeating from it. Dietary employee #1 stated, "It stinks there."  b. There was a roach crawling on the wall underneath the three compartment sink.  c. On 9/27/06 at 10:11 a.m., there were two roaches crawling on the wall in the janitors's closet.  d. The floor to the janitors's closet was wet and corroded with brown substance around the edges of the floor.  e. Dietary Employee #2 stated, "We have roaches. When you open the door to the janitors's closet they come out crawling. She stated, the bug man was here last month to spray."  3. On 9/27/06 at 10:20 a.m., Dietary Employee #3 picked up a water hose in the dish machine room and sprayed left over food items from the dishes. She picked up a dish rack, placed dishes in it and pushed it in the dish machine. She pushed the trash can away with her bare hand, then picked up a rag and wiped off the dish machine counter. With out washing her hands she started stacking clean plates and utensils with her hands inside the plates.  4. On 9/27/06 at 12:12 p.m., a roach was crawling on the wall in the janitors's closet.	F 371			
F 441	483.65(a) INFECTION CONTROL	F 441			

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F 441 SS=D	<p>Continued From page 14</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and record, the facility failed to ensure the over-the-bed table was cleaned after removal of 2 basins of water/soap that had been used for incontinent care and bathing. This failed practice had the potential to affect 44 residents who were incontinent and 86 residents who were dependent on staff for for bathing according to the Resident Census and Conditions of Residents report dated 9/26/06. The findings are:</p> <p>Resident #7 had diagnoses of Diabetes Mellitus, Renal Failure and Dementia. The MDS (Minimum Data Set) dated 9/1/06 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent for hygiene/bathing and incontinent care.</p> <p>a. On 9/25/06 at 1:30 p.m., CNA (Certified Nursing Assistant) #1 gave the resident a bed bath and incontinent care. The CNA cleansed</p>	F 441		

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F 441	Continued From page 15 loose brown feces from the resident's buttocks with a soapy wash cloth from 1 basin and rinsing with another washcloth from 2nd basin. The basins were sitting in the over-the bed table. After completing incontinent care, the CNA took the basins of water into the bathroom, emptied them, then took paper towels and wiped off the over-the-bed table where the basins had been setting. The CNA then removed her gloves and washed her hands.	F 441			
F 444 SS=D	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 and record review, the facility failed to ensure nursing staff washed their hands after providing incontinent care and bathing and before applying lotion/ointment and changing bed linen. This failed practice had the potential to affect 44 residents who were incontinent and 86 residents who were dependent on staff for for bathing according to the Resident Census and Conditions of Residents report dated 9/26/06. The findings are:  Resident #7 had diagnoses of Diabetes Mellitus, Renal Failure and Dementia. The MDS (Minimum Data Set) dated 9/1/06 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent for hygiene/bathing and incontinent	F 444			

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F 444	Continued From page 16 care.  a. On 9/25/06 at 1:30 p.m., CNA (Certified Nursing Assistant) #1 gave the resident a bed bath and incontinent care. CNA #1 wore gloves and dried the residents back, then applied lotion. The CNA cleansed loose brown feces from the resident's buttocks with a soapy wash cloth from 1 basin and rinsing with another washcloth from the 2nd basin. After cleansing the feces from the resident the CNA applied Lantiseptic Ointment to the sacral area without changing gloves and washing hands. The CNA removed the soiled linen from under the resident and turned the resident onto her back. Without changing gloves and washing her hands the CNA applied Lantiseptic Ointment to the resident's mons pubis. The CNA continued to wear soiled gloves while placing the soiled linen into a plastic bag, placed clean pillow cases on the pillows, then placed 2 pillows under the resident's feet which had dressings on them. The CNA took the basins of water into the bathroom, emptied them, then took paper towels and wiped off the over-the-bed table where the basins had been setting. The CNA then removed her gloves and washed her hands.	F 444			
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by:  Based on observation, the facility failed to ensure the emergency call light in the shower room on	F 463			

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F 463	Continued From page 17 the East Hall was operational. This failed practice had the potential to affect 2 residents on the East hall that used the shower room according to the Administrator on 9/28/06. The findings are:  On 9/26/06 at 9:10 a.m., the East Hall shower room emergency call light did not sound an alarm or light up and when the cord was pulled the panel partially pulled away from the wall.	F 463			