STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 SS=D	483.25 QUALITY OF CARE 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure clean areas of a cloth were used in front to back cleansing motions during incontinent care and Foley catheter care was provided for 1 (Resident #6) of 2 (Residents #1 and #6) case mix residents who had indwelling catheters. This failed practice had the potential to affect 2 residents with indwelling catheters, as documented on the Resident Census and Conditions of Residents form dated 10/20/08. The findings are: 1. Resident #6 had diagnoses of Dementia, Lupus, Osteoarthritis, Diabetes Mellitus and Renal Failure. The Admission Nursing Assessment dated 10/16/08 documented the resident was dependent on staff for activities of daily living, was incontinent of bowel, had an indwelling Foley catheter and was disoriented times three. a. A lab report with a collected [at local clinic] date of 10/13/08 and a reported date of 10/18/08 documented, "...Specimen Source: Coccyx Wound... Result... Methicillin Resistant Staphylococcus Aureus (MRSA)..."	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	**903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653**

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F 309	Continued From page 1 b. Physician orders dated 10/20/08 documented, "...Foley catheter care [with] soap [and] H2O (water) q (every) shift ...Contact Isolation." c. On 10/21/08 at 11:40 a.m., during the resident's bed bath and care for fecal incontinence, Certified Nursing Assistant (CNA) #4 wiped down the resident's groin and vaginal areas two times, without changing to a clean area of the cloth. Bowel movement was wiped from the rectum and across the Foley catheter tubing three times. The mons pubis and Foley catheter tubing were not cleansed. Foley catheter care was not provided. d. On 10/22/08, the following staff were asked, Who does the Foley care? 1) At 10:35 a.m., Licensed Practical Nurse (LPN) #2 stated, "I do at times, but the CNAs are supposed to do it during a bath or pericare." 2) At 10:36 a.m., LPN #3 stated, "The CNAs during pericare or a bath." 3) At 10:40 a.m., LPN #4 stated, "The CNAs when they do a bath or the pericare." 2. The facility's policy and procedure "Perineal care" documented, "...If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area..."	F 309		
F 312 SS=E	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.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	**903 BORGOGNONI DRIVE** **LAKE VILLAGE, AR 71653**

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F 312	Continued From page 2	F 312		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure nail care was provided to keep nails clean and trimmed for 7 (Residents #1, #4 through #8 and #11), all areas of the body were washed and rinsed of soap during a bed bath for 1 (Resident #4) and oral care was provided for 1 (Resident #5) of 13 (Residents #1 through #13) case mix residents who were dependent on staff for sanctities of daily living and all areas were cleaned using front to back motions with a clean area of a cloth for each cleansing wipe during peri-care for 3 (Residents #2, #5 and #6) of (Residents #1 through #9) case mix residents who were incontinent. This failed practice had the potential to affect 80 residents in the facility who were dependent on staff for activities of daily living per documentation received from the Administrator on 10/23/08, 47 residents incontinent of bowel and 47 residents incontinent of bladder, documented on the Resident Census and Conditions of Residents form dated 10/20/08.
The findings are:

1. Resident #8 had diagnoses of Osteoarthritis, Urinary Incontinence, Hypertension, Cerebrovascular Accident, Alzheimer's Disease and Psychosis. The Quarterly Minimum Data Set (MDS) dated 7/14/08 documented the resident had severely impaired cognitive skills for daily decision-making and was totally dependent on staff for personal hygiene.

On 10/21/08 at 8:55 a.m., during a body audit, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	**903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653**

(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 312	Continued From page 3 toenail on the resident's left great toe was thick, discolored and curled in a downward direction, approximately 1 centimeter (cm) in length. The toenail on the right great toe was thick, discolored and curled in a downward direction, approximately 2 cm in length. The first and second toenails of the right foot were approximately 1 cm in length, past the tips of the toes. 2. Resident #4 had diagnoses of Muscle Weakness, Alzheimer Disease and Congestive Heart Failure. The MDS dated 7/2/08 documented the resident was moderately impaired in cognitive skills for daily decision making and required extensive physical assistance for activities of daily living. a. On 10/21/08 at 10:10 a.m., the resident received a bed bath provided by CNA #9. The resident was bathed with Aloe Vesta Body Wash and Shampoo. The resident's back was not washed. b. The resident's toenails were long, pointed and uneven. On the right foot, the second toenail was curved over the end of the toe greater than 1/4-centimeter, the fourth toe had a sharp pointed nail and the third toe nail was uneven and rough. On the left foot, toenails on the second, third and fourth toes were uneven with sharp points. 3. Resident #5 had diagnoses of End Stage Renal Disease and Decubitus Ulcer. The MDS dated 6/21/08 documented the resident was moderately impaired in cognitive skills for daily decision making and was totally dependent on the physical assistance of one person for personal hygiene.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 312	Continued From page 4	F 312		

Continued From page 4

a. On 10/21/08 at 8:40 a.m., the resident was in bed and had dried saliva around the mouth. The resident's breakfast was served by CNA #1 and the resident's face was washed, but the resident was not offered or given oral care.

b. On 10/21/08 at 12:00 p.m., the resident received a bed bath provided by CNA #6. The resident was positioned on the left side and had a moderate amount of formed feces present. The CNA wiped from back to front, contaminating the perineum and scrotal areas, that were previously washed, with feces.

c. The resident's toenails were uneven and needed trimming on both feet; the nails extended approximately 1/4-centimeter over the end of the toes.

4. Resident #2 had diagnoses of Cerebrovascular Accident and History of Urinary Tract Infection. The Minimum Data Set dated 6/20/08 documented the resident was moderately impaired in cognitive skills for daily decision making and was totally dependent on the physical assistance of staff for activities of daily living.

a. On 10/21/08 at 9:50 a.m., the resident had been incontinent of bladder and his brief was wet. Certified Nursing Assistant (CNA) #7 provided incontinent care for the resident, but did not pull back the resident's foreskin to cleanse.

b. The facility's Perineal Care Policy documented, "For a male resident: (1) Retract the foreskin of the uncircumcised male. (2) Wash and rinse urethral area using a circular motion."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 312	Continued From page 5 5. Resident #6 had diagnoses of Dementia, Lupus, Osteoarthritis and Renal Failure. The Admission Nursing Assessment dated 10/16/08 documented the resident was disoriented times three, was dependent on staff for activities of daily living and was incontinent of bowel. a. On 10/21/08 at 11:40 a.m., during the resident's bed bath and care for bowel incontinence, Certified Nursing Assistant (CNA) #4 wiped down the resident's groin 2 times without changing to a clean area of the cloth. The mons pubis was not cleansed. b. The toe nails on the resident's right foot were thick and long, approximately 1/4-inch over the tips of the toes. The left toes were not viewed, as they were covered by a bandage. 6. Resident #7 had a diagnosis of Psychosis. The Quarterly MDS dated 10/21/08 documented the resident had severely impaired cognitive skills for daily decision making and required extensive to total assistance of staff for performance of activities of daily living. On 10/21/08 at 10:25 a.m., the resident's toe nails were thick and long and extended approximately 1/4-inch over the tips of the toes. 7. Resident #1 had diagnoses of Dementia, Skin Disorders and Joint Contracture. The Medicare 14-Day MDS dated 8/5/08 documented the resident had moderately impaired cognitive skills for daily decision-making and had total dependence on staff for personal hygiene. On 10/21/08 at 11:00 a.m., the resident had long fingernails on the left hand; the fingertips and	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	**903 BORGOGNONI DRIVE** **LAKE VILLAGE, AR 71653**

(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 312	Continued From page 6 nails rested on the palm of the hand. The fingernails were approximately 1/2-centimeter long and against the palm of the hand; the hand in a fist-like position. 8. Resident #11 had diagnoses of Diabetes Mellitus, Acute Renal Failure, and Dementia. The Medicare 5 Day MDS dated 10/10/08 documented the resident had severely impaired cognitive skills for daily decision making and had total dependence on staff for personal hygiene. a. A Comprehensive Care Plan dated 8/24/08 documented, "Problem 1. Routine Care Needs R/T (related to) resident needs assistance with ADLs (activities of daily living) D/T (due to) Decline in health Goal Will have ADL's met on a daily basis. Approach/Disciplines ...Fingernails ...cleaned and checked. b. On 10/22/08 at 4:15 p.m., the resident had long fingernails on both hands, with a black substance underneath the fingernails. The fingernails were approximately 1/2 to 3/4-centimeters in length from the fingertips. c. On 10/23/08 at 8:30 a.m., the resident's fingernails remained long and dirty. d. On 10/23/08 at 10:40 a.m., the resident's right hand fingernails had black substance underneath the second, third and fourth nails. On the left hand, the third and fourth fingernails were dirty with a black substance under the nails. e. On 10/23/08 at 11:58 p.m., Licensed Practical Nurse (LPN) #1 was asked if the resident was a diabetic; the LPN stated, "Yes." When asked who trimmed and cleaned the fingernails of diabetics,	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	**903 BORGOGNONI DRIVE** **LAKE VILLAGE, AR 71653**

(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 312	Continued From page 7 the LPN stated, "I do. The nurses. Usually the treatment nurse." f. On 10/23/08 at 12:00 p.m., the Director of Nursing (DON) was asked if nurses trim or clean fingernails on residents or diabetics. The DON stated, "Yes, or one of us." When asked where this was documented, the DON stated, "I don't [document]." g. On 10/23/08 at 12:20 p.m., Registered Nurse (RN) #1 was at the resident's bedside and stated, "...her fingernails need cleaning and trimming." h. As of 10/23/08, review of the resident's clinical record had no documentation on the treatment records or nurses notes of nail care or trimming. 9. The facility's guidelines for care of the fingernails/toenails received from the Administrator on 10/23/08 documented, "...General Guidelines...4. Nails can be partially cleaned during bath time... 6. Nail care includes daily cleaning and regular trimming. 7. Proper nail care can aid in the prevention of skin problems around the nail bed. 8. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin..."	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 services to promote healing, prevent infection and	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 314	Continued From page 8	F 314		

prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure soap was rinsed from the skin to decrease the potential for skin breakdown for 2 (Residents #1 and #4) of 9 (Residents #1 through #9) case mix resident who received bed baths. This failed practice had the potential to affect 22 residents who were dependent on staff for bed baths, and 19 residents who had the potential for skin breakdown, per documentation received from the Administrator on 10/23/08. The findings are:

1. Resident #1 had diagnoses of Dementia, Skin Disorders and Joint Contracture. The Medicare 14 Day Minimum Data Set dated 8/5/08 documented the resident had moderately impaired cognitive skills for daily decision-making, had total dependence on staff for bathing, had pressure ulcers and had skin tears.

a. The resident's skin audit dated 9/23/08 documented a history of skin breakdown on the coccyx.

b. The resident's Braden Skin Assessment dated 10/6/08 documented, "...Total score of 12 or less represents High Risk ...9."

c. The resident's skin audit dated 10/20/08 documented reopened skin tears on the resident's left elbow.

c. On 10/21/08 at 11:00 a.m., Certified Nursing Assistant (CNA) #6 bathed the resident with Aloe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	**903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653**

(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 314	Continued From page 9	F 314		

Vesta body wash poured onto a wet washcloth and wiped the resident's forearms, back and hips. The CNA did not rinse the soap off of the resident's skin, with soap suds remaining on the forearms, back and hips. The CNA wiped the skin with a dry towel only.

2. Resident #4 had diagnoses of Muscle Weakness, Alzheimer's Disease and Congestive Heart Failure. The MDS dated 7/2/08 documented the resident was moderately impaired in cognitive skills for daily decision making and required extensive physical assistance for activities of daily living.

On 10/21/08 at 10:10 a.m., the resident was receiving a bed bath provided by CNA #9. The CNA poured an unmeasured amount of Aloe Vesta Body Wash and Shampoo into approximately 5 cups of water; the water became very soapy. The CNA washed the resident's chest, arms, hands, legs and feet were washed using the soapy water, leaving soap suds on the resident's skin. The soap was not rinsed off.

3. The Aloe Vesta body wash and shampoo manufacturer's recommendations on the bottle's label, received 10/22/08 at 1:30 p.m. from the Administrator, documented: "No-rinse bed bathing... Dilute 2-4 oz. (ounces) of body wash per gallon of warm water. ...Proper dilution ensures best results."

4. The facility's guidelines titled "Giving a Bedbath", received on 10/23/08 at 9:00 a.m. from the Administrator, documented: "...General Guidelines ...3. ...rinse...4. ...Soap has a drying effect on the skin. Be sure you rinse the skin well..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 314	Continued From page 10 5. On 10/23/08 at 1:30 p.m. the Director of Nursing (DON) was asked if soap should be rinsed from the skin. The DON stated, "We read the back of our bottles, if it's diluted it doesn't have to be, but if it's put straight, yes."	F 314		
F 318 SS=E	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure positioning devices were provided to decrease the potential for further contracture and decline in range of motion for 3 of 3 (Residents #1, #3 and #5) case mix residents with contractures. This failed practice had the potential to affect 6 residents in the facility with contractures, as per the Resident Census and Conditions of Residents form dated 10/20/08. The findings are: 1. Resident #5 had diagnoses of End Stage Renal Disease, Joint Contracture of the Right Hand and Decubitus Ulcer. The Minimum Data Set (MDS) dated 9/19/08 documented the resident had short/long-term memory problems, was moderately impaired in cognitive skills for daily decision making, was dependent on the physical assistance of staff for activities of daily living and had functional limitation in range of	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 318	Continued From page 11 motion with partial loss of voluntary movement of one hand and limitation in functional limitation in range of motion with partial loss of voluntary movement in both legs. a. The resident's Comprehensive Care Plan dated 9/18/08 documented, "Problem... Potential for alteration in comfort r/t (related to) contractures... cont (continues) to have contractures to BLE (both lower extremities) [and] R (right) hand... offer care q (every) 2 hrs (hours) to ensure needs are met..." b. On 10/21/08 at 8:40 a.m., the resident was in bed. The resident's right hand was contracted, but there was no positioning device in place to prevent further contractures. c. On 10/22/08 at 9:30 a.m., the resident's right hand was contracted, but there was no positioning device in place to prevent further contractures. d. On 10/22/08 at 10:10 a.m., the resident had no positioning device in the right hand to prevent further contractures. The resident's right thumb came down between the fourth and fifth fingers and the other fingers were completely closed shut. 2. Resident #1 had diagnoses of Dementia, Skin Disorders and Joint Contracture. The Medicare 14 Day Minimum Data Set dated 8/5/08 documented the resident had moderately impaired cognitive skills for daily decision-making and had functional limitation in range of motion with partial loss of voluntary movement of one leg and one foot.	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 318	Continued From page 12 a. On 10/20/08 at 3:50 p.m., the resident had a contracted left hand; there was no positioning device in place. b. On 10/21/08 at 10:35 a.m., the resident's left hand was contracted with the fingers closed; there was no positioning device in place. c. On 10/21/08 at 11:00 a.m., Certified Nursing Assistant (CNA) #6 attempted to open the resident's fingers on the left hand to bathe the hand and stated, "He's suppose to have a roll." The resident's left hand was contracted with fingers resting on the palm and no positioning device between the fingers and palm. 3. On 10/23/08 at 2:15 p.m., when asked if there was a policy for positioning devices or contractures, the Director of Nursing (DON). The DON stated, "No, only for range of motion."	F 318		
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 staff washed their hands prior to preparation and administration of medications and the syringe plunger, medication containers and a closure device were not	F 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 322	Continued From page 13 contaminated for 1 of 1 (Resident #7) case mix resident who had a Percutaneous Endogastrostomy (PEG) tube. This failed practice had the potential to affect 4 residents with a PEG tube, as identified by the Resident Census and Conditions of Residents form dated 10/20/08. The findings are: 1. Resident #7 had diagnoses of Gastroesophageal Reflux and Anorexia. The Quarterly Minimum Data Set dated 10/21/08 documented the resident had severely impaired cognitive skills for daily decision making and required extensive to total assistance of staff for activities of daily living. a. The Physician order dated 10/31/07 documented, "Fibersource HN 1 can bolus per GT (Gastrostomy Tube) [at] 2[:00] a.m. feeding." The Physician orders dated 5/7/08 documented, "Bolus 1 can Fibersource HN [at] 10[:00] a.m. ...Bolus 1 can Fibersource HN [at] 2:30 p.m. - Anorexia." b. On 10/21/08 at 9:40 a.m., Licensed Practical Nurse (LPN) #1 did not wash his hands before preparing the resident's medications. The LPN then carried the plastic cups that contained the medications into the resident's room by placing his index finger, middle finger and thumb on the rim of two of the cups. The LPN carried the third cup by placing his hand over the top of the cup. Without washing his hands, the LPN opened the feeding tube by removing a rubber band, that subsequently fell on the floor. After checking the tube for placement and patency, the LPN placed the syringe plunger on top of the resident's	F 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ____ B. WING ____	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 322	Continued From page 14 blanket twice. After administering the resident's medications and supplement, the LPN picked the rubber band up off of the floor and secured the feeding tube closed. c. The facility's policy and procedure "Handwashing/Hand Hygiene" documented, "...To prevent and to control the spread of infectious diseases... a. When hands are visibly dirty or soiled with blood or other body fluids; b. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; c. After handling items potentially contaminated with blood, body fluids, or secretions... 4. If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations: a. Before direct contact with residents; b. Before donning sterile gloves; c. Before performing any non-surgical invasive procedures; d. Before preparing or handling medications; e. Before handling clean or soiled dressings, gauze pads, etc; f. Before moving from a contaminated body site to a clean body site during resident care g. After contact with resident's intact skin; h. After handling used dressings, contaminated equipment, etc; i. After contact with inanimate objects (e.g. medical equipment in the immediate vicinity of the resident; and or j. After removing gloves..."	F 322		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 323		F 323		

Continued From page 15

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure physical restraints were applied per manufacturer instructions for 1 (Resident #8) of 6 (Residents #1, #4, #5, #7, #8 and #9) case mix residents with orders for physical restraints, a transfer was not conducted using the waistband to prevent injury for 1 (Resident #2) of 3 (Residents #2, #4 and #9) case mix residents who required physical assistance for transfers and a multiple extension plug outlet was not in use. These failed practices had the potential to affect 12 residents who required physical assistance for transfers, as documented by the Administrator on 10/23/08 and 9 residents who had physical restraints, as documented on the Resident Census and Conditions of Residents form dated 10/20/08. The findings are:

1. The instruction sheet titled, "Posey Lap Belt/Padded Lap Belt Application Instruction Sheet" reviewed on 10/23/08 at 2:15 p.m. documented, "...the belt should be over the resident's hips against the back of the wheelchair... the straps should always be snug... should be able to slide open hand (flat) between the device and the patient."

2. The facility policy received on 10/23/08 at 1:45 p.m. titled,
" General Guidelines for the Use of Physical Restraints" documented, "Physical restraints include, but are not limited to, the
use of such devices as leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars, geri-chairs, seat belts,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 323	Continued From page 16	F 323		

side rails, and lap cushions and trays that the resident can not remove easily and that prevents the resident from rising when used in conjunction with a chair."

3. Resident #8 had diagnoses of Osteoarthritis, Urinary Incontinence, Hypertension, Cerebrovascular Accident, Alzheimer's Disease and Psychosis. The Quarterly Minimum Data Set (MDS) dated 7/14/08 documented the resident had severely impaired cognitive skills for daily decision-making, had total dependence on staff for transfers and locomotion, required partial physical support or did not follow directions during a test for balance while sitting and required use of a chair that prevented rising.

a. The Physician order dated 5/16/07 documented, "Soft belt while up in w/c (wheelchair) to prevent sliding and to prevent falls, visual check Q (every) 2 hrs (hours) for repositioning and ROM (range of motion)."

b. The Comprehensive Care Plan dated 10/15/08 documented, "Soft belt to reclining w/c while up in w/c."

c. On 10/20/08 at 1:30 p.m., a soft belt restraint was positioned over the resident's abdomen, loosely extending from the resident's body approximately 6 inches, with the left arm underneath the restraint up to the elbow, with free range of movement of the arm.

Licensed Practical Nurse (LPN) #2 repositioned the resident's left arm from under the loosely applied soft belt restraint. The LPN failed to tighten or correct the loose application of the resident's soft belt restraint.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 323	Continued From page 17 d. On 10/23/08 at 1:45 p.m., the Director of Nurses stated when asked regarding the correct distance between the soft belt and the resident's body replied, "Snug... should be able to put both hands between the body and the restraint." 4. Resident #2 had diagnoses of Cerebrovascular Accident and Urinary Tract Infection. The MDS dated 9/18/08 documented the resident was moderately impaired in cognitive skills for daily decision making and was totally dependent on staff for activities of daily living with 1 person to physical assist. The findings are: On 10/21/08 at 8:30 a.m., the resident was observed being transferred back to bed from a wheelchair by Certified Nursing Assistant (CNA) #6 and CNA #7. A gait belt was placed around the resident and then held on each side to lift up on the resident. The CNAs, while holding onto the gait belt, also pulled up on the resident's pants in the back to help assist him to the bed. The resident was unable to assist in the transfer. 5. On 10/20/08 at 1:06 p.m., during initial tour of the facility, there was a yellow power strip in Resident Room 116 that had a radio plugged into it.	F 323		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	**903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653**

(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 328	Continued From page 18	F 328		

Respiratory care;
Foot care; and
Prostheses.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure diabetic foot care was provided to maintain nail and skin integrity to prevent the potential for diabetic foot complications for 1 (Resident #11) of 2 (Residents #6 and #11) case mix residents who had diabetes and were dependent on staff for foot and toenail care. This failed practice had the potential to affect 25 diabetic residents in the facility, as documented by the Director of Nursing (DON) on 10/23/08. The findings are:

1. Resident #11 had diagnoses of Diabetes Mellitus Type 2 and Acute Renal Failure. The Medicare 5-Day Minimum Data Set dated 10/10/08 documented the resident had severely impaired cognitive skills for daily decision making, had total dependence on staff for activities of daily living, had a history of a resolved ulcer to the foot and had no foot/nail care in the past 90 days.

a. A Comprehensive Care Plan dated 8/24/08 documented, "Problem 1. Routine Care Needs R/T (related to) resident needs assistance with ADLs (activities of daily living) D/T (due to) Decline in health Goal Will have ADL's met on a daily basis. Approach/Disciplines ...Fingernails and toenails cleaned and checked. ...3. Altered Health Maintenance R/T Diabetes ...Provide good skin care daily especially to the feet..."

b. The October 2008 Physician Orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 328	Continued From page 19	F 328		

documented, "...Podiatrist to see resident and treat as indicated..."

c. On 10/23/08 at 12:10 p.m., Registered Nurse (RN) #1 removed the resident's heel pads and socks; the skin and toenails of both feet were viewed. The skin on both feet was dry and flaky; there was crusted-like skin covering the entire sole and heels of both feet. The second toe on each foot was angled and slightly overlaped onto the great toe. When the RN separated each of these toes, there was a material of skin-like exudate between the toes.

On the left foot, the toenails of the third and fourth toes were pointed and approximately 1/4 to 1/2-centimeter (cm) in length from the tip of the toes.

The right foot had a pointed toenail on the third toe that extended from the tip of the toe to approximately 1/2-cm. The resident cried out when the feet were touched by the RN.

d. On 10/23/08 at 12:20 p.m., RN #1 was asked who did the diabetic nail and foot care; the RN replied, " [Licensed Practical Nurse (LPN) #2] and sometimes [LPN #1], but mostly the treatment nurse." The RN was asked when foot care and nail care was done. The RN stated, "She has a schedule hanging on the wall." When asked if there were any problems with the resident's feet, the RN stated, "Her skin is rather dry looking and need to keep toes separated and toenails are kind of jagged." When asked if the Certified Nursing Assistants (CNA) could bathe the diabetics feet, the RN stated, "Yes."

e. As of 10/23/08 at 12:50 p.m., a list of diabetic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	**903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653**

(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 328	Continued From page 20	F 328		

residents seen by the podiatrist was received from the DON. The resident's name was not on the list.

f. On 10/23/08 at 1:30 p.m. the Director of Nursing (DON) was asked when the resident's should have feet bathed and the DON stated, "Whenever they get their bath or as needed." The DON was asked if the CNA's can bathe the diabetics feet. The DON stated, "Yes they can bathe." The DON was asked where the diabetic foot and nail care was documented and the DON replied, "I don't know. On ADL (activity of daily living) flow sheets it's just got bath."

When asked if there were other flow sheets where foot care was documented, the DON stated, "No." When asked if there were diabetic residents that received podiatry care, the DON stated, "There are some, a few that see the podiatrist, but the podiatrist does not make visits here."

g. As of 10/23/08, the resident's clinical record and treatment record had no documentation of when diabetic foot care, nail care or podiatrist visits had occurred.

The resident lists in the notebook titled, "Skin Audits" were reviewed for this resident. The resident had a hisotry of skin problems with the feet as documented on, "8/12/08 Black Eschar Lt heel 5 X (by) 2X 0 cm (centimeter), on 8/19/08 ulcer heel, 8/26/08 Eschar Lt (left) heel, 9/2/08 ulcer left heel, 9/9/08 black eschar heel..."

2. The facility's Nursing Care of the Adult Diabetes Mellitus Resident guidelines received from the DON on 10/23/08 documented,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ____ B. WING ____	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 328	Continued From page 21 "...Documentation ...12. Assessment of the feet should include the following: a. hygiene b. temperature c. color; d. circulation (e.g. pedal pulses, toe capillary refill); e. any abrasions, sores, and/or injuries; f. any corns or callouses; and g. the condition of the toes and toenails. ...Hygiene Aspects 1. Skin should remain ...clean. 2. Lotion should be applied to dry skin as needed, unless contraindicated. ...4. Bathe feet as necessary to keep clean..."	F 328		
F 441 SS=E	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: Based on observation, record review and interview, the facility failed to ensure contaminated personal and environmental care equipment was sanitized to decrease the potential for the spread of infection for 2 (Residents #2 and #6) of 13 (Residents #1 through #13) case mix residents. This failed practice had the potential to effect all 80 residents in the facility, as documented on the Resident Census and Conditions of Residents form dated 10/20/08. The findings are:	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	**903 BORGOGNONI DRIVE** **LAKE VILLAGE, AR 71653**

(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 441	Continued From page 22	F 441		

1. Resident #6 had diagnoses of Dementia, Lupus, Osteoarthritis, Diabetes Mellitus and Renal Failure. The Admission Nursing Assessment dated 10/16/08 documented the resident was disoriented times three, was dependent on staff for activities of daily living, had a Foley catheter and was incontinent of bowel.

a. A lab report with a collected [at local clinic] date of 10/13/08 and a reported date of 10/18/08 documented, "...Specimen Source: Coccyx Wound... Result... Methicillin Resistant Staphylococcus Aureus (MRSA)..."

b. Physician orders dated 10/20/08 documented, "...Contact Isolation."

c. On 10/21/08 at 10:12 a.m., the housekeeping supervisor removed the housekeeping cart from the janitor's closet on 100 hall. She took the mop from the water pail, went in to the resident's room and mopped up water from the floor around and underneath the resident's bed, took the mop back outside the room and rinsed it again in the water pail. She then took the mop back inside the resident's room, re-mopped the floor, replaced the mop back into the water pail on the cart and placed the housekeeping cart back into the janitor's closet. There were no housekeeping supplies or equipment in the resident's room or bathroom.

d. On 10/20/08 the following staff were interviewed regarding housekeeping in a resident isolation room:

1) At 11:20 a.m., when asked, How do you take care of a resident in isolation? The Housekeeping Supervisor stated "I only know that you knock on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	**903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653**

(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 441	Continued From page 23	F 441		

the door, wear gloves, and do all of the main cleaning that you always do." When asked, What do you do with the cleaning equipment? the Supervisor stated, "I'm not real sure about that." When asked, Where do you keep the housekeeping supplies and equipment for a resident on isolation? The Housekeeping Supervisor stated, "In the janitor's closet."

2) At 11:23 a.m., when asked, How do you take care of a resident in isolation? The Administrator stated, "Same type of care as any other room." When asked, What do you do with the cleaning equipment? The Administrator stated, "Housekeeping is contracted, I guess it depends on the type of isolation." When asked, Where do you keep the housekeeping supplies and equipment for a resident on isolation? The Administrator stated, "You should keep everything in the room and not use it anywhere else."

3) At 11:25 a.m., when asked, How do you take care of a resident in isolation? The Director of Nursing (DON) stated, "I really can't tell you, they're [housekeeping] contracted." When asked, Where do you keep the housekeeping supplies and equipment for a resident on isolation? The DON stated. "Keep everything in the janitor's closet."

e. The contracted housekeeping service form, received from the Administrator on 10/22/08 and entitled, Job to be done: Contaminated Isolation Room Cleaning policy and procedure documented, "Additional Information: Isolation is the separating of one patient or group of patients from the rest of the facility because they have some type of communicable illness. The purpose is to prevent the spread of this disease. To

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ______ B. WING ______	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE VILLAGE HEALTHCARE CENTER	903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653

(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 441	Continued From page 24 protect the facility from the patient, every effort is made to deep the bacteria in the room. Cleaning equipment is kept in the isolation room. Or must disinfect it before removing it." f. The facility's "Initiating Isolation" policy and procedure documented, "Place necessary equipment and supplies in the room that will be needed during the period of isolation." 2. Resident #2 had diagnoses of Cerebrovascular Accident and History of Urinary Tract Infection. The MDS dated 6/20/08 documented the resident was moderately impaired in cognitive skills for daily decision making and was totally dependent on the physical assistance of one person for activities of daily living. On 10/21/08 at 12:50 p.m., the resident's pressure relief device (PRD) was taken out of the wheelchair by CNA #2. The CNA placed the PRD on the floor and then placed it back in the wheelchair without washing or disinfecting it.	F 441		
F 444 SS=E	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 staff washed their hands before and after direct resident contact to prevent the potential for the spread of infection for 2 (Residents #6 and #7) of 13 (Residents #1	F 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. BUILDING ____ B. WING ____	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 444	Continued From page 25	F 444		

through #13) case mix residents. This failed practice had the potential to affect all 80 residents in the facility, as documented on the Resident Census and Conditions of Residents form dated 10/20/08. The findings are:

1. Resident #6 had diagnoses of Dementia, Lupus, Osteoarthritis, Diabetes Mellitus and Renal Failure. The Admission Nursing Assessment dated 10/16/08 documented the resident was disoriented times three, was dependent on staff for activities of daily living and was incontinent of bowel, had an indwelling catheter .

a. A lab report with a collected [at local clinic] date of 10/13/08 and a reported date of 10/18/08 documented, "...Specimen Source: Coccyx Wound... Result... Methicillin Resistant Staphylococcus Aureus (MRSA)..."

b. Physician orders dated 10/20/08 documented, "...Contact Isolation."

c. On 10/21/08 at 6:41 p.m., after delivering the resident's dinner tray into the resident's room, Certified Nursing Assistant (CNA) #8 left the resident's room without washing her hands. The CNA then returned to the dietary department serving area, without first washing her hands.

d. On 10/22/08 at 10:56 a.m., during pressure ulcer care, LPN #2 removed her gloves, and without washing her hands, left the resident's room and got a tube of Saf gel from a drawer in the Assistant Director of Nursing's office.

e. The facility's "Initiating Isolation" policy and procedure documented, "...Employees are

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	045184	A. BUILDING ______ B. WING ______	10/23/2008

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F 444	Continued From page 26	F 444		

expected to use appropriate hand hygiene techniques to decrease the possibility of colonization or transient carriage of the organism... Observe proper hand hygiene procedures either by washing with conventional antiseptic-containing soap and water or with waterless alcohol-based gels or foams..."

2. Resident #7 had diagnoses of Dementia, Psychosis, Nausea and Vomiting, Acute Upper Respiratory Infection, Cough, Skin Disorder and Respiratory Distress Syndrome. The Quarterly Minimum Data Set dated 10/21/08 documented the resident had severely impaired cognitive skills for daily decision making, required extensive to total assistance of staff for activities of daily living and was incontinent of bowel and bladder

a. On 10/21/08 at 10:30 a.m., during incontinent care, a bottle of hand sanitizer gel fell to the floor. Certified Nursing Assistant (CNA) #1 picked up the bottle off of the floor while wearing gloves used for incontinent care. The CNA placed the bottle in her pocket and then continued the incontinent care without washing her hands and changing gloves.

3. The facility's policy and procedure "Handwashing/Hand Hygiene" documented, "...To prevent and to control the spread of infectious diseases... a. When hands are visibly dirty or soiled with blood or other body fluids; b. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; c. After handling items potentially contaminated with blood, body fluids, or secretions... 4. If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations: a. Before direct contact with residents; b. Before donning sterile

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F 444	Continued From page 27 gloves; c. Before performing any non-surgical invasive procedures; d. Before preparing or handling medications; e. Before handling clean or soiled dressings, gauze pads, etc; f. Before moving from a contaminated body site to a clean body site during resident care g. After contact with resident's intact skin; h. After handling used dressings, contaminated equipment, etc; i. After contact with inanimate objects (e.g. medical equipment in the immediate vicinity of the resident; and or j. After removing gloves..."	F 444		
F 445 SS=D	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure staff washed their hands in between contact with dirty and clean linen to prevent the potential spread of infection for 1 (Resident #7) of 13 (Residents #1 through #13) case mix residents. This failed practice had the potential to affect all 80 residents in the facility, as documented on the Resident Census and Conditions of Residents form dated 10/20/08. The findings are: Resident #7 had diagnoses of Dementia, Psychosis, Nausea and Vomiting, Acute Upper Respiratory Infection, Cough, Skin Disorder and Respiratory Distress Syndrome. The Quarterly Minimum Data Set dated 10/21/08 documented the resident had severely impaired cognitive skills for daily decision making, required extensive to total assistance of staff for activities of daily living	F 445		

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F 445	Continued From page 28 and was incontinent of bowel and bladder. On 10/21/08 at 10:30 a.m., after performing incontinent care, Certified Nursing Assistant #1 bagged up soiled incontinent brief and wipes, removed her gloves, took the bag into the hallway and placed it into the trash barrel. She then went to the clean linen closet in the hallway and got clean linen from the closet, without first washing her hands.	F 445		
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure labs specimens were obtained as ordered by the Physician for 1 (Resident #1) of 13 (Residents #1 through #13) case mix residents with orders for lab tests. This failed practice had the potential to affect 80 residents in the facility, as documented on the Resident Census and Conditions of Residents form dated 10/20/08. The findings are: Resident #12 had diagnoses of Lung Cancer, Schizo-Affective Disorder with Chronic Exacerbation and Hypertension. The Minimum Data Set dated 9/30/08 documented the resident was moderately impaired in cognitive skills for daily decision making. a. A Physician Order dated 9/30/08 documented, "CBC (Complete Blood Count), CMP	F 502		

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F 502	Continued From page 29 (Comprehensive Metabolic Panel) next day labs." b. On 10/23/08 at 1:05 p.m., the Director of Nursing was asked if the lab tests had been done. She stated, "I called the lab and they did not have any for the resident, there were none drawn." When asked when the next lab day after the resident's admission on 9/30/08 would have been, she stated, "It was 10/1/08."	F 502		