PRINTED: 07/21/2015 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		045457	B. WING				C
NAME OF PE	ROVIDER OR SUPPLIER	040407			STREET ADDRESS, CITY, STATE, ZIP CODE	077	15/2015
	(0 / 15 L / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 /				6907 HIGHWAY 5 NORTH		
STAGECO	ACH NURSING AND RE	HABILITATION CENTER			BRYANT, AR 72022		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
F 000	INITIAL COMMENTS		F	000			
		7 (Statement of Deficiencies)					
		cument. All information must scept for entering the plan of					
		dates, and the signature ncy in the original deficiency					
		orted to the Dallas Regional					
	Inspector General (O	IG) for possible fraud. If					
	provider/supplier, the	tently changed by the State Survey Agency (SA)					
	should be notified imr	mediately.					
	O	D 00040400\					
	Complaint #20331 (A substantiated (all or in at F224, F312, F490)	n part) with deficiencies cited					
	Complaint #20340 (A	R 00018445) was					
	at F224, F312, F490	n part) with deficiencies cited and F520					
	Complaint #20309 (A	R 00018404) was					
	unsubstantiated Complaint #20323 (A	R 00018420) was					
F 224		n part) without deficiencies.		224			
SS=H	<u> </u>	GLECT/MISAPPROPRIATN	F .				
		elop and implement written					
		t, and abuse of residents					
	and misappropriation	of resident property.					
		SUPPLIER REPRESENTATIVE'S SIGNATURE			TITI F		(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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	ATE SURVEY MPLETED
		045457	B. WING			C 07/15/2015
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		J7713/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 224	Continued From pag		F 2	24		
	by: Complaint #20331 (AR 00018445) were in these findings. Based on observation interviews, the facility procedures to prohibit to assure necessary consistently provided prevent infections of (Resident #6) case in use of dentures, was care, and was cognitin a pattern of harm to hospitalized with a diffrom lack of oral and practice had the pote minimal harm to 15 in use of dentures, were and cognitively impa	AR 00018438) and #20340 substantiated (all or in part) ans, record review and failed to ensure policies and it neglect were implemented care and services were for oral and denture care to the oral cavity for 1 of 1 nix resident who required the dependent on staff for oral ively impaired. This resulted for Resident #6 who was agnoses of Osteomyelitis denture care. This failed ential to cause more than esidents who required the dependent for oral care, fired as per a list provided by er on 7/15/15 at 12:45 p.m.				
	goods and services in harm, mental anguis occurs on an individu does not receive care	dent Abuse" policy eglect-Failure to provide necessary to avoid physical h, or mental illness. Neglect ial basis when a resident e in one or more areas. iagnoses of Dementia and				
	Alzheimer's. The An an Assessment Refe documented the resi in cognitive skills for	nual Minimum Data Set with rence date of 6/10/15 dent was severely impaired daily decision making per the Mental Status and required				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		045457	B. WING			C 07/15/2015
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 6907 HIGHWAY 5 NORTH BRYANT, AR 72022	CODE	07/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 224	extensive assistance a. A dental report da "Cleaned upper part thick buildup prophy b. A grievance repor "Resident went to de dentures were noted them." The action ta "Denture/oral care ir for oral/denture care c. A physician orders "Ensure dentures ar denture cup with cle bedtime." d. A grievance repor "[Name of daughter] [Resident #6] report (Director of Nursing) to the ER [Emergeneresident's toenails we mother is a diabetic. times when has had teeth being unclean. "The DON had a len family member. [Tre [treatment] nurse is immediately. I will s supervisor as well as to the other issues."	ted 1/21/15 documented, ial -very very dirty-covered in laxis on lower teeth." It dated 1/21/15 documented, entist today. Upon arrival, I to be unclean with food on aken documented, enservice started on 1/21/15 to be done every shift." Is dated 2/6/15 documented, enservice and placed in lanser Q [every] HS at It, not dated, documented, the daughter of resident ed to the interim DON that when her mother went expressively long. Her she further states that other issue with the resident's "The response documented, gthy conversation with the eatment Nurse] the tx to get the toenails trimmed peak to the housekeeping is the nursing staff in regards The form had the ature at the bottom of the	F2	224		
	topics covered as "C	ed 3/20/15 documented the Checking orders/24 hour chart for admit, Bagging linens,				

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		045457	B. WING			I	C 15/2015
	ROVIDER OR SUPPLIER DACH NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, S 6907 HIGHWAY 5 NORTH BRYANT, AR 72022	TATE, ZIP CODE	<u> </u>	13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 224	care, handwashing, inurse; CNA roles, memeals for employees Incentive program." documentation on this staff was in-serviced. The in-service was seen the Administrator. f. Progress Notes dad documented, "Send to due to swelling of not. There was no other conotes regarding this in the swellength of t	n cart down hallway, nail n-service book, charge eal service/meal monitoring, documentation and There was no is form that indicated the regarding oral/denture care. Igned as being conducted by ted 7/9/15 at 4:33 a.m., to ER for eval [evaluation] se, cheeks and upper lip." documentation in the nurses issue. ated 7/9/15 at 4:44 a.m., cription as: "CNA [Certified ought this writer to rm [room] esident's] face. Noted her around mouth, nose seems and under eyes. Small amt I seen in mouth, dried around the but res is very tender in pening mouth and also very neeks, nose and upper lip is otes section documented, lood in mouth and dried on the but res has difficulty opain. On close exam llen and very tender to touch both cheeks and under answer yes and no relaborate as to anything that to her face. She can say ten APAP [acetaminophen] crushed in applesauce,	F	224			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		045457	B. WING			C 7/15/2015
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		7710,2010
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 224	h. The Emergency 4:47 a.m., documer amount of facial sw face over the maxill tender to palpation. The oral pharynx is dentures which have some time and are fetid odor to her bre to be any intraoral to interpretation document tomography] of the to have some bony maxillary portion of which could be con This patient will be [intravenous] antibic ER notes document daughter concerning daughter did help keremoved the patient of foul-smelling odd on the right maxillatic bleeding and broke in the ENT (Ears, Noreport dated 7/9/15 "CT showed some the right. Apparent dentures out. Grangofabial groove diagnosis was document of the control of the right. Apparent dentures out. Grangofabial groove diagnosis was document of the control of the right. Apparent dentures out. Grangofabial groove diagnosis was document of the control of the	Room report dated 7/9/15 at nted, "Patient has a small relling noted to right side of her lary sinus region. This area is It is slightly erythematous. This patient to have upper re not been removed for quite firmly in place. She has a reath. There does not appear rauma." The Radiology mented, "CT [computerized facial bones reveal this patient like destruction noted to the her face on the right side sistent with an Osteomyelitis. admitted to the hospital for IV otics and further care." The ted, "I spoke with the patient's g the findings of the CT. The eep the patient, while I t's dentures. There was a lot or to this and the patient's gum ry side of her mouth is n down from infection." Ilose and Throat) specialist at 5:20 p.m., documented, bony erosion of the maxilla on y ER had a hard time getting relation tissue along the right along the right maxilla." The umented as "Cellulitis with right his is secondary to her ding into her gum line." p.m., the ENT specialist on the history that he received have been there a long time. The received of have been there a long time. The received of have been there a long time. The received of have been there a long time.	F 22	24		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	' '	DATE SURVEY COMPLETED
		045457	B. WING _			C 07/15/2015
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 6907 HIGHWAY 5 NORTH BRYANT, AR 72022	E	01710/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 224	and it had to have by j. The July 2015 Medocumented an orderemoved and placed q HS at bedtime." Inurses' initials, as by from 7/1 - 8/15. k. On 7/15/15 at 7:5 Nurse (LPN) #1 was the dentures in the completed on 7/8/15 CNA's told me that it. On 7/15/15 at 8:30 "Did you visually sewhen you initialed it and 7/6/15?" She mand they told me that m. On 7/15/15 at 8:30 she had worked for that she floats. She resident would refus removed but she did not contain the contains on 7/15/15 at 8:30 she had worked at the 2015 and she did not dentures. o. On 7/15/15 at 8:20 the resident had held removed them. She the hall where the resident where the resident where the resident where the resident had held where the resident where the resident had held where the resident where t	dication Administration record er, "Ensure dentures are din denture cup with cleaner This was documented, with eing completed at 7:00 p.m. 5 p.m., Licensed Practical sasked, "Did you visually see cup when you initialed it being 5?" She replied, "No, the t was done." 10 p.m., LPN #2 was asked, et the dentures in the cup being completed on 7/3/15 eplied, "No, I asked the CNA's ey were." 10 p.m., CNA #1 stated that the facility for 7 months and estated that sometimes the set to have her dentures doral care on her. 15 p.m., CNA #2 stated that the facility since February of know the resident even had 15 p.m., CNA #3 stated that if dentures in her mouth she estated that she only works esident resides two nights a lid put the resident's dentures	F2	224		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		045457	B. WING			C 07/15/2015
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 6907 HIGHWAY 5 NORTH BRYANT, AR 72022	lE	07/19/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	DATE
F 224	p. A form titled, "Ora Completed" was utili document the date at the care on the indiv There were forms do for January through On 7/15/15 at 10:10 stated that she started that she started the form was already why. She was asked documentation of this resident. As of Administrator did not documented oral care in documented a proble limited physical mob process (hip fracture on 7/13/15 of "Clean morning, bedtime and	le 6 I Care/Denture Care zed by the CNA's to and shift that they completed iduals who had dentures. commenting oral/denture care May 2015. a.m., the Administrator and here in February 2015 and and in place. She did not know and to locate any as form being completed for and the strength of the streng	F 2	DEFICIENCY)		
	regarding denture car. On 7/15/15 at 1:10 stated that she was 2015 grievance was what the facility did. when the March 201 submitted and staff with know if she talked at stated that she did n in-service sheet and Administrator was as put in place to preve	nentation on the plan of care are until 7/13/15. I p.m., the Administrator not here when the January filed and she did not know She stated she was here 5 grievance report was vere in-serviced but did not bout oral care or not. She ot document it on the she usually does. The sked, "What system did you nt this re-occurring again?" put any system in place."				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SI COMPLE	
		045457	B. WING _			C 07/14	5/2015
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 6907 HIGHWAY 5 NORTH BRYANT, AR 72022)E	3 7710	3/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 224	regarding denture can demonstrations and t to the nurse if anyone	she has in-serviced the staff re with return hat the CNA's were to report e refuses and that the LPN make sure the dentures	F 2				
SS=H	DEPENDENT RESID A resident who is una daily living receives the						
	by: Complaint #20331 (A	is not met as evidenced AR 00018438) and #20340 substantiated (all or in part)					
	interviews, the facility care and services we oral and denture care oral cavity for 1 of 1 (resident who required dependent on staff for cognitively impaired. harm for Resident #6 diagnoses of Osteom denture care. This fair potential to cause more residents who required dependent for oral care.	This resulted in a pattern of who was hospitalized with a yelitis from lack of oral and led practice had the re than minimal harm to 15 de the use of dentures, were re, and cognitively impaired by the Medicare Manager					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6907 HIGHWAY 5 NORTH BRYANT, AR 72022	0//19/2015
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F 312	Continued From page 8		F 31	2	
	Alzheimer's. The A an Assessment Re documented the re in cognitive skills for Staff Assessment ff extensive assistant a. A dental report of "Cleaned upper pathick buildup prophets. A grievance report "Resident went to ordentures were note them." The action "Denture/oral care for oral/denture care c. A physician orde "Ensure dentures a	agnoses of Dementia and Annual Minimum Data Set with ference date of 6/10/15 sident was severely impaired or daily decision making per the or Mental Status and required be with personal hygiene. Lated 1/21/15 documented, ritial -very very dirty-covered in ylaxis on lower teeth." Lort dated 1/21/15 documented, dentist today. Upon arrival, and to be unclean with food on taken documented, in-service started on 1/21/15 are to be done every shift." Lort dated 2/6/15 documented, in-service and placed in eanser Q [every] HS at			
	"[Name of daughte [Resident #6] report (Director of Nursing to the ER [Emergeresident's toenails mother is a diabetic times when has hat teeth being unclear "The DON had a lefamily member. [T [treatment] nurse is immediately. I will	ort, not dated, documented, r] the daughter of resident ted to the interim DON g) that when her mother went ncy Room] following a fall the were excessively long. Her c. She further states that other d issue with the resident's n." The response documented, ingthy conversation with the reatment Nurse] the tx is to get the toenails trimmed speak to the housekeeping as the nursing staff in regards			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		045457	B. WING			C	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		7/15/2015	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 312	Continued From page to the other issues." Administrator's sign form with a date of 3 e. An in-service date topics covered as "Cohecks, Responsible peri-care -supplies of care, handwashing, nurse; CNA roles, meals for employee Incentive program." documentation on the staff was in-service was at the Administrator. f. Progress Notes dadocumented, "Send due to swelling of not There was no other notes regarding this g. A Incident report	ge 9 The form had the ature at the bottom of the 3/17/15 ed 3/20/15 documented the Checking orders/24 hour chart e for admit, Bagging linens, on cart down hallway, nail in-service book, charge heal service/meal monitoring, s, documentation and There was no his form that indicated the d regarding oral/denture care. Signed as being conducted by atted 7/9/15 at 4:33 a.m., to ER for eval [evaluation] ose, cheeks and upper lip." documentation in the nurses	F 3:	DEFICIENCY)			
	Nursing Assistant] b 105 to observe res face seems swollen swollen, also cheek [amount] of old bloo lips. Mouth care do mouth, has trouble of tender to touch on of also swollen." The "Noted res had old blips. Mouth care do opening mouth due found face to be swollen."	prought this writer to rm [room] fresident's] face. Noted her around mouth, nose seems and under eyes. Small amt d seen in mouth, dried around ne but res is very tender in opening mouth and also very cheeks, nose and upper lip is notes section documented, clood in mouth and dried on ne but res has difficulty to pain. On close exam collen and very tender to touch ex, both cheeks and under					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE S COMPLI	
		045457	B. WING _			C 07/1	5/2015
	ROVIDER OR SUPPLIER DACH NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 6907 HIGHWAY 5 NORTH BRYANT, AR 72022	E	U	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	I	(X5) COMPLETION DATE
F 312	eyes. Res is able to questions but cannot may have happened 'yes' that it hurts, Giv 650 mg [milligrams] of which she did get down the face over the maxillatender to palpation. The oral pharynx is the dentures which have some time and are fit fetid odor to her breat to be any intraoral trainterpretation docume tomography] of the fact to have some bony limaxillary portion of hwhich could be consitated aughter concerning daughter did help keer moved the patient's of foul-smelling odor on the right maxillary bleeding and broken i. The ENT (Ears, No report dated 7/9/15 a "CT showed some bothe right. Apparently dentures out. Granu Gingofabial groove a	answer yes and no elaborate as to anything that to her face. She can say en APAP [acetaminophen] crushed in applesauce, wn with difficulty." com report dated 7/9/15 at ed, "Patient has a small ling noted to right side of her ry sinus region. This area is t is slightly erythematous. his patient to have upper not been removed for quite mly in place. She has a th. There does not appear numa." The Radiology ented, "CT [computerized cicial bones reveal this patient the destruction noted to the er face on the right side estent with an Osteomyelitis. dmitted to the hospital for IV ics and further care." The d, "I spoke with the patient's the findings of the CT. The ep the patient, while I se dentures. There was a lot to this and the patient's gum	F3	12			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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F 312	Continued From pag	ge 11	F 3	12			
		this is secondary to her ing 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."						
	"Did you visually see when you initialed it	p.m., LPN #2 was asked, the dentures in the cup being completed on 7/3/15 eplied, "No, I asked the CNA's by were."					
	she had worked for t that she floats. She	0 p.m., CNA #1 stated that the facility for 7 months and stated that sometimes the e to have her dentures oral care on her.					
	she had worked at th	5 p.m., CNA #2 stated that ne facility since February st know the resident even had					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		045457	B. WING			C 7/ 15/2015	
	ROVIDER OR SUPPLIER ACH NURSING AND RI	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		7/15/2015	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 312	the resident had her removed them. She the hall where the reweek and that she din a cup on those tw. p. A form titled, "Ora Completed" was utilidocument the date at the care on the indiv. There were forms do for January through. On 7/15/15 at 10:10 stated that she start the form was already why. She was askedocumentation of this resident. As of Administrator did no documented oral care idocumented a problem.	5 p.m., CNA #3 stated that if dentures in her mouth she stated that she only works sident resides two nights a id put the resident's dentures o nights. I Care/Denture Care ized by the CNA's to and shift that they completed iduals who had dentures. Documenting oral/denture care May 2015. a.m., the Administrator ed here in February 2015 and y in place. She did not know do to locate any some being completed for 7/15/15 at 2:00 p.m., the to provide any more forms that refor this resident.	F 3:	,			
	process (hip fracture on 7/13/15 of "Clear morning, bedtime ar dentures in cup with There was no docum regarding denture car. On 7/15/15 at 1:10 stated that she was 2015 grievance was what the facility did.	e) with interventions initiated teeth/partial dentures every and PRN [as needed]. Place cleaner every bedtime."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		045457	B. WING				C 15/2015
	ROVIDER OR SUPPLIER ACH NURSING AND RE	HABILITATION CENTER		69	TREET ADDRESS, CITY, STATE, ZIP CODE 907 HIGHWAY 5 NORTH RYANT, AR 72022	077	13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	know if she talked ab stated that she did no in-service sheet and s Administrator was as put in place to preven She stated, "I didn't p She stated that now s regarding denture can demonstrations and t to the nurse if anyone	ere in-serviced but did not out oral care or not. She out oral care or not. She out document it on the she usually does. The ked, "What system did you out this re-occurring again?" out any system in place." She has in-serviced the staff re with return that the CNA's were to report the refuses and that the LPN make sure the dentures	F	312			
F 490 SS=H	A facility must be adn enables it to use its re efficiently to attain or	mental, and psychosocial	F	490			
	by: Complaint #20331 (AR 00018445) were in these findings. Based on observation interviews, the facility Administration failed system in place to as services were consist denture care to preve cavity for 1 of 1 (Resi	Administration and Nursing to ensure there was a sure necessary care and tently provided for oral and int infections of the oral dent #6) case mix resident of dentures, was dependent					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		045457	B. WING			C 07/15/2015	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		1//13/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 490	Resident #6 who wadiagnoses of Osteon denture care. This fapotential to cause m residents who requiredependent for oral cas per a list provided on 7/15/15 at 12:45. 1. The Job Description obtained on 7/15/15. "Purpose of your Job purpose of goildlines, and regulacilities to assure the quality of care can be all times" 2. The Job Description obtained on 7/15/15. "Purpose of your Job purpose of job position direct the overall open Department in according state, and local standaregulations, that gove be directed by the Acconsultant and the resultant and the result	ed in a pattern of harm for s hospitalized with a nyelitis from lack of oral and ailed practice had the ore than minimal harm to 15 ed the use of dentures, were are, and cognitively impaired by the Medicare Manager p.m. The findings are: on for the Administrator at 12:45 p.m., documented, or Position The primary position is to direct the day to facility in accordance with e, and local standards, lations that govern nursing at the highest degree of e provided to our residents at 12:45 p.m., documented, or Description The primary on is to plan, develop, and the primary on is to plan the pri	F 4	90			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		045457	B. WING _			C 7/ 15/2015	
	ROVIDER OR SUPPLIER DACH NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		7713/2013	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 490	resident request 36 are unable to call for 37. Develop and part conducting, and sche training classes that to do the job", and er nursing service depa written plan of care, p comprehensive, for et the problems/needs care to be given, goa which professional se element of care" 3. Resident #6 had d Alzheimer's. The An an Assessment Refe documented the resic in cognitive skills for Staff Assessment for extensive assistance a. A dental report dat "Cleaned upper parti thick buildup prophyl." b. A grievance report "Resident went to de dentures were noted them." The action ta "Denture/oral care in for oral/denture care c. A physician orders "Ensure dentures are	in accordance with the in accordance with the in accordance with the in accordance with the in accordance who help are checked frequently. It is in a cicipate in planning, aduling of timely in-service provide instructions on "How insure a well-educated rtment 49. Develop a coreliminary and each resident that identified of the resident, indicates the als, to be accomplished, and ervice is responsible for each in accordance with a cordance with rence date of 6/10/15 dent was severely impaired daily decision making per the in accordance with personal hygiene. In accordance with the indicates who is a cordance with personal hygiene. In accordance with the indicates who is a cordance with personal hygiene. In accordance with the indicates who is a cordance with personal hygiene. In accordance with the indicates who is a cordance with personal hygiene. In accordance with the indicates who is a cordance with personal hygiene.	F 4	90			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		045457	B. WING _				C 15/2015
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 6907 HIGHWAY 5 NORTH BRYANT, AR 72022	DDE	, <u> </u>	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 490	"[Name of daughter] [Resident #6] reporter (Director of Nursing) to the ER [Emergency resident's toenails we mother is a diabetic. times when has had teeth being unclean. "The DON had a leng family member. [Tree [treatment] nurse is toe immediately. I will sy supervisor as well as to the other issues." Administrator's signat form with a date of 3. e. An in-service date topics covered as "C checks, Responsible peri-care -supplies of care, handwashing, in nurse; CNA roles, me meals for employees Incentive program." documentation on the staff was in-serviced The in-service was seen the Administrator. f. Progress Notes da documented, "Send of due to swelling of no There was no other of notes regarding this g. A Incident report of	the daughter of resident and to the interim DON that when her mother went by Room] following a fall the ere excessively long. Her she further states that other issue with the resident's The response documented, of the conversation with the atment Nurse] the tx of get the toenails trimmed beak to the housekeeping of the nursing staff in regards the nursing staff in regards The form had the ture at the bottom of the conversation with the atment Nurse] the tree at the bottom of the conversation and the toenails trimmed beak to the housekeeping or the nursing staff in regards the nursing staff in regards the conversation of the conversation and the tree at the bottom of the conversation and there was not as form that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that indicated the regarding oral/denture care. It is given that the resident is given that it is given that it is given that it	F	190			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		045457	B. WING			C 07/15/2015	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		11/15/2015	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 490	105 to observe res [I face seems swollen swollen, also cheeks [amount] of old blood lips. Mouth care dor mouth, has trouble of tender to touch on calso swollen." The range of the tender to touch on calso swollen." The range of the tender to touch on calso swollen. The range of the tender to touch on the tender to be swollen. The swollen swo	rought this writer to rm [room] resident's] face. Noted her around mouth, nose seems and under eyes. Small amt diseen in mouth, dried around he but res is very tender in opening mouth and also very heeks, nose and upper lip is notes section documented, blood in mouth and dried on he but res has difficulty to pain. On close exam bllen and very tender to touch and both cheeks and under answer yes and no to telaborate as to anything that to her face. She can say wen APAP [acetaminophen] crushed in applesauce, but with difficulty." The coom report dated 7/9/15 at ted, "Patient has a small elling noted to right side of her ary sinus region. This area is lit is slightly erythematous. This patient to have upper the not been removed for quite armly in place. She has a path. There does not appear auma." The Radiology tented, "CT [computerized acial bones reveal this patient like destruction noted to the ner face on the right side	F4	90			
	This patient will be a [intravenous] antibio	istent with an Osteomyelitis. dmitted to the hospital for IV tics and further care." The ed, "I spoke with the patient's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		045457	B. WING _			C 07/15/2015	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		01/15/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 490	daughter concerning daughter did help ker removed the patient's of foul-smelling odor on the right maxillary bleeding and broken i. The ENT (Ears, No report dated 7/9/15 a "CT showed some both the right. Apparently dentures out. Granu Gingofabial groove a diagnosis was docum Osteomyelitis, I think upper dentures erodi On 7/14/15 at 4:45 p stated that based on her dentures had to he further stated that dentures, but was in and it had to have be j. The July 2015 Med documented an order removed and placed q HS at bedtime." Thurses' initials, as be from 7/1 - 8/15. k. On 7/15/15 at 7:55 Nurse (LPN) #1 was the dentures in the completed on 7/8/15 CNA's told me that it	the findings of the CT. The ep the patient, while I is dentures. There was a lot to this and the patient's gum is side of her mouth is down from infection." It is and Throat) specialist is 5:20 p.m., documented, only erosion of the maxilla on ER had a hard time getting lation tissue along the right long the right maxilla." The mented as "Cellulitis with it is secondary to her ing into her gum line." I.m., the ENT specialist the history that he received have been there a long time. It he did not see her with her the area that the dentures fit then there a long time. Ilication Administration record r, "Ensure dentures are in denture cup with cleaner his was documented, with lang completed at 7:00 p.m. In p.m., Licensed Practical asked, "Did you visually see up when you initialed it being ?" She replied, "No, the	F 4	90			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	' '	(X3) DATE SURVEY COMPLETED	
		045457	B. WING			C)7/15/2015	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6907 HIGHWAY 5 NORTH BRYANT, AR 72022				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 490	and 7/6/15?" She and they told me the m. On 7/15/15 at 8 she had worked for that she floats. She resident would refuremoved but she don. On 7/15/15 at 8 she had worked at 2015 and she did redentures. O. On 7/15/15 at 8: the resident had he removed them. She the hall where the week and that she in a cup on those to p. A form titled, "Or Completed" was ut document the date the care on the ind	it being completed on 7/3/15 replied, "No, I asked the CNA's rey were." :10 p.m., CNA #1 stated that r the facility for 7 months and e stated that sometimes the rise to have her dentures rid oral care on her. :15 p.m., CNA #2 stated that the facility since February root know the resident even had 25 p.m., CNA #3 stated that if rer dentures in her mouth she resident resides two nights a did put the resident's dentures wo nights. ral Care/Denture Care rilized by the CNA's to and shift that they completed ividuals who had dentures.	F 49	,			
	On 7/15/15 at 10:1 stated that she star the form was already why. She was ask documentation of the this resident. As or Administrator did not start the start of	0 a.m., the Administrator rted here in February 2015 and dy in place. She did not know ed to locate any his form being completed for f 7/15/15 at 2:00 p.m., the ot provide any more forms that are for this resident.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION IG	· /	(X3) DATE SURVEY COMPLETED	
		045457	B. WING			C 07/15/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		07/19/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	limited physical mobil process (hip fracture) on 7/13/15 of "Clean morning, bedtime and dentures in cup with of There was no docume regarding denture car. 7. On 7/15/15 at 1:10 stated that she was no 2015 grievance was find what the facility did. Submitted and staff with know if she talked about stated that she did not in-service sheet and stated that she did not in-service sheet and shadministrator was as put in place to preven She stated, "I didn't put in place to preven She stated that now strengarding denture car demonstrations and the to the nurse if anyone will visually check to rewere in a cup at night 483.75(o)(1) QAA COMMITTEE-MEMB QUARTERLY/PLANS	m of "The resident has ity r/t [related to] disease with interventions initiated teeth/partial dentures every I PRN [as needed]. Place cleaner every bedtime." entation on the plan of care re until 7/13/15. p.m., the Administrator of here when the January illed and she did not know She stated she was here if grievance report was ere in-serviced but did not but oral care or not. She at document it on the she usually does. The ked, "What system did you at this re-occurring again?" the has in-serviced the staff re with return that the CNA's were to report the refuses and that the LPN make sure the dentures certain the content in the certain that t	F 4				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		045457	B. WING _			C 07/15/2015	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		01710/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 520	issues with respect and assurance activ develops and imple	nent and assurance least quarterly to identify to which quality assessment ities are necessary; and ments appropriate plans of	F §	520			
	A State or the Secretisclosure of the receive except insofar as su compliance of such requirements of this	section. by the committee to identify deficiencies will not be used as					
	by: Complaint #20331	IT is not met as evidenced (AR 00018438) and #20340 e substantiated (all or in part)					
	interviews, the facilitial Assurance and Assemet every 3 months and developed a pland address complaints to provide oral and development of an acceptance of dentures, was care, and was cognitin a pattern of harm hospitalized with a complact of oral and from lack of oral and	ons, record review and by failed to ensure the Quality essment (QAA) committee, identified quality deficiencies an of corrective action to regarding the staff's failures denture care to prevent oral cavity infection for 1 of 1 mix resident who required the sedependent on staff for oral tively impaired. This resulted for Resident #6 who was diagnoses of Osteomyelitis and denture care. This failed ential to cause more than					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		045457	B. WING			C 07/15/2015
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		07710/2010
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 520	use of dentures, wand cognitively imported the Medicare Mana. The findings are: 1. On 7/15/15 at 12 asked the following: a. How often does She replied, "Every be. When was the lareplied, "Have not have a daily stand grievances." c. Did the QAA Complement a system for Resident was no system put 2. Resident #6 ha Alzheimer's. The Alzheimer's. The Alzheimer's wills for Staff Assessment for Staff Assessmen	or residents who required the ere dependent for oral care, paired as per a list provided by ager on 7/15/15 at 12:45 p.m. 10 p.m., the Administrator was a questions: In the QAA committee meet?" A Quarter." The ast QAA meeting?" She had one since February. We up meeting and we go over the part of the p	F 52			
	a. A dental report of "Cleaned upper pathick buildup proph" b. A grievance repi "Resident went to dentures were note them." The action	dated 1/21/15 documented, rtial -very very dirty-covered in hylaxis on lower teeth." Ort dated 1/21/15 documented, dentist today. Upon arrival, ed to be unclean with food on taken documented, in-service started on 1/21/15				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED	
		045457	B. WING			C 07/15/2015	
	ROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		I DE	07/13/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 520	c. A physician orders "Ensure dentures are denture cup with clear bedtime." d. A grievance report "[Name of daughter] [Resident #6] reporte (Director of Nursing) to the ER [Emergence resident's toenails we mother is a diabetic. times when has had it teeth being unclean." "The DON had a leng family member. [Tree [treatment] nurse is to immediately. I will sp supervisor as well as to the other issues." Administrator's signa form with a date of 3/ e. An in-service date topics covered as "Cl checks, Responsible peri-care -supplies or care, handwashing, in nurse; CNA roles, me meals for employees Incentive program." documentation on thi staff was in-serviced The in-service was si the Administrator.	dated 2/6/15 documented, removed and placed in inser Q [every] HS at not dated, documented, the daughter of resident d to the interim DON that when her mother went y Room] following a fall the ere excessively long. Her She further states that other ssue with the resident's The response documented, other than the east to the housekeeping the nursing staff in regards the nursing staff in regards the form had the ture at the bottom of the 17/15 d 3/20/15 documented the necking orders/24 hour chart for admit, Bagging linens, in cart down hallway, nail in-service book, charge eal service/meal monitoring, documentation and	F 5.	20			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		· ,	(X3) DATE SURVEY COMPLETED	
		045457	B. WING _			C)7/15/2015	
NAME OF PROVIDER OR SUPPLIER STAGECOACH NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		07/19/2015		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE CROSS-RE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 520	due to swelling of There was no oth notes regarding the gradient of the common of the	nd to ER for eval [evaluation] nose, cheeks and upper lip." er documentation in the nurses	F	520			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		045457	B. WING			C 07/15/2015		
NAME OF PROVIDER OR SUPPLIER STAGECOACH NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CC 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		07/15/2015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 520	to have some bony lit maxillary portion of his which could be consist. This patient will be ac [intravenous] antibioting the Rotes documented daughter concerning daughter did help keer removed the patient's of foul-smelling odor on the right maxillary bleeding and broken i. The ENT (Ears, No report dated 7/9/15 ar "CT showed some bother right. Apparently dentures out. Granul Gingofabial groove aldiagnosis was docum Osteomyelitis, I think upper dentures erodin. On 7/14/15 at 4:45 p. stated that based on her dentures had to her dentures, but was in and it had to have be j. The July 2015 Med documented an order removed and placed q HS at bedtime." The nurses' initials, as befrom 7/1 - 8/15.	cial bones reveal this patient be destruction noted to the er face on the right side stent with an Osteomyelitis. It is and further care." The d, "I spoke with the patient's the findings of the CT. The ep the patient, while I is dentures. There was a lot to this and the patient's gum side of her mouth is down from infection." See and Throat) specialist to 5:20 p.m., documented, any erosion of the maxilla on ER had a hard time getting ation tissue along the right long the right maxilla." The mented as "Cellulitis with this is secondary to her night one for gum line." m., the ENT specialist the history that he received have been there a long time. The did not see her with her the area that the dentures fit	F 5	520				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		045457	B. WING _			1	C 15/2015
NAME OF PROVIDER OR SUPPLIER STAGECOACH NURSING AND REHABILITATION CENTER				690	REET ADDRESS, CITY, STATE, ZIP CODE 7 HIGHWAY 5 NORTH YANT, AR 72022	1 011	13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	e 26	F !	520			
	the dentures in the co	asked, "Did you visually see up when you initialed it being ?" She replied, "No, the was done."					
	"Did you visually see when you initialed it to	p.m., LPN #2 was asked, the dentures in the cup being completed on 7/3/15 plied, "No, I asked the CNA's y were."					
	she had worked for the that she floats. She	O p.m., CNA #1 stated that ne facility for 7 months and stated that sometimes the e to have her dentures oral care on her.					
	she had worked at th	5 p.m., CNA #2 stated that e facility since February know the resident even had					
	the resident had her removed them. She the hall where the res	i p.m., CNA #3 stated that if dentures in her mouth she stated that she only works sident resides two nights a d put the resident's dentures o nights.					
	the care on the indivi	zed by the CNA's to nd shift that they completed duals who had dentures. cumenting oral/denture care					
	stated that she starte	a.m., the Administrator d here in February 2015 and in place. She did not know					

* '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		045457	B. WING		C 07/15/2015	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6907 HIGHWAY 5 NORTH BRYANT, AR 72022		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 520	why. She was asked documentation of this this resident. As of 7 Administrator did not documented oral care q. The plan of care in documented a proble limited physical mobi process (hip fracture on 7/13/15 of "Clean morning, bedtime and dentures in cup with There was no docum regarding denture care. On 7/15/15 at 1:10 stated that she was reconstructed and staff when the March 2015 grievance was what the facility did. when the March 2015 submitted and staff whow if she talked abstated that she did not in-service sheet and Administrator was as put in place to prever She stated, "I didn't put She stated that now regarding denture care demonstrations and to the nurse if anyone."	It to locate any so form being completed for 1/15/15 at 2:00 p.m., the provide any more forms that e for this resident. Initiated on 6/8/14 sem of "The resident has lity r/t [related to] disease with interventions initiated teeth/partial dentures every d PRN [as needed]. Place cleaner every bedtime." entation on the plan of care re until 7/13/15. p.m., the Administrator not here when the January filled and she did not know She stated she was here of grievance report was were in-serviced but did not out oral care or not. She of document it on the she usually does. The ked, "What system did you not this re-occurring again?" but any system in place." she has in-serviced the staff re with return that the CNA's were to report the refuses and that the LPN make sure the dentures	F 520			