

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

PRINTED: 06/04/2008
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 05/22/2008
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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F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>Complaint #13510 was substantiated (all or in part) with deficiencies cited at F282 and F309</p> <p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13510 was substantiated (all or in part) with these findings:</p> <p>Based on record review and interview, the facility failed to ensure that medications were given and residents kept appointments as ordered by the physician for 1 (Resident # 5) of 5 (Residents #1, # 2, # 3, #4, and #5) case mix residents with orders for medications. This failed practice had the potential to affect all 74 residents in the facility as documented on a list provided by the Administrator Designee on 05/19/08. The findings are:</p> <p>Resident #5 had diagnoses of Myocardial Infarction, Peripheral Vascular Disease and Diabetes Mellitus. The Initial Minimum Data Set dated 11/16/07 documented the resident was independent in cognitive skills for daily decision making.</p> <p>a. The resident had a scheduled cardiologist appointment for 12/14/07. There was no documentation in the Nurses Notes, Physician progress notes available as to why the resident</p>	F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From page 1 did not keep this appointment. b. On 05/21/08 at 10:50 a.m., the DNS (Director of Nursing Service) stated, "I don't know why he didn't attend the appointment with the cardiologist on 12/14/08. I went through his chart yesterday and couldn't find anything. I don't remember why he didn't go..." c. A Physician order on a physician prescription sheet dated 12/7/2007 documented for Nitrobid 13mg (milligrams) Bid (twice a day) and to stop Imdur. The December 2007 Medication Administration Record documented that the Nitrobid was started on 12/09/07 and the Imdur was not discontinued until 12/10/07. d. On 05/21/08 at 1:30 p.m., the DNS was asked by the surveyor if a Medication Error Report was made out? The DNS stated, "No, I didn't know about it till now."	F 282		
F 309 SS=J	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: Complaint #13510 was substantiated (all or in part) with these findings: Based on observation, record review and interview, the facility failed to ensure the initiation	F 309		

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F 309	<p>Continued From page 2</p> <p>of Cardiopulmonary Resuscitation (CPR) when 1 (Resident #5) case-mix resident, who had a care plan intervention and a physician order for a full code, was found with no heart rate or respirations. The failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death for Resident #5 and had a potential to affect 38 residents with physician orders for full code status according to a list provided by the Director of Nursing on 5/21/08 at 1:36 p.m. The facility was informed of the Immediate Jeopardy on 5/21/08 at 11:55 a.m. The findings are:</p> <p>Resident #5 had diagnoses of Myocardial Infarction, Peripheral Vascular Disease and Diabetes Mellitus. The Initial Minimum Data Set dated 11/16/07 documented the resident was independent in cognitive skills for daily decision making.</p> <p>a. The care plan dated 11/15/07 documented, "Problem: Full Code Status ... Goal: Resident resuscitation as arrest occurs ... Approach: CPR (cardio-pulmonary resuscitation) to be started immediately by licensed personnel if resident becomes pulseless or breathless ... call ambulance and send to hospital as needed ..."</p> <p>b. Physician's orders dated 12/04/07 documented the resident was a "Full Code."</p> <p>c. Nurse's notes dated 12/23/07 documented, "6:40 a.m., called to res (resident) room he was unresponsive to verbal and tactile stimuli - [Doctor] notified new rx (order) to send to ER (emergency room) stat (immediately) d/t (due to) cond (condition) ..."</p>	F 309			

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F 309	<p>Continued From page 3</p> <p>1) On 5/20/08 at 7:01 p.m., CNA (Certified Nursing Assistant) #2 was interviewed by telephone. The CNA was asked about the incident on 12/23/07. She stated, "...I was making my last rounds at 6:20 a.m. or so ... I went around the corner talking to him ... he didn't answer me. I went back to him and he wasn't breathing and didn't have a pulse ... I had another CNA come into the room and I went to the nurse's station and told [LPN (Licensed Practical Nurse) #2]...that he was unconscious and didn't have a pulse ... [LPN #1] came in and then went to call the ambulance ... they did not start CPR."</p> <p>2) LPN #2 was interviewed via telephone on 5/20/08 at 10:00 p.m. The LPN was asked about the events on the morning of 12/23/07. She stated "...a CNA came and told me he was unconscious. I went to his room ... I checked his pulse and I don't think I got one. He wasn't my patient ... when [LPN #1] his nurse came into the room, I left to get papers ready ..."</p> <p>3) LPN #1 was interviewed by phone on 5/21/08 at 9:25 a.m. The LPN was asked about the events that lead up to the resident's transfer to the hospital emergency room on 12/23/07. She stated, "...when I got to the room, [LPN #2] and 2 CNAs were there. I checked him and felt for a pulse and couldn't feel a pulse and couldn't see any breaths ... all I could think of was oxygen. I went to get the oxygen ..." The surveyor then asked the LPN why CPR (Cardio Pulmonary Resuscitation) wasn't started, the LPN stated, "I thought I saw a pulse in his neck and all I could think of was oxygen ..."</p> <p>4) CNA #1 was interviewed on 5/20/08 at the facility. The CNA was asked what she knew</p>	F 309			

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F 309	<p>Continued From page 4</p> <p>about the events that took place for the resident on the morning of 12/23/07 and if he received CPR. The CNA stated, "... I was at the nurse's station ... they [nursing personnel] didn't page a ' Code Blue ' [a CODE BLUE is the call for immediate assistance to a resident who is not breathing]..."</p> <p>d. The Emergency Ambulance Service Paramedic Report dated 12/23/07 documented: "Scene: Pt (patient) found supine in nursing home bed. Several nursing home staff members present. Pt. has SFM (soft face mask) on unknown how many liters [oxygen]. Pt. pulseless and apneic. No CPR in progress ... Comments: Pt's jaw stiff upon EMS (emergency medical services) arrival. Pt. was ventilated ... enroute ..."</p> <p>e. On 5/20/08 at 9:55 a.m., the Director of Nursing (DON) was asked what the facility's policy was in regards to residents with full codes. She stated, "We don't have a policy and procedure on full code. I mean, you are either a Full Code or a DNR [Do Not Resuscitate]. Full Code means you start CPR."</p> <p>f. On 5/21/08 at 10:50 a.m., the DON was interviewed regarding why CPR was not started on Resident #5 on 12/23/07. She stated, "I honestly don't know what went down. I was told he coded. When I got the call, they told me [Resident #5] 'coded on us'. I said, 'did you start CPR?' ... [LPN #1] told me he still had a pulse ... I asked people who were here. Some said he had a pulse, some said he didn't. I didn't write anything down. I did not begin a formal investigation."</p> <p>The DON was asked if she talked to the LPNs</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>who were there at the time. The DON stated, "[LPN #3] had already left when I got to the building. I never could get in touch with her. [LPN #1] kept telling me he [Resident #5] had a pulse, it was faint."</p> <p>The DON was informed that staff had told the surveyor that a Code Blue was never announced. The DON stated, "I don't know. I can't say it was or it wasn't. I don't know." When the surveyor asked if the Crash Cart was in the room, the DON stated, "Not when I got here. I checked the Cart and I did not have to replace anything on the Cart. It did not look like it had been used.</p> <p>f. On 5/21/08 at 2:15 p.m., the Immediate Jeopardy was removed on 5/22/08 at 7:40 a.m. and the scope and severity reduced to "G" when the facility implemented the following plan of removal:</p> <p>1) The code status book will be updated by the Social Services or Designee upon each new admit or discharge and each resident will have a code status printed on the MAR (Medication Administration Record) each month. The DNS (Director of Nursing Services) or Designee will monitor the MARs (Medication Administration Record) monthly for code status entry.</p> <p>2) All staff will be inserviced beginning on 5/21/08 by the DNS or Designee on how to tell code status of each resident, when to initiate a code and that events must be documented in chronological order, and ABCs (Airway, breathing and circulation) must be established. No employee will start their shift to work until they have been inserviced on codes and documentation.</p>	F 309			

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F 309	Continued From page 6 3) All staff will be re-inserviced following each code and monthly times 6 months, then quarterly by the DNS or Designee. 4) Each new employee will be inserviced upon hire on how to tell FULL CODE from a DNR (do not resuscitate), will be shown where the crash cart is kept, and that a CODE BLUE is the call for a resident who is not breathing by the DNS or Designee. Documentation of inservice on each new employee will be kept in employees' file. 5) The facility will have a mock code performed each quarter on different shifts with documentation to support the mock code by the DNS or designee.	F 309			