

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

PRINTED: 07/11/2007
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 06/29/2007
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 282 SS=E	<p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written 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 physician orders for thickened liquids were followed for 1 (Resident # 4) of 1 case mix residents who had physician orders for pudding thickened liquids. The facility also failed to ensure dietary recommendations for fortified foods were followed for 1 (Resident #7) of 3 (Resident #6 and 9) case mix residents at risk for weight loss. This failed practice had the potential to affect 9 residents who were at risk for weight loss as documented on a listing provided by the Administrator on 6/28/07 at 3:05 p.m. and 10 residents who received thickened liquids according to a list provide by the Director of Nursing on 6/28/07. The findings are:</p> <p>1. Resident #4 had diagnoses of Dysphagia and Anxiety. The Annual Minimum Data Set dated 4/9/07 documented the resident was moderately impaired in cognitive skills for daily decision making, required one person physical assist with eating, and received a mechanically altered diet.</p> <p>a. The physician order dated 6/13/07 documented, "Change diet to puree with pudding thickened liquids."</p> <p>b. On 6/26/07 at 8:10 a.m., the resident was in</p>	F 282		
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 282	<p>Continued From page 1</p> <p>the dining room and was served 2 bowls of supercereal, 4 ounces of juice, 8 ounces of milk, pureed eggs, and pureed sausage. The milk and juice were a honey thick consistency.</p> <p>c. On 6/26/07 at 12:20 p.m., the resident was served pureed green beans, pureed barbecue chicken, pureed macaroni and cheese, a 4 ounce chocolate magic cup, 2 8 ounce glasses of water, and a 8 ounce glass of milk. The water and milk were a honey consistency. At 12:40 p.m. the resident drank approximately one third of the milk.</p> <p>d. On 6/26/07 at 5:22 p.m., the resident was served a chocolate magic cup, 8 ounce of milk, 8 ounce of water, pureed ham, pureed potato salad, and pureed carrots. The milk and water were honey consistency. At 5:50 p.m. the resident drank approximately one third of the milk and water.</p> <p>e. On 6/27/07 at 8:15 a.m. the resident was served pureed eggs, pureed sausage, 2 bowls of supercereal, a chocolate magic cup, 4 ounces of cranberry juice, 8 ounces of milk, and 8 ounces of water. The juice, milk, and water were a honey consistency. Certified Nursing Assistant (CNA) # 2 was asked by the surveyor what consistency was the residents liquids and CNA # 2 stated, "Honey, I know it's not pudding cause pudding is thick."</p> <p>2. Resident #7 had diagnoses of Alzheimer's Dementia, Trans Ischemic Attacks, Seizure and Appetite Loss. The Significant Change of Condition Minimum Data Set dated 4/20/07 documented the resident was moderately impaired in cognitive skills for daily decision</p>	F 282			

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F 282	<p>Continued From page 2</p> <p>making, required total assistance with one person physical assistance for eating, had chewing and swallowing problems and was on a mechanically altered diet.</p> <p>a. A physician order dated 3/27/07 documented, Diet: Regular.</p> <p>b. The Nutritional Assessment documented, "6/15/07 RD (Registered Dietitian) Note: Monthly wt. (weight) 116# (pounds). Weekly 118# Monthly represents a 15.4% 90 day loss... Recommend Enhance Foods with all meals. Monitor as necessary."</p> <p>There was no documentation in the clinical record of a physician order for enhanced foods with meals.</p> <p>c. On 6/26/07 at 12:05 p.m., the resident was served a roll, green beans, macaroni and cheese, barbecue chicken, peach cobbler, 1 carton of whole milk, 8 oz. of coffee, 8 oz. of water, 1 Mighty Shake and one carton of ice cream. The menu documented the fortified foods for the meal were chocolate pudding and/or mashed potatoes. The resident was not served chocolate pudding or mashed potatoes.</p> <p>At 12:35 p.m. the resident's diet card documented, Lunch preferences: Mighty Shake, coffee, milk, ice cream and Hot liquid risk." The card did not document fortified foods.</p> <p>d. On 6/26/07 at 5:20 p.m., the resident was served sliced ham, carrots, potato salad, crackers, mud cake, 8 oz. of water, 8 oz. of coffee, 1 carton whole milk, 1 Mighty Shake and one carton of ice cream. The menu documented</p>	F 282			

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F 282	Continued From page 3 the fortified foods for the meal were chocolate pudding and/or mashed potatoes. The resident was not served chocolate pudding or mashed potatoes. e. On 6/28/07 at 2:17 p.m., the Dietary Manager (DM) was shown the RD recommendation. The DM was asked what the process was for communicating the recommendations. The DM stated the RD writes out the recommendations and leaves a copy for the DM and for the Director of Nurses. When asked how long it takes for those recommendations to be carried out, he stated in 2-3 days of when they were written. The DM was also asked if the recommendation would be on the diet card. The DM stated if the resident was on fortified food, it should be on the diet card for the tray line to know to serve it. f. On 6/27/07 at 2:49 p.m. the resident's weight was 116.3 pounds, down from 6/13/07 118 pounds.	F 282			
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 incontinent care was provided for 1 (Resident #10) of 7 (Resident #1, 2, 4, 6, 8, 9 and 10) case mix residents who were incontinent of urine. This failed practice had the potential to affect 54 residents who where	F 312			

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F 312	Continued From page 4 incontinent of bladder as documented on the Resident Census and Conditions of Residents report dated 6/26/07. The findings are: Resident #10 had diagnoses of Dementia with Delusions and Glaucoma. The Medicare 14 Day Minimum Data Set (MDS) dated 6/18/07 documented the resident was severely impaired in cognitive skills for daily decision making and incontinent of bladder. a. On 6/26/07 at 4:25 p.m., CNA (Certified Nursing Assistant) #3 and 4 transferred the resident from the geri chair to the bed. The resident was incontinent of urine. CNA #3 and 4 removed the resident's incontinent brief and without providing any cleansing to the perineal area, placed a clean incontinent brief on the resident, repositioned the resident and covered up the resident.	F 312		
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure tube feeding equipment was maintained in a manner to prevent the potential for infection for 1 (Resident #21) of 2 (Resident #10 and 21) case mix residents who	F 322		

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F 322	Continued From page 5 had a feeding tube. This failed practice had the potential to affect 2 residents who had a feeding tube as documented by the Director of Nursing on 6/28/07 at 12:00 p.m.. The findings are: Resident #21 had diagnoses of Dementia, Associated Psychosis, and Anorexia. The Quarterly Minimum Data Set dated 4/27/07 documented the resident was severely impaired in cognitive skills for daily decision making and had a feeding tube. a. The June 2007 Physicians Orders sheet documented, "Jevity 1.2 cal (calorie) at 40 cc/hr (cubic centimeters per hour) and Colace 100 mg (milligrams) Give 10 cc per tube bid (twice a day)." b. On 6/26/07 at 4:13 p.m., Licensed Practical Nurse (LPN) #1 turned the resident's tube feeding to hold, disconnected the resident's tube feeding port from the tube and laid the port on the resident's right pants leg. The LPN removed the piston syringe from the bag and checked placement, removed the syringe from the tube and laid the syringe on the resident's brown throw covering her lap, picked up the syringe and returned it to the tube and instilled 60 cc of tap water, removed the syringe from the tube, laid the syringe down on the resident's left forearm with the tip touching the resident's skin, picked the syringe back up and placed it back in the tube, administered the Colace liquid, 60 cc water, and removed the syringe from the tube, laid the syringe down on the resident's left pants leg, reconnected the tubing to the resident's feeding tube, and returned the rate to 40 cc/hr. The port of the tube feeding line laid on the resident's pants leg from 4:13 p.m. until 4:21 p.m. The LPN	F 322		

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F 322	Continued From page 6 returned the syringe to the bag without cleaning the syringe. c. The facility's policy on Medication Administration via Feeding Tubes, provided by the Administrator on 6/28/07 at 10:30 a.m. documented, "...place the equipment on the bedside stand or overbed table. Arrange supplies so they can be easily reached... clean reusable equipment according to the manufacturer's instructions..."	F 322		
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure doors and trim were free of gouges and splinters, air conditioner units were free of sharp plastic edges and a handrail was free of splinters. This failed practice had the potential to affect 1 mobile resident on 100 Hall, 5 mobile residents on 300 Hall, 6 mobile residents on 400 Hall and 7 mobile residents in the main dining room according to a list provided by the Director of Nursing on 6/28/07. The findings are: On 6/27/07 at 10:40 a.m., the following observations were made: a. The entrance door to the whirlpool/shower room on 100 Hall had gouges, exposing splinters on the hinged side of the door approximately 3 feet up from the floor.	F 323		

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F 323	Continued From page 7 b. The right fire door on 300 Hall had gouges, exposing splinters on the hinged side of the door approximately 1 foot up from the floor. c. The door to Resident Room #213 had gouges, exposing splinters on the hinged side of the door approximately 1 1/2 feet up from the floor. d. In the main dining room to the right of the 300 Hall entrance door, the wood wall trim had splinters exposed on the bottom side of the trim approximately 6 inches in length. e. In the Dining/TV room on 100 hall and in Resident Room #417, the air conditioner louvers on the top side of the unit were broken exposing sharp plastic edges. f. Between Resident Room #402 and the shower/whirlpool room, there was 18 feet of handrail that was rough on the bottom edge exposing small splinters.	F 323		
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed ensure food stored in the freezer and storage area was sealed or covered to prevent the potential for cross contamination, employees washed their hands between handling food and the ice machine scoop holder was free of debris.	F 371		

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F 371	<p>Continued From page 8</p> <p>These failed practice had the potential to affect 96 residents who received meals from the kitchen according to the Resident Census and Conditions of Residents form dated 6/26/07. The findings are:</p> <p>On 6/27/07 at 11:15 a.m., the following observations made were:</p> <p>a. Dietary Employee #1 picked up a pan that contained beef breaded steak, placed it on the counter, picked up a knife and positioned the blender motor. Without washing her hands she proceeded to pick up the breaded beef steak with her bare hands, cut them into chunks, place them in the blender and grind them up to be served to the residents on a ground diet at the supper meal.</p> <p>b. The ice scoop holder on the wall by the ice machine had brownish water standing in it. The bottom of the ice scoop holder had wet blackish and grayish matter in it. There were two ice scoops sitting directly on the corroded matter inside the holder.</p> <p>c. A rubber container in the storage room that contained dry milk was not completely covered exposing it to air.</p> <p>d. A box of Salisbury steak on the shelf in the freezer was not sealed.</p> <p>e. There was a dirty towel that was to remove food from the oven was resting on the loose waffles in a tray on the counter where Dietary Employee #2 was pureeing waffles. The same employee picked up the waffles that had the dirty towel on them, broke them into pieces and placed them into the blender to be pureed for residents</p>	F 371		

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F 371	Continued From page 9 on a pureed diet at the supper meal.	F 371			
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure Certified Nursing Assistants (CNA's) washed their hands after changing a soiled incontinent brief for 1 (Resident #10) of 7 (Resident #1, 2, 4, 6, 8, 9, and 10). This failed practice had the potential to affect all 98 residents. The findings are: Resident #10 had diagnoses of Dementia with Delusions and Glaucoma. The Medicare 14 Day Minimum Data Set dated 6/18/07 documented the resident was severely impaired in cognitive skills for daily decision making and incontinent of bladder. a. On 6/26/07 at 4:25 p.m. CNA (Certified Nursing Assistant) #3 and 4 transferred the resident from the geri chair to the bed. The resident was incontinent of urine. CNA #3 and 4 removed the resident's incontinent brief with their gloved hands. CNA #4 removed her gloves and without washing her hands, exited the room, entered Resident #21's room, removed the resident's hat and throw cover, exited the room and obtained several pair of gloves from the clean linen cart, reentered Resident #21's room and closed the door.	F 444			

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F 444	Continued From page 10 b. The facility's policy on Infection Control, Standard Precautions, provided by the Director of Nursing on 6/28/07 at 12:00 p.m. documented, "...wash hands after touching blood, body fluids, secretions, and contaminated items, whether or not gloves are worn... wash hands immediately after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or environments..."	F 444		