

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

PRINTED: 07/18/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045203	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/07/2008
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NAME OF PROVIDER OR SUPPLIER BATESVILLE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1975 WHITE DRIVE BATESVILLE, AR 72501
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(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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F 000	INITIAL COMMENTS Complaint #13651 was substantiated (all or in part) with a deficiency cited at F502.	F 000		
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Complaint #13657 was substantiated (all or in part) with these findings: Based on record review and interview, the facility failed to ensure laboratory tests for Prothrombin Time and International Normalized Ratio (PT/INR) were conducted in a timely manner for 1 (Resident #1) of 5 (Residents #1through 5) case mix residents who received Coumadin (an Anticoagulant) therapy and had physician ' s orders for monitoring PT/INR's. This failed practice had the potential to affect 7 facility residents who received Coumadin and had physician ' s orders for PT/INR's as documented on a list provided by the Director of Nursing (DON) on 7/7/08 at 10:05 a.m... The findings are: Resident #1 had diagnosis of Cerebral Thrombosis. a. A physician's order dated 2/27/08 documented, "Coumadin 10 mg per Gastro tube daily. " b. A physician ' s order dated 7/1/08 documented Bactrim DS (double strength) per Percutaneous Endoscopic Gastrostomy Tube twice a day for 7	F 502		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 502	Continued From page 1 days. c. A physician ' s order dated 7/2/08 documented, " Check PT/INR [every] 2 days while on ABT (Antibiotic therapy related to) Coumadin Therapy. d. The facility maintained a calendar into which Laboratory orders were entered. The calendar documented the first PT/INR was to be drawn on 7/4/08. The results were PT 41.9 and INR of 3.5. e. The next entry for a PT/INR was for 7/7/08 instead of 7/6/08 as ordered. f. Results of the next PT/INR were dated 7/7/08. There was no evidence a PT/INR was done on 7/6/08 as ordered by the physician. g. At 1:10 p.m., the Interim DON, reviewed the lab calendar. She stated that the only thing she could think of that might have happened was the nurse just missed 7/6/08 because the others are scheduled 2 days apart.	F 502			