

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

PRINTED: 04/18/2008
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 04/04/2008
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 309 SS=D	<p>Complaint #13383 was unsubstantiated.</p> <p>483.25 QUALITY OF CARE</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that staff did not use latex gloves during care for 1 of 1 (Resident #8) case mix resident with an allergy to latex. This failed practice had the potential to affect 1 resident in the facility who had a documented latex allergy, according to the Director of Nurses on 4/3/08. The findings are:</p> <p>1. Resident #8 had diagnoses of Multiple Myeloma and Paraplegia. The Minimum Data Set dated 3/28/08 documented the resident had modified independence in cognitive skills for daily decision making and required supervision to extensive assistance with activities of daily living.</p> <p>a. The Plan of Care dated 3/28/08 documented "1/6/08 Latex Allergy... ADL (activities of daily living) Standard Care Plan. Resident requires assist with ADL's because of Paraplegia, Impaired ROM (range of motion) to BLE (bilateral lower extremity) and feet... Aides/Tools Needed... To use silicone non-latex condom catheters (catheters) d/t (due to) latex allergy..."</p>	F 309			
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.

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

PRINTED: 04/18/2008
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 04/04/2008
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 309	Continued From page 1	F 309		
F 333 SS=E	<p>b. On 4/1/08 at 12:12 p.m., Certified Nursing Assistant (CNA) #1 put on latex gloves, to dress the resident. There was a sign above the Resident's bed that documented "Allergic to Latex." The CNA stated the gloves were latex powder-free gloves. The surveyor stopped the CNA prior to her touching the resident. The Resident had a pair of latex free gloves in his beside dresser drawer, which the CNA got out of the drawer and put on. CNA #2 came into the room to help CNA #1 get the resident up. She had latex gloves on. CNA #2 was stopped by CNA #1 from using the latex gloves and CNA #2 left the room to get latex free gloves. Upon return to the room CNA #2 stated, "The LPN (Licensed Practical Nurse) [LPN #1] told me to go ahead and use these gloves." Again, the CNA was stopped from using latex gloves to care for the resident.</p> <p>483.25(m)(2) MEDICATION ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure physician orders were followed to ensure residents were free of significant medication errors for 1 (Resident #20) of 19 (Residents #1 through #18 and #20) case mix residents. This failed practice had the potential to effect all 102 residents in the facility, according to the Resident Census and Conditions of Residents form dated 3/31/08. The findings are:</p>	F 333		

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

PRINTED: 04/18/2008
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 04/04/2008
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 333	Continued From page 2 1. Resident # 20 had a diagnosis of Hypocalcemia and a physicians order dated 10/5/04 for Miacalcin Nasal spray, 1 spray alternate nares every day. A hospital laboratory Calcium level dated 4/1/08 documented the resident's Calcium level as "8.7" (low) with reference range of 8.8-10.6 mg/dl. 2. On 4/1/08 at 10:35 a.m., during the medication cart inspection, a vial of Miacalcin Nasal Spray was located with the resident's name on it . The vial was dated as filled by the pharmacy on 1/10/08 and held 30 doses when full. The vial had been opened and was approximately 3/4 full. 3. On 4/1/08, the Pharmacy provider supplied documentation that the last time the Miacalcin Nasal Spray had been filled was 1/10/08. From the fill date of 1/10/08 through 2/9/08 is 30 days and 30 doses; (1 vial) should have been administered. From medication reconciliation, approximately 52 doses had not been administered. 4. This was a significant medication error due to the frequency of the error and the condition of the resident.	F 333			
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363			

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

PRINTED: 04/18/2008
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 04/04/2008
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 363	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure menus were followed to ensure nutritional adequacy. This failed practice had the potential to affect 14 residents on pureed diets, according to the diet list dated 4/1/08. The findings are: 1. On 4/1/08 at 3:38 p.m., Dietary Aide #1 portioned 1/2-cup servings of sliced peaches into bowls for residents on regular diets. 2. On 4/1/08 at 3:51 p.m., Dietary Aide #1 poured syrup, that had been drained from the sliced peaches, into the blender and pureed the syrup and added an unspecified amount of food thickener and pureed it. During this time it was brought to the attention of the Dietary Manager. Dietary Aide #1 was asked if she always pureed the syrup with thickener; she stated that she had always pureed the syrup with thickener for residents on pureed diets. She stated that was how she was trained to do. When asked who had trained her, the Dietary Aide did not answer. The Dietary Manager was asked if she was aware of using juice and thickener for the residents on a pureed diet; she stated, "No." She stated that Dietary Aide #1 had been there for two years when she came. She stated she thought the dietary aide knew what she was doing and she had never watched her.	F 363			
F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is	F 364			

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

PRINTED: 04/18/2008
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 04/04/2008
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 364	Continued From page 4 palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure hot food was served hot for residents who ate in their rooms. This failed practice had the potential to affect 30 residents who ate in their room, as identified by the Dietary Manager on 4/1/08. The findings 1. On 4/1/08 at 5:20 p.m., the p.m. Cook took the temperature of the food on the steam table and it registered as follows: Hash Brown Casserole 187 degrees Fahrenheit, Ground Sausage 186 degrees Fahrenheit and French Toast 169 degrees Fahrenheit. 2. On 4/1/08 at 5:34 p.m., approximately 20 trays were transported in a cart to residents who ate meals in their rooms and in the back dining room on 100 hall. One Certified Nursing Assistant (facility transport driver), was assigned to serve all the trays from this cart. 3. On 4/1/08 at 6:06 p.m., when the last tray on the cart was served, the temperature of the food on the test tray was taken by the Dietary Manager with the following results: Hash Brown Casserole 98 degrees Fahrenheit, Ground Sausage 82 degrees Fahrenheit and French Toast 80 degrees Fahrenheit.	F 364		
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 425		

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

PRINTED: 04/18/2008
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 04/04/2008
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 425	<p>Continued From page 5</p> <p>§483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure medications were labeled and expired medications were removed from use and destroyed. This failed practice had the potential to affect all 102 residents in the facility, as documented on the Resident Census and Conditions of Residents dated 3/31/08. The findings are:</p> <p>1. On 4/1/08 from 9:15 a.m. to 11:00 a.m., inspection of the medication room and medication carts was conducted with the following findings:</p> <p>a. Twenty-one (8-ounce) cans of Jevity 1.2 calorie 8-ounce cans that expired February 1, 2008 in the medication room.</p> <p>b. In the medication cart for the 200 Hall and 4</p>	F 425		

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

PRINTED: 04/18/2008
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 04/04/2008
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 425	Continued From page 6 resident rooms on the 100 Hall there were 2 Prilosec OTC (Over the Counter) loose and unlabeled. c. In the medication cart for the 200 Hall and 4 resident rooms on the 100 Hall there were 2 Pink Bismuth tablets loose and unlabeled. d. In the medication cart used for the 300 Hall and 4 resident rooms on the 400 Hall there was 1 bottle of Metamucil Fiber Capsules that was dated as expired 11/2007 and was dated as opened 3/27/08. Resident #12 had received 6 doses of the expired medication, as documented on the resident's medication administration record. e. In the medication cart used for the 300 Hall and 4 resident rooms on the 400 Hall there was 1 bottle of Excedrin Extra Strength tablets 100 count that expired 2/2008 and dated as opened 3/20/08. f. In the medication cart used for the remainder of the 400 Hall resident rooms there were 15 Iron tablets 65 mg, loose and not labeled.	F 425		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		

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

PRINTED: 04/18/2008
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 04/04/2008
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 431	<p>Continued From page 7</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure all prescription medications were labeled in accordance with current laws and accepted standards of practice. This failed practice had the potential to affect all 102 residents in the facility. The findings are:</p> <p>1. On 4/1/08 at 9:30 a.m., the following prescription only items were observed unlabeled in the medication room:</p> <p>a. Two prefilled 5 ml (milliliter) syringes of Heparin lock flush 100 units/ml, for injection.</p>	F 431			

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

PRINTED: 04/18/2008
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 04/04/2008
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 431	Continued From page 8 b. One prefilled 10 ml syringe of 0.9% Sodium Chloride for injection. 2. On 4/1/08 at 10:10 a.m., the following prescription only items were observed unlabeled in the medication cart that was used on the 300-Hall and the first four rooms of the 400-Hall: Four vials of Albuterol Sulfate 0.083% 2.5 mg/3 ml for inhalation via a nebulizer, contained in one foil package. 3. On 4/1/08 at 11:00 a.m., the following prescription only item was observed unlabeled in the medication cart that was used on the Medicare Unit : One prefilled 5 ml syringe of Heparin lock flush 100 units/ml, for injection.	F 431			