

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

PRINTED: 03/06/2008
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 02/22/2008
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NAME OF PROVIDER OR SUPPLIER HERITAGE LIVING CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1175 MORNINGSIDE DRIVE CONWAY, AR 72034
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F 000	INITIAL COMMENTS Complaint #13292 was unsubstantiated Complaint #13297 was substantiated (all or in part) with deficiencies cited at F314, F315 and F441.	F 000		
F 312 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure all areas of the perineum were cleansed during incontinent care for 1 (Resident #1) of 4 (Residents #1 through #4) case mix residents who were dependent on staff for incontinent care. This failed practice had the potential to affect 53 residents in the facility who were occasionally or frequently incontinent of bladder and 35 residents who were occasionally or frequently incontinent of bowel, as documented on the Resident Census and Conditions of Residents form received from the facility on 2/20/08. The findings are: 1. Resident #1 had diagnoses Alzheimer's Dementia, Congestive Heart Failure, Fatigue, Acute Renal Failure, Urinary Incontinence, Anxiety and Depression. The Significant Change Minimum Data Set (MDS) dated 1/29/08 documented the resident had moderate impaired cognitive skills for daily decision making, was	F 312		

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 312	Continued From page 1 totally dependent on the physical assistance of two-plus persons for hygiene and was incontinent of bowel and bladder. a. The resident's Admission Care Plan dated 12/20/07 documented to check for incontinence q (every) 2 hours. b. The Bowel and Bladder Assessment dated 1/2/08 documented the resident was incontinent of bowel and bladder and required "check and change q 2 hours." c. On 2/21/08 at 9:25 a.m., the resident had been incontinent of bladder. During incontinent care, the resident's perineum, suprapubic area or groin areas were not cleansed by Certified Nursing Assistant (CNA) #4 or CNA #5. 2. The facility's Perineal Care procedure, received on 2/21/08 at 6:58 p.m. from the Minimum Data Set Coordinator, documented on page 8, "...For a female resident: ...(1) Separate labia and wash area downward from front to back... (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. ...e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks..."	F 312		
F 314 SS=E	483.25(c) PRESSURE SORES 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	F 314		

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F 314	<p>Continued From page 2</p> <p>services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13297 was substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure skin breakdown was reported to licensed nursing staff to allow for prompt assessment and initiation of treatment and Certified Nursing Assistants did not perform wound treatments for 1 (Resident #4) and skin was dried during incontinent care to decrease the potential for skin breakdown for 1 (Resident #3) of 5 (Residents #1 through #5) case-mix residents who were at risk for skin breakdown. This failed practice had the potential to affect 80 residents who were at risk for skin problems, according to the Skin Risk Scores list received from the facility on 2/22/08 at 10:15 a.m. The findings are:</p> <p>1. Resident #4 was admitted to the facility with diagnoses of Dementia, Transient Ischemic Attack, Cerebrovascular Insufficiency and Depression. The Significant Change Minimum Data Set (MDS) dated 1/5/08 documented the resident was moderately impaired in cognitive skills for daily decision making, had total dependence on staff for bed mobility, toilet use, locomotion on and off the unit and bathing and was incontinent of bowel and bladder.</p> <p>a. The Pressure Ulcer Risk Assessment dated 1/5/08 documented, "Total Score ...Total score of 8 or above represents HIGH RISK ...(score) 11."</p>	F 314			

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F 314	Continued From page 3 b. A body audit dated 2/19/08 and performed by Licensed Practical Nurse (LPN) #1 documented the resident's skin was intact and the resident was at high risk for skin breakdown. c. On 02/21/08 at 6:20 p.m., Certified Nursing Assistant (CNA) #1 and CNA #2 performed peri-care on the resident. After peri-care was completed, a body audit was performed. Two Stage II pressure ulcers, approximately 2 centimeters (cm) x 2 cm each, were discovered at the fold of the right buttocks. CNA #2 left the room and returned with a single dose package of Lantiseptic ointment, opened the package and applied the medication to the open areas. After disposal of the supplies used on this resident, the CNAs were observed and did not report this to the charge nurse, but were observed entering other resident' s room. d. On 2/21/08 at 6:40 p.m., LPN #1 was interviewed regarding the two Stage II pressure ulcers on the resident. According to the LPN, no treatment sheet was available for this resident. When told CNA #2 had applied Lantiseptic ointment to the pressure areas, the LPN stated, "That's not even our protocol. Here is a copy of our standing orders for pressure ulcers." e. The facility's Skin Care Protocol: Standing Orders, received from LPN #1 on 2/21/08 at 6:45 p.m., documented: "Stage 2 Pressure Ulcer & Partial Thickness Wound Clean wound with normal saline or wound cleanser and pat dry with gauze prior to applying new dressing; Apply Skin barrier wipe to surrounding intact skin as indicated; Apply a thin film of Celerate Gel or Cellerate Powder or 1/4 inch of Saf-Gel to wound	F 314			

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F 314	<p>Continued From page 4</p> <p>bed; Cover with CombiDERM, Lyofoam or DuoDERM dressing; Monitor dressing and peri-wound area daily; Change dressing up to 3 times weekly according to bath schedule (or according to physician's orders) and prn (as needed)..."</p> <p>f. On 2/21/08 at 7:50 p.m., the Director of Nursing (DON) stated, "CNAs can not do any treatments on any stages of pressure ulcers. They are allowed to apply barrier cream as preventive measures, but not to any stages of pressure areas."</p> <p>2. Resident #3 had diagnoses of Seizure Disorder, Urinary Tract Infections, Dementia and Diabetes Mellitus versus Glucose Intolerance. The Initial Minimum Data Set dated 2/21/08 documented the resident had moderately impaired cognitive skills for daily decision-making, was dependent on staff for personal hygiene, was incontinent of bowel and bladder and had a Stage I pressure area.</p> <p>a. The ADL (Activities of Daily Living) Standard Care Plan dated 2/11/08 documented, "...Resident will be clean, dry..."</p> <p>b. The Standard Care Plan for Skin Integrity dated 2/14/08 documented, "...Routine Skin Care ...C.N.A. (Certified Nursing Assistant) inspects resident skin with care daily; Incontinent care after each incontinent episode using soap & water or Peri-wash..."</p> <p>c. On 2/21/08 at 6:22 p.m., CNA #3 provided pericare to the resident. The CNA applied Aloe Vesta peri-cleanser to a washcloth that had been dampened with water and wiped the resident's</p>	F 314			

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F 314	Continued From page 5 groins, perineum, rectum and buttock, but did not pat dry the skin; the right groin and labia majora were reddened. d. The Perineal Care procedure received from the Minimum Data Set Coordinator on 2/21/08 at 6:58 p.m. documented page 8, "8. For a female resident: ...(4) Gently dry perineum. ..." e. On 2/21/08 at 7:45 p.m., the Director of Nursing (DON) was asked what was to be done after peri-cleanser was applied to the skin. The DON stated, "No that's an air dry. The label will tell you that's a no rinse, air dry." f. On 2/21/08 at 7:50 p.m., a copy received from the facility staff of the Aloe Vesta Cleansing Foam manufacturer's label documented, "For perineal/skin cleansing: ...Pat dry..." g. The Daily Skilled Nurses Notes from the resident's admission on 2/4/08 to 2/21/08 were reviewed and copied 2/22/08 at 10:50 a.m.; there was no documentation of the reddened skin of the resident's perineum and no documentation of communication from the CNA staff to the licensed nurses that the resident had reddening of the perineum. h. The facility's Prevention and Treatment of Pressure Ulcers procedure received from the Director of Nursing on 2/22/08 at 11:00 a.m. documented, "...Steps in the Procedure ...6. If the resident is incontinent, clean the resident of urine and/or feces as necessary. ...dry the resident; ...Documentation ...3. During daily care and bathing, the C.N.A. (Certified Nursing Assistant) will note the condition of the resident's skin (i.e., the size and location of any new red or tender	F 314			

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F 314	Continued From page 6 areas) on the Bath Sheet and forward to the Charge Nurse/Treatment Nurse for review and intervention..."	F 314			
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Complaint #13297 was substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure the perineum was cleansed using front to back wiping motions during incontinent care to decrease the potential for urinary tract infections for 1 (Resident #3) of 4 (Residents #1 through #4) case mix residents who were dependent on staff for incontinent care. This failed practice had the potential to affect 53 residents in the facility who were occasionally or frequently incontinent of bladder and 35 residents who were occasionally or frequently incontinent of bowel, as documented on the Resident Census and Conditions of Residents form received from the facility on 2/20/08. The findings are: 1. Resident #3 had diagnoses of Seizure Disorder, Dementia and Diabetes Mellitus versus	F 315			

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F 315	<p>Continued From page 7</p> <p>Glucose Intolerance and past history of Urinary Tract Infections. The Initial Minimum Data Set dated 2/21/08 documented the resident had moderately impaired cognitive skills for daily decision-making, was dependent on staff for personal hygiene and was incontinent of bowel and bladder.</p> <p>a. The Admission History and Physical dated 2/7/08 documented, "...Past Medical History: ...UTI (Urinary Tract Infection); ...Assessment: ...UTI's..."</p> <p>b. The ADL (Activities of Daily Living) Standard Care Plan dated 2/11/08 documented, "...Toileting: Incontinent frequently of bowel and bladder. Requires extensive assist of 2 with peri care/changing briefs/changing clothing PRN (as needed)."</p> <p>c. On 2/21/08 at 6:22 p.m., Certified Nursing Assistant (CNA) #3 provided pericare for the resident. With the resident positioned on her right side, the CNA wiped the rectal area from the back towards the front to the vagina and urinary meatus.</p> <p>d. On 2/21/08 at 6:55 p.m., CNA #3 was asked what direction was wiped during pericare. The CNA stated, "Front to back." When asked, when the resident was turned and the rectal and buttocks area cleansed, what direction is to be wiped; the CNA stated, "Back to front."</p> <p>2. The facility's Perineal Care procedure, received on 2/21/08 at 6:58 p.m. from the Minimum Data Set Coordinator, documented on page 8, "...For a female resident: ...b. Wash perineal area, wiping front to back. (1) Separate</p>	F 315			

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F 315	Continued From page 8 labia and wash area downward from front to back... (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. ...e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks..." 3. On 2/21/08 at 7:45 p.m., the Director of Nursing (DON) was asked how incontinent care was to be given. The DON stated, "Per the policy, not to repeat an area, cleanse from the front to back." The DON was then asked how the rectum and buttocks should be cleansed and she stated, "I can go from the small of the back to the rectum but not from the rectum to the vaginal vault. As long as I didn't go to the vaginal vault."	F 315		
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an 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: Complaint #13297 was substantiated (all or in part) in these findings.	F 441		

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F 441	<p>Continued From page 9</p> <p>Based on record review and interview, the facility failed to ensure an effective infection control program was maintained for 1 (Resident #6) of 3 (Residents #1, #2, and #6) case mix residents who had urinary tract infections after admission to the facility, as evidenced by the facility's failure to identify, track and trend urinary tract infection processes from one month to the next by not maintaining a complete infection control log. This failed practice had the potential to affect all 103 residents in the facility, based on the Resident Census and Conditions of Residents form received from the facility on 2/20/08. The findings are:</p> <p>1. Resident #6 had diagnoses Urinary Tract Infection and Dementia. The Significant Change Minimum Data Set (MDS) dated 12/21/07 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance for dressing, hygiene, bathing and toilet use, was frequently incontinent of bladder and had a urinary tract infection in the last 30 days.</p> <p>a. The resident's Admission Care Plan dated 8/22/07 was updated 8/27/07 to include confusion, UA [with] C&S (culture and sensitivity).</p> <p>b. The resident's Physician Progress Notes dated 10/17/07 documented, "The resident is having Hematuria, actually holding her coumadin. It stated, "Hematuria, probably secondary to urinary tract infection."</p> <p>c. The resident's urinalysis results for 10/23/07, 10/24/07, 11/5/07, 11/27/07, 12/15/07, 1/16/08 and 1/28/08 documented, "bacteria: too</p>	F 441			

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F 441	Continued From page 10 numerous to count" and "culture indicated: Escherichia Coli greater than 100,000 CFU/ml (Colony Forming Unit per milliliter)." d. On 2/21/08 at 3:50 p.m., the facility's Infection Control Log did not document any of the resident's urinary tract infections. The Infection Control Nurse (ICN) was asked what kind of system was in place to track and monitor infections in the facility. She stated that she kept a monthly log using the McGreer's List for criteria to be added to the log. She said the resident must have 2 criteria and the results of the culture to be added to the log. The ICN was asked if repeated infections qualify to be added to the log for tracking/trending and monitoring infections. She said,"not unless they have 2 criteria, are symptomatic, repeated infections do not qualify." 2. The facility's policy statement on infections documented, "Urinary Tract Infections: includes only symptomatic of: fever >100 F or chills, new or increasing burning pain on urination, new flank pain or suprapubic pain/tenderness, change in character of urine (blood, cloudiness, foul smell, sediment). worsening of mental or functional status (may be new or increased incontinence).	F 441			