STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045457	A. BUILDING _____ B. WING _____	C 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAGECOACH NURSING AND REHABILITATION CENTER	6907 HIGHWAY 5 NORTH BRYANT, AR 72022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. Complaint #20331 (AR 00018438) was substantiated (all or in part) with deficiencies cited at F224, F312, F490 and F520 Complaint #20340 (AR 00018445) was substantiated (all or in part) with deficiencies cited at F224, F312, F490 and F520 Complaint #20309 (AR 00018404) was unsubstantiated Complaint #20323 (AR 00018420) was substantiated (all or in part) without deficiencies.	F 000		
F 224 SS=H	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224		

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 224	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #20331 (AR 00018438) and #20340 (AR 00018445) were substantiated (all or in part) in these findings. Based on observations, record review and interviews, the facility failed to ensure policies and procedures to prohibit neglect were implemented to assure necessary care and services were consistently provided for oral and denture care to prevent infections of the oral cavity for 1 of 1 (Resident #6) case mix resident who required the use of dentures, was dependent on staff for oral care, and was cognitively impaired. This resulted in a pattern of harm for Resident #6 who was hospitalized with a diagnoses of Osteomyelitis from lack of oral and denture care. This failed practice had the potential to cause more than minimal harm to 15 residents who required the use of dentures, were dependent for oral care, and cognitively impaired as per a list provided by the Medicare Manager on 7/15/15 at 12:45 p.m. The findings are: 1. The facility's "Resident Abuse" policy documented, "...1. Neglect-Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs on an individual basis when a resident does not receive care in one or more areas. 2. Resident #6 had diagnoses of Dementia and Alzheimer's. The Annual Minimum Data Set with an Assessment Reference date of 6/10/15 documented the resident was severely impaired in cognitive skills for daily decision making per the Staff Assessment for Mental Status and required	F 224		

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F 224	Continued From page 2	F 224		

extensive assistance with personal hygiene.

a. A dental report dated 1/21/15 documented, "Cleaned upper partial -very very dirty-covered in thick buildup prophylaxis on lower teeth."

b. A grievance report dated 1/21/15 documented, "Resident went to dentist today. Upon arrival, dentures were noted to be unclean with food on them." The action taken documented, "Denture/oral care in-service started on 1/21/15 for oral/denture care to be done every shift."

c. A physician orders dated 2/6/15 documented, "Ensure dentures are removed and placed in denture cup with cleanser Q [every] HS at bedtime."

d. A grievance report, not dated, documented, "[Name of daughter] the daughter of resident [Resident #6] reported to the interim DON (Director of Nursing) that when her mother went to the ER [Emergency Room] following a fall the resident's toenails were excessively long. Her mother is a diabetic. She further states that other times when has had issue with the resident's teeth being unclean." The response documented, "The DON had a lengthy conversation with the family member. [Treatment Nurse] the tx [treatment] nurse is to get the toenails trimmed immediately. I will speak to the housekeeping supervisor as well as the nursing staff in regards to the other issues." The form had the Administrator's signature at the bottom of the form with a date of 3/17/15

e. An in-service dated 3/20/15 documented the topics covered as "Checking orders/24 hour chart checks, Responsible for admit, Bagging linens,

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peri-care -supplies on cart down hallway, nail care, handwashing, in-service book, charge nurse; CNA roles, meal service/meal monitoring, meals for employees, documentation and Incentive program." There was no documentation on this form that indicated the staff was in-serviced regarding oral/denture care. The in-service was signed as being conducted by the Administrator.

f. Progress Notes dated 7/9/15 at 4:33 a.m., documented, "Send to ER for eval [evaluation] due to swelling of nose, cheeks and upper lip." There was no other documentation in the nurses notes regarding this issue.

g. A Incident report dated 7/9/15 at 4:44 a.m., documented the description as: "CNA [Certified Nursing Assistant] brought this writer to rm [room] 105 to observe res [resident's] face. Noted her face seems swollen around mouth, nose seems swollen, also cheeks and under eyes. Small amt [amount] of old blood seen in mouth, dried around lips. Mouth care done but res is very tender in mouth, has trouble opening mouth and also very tender to touch on cheeks, nose and upper lip is also swollen." The notes section documented, "Noted res had old blood in mouth and dried on lips. Mouth care done but res has difficulty opening mouth due to pain. On close exam found face to be swollen and very tender to touch around mouth, nose, both cheeks and under eyes. Res is able to answer yes and no questions but cannot elaborate as to anything that may have happened to her face. She can say 'yes' that it hurts, Given APAP [acetaminophen] 650 mg [milligrams] crushed in applesauce, which she did get down with difficulty."

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h. The Emergency Room report dated 7/9/15 at 4:47 a.m., documented, "Patient has a small amount of facial swelling noted to right side of her face over the maxillary sinus region. This area is tender to palpation. It is slightly erythematous. The oral pharynx is this patient to have upper dentures which have not been removed for quite some time and are firmly in place. She has a fetid odor to her breath. There does not appear to be any intraoral trauma." The Radiology interpretation documented, "CT [computerized tomography] of the facial bones reveal this patient to have some bony like destruction noted to the maxillary portion of her face on the right side which could be consistent with an Osteomyelitis. This patient will be admitted to the hospital for IV [intravenous] antibiotics and further care." The ER notes documented, "I spoke with the patient's daughter concerning the findings of the CT. The daughter did help keep the patient, while I removed the patient's dentures. There was a lot of foul-smelling odor to this and the patient's gum on the right maxillary side of her mouth is bleeding and broken down from infection."

i. The ENT (Ears, Nose and Throat) specialist report dated 7/9/15 at 5:20 p.m., documented, "CT showed some bony erosion of the maxilla on the right. Apparently ER had a hard time getting dentures out. Granulation tissue along the right Gingofabial groove along the right maxilla." The diagnosis was documented as "Cellulitis with Osteomyelitis, I think this is secondary to her upper dentures eroding into her gum line."

On 7/14/15 at 4:45 p.m., the ENT specialist stated that based on the history that he received her dentures had to have been there a long time. He further stated that he did not see her with her

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dentures, but was in the area that the dentures fit and it had to have been there a long time.

j. The July 2015 Medication Administration record documented an order, "Ensure dentures are removed and placed in denture cup with cleaner q HS at bedtime." This was documented, with nurses' initials, as being completed at 7:00 p.m. from 7/1 - 8/15.

k. On 7/15/15 at 7:55 p.m., Licensed Practical Nurse (LPN) #1 was asked, "Did you visually see the dentures in the cup when you initialed it being completed on 7/8/15?" She replied, "No, the CNA's told me that it was done."

l. On 7/15/15 at 8:30 p.m., LPN #2 was asked, "Did you visually see the dentures in the cup when you initialed it being completed on 7/3/15 and 7/6/15?" She replied, "No, I asked the CNA's and they told me they were."

m. On 7/15/15 at 8:10 p.m., CNA #1 stated that she had worked for the facility for 7 months and that she floats. She stated that sometimes the resident would refuse to have her dentures removed but she did oral care on her.

n. On 7/15/15 at 8:15 p.m., CNA #2 stated that she had worked at the facility since February 2015 and she did not know the resident even had dentures.

o. On 7/15/15 at 8:25 p.m., CNA #3 stated that if the resident had her dentures in her mouth she removed them. She stated that she only works the hall where the resident resides two nights a week and that she did put the resident's dentures in a cup on those two nights.

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p. A form titled, "Oral Care/Denture Care Completed" was utilized by the CNA's to document the date and shift that they completed the care on the individuals who had dentures. There were forms documenting oral/denture care for January through May 2015.

On 7/15/15 at 10:10 a.m., the Administrator stated that she started here in February 2015 and the form was already in place. She did not know why. She was asked to locate any documentation of this form being completed for this resident. As of 7/15/15 at 2:00 p.m., the Administrator did not provide any more forms that documented oral care for this resident.

q. The plan of care initiated on 6/8/14 documented a problem of "The resident has limited physical mobility r/t [related to] disease process (hip fracture) with interventions initiated on 7/13/15 of "Clean teeth/partial dentures every morning, bedtime and PRN [as needed]. Place dentures in cup with cleaner every bedtime." There was no documentation on the plan of care regarding denture care until 7/13/15.

r. On 7/15/15 at 1:10 p.m., the Administrator stated that she was not here when the January 2015 grievance was filed and she did not know what the facility did. She stated she was here when the March 2015 grievance report was submitted and staff were in-serviced but did not know if she talked about oral care or not. She stated that she did not document it on the in-service sheet and she usually does. The Administrator was asked, "What system did you put in place to prevent this re-occurring again?" She stated, "I didn't put any system in place."

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F 224	Continued From page 7 She stated that now she has in-serviced the staff regarding denture care with return demonstrations and that the CNA's were to report to the nurse if anyone refuses and that the LPN will visually check to make sure the dentures were in a cup at night.	F 224		
F 312 SS=H	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Complaint #20331 (AR 00018438) and #20340 (AR 00018445) were substantiated (all or in part) in these findings. Based on observations, record review, and interviews, the facility failed to ensure necessary care and services were consistently provided for oral and denture care to prevent infections of the oral cavity for 1 of 1 (Resident #6) case mix resident who required the use of dentures, was dependent on staff for oral care, and was cognitively impaired. This resulted in a pattern of harm for Resident #6 who was hospitalized with a diagnoses of Osteomyelitis from lack of oral and denture care. This failed practice had the potential to cause more than minimal harm to 15 residents who required the use of dentures, were dependent for oral care, and cognitively impaired as per a list provided by the Medicare Manager on 7/15/15 at 12:45 p.m. The findings are:	F 312		

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Resident #6 had diagnoses of Dementia and Alzheimer's. The Annual Minimum Data Set with an Assessment Reference date of 6/10/15 documented the resident was severely impaired in cognitive skills for daily decision making per the Staff Assessment for Mental Status and required extensive assistance with personal hygiene.

a. A dental report dated 1/21/15 documented, "Cleaned upper partial -very very dirty-covered in thick buildup prophylaxis on lower teeth."

b. A grievance report dated 1/21/15 documented, "Resident went to dentist today. Upon arrival, dentures were noted to be unclean with food on them." The action taken documented, "Denture/oral care in-service started on 1/21/15 for oral/denture care to be done every shift."

c. A physician orders dated 2/6/15 documented, "Ensure dentures are removed and placed in denture cup with cleanser Q [every] HS at bedtime."

d. A grievance report, not dated, documented, "[Name of daughter] the daughter of resident [Resident #6] reported to the interim DON (Director of Nursing) that when her mother went to the ER [Emergency Room] following a fall the resident's toenails were excessively long. Her mother is a diabetic. She further states that other times when has had issue with the resident's teeth being unclean." The response documented, "The DON had a lengthy conversation with the family member. [Treatment Nurse] the tx [treatment] nurse is to get the toenails trimmed immediately. I will speak to the housekeeping supervisor as well as the nursing staff in regards

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to the other issues." The form had the Administrator's signature at the bottom of the form with a date of 3/17/15

e. An in-service dated 3/20/15 documented the topics covered as "Checking orders/24 hour chart checks, Responsible for admit, Bagging linens, peri-care -supplies on cart down hallway, nail care, handwashing, in-service book, charge nurse; CNA roles, meal service/meal monitoring, meals for employees, documentation and Incentive program." There was no documentation on this form that indicated the staff was in-serviced regarding oral/denture care. The in-service was signed as being conducted by the Administrator.

f. Progress Notes dated 7/9/15 at 4:33 a.m., documented, "Send to ER for eval [evaluation] due to swelling of nose, cheeks and upper lip." There was no other documentation in the nurses notes regarding this issue.

g. A Incident report dated 7/9/15 at 4:44 a.m., documented the description as: "CNA [Certified Nursing Assistant] brought this writer to rm [room] 105 to observe res [resident's] face. Noted her face seems swollen around mouth, nose seems swollen, also cheeks and under eyes. Small amt [amount] of old blood seen in mouth, dried around lips. Mouth care done but res is very tender in mouth, has trouble opening mouth and also very tender to touch on cheeks, nose and upper lip is also swollen." The notes section documented, "Noted res had old blood in mouth and dried on lips. Mouth care done but res has difficulty opening mouth due to pain. On close exam found face to be swollen and very tender to touch around mouth, nose, both cheeks and under

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eyes. Res is able to answer yes and no questions but cannot elaborate as to anything that may have happened to her face. She can say 'yes' that it hurts, Given APAP [acetaminophen] 650 mg [milligrams] crushed in applesauce, which she did get down with difficulty."

h. The Emergency Room report dated 7/9/15 at 4:47 a.m., documented, "Patient has a small amount of facial swelling noted to right side of her face over the maxillary sinus region. This area is tender to palpation. It is slightly erythematous. The oral pharynx is this patient to have upper dentures which have not been removed for quite some time and are firmly in place. She has a fetid odor to her breath. There does not appear to be any intraoral trauma." The Radiology interpretation documented, "CT [computerized tomography] of the facial bones reveal this patient to have some bony like destruction noted to the maxillary portion of her face on the right side which could be consistent with an Osteomyelitis. This patient will be admitted to the hospital for IV [intravenous] antibiotics and further care." The ER notes documented, "I spoke with the patient's daughter concerning the findings of the CT. The daughter did help keep the patient, while I removed the patient's dentures. There was a lot of foul-smelling odor to this and the patient's gum on the right maxillary side of her mouth is bleeding and broken down from infection."

i. The ENT (Ears, Nose and Throat) specialist report dated 7/9/15 at 5:20 p.m., documented, "CT showed some bony erosion of the maxilla on the right. Apparently ER had a hard time getting dentures out. Granulation tissue along the right Gingofabial groove along the right maxilla." The diagnosis was documented as "Cellulitis with

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Osteomyelitis, I think this is secondary to her upper dentures eroding into her gum line."

On 7/14/15 at 4:45 p.m., the ENT specialist stated that based on the history that he received her dentures had to have been there a long time. He further stated that he did not see her with her dentures, but was in the area that the dentures fit and it had to have been there a long time.

j. The July 2015 Medication Administration record documented an order, "Ensure dentures are removed and placed in denture cup with cleaner q HS at bedtime." This was documented, with nurses' initials, as being completed at 7:00 p.m. from 7/1 - 8/15.

k. On 7/15/15 at 7:55 p.m., Licensed Practical Nurse (LPN) #1 was asked, "Did you visually see the dentures in the cup when you initialed it being completed on 7/8/15?" She replied, "No, the CNA's told me that it was done."

l. On 7/15/15 at 8:30 p.m., LPN #2 was asked, "Did you visually see the dentures in the cup when you initialed it being completed on 7/3/15 and 7/6/15?" She replied, "No, I asked the CNA's and they told me they were."

m. On 7/15/15 at 8:10 p.m., CNA #1 stated that she had worked for the facility for 7 months and that she floats. She stated that sometimes the resident would refuse to have her dentures removed but she did oral care on her.

n. On 7/15/15 at 8:15 p.m., CNA #2 stated that she had worked at the facility since February 2015 and she did not know the resident even had dentures.

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o. On 7/15/15 at 8:25 p.m., CNA #3 stated that if the resident had her dentures in her mouth she removed them. She stated that she only works the hall where the resident resides two nights a week and that she did put the resident's dentures in a cup on those two nights.

p. A form titled, "Oral Care/Denture Care Completed" was utilized by the CNA's to document the date and shift that they completed the care on the individuals who had dentures. There were forms documenting oral/denture care for January through May 2015.

On 7/15/15 at 10:10 a.m., the Administrator stated that she started here in February 2015 and the form was already in place. She did not know why. She was asked to locate any documentation of this form being completed for this resident. As of 7/15/15 at 2:00 p.m., the Administrator did not provide any more forms that documented oral care for this resident.

q. The plan of care initiated on 6/8/14 documented a problem of "The resident has limited physical mobility r/t [related to] disease process (hip fracture) with interventions initiated on 7/13/15 of "Clean teeth/partial dentures every morning, bedtime and PRN [as needed]. Place dentures in cup with cleaner every bedtime." There was no documentation on the plan of care regarding denture care until 7/13/15.

r. On 7/15/15 at 1:10 p.m., the Administrator stated that she was not here when the January 2015 grievance was filed and she did not know what the facility did. She stated she was here when the March 2015 grievance report was

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F 312	Continued From page 13 submitted and staff were in-serviced but did not know if she talked about oral care or not. She stated that she did not document it on the in-service sheet and she usually does. The Administrator was asked, "What system did you put in place to prevent this re-occurring again?" She stated, "I didn't put any system in place." She stated that now she has in-serviced the staff regarding denture care with return demonstrations and that the CNA's were to report to the nurse if anyone refuses and that the LPN will visually check to make sure the dentures were in a cup at night.	F 312		
F 490 SS=H	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint #20331 (AR 00018438) and #20340 (AR 00018445) were substantiated (all or in part) in these findings. Based on observations, record review and interviews, the facility Administration and Nursing Administration failed to ensure there was a system in place to assure necessary care and services were consistently provided for oral and denture care to prevent infections of the oral cavity for 1 of 1 (Resident #6) case mix resident who required the use of dentures, was dependent on staff for oral care, and was cognitively	F 490		

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impaired. This resulted in a pattern of harm for Resident #6 who was hospitalized with a diagnoses of Osteomyelitis from lack of oral and denture care. This failed practice had the potential to cause more than minimal harm to 15 residents who required the use of dentures, were dependent for oral care, and cognitively impaired as per a list provided by the Medicare Manager on 7/15/15 at 12:45 p.m. The findings are:

1. The Job Description for the Administrator obtained on 7/15/15 at 12:45 p.m., documented, "Purpose of your Job Position The primary purpose of your job position is to direct the day to day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality of care can be provided to our residents at all times..."

2. The Job Description for the Director of Nurses obtained on 7/15/15 at 12:45 p.m., documented, "Purpose of your Job Description The primary purpose of job position is to plan, develop, and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations, that govern our facility, and as may be directed by the Administrator and/or Company Consultant and the medical Director, to ensure that the highest degree of quality of care is maintained at all times... Standard Requirements... 17. Make daily rounds of the nursing service department to ensure that all nursing service personnel are performing their work assignments in accordance with acceptable nursing standards... 32. Schedule daily rounds to observe residents and to determine if nursing

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needs are being met in accordance with the resident request... 36. Ensure that residents who are unable to call for help are checked frequently. 37. Develop and participate in planning, conducting, and scheduling of timely in-service training classes that provide instructions on "How to do the job", and ensure a well-educated nursing service department... 49. Develop a written plan of care, preliminary and comprehensive, for each resident that identified the problems/needs of the resident, indicates the care to be given, goals, to be accomplished, and which professional service is responsible for each element of care..."

3. Resident #6 had diagnoses of Dementia and Alzheimer's. The Annual Minimum Data Set with an Assessment Reference date of 6/10/15 documented the resident was severely impaired in cognitive skills for daily decision making per the Staff Assessment for Mental Status and required extensive assistance with personal hygiene.

a. A dental report dated 1/21/15 documented, "Cleaned upper partial -very very dirty-covered in thick buildup prophylaxis on lower teeth."

b. A grievance report dated 1/21/15 documented, "Resident went to dentist today. Upon arrival, dentures were noted to be unclean with food on them." The action taken documented, "Denture/oral care in-service started on 1/21/15 for oral/denture care to be done every shift."

c. A physician orders dated 2/6/15 documented, "Ensure dentures are removed and placed in denture cup with cleanser Q [every] HS at bedtime."

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d. A grievance report, not dated, documented, "[Name of daughter] the daughter of resident [Resident #6] reported to the interim DON (Director of Nursing) that when her mother went to the ER [Emergency Room] following a fall the resident's toenails were excessively long. Her mother is a diabetic. She further states that other times when has had issue with the resident's teeth being unclean." The response documented, "The DON had a lengthy conversation with the family member. [Treatment Nurse] the tx [treatment] nurse is to get the toenails trimmed immediately. I will speak to the housekeeping supervisor as well as the nursing staff in regards to the other issues." The form had the Administrator's signature at the bottom of the form with a date of 3/17/15

e. An in-service dated 3/20/15 documented the topics covered as "Checking orders/24 hour chart checks, Responsible for admit, Bagging linens, peri-care -supplies on cart down hallway, nail care, handwashing, in-service book, charge nurse; CNA roles, meal service/meal monitoring, meals for employees, documentation and Incentive program." There was no documentation on this form that indicated the staff was in-serviced regarding oral/denture care. The in-service was signed as being conducted by the Administrator.

f. Progress Notes dated 7/9/15 at 4:33 a.m., documented, "Send to ER for eval [evaluation] due to swelling of nose, cheeks and upper lip." There was no other documentation in the nurses notes regarding this issue.

g. A Incident report dated 7/9/15 at 4:44 a.m., documented the description as: "CNA [Certified

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Nursing Assistant] brought this writer to rm [room] 105 to observe res [resident's] face. Noted her face seems swollen around mouth, nose seems swollen, also cheeks and under eyes. Small amt [amount] of old blood seen in mouth, dried around lips. Mouth care done but res is very tender in mouth, has trouble opening mouth and also very tender to touch on cheeks, nose and upper lip is also swollen." The notes section documented, "Noted res had old blood in mouth and dried on lips. Mouth care done but res has difficulty opening mouth due to pain. On close exam found face to be swollen and very tender to touch around mouth, nose, both cheeks and under eyes. Res is able to answer yes and no questions but cannot elaborate as to anything that may have happened to her face. She can say 'yes' that it hurts, Given APAP [acetaminophen] 650 mg [milligrams] crushed in applesauce, which she did get down with difficulty."

h. The Emergency Room report dated 7/9/15 at 4:47 a.m., documented, "Patient has a small amount of facial swelling noted to right side of her face over the maxillary sinus region. This area is tender to palpation. It is slightly erythematous. The oral pharynx is this patient to have upper dentures which have not been removed for quite some time and are firmly in place. She has a fetid odor to her breath. There does not appear to be any intraoral trauma." The Radiology interpretation documented, "CT [computerized tomography] of the facial bones reveal this patient to have some bony like destruction noted to the maxillary portion of her face on the right side which could be consistent with an Osteomyelitis. This patient will be admitted to the hospital for IV [intravenous] antibiotics and further care." The ER notes documented, "I spoke with the patient's

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daughter concerning the findings of the CT. The daughter did help keep the patient, while I removed the patient's dentures. There was a lot of foul-smelling odor to this and the patient's gum on the right maxillary side of her mouth is bleeding and broken down from infection."

i. The ENT (Ears, Nose and Throat) specialist report dated 7/9/15 at 5:20 p.m., documented, "CT showed some bony erosion of the maxilla on the right. Apparently ER had a hard time getting dentures out. Granulation tissue along the right Gingofabial groove along the right maxilla." The diagnosis was documented as "Cellulitis with Osteomyelitis, I think this is secondary to her upper dentures eroding into her gum line."

On 7/14/15 at 4:45 p.m., the ENT specialist stated that based on the history that he received her dentures had to have been there a long time. He further stated that he did not see her with her dentures, but was in the area that the dentures fit and it had to have been there a long time.

j. The July 2015 Medication Administration record documented an order, "Ensure dentures are removed and placed in denture cup with cleaner q HS at bedtime." This was documented, with nurses' initials, as being completed at 7:00 p.m. from 7/1 - 8/15.

k. On 7/15/15 at 7:55 p.m., Licensed Practical Nurse (LPN) #1 was asked, "Did you visually see the dentures in the cup when you initialed it being completed on 7/8/15?" She replied, "No, the CNA's told me that it was done."

l. On 7/15/15 at 8:30 p.m., LPN #2 was asked, "Did you visually see the dentures in the cup

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when you initialed it being completed on 7/3/15 and 7/6/15?" She replied, "No, I asked the CNA's and they told me they were."

m. On 7/15/15 at 8:10 p.m., CNA #1 stated that she had worked for the facility for 7 months and that she floats. She stated that sometimes the resident would refuse to have her dentures removed but she did oral care on her.

n. On 7/15/15 at 8:15 p.m., CNA #2 stated that she had worked at the facility since February 2015 and she did not know the resident even had dentures.

o. On 7/15/15 at 8:25 p.m., CNA #3 stated that if the resident had her dentures in her mouth she removed them. She stated that she only works the hall where the resident resides two nights a week and that she did put the resident's dentures in a cup on those two nights.

p. A form titled, "Oral Care/Denture Care Completed" was utilized by the CNA's to document the date and shift that they completed the care on the individuals who had dentures. There were forms documenting oral/denture care for January through May 2015.

On 7/15/15 at 10:10 a.m., the Administrator stated that she started here in February 2015 and the form was already in place. She did not know why. She was asked to locate any documentation of this form being completed for this resident. As of 7/15/15 at 2:00 p.m., the Administrator did not provide any more forms that documented oral care for this resident.

q. The plan of care initiated on 6/8/14

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F 490	Continued From page 20 documented a problem of "The resident has limited physical mobility r/t [related to] disease process (hip fracture) with interventions initiated on 7/13/15 of "Clean teeth/partial dentures every morning, bedtime and PRN [as needed]. Place dentures in cup with cleaner every bedtime." There was no documentation on the plan of care regarding denture care until 7/13/15. r. On 7/15/15 at 1:10 p.m., the Administrator stated that she was not here when the January 2015 grievance was filed and she did not know what the facility did. She stated she was here when the March 2015 grievance report was submitted and staff were in-serviced but did not know if she talked about oral care or not. She stated that she did not document it on the in-service sheet and she usually does. The Administrator was asked, "What system did you put in place to prevent this re-occurring again?" She stated, "I didn't put any system in place." She stated that now she has in-serviced the staff regarding denture care with return demonstrations and that the CNA's were to report to the nurse if anyone refuses and that the LPN will visually check to make sure the dentures were in a cup at night.	F 490		
F 520 SS=H	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		

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The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Complaint #20331 (AR 00018438) and #20340 (AR 00018445) were substantiated (all or in part) in these findings.

Based on observations, record review and interviews, the facility failed to ensure the Quality Assurance and Assessment (QAA) committee met every 3 months, identified quality deficiencies and developed a plan of corrective action to address complaints regarding the staff's failures to provide oral and denture care to prevent development of an oral cavity infection for 1 of 1 (Resident #6) case mix resident who required the use of dentures, was dependent on staff for oral care, and was cognitively impaired. This resulted in a pattern of harm for Resident #6 who was hospitalized with a diagnoses of Osteomyelitis from lack of oral and denture care. This failed practice had the potential to cause more than

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minimal harm to 15 residents who required the use of dentures, were dependent for oral care, and cognitively impaired as per a list provided by the Medicare Manager on 7/15/15 at 12:45 p.m. The findings are:

1. On 7/15/15 at 1:10 p.m., the Administrator was asked the following questions:

a. How often does the QAA committee meet?" She replied, "Every Quarter."

b. When was the last QAA meeting?" She replied, "Have not had one since February. We have a daily standup meeting and we go over the grievances."

c. Did the QAA Committee develop and implement a system to prevent the continued harm for Resident #6?" She replied, "No, there was no system put in place."

2. Resident #6 had diagnoses of Dementia and Alzheimer's. The Annual Minimum Data Set with an Assessment Reference date of 6/10/15 documented the resident was severely impaired in cognitive skills for daily decision making per the Staff Assessment for Mental Status and required extensive assistance with personal hygiene.

a. A dental report dated 1/21/15 documented, "Cleaned upper partial -very very dirty-covered in thick buildup prophylaxis on lower teeth."

b. A grievance report dated 1/21/15 documented, "Resident went to dentist today. Upon arrival, dentures were noted to be unclean with food on them." The action taken documented, "Denture/oral care in-service started on 1/21/15

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for oral/denture care to be done every shift."

c. A physician orders dated 2/6/15 documented, "Ensure dentures are removed and placed in denture cup with cleanser Q [every] HS at bedtime."

d. A grievance report, not dated, documented, "[Name of daughter] the daughter of resident [Resident #6] reported to the interim DON (Director of Nursing) that when her mother went to the ER [Emergency Room] following a fall the resident's toenails were excessively long. Her mother is a diabetic. She further states that other times when has had issue with the resident's teeth being unclean." The response documented, "The DON had a lengthy conversation with the family member. [Treatment Nurse] the tx [treatment] nurse is to get the toenails trimmed immediately. I will speak to the housekeeping supervisor as well as the nursing staff in regards to the other issues." The form had the Administrator's signature at the bottom of the form with a date of 3/17/15

e. An in-service dated 3/20/15 documented the topics covered as "Checking orders/24 hour chart checks, Responsible for admit, Bagging linens, peri-care -supplies on cart down hallway, nail care, handwashing, in-service book, charge nurse; CNA roles, meal service/meal monitoring, meals for employees, documentation and Incentive program." There was no documentation on this form that indicated the staff was in-serviced regarding oral/denture care. The in-service was signed as being conducted by the Administrator.

f. Progress Notes dated 7/9/15 at 4:33 a.m.,

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documented, "Send to ER for eval [evaluation] due to swelling of nose, cheeks and upper lip." There was no other documentation in the nurses notes regarding this issue.

g. A Incident report dated 7/9/15 at 4:44 a.m., documented the description as: "CNA [Certified Nursing Assistant] brought this writer to rm [room] 105 to observe res [resident's] face. Noted her face seems swollen around mouth, nose seems swollen, also cheeks and under eyes. Small amt [amount] of old blood seen in mouth, dried around lips. Mouth care done but res is very tender in mouth, has trouble opening mouth and also very tender to touch on cheeks, nose and upper lip is also swollen." The notes section documented, "Noted res had old blood in mouth and dried on lips. Mouth care done but res has difficulty opening mouth due to pain. On close exam found face to be swollen and very tender to touch around mouth, nose, both cheeks and under eyes. Res is able to answer yes and no questions but cannot elaborate as to anything that may have happened to her face. She can say 'yes' that it hurts, Given APAP [acetaminophen] 650 mg [milligrams] crushed in applesauce, which she did get down with difficulty."

h. The Emergency Room report dated 7/9/15 at 4:47 a.m., documented, "Patient has a small amount of facial swelling noted to right side of her face over the maxillary sinus region. This area is tender to palpation. It is slightly erythematous. The oral pharynx is this patient to have upper dentures which have not been removed for quite some time and are firmly in place. She has a fetid odor to her breath. There does not appear to be any intraoral trauma." The Radiology interpretation documented, "CT [computerized

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	045457	A. BUILDING _____ B. WING _____	C 07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAGECOACH NURSING AND REHABILITATION CENTER	6907 HIGHWAY 5 NORTH BRYANT, AR 72022

(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
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tomography] of the facial bones reveal this patient to have some bony like destruction noted to the maxillary portion of her face on the right side which could be consistent with an Osteomyelitis. This patient will be admitted to the hospital for IV [intravenous] antibiotics and further care." The ER notes documented, "I spoke with the patient's daughter concerning the findings of the CT. The daughter did help keep the patient, while I removed the patient's dentures. There was a lot of foul-smelling odor to this and the patient's gum on the right maxillary side of her mouth is bleeding and broken down from infection."

i. The ENT (Ears, Nose and Throat) specialist report dated 7/9/15 at 5:20 p.m., documented, "CT showed some bony erosion of the maxilla on the right. Apparently ER had a hard time getting dentures out. Granulation tissue along the right Gingofabial groove along the right maxilla." The diagnosis was documented as "Cellulitis with Osteomyelitis, I think this is secondary to her upper dentures eroding into her gum line."

On 7/14/15 at 4:45 p.m., the ENT specialist stated that based on the history that he received her dentures had to have been there a long time. He further stated that he did not see her with her dentures, but was in the area that the dentures fit and it had to have been there a long time.

j. The July 2015 Medication Administration record documented an order, "Ensure dentures are removed and placed in denture cup with cleaner q HS at bedtime." This was documented, with nurses' initials, as being completed at 7:00 p.m. from 7/1 - 8/15.

k. On 7/15/15 at 7:55 p.m., Licensed Practical

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Nurse (LPN) #1 was asked, "Did you visually see the dentures in the cup when you initialed it being completed on 7/8/15?" She replied, "No, the CNA's told me that it was done."

l. On 7/15/15 at 8:30 p.m., LPN #2 was asked, "Did you visually see the dentures in the cup when you initialed it being completed on 7/3/15 and 7/6/15?" She replied, "No, I asked the CNA's and they told me they were."

m. On 7/15/15 at 8:10 p.m., CNA #1 stated that she had worked for the facility for 7 months and that she floats. She stated that sometimes the resident would refuse to have her dentures removed but she did oral care on her.

n. On 7/15/15 at 8:15 p.m., CNA #2 stated that she had worked at the facility since February 2015 and she did not know the resident even had dentures.

o. On 7/15/15 at 8:25 p.m., CNA #3 stated that if the resident had her dentures in her mouth she removed them. She stated that she only works the hall where the resident resides two nights a week and that she did put the resident's dentures in a cup on those two nights.

p. A form titled, "Oral Care/Denture Care Completed" was utilized by the CNA's to document the date and shift that they completed the care on the individuals who had dentures. There were forms documenting oral/denture care for January through May 2015.

On 7/15/15 at 10:10 a.m., the Administrator stated that she started here in February 2015 and the form was already in place. She did not know

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why. She was asked to locate any documentation of this form being completed for this resident. As of 7/15/15 at 2:00 p.m., the Administrator did not provide any more forms that documented oral care for this resident.

q. The plan of care initiated on 6/8/14 documented a problem of "The resident has limited physical mobility r/t [related to] disease process (hip fracture) with interventions initiated on 7/13/15 of "Clean teeth/partial dentures every morning, bedtime and PRN [as needed]. Place dentures in cup with cleaner every bedtime." There was no documentation on the plan of care regarding denture care until 7/13/15.

r. On 7/15/15 at 1:10 p.m., the Administrator stated that she was not here when the January 2015 grievance was filed and she did not know what the facility did. She stated she was here when the March 2015 grievance report was submitted and staff were in-serviced but did not know if she talked about oral care or not. She stated that she did not document it on the in-service sheet and she usually does. The Administrator was asked, "What system did you put in place to prevent this re-occurring again?" She stated, "I didn't put any system in place." She stated that now she has in-serviced the staff regarding denture care with return demonstrations and that the CNA's were to report to the nurse if anyone refuses and that the LPN will visually check to make sure the dentures were in a cup at night.