

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

PRINTED: 05/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045184	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/22/2007
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NAME OF PROVIDER OR SUPPLIER LAKE VILLAGE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653
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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
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F 000 F 324 SS=E	<p>INITIAL COMMENTS</p> <p>Complaint #12578 substantiated F324 cited 483.25(h)(2) ACCIDENTS</p> <p>The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure bed alarms and chair alarms were applied and worked properly for 2 (Resident #4 and #6) of 6 casemix residents (Resident #1-6), who were at risk for falls. This failed practice had the potential to affect 45 residents who were at risk for falls as identified by the Director of Nursing (DON) on 5/22/07. The findings are:</p> <p>1. Resident #4 had a diagnosis of Dementia without Behavior Disturbances. The Quarterly Minimum Data Set (MDS) dated 5/4/07 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistance with all activities of daily living (ADLs) and had fallen in the past 30-180 days.</p> <p>a. The Fall Risk Assessment dated 2/11/07 documented the resident's score of 16. The Fall Risk Assessment documented that a score of 10 or above represented 'High Risk' for falls.</p> <p>b. The Nurse's Notes dated 4/15/07 at 6:30 p.m. documented, "...nurse summoned to [Resident room number], resident found lying on the floor in front of her recliner in her room. Nurse noticed</p>	F 000 F 324		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 324	Continued From page 1 resident has small laceration under her left eye. areas cleaned with alcohol prep applying antibiotic ointment to the area very small bleed noted resident is lifted back into her bed with no other bruises or abrasions noted on her body. incont. (incontinent) care given PRN (as necessary) per nurse-aides assistance with siderail up x2 with call light within her reach..." c. The Incident and Accident (I/A) report dated 4/15/07 documented, "...nurse aide summoned nurse in resident room. Resident found at bedside. Resident lifted back into her bed with her siderails up times 2 with call light within her reach. Past Interventions Attempted: ...4/13/07-alarm in chair and bed. Recommendation/New Interventions: To place alarm in chair and on bed to alert staff when she gets up..." d. The careplan updated 5/3/07 documented, "...4/16/07-Alarm put in chair and bed..." e. On 5/21/07 at 1:54 p.m., the resident was sitting in a recliner next to the bed in her room. There was no chair or bed alarm in use or attached to the resident. f. On 5/21/07 at 4:15 p.m., the resident was sitting up in bed with half siderails in the upright position. The resident was positioned toward the end of the bed with her legs dangling down off the right side of the bed. There was no bed alarm on the bed or attached to the resident. g. On 5/22/07 at 8:30 a.m., the sitter stated she had been the resident's sitter for approximately 7 years, Monday through Friday and she had never seen an alarm on the bed or the chair. "...While	F 324			

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F 324	<p>Continued From page 2</p> <p>I'm here they don't put one on her, I'm not sure what they do when I'm not here."</p> <p>h. On 5/22/07 at 10:15 a.m., the DON was showed the documentation on the I/A report and the resident's careplan that indicated an alarm should be used. She was asked if the resident should have a bed alarm and a chair alarm in use or not. She stated, "I don't know, let's go see if she has one." The DON checked the resident's mattress for the bed alarm and looked behind the resident's head of bed while the resident was lying in the bed and could not locate an alarm. She stated, "I can find out who took it off of her and we can get another one to put on her." She was also asked if the facility had a policy and procedure for monitoring the bed and chair alarms. She said no, but provided the manufacturer's guidelines.</p> <p>2. Resident #6 had diagnoses of Glaucoma, Dementia and Osteoporosis. The Quarterly MDS dated 4/24/07 documented the resident was modified independent in cognitive skills for daily decision making, independent with transfers, ambulation and bed mobility and had fallen in the past 30-180 days.</p> <p>a. The careplan updated 4/24/07 documented the resident had fallen on 12/26/06, 1/22/07, 1/28/07, 2/28/07, 3/26/07 and 5/4/07. Interventions included ..."2/28/07 Resident family agreed to bed alarm to be placed on bed."</p> <p>b. On 5/22/07 at 8:55 a.m., the resident was in bed and was asked if the bed alarm could be checked. The resident stated the alarm wasn't working. The DON helped the resident transfer to a wheelchair then checked the bed alarm. It did</p>	F 324			

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F 324	Continued From page 3 not work. The resident stated, "No, honey it's not been going off, I've been up 2 or 3 times last night, it wasn't working." c. On 5/22/07 at 9:06 a.m., the DON asked Licensed Practical Nurse (LPN) #1, Unit Manager to check the resident's bed alarm and find out why it was not working. The DON said LPN #1 monitored the bed alarms. The LPN was asked how often the alarms were monitored to see if they worked properly. He stated, "about every other day." He was asked if he had a monitoring system where he signed off that the alarms worked properly. He stated, "No." LPN #1 checked the resident's alarm and said the cord was not pushed all the way into the device. d. The Manufacturer's guidelines provided by the DON on 5/22/07 at 9:50 a.m. documented, "...Use your monitor in conjunction with your facility's fall management program, monitors are not a substitute for proper nursing care. The effectiveness of the system relies entirely on an immediate response by the caregiver to the monitor's alarm."	F 324			