

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

PRINTED: 01/29/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045308</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/16/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE LIVING CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1175 MORNINGSIDE DRIVE</b> <b>CONWAY, AR 72034</b>	
(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	F 000		
F 155 SS=D	<p>Complaint #14156 was unsubstantiated</p> <p>483.10(b)(4) NOTICE OF RIGHTS AND SERVICES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that a request notice of refusal for ordered diet for thickened liquids and signed waiver to refuse thickened liquids was implemented for 1 of 1 case mix residents (Resident #1) who had a waiver to refuse a diet for thickened liquids. The failed practice had the potential to affect 1 resident in the facility with waivers to refuse thickened liquids according to the Administrator on 1/16/09 at 10:05 a.m. The findings are:</p> <p>1. Resident #1 had diagnoses of Percutaneous Endoscopic Gastrostomy (PEG) Tube and Dysphagia. The minimum data set dated 12/22/08 documented the resident had short term memory problems, was moderately impaired in cognitive skills for daily decision making, had a feeding tube, and had a therapeutic diet.</p> <p>a. An Oropharyngeal Videofluoroscopy dated 12/12/08 documented moderate to severe dysphagia and recommended puree diet and honey thickened liquids.</p>	F 155		

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 155	Continued From page 1 b. A Refusal of Treatment Hold Harmless Release form dated 12/19/08 signed by the resident and his son documented, "Refuses thickened liquids." c. On 1/12/09 at 5:38 p.m., the resident was eating supper and had been served a pureed diet with honey thickened liquids. d. On 1/13/09 at 8:17 a.m. the resident was eating breakfast and had been served a pureed diet with honey thickened liquids. The resident stated, "I wished I didn't have to eat." e. On 1/13/09 at 12:10 p.m., the resident was eating lunch and had been served a pureed diet with honey thickened liquids. At 2:45 p.m., the Director of Nursing (DON) was asked if the waiver had been addressed, dated 12/19/08 indicating that the resident wishes to refuse the thickened liquids. The DON stated, "I'll get right on that and check with the doctor." f. On 1/15/09 at 1:30 p.m., the DON and the Nurse Consultant was asked again if the waiver had been addressed and both stated, "We asked the doctor about the waiver and their response was, the doctor sent a faxed letter today, however we understand that the doctor did not offer any alternative treatment after the resident and his son signed the waiver. The Nurse Consultant stated, "We just have nothing and no explanation at this time."	F 155			
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		8/14/07	

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F 253	Continued From page 2  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed ensure that handrails were free of dust, air vents, inner door openings and base boards were free of dirt and dust build up. The failed practice had the potential to affect all 97 residents residing in the facility as identified on the Resident Census and Conditions of Residents form dated 1/12/09. The findings are:  1. On 1/14/08 at 11:15 a.m., on the 100, 200, 300, and 400 halls, the hand rails had a thick build up of light rolls of dust balls, the dust balls were approximately one inch thick on the handrails throughout the facility.  2. On 1/14/09 at 11:35 a.m., the sitting room next to the medicare private dining room, the vent was occluded with a thick grey and black build-up of dust. The vent was 4 inches in length and six inches in width.  3. On 1/14/09 at 11:40 a.m., on the 400 hall a thick grey build-up of dust was along the base board on the right side of the hallway.  4. On 1/14/09 at 11:55 a.m., the Hazardous Waste room had a grey and black build-up of dust in the inner door opening from the bottom of the door all around the door seal.	F 253			
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING  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.	F 312			

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F 312	Continued From page 3  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the fingernails were clean for 1 (Resident #3) and facial hair was removed for 2 (Residents #14 and # 15) of 15 case-mix residents (Resident #2 - 10, and #12 - 17) who were dependent on staff for personal hygiene. This failed practice had the potential to affect 70 residents who were dependent on staff for personal hygiene according to the Administrator on 1/16/09 at 8:35 a.m. The findings are:  1. Resident #3 had diagnoses of Alzheimer's Disease, Dementia, and Diabetes Mellitus. The quarterly Minimum Data Set (MDS) dated 10/28/08 documented the resident was moderately impaired in cognitive skills for daily decision making and required extensive assistance from staff for personal hygiene.  a. On 1/13/09 at 9:45 a.m., 11:00 a.m., and 1:10 p.m., on 1/14/09 at 9:30 a.m., and on 1/15/09 at 8:55 a.m., the 3rd fingernail on the resident ' s right hand and the 3rd and 4th fingernail on the resident ' s left hand had brown material underneath the nails.  b. On 1/15/09 at 8:55 a.m., Certified Nurse Assistant (CNA) #1 stated, " The resident had a bath yesterday...there is brown material underneath the fingernails on the right and left hands...the nails are supposed to be cleaned on bath day." The resident nails had a brown substance underneath.	F 312		

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F 312	Continued From page 4  c. The facility's policy entitled Care of Fingernails/Toenails received from Administrator on 1/15/09 at 5:38 p.m. documented, "Nail care includes daily cleaning and regular cleaning."  2. Resident #14 had a diagnosis of Dementia with behaviors. The quarterly MDS dated 11/17/08 documented the resident was moderately impaired in cognitive skills for daily decision making and required extensive assistance from staff for personal hygiene.  a. On 1/12/09 at 2:35 p.m., on 1/13/09 at 10:40 p.m., and on 1/15/09 at 10:40 p.m., the resident had multiple chin hairs approximately 1/2 inch in length.  b. On 1/15/09 10:40 a.m., CNA #2 stated, "Her chin has hair on it...she needs to be shaved. Residents are shaved on shower days."  3. Resident # 15 had a diagnosis of Vascular Dementia with Delusions. The quarterly MDS dated 11/19/08 documented the resident had severely impaired cognitive skills for daily decision making and required extensive assistance from staff for personal hygiene.  a. On 1/12/09 at 1:20 p.m., on 1/13/09 at 10:35 a.m., and on 1/15/08 at 10:45 p.m., the resident had multiple chin hairs approximately 1 inch in length and curling.  b. On 1/15/09 at 10:45 a.m., CNA #2 stated, "The resident has long curling hairs on chin...she needs shaving."	F 312			
F 314 SS=D	483.25(c) PRESSURE SORES	F 314			

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F 314	<p>Continued From page 5</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that heels were bridged to prevent the potential of break down for 1 (Resident #12) of 11 case mix residents (Residents #1- 10 and 12) who were at risk for pressure sores. The failed practice had the potential to affect 62 residents in the facility who were at risk for pressure sores according to the Administrator on 1/16/09. The findings are:</p> <ol style="list-style-type: none"> <li>1. Resident #12 had a diagnosis of History of Pressure sores. <ol style="list-style-type: none"> <li>a. The admission assessment dated 11/20/08 documented the resident's right heel was red and had a diagnoses of History of Pressure Sores, Coronary Heart Disease and Cerebrovascular Accident.</li> <li>b. The Minimum Data Set (MDS) dated 11/27/08 documented the resident was moderately impaired in cognitive skills for daily decision making, was dependent on staff for personal hygiene and bathing with the assistance of 2 person, and had one or more foot problems.</li> </ol> </li> </ol>	F 314			

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F 314	Continued From page 6 c. The Plan of Care dated 12/18/08 documented, "Heel Protectors. Bridge Heels."  d. On 1/13/09 at 10:15 a.m., the resident was in bed and the resident's feet were not bridged off the bed.  e. On 1/14/09 at 9:47 a.m., the resident was sitting in a gerichair with the right foot across the left foot, and the heels were resting on the footrest of the gerichair. The top portion of the residents feet were dangling off the gerichair but both heels were resting on the footrest.  f. On 1/15/09 at 3:50 p.m., the resident was in bed, there was a pillow underneath the resident's lower extremities, but the resident's heels were resting directly on the bed. The resident's grand daughter was visiting and was asked if the resident's heels were kept off of the bed and she stated, "No." The grand daughter was asked if heel protectors had ever been used. The grand daughter stated, "Since admission she has only noticed heel protectors on for 2 weeks and that was when [Resident #12] was first admitted." g. On 1/15/09 at 4:35 p.m., the Director of Nursing stated, "Pillows are all they've been using."	F 314		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 7  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that a door stripping was secure, legs and arms of chairs and/or tables were secure, there were not sharp jagged edges on the formica at the Nurse Stations, and wheel chair armrests padding was in good repair. These failed practices had the potential to affect all 97 residents residing in the facility according to the Resident Census and Conditions of Residents form dated 1/12/09. The findings are:  On 1/14/09 the following observations were made:  1. At 11:10 a.m., in patient room 103 the black threshold strip measuring 36 inches long had 1/2 of the strip was unattached, and would catch on anything when trying to cross the threshold.  2. At 11:25 a.m., in the medicare private dining room a sofa table measuring approximately 34 inches in height and 4 inches wide had legs that were loose and shaky when touched.  3. At 11:35 a.m., the main nurses station which had formica covering had a sharp and jagged edge sticking out approximately 1/2 inch at the bottom left entrance. The main nurse ' s station also had 4 inches area of formica in the center of the nurse ' s station approximately 1/2 foot from the floor that was moveable and coming loose.  4. At 11:57 a.m., the bottom right side of the right entry swing door of the nurse ' s station there was approximately a 2 inches jagged sharp edged area of formica.	F 323			

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F 323	Continued From page 8  In the front foyer entrance of the facility a four legged coffee table 12 inches in height and 12 inches in width was shaky when touched.  In the front foyer entrance of the facility a wheel chair was parked. The Administrator stated that " this chair was used to for transferring resident in and out of the facility. " The padding on the left armrest was cracked with a sharp rough texture from the front end of the arm rest to the back end.  5. At 12:05 p.m., eight chairs located in the sitting area near the fish tank were shaky when touched. The arms of the chairs were shaky and the legs of the chair were loose.	F 323			
F 329 SS=E	483.25(l) UNNECESSARY DRUGS  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.  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.	F 329			

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F 329	Continued From page 9  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that drugs were not used for an excessive duration for 1 (Residents #7) of 1 case mix residents who received Nexium, a proton pump inhibitors, gradual dose reductions were attempted in the absence of a risk versus benefit statement that indicated why a dose reduction would be contraindicated for 1 (Resident #10) of 2 case mix residents (Residents #9 and #10) who received the antipsychotic Seroquil, 1 (Resident #2 ) of 1 case mix residents who received Ambien a hypnotic medication and 2 (Resident #2 and 7) of 8 (Residents #2, 4, 5, 6, 7,9, 10, and 17) case mix resident who received antidepressants, and free of duplicate therapy for 1 (Resident #7) of 8 (Residents #2, 4, 5, 6, 7,9, 10, and 17) case mix resident who received antidepressant therapy. The failed practices had the potential to affect 2 residents receiving proton pump inhibitors (Nexium), 16 residents receiving Seroquil (antipsychotic), 9 residents receiving Ambien (hypnotic) according to lists provided by the Nurse Consultant on 1/15/09, and 57 residents receiving antidepressant therapy according to the Resident Census and Conditions of Residents form dated 1/12/09. The findings are:  1. Resident #2 had diagnoses of Depression with Delusional Ideation, Gastroesophageal Reflux Disease (GERD), and Renal Insufficiency. The quarterly Minimum Data Set (MDS) dated	F 329			

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F 329	<p>Continued From page 10</p> <p>11/10/08 documented the resident had modified independent cognitive skills for daily decision making, repetitive health complaints, and behaviors not exhibited in the last 7 days.</p> <p>a. The Consultant Pharmacist Monthly Report to the physician dated 4/02/08 documented, "This resident has been receiving Cymbalta 60 mg bid ... since 11/12/07 for Depression.... "Please consider tapering or GDR (Gradual Dose Reduction) of this medication [Cymbalta 60 MG BID] in an effort to determine if it may be unnecessary for this resident... Response: ... No [change] benefit [greater than] risk. " Signed per physician with no date.</p> <p>b. The January 2009 Physician's Order sheet documented for Cymbalta 60 mg (milligram) PO (by mouth) QD (daily).</p> <p>c. On 1/15/09 at 3:00 p.m., the medication start dates provided by the ADON (Assistant Director of Nursing) documented that the medication Cymbalta was initiated on 11/12/07 at 60 mg (milligrams) bid (twice daily) and the dose was reduced on 6/16/08 to 60 mg qd (every day). There was no documented indications in the clinical record of an adverse response during the dose reduction and there was no documentation of further attempts at a dose reduction.</p> <p>d. On 1/16/09 at 11:10 a.m., the DON (Director of Nursing) stated, "The Nurses Notes will document by exception if there is a behavior problem." Nurses Notes were reviewed from 10/16/08 through 1/15/09. No documentation of behavior problems were found and none was provided by the DON. The last documented psychiatric visit found in the clinical record was</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE LIVING CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1175 MORNINGSIDE DRIVE</b> <b>CONWAY, AR 72034</b>		
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F 329	<p>Continued From page 11</p> <p>dated, 12/19/07 and the Psychiatrist documented, "Reasonably stable."</p> <p>e. The January 2009 Physician's Order sheet documented for Ambien 6.25 mg PO at HS (bedtime). The ADON provided documentation that Ambien was originally ordered on 11/12/07 for 12.5 mg at HS (bedtime). The same documentation indicated that on 8/27/08 Ambien was decreased to 6.25 mg at HS.</p> <p>f. The Consultant Pharmacist Monthly Report dated 9/1/08 and 11/7/08 documented to the physician, "This resident has been receiving Ambien 6.25 mg q hs (every bedtime) since 8/27/08. Please consider tapering of this medication (Ambien) in order to determine if it may be unnecessary for this resident..." On the form dated 9/12/08 the physician response documented, " Pt (patient can not sleep [without] medicine. " No response was documented on the form dated 11/7/08.</p> <p>g. The December 2009 Medication Administration Record (MAR) documented the resident received the medication every day at HS except where the record indicated the resident was in the hospital.</p> <p>2. Resident #7 had diagnosis of Dementia with behavior(s), Delusions, and Gastroesophageal Reflux. The Significant Change MDS dated 12/16/08 documented the resident had moderately-impaired cognitive skills for daily decision making and no behaviors present.</p> <p>a. Admission orders dated 7/30/07 documented, "Remeron 30 mg (milligram) at hs (bedtime) PO (by mouth) ... " Nexium 40 mg PO q d (every</p>	F 329			

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F 329	<p>Continued From page 12 day) at 1600 (4:00 p.m.) ... "</p> <p>b. Readmission Orders dated 7/2/08 documented, "Nexium 40 mg (milligram) PO (by mouth) q d (every day) at 1600 (4:00 p.m.) ... Remeron 30 mg at hs (bedtime) ... "</p> <p>c. Readmission orders dated 11/12/08 documented, " Nexium 40 mg [one] PO q day ... Remeron 30 mg PO q hs ... "</p> <p>d. The January 2009 Physician Order sheet documented, "Remeron tablets 30 mg po q hs (by mouth every bedtime)."</p> <p>e. On 1/15/09 at 11:30 a.m., the DON stated, " [Resident #7] has been on Remeron 30 mg since 7/30/07. " She provided an unsigned and undated typed statement via LPN #1 on 1/15/09 at 11:55 a.m. The statement documented, "...Original orders for Remeron 30 mg po q hs is 7/30/2007."</p> <p>f. Readmission orders dated 7/2/08 documented, " Celexa 10 mg PO q HS. " There was documentation of only 1 dose reduction attempted for Celexa. The typed statement provided by LPN #1 on 1/15/09 documented the resident had been receiving Celexa 10 mg q hs starting on 7/2/2008.</p> <p>g. The Consultant Pharmacist Monthly Report dated 7/15/08 documented, "This resident has been receiving Remeron 30 mg q hs and Celexa 20 mg q hs since 7/30/07." The Consultant Pharmacist Report date 10/9/08 documented, "This resident is currently receiving, "Tramadol, Depakote, Remeron and Celexa. Potential Interaction(s): 1. Celexa-Remeron... 2. Celexa-</p>	F 329			

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F 329	<p>Continued From page 13</p> <p>tramadol... 3. Depakote-Remeron... 4. Depakote tramadol... 5. Remeron -tramadol... Please consider the potential for adverse effects of the combined use of these medications. If you feel that these medications are necessary to maintain or improve this resident's function and quality of life and the benefits of continued use outweigh these risks, please provide this evidence in your progress notes and/or in the space provided below...." The physician response was, "Taper or gradually reduce the following medication(s): Tramadol."</p> <p>h. Readmission Orders dated 7/2/08 and 11/12/08 documented Nexium 40 mg po qd (by mouth daily). The January 2009 Physician's Order sheet documented, Nexium 40 mg po qd with a readmission start date of 11/12/08.</p> <p>i The Consultant Pharmacist Monthly Report dated 5/12/08 and 1/8/09 documented, "This resident has been receiving Nexium 40 mg qd since 7/30/07 for Esophageal Reflux Disease)...If used for greater than 12 weeks, clinical rationale for continued need and/or documentation should support an underlying chronic disease..." The physician response (undated) was to check a box marked, "Do not change orders due to: (blank)."</p> <p>j. The CMS regulations document at F329, proton pump inhibitors and H-2 antagonists should be based on clinical symptoms and/or endoscopic findings and if used for greater than 12 weeks, clinical rationale for continued used and/or documentation should support an underlying chronic disease or risk factors.</p> <p>k On 1/16/08 the Director of Nursing or the Nurse Consultant was not able to supply documentation</p>	F 329			

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F 329	Continued From page 14 that a dose reduction had been completed or a failed attempt had been tried for Celexa, since 7/2/09, and no attempt for Nexium or Remeron. On 1/16/09 after review of the clinical record no documentation was found that indicated signs and symptoms or a risk versus benefit statement for the clinical rationale why a dose reduction would be contraindicated for these medications.  3. Resident # 10 had diagnoses of Dementia with behaviors, Hypertension, Hypothyroidism, Osteoarthritis and Depression. The Significant Change MDS dated 10/22/008 documented the resident was moderately impaired in cognitive skills for daily decision making, failed to exhibit any indicators of depressive, sad or anxious mood, no behavioral symptoms, was at ease interacting with others and was at ease doing self-imitated activities.  a. Physician ' s Orders dated 1/16/08 documented, " Seroquel 25 mg (milli-grams) PO (by mouth) QD (everyday)."  b. The Pharmacy Consultant Letter to the Physician dated 12/9/08 documented, "Resident has been receiving Seroquel 25 mg Q HS since 1/16/08...please consider a Gradual Dose Reduction of this medication. ... Response: Benefit [greater than] risk (quality of life) " Physician signature and dated 11/13/08  c. On 1/15/09 the Director of Nursing failed to provide documentation of risks verses benefits for not attempting the gradual dose reduction attempt.	F 329			
F 441 SS=B	483.65(a) INFECTION CONTROL  The facility must establish and maintain an	F 441			

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F 441	Continued From page 15 infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.  This REQUIREMENT is not met as evidenced by: Based on observation, and record review, the staff failed to ensure the ice pitcher was not held over the ice in the ice chest when being filled, and the ice scoop was pushed down into the water pitchers when filling them. These failed practices had the potential to affect all 84 residents who resided in the facility according to the Resident Census and Conditions of Residents form dated 1/12/09. The findings are:  1. On 1/7/09 at 4:30 p.m., CNA (Certified Nursing Assistant) #3 took the ice scoop from the ice scoop holder on the cart and filled 4 water pitchers. The pitchers were held over the ice in the chest and then the scoop was pushed down into the water pitchers to fill them.  2. The facility's policy and procedure "Infection Control Protocol and Safety documented: 3. Use the ice scoop to fill the pitcher. Do not dip the water pitcher into the ice. 4. Do not touch the water pitcher with the ice scoop."	F 441			
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES  The facility must provide or obtain laboratory	F 502			

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F 502	<p>Continued From page 16</p> <p>services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that the medications coumadin, dilantin, depakote, and potassium and lasix , for 1 (Resident #1) of 4 case mix residents (Residents #1 #3 #7 and #12) who were taking these medications. This failed practice had the potential to affect 34 residents who were taking potassium, 22 residents taking coumadin, 6 residents taking dilantin and 8 residents taking Depakote as per list given by the Administrator on 1/16/09. The findings are:</p> <p>1. Resident #1 was admitted on 12/7/08 and had a diagnoses of Percutaneous Endoscopic Gastrostomy [PEG ] Tube, Congestive Heart Failure [CHF], Hypertension [HT], Seizure Disorder and Dysphagia. The Minimum Data Set dated 12/22/08 documented the resident was moderately impaired in cognitive skills for daily decision making.</p> <p>a. Physician orders dated 12/7/08 documented, " Coumadin 2.5 mg (milligram) per PEG daily, dilantin 12 mg/5 ml (milliliter) take 4 ml per PEG TID (three times per day), Lasix [Furosemide] 40 mg per PEG daily, Depakote Sprinkle Capsule 125 mg per PEG 4 caps BID (twice a day) and KIOR CON 20 MEq (Milli equivalent) per PEG BID. ... KLOR CON [Potassium Chloride] 20 MEq (mili equivalent) per PEG BID (twice a day) ... "</p> <p>b. On 1/13/09 at 10:30 a.m., the resident's</p>	F 502			

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F 502	<p>Continued From page 17</p> <p>clinical record was reviewed and there were no routine labs ordered to monitor the therapeutic values and/or the adverse effects for Coumadin, Depakote, Potassium, Dilantin or Lasix.</p> <p>c. On 1/13/09 at 2:45 p.m., the Director of Nursing (DON) was asked why there were no labs ordered to monitor the use of the medications Coumadin, Depakote, Potassium and Dilantin and Lasix. "The DON stated, "I'll get right on it."</p> <p>d. The Physician Desk Reference 55th edition, page 2121 documented, Furosemide [Lasix] ... Laboratory test: Serum electrolytes, (particularly potassium), CO2 (Carbon Dioxide), creatinine and BUN (Blood Urea Nitrogen) should be determined frequently during the first few months of furosemide therapy and periodically thereafter. ... "</p> <p>Page 1137 - 1141 documented, " Coumadin ... Precautions: Periodic determination of PT/INT [Protime/International Ratio] or other suitable coagulation test is essential. ... "</p> <p>Page 2425 -2427 documented, " Dilantin ... Laboratory test: Phenytoin [Dilantin] serum level determinations may be necessary to achieve optimal dosage adjustments. Drug Interactions: There are drugs which may increase or decrease phenytoin levels ... 2. Drugs that may increase or decrease phenytoin serum levels include: ... Valporic Acid. Similarly, the effect of phenytoin on ... valporic acid ... serum levels is unpredictable ... "</p> <p>e. The 24th edition of the Nursing Drug book page 435-437 documented Depakote Sprinkle ...</p>	F 502			

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F 502	Continued From page 18 Interactions Drug ... Pheytoin: Increases or decreases phenytoin levels, decreases valproate (depakote) level. Monitor levels.  Page 877 - 878 documented, Potassium Chloride ... Monitor ... electrolyte levels [blood test] during therapy ... Monitor renal function ... "	F 502			