

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

PRINTED: 02/10/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2009
NAME OF PROVIDER OR SUPPLIER WHITE SULPHUR SPRINGS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 345 POCAHONTAS TRAIL PO BOX 249		
(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 272 SS=D	<p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>Based on medical record review, observation, resident interview, and staff interview, the facility failed to ensure the minimum data set (MDS) assessment for two (2) of eleven (11) sampled residents were accurate. One (1) MDS was inaccurate regarding a resident's height, the</p>	F 272	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.	09/29/09	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

09/29/2009

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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	<p>other regarding dental status. Resident identifiers: #25 and #32. Facility census: 58.</p> <p>Findings include:</p> <p>a) Resident #25</p> <p>This resident was admitted to the facility on 01/09/09. Review of the resident's admission and quarterly MDS assessments revealed his height was documented as 70 inches (5 ft 10 inches).</p> <p>On 08/19/09 at 2:00 p.m., this resident was observed being assisted to ambulate in the hallway. He appeared very tall.</p> <p>On 08/20/09 at 4:00 p.m., an interview was conducted with the resident. When asked how tall he was, the resident stated that he was 6' 4" tall (76 inches).</p> <p>Nursing staff was asked to measure the resident. They did, and reported the resident was 76 inches tall, not 70 inches tall.</p> <p>This discrepancy in height measurement resulted in the dietitian calculating caloric needs, protein needs, tube feeding formula, ideal body weight, etc. based on inaccurate information.</p> <p>b) Resident #32</p> <p>This resident was admitted to the facility on 06/09/09. His admission MDS indicated he had dentures.</p> <p>During observation of the noon meal, on 08/19/09, the resident stated he could not chew the meat he was served, because he did not</p>				

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F 329 SS=D	<p>have any teeth.</p> <p>At 4:00 p.m. on 08/19/09, the resident was interviewed regarding his chewing problem. He stated his dentures hurt his jaw, so he did not bring them with him to the nursing home.</p> <p>.</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p>	F 329	<p>PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.</p>	09/29/09	

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	<p>Based on medical record review and staff interview, the facility failed to ensure the drug regimen of one (1) of thirteen (13) sampled residents was free of unnecessary medications. This resident was ordered an antipsychotic medication without adequate indication for its use and without evidence of non-pharmacological interventions attempted prior to the decision to use an antipsychotic medication. Resident identifier: #32. Facility census: 58.</p> <p>Findings include:</p> <p>a) Resident #32</p> <p>Medical record review, on 08/20/09, revealed this resident was admitted to the facility on 06/09/09. On 07/28/09, the resident was ordered Risperdal 0.25 mg twice daily. Medical record review revealed that, at 9:00 a.m. on 07/28/09, the resident was "noted for aggressive behavior /c (with) staff member in hallway after staff attempted to take razor from resident. Resident became verbally abusive & threw razor down hallway." The physician was notified and ordered the Risperdal. This was a new resident, and there was no evidence that staff made a calm attempt to explain why the facility did not want him to have a razor. The medication was ordered without adequate indication for its use and without attempts at non-pharmacological interventions prior to its use.</p> <p>On 07/31/09, the physician increased the Risperdal to 0.50 mg twice daily. The medical record contained no evidence of why this action was necessary and no evidence of unsuccessful attempts with non-pharmacological interventions prior to increasing dosage of an antipsychotic medication.</p>			

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F 364 SS=C	<p>On 08/20/09 at 10:30 a.m., the director of nursing confirmed the Risperdal was ordered without adequate indication for its use and the dosage was increased without adequate indication and/or non-pharmacological intervention.</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation, menu review, and staff interview, the facility failed to ensure meals were attractive. The menu called for a garnish for regular diets, but one was not used. In addition, no garnishes were planned for residents who required mechanically altered or pureed diets. This practice has the potential to affect all residents who receive nourishment from the dietary department. Facility census: 58.</p> <p>Findings include:</p> <p>a) Observation during the noon meal, at 11:45 a.m. on 08/20/09, revealed the meal (which was planned and served) included roast pork, brown gravy, seasoned cauliflower, tropical sweet potatoes, and banana cream pie. All foods, except the sweet potatoes, were white to brown in color. The menu called for parsley for the regular meal trays, but this was not placed on the</p>	F 364	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.	09/29/09	

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F 371 SS=F	<p>trays. No garnish was planned for mechanically altered or pureed meals.</p> <p>At 12:00 p.m., the dietary manager (DM) was asked why parsley had not been used. She stated that it "did not come in". When asked why some other garnish had not been substituted, the DM confirmed it should have been.</p> <p>Menu review revealed it did not call for garnishes for any meals, except meals with regular consistency meats. Upon inquiry, the DM confirmed all residents should have the benefit of an attractive meal presentation through the use of garnishes, no matter what consistencies they might require.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on random observation, the facility failed to store and serve food under sanitary conditions. An employee of the therapy department contaminated the ice machine in the dietary department from which ice is used to serve the general population of the facility. This</p>	F 371	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.	09/29/09	

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F 514 SS=D	<p>has the potential to affect all residents in the facility. Facility census: 58</p> <p>Findings include:</p> <p>a) On 08/18/09 at 9:30 a.m., the physical therapy assistant (PTA) was observed filling an ice pack directly from the ice machine at the dietary department. While filling the ice pack, the ice scoop came in contact with the opening of the ice pack and then came into contact with the ice in the ice machine, when the PTA retrieved additional ice.</p> <p>.</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on medical record review and staff interview, it was determined the facility failed to assure each resident's medical record was accurately documented and/or complete for two (2) of fifteen (15) sampled residents. Recapitulation orders were not accurate, and</p>	F 514	PLEASE SUBMIT CREDIBLE EVIDENCE IN ADDITION TO AN ACCEPTABLE PLAN OF CORRECTION FOR THIS CITATION.	09/29/09	

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	<p>rehabilitation screenings were not filed in the medical records. Resident identifiers: #25 and #32. Facility census: 58.</p> <p>Findings include:</p> <p>a) Resident #25</p> <p>Medical record review revealed this resident had two (2) "as needed" (PRN) orders for Tylenol. If both orders had been given, the resident could have potentially received 7800 mg of Tylenol daily. Review of the medication administration records revealed there was only one (1) order for Tylenol. Interview with the director of nursing, at 10:00 a.m. on 08/20/09, revealed one (1) of the orders had been discontinued; however, it continued to be printed on the recapitulation orders for June, July, and August 2009.</p> <p>b) Resident #32</p> <p>Medical record review revealed no evidence of speech therapy screening for this resident. Interview with the speech therapist, at 11:00 a.m. on 08/20/09, revealed the resident had been screened, but records of all resident therapy screenings were kept in the therapy department. Further interview revealed therapy screenings were never placed on each resident's individual medical record.</p>			