

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

PRINTED: 03/30/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045184</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/17/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKE VILLAGE HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>903 BORGOGNONI DRIVE</b> <b>LAKE VILLAGE, AR 71653</b>	
(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 #11402 was substantiated (all or in part) with a deficiency cited at F324.  Complaint #11554 was substantiated (all or in part) with deficiencies cited at F282, F332, F333, F324 and F325.	F 000		
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Complaint #11554 was substantiated (all or in part) with these findings.  Based on observation and record review, the facility failed to ensure the physician's plan of care for thickened liquids was implemented for 1 (Resident #6) of 2 case mix residents with physician orders for thickened liquids (Residents #1 and #6). The facility also failed to ensure the physician's plan of care for narcotic analgesic administration was implemented for 1 (Resident #5) of 2 case mix residents with physician orders for narcotic analgesics (Residents #1 and #5). The failed practices had the potential to affect 51 residents with physician orders for narcotic medications, as documented on a list provided by the Administrator on 3/17/06 at 8:40 a.m. and 2 residents with physician orders for thickened	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	Continued From page 1 liquids, as documented on a list provided by the Administrator on 3/17/06 at 10:10 a.m. The findings are:  1. Resident #5 had diagnoses of Neuropathy in Diabetes and Diabetes Mellitus Type II. The Minimum Data Set (MDS) dated 2/8/06 documented the resident had modified independence in cognitive skills for daily decision-making and did not complain of pain in the 7 days preceding the assessment date.  a. A physician's order dated 11/3/05 documented the resident was to receive Lyrica 50 milligrams (mg) 3 times daily.  b. A physician order dated 11/29/05 documented the order for Lyrica 50 mg 3 times daily was discontinued. The Narcotic Book documented Lyrica 50 mg was signed out for the resident on 11/30/05. There was no physician order for administration of Lyrica on that date.  c. A physician order dated 12/1/05 documented: "Lyrica 50 mg Q [every] day." The Narcotic Book documented Lyrica was signed out for the resident twice daily (at 9:00 a.m. and 12:00 p.m.) on 12/2/05, 12/4/05, 12/8/05, 12/10/05 and 12/13/05, instead of once daily as ordered by the physician. The December 2005 Medication Administration Record (MAR) documented the Lyrica was administered only once daily on those dates; however, the narcotic count documented in the Narcotic Log decreased by 2 tablets on each of the above dates.  d. The Narcotic Book had no documentation of Lyrica signed out for the resident on 1/30/06, 1/31/06 or 2/1/06. The January 2006 MAR	F 282			

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F 282	<p>Continued From page 2</p> <p>documented 1 dose of Lyrica was administered on 1/30/06 and 1 dose circled as not administered on 1/31/06 with no documentation of a rationale for omitting the dose. The February MAR had no documentation that the Lyrica was administered on 2/1/06.</p> <p>e. A physician order dated 2/1/06 documented the Lyrica 50 mg was increased to twice daily. The Narcotic Book documented Lyrica was signed out for the resident only once on 2/3/06 and not at all on 2/7/06. The February 2006 MAR documented both 2/7/06 doses were omitted, but there was no documentation of a rationale for the omission.</p> <p>f. A physician order dated 2/8/06 documented the Lyrica was again discontinued.</p> <p>g. A Quarterly Progress Note dated 2/8/06 documented: "...Resident also had new medication started on 11/03/05 Lyrica for Neuropathy per MD [Medical Doctor], but medication was D/C'd [discontinued] per MD on 2/8/06 due to decline in cognition and loss of ambulating ability..."</p> <p>h. A physician order dated 2/21/06 documented the resident was to receive Lyrica 50 mg daily. No entries were documented in the Narcotic Book to indicate that the resident received Lyrica until 3/2/06, a period of 9 days after the medication was ordered by the physician. On 3/15/06 at 9:00 a.m. after the 8:00 a.m. dose of Lyrica was administered, the number of Lyrica tablets remaining matched the number documented on the Narcotic Log.</p> <p>i. The February and March 2006 MAR's</p>	F 282			

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F 282	<p>Continued From page 3</p> <p>documented the Lyrica was not administered from 2/22/06 through 3/4/06. The doses were circled to indicate the doses were omitted. The omissions of 2/24/06, 2/25/06, 2/27/06, 3/1/06, 3/3/06 and 3/4/06 documented that the resident refused the medication. No rationale was documented for the omissions on 2/22/06, 2/23/06, 2/26/06, 2/28/06 and 3/2/06.</p> <p>2. Resident #6 had a diagnosis of Cerebrovascular Accident. The Minimum Data Set (MDS) dated 2/6/06 documented the resident had modified independence in cognitive skills for daily decision-making, was independent with eating after tray set-up and did not have a chewing or swallowing problem.</p> <p>a. A physician order dated 8/24/05 documented: "Please give thicken liquids." (As of 3/15/06 at 9:12 a.m., there was no documentation in the Physician Orders Sheets of a physician order to discontinue the thickened liquids and the resident was observed during the survey drinking thickened liquids on 3/15/06 at 11:49 a.m. and 12:35 p.m.)</p> <p>b. A Nutritional Assessment Note dated 9/5/05 documented: "Thicken liquids nectar consistency."</p> <p>c. On 3/15/06 at 5:06 p.m., Certified Nursing Assistant (CNA) #4 poured a cup of regular, non-thickened water from a pitcher on the dining room table and held the cup to the resident's mouth to drink.</p> <p>d. On 3/16/06 at 10:00 a.m., Licensed Practical Nurse (LPN) #1 gave the resident approximately 2 ounces of regular, unthickened water from a</p>	F 282			

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F 282	Continued From page 4 pitcher on top of the medication cart.	F 282			
F 318 SS=D	<p>483.25(e)(2) RANGE OF MOTION</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure positioning devices were provided in accordance with the plan of care to prevent worsening of contractures for 1 (Resident #1) of 2 case mix residents with contractures (Residents #1 and #6). The failed practice had the potential to affect 8 residents with contractures, as documented on a list provided by the Administrator on 3/17/06 at 8:40 a.m. The findings are:</p> <p>Resident #1 had diagnoses of Hemiplegia and Contracture. The Minimum Data Set dated 1/19/06 documented the resident was dependent on staff for bed mobility and had full loss of range of motion in one arm, hand, leg and foot.</p> <p>a. A physician order dated 7/25/05 documented: "Restorative POC [plan of care] daily, duration ongoing consisting of L [left] upper extremity/bilateral lower extremities PROM [passive range of motion] with daily application of L elbow splint with hand cone." This was</p>	F 318			

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F 318	Continued From page 5 documented on the March 2006 Physician Orders sheet as a current order.  b. The Plan of Care dated 7/25/05 and reviewed/ revised by the facility on 1/19/06 documented: "Restorative therapy as ordered for ROM + [and] splint application daily for ongoing duration..."  c. On 3/15/06 at 11:50 a.m. and 12:30 p.m., the resident had a rolled up washcloth in the left hand. There was a sign on the wall over the resident's bed which documented: "Splint on L arm at all times, thanks OT [Occupational Therapy]."  d. On 3/15/06 at 1:20 p.m., 3:15 p.m., 4:55 p.m. and 6:30 p.m. and 3/16/06 at 8:10 a.m. and 12:00 p.m., the resident had no splint or other positioning device in the left hand or on the left arm.  e. On 3/17/06 at 8:30 a.m., the Occupational Therapist (OT) stated he had taken the splint to be washed about 2 weeks ago and he, "hated to put it back on" because he did not think it would improve the contracture. The OT was asked what interventions were being implemented in lieu of the splint to prevent the resident's contractures from worsening. The OT again stated he did not believe the splint would improve the contractures. When asked if he had documented this anywhere in the resident's clinical record, the OT stated, "No."	F 318			
F 323 SS=D	483.25(h)(1) ACCIDENTS  The facility must ensure that the resident environment remains as free of accident hazards	F 323			

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F 323	Continued From page 6 as is possible.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a soft belt restraint was applied in accordance with the manufacturer's recommendations to prevent potential accidents for 1 (of 1) case mix resident with a physician order for a soft belt restraint (Resident #6). The failed practice had the potential to affect 7 residents with soft belt restraints in use, as documented on a list provided by the Administrator on 3/17/06. The findings are:  Resident #6 had diagnoses of Alzheimer's Disease, Agitation and Alcoholism. The Quarterly Minimum Data Set dated 2/6/06 documented the resident had modified independence in cognitive skills for daily decision-making, was totally dependent on staff for transfers and used side rails and a chair that prevented rising less often than daily.  a. An Incident/Accident Report dated 1/29/06 at 10:15 a.m. documented: "found on floor... Intervention - instruct to call for assistance [with] CL [call light]."  b. A physician order dated 1/30/06 documented: "May have soft belt restraint as needed to prevent resident from standing without assistance and enable resident to socialize in the facility."  c. The manufacturer's Application Instruction Sheet for the soft belt restraint used for Resident #6 documented: "...Go around the back post and	F 323		

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F 323	Continued From page 7 cross the straps behind the patient. Secure the loops on the wheelchair tilt levers." The illustration on the instruction sheet showed the straps crossed in an "X" behind the wheelchair.  d. On 3/15/06 at 9:12 a.m., the resident was sitting in a wheelchair with a soft belt restraint applied. The restraint straps were both attached to one tilt bar of the wheelchair and were not crossed.  e. On 3/15/06 at 11:49 a.m., 1:35 p.m. and 5:02 p.m. and 3/16/06 at 8:10 a.m. and 9:40 a.m., the resident was sitting in a wheelchair with a soft belt restraint applied. The straps were not crossed in back and were attached straight down each side to the wheelchair tilt bars.	F 323			
F 324 SS=E	483.25(h)(2) ACCIDENTS  The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Complaint #1142 was substantiated (all or in part) with these findings.  Based on observation, record review and interview, the facility failed to ensure repeated falls were assessed for causative factors, such as medications and the need for toileting, in order to develop effective interventions to prevent further potential falls for 1 (Resident #6) of 2 case mix residents who experienced falls since 2/16/06 (Residents #2 and #6). The facility also failed to	F 324			

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F 324	Continued From page 8  ensure a chair alarm was properly attached to alert the staff of attempts to transfer without assistance for 1 (of 1) case mix resident with physician orders for a chair alarm (Resident #6). The facility also failed to ensure ankle alarms (Wanderguards) for the prevention of elopement were checked daily in accordance with the manufacturer's guidelines, to ensure the alarms were functioning properly for 2 of 2 case mix residents with physician orders for ankle alarms (Residents #6 and #7). The failed practice had the potential to affect 13 residents who experienced falls since 2/16/06, 1 resident with a physician order for a chair alarm and 8 residents with ankle alarms in use, as documented on lists provided by the Administrator on 3/17/06 at 8:40 a.m. The findings are:  1. Resident #6 had diagnoses of Alzheimer's Disease, Agitation and Cerebrovascular Accident (CVA). The Quarterly Minimum Data Set (MDS) dated 2/6/06 documented the resident had modified independence in cognitive skills for daily decision-making, short-term memory problems, partial loss of range of motion in both legs and feet, was totally dependent on staff for transfers and toilet use, required extensive assistance from staff for locomotion in his room and the adjacent corridor and fell in the past 30 days and the past 31 to 180 days.  a. A physician order dated 9/29/95 documented: "Chlordiazepoxide HCL [hydrochloride] caps [capsules] 25 mg [milligrams] one cap po [by mouth] QD [every day] TID [three times daily]." The Mosby's Drug Guide for Nurses Fourth Edition documented: "...chlordiazepoxide (Librium) Uses: short-term management of anxiety, acute alcohol withdrawal, preoperative	F 324			

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F 324	Continued From page 9 relaxation... Adverse effects: dizziness, drowsiness, orthostatic hypotension... Education: Caution patient to rise slowly or fainting may occur, especially in elderly..."  b. A physician order dated 10/5/05 documented: "Prolixin 37.5 mg IM [intramuscular] Q2wks [every 2 weeks]." The Mosby's Drug Guide for Nurses Fourth Edition documented: "Prolixin... Uses: psychotic disorders, schizophrenia... Adverse effects: orthostatic hypotension... Assessment: check for dizziness, fainting, palpitations, tachycardia on rising; severe orthostatic hypotension is common... Education: Inform patient that orthostatic hypotension occurs often and to rise from sitting or lying position gradually..."  c. A physician order dated 10/8/05 documented: "Zyprexa tabs [tablets] 5 mg one tab po BID [twice daily]." The Mosby's Drug Guide for Nurses Fourth Edition documented: "Zyprexa... Uses: Psychotic disorders... Adverse effects: orthostatic hypotension... Assessment: assess dizziness, faintness, palpitations, tachycardia on rising... Education: Advise patient that orthostatic hypotension occurs often and to rise from sitting or lying position gradually."  d. The Plan of Care dated 11/9/05 documented: "Potential for Trauma R/T [related to] external factors: Falls secondary to CVA and weakness... Approach - ...encourage to request assist [assistance] before transferring, keep call light in reach at all times... evaluate medication orders and consult physician for possible medication reduction... Soft waist restraint as enabler while up in W/C [wheelchair]..." Handwritten entries on the Plan of Care documented: "...9/28/05 chair	F 324			

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F 324	Continued From page 10 alarm... 10/1/05 [low bed with] floor mat... 2/10/06 PT [Physical Therapy] to evaluate..."  e. An Incident/Accident Report dated 1/28/06 at 3:45 a.m. documented: "Res [resident] found on floor in Rm [room] beside bed. Could not verbalize why he was trying to get OOB [out of bed]... Steps taken to prevent recurrence: Replace reg [regular] bed [with] previous one that was on the floor. Res is constantly crawling OOB..."  f. An Incident/Accident Report dated 1/29/06 at 10:15 a.m. documented: "Called to room by CNA [Certified Nursing Assistant]. Found res [resident] lying on floor by bed. Res said he was trying to get to the chair to sit down... Steps taken to prevent recurrence: Low bed - get order from [physician]..." The attached Change in Condition Report dated 1/29/06 documented: "...Intervention - instruct to call for assistance [with] CL [call light]. Voiced understanding."  g. An Incident/Accident Report dated 2/2/06 at 6:00 p.m. documented: "Res found on floor beside bed. Bed is low to floor. Unable to verbalize why he got out of bed... Steps taken to prevent recurrence: Mat on floor..." The attached Change in Condition Report dated 2/2/06 documented: "...Intervention - Oriented to call light. Instructed to use for assistance. Voiced understanding."  h. An Incident/Accident Report dated 2/9/06 at 9:00 p.m. documented: "CNA informed me that [resident] fell forward from his W/C to his bed which is located on the floor..." The section of the form designated for documentation of steps taken to prevent recurrence was not completed. The	F 324			

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PRINTED: 03/30/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045184</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/17/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKE VILLAGE HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>903 BORGOGNONI DRIVE</b> <b>LAKE VILLAGE, AR 71653</b>		
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F 324	<p>Continued From page 11</p> <p>attached Change in Condition Report dated 2/9/06 did not document any new interventions to prevent further falls. The Investigation Follow-Up form dated 2/10/06 documented: "Summary of Investigation: Resident unable to verbalize what happened... Interventions - PT [Physical Therapy] to reevaluate." There was no documentation that the resident's environment, medication regimen or other potential causative factors were evaluated.</p> <p>i. A Restorative Plan of Care dated 2/7/06 documented: "PT [Physical Therapy]... Generalize weakness... Goals: Maintain current functional independence for ADL [activities of daily living]... Treatment plan: ROM [range of motion] exer [exercise] BUE/LE [both upper and lower extremities] &amp; [and] B/B [bowel/bladder] program... Precautions: Risk for fall... Frequency: 3 x/wk [times per week]... Duration: 2 months." This document was completed and signed by a Physical Therapist.</p> <p>j. A Physical Therapy Functional Needs Worksheet dated and signed by a Physical Therapist on 2/7/06 documented: "Physical Therapy not indicated at this time secondary to: No significant changes. Recommended for restorative therapy."</p> <p>k. On 3/15/06 at 9:12 a.m. and 5:02 p.m., a chair alarm box was attached to the back of the resident's wheelchair. The clip was not fastened to the resident and dangled down behind the wheelchair. The User Instructions for the Personal Monitor System provided by the facility business office on 3/16/06 documented: "Clip the control box to the back of the resident's chair or wheelchair.... Fasten the clip on the end of the</p>	F 324			

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F 324	Continued From page 12 string securely to the resident's clothing."  l. On 3/15/06 at 1:35 p.m., the resident was transported in a wheelchair from the dining room back to his room by Certified Nursing Assistant (CNA) #2. The CNA returned the resident to his room and did not offer toileting before transferring the resident to bed.  m. On 3/16/06 at 2:40 p.m., CNA's #1 and #3 checked the resident to determine if he was clean and dry. The CNA's did not offer toileting assistance to the resident. The resident's wheelchair was stored in the bathroom. Certified Nursing Assistant (CNA) #1 was asked if the resident was able to use the call light. The CNA stated, "He doesn't use the call light to my knowledge."  n. On 3/16/06 at 2:57 p.m., the Director of Nursing (DON) and MDS Coordinator were interviewed. When asked if they had attempted to discover why the resident was attempting to get up by himself and repeatedly falling, the MDS Coordinator stated the resident was, "trying to get up to the bathroom and fell. This was the usual reason for the falls." When asked if the resident was on a toileting program, the MDS Coordinator stated, "Not on a toileting plan, just routine assist to the bathroom..." The Director of Nursing (DON) was asked to provide documentation of any interventions, including Restorative Therapy, that the facility had implemented to address the resident's falls. The DON did not provide documentation of Restorative Therapy and no documentation was available for review to indicate an evaluation of the resident's medications and potential adverse effects was completed (such as an assessment of the	F 324			

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F 324	Continued From page 13 resident's blood pressure while lying, standing and sitting to rule out orthostatic hypotension).  2. The manufacturer's Adult Transmitter User Guide documented: "...[Name of transmitter company] requires facilities to test the transmitter for proper operation on a daily basis... A documented test of each ankle transmitter at the facility must be made each day. This testing should also include those transmitters not currently in use. The procedure involves using the #707 transmitter tester and/or the exit panel on the wall by the exit, and documenting the performance of the transmitter."  3. On 3/16/06 at 9:15 a.m., the Maintenance Supervisor was asked for documentation of daily ankle transmitter testing. The Daily Transmitter Testing Log documented the alarms were tested on each shift during the week from 1/3/06 through 3/16/06, but there was no documentation that the alarms were tested on the weekends. All entries for all shifts were signed by the Maintenance Supervisor. The Maintenance Supervisor was asked if he checked the alarms on every shift, including the night shift. He stated the staff checked the alarms, "when they come on the night shift." He stated he either came to the facility or asked the night shift, then documented the testing on the Log. When asked if the alarms were tested on the weekends, he stated, "No."  4. The Daily Transmitter Testing Log form dated January 2006 through March 16, 2006, had no documentation of any Wanderguard function tests conducted on weekends.  5. On 3/16/06 at 10:00 a.m., the Administrator was informed that the Transmitter Log did not	F 324			

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F 324	Continued From page 14 document Wanderguard function tests on weekends. She stated the Wanderguard checks would be documented on the MAR.  6. Resident #10 had diagnoses of Pre-senile Dementia and Episodic Mood Disorder. The Minimum Data Set (MDS) dated 11/8/05 documented the resident was severely impaired in cognitive skills for daily decision-making, exhibited wandering behaviors 4 to 6 times a week which were not easily altered and was independently ambulatory.  a. A physician order dated 7/21/04 documented: "Presenile Dementia... Wanderguard bracelet to prevent elopement attempts. Wanderguard function test daily. Wanderguard placement check every shift."  b. The March 2006 Medication Administration Record (MAR) documented: "Wanderguard placement check every shift." The MAR did not include any documentation regarding daily Wanderguard function tests.  7. Resident #6 had diagnoses of Alzheimer's Disease, Agitation and Cerebrovascular Accident (CVA). The Quarterly Minimum Data Set (MDS) dated 2/6/06 documented the resident had modified independence in cognitive skills for daily decision-making, short-term memory problems, partial loss of range of motion in both legs and feet and fell in the past 30 days and the past 31 to 180 days.  a. A physician order dated 10/17/05 documented: "Wanderguard bracelet to prevent elopement attempts... Wanderguard function test daily... Wanderguard placement check every shift."	F 324		

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F 324	Continued From page 15  b. The March 2006 MAR documented: "Wanderguard placement check every shift." The MAR did not include any documentation regarding daily Wanderguard function tests.  8. On 3/16/06 at 10:30 a.m., Licensed Practical Nurse (LPN) #2 was asked if she conducted daily function tests on Wanderguard ankle alarms. She stated she checked to make sure the Wanderguards were in place on each resident with an order for one, but did not test for proper function unless the physician order on the MAR specified to test function. The LPN was asked to show the Surveyor documentation of Wanderguard checks. She presented Resident #10's MAR, which documented: "Wanderguard placement check every shift. Start Date: 7/21/04. The LPN stated, "No, I don't have to check function, just that it is there. I don't have to check function unless it is written on the MAR."	F 324			
F 325 SS=D	483.25(i)(1) NUTRITION  Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.  This REQUIREMENT is not met as evidenced by:  Complaint #11554 was substantiated (all or in part) with these findings.  Based on observation, record review and	F 325			

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F 325	<p>Continued From page 16</p> <p>interview, the facility failed to ensure interventions to prevent weight loss were implemented for 1 (Resident #4) of 2 case mix residents with feeding tubes (Residents #1 and #4), as evidenced by failure to schedule feedings and water flushes at times that would facilitate digestion and prevent overfilling of the resident's stomach and failure to notify the physician of an ongoing problem with administration of bolus feedings. The failed practice had the potential to affect 2 residents who received tube feedings, as documented on the Roster/Sample Matrix provided by the Administrator on 3/15/06 at 9:00 a.m. The findings are:</p> <p>Resident #4 had a diagnosis of Anorexia. The Minimum Data Set (MDS) dated 2/15/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, totally dependent for eating, had a chewing problem, had experienced a weight loss of 5% or more in the last 30 days or 10% or more in the last 180 days and a feeding tube through 51 to 75% of the resident's total daily caloric intake was provided.</p> <p>a. A physician order dated 5/28/05 documented: "Flush with 150 cc [cubic centimeters] of H2O [water] after each feeding..." A physician order dated 2/28/06 documented: "Diabetesource 1 can bolus feedings 5 x day [5 times per day]." A physician order dated 4/26/05 documented: "Flush G [gastrostomy] Tube with 150 cc Q [every] shift." The resident also had a physician order dated 7/1/04 for a mechanical soft diet and house supplement 3 times daily.</p> <p>b. The Weight Record documented the following weights for this resident:</p>	F 325			

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F 325	<p>Continued From page 17</p> <p>9/8/05 - 91.4 pounds (lbs.) 10/6/05 - 89.6 lbs. 11/11/05 - 78.8 lbs. 12/7/05 - 78.6 lbs. 1/5/06 - 79.75 lbs. 2/6/06 - 77.6 lbs. 3/6/06 - 78.0 lbs.</p> <p>This was a 13.4 pound (14.66%) weight loss over a 6-month period.</p> <p>c. On 3/16/06 at 8:50 a.m. during a medication pass, Licensed Practical Nurse (LPN) #2 flushed the resident's gastrostomy tube with 150 cc water prior to attempting to administer the bolus feeding of Diabatasource. When the LPN attempted to administer the Diabatasource, only about 50 cc's of the formula was instilled before the remainder began to back up out of the tube. The LPN stopped the feeding.</p> <p>d. On 3/16/06 at 10:35 a.m., LPN #2 was asked how often she had a problem with the resident's bolus feeding backing up in the feeding tube. She stated, "Quite often. Almost always in the morning. I think her a.m. [morning] feeding needs to be moved to 11:00 a.m., because she eats a good breakfast. Even later in the day, some of the flushed water will back up in the tube."</p> <p>e. On 3/16/06 at 11:40 a.m., LPN #2 was asked what actions she took when the resident's bolus feeding was not successfully administered. She stated, "If I can't give it all, I chart it on the back of my MAR [Medication Administration Record]." The LPN was asked to show the Surveyor the back of the March 2006 MAR. There was no documentation on the back of the MAR regarding</p>	F 325			

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F 325	Continued From page 18 the resident's inability to receive the physician-ordered tube feeding, with the exception of one entry on 3/3/06 when the feeding could not be administered because the feeding tube had been pulled out. LPN #2 was asked what she did when the resident could not tolerate the entire ordered feeding. She stated, "I throw it out." When asked if she notified the resident's physician, she stated "No, I don't call the doctor."	F 325		
F 329 SS=D	483.25(I)(1) UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interview, the facility failed to ensure the drug regimen of 1 (Resident #6) of 2 case mix residents with physician orders for antipsychotic medications (Resident #6 and #7) was free from unnecessary drugs, as evidenced by the administration of 2 antipsychotic medications without documentation of adequate indications for antipsychotic drug use and failure to monitor for therapeutic response and potential adverse reactions to the drugs. The failed practice had the potential to affect 23 residents who received antipsychotic medications, as documented on the	F 329		

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F 329	<p>Continued From page 19</p> <p>Resident Census and Conditions of Residents Detail Report provided by the Administrator on 3/15/06. The findings are:</p> <p>Resident #6 had diagnoses of Agitation, Depression, Cerebrovascular Accident, Alcohol Withdrawal and Dementia without Behaviors. The Quarterly Minimum Data Set (MDS) dated 2/6/06 documented the resident had modified independence in cognitive skills for daily decision-making, short-term memory problems, periods of restlessness and varying mental function and exhibited behavioral symptoms including repetitive physical movements and verbally abusive behaviors.</p> <p>a. A Physician's Progress Note dated 10/5/05 documented: "He has been having more falling episodes and he has become very difficult to manage. He will try to flip his wheelchair, he pulls the curtains in the room, and he hit one other resident with a wet floor sign... He is becoming a potential risk to himself and others and I am going to put him on Prolixin 37.5 mg [milligrams] every 2 weeks, and in three days if no improvement will consider even adding Zyprexa."</p> <p>b. A physician order dated 10/5/05 documented: "Prolixin 37 1/2 mg IM [intramuscular] Q [every] 2 weeks. If no better in 3 days start Zyprexa 5 mg BID [twice daily] - can then hold prn [as needed] too much sedation." The October 2005 Medication Administration Record (MAR) documented the first dose of Prolixin 37.5 mg was administered 10/7/05 at 9:00 a.m. The first dose of Zyprexa 5 mg was administered on 10/11/05 at 9:00 a.m.</p> <p>c. The October 2005 Behavior/Intervention</p>	F 329			

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F 329	<p>Continued From page 20</p> <p>Monthly Flow Record documented the resident had one combative episode on 10/8/05; no other episodes were documented to warrant the initiation of treatment with Zyprexa. The October 2005 Medication Administration Record (MAR) documented a 1 milligram Ativan injection was administered on 10/3/05 and 10/8/05. No Behavior/Intervention Monthly Flow Records for November 2005, December 2005 and January 2006 were available for review in the resident's clinical record as of 3/15/06 at 3:27 p.m.</p> <p>d. A Consultation Report dated 11/5/05 by a Licensed Social Worker documented: "Reason for referral: Anxiety, Dementia, Alzheimer's, Treatment Plan Review, Behavioral combative during ADL's [activities of daily living], can become violent towards staff... Impression/diagnosis: Axis I: Alcoholism, Alcohol withdrawal, R/O [rule out] early dementia... Axis II: none... Axis III: see medical record... Recommendations: Contact physician for medication review... Summary: Pts [patient's] mental status was indicative of mild dementia and anxiety. He was relatively oriented and appeared to have insight into his condition as well as situation. Pt would probably benefit from a low dose of an antianxiety medication to ease his adjustment. I also suggest some 1 on 1 to further assess and comfort him..."</p> <p>e. The February 2006 and March 2006 Behavior/Intervention Monthly Flow Record documented no agitated or combative episodes.</p> <p>f. Nurses' Notes dated 3/8/06 documented a telephone order was received to decrease the frequency of Prolixin administration from 37.5 mg IM every 2 weeks to every 4 weeks.</p>	F 329			

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F 329	Continued From page 21  g. On 3/15/06 at 5:02 p.m., the resident sat in a wheelchair at a dining room table with his head bowed and eyes closed. He did not respond to his name being called. On 3/16/06 at 9:40 a.m., the resident was sitting in a wheelchair in his room with his head bowed and eyes closed. At 10:09 a.m., the resident remained in the wheelchair with his head bowed and eyes closed. When asked how he was doing, the resident stated with slurred speech, "Okay."  h. On 3/16/06 at 2:40 p.m., Certified Nursing Assistant (CNA) #3 stated the resident was, "Sleepy, but can be active."  i. Mosby's Drug Guide for Nurses Fourth Edition documented: "Prolixin... Uses: Psychotic disorders, schizophrenia... Dosage: IM initially 1.25 mg then 2.5 - 10 mg in divided doses q 6-8 h [every 6 to 8 hours]... Nursing Considerations Assessment: Assess mental status: orientation, mood, behavior, presence of hallucinations, and type before initial administration and monthly; this drug should significantly reduce psychotic behavior... Monitor bilirubin, CBC [complete blood count], liver function studies monthly."  j. Mosby's Drug Guide for Nurses Fourth Edition also documented: "Zyprexa... Uses: Psychotic disorders... Nursing Considerations Assessment: Assess mental status, orientation, mood, behavior, presence of hallucinations and type before initial administration and monthly... Monitor bilirubin, CBC, liver function studies monthly."  k. As of 3/16/06 at 2:00 p.m., there was no physician order to routinely check the resident's bilirubin, CBC and liver function studies.	F 329			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045184</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/17/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKE VILLAGE HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>903 BORGOGNONI DRIVE</b> <b>LAKE VILLAGE, AR 71653</b>		
(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 329	Continued From page 22	F 329			
F 332 SS=E	<p>483.25(m)(1) MEDICATION ERRORS</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation of the 9:00 a.m. medication pass on 3/16/06, record review and interview, the facility failed to ensure physician orders were followed to maintain a medication error rate of less than 5%. Physician orders were not followed for 3 (Residents #1, #12 and #14) of 9 residents observed during the medication pass. Medication errors were made by 2 of 2 Licensed Practical Nurses (LPN's) who were observed administering medications (LPN's #1 and #2). The failed practice had the potential to affect all 85 residents who received medications from these LPN's, as identified by the facility on 3/16/06. The medication error rate was 10.17%, based on observation of 58 medications administered, 1 medication ordered but not</p>	F 332			

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F 332	<p>Continued From page 23</p> <p>administered and a total of 6 errors detected. The findings are:</p> <ol style="list-style-type: none"> <li>1. Resident #12 had a physician order dated 11/28/05 for Coumadin 4 milligrams (mg) daily and a physician order dated 6/17/05 for Lanoxin 0.25 mg daily and Imdur 60 mg daily.</li> </ol> <p>On 3/16/06 at 7:16 a.m., LPN#1 handed the resident a medication cup which contained the Coumadin, Lanoxin and Imdur, but did not observe the resident to ensure that he took the medications. The resident hid the medication and pretended to take the medication from an empty cup. The LPN was not aware of this until she was informed by the Surveyor. This resulted in 3 medication errors.</p> <ol style="list-style-type: none"> <li>2. Resident #14 had a physician order dated 6/17/05 for Florinef 1.1 mg, 2 tablets daily. On 3/16/06 at 7:30 a.m., LPN #1 administered 1 Florinef 1.1 mg tablet, instead of 2 tablets as ordered by the physician.</li> <li>3. Resident #1 had a physician order dated 10/22/05 for Tenormin 100 mg daily. <ol style="list-style-type: none"> <li>a. The March 2006 Medication Administration Record (MAR) documented the Tenormin 100 mg was discontinued on 2/25/06 and changed to 50 mg daily. The MAR documented the Tenormin was to be administered at 9:00 a.m. daily.</li> <li>b. On 3/16/06 at 10:30 a.m., LPN #2 administered the resident's other 9:00 a.m. medications, but did not administer the Tenormin.</li> </ol> </li> <li>4. Resident #1 had a diagnosis of Heart Disease, Cardiac Dysrhythmia and Cardiac Pacemaker.</li> </ol>	F 332			

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F 332	Continued From page 24  a. A physician order dated 2/25/05 documented the resident was to receive a Nitroglycerin 0.4 mg. patch, to be applied in the morning and removed in the evening.  b. On 3/16/06 at 10:30 a.m., as LPN #2 began to apply the Nitroglycerin patch, the Surveyor asked her to check and ensure that the old patch had been removed the previous evening as ordered. The LPN searched and discovered that the patch dated 3/15/06 remained on the resident. The patch had not been removed the previous evening as ordered by the physician.	F 332			
F 333 SS=E	483.25(m)(2) MEDICATION ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation of the 9:00 a.m. medication pass on 3/16/06 and record review, the facility failed to ensure physician orders were followed to prevent significant medication errors for 2 (Residents #1 and #12) of 9 residents observed during the medication pass. The failed practice had the potential to affect all 85 residents who received medications, as identified by the facility on 3/16/06. The findings are:  1. Resident #12 had diagnoses of Atrial Fibrillation and Chronic Ischemic Heart Disease.  a. A physician order dated 11/18/05 documented the resident was to receive Coumadin 4	F 333			

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F 333	Continued From page 25 milligrams (mg) daily. A physician order dated 6/17/05 documented the resident was to receive Lanoxin 0.25 mg daily and Imdur 60 mg daily.  b. On 3/16/06 at 7:16 a.m., Licensed Practical Nurse (LPN) #1 handed the resident a medication cup which contained the Coumadin, Lanoxin and Imdur, but did not watch the resident take the medication. The resident hid the medications and pretended to take the medications from an empty cup. The LPN was not aware of this until the Surveyor informed her.  c. These medication errors were significant due to the classifications of the drugs (Coumadin - anticoagulant; Lanoxin - cardiac glycoside; Imdur - anti-anginal).  2. Resident #1 had a diagnosis of Heart Disease, Cardiac Dysrhythmia and Cardiac Pacemaker.  a. A physician order dated 2/25/05 documented the resident was to receive a Nitroglycerin 0.4 mg. patch, to be applied in the morning and removed in the evening.  b. On 3/16/06 at 10:30 a.m., the patch dated 3/15/06 remained on the resident, as observed by LPN #2. The patch had not been removed the previous evening as ordered by the physician.  c. This medication error was significant due to the classification of the drug, which was an anti-anginal agent.	F 333			
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY  Menus must meet the nutritional needs of	F 363			

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F 363	<p>Continued From page 26</p> <p>residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure large portions were served to 1 of 1 case mix resident with a physician order for large portions (Resident #6). The facility also failed to ensure the menu was followed for 3 (Residents #2, #5 and #6) of 4 case mix residents with physician orders for low-concentrated sweets diets (Residents #2, #3, #5 and #6). The failed practices had the potential to affect 1 resident with a physician order for large portions and 35 residents with physician orders for low-concentrated sweets diets, as documented on a list provided by the Administrator on 3/17/06. The findings are:</p> <p>1. Resident #6 had a diagnosis of Diabetes Mellitus and a history of weight loss. The Quarterly Minimum Data Set (MDS) dated 2/6/06 documented the resident had modified independence in cognitive skills for daily decision-making and was independent with eating after tray set-up.</p> <p>a. A physician order dated 11/15/05 documented: "Mech [mechanical] soft LCS [low concentrated sweets] NSP [no salt packet] diet large portions."</p> <p>b. A Nutritional Assessment form completed by the Dietary Department on 2/6/06 documented: "...Plus he is on diet of fortified pudding @ [at]"</p>	F 363			

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F 363	Continued From page 27 lunch and supper... Diet ordered mech [mechanical] soft LCS NSP large portions."  c. The diet card for the resident's lunch and supper meals on 3/15/06 documented: "FORTIFIED PUDDING... LARGE PORTIONS."  d. The facility's menu for the 3/16/06 lunch meal documented the residents on large portion diets should receive 3 ounces Swiss steak, one #8 scoop of mashed potatoes, 2 ounces of gravy, 1/2 cup of mixed vegetables, 2 dinner rolls, 2 pats of margarine and 1 slice of cheesecake. The menu for low concentrated sweets diets documented 1/2 slice of cheesecake instead of 1 slice.  e. On 3/15/06 at 12:35 p.m., the resident was served ground Salisbury steak, mashed potatoes with gravy, 1 roll and 1 pat of margarine, mixed vegetables, cheese cake and one pepper packet. The resident was served the same portion sizes as the other residents and was not served fortified pudding.  f. The menu for the 3/15/06 supper meal documented the residents on large portion diets should receive 3 ounces of turkey divan with broccoli, 1/2 cup cooked rice, 2 dinner rolls, 2 pats of margarine and 1/2 cup fruit.  g. On 3/15/06 at 5:35 p.m., the resident was served turkey with broccoli and rice, 1 roll, 1 pat of margarine, 1 pepper packet and fruit cocktail. The serving portions were the same as the other residents' serving sizes. There was no fortified pudding on the tray.  h. On 3/16/06 at 3:19 p.m., the Dietary Manager	F 363			

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F 363	<p>Continued From page 28</p> <p>was informed the resident did not receive fortified pudding on 3/15/06 and received a full-size dessert for lunch. The Dietary Manager stated, "He didn't get fortified soup last night?" and "He was supposed to get half a dessert."</p> <p>2. Resident #2 had diagnoses of Diabetes Mellitus and Congestive Heart Failure. The MDS dated 12/23/05 documented was independent with eating after tray set-up.</p> <p>a. A physician order dated 12/23/05 documented the resident was to receive a Regular/Low Concentrated Sweets Diet.</p> <p>b. The menu for the Low Concentrated Sweets lunch meal on 3/15/05 documented the meal would include Swiss steak, mashed potatoes with gravy, mixed vegetables, dinner roll/bread, margarine, cheesecake (1/2 serving) and unsweetened beverage of choice.</p> <p>c. On 3/15/05 at 12:00 p.m., the resident received a full serving of cheesecake with lunch, instead of a half serving as documented on the menu.</p> <p>3. Resident #5 had diagnoses of Neuropathy in Diabetes Mellitus and Diabetes Mellitus Type II. The MDS dated 2/8/06 documented the resident was independent with eating after tray set-up.</p> <p>a. A physician order dated 5/17/05 documented: "Regular LCS [low concentrated sweets] Diet."</p> <p>b. The menu for Low Concentrated Sweets on 3/15/05 was Swiss steak, mashed potatoes with gravy, mixed vegetables, dinner roll/bread, margarine, cheesecake (1/2 serving) and</p>	F 363			

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F 363	Continued From page 29 unsweetened beverage of choice.  c. On 3/15/05 at 12:00 p.m., the resident received a full serving of cheesecake instead of a half serving as documented on the menu.	F 363			