

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

PRINTED: 08/23/2005
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 08/09/2005
NAME OF PROVIDER OR SUPPLIER HERITAGE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 MORNINGSIDE DRIVE CONWAY, AR 72032	
(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 Complaint #10338, unsubstantiated. Complaint #10400, unsubstantiated.	F 000		
F 157 SS=G	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to consult with the physician for 1 case mix resident (Resident #3) who had multiple episodes of diarrhea and 1 case mix resident (Resident #6) who had blisters and pressure ulcers. This failed practice resulted in actual harm to Resident #3 and had the potential to affect all 100 residents in the facility as identified by the Administrator on 8/07/05 during the entrance conference. The findings are: 1. Resident #3 had Diagnoses of Renal Insufficiency, Alzheimer Disease, Depression, and Chronic Obstructive Pulmonary Disease. The Quarterly Minimum Data Set (MDS) dated 4/19/05 documented the resident was severely impaired in cognitive skills for daily decision making, rarely/never understood and rarely/never understands, dependent on staff for personal hygiene and toilet use, incontinent of bowel and required monitoring of acute medical condition. a. The Care Plan reviewed on 4/19/05 documented: 1) "At Risk for Poor Nutritional/Hydrational status with possible wt (weight) fluctuations d/t (due to) CHF (Congestive Heart Failure), Alzheimer's, depression, GERD (Gastroesophageal Reflux Disease), and daily diuretic use."	F 157			

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F 157	Continued From page 2 2) The Goal documented, "Will maintain current weight/nutrition/hydration status and complications will not go unnoticed." 3) The Approaches documented, "Medication as ordered by physician. Monitor [Resident #3] for sx. (symptoms) of infection, e.g. (such as) elevated temp (temperature), congestion, lethargy, weakness. b. The Comprehensive Metabolic Panel drawn on 5/23/05 documented a BUN of "42" and Creatinine of "2.1". c. The July 2005 Standardized Physician Orders documented Lasix tablets 40 mg (milligrams) PO (by mouth) QD (every day) which was initially ordered on 1/11/05. d. The Bowel Movement record dated 7/16/05 on the 7:00 a.m.- 3:00 p.m. shift documented, "Lg (large) loose" stool. The 3:00 p.m. - 11:00 p.m. shift documented, "Lg Loose and M (medium) loose" stool. e. The Bowel Movement record dated 7/17/05 on the 7:00 a.m. - 3:00 p.m. shift documented, "Lg x 6 loose" stools. f. The Consumption Report documented in the section for Dinner Food % and Fluids on 7/15/05 and 7/16/05, 7/18/05 an "R (refused)" under each. g. The Consumption Report documented in the section for Lunch Food % and Fluids on 7/17/05 an "R" under each. h. The Consumption Report in the section for Lunch Food % and Fluids for 7/18/05 was blank.	F 157			

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F 157	Continued From page 3 i. There were no entries in the Nurses Notes for 7/15/05 or 7/16/05 and as of 8/9/05 the facility could not provide copies of any nurses notes for that time period. j. Nurses Progress Note dated 7/16/05 and reviewed on 7/17/05 documented under Additional Comments, "No new problems noted". k. Nurses Notes dated 7/17/05 at 6:00 p.m. documented, "Wife here... R (resident) has had loose stools this weekend. Asymptomatic otherwise. CNA's (Certified Nursing Assistants) have been applying Lanaseptic to peri area to decrease excoriation. Family aware." The entry signed by Licensed Practical Nurse (LPN) #1. l. Nurses Notes dated 7/18/05 at 5:40 p.m. documented, "This nurse called to R rm (room). R [up] in w/c (wheelchair) [with] lap buddy on. Leaned over jerking, nonresponsive to painful stimuli. R has tenting, crackles RLL (right lower lobe), BS (blood sugar) 115. Family reports diarrhea x 2d (days). Called placed to [Physician]. Awaiting c/b (call back). Family reports R has not eaten all day." This entry was documented by LPN #4. The Nurse's Notes at 6:00 p.m. documented, "[Physician] c/b [with] N.O. (new orders) to send to ER (emergency room)." This entry was documented by LPN #4. m. The Hospital History and Physical documented under "History of Illness: 83 year old white male with severe dementia, followed at [nursing facility], with a four day history of significant diarrhea, becoming unresponsive	F 157			

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F 157	<p>Continued From page 4</p> <p>today with decreased oral intake...He was brought to the emergency room where he was noted to have a markedly increased BUN and creatinine. He does have mild renal insufficiency with creatinine running in the 2 to 4 range, but he was with a creatinine of 7.7 in the emergency room. He subsequently is admitted for correction of his significant dehydration versus renal failure. Urine is also purulent...In the emergency department he was given some fluid and his mental status is improving some, with some agitation forthcoming."</p> <p>1) Under Physical Examination, "General: He is obviously dehydrated. He is moving his extremities some at this time, but is minimally responsive otherwise." "HEENT: Mucous membranes are parched."</p> <p>2) Under Laboratory Data, "BUN and creatinine 145 and 7.7".</p> <p>3) Under Impression, "1. Renal failure (acute) secondary to dehydration secondary to gastroenteritis with diarrhea."</p> <p>n. On 8/8/05 at 1:58 p.m., LPN #1 stated that on Sunday 7/17/05 the resident's wife said the resident had been lethargic that weekend. The nurse stated the resident had a couple of loose stools that day. She stated he had had loose stools on Saturday but it was not brought to her attention until Sunday. She stated she offered to call the physician but told the family it would be an on call physician and they "opted to not call". LPN #1 stated she looked at the resident's bottom and "it was red".</p> <p>o. On 8/8/05 at 4:21 p.m. the Administrator</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>provided a copy of Action Plan for QAA (Quality Assurance and Assessment) that documented an inservice was conducted on 8/1/05 titled "Notification of Change of Condition."</p> <p>p. On 8/9/05 at 9:24 a.m., the facility provided a copy of the Change in a Resident's Condition or Status which documented:</p> <p>1) Under Policy Statement, "Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.)".</p> <p>2) Under Policy Interpretation and Implementation, "1. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been:... d. A significant change in the resident's physical/emotional/mental condition...5. The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status."</p> <p>2. Resident #6 was admitted on 7/29/05 and had a Diagnosis of Diabetes Mellitus Type II.</p> <p>a. Nurses Notes dated 8/8/05, no time noted, on the 3:00 p.m. - 11:00 p.m. shift documented, "R in bathroom, CNA reported a red open area about size of walnut. Another blister noted about 1 1/2" (inches) away from open area on (R) (right) hip. Lanaseptic applied & (and) under garments put on." The entry was documented by LPN #5.</p> <p>b. On 8/9/05 at 11:41 a.m., the Assistant Director</p>	F 157			

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F 157	Continued From page 6 of Nurses) conducted a body audit. The ADON stated that on the right buttocks was an open blister that was 3 cm (centimeter) by 1 cm and a closed blister that was 2 cm by 1 cm. The resident had 6 Stage I ulcers on the left buttocks. The ADON stated, "one nickel size, 4 dime size, 1 quarter size". c. On 8/9/05 at 11:51 a.m., LPN #5 when asked if she consulted the physician on 8/8/05 after finding the blisters and she stated "No I did not ."	F 157			
F 327 SS=G	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure assessment of fluid needs to develop/implement interventions to maintain hydration and to consult with the physician regarding increased fluids levels for 1 case mix resident who experienced diarrhea and was at risk for diarrhea. This failed practice resulted in actual harm to Resident #3 and had the potential to affect all 100 residents. The findings are: Resident #3 had diagnoses of Renal Insufficiency, Alzheimer Disease, Depression, and Chronic Obstructive Pulmonary Disease. The Quarterly Minimum Data Set dated 4/19/05 documented the resident was severely impaired in cognitive skills for daily decision making skills daily decision making, rarely/never understood and rarely/never understands, dependent on staff	F 327			

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F 327	<p>Continued From page 7</p> <p>for personal hygiene and toilet use, incontinent of bowel and required monitoring of acute medical condition.</p> <p>a. The Care Plan reviewed on 4/19/05 documented:</p> <p>1) "at Risk for Poor Nutritional/Hydrational status with possible wt (weight) fluctuations d/t (due to) CHF (Congestive Heart Failure), Alzheimer's, depression, GERD (Gastrointestinal Reflux Disease), and daily diuretic use."</p> <p>2) The Goal documented, "Will maintain current weight/nutrition/hydration status and complications will not go unnoticed."</p> <p>3) The Approaches documented, "Medication as ordered by physician. Monitor [Resident #3] for sx. (symptoms) of infection, e.g. (such as) elevated temp (temperature), congestion, lethargy, weakness. Report to physician. Diet as ordered by physician x (times) set up assistance. Monitor Diet, % intake and weights. Monitor for significant weight gain (greater than 0.5 KG (kilograms)/day) and report to physician. Resident may eat in room." The Care Plan did not include substitution of other liquids, encouragement of fluids, or other measures to provide the resident with the amount of fluids necessary to maintain optimum health.</p> <p>b. The Comprehensive Metabolic Panel drawn on 5/23/05 documented a BUN of "42" and Creatinine of "2.1".</p> <p>c. The July 2005 Physician Orders documented a physician order dated 1/11/05 for Lasix tablets 40 mg (milligrams) PO (by mouth) QD (every day).</p>	F 327			

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F 327	Continued From page 8 d. The Bowel Movement record dated 7/16/05 on the 7:00 a.m.- 3:00 p.m. shift documented, "Lg (large) loose" stool. The 3:00 p.m. - 11:00 p.m. shift documented, "Lg Loose and M (medium) loose" stool. e. The Bowel Movement record dated 7/17/05 on the 7:00 a.m. - 3:00 p.m. shift documented, "Lg x 6 loose" stools. f. The Consumption Report documented in the section for Dinner Food % and Fluids on 7/15/05 and 7/16/05, 7/18/05 an "R (refused)" under each. g. The Consumption Report documented in the section for Lunch Food % and Fluids on 7/17/05 an "R" under each. h. The Consumption Report in the section for Lunch Food % and Fluids for 7/18/05 was blank. i. There were no entries in the Nurses Notes for 7/15/05 or 7/16/05 and as of 8/9/05 the facility could not provide copies of any nurses notes for that time period. j. Nurses Progress Note dated 7/16/05 and reviewed on 7/17/05 documented under Additional Comments, "No new problems noted". k. Nurse's Notes dated 7/17/05 at 6:00 p.m. documented, "Wife here...R has had loose stools this weekend. Asymptomatic otherwise. CNA's (Certified Nursing Assistants) have been applying Lanaseptic to peri area to decrease excoriation. Family aware." The entry was signed by Licensed Practical Nurse (LPN) #1.	F 327			

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F 327	Continued From page 9 l. Nurse's Notes dated 7/18/05 at 1:30 a.m. documented the resident's vital signs and "In bed resting quietly @ (at) this time." This entry was signed by LPN #2. This was the only entry for 11:00 p.m. - 7:00 a.m. shift. m. Nurse's Notes dated 7/18/03, no time noted, on the 7:00 a.m. - 3:00 p.m. shift documented the resident's vital signs and "...no c/o (complaints of) pain or discomfort". This entry was signed by LPN #3. There was no other documentation on the 7:00 a.m. - 3:00 p.m. shift. n. Nurse's Notes dated 7/18/05 at 5:40 p.m. documented, "This nurse called to R rm (room). Family (dtr. [daughter] & wife) in rm [with] R. R [up] in w/c (wheelchair) [with] lap buddy on. Leaned over jerking, nonresponsive to painful stimuli. R has tenting, crackles RLL (right lower lobe), BS (blood sugar) 115. Family reports diarrhea x 2d (days). V/S (Vital signs) 122/64 [blood pressure], 71 [pulse], 22 [respirations], 96.9 ax (axillary) [temperature]. Call placed to [Physician]. Awaiting c/b (call back). Family reports R has not eaten all day." This entry was documented by LPN #4. o. Nurse's Notes dated 7/18/05 at 6:00 p.m. documented, "[Physician] c/b [with] N.O. (new orders) to send to ER (emergency room)." This entry was documented by LPN #4. p. The Hospital History and Physical with an admission date of 7/18/05 documented: 1) Under Chief Complaint, "Decreased level of consciousness, diarrhea." 2) Under History of Illness documented, "83 year	F 327			

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F 327	Continued From page 10 old white male with severe dementia, followed at [nursing facility], with a four day history of significant diarrhea, becoming unresponsive today with decreased oral intake... He was brought to the emergency room where he was noted to have a markedly increased BUN (Blood urea nitrogen) and creatinine. He does have mild renal insufficiency with creatinine running in the 2 to 4 range, but he was with a creatinine of 7.7 in the emergency room. He subsequently is admitted for correction of his significant dehydration versus renal failure. Urine is also purulent... In the emergency department he was given some fluid and his mental status is improving some, with some agitation forthcoming." 3) Under Physical Examination documented, "General: He is obviously dehydrated. He is moving his extremities some at this time, but is minimally responsive otherwise... HEENT (head, ears, eyes, nose, throat): Mucous membranes are parched." 4) Under Laboratory Data documented, "BUN and creatinine 145 and 7.7". 5) Under Impression, "1. Renal failure (acute) secondary to dehydration secondary to gastroenteritis with diarrhea." q. On 8/8/05 at 1:58 p.m., LPN #1 stated that on Sunday 7/17/05 the resident's wife said the resident had been lethargic that week end. The nurse stated the resident had a couple of loose stools that day. She stated he had had loose stools on Saturday but it was not brought to her attention until Sunday. She stated she offered to call the physician but told the family it would be an	F 327			

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F 327	<p>Continued From page 11</p> <p>on call physician and they "opted to not call". LPN #1 stated she looked at the resident's bottom and "it was red".</p> <p>r. On 8/8/05 at 3:50 p.m., LPN #4 stated she worked with the resident the day he was sent to the hospital and denied any loose stools were reported to her that day. The LPN stated the resident did not eat that evening. She stated he had had some loose stools over the weekend. The nurse stated the resident "looked dehydrated with poor skin turgor".</p> <p>s. On 8/9/05 at 8:23 a.m., LPN #2 stated that 7/18/05 was one of the few nights she worked with the resident. She stated there was "no diarrhea" reported to her or "noted". The LPN stated the off going nurse did not report the resident had diarrhea.</p> <p>t. On 8/9/05 at 9:26 a.m., LPN #3 stated she worked with the resident the last day he was in the facility. She stated there was "nothing abnormal" about the resident. The LPN stated the nurse's notes said he had diarrhea over the weekend but there was "nothing out of the ordinary" going on. She stated that LPN #2 told her the resident had diarrhea over the weekend but not on Sunday. LPN #3 denied that the resident had diarrhea episodes on her shift. She stated she thought the resident had a "24 hour bug that was resolved". She stated sometimes the resident ate well, sometimes didn't." The LPN stated, "He was drinking some and his level of consciousness was the same to me." She stated, "I didn't feel the need" to call the physician- he had already been notified over the weekend.</p> <p>u. Refer to F157 for failure to consult with the</p>	F 327			

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

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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 08/09/2005
NAME OF PROVIDER OR SUPPLIER HERITAGE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 MORNINGSIDE DRIVE CONWAY, AR 72032		
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F 327	Continued From page 12 physician.	F 327			