STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **045450**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/20/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST MARKHAM SUB ACUTE AND REHABILITATION CENTER	**5720 WEST MARKHAM STREET LITTLE ROCK, AR 72205**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0312 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # was substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure shaving and bathing services were consistently provided in order to maintain good grooming and personal hygiene for 1 (Resident #1) of 6 (Residents #1, 2, 4, 7, 8 and 9) case mix residents who resided on the 4th floor and required assistance with bathing and grooming. The failed practice had the potential to affect 40 residents who resided on the 4th floor and required assistance with bathing and grooming, according to a list received from the Administrator on 3/7/14. The findings are: Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 12/13/13 documented the resident scored 8 (8 - 12 indicates moderately impaired) on the Brief Interview for Mental Status, did not reject care and was totally dependent for personal hygiene and bathing. a. The Care Plan initiated on 8/12/13 with a review date of 12/13/13 documented, Focus: (Resident # 1) has an alteration in his ADL (Activities of Daily Living) functions (post) ([MEDICAL CONDITION]) d/t (due to) unattended fall within past 6 months. Interventions: Assist (Resident #1) with showers three times weekly, (as needed) and upon request. b. A Concern form dated 1/10/14 documented, .Receipt of Concern: 1/10/14. Documentation of Concern: .Not shaved .Resolution of Concern: Was patient concern resolved? Yes. Inserviced. Identify the method(s) used to notify the patient and or patient representative of the resolution: .One to one discussion. Date of notification: 1/10/14. The attached Inservice Training Record dated 1/13/14 documented, .(Resident #1). and to be shaved on bath days. c. The February and March 2014 ADL Flow sheets documented the resident received a bed bath on 2/1/14, 2/3/14, 2/5/14, 2/7/14, 2/10/14, 2/12/14, 2/14/14, 2/17/14, 2/21/14, 3/3/14 and 3/5/14. The form documented the bath on 3/5/14 was a bed bath on the 7:00 a.m. to 3:00 p.m. shift, but the entry was not initialed by a CNA. d. On 3/4/14 at 3:53 p.m., during initial rounds and on 3/5/14 at 8:40 a.m., the resident was noted with a moustache and partial beard covering his chin area. His cheeks and neck had whisker stubble approximately 1/8th of an inch long. e. On 3/5/14 at 11:05 a.m., Certified Nurse Assistant (CNA) # 8, who worked on the resident's floor, was asked, How do you know who gets a bath and when? CNA # 8 stated, The even rooms are done today and the odd rooms are done tomorrow. Resident # 1 was in an even numbered room. f. On 3/6/14 at 6:12 a.m., the resident had whisker stubble on his cheeks and neck area. The whiskers were approximately 1/8th to 1/4th of an inch long. g. On 3/6/14 at 11:55 a.m. the resident was asked, Did you get a bed bath or shower yesterday? The resident stated, No. The resident was asked, Do you know when you were shaved last? The resident stated, Three days ago. The resident was asked, Does the 3-day stubble bother you? The resident stated No. h. On 3/6/14 at 2:10 p.m., the resident was in a wheelchair on the 1st floor by the elevators. The resident remained unshaven. i. On 3/7/14 at 8:40 a.m., the resident was lying in bed and remained unshaven. The resident was asked, Did you get a bath yesterday? The resident stated, No. The resident was asked, Did you get shaved yesterday? The resident stated, No. The resident's whisker stubble on his cheeks and neck measured approximately 1/8th to 1/4th inch long. There were no body odors detected. j. On 3/7/14 at 7:09 a.m., CNA # 2, who worked the hall on which (Resident # 1) resided, was asked, Have you helped with a bath or shower for (Resident # 1) this week? CNA # 2 stated, No, I only helped to change him. k. On 3/7/14 at 10:10 a.m., Registered Nurse (RN) #1 was asked to observe the resident (Resident #1) who still had whisker stubble on his cheeks and neck which were approximately 1/8th to 1/4th inch long. RN # 1 was asked, Has he been shaved? RN # 1 stated, No. RN # 1 was asked, Did you see him go to the shower this week? RN # 1 stated, I don't know, let me check my shower book. RN # 1 went to the nurses' station and reviewed the shower book which contained body audit sheets. RN # 1 stated, I don't see a sheet for him from Wednesday (3/5/14). Staff do their own showers, so whoever had him should have done it. What's the problem? This surveyor stated, The ADL book documents a bed bath was done 3/5/14 but the resident states no. RN # 1 stated, I'd believe (Resident # 1), he knows. RN # 1 was asked, Did you turn off or pause his tube feeding pump for a bed bath or shower on Wednesday, 3/5/14? RN # 1 stated, No. l. On 3/7/14 at 10:17 a.m., Licensed Practical Nurse (LPN) # 6, the resident's 7:00 a.m. to 3:00 p.m. charge nurse on Wednesday 3/5/14 was asked, Have you seen (Resident #1) get a shave or bath this week? LPN # 6 stated, I saw (CNA # 8) shave him last week but not this week. I have not seen him get a bath this week and I did not turn his feeding pump off for bathing on Wednesday. m. On 3/7/14 at 10:25 a.m., the Director of Nurses (DON) was asked, Who monitors to ensure bathing is done? The DON stated, There is a policy in place for the nurses to check it off. The DON was asked, Who follows up to make sure the nurses are checking? The DON stated, We have a stand up (meeting) every morning and the concierge is assigned to a group of people (residents) to make rounds and check up on it. The DON was asked, Who does that for the 4th floor? The DON stated, I think (CNA # 9). The DON was asked, Do you check on the nurses to make sure they are monitoring the residents' bathing? The DON stated, I don't know how it's done. I haven't been here that long. Can you ask someone who has been here longer? n. On 3/7/14 at 10:30 a.m., CNA # 9 was asked, Do you do quality rounds on the 4th floor? CNA # 9 stated, Yes, 4th floor short hall even numbered rooms (00 to 12). CNA # 9 was asked, Are there any concerns regarding residents not getting bathed or shaved? CNA # 9 stated, No. CNA # 9 was asked, Do your rounds include grooming for (Resident # 1)? CNA # 9 stated, Yes, but I was told he had a beard and mustache on the mouth and chin area and everything else is to be clean shaven. CNA # 9 was asked, Have you noticed he's not had shave this week? CNA # 9 stated, No, I've been rounding on the other side of the hall this week. CNA # 9 was asked, Who has rounded on (Resident #1's) side of the hall this week? CNA # 9 stated, (CNA # 7), I'll get her for you. o. On 3/7/14 at 11:10 a.m., CNA # 7 was asked, Do you do care keeper, quality rounds? CNA # 7 stated, Yes on assigned rooms. CNA # 7 was asked, Did you round on (Resident # 1) this week? CNA # 7 stated, Yes. CNA # 7 was asked, Has (Resident # 1) been shaved this week? CNA # 7 stated, Tuesday (3/4/14), I helped her. Maybe we didn't get to close. Know he's not had a shower this week. CNA #7 was asked, Who did you help? CNA #7 did not respond. CNA # 7 was asked, Did you know he's not had a shower this week? CNA # 7 stated, No I didn't notice he's not had a shower this week. I asked him if he wants a bath and he says no. I encourage him and then I ask if he wants a bed bath and if he says no, there's nothing I can do. I tell the nurse he's refused. There was no documentation on the ADL Flowsheets for February and March 2014 that the resident had refused a shower or bed bath.
F 0314 **Level of harm -** Actual harm **Residents Affected -** Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaints # and # were substantiated (all or in part) with these findings: Based on observation, record review and interview, the facility failed to ensure necessary treatment and services were provided to prevent deterioration and promote healing of pressure ulcers for Residents #1, #2 and #3. The facility failed to ensure clean technique was maintained during wound care to prevent potential infection 2 (Resident #s 1 and 3) of 4 (Resident #s 1, 2, 3, and 4) case

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 0314 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 1) mix residents who had physician orders for pressure ulcer treatments; The facility failed to ensure pressure ulcer treatments were provided as ordered by the physician to promote healing for 1 (Resident # 1) of 4 (Resident #s 1, 2, 3, and 4) case mix residents who had physician orders for pressure ulcer treatments; The facility failed to ensure dressings and positioning devices were applied properly to avoid causing increased pressure to the wound bed of an existing pressure ulcer, which could result in deterioration or delayed healing for 1 (Resident # 1) of 4 (Resident #s 1, 2, 3, and 4) case mix residents who had pressure ulcers. The facility failed to ensure specialty mattress coverings/sheets were used in accordance with the manufacturer's instructions to prevent unnecessary shearing/friction that could result in impaired skin integrity and increased risk for pressure ulcer development for 1 (Resident # 1) of 2 (Resident #s 1 and 3) case mix residents who had pressure ulcers and were on specialty beds. The facility failed to ensure the appropriate type of mattress was provided to decrease pressure for 1 (Residents # 2) of 3 (Resident #s 1, 2 and 3) case mix residents who had Stage III, Stage IV or unstageable pressure ulcers. The facility failed to ensure pressure ulcers were reassessed to include staging, measurements and wound description weekly and that the assessments were documented to assure prompt identification of any deterioration or failure to heal to prevent delays in changes to treatment for 3 (Resident #s 1, 2 and 3) of 4 (Resident #s 1, 2, 3, and 4) case mix residents who had pressure ulcers These failed practices resulted in a pattern of actual harm for Resident #1 who developed multiple pressure sores, Resident #2, whose pressure sore deteriorated, and Resident #3 who developed a Stage IV pressure sore. The failed practices also had the potential to cause more than minimal harm for 11 residents who had physician orders for pressure ulcer treatments, including 6 residents who had Stage III, Stage IV and/or unstageable pressure ulcers, according to lists received from the Administrator on 3/7/14. The findings are: 1. The facility's policy titled Pressure Sore Prevention ABCs - Quick Look documented, .Pressure relieving. Evaluate for pressure relieving mattress. Use pressure redistribution device/positioning device. Manage urinary/fecal incontinence - clean and protect every 1 - 2 hours. Keep resident dry at all times. 2. On 3/7/14 at 3:05 p.m., the Nurse Consultant provided the following, from Best Practices Evidence-Based Nursing Procedures. 2nd edition (ed.) Lippincott Williams & Wilkins, 2007, pages 527-529, as the facility policy on wound care for pressure ulcers: Pressure ulcer care. Successful pressure ulcer treatment involves relieving pressure. Although many systems have been developed to help classify or 'stage' wounds, the system that the Agency for Healthcare Research and Quality the Wound, Ostomy and Continence Nurses Society (WOCN) recommend is a four-stage system based on the tissue layers involved . Treatment includes methods to decrease pressure. Treatment may involve special pressure-reducing devices, such as beds, mattresses. Other therapeutic measures include decreasing risk factors and use of topical treatments, wound cleansing, debridement, and the use of dressings to support moist wound healing. The WOCN suggests using clean gloves for wound cleaning and routine dressing changes. Nurses usually perform or coordinate treatments, according to facility policy. The procedures detailed below address cleaning and dressing the pressure ulcer. Equipment: .piston irrigating system. Implementation: .Before a dressing change, wash your hands. Cleaning the pressure ulcer. Position the patient to increase his comfort, but make sure his position allows easy access to the pressure ulcer site. Open the normal saline solution container and the piston syringe. Carefully pour normal saline solution into an irrigation container to avoid splashing. Put on gloves to remove the old dressing and expose the pressure ulcer. Discard the soiled dressing. Inspect the wound. Measure the wound perimeter with the disposable wound-measuring device. Using the piston syringe, apply full force to irrigate the pressure ulcer to remove necrotic debris. Remove and discard your soiled gloves and put on fresh pair. Insert sterile cotton swab into the wound to assess wound tunneling or undermining . Prepare to apply the appropriate topical dressing . Assessing pressure ulcers (page 528) . Keep in mind that if the wound contains necrotic tissue, you won't be able to determine the stage until you can see the wound base. 3. Resident #1 had [DIAGNOSES REDACTED]. The Admission Data Collection Form dated 8/12/13 documented the resident had an open area above the left outer ankle and redness to the inner left foot at the great toe area. The Risk for Pressure Ulcer form documented a total score of 15, with a score of 13 to 14 indicating a moderate risk for pressure ulcer development. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/13/13 documented the resident scored 8 (8 - 12 indicates moderately impaired) on the Brief Interview for Mental Status, was totally dependent for bed mobility and toilet use, was always incontinent of urine and bowel, was at risk for pressure ulcers, had one or more unhealed pressure ulcers, had 2 Stage 1 pressure ulcers, had 1 Stage 2 pressure ulcer, had 1 Stage 3 pressure ulcer that was 2.5 cm (centimeters) in length, 0.3 cm in width, and 0.2 cm deep, had 1 worsening Stage 2 and 1 worsening Stage 3 pressure ulcers, and no venous and arterial ulcers. a. The Care Plan dated as initiated on 8/12/13 and updated on 2/28/14 documented, (Resident # 1) has an alteration in his skin integrity (due to) presence of a Stage 2 pressure ulcer to his (left) outer ankle on admit (post) [MEDICAL CONDITION] needs extensive to total assist with bed mobility, toileting. (incontinent) of bowel and bladder. (2/7/14) to wound clinic care for (evaluation and (prescription)/order. (2/11/14) Now cleaning all wounds (with) 1/4th (strength) Dakin's (solution) applying (nickel) size thickness (Santyl) (cover) (with) moist dressing (and) dry dressing/Kerlix. 2/14/13 Prostat. 2/28/14 (Resident) (with) Pressure sores - heels, feet, sacrum . Interventions: 1. Turn (every) 2 (hours) side to side. (Note) family refuses back. 2. (Elevate) feet on pillows so no area that has (dressing) touches bed. Air mattress. b. The February 2014 Physician Orders documented, Start Date: 1/29/14 .Glucerna 1.5 (cubic centimeters) per PEG (percutaneous endoscopic gastrostomy) via continuous pump at 60 ml/hr (milliliters per hour) .Anorexia . c. Measurements of the pressure ulcer to the resident's coccyx and interventions were documented in various parts of the clinical record as follows: 1) Care Plan: 10/13/13: coccyx 3.0 x (by) 3.0 by 0.2. 10/17/13: Hospital. 10/21/13: coccyx: 4.5 x 3.0 x 0.3 (IV (Stage 4)) (deteriorated) while (at) (hospital). 2) The wound clinic Patient Wound Care Order Sheet and Wound Care Skin Integrity Evaluation sheets documented wound care from 11/8/13 thru 12/4/13. The Wound assessment dated [DATE] documented, .Coccyx .Full Thickness .Pressure Ulcer Stage III . Length x (by) Width: 2.40 X 0.80 . Depth: (less than) .020 .100% granulation . The Pressure Ulcer Record documented weekly wound measurements from 12/2/13 through 12/23/13. The 12/23/13 measurements were documented as, .Length x (by) Width: 4.5 x 2.8. Depth: UTD (unable to determine). 3) Care Plan: Measurements and stages were noted weekly on the care plan until 1/30/14. The 1/30/14 coccyx wound measurement was documented as 1.4 x 3.0 x (less than) 0.2 4) Physician ' s orders dated 2/7/14 documented, To wound clinic care for evaluation of wounds . On 3/6/14 at 2:30 p.m. the Administrator was asked to provide wound clinic documentation and measurements for Resident #1. As of 3/7/14 at 4:30 p.m. on exit, no additional wound clinic documentation other than records dated 11/18/13 and 12/4/13, which were located in the clinical record, were received. 5) Physician ' s Orders dated 2/11/14 documented, .Vitamin C 500 mg (milligrams) qd (every day) per tube. Zinc 220 mg qd x (times) 2 wks (weeks) per tube . Physician ' s Orders dated 2/14/14 documented, Prostat (protein supplement) 30 cc (cubic centimeters) Bid (twice daily) per tube. Dx (diagnosis) [MEDICATION NAME]. Physician ' s Orders dated 2/21/14 documented, .Foley cath (urinary catheter) to BSD (bedside drainage) . 6) The Pressure Ulcer Record dated 3/4/14 documented, .Stage: Unstageable. Length x Width: 2.0 x 0.6. Depth: UTD. 90% slough, 10% granulation. 7) Physician Orders dated 3/6/14 increased the Glucerna 1.5 (cubic centimeters) per PEG from 60 cc to 65 cc. d. The following measurements were documented in various sections of the clinical record for the left 5th metatarsal: 1) Care Plan: 1/30/14: (left) 5th metatarsal 0.3 x 0.3 x (less than) 0.2. There was no stage specified. 2) The Pressure Ulcer Record documented wound measurements beginning 1/27/14 through 2/4/14. The 2/4/14 measurements were documented as, Resolved. e. The following measurements were documented for the pressure ulcer proximal to the left 5th toe: 1) Care Plan: 1/30/14: Proximal (left) 5th toe 0.4 x 0.4 x (less than) 0.2. There was no stage specified. 2) The Pressure Ulcer Record documented wound measurements beginning 1/27/14 through 2/17/14. The 2/17/14 measurements were documented as, .Length x Width: 0.3 x 0.3. Depth: (less than) 0.2. 3) The Pressure Ulcer Record dated 3/6/14 documented, .Stage: II. Length x Width: 0.4 x 0.2 Depth: 0. f. The following measurements were documented for the left foot: 1) Care Plan: 1/30/14: (Left) foot 2.0 x 2.0 x (less than) 0.2. There was no stage specified. 2) There were no other measurements available for review regarding this pressure ulcer. g. The following measurements were documented for the pressure ulcer on the right lateral edge of foot: 1) Care Plan: 1/30/14: Proximal (right) toe 0.6 x 0.4 x (less than) 0.2. There was no stage specified. 2) The Pressure Ulcer Record dated 3/4/14 documented, .Stage: Unstageable. Length x Width: 1.0 x 1.0 Depth: UTD . 100% slough . Santyl. h. The following measurements were documented for the pressure ulcer on the right great toe: The Pressure Ulcer Record dated 3/4/14 documented, .Stage: Unstageable. Length x Width: 0.7 x 0.8 Depth: UTD. Reabsorbed blood blister. i. The following measurements were documented for the pressure ulcer proximal to the right 5th toe: 1) Care Plan: 1/30/14: (Right) 5th (metatarsal) 0.4 x 0.4 x (less than) 0.2. There was no stage specified. 2) The Pressure Ulcer Record documented wound measurements beginning 12/9/13 through 2/17/14. The 2/17/14 measurements were documented as .Length x Width: 0.4 x 0.8. Depth: UTD. SDTI (Suspect Deep Tissue Injury). j. The following measurements were documented for the pressure ulcer proximal to the right 5th toe: The Pressure Ulcer Record documented wound measurements beginning 1/27/14 through 2/17/14.

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 2) The 2/17/14 measurements were documented as, .Stage: SDTI. Length x Width: 2.0 x 2.0 . Depth: UTD. There were no further measurements available for review for this pressure ulcer, as of 3/7/14 at 4:30 p.m. During wound care observations on 3/5/14, there were two wounds to the right lateral foot; one was just below the small toe and the other was mid lateral foot. k. The following measurements were documented for the pressure ulcer on the right medial heel: The Pressure Ulcer Record dated 3/4/14 documented, .Stage: Unstageable. Length x Width: 2.1 x 1.7 Depth: UTD. 100% re-absorbing blood blister. l. The following measurements were documented for the right inner ankle: 1) Care Plan: 1/30/14: (Right) ankle 0.6 x 1.0 x UTD. There was no stage specified. 2) The Pressure Ulcer Record documented wound measurements beginning 1/6/14 through 2/17/14. The 2/17/14 measurements were documented as, .Length x Width: 0.8 x 0.7. Depth: UTD. SDTI. 3) The Pressure Ulcer Record dated 3/4/14 documented, .Stage: Unstageable. Length x Width: 0.5 x 1.0 Depth: UTD . 100% Slough. Santyl. m. The clinical record (Physician Orders, Care Plan, Wound Clinic Evaluations, and Pressure Ulcer records) was reviewed on 3/5/14 and there were documented changes in wound care orders on 10/21/13, 10/23/13, 1/3/14, 1/27/14, 2/11/14, 2/25/14 and 3/4/14. n. On 3/5/14 at 9:05 a.m. Restorative Nurses Assistant (RNA) # 1, Certified Nurses Assistants (CNAs) # 7 and # 8 were present in the room. RNA # 1 was completing passive range of motion. The resident had dressings on his bilateral feet dated 3/4/14. The dressings were not covering the resident's bilateral inner ankle wounds. The wounds were covered with gauze wrapped in a figure 8 around the ankles and foot. The left inner ankle had gauze and 4 x (by) 4 dressings that were soiled with bright red serous drainage approximately 1/2 centimeter long and 3 centimeters wide. Serous red drainage was noted on the pillow case, which RNA # 1 removed from between the resident's legs. The wound on the inner left ankle was approximately the size of a quarter with slough/eschar covering part of the wound bed. A small amount of blood was noted in the wound bed. The right inner ankle wound was approximately the size of a dime with a scab/slough/eschar covering the wound bed. The peri wound area was red. There was a purple area approximately the size of a half dollar on the right inner heel area. RNA # 1 and CNAs # 7 and 8 positioned the resident using a foam wedge and 2 pillows between the posterior thighs and calves. The resident's heels were off the bed. RNA # 1 and CNAs # 7 and 8 put a pillow between the resident ' s legs that extended above the resident's knees and past the resident's ankles and heels. The resident was then turned onto the left side with his inner ankles at the same area, covered by and resting on the pillow that was between his legs. The resident was on a DermaFloat LAL (Low Air Loss) mattress. There was a flannel blanket folded into fourths noted under the resident from the mid back/flank area to the mid thigh area. The User-Service Manual for the DermaFloat LAL mattress documented, .Recommended Linen: Special linens are not necessary for the DermaFloat LAL. There is no need for a bottom sheet as the therapy pad should be covering the therapy cells at all times. Based upon the resident specific needs, the following linens may be utilized: Draw or slide sheet to aid in positioning and to further minimize friction and shearing . Keep the amount of padding between the resident and bed to a minimum for optimum performance. o. On 3/5/14 at 11:15 a.m., CNAs # 2, #7 and # 8 went into the resident's room with incontinent supplies. The CNAs removed the top covers and the resident was lying on a flannel bath blanket folded into fourths. The resident was positioned on his back and CNA # 8 provided incontinent care after the resident's brief was lowered on the front. CNA # 8 left the room to get the resident's Charge Nurse. The Charge Nurse, Licensed Practical Nurse (LPN) # 6 entered the room and paused the tube feeding pump. The head of the bed was lowered. The resident was turned back onto his left side and the brief was opened on the back. The resident was incontinent of stool. CNA # 8 wiped the stool upward toward the dressing but stopped prior to the edge of the dressing on the coccyx. The lower edge of the dressing was loose and there was a brown substance noted on the outside and inside edges of the dressing. LPN # 6 stated I need to get the Treatment Nurse in to change the dressing, it's coming off. LPN # 6 sent CNA # 8 to get the Treatment Nurse. CNA # 8 removed the soiled dressing and completed incontinent care. A clean brief and draw sheet were placed under the resident. p. On 3/5/14 at 11:30 a.m., Treatment Nurses # 1 and # 3 entered the resident's room. Treatment Nurse # 1 cleaned the wound with a 4 x 4 sprayed with wound cleanser and repeatedly patted the coccyx wound with the same area of the 4 x 4. Treatment Nurse # 1 dried the wound with a dry 4 x 4 in the same manner as it was cleaned. Treatment Nurse # 1 noted the dressings on the resident's feet were not covering the wounds. Treatment Nurse # 1 stated, I need to do wound care to his feet. After removing her gloves and picking up trash, Treatment Nurse # 1 washed her hands, picked up the tray used as a clean field and went to the treatment cart. At 12:11 p.m., Treatment Nurse # 1 placed a new paper towel on the tray used for a clean field. Treatment Nurse # 1 placed a medication cup with Santyl ointment, multiple dry 4 x 4's, multiple packets of q-tips, a cup with 4 x 4 over which Dakins 0.25% (1/4th) strength was poured. Treatment Nurse # 1 was wearing a spiral plastic bracelet with a key attached to the bracelet on her left wrist. As Treatment Nurse # 1 set up the supplies the key rubbed across the top of the TARs (Treatment Administration Record), the treatment cart, and against her uniform top. Treatment Nurse # 1 placed multiple packets of skin prep, 2 rolls of gauze and 1 packet of Duoderm Signal on the clean field. Treatment Nurse # 1 entered the resident's room and placed the tray on the resident's over bed table, then washed her hands. Treatment Nurse # 1 put gloves on and removed scissors from the right hand pocket on her uniform top. At 12:22 p.m., Treatment Nurse # 1 partially cut the dressing on the resident's right foot with the scissors. Treatment Nurse # 1 laid the scissors on the foot of the resident's bed and attempted to remove the dressing. Treatment Nurse # 1 partially cut the dressing 3 more times (total of 4 cuts), placing the scissors on the resident's bed after each partial cut and attempting to remove the dressing. After the fourth partial cut, Treatment Nurse # 1 was able to remove the dressing on the resident's right foot. At 12:25 p.m., Treatment Nurse # 1 cut the dressing on the left foot. As Treatment Nurse # 1 was cutting the dressing, the key on the spiral bracelet on her left wrist was rubbing against the resident's left shin area. Treatment Nurse # 1 removed the dressing from the left foot, laid the scissors on the paper on top of the bedside table and changed her gloves. At 12:30 p.m., Treatment Nurse # 1 measured all of the resident's wounds using a new measuring tape with each wound. The proximal wound on the lateral right foot was measured as 1.0 x 1.0 centimeters. Treatment Nurse # 1 stated this wound was Unstageable. The distal wound of the lateral right foot by the toe was measured as 2.0 x 2.0 centimeters. Treatment Nurse # 1 stated this wound was Unstageable. The wound by the great toe on the left foot was measured as 2.0 x 2.5 centimeters. The wound on the left inner ankle was measured as 2.0 x 2.0 centimeters. The wound on the inner right ankle was measured as 1.0 x 1.0 centimeters. The purple area on the inner right heel area was measured as 2.0 x 2.0 centimeters. Treatment Nurse # 1 changed gloves, held the Treatment Administration Records (TARs) in her hands and reviewed the ordered treatments. Treatment Nurse # 1 used a 4 x 4 with Dakin's solution on it to clean the distal wound on the right lateral foot wearing the same gloves she had on while holding the TARs. Treatment Nurse # 1 patted the wound repeatedly using the same area of the 4 x 4. Treatment Nurse # 1 cleaned the distal wound on the right lateral foot again with another 4 x 4 with Dakin's solution, again patting the wound bed repeatedly using the same area of the 4 x 4. Treatment Nurse # 1 patted the wounds dry with a different 4 x 4 for each wound in the same manner that she cleaned the wounds. Treatment Nurse # 1 used a q-tip to get Santyl from the medicine cup, then applied Santyl to the wound bed to the distal wound on the right lateral foot. Treatment Nurse # 1 used the same q-tip to get more Santyl from the medicine cup (possible cross contamination of Santyl) and applied Santyl to wound bed of the proximal wound on the right lateral foot. Treatment Nurse # 1 changed gloves, used a 4 x 4 with Dakin's solution to clean the right inner ankle wound. Treatment Nurse # 1 held the resident's right leg up off the mattress with her left hand and cleaned the wound on the inner right ankle. As Treatment Nurse # 1 was holding the leg up, the key on the spiral bracelet on her left wrist was touching the wound on the inner left ankle. Treatment Nurse # 1 patted the wound with the 4 x 4 with Dakin's solution repeatedly with the same area of the 4 x 4. Treatment Nurse # 1 laid the resident ' s right leg down and the area that was just cleaned was against the mattress. Treatment Nurse # 1 picked the right leg back up and patted the wound with a dry 4 x 4 repeatedly using the same area of the 4 x 4. Treatment Nurse # 1 laid the leg back down with the wound on the right inner ankle touching the mattress. Treatment Nurse # 1 used a clean q-tip to get Santyl from the contaminated medicine cup, lifted the right leg up and applied Santyl to the wound bed. Treatment Nurse # 1 laid the right leg down with the wound on the inner right ankle against the mattress. Treatment Nurse # 1 folded three 4 x 4's into fourths and placed a 4 x 4 on the wounds on the right lateral foot. Treatment Nurse # 2 then held the 4 x 4's in place as Treatment Nurse # 1 put a folded 4 x 4 on the right inner ankle wound and wrapped the foot with gauze. Using a folded 4 x 4, instead of a flat 4x4 over a larger surface area could potentially cause increased pressure to the wound bed. Both Treatment Nurses changed gloves. Treatment Nurse # 1 applied tape to the dressing on the right foot and dated the dressing. Treatment Nurse # 1 changed gloves and used 4 x 4 with Dakin's solution to clean the wound on the right foot by the great toe area. Treatment Nurse # 1 patted the wound repeatedly using the same area of the 4 x 4. Treatment Nurse # 1 used a dry 4 x 4 to dry the wound by repeatedly patting with the same area of the 4 x 4. Treatment Nurse # 1 opened a q-tip, removed Santyl from the contaminated medicine cup and applied the Santyl to the wound bed. Treatment Nurse # 1 used a 4 x 4 with Dakin's solution to clean the left inner ankle wound by repeatedly patting the wound bed with the same area of the 4 x 4.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **045450**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/20/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST MARKHAM SUB ACUTE AND REHABILITATION CENTER	**5720 WEST MARKHAM STREET LITTLE ROCK, AR 72205**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0314 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 3) Treatment Nurse # 1 patted the inner left ankle wound dry with a 4 x 4, patting repeatedly with the same area of the 4 x 4. Treatment Nurse # 1 used a clean q-tip to get Santyl from the contaminated medicine cup and applied the Santyl to the wound bed on the inner left ankle. Treatment Nurse # 1 folded two 4 x 4s into fourths and put the folded 4 x 4 onto each wound on the right foot. Treatment Nurse # 1 wrapped the foot with gauze in a figure 8 wrap using multiple layers over the ankle area to hold the folded 4 x 4 onto the wound bed. Treatment Nurse # 1 applied 3 pieces of tape across the ankle area covering the gauze and extending onto the skin surrounding the ankle to hold it in place. Treatment Nurse # 1 removed her gloves. Treatment Nurse # 1 wore the same gloves throughout the wound care of both wounds on the right foot. At 1:00 p.m., this surveyor left the room. Treatment Nurse # 1 did not use the Duoderm that was set up on the clean field. Treatment Nurse # 1 failed to follow the orders for wound care on the lateral left 5th toe area, the right heel, the top of the left foot, the inner left ankle, and the inner right ankle. 1) Physician orders dated 3/4/14 documented (1). Cleanse wound to (right) foot (with) wound cleanser, pat dry. Apply Santyl to wounds. Cover (with) dry (dressing), secure (with) roll gauze (and) tape. (Change) daily. 2. Cleanse wound to (left) foot (with) (wound cleanser), pat dry. Apply Santyl to wounds. Cover (with) dry (dressing), secure (with) roll gauze (and) tape. Change daily. 3. Cleanse sacral wound (with) (wound cleanser). Apply [MEDICATION NAME] (dressings) to cover, (change) (every) 72 (hours). Physician Orders dated 2/25/14 documented, .(change) tx (treatment) order to L (left) inner ankle to cleanse L inner ankle (with) ? strength dakins apply Santyl (and) Calcium AG (silver) dsg (dressing) cover (with) dry dsg QOD (every other day) (and) prn (as necessary) .NO (new order) Apply skin prep to blister lateral L 5th toe area (and) cover (with) duoderm for protection Q (every) 3 days (and) prn . The March TAR did not document the physician orders dated 3/4/14. The March TAR was copied on 3/5/14 at 4:20 p.m. Treatment Nurse # 1 had not initialed the treatments that were observed from 11:30 a.m. to 1:00 p.m. 2) On 3/7/14 at 11: 20 a.m. Treatment Nurse # 1 was asked, Should open wounds touch the bedding? Treatment Nurse # 1 stated Never. The whole problem is with the aides not keeping him turned and his feet off the bed. He is not positioned like he should be, even after inservices. Treatment Nurse # 1 was asked, What should happen if wounds touch the bedding, etc.? Treatment Nurse # 1 stated, It should be recleaned. Treatment Nurse # 1 was asked Did anyone notify you the resident's wounds were exposed 3/5/14 at 8:40 a.m.? Treatment Nurse # 1 stated, No. Treatment Nurse # 1 was asked, What if the wound with Santyl touches the bed? Treatment Nurse # 1 stated, Reclean and reapply. Treatment Nurse # 1 was asked, If you fold a 4 x 4 into fourths, place it on the wound, and wrap it with gauze what would it cause to the wound bed? Treatment Nurse # 1 stated, Causes more pressure. Treatment Nurse # 1 was asked, Why did you fold the 4 x 4s on (Resident # 1's) wounds? Treatment Nurse # 1 stated, That's what the other lady did. Treatment Nurse # 1 was asked, Who? Treatment Nurse # 1 stated (Wound Care Specialist). Treatment Nurse # 1 was asked, Did you realize the inner right ankle touched the bed during wound care on 3/5/14? Treatment Nurse # 1 stated, No. Treatment Nurse # 1 was asked, What do you think is going on with (Resident # 1's) feet? Treatment Nurse # 1 stated, I think he's never positioned like he should be because every time I go in there his feet aren't floated as ordered. Treatment Nurse # 1 was asked, Have you seen the wound care orders dated 3/4/14 on (Resident # 1)? Treatment Nurse # 1 stated, Yes, I wrote it. Treatment Nurse # 1 was asked, What happened to this on the TAR, it's not there? Treatment Nurse # 1 stated, I wrote it on the TAR, a blank one. I don't know what happened to that one. Treatment Nurse # 1 was asked, Did you see the orders on the TAR for the blisters on his feet? Treatment Nurse # 1 stated, Yes, but (Wound Care Specialist) that comes here specifically told me not to do that. Treatment Nurse # 1 was asked, Did you put Calcium Silver dressing on the inner ankle? Treatment Nurse # 1 stated No. Treatment Nurse # 1 was asked, Whose responsibility is it to ensure the physician orders for wound care get transcribed to the TAR? Treatment Nurse # 1 stated, Mine, if I take it, but I'm sure I did it with (Wound Care Specialist) here and things are a mess, so I can hardly find the TAR books. Treatment Nurse # 1 was asked, On the right foot of (Resident #1), he has multiple wounds, did you know you went from wound to wound with the same cleaning sponge? Treatment Nurse # 1 stated, No. Treatment Nurse # 1 was asked, What happens when you go from one wound to the other wound like that? Treatment Nurse # 1 stated, It transfers microorganisms and increases the risk of infection. Treatment Nurse # 1 was asked, When should you change gloves during wound care? Treatment Nurse # 1 stated, When entering, after removing dirty dressing, at each change of wound site and after care complete. Treatment Nurse # 1 was asked, Did you realize you failed to change gloves at all during wound care to the right foot on (Resident # 1)? Treatment Nurse # 1 stated, No. Treatment Nurse # 1 was asked, Tell me about the scissors you used. Treatment Nurse # 1 stated, Should be cleaned before and after use. Treatment Nurse # 1 was asked, Where should they be placed during use? Treatment Nurse # 1 stated, Somewhere away from other residents in a safe place. Treatment Nurse # 1 was asked, When they were used in wound care on 3/5/14, you laid them in the bed. Where should they have been? Treatment Nurse # 1 stated, On a clean surface. Treatment Nurse # 1 was asked, How much training have you had for wound care? Treatment Nurse # 1 stated, Not much; I've been here 6 weeks. (Wound Care Specialist) has spent some time with me; 3 or 4 times, and she stays maybe 4 hours at the most. 4. Resident # 2 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/20/14 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment of Mental Status,was totally dependent for bed mobility, had no indwelling catheter, was always incontinent for urinary and bowel continence, was at risk for pressure ulcers, had one Stage 3 pressure ulcer with a length of 4.0 cm (centimeters), a width of 3.5 cm and a depth of 2.0 cm with the most severe tissue type of slough present in the ulcer bed. a. The care plan initiated on 1/23/14 documented Focus: (Resident # 2) is at risk for skin breakdown and pressure ulcers (related to) incontinence, decrease mobility . Interventions: . Provide/monitor effectiveness of pressure relieving or reduction device(s): Pressure reduction mattress to bed . Focus: (Resident # 2) is incontinent of bladder (related to) needed assistance with mobility, unsteady gait and transfers . Interventions: .Check her every two hours and provide incontinent care as needed. b. The Pressure Ulcer Record dated 2/17/14 indicated a pressure ulcer on the coccyx (x drawn on coccyx area of the body diagram) and documented Date First Observed: 2/17/14 on admission coccyx. Stage III. Size: 2.0 x (by) 1.5 x 2.8 (Length x Width x Depth) Date: 2/17/14. readmitted . c. A physician order dated 3/4/14 documented, 1. (Discontinue previous border to sacral wound. 2. Cleanse sacral wound per protocol, pat dry, apply Santyl moistened (with) 4 x (by) 4's, cover (with) dry (dressing), (change) daily. d. The Pressure Ulcer Record dated 3/4/14 indicated a pressure ulcer on the coccyx (x drawn on coccyx area of the body diagram) and documented Date: 3/4/14. Stage: Unstageable. Length x (by) Width: 3 x 2.5. Depth: UTD (Unable To Determine) . 90% slough/10% hypogranulation. There were no other measurements documented other than the 2/17/14 measurements and the 3/4/14 measurements. e. On 3/4/14 at 4:15 p.m., the resident was not on a specialty mattress. On 3/5/14 at 8:35 a.m., 9:55 a.m., 10:30 a.m., 11:18 a.m., 1:00 p.m., 3:10 p.m. 4:45 p.m. and 6:05 p.m. and on 3/6/14 at 4:58 a.m., 7:25 a.m., 9:40 a.m., 12:05 p
F 0322 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Give proper treatment to residents with feeding tubes to prevent problems (such as aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers) and help restore eating skills, if possible.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # was substantiated (all or in part) in these findings: Based on observation, record review and interview, the facility failed to ensure gastrostomy tube flushes were administered per physician orders [REDACTED].# 1, 2, 3, and 9) case mix residents with physician ordered flushes. The facility failed to ensure medications were crushed and dissolved prior to attempting to administer medications via a gastrostomy tube to prevent potential occlusion of the tube for 2 (Residents #3 and 9) of 4 (Residents # 1, 2, 3, and 9) case mix residents who received medications via gastrostomy tubes. The facility failed to ensure correct placement of the gastrostomy tube was verified prior to administering medications through the tube, to prevent potential aspiration for 1 (Resident # 3) of 4 (Residents # 1, 2, 3, and 9) case mix residents who received medications via gastrostomy tubes. The facility failed to ensure enteral formula was discarded within the manufacturer's recommended timeframe to prevent possible spoilage which could result in food borne illness for 1 (Resident # 2) of 4 (Residents # 1, 2, 3, and 9) case mix residents who received continuous tube feedings. The failed practices had the potential to affect 7 residents who had continuous tube feedings and received flushes and medications via gastrostomy tubes, according to a list received from the Administrator on 3/7/14. The findings are: 1. The facility policy titled Enteral Tubes documented, .5. The manufacturer's written recommendations regarding suggested time period for hanging of the product are consulted when determining the schedule for enteral feeding administration. 6. .Medications for enteral administration are obtained in easily pulverized or liquid form. The provider pharmacy is consulted to determine the best method for preparing dosage forms for enteral tube administration when liquid formulations are not available. 8. Verify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **045450**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/20/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST MARKHAM SUB ACUTE AND REHABILITATION CENTER	**5720 WEST MARKHAM STREET LITTLE ROCK, AR 72205**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0322 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) tube placement. a. Unclamp tube and the use the following procedures: Insert a small amount of air into the tube with the syringe and listen to stomach with stethoscope for gurgling sounds. Aspirate stomach contents with syringe. Check residual. 2. Resident # 9 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/6/14 documented the resident scored 8 (8 - 12 indicates moderately impaired) on the Brief Interview for Mental Status and had a feeding tube. a. Physician orders [REDACTED]. flush PEG with 60 ml of water before connecting and after disconnecting feeding and before and after each (medication) administration . Flush PEG with 150 ml water (every(6 hours. b. A physician order [REDACTED]. c. A physician order [REDACTED]. d. The hospital [MEDICATION NAME] Radiology report dated 3/1/14 documented, .Clinical Information: .gastrostomy tube (placed 1/23/14) is clogged. The Emergency Department unable to clear the gastrostomy tube despite multiple attempts. Procedure: Fluoroscopy guided G (Gastrostomy)-tube exchange . Peri-procedure medication: Local 1% [MEDICATION NAME] .Description of Procedure: . Attempts to inject contrast through the gastrostomy tube were unsuccessful. The indwelling gastrostomy tube was removed over a wire and new gastrostomy tube was placed over a wire . Fluoroscopy time: 1.8 minutes. e. A physician order [REDACTED]. f. The hospital emergency room General Medical - Adult form documented, .Chief Complaint: Clogged G (gastrostomy) tube. (Patient) states they aren't flushing tube at night so it repeatedly becomes clogged. The hospital [MEDICATION NAME] Radiology report dated 3/4/14 documented, .Reason for Exam: Clogged [DEVICE] . Procedure: Gastrostomy tube exchange using fluoroscopy guidance . Pre procedure medications: None. Intra procedure medications: 1% [MEDICATION NAME] was used for local anesthesia .Fluoroscopy time: 0.4 minutes . Procedure: . The indwelling gastrostomy tube was clotted and contrast cannot be injected. Access into the gastric lumen was obtained with a guide wire and catheter sire of into the tube. The tube was removed. .gastrostomy tube was placed. g. A physician order [REDACTED]. [MEDICATION NAME] 30 mg (milligrams) (per tube) (twice a day). [MEDICATION NAME] liquid 500 mg (per) 15 (milliliters) give 19.5 ml (to equal) 650 mg (every) 6 hours (per tube). h. The OLTC (Office of Long Term Care) Incident and Accident Report (I & A) documented, .Date of I & A: 3/4/14. Time: 2:00 p.m. Name of Resident: (Resident # 9) . Type of Incident: Neglect . Summary of Incident . On 3/4/14 at approximately 2:00 p.m., the Unit Manager (UM) on 4th floor received a call from a ER (emergency room) physician from (hospital name). The physician stated that one of the facility's female patients, (Resident # 9), was there because of a plugged PEG tube. He stated that (Resident # 9) was there on 3/1/14 for the same reason, 'beads of meds' were plugging the tube and if we were flushing properly, it would not happen. He (asked) the UM if she knew what 'sub-standard care was?' UM replied 'I do'. He then stated 'fix it' and hung up. (Resident # 9) was still in ER at that time. UM reported conversation to the DON (Director of Nursing). Steps Taken to Prevent Continued Abuse or Neglect During the Investigation .: On 3/4/14, at approximately 2:30 p.m., the DON instructed the (Unit) Manager to start an inservice with present licensed nurses. On 3/4/14 at approximately 6:30 p.m., the Administrator instructed to the DON to review (Resident # 9's) MAR (Medication Administration Record) and see if some (medications) could be changed to liquid or something that would crush finer and to eliminate the 'beads' if possible. DON informed Administrator that (Resident # 9's) tube is the smaller type. On 3/4/14 the Administrator instructed the DON to assess all residents on enteral feedings. On 3/5/14, at approximately 9:30 a.m., the Administrator instructed the DON to have two licensed nurses to (be) present when medication is administered until the female nurse could be identified. i. On 3/7/14 at 12:05 p.m. the Director of Nurses was asked, Did you look at (Resident # 9's) medications after the PEG was clogged on 3/1/14 to identify problem medications? The DON stated, No. The DON was asked, Were you aware her PEG tube has been clogged three times now? The DON stated, No. 3. Resident # 2 had a [DIAGNOSES REDACTED]. a. The care plan dated 1/23/13 and revised on 1/23/14 documented, (Resident # 2) is at risk for decline in nutrition/hydration status (related to) needed assist to consume meals . Diet: Regular . Interventions: . Assist her as needed with eating . Feed her meals and snack . Offer her diet per orders. There was no documentation on the care plan that the resident had a feeding tube. b. Physician orders [REDACTED].2 Cal HN 30 ml (milliliters) via PT (gastrostomy tube). c. The February 2014 Medication Administration Record [MEDICATION ADMINISTRATION RECORD DETAILS REDACTED]HN 2 Cal (per tube) at 30 ml/hr (milliliters per hour) via continuous pump, flush PEG (gastrostomy tube) with 60 ml of water before and after each (medication) administration. d. On 3/4/14 at 4:15 p.m., a 1,000-milliliter container of tube feeding was hanging. The container was dated 3/4/14 at 4:00 p.m. and was full. The pump tubing and dual pump bag of water were dated 3/4/14 at 4:00 p.m. e. On 3/6/14 at 4:58 a.m., the same container of Two Cal HN was hanging that was infusing at 30 cc per hour and dated 3/4/14. The dual pump water bag was dated 3/5/14 at 4:00 p.m. At 7:25 a.m., LPN #5 changed the Two Cal HN and dual pump water bag tubing set at this time. The two cal HN container had approximately 100 milliliter left in the container when it was removed. The dual pump water bag tubing set was a closed system and could not be changed without disconnecting the Two Cal HN feeding from the system. According to the dates the feeding had been hanging for 39 hours and the tubing had been changed 12 hours into the initial start time of 3/4/14 at 4:00 p.m. The manufacturers label on a 1,000 milliliter container of [MEDICATION NAME] HN Calorie and Protein Dense Nutrition documented, Ready to hang enteral feeding container . Contains milk and soy ingredients. Hang product up to 48 hours after initial connection when clean techniques and only one new feeding set are used. Otherwise hang no longer than 24 hours. 4. Resident # 1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/13/13 documented the resident scored 8 (8 - 12 indicates moderately impaired) on the Brief Interview for Mental Status, and had a feeding tube. a. A physician order [REDACTED]. b. The care plan dated 8/12/13 and reviewed on 12/13/13 documented, (Resident # 1) has an alteration in his nutritional status (due to) .presence of PEG for possible feedings. Interventions: . 1/24/14 NPO (nothing by mouth) glucerna 1.5 (at) 60 ml/hr (milliliters per hour) continuous. c. A physician order [REDACTED]. d. A physician order [REDACTED]. e. The Medication Administration Record [MEDICATION ADMINISTRATION RECORD DETAILS REDACTED]Flush PEG with 150 ml Normal Saline (every) 6 hours. The administration times were documented as 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. f. On 3/6/14 at 6:12 a.m. LPN # 2 prepared to administer the resident's 6:00 a.m. medications. LPN # 2 called a second nurse, LPN # 3, to come to the floor. LPN # 2 was asked Why call another nurse for medication administration? LPN # 2 stated It's a new policy that 2 nurses have to be present when giving anything per PEG tube. LPN # 2 set up the resident's medications which included 4 pills. LPN # 2 mixed the pills with water and had a second cup with water. LPN # 2 verified PEG placement, flushed the PEG tube with 60 cc of water, gave the medications mixed with water, flushed the PEG with 60 cc of water, reconnected the PEG to the pump tubing and turned on the pump. At 6:30 a.m. LPN # 2 was asked Did you administer all of his 6:00 a.m. medications? LPN # 2 stated All but his normal saline flush. I'll do it when I do his blood sugar. g. On 3/6/14 at 6:50 a.m. LPN # 2 stated There is no normal saline for the resident's flush. I'll go downstairs and get some. h. On 3/6/14 at 7:00 a.m. LPN # 2 stated There is no sodium chloride in the building for the flush. LPN # 2 was asked So what did you give at midnight, it's initialed as given? LPN # 2 stated The water that runs out of the bag. I didn't give it; I'll circle it. i. On 3/6/14 at 7:57 a.m. Registered Nurse (RN) # 1 brought 4 bottles of 250 cc normal saline to LPN # 2. j. A physician order [REDACTED]. k. A physician order [REDACTED]. 5. Resident #3 was admitted on [DATE] and had [DIAGNOSES REDACTED]. A 14-day Minimum Data Set with an Assessment Reference date of 2/14/14 documented the resident scored 12 (8-12 indicated moderately impaired) on the Brief Interview for Mental Status, required extensive assistance of 1 person for and had a feeding tube. a. The Physician telephone orders dated 1/16/14, 1/31/14, 2/11/14 and 2/23/14 documented the resident was sent to the emergency room due to the tube being clogged. b. Admission physician's orders [REDACTED]. . c. On 3/5/14 at 6:12 p.m., LPN #7 crushed the [MEDICATION NAME] HCL 200 mg tablet and placed the medication in a medication cup. The LPN then added water to the medication cup, stirred it with a straw, then poured the mixture of medication and water into the resident's feeding tube. The medication cup was then thrown into the trash can in the resident's room. The LPN was asked, Could you show me that cup? The LPN did so, and there was a small yellow piece of medication left in the bottom of the medication cup. The LPN was asked, What is that in the bottom of the cup? The LPN stated, Oh, a little bit of the medicine. I thought I got it all out of there. All of the medication had not been properly dissolved before administration. 6. On 3/7/14 at 12:05 p.m., the Director of Nurses (DON) was asked Have you done an inservice on tube feedings and flushing after medication for all the floors? The DON stated Yes, it was put out on all the floors for staff to read. They go in with two nurses to make sure it's working properly. I put it out about 6:00 p.m. to 7:00 p.m. on 3/5/14. They are just there to observe it was flushed and it was open. The DON was asked So they are not there to verify the correct flush or amount of flush was given? The DON stated No. The DON was asked Did you inservice staff on crushing medications and letting them dissolve prior to administering medications? The DON stated (RN # 1) did on the fourth floor but I'm not sure if it was done on every floor. 7. On 3/7/14 at 1:10 p.m. the DON presented written inservices dated 3/4/14 for the second floor which had been signed by LPN # 7. This inservice documented [DEVICE] meds that have to be crushed need to put in very hot water to ensure it is small enough to not (clog) up the tube.

F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is free from accident hazards and risks and**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **045450**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/20/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST MARKHAM SUB ACUTE AND REHABILITATION CENTER	**5720 WEST MARKHAM STREET LITTLE ROCK, AR 72205**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) **provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # was substantiated (all or in part) in these findings: Based on observation, record review, and interview the facility failed to ensure planned fall/injury prevention interventions were consistently implemented, as evidenced by: failure to ensure bed and chair alarms were functioning to alert staff of unassisted transfer attempts, in order to minimize the potential for injury from falls for 1 (Resident # 7) of 3 (Residents # 3, 4, and 7) who were care planned for bed alarms and of 3 (Residents #2, #4 and #7) case mix residents care planned for chair alarms; and, failure to ensure the bed was kept in the lowest position when staff were not present to minimize the potential for injury from falls for for 2 (Residents # 8 and 9) of 3 (Residents #2, 8 and 9) case mix residents who were care planned for beds to be lowered. The facility also failed to ensure new fall prevention interventions were developed and consistently implemented to minimize the potential for further falls or injuries and failed to ensure injuries (including bruises) were evaluated for causative factors to facilitate the ability to develop and implement effective interventions to prevent further injury for 1 of 1 (Resident # 9) case mix residents with falls or bruising since 2/1/14. The failed practices had the potential to affect 12 residents who were care planned for bed alarms, 8 residents who were care planned for chair alarms, 8 residents who were care planned for beds low to the floor, 12 residents with falls since 2/1/14 and 2 residents with bruising since 2/1/14 according to lists received from the Administrator on 3/7/14. The findings are: 1. The facility's policy and procedure titled Resident Incident/Accident Reports - quality Assurance documented, .Procedure: 1. Any happening not consistent with routine operations of the facility or care of a resident will the completion of an incident report. 5. Incident reports shall be reviewed daily by the Director of Nursing and approved. 2. Resident # 7 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/4/14 documented the resident had moderately impaired cognitive skills for daily decision making per a Staff Assessment of Mental Status, required extensive assistance of 1 person with transfers and walking in room, had balance that was not steady and was only able to stabilize with staff assistance for moving from seated to standing position and walking and had one fall with no injury since the prior assessment. a. A physician order [REDACTED]. b. The Care Plan dated 8/1/13, updated on 2/6/14 documented, Focus: (Resident # 7) is at risk for falls/injuries (related to) unsteady gait, needed assistance with mobility . Interventions: . 2/6/14 (wheelchair) alarm. c. On 3/5/14 at 10:27 a.m., the resident was out of the room. A pad alarm was on the bed with the alarm unit on the left bed frame by the side rail. The cord going from the pad to the alarm unit was disconnected from the alarm box. There was no plug/connector present on the end of the cord and there were 2 wires showing. d. On 3/5/14 at 10:27 a.m., 11:00 a.m., 12:58 p.m., 3:12 p.m. and 4:55 p.m.; and on 3/6/14 at 7:06 a.m. the resident in a wheelchair. There was no chair alarm present. e. On 3/6/14 at 5:00 a.m. the resident was in bed lying on her right side. A pad alarm was on the bed with the alarm unit on the left bed frame by the side rail. The cord going from the pad to the alarm unit was disconnected from the alarm box. There was no plug/connector present on end of the cord and there were 2 wires showing. f. On 3/6/14 at 5:32 a.m., Licensed Practical Nurse (LPN) # 2 entered the resident's room to assess the resident for a complaint of pain in her right hip. LPN # 2 attempted to turn the resident to assess the resident's right hip but the resident refused. LPN # 2 did not note the cord from the pad alarm was not connected to the alarm unit. The March 2014 Medication Administration Record documented, Fall Precautions: Bed alarm, fall mat to be checked every eight hours by the charge nurse. g. On 3/6/14 at 5:40 a.m., Certified Nurse Assistant (CNA) # 1 entered the resident's room to provide incontinent care, dress the resident and get the resident out of bed. During incontinent care and dressing the resident, the CNA rolled the resident from side to side, and the pad alarm did not sound. This surveyor asked CNA # 1, Why isn't the bed alarm sounding? CNA # 1 stated, I turned it off. This surveyor asked CNA # 1 to check the cord to see if it was plugged in. CNA # 1 lifted the cord off the floor and stated, It's broke. There were 2 wires showing and it could not be plugged in. CNA # 1 was asked, Did you notice that this shift? CNA # 1 stated, No. CNA # 1 and this surveyor checked the alarm unit. The switch was On. There was no wheelchair alarm or personal alarm on the resident's wheelchair. After CNA # 1 transferred the resident into the wheelchair, this surveyor asked, Does she have a wheelchair alarm? CNA # 1 stated, No. CNA # 1 propelled the resident to the lobby at 5:55 a.m. CNA # 1 stated to this surveyor No wonder that thing never goes off when I turned her; it's broke. CNA # 1 was asked, What is your process to test, check bed alarms on your shift? CNA # 1 stated, Go down the hall and turn them on, roll them and turn them off. I noticed it wasn't going off. CNA # 1 was asked, Do you have CNA care plans? CNA # 1 stated, In the ADL (Activities of Daily Living) book. h. On 3/6/14 at 6:55 a.m., CNA # 3 was asked, Do you have CNA care plans? CNA # 3 stated, No, we have ADL flow sheets, it tells us what to do. The March 2014 ADL (Activity Daily Living) Flow Record provided no directions to CNAs regarding a bed alarm, fall mat, or wheelchair alarm for this resident. i. On 3/7/14 at 7:09 a.m., the resident was in a wheelchair in the dining room. There was no chair alarm present. CNA # 2 was present in the dining room. CNA # 2 was asked, Do you see a chair alarm on her wheelchair? CNA # 2 stated, No. j. On 3/7/14 at 7:12 a.m., the Director of Nurses (DON) was asked to observe the resident. The DON was asked, Do you see an alarm on her wheelchair? The DON stated, No. 3. Resident # 9 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 2/6/14 documented the resident scored 8 (8 - 12 indicates moderately impaired) on the Brief Interview for Mental Status, and had no falls since admission. a. A physician order [REDACTED]. b. A Nurse's Note dated 2/8/14 at 11:27 p.m. documented, (Resident) showing (signs/symptoms) of (decreased) mental changes. Received orders to send to (hospital name) via (ambulance service name) (due to) (decreased) mental status and on (previous) shift (resident) pulled IV (intravenous) pole on her which went across side and (abdomen) . c. A form titled Bruise Investigation dated (2/8/14) at 11:30 p.m. documented, .Describe the Bruise: Location: Chest. Size: 4 (inches). Color: Red . Care Plan Reviewed/Revised as needed: (Blank) . Based on investigation, determine the cause of the bruise: (Blank). d. A Nurse's Notes dated 2/9/14 at 4:30 a.m. documented, (Resident) returned back . Contusions on wrist/forearm left side. e. A Skilled Nursing Notes dated 2/15/14 at 1:00 p.m. documented, Found on floor, helmet off head. Resting on a metal support under her bed . laceration 2 inches above (left) occipital region of skull . (Patient) to be transported out to (hospital name). f. A OLTC (Office of Long Term Care) Witness Statement dated 2/15/14 at 1:00 p.m. documented, (Patient) found on floor. She said she was reaching for something but could not remember what. (Resident #9) removed her helmet. Her bed was raised to the highest level. g. A Nurse's Note dated 2/23/14 at 6:50 a.m. documented, Resident found on floor. h. A Fall Investigation form dated 2/23/14 documented, .8. How many falls have they had in the last 30 days? 4 (four) .12. What was resident doing prior to fall? Reaching for something . 2. Care Plan must be updated with new intervention: Bed in (low) position. Conclusion (Indicate what may have caused the accident). Resident reaching for objects on table (and) bed (up) high. Supervisor Report. 1. Did resident sustain injury? No . 4. Have falls been care planned? Yes. 5. Was care plan updated after fall? Yes. 6. If so, what is the problem number? Bed (elevated). Fall Committee Review/Recommendations: (Blank). i. An Admission Care Plan updated on 2/23/14 documented . 11. Falls/Safety Risk/elopement Risk . (Resident) (frequently) throws self around in bed. 2/23/14 Keep bed low. On the reverse side of the page, the following was documented, (2/15/14) fall - (resident) fell out of bed sustained cut head, low bed and mat. j. On 3/7/14 at 10:30 a.m., Registered Nurse (RN) # 1 was asked, Is there a care plan other than the temporary care plan for (Resident # 9)? RN # 1 stated, No and you're lucky you have that. It was on another floor. k. On 3/7/14 at 12:05 p.m., the DON was asked, Do you have an I & A (incident and accident) report for 2/8/14 regarding the resident pulling her IV pole over onto herself? The DON stated, I'll have to check. The DON was asked, Can you find an intervention on the care plan to prevent reoccurrence? The DON stated, Most of that was behavior and I probably didn't put anything into place. The DON was asked, On the I & A for 2/23/14 fall, can you find an intervention other than low bed? What is the new intervention? The DON stated, I'll have to check. The DON left the conference room at 12:30 p.m. l. On 3/7/14 at 1:00 p.m., the DON presented an I & A for 2/8/14 with no interventions documented. The DON stated, That's all there is. The DON stated there was no I & A for the 2/15/14 fall, only the witness statement. The DON stated there was no new intervention for the 2/23/14 fall. m. On 3/7/14 at 3:05 p.m., the Nurse Consultant was asked, After an incident or accident for a fall, bruising, etc., should staff identify interventions to prevent possible reoccurrence? The Nurse Consultant stated Yes, that's part of our form and then it's reviewed by the fall committee for interventions as needed. 4. Resident # 8 had a [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 12/14/13 documented the resident scored 7 (0 - 7 indicates severely impaired) on the Brief Interview for Mental Status, required extensive assistance of 2 persons with transfers and walking, balance was not steady and was only able to stabilize with staff assistance for moving from seated to standing position and walking and had one fall with no injury since the prior assessment. a. A physician's orders [REDACTED]. b. The Care Plan initiated on 6/6/13 and reviewed on 12/14/13 documented, Focus: (Resident #8) is at risk for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **045450**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/20/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST MARKHAM SUB ACUTE AND REHABILITATION CENTER	**5720 WEST MARKHAM STREET LITTLE ROCK, AR 72205**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) falls/injuries (related to) unsteady gait, needed assistance with mobility, (history) (Cerebrovascular Accident), Right Hemiparesis . Interventions: . (Resident # 8) to have bed in lower position while in bed. c. The March 2014 Medication Administration Record documented, Fall Precautions: Low Bed. There were spaces for nurses to initial that the low bed was checked every eight hours by the charge nurse. d. On 3/5/14 at 10:20 a.m. and 3/6/14 at 5:02 a.m., the resident was in bed with bed elevated approximately 30 to 32 inches from the floor to the top of the mattress. e. On 3/6/14 at 6:45 a.m., CNA # 1 was asked, Do you have a CNA care plan for this resident? CNA # 1 stated, Yes, they are in the ADL book. As of 3/6/14, the March 2014 ADL provided no directions to CNAs regarding a low bed for the resident. f. On 3/6/14 at 6:47 a.m., the resident was in bed lying on his back with the bed height elevated approximately 30 to 32 inches from the floor to the top of the mattress. LPN # 1 was asked to observe the bed. LPN # 1 was asked, What position is his bed in? LPN # 1 stated, It's not in the lowest, locked position. LPN # 1 lowered the bed which was approximately 12 inches from the floor to the top of the mattress. LPN # 1 checked the closet for a CNA care plan at this surveyor's request. LPN # 1 stated, No CNA care plan in the closet. g. On 3/6/14 at 6:50 a.m., the DON was asked, Do you have CNA care plans? The DON stated, No, but maybe you better ask someone who's been here longer. h. On 3/6/14 at 10:09 a.m., CNAs # 2 and 4 entered the resident's room to provide incontinent care. The resident was in bed lying on his back with the bed height elevated approximately 30 to 32 inches from the floor to the top of the mattress. CNAs #2 and 4 were asked, Did you raise the height of the bed? CNAs #2 and 4 stated, No. j. On 3/7/14 at 7:02 a.m., the resident was in bed lying on his back, asleep, with the bed height elevated approximately 36 inches from the floor to the top of the mattress. k. On 3/7/14 at 7:12 a.m., the resident was lying in bed on his back, asleep, with the bed height elevated approximately 36 inches from the floor to the top of the mattress. The DON was asked to observe the resident's bed. The DON was asked Is it in a low position? The DON stated, No.