

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

PRINTED: 03/02/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/19/2009
NAME OF PROVIDER OR SUPPLIER HERITAGE LIVING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 MORNINGSIDE DRIVE CONWAY, AR 72034	
(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 314 SS=E	<p>Complaint #14254 substantiated (all or in part) with deficiency at F-314.</p> <p>483.25(c) PRESSURE SORES</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: Complaint #14254 was substantiated (all or in part) with these findings:</p> <p>Based on observation, record review and interview, the facility failed to ensure the physician was consulted timely to prevent the delay in treatment to prevent the potential for further skin breakdown for 2 (Residents #3 and #5) of 3 case mix residents (Residents #3 through #5) who had pressure sores. The failed practice had the potential to affect 3 residents in the facility who had pressure sores according to the Resident Census and Conditions of Residents form dated 2/17/09. The findings are:</p> <p>1. Resident # 5 had diagnoses of Anoxic Brain Damage and Diabetic Neuropathy. The quarterly Minimum Data Set (MDS) dated 1/8/09 documented the resident had independent cognitive skills for daily decision making, required total assistance for bed mobility and personal</p>	F 314		

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 314	<p>Continued From page 1</p> <p>hygiene and had one or more foot problems-e.g., corns, calluses, bunions, hammer toe, overlapping toes, and pain or structural problems.</p> <p>a. On 2/17/09 at 2:06 p.m., during initial rounds, Licensed Practical Nurse #1 stated that the resident had a blister that was found on the resident's foot this morning.</p> <p>b. On 2/18/09 at 8:50 a.m., Certified Nursing Assistant #1 and 2 transferred the resident to bed. The surveyor performed a body audit at this time. The resident had a fluid filled blister on the right great toe measuring approximately 2 cm (centimeters) by 1.5 cm with redness around the blister.</p> <p>c. On 2/18/09 at 3:31 p.m., the Treatment Nurse was asked about the blister on the resident's foot. The Treatment Nurse stated, "I knew the blister was there yesterday, I got busy and I haven't written anything about it yet. It was a fluid filled blister, it wasn't red around the blister yesterday, but it is today. I put booty goo on it yesterday." The Treatment nurse was asked if the physician had been consulted about the blister. The treatment nurse stated, "I screwed up, I didn't call him yesterday."</p> <p>2. Resident #3 had diagnoses of End Stage Multiple Sclerosis, Sepsis, Dysphagia, Cerebrovascular Accident, Osteoarthritis, and Degenerative Joint Disease. The Quarterly MDS dated 11/21/08 documented the resident had moderately impaired cognitive skills for daily decision-making, required total assistance in activities of daily living and had no pressure sores.</p>	F 314			

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F 314	<p>Continued From page 2</p> <p>a. The Narrative RAP (Resident Assessment Protocol) Summary for Pressure Ulcers dated 9/8/08 documented, "Pressure Ulcer RAPS Triggered: Yes, Care Plan: Yes See Incontinence."</p> <p>b. The Plan of Care dated 11/21/08 documented, "Potential for skin breakdown related to CVA [Cerebrovascular Accident], MS [Multiple Sclerosis], Steroid and Analgesic meds, Incont B&B [Incontinent bowel and bladder], Ext [Extensive] Total Assist, Confusion...At risk for unavoidable pressure ulcers."</p> <p>c. Nurse's Notes dated 1/17/09 at 10:10 p.m. documented, "[name] ER [emergency room] states [resident] admitted for dehydration [and] Sepsis."</p> <p>d. Nurse's Note dated 2/1/09 at 3:05 p.m. documented, "...Open areas to both heels, [no] drainage or bleeding noted..." There was no documentation the physician was consulted or treatment was initiated to the open areas on the resident's heels.</p> <p>e. Nurse's Notes dated 2/3/09 at 3:00 p.m. documented the resident was transferred to another facility. There was no documentation about the resident's heels or the need for treatment.</p> <p>f. As of 2/18/09 at 3:30 p.m., there was no documentation in the Nurses Notes or the physician orders that indicated the physician had been consulted for intervention on the open areas of the residents heels.</p> <p>g. On 2/18/09 at 3:36 p.m., the Treatment Nurse</p>	F 314			

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F 314	<p>Continued From page 3</p> <p>stated, "The nurse on duty did an assessment on the resident's return from the hospital [on 2/1/09]." The treatment nurse was shown the Nurse's Note from 2/1/09 which documented the open areas to the resident's heels. She stated, "I was not aware of that. If I had been, obviously I would have treated it. If there was a treatment sheet for the heels I would have known about it. There was a treatment sheet for the peg tube site. I didn't know anything about the heels." The Treatment Nurse stated the week-end option nurse did the assessment. "If she had told anyone about the heels, they would have passed it on, so I could have done something. Or, they would have done something themselves, I think."</p> <p>h. On 2/19/09 at 4:12 p.m., the Director of Nursing (DON) stated, "There are no 24 hour nurse reports from 2/1/09, 2/2/09 or 2/3/09. We have no CNA [Certified Nursing Assistant] bath flow sheets." The DON was shown the Nurse's Notes for the resident which documented the open areas to both heels. The DON denied knowing about the open areas to the heels and asked the Assistant DON (ADON) if she had known about the open areas to the resident's heels. The ADON stated, "No, ma'am."</p>	F 314			