

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

PRINTED: 07/26/2006  
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>07/14/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKE VILLAGE HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653</b>	
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F 241 SS=D	<p>483.15(a) DIGNITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure that dignity was maintained by not pulling a resident backwards in a geri-chair for 1 (Resident #20) of 5 case mix residents (Resident #2, 5, 10, 20 and 21) who were transported in a geri-chair. The facility to ensure dignity was maintained by not covering the resident's nude body completely for 1 (Resident #21) of 11 case mix residents (Resident #2, 3, 4, 5, 6, 7, 10, 14, 16, 20 and 21) who were transported in a shower chair. This failed practice had the potential to affect 8 residents who were transported in geri-chairs and 47 residents who were transported in a shower chair according to a list provided by the facility. The findings are:</p> <p>1. Resident #20 had diagnoses of Senile Dementia and Bilateral Amputee. The Annual Minimum Data Set (MDS) dated 6/9/06 documented the resident was severely impaired in cognitive skills for daily decision-making and totally dependent on staff for locomotion on the unit.</p> <p>On 7/10/06 at 6:20 p.m., Certified Nursing Assistant (CNA) #5 pulled the resident in a white plastic geri-chair backward from near the nurses station to the resident room half-way down the</p>	F 241		

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 241	Continued From page 1 hallway.  2. Resident #21 had diagnoses of Alzheimer's Disease and Blindness in Both Eyes. The Annual MDS dated 5/31/06 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for locomotion on the unit and was totally dependent on staff for bathing.  a. On 7/14/06 at 10:35 a.m., CNA #3 pushed the resident in a shower chair from Resident Room 111 to the shower room near the other end of the hall. The resident had a drape over the front but both hips were visible on each side of the shower chair. Both buttocks were visible through the back of the shower chair.  b. The Shower/Tub Bath policy provided by the Director of Nurses on 7/14/06 documented, "When transporting the resident to and from the bath area in a wheelchair or bath chair, be sure the resident is appropriately covered so that his or her body will not be exposed and so that he or she will be warm."	F 241		
F 253 SS=C	483.15(h)(2) HOUSEKEEPING/MAINTENANCE  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by:  Based on observation and interview, the facility failed to ensure walls did not have holes or chipped paint, baseboard and corner molding was attached to the wall, the walls, doors and floors	F 253		

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F 253	<p>Continued From page 2</p> <p>were clean, resident items were not stored on the floor, privacy curtains were clean, outdated fluids were not left in a resident refrigerator, window screens were in good repair and in place, window blinds were in good repair and commode seats in good repair. This failed practice had the potential to affect all 80 residents. The findings are:</p> <p>1. On 7/12/06 at 9:05 a.m., the following observations were made:</p> <p>a. On the 100 Hall:</p> <p>1) Resident Room #103 had paint chipped in several places on the wall next to the window approximately 4 feet from the floor and approximately 18 inches wide.</p> <p>2) The bath and shower room had one detached metal corner molding and two detached 4 inch high rubber baseboard moldings on the left side wall of the first shower stall counting from the left. The middle shower stall was missing a large piece of linoleum (approximately 2 1/2 feet by 7 inches) at the shower threshold.</p> <p>3) The dining room had a 7 1/2 by 2 1/2 inch paint chipped area on the wall to the left of the double doors approximately 9 inches from the floor, scuff marks 6 inches from the floor extending across the entire wall between two kitchen doors, pink and yellow streaks/splashes down the wall underneath the dishwasher and the wall perpendicular to the dishwasher had a 10 1/2 by 1/16 inch crack approximately 10 inches from the floor, was very soft to the touch and stained/spotted with a grayish colored substance. The serving line door was also scuffed 6 inches from the floor and extended the entire length of</p>	F 253			

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F 253	<p>Continued From page 3</p> <p>the door. The dinning room had three tables (one circular and two square) which had loose legs that caused the tables to be unsteady.</p> <p>b. On the 200 Hall there was a bed alarm pad on the floor of a central supply closet. The maintenance supervisor picked the pad up off of the floor and placed it on the top of other bed alarm pads on a shelf.</p> <p>c. On the 300 Hall:</p> <p>1) Resident bath #2 had paint chipped from the wall above the whirlpool where there was once a soap dispenser, according to the maintenance supervisor.</p> <p>2) Resident Room #302 had several brown and yellow dime size stains on the privacy curtain by A-Bed.</p> <p>d. In Resident Room #403 there was a brown stain on the privacy curtain by B-Bed.</p> <p>e. Exterior of Building:</p> <p>1) The occupational therapy room screen had three, smaller than a nickle size holes and two, less than 1 1/2 inch rips in it.</p> <p>2) Resident Room #114 had no screen on it.</p> <p>2. On 7/10/06 at 2:30 p.m., the refrigerator in Resident Room 103 contained 8 ounces of non-thickened Boost and a box of nectar thickened water.</p> <p>a. On 7/10/06 at 6:10 p.m. and 7/11/06 at 11:00 a.m., the refrigerator contained the 8 ounce</p>	F 253			

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F 253	Continued From page 4 container of non-thickened Boost, a box of nectar thickened water dated 12/18/05, a 6 ounce cup that was approximately half full of thickened water with 2 black spots of unidentified substance in the water and a 8 ounce cup of thickened water from dietary covered and dated 7/5/06.  b. On 7/10/06 at 6:35 p.m., the resident stated, "I don't get around well and I never open the refrigerator."  c. On 7/11/06 at 11:12 a.m., Licensed Practical Nurse (LPN) #3 was asked who was responsible for the resident's refrigerator and the LPN stated, "Housekeeping usually takes care of this." LPN #3 also stated that the resident could not get into the refrigerator by himself.  4. On 7/11/06 at 8:50 a.m., the raised commode seat in Resident Room 305 had one rubber foot intake. One rubber foot was missing and the two other legs were wrapped in grey duct tape. There was a concave hole in the flooring approximately 3 by 2 inches near the back of the toilet.  5. On 7/11/06 at 9:10 a.m., in Resident #10's room there was a hole in the wall at the foot of the bed approximately 2 inches by 3 inches. The hole was approximately 8 inches up from the floor. Around the hole there was also a circular chip in the sheet rock approximately 5 inches across.  6. On 7/11/06 at 3:55 p.m., in Resident #9's room the louver in the vertical blind was broken and would not close.	F 253		
F 254 SS=B	483.15(h)(3) ENVIRONMENT- LINENS	F 254		

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F 254	Continued From page 5 The facility must provide clean bed and bath linens that are in good condition.  This REQUIREMENT is not met as evidenced by:  Based on observation and interview, the facility failed to ensure linen was in good condition. This failed practice had the potential to affect all 80 residents. The findings are:  1. On 7/10/06 at 5:45 p.m., 15 of 41 residents in the dining room had clothing protectors with holes, ripped threads or dinginess. Seven of the 15 residents sat at assist tables.  2. On 7/13/06 at 11:07 a.m., the bedspread on the bed of Resident #8 had a hole approximately the size of a 50 cent piece near the foot of the bed.	F 254			
F 312 SS=D	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.  This REQUIREMENT is not met as evidenced by:  Based on observation and record review, the facility failed to ensure the buttocks were cleaned during incontinent care for 1 (Resident #10) of 8 case mix residents (Residents #2, 3, 5, 6, 7, 8, 9 and 10) who were incontinent. This failed practice had the potential to affect 43 residents	F 312			

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F 312	Continued From page 6 who were incontinent as identified on a list provided by the Acting Director of Nursing on 7/13/06 at 5:00 p.m. The findings are:  Resident #10 had diagnoses of Peripheral Vascular Disease, Alzheimers, Congestive Heart Failure, and Hypothyroidism. The Admission Minimum Data Set (MDS) dated 5/19/06 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistance of 1 person for personal hygiene and was incontinent of bowel and bladder.  On 7/12/06 at 10:07 a.m., Certified Nursing Assistants (CNA) #1 and 2 provided incontinent care. The resident's gown, incontinence pad, and sheet were soaked with wet urine. CNA #1 used disposable incontinence wipes and cleaned to the left and right of the labia majora, front to back, and then front to back between the labia two times. The resident was turned to her side and the area between her buttocks was cleaned by wiping front to back with two different disposable wipes. Then a clean incontinent brief was placed on the resident. The buttocks were not wiped at all before the incontinent brief was applied.	F 312			
F 323 SS=D	483.25(h)(1) ACCIDENTS  The facility must ensure that the resident environment remains as free of accident hazards as is possible.  This REQUIREMENT is not met as evidenced by:  Based on observation the facility failed to ensure the environment was free of hazards as	F 323			

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F 323	Continued From page 7 evidenced by an uncovered used disposable safety razor and a table with sharp edges. This failed practice had the potential to affect 34 cognitively impaired residents who were showered in the 300 hall shower room and 17 residents who used the treatment room as identified on a list of residents provided by the Administrator on 7/13/06 and the Director of Nurses on 7/14/06. The findings are:  On 7/12/06 at 9:05 a.m., the following observations were made on the 300 wing:  a. In Resident Bath #2 there was an uncovered blue disposable razor on top of the soap dispenser in the last shower on the right.  b. In the therapy room there was a 6 foot by 2 1/2 foot table that had a chipped/jagged corner underneath the table.	F 323		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by:  Based on observation of the 4:00 p.m. medication pass on 7/10/06 and the 8:00 a.m. medication pass on 7/11/06, the facility failed to follow physicians orders to ensure the medication error rate was less than 5%. Physicians orders were not followed on 2 (Residents #11 and 12) of 9 residents observed during the medication passes. Medication errors were made by 2 Licensed Practical Nurses (LPN) #1 and 2 of 5 nurses	F 332		

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F 332	<p>Continued From page 8</p> <p>observed administering medication. The medication error rate was 7.02% based on administration of 55 medications plus 2 medications ordered but not administered and observation of a total of 4 errors. This failed practice had the potential to affect 42 residents who received medication from these nurses according to Registered (RN) #1. The findings are:</p> <p>1. Resident #11 had a physician order dated 3/30/06 for Caltrate 600 mg (milligrams) per tube 3 times a day</p> <p>a. On 7/10/06 at 6:08 p.m., LPN #1 administered Caltrate 600 mg plus D.</p> <p>b. Resident #11 had a physician order for Tegretol, Valproic Acid and Caltrate to be administered per tube 3 times a day.</p> <p>1) On 7/10/06 at 6:08 p.m. LPN #1 did not flush the feeding tube with at least 30 cc (cubic centimeters) of water prior to administering the medications.</p> <p>2) The Centers for Medicare and Medicaid Services guidelines documented, "Flush the enteral feeding tube with at least 30 ml of preferably warm water before and after medications are administered..."</p> <p>2. Resident #12 had a physician order dated 1/19/06 for Citroma Oral solution.</p> <p>a. The July 2006 Medication Administration Record documented to administer one bottle of Citroma Oral on Saturday and Tuesday at 8:00 a.m.</p>	F 332			

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F 332	Continued From page 9  On 7/11/06 at 8:00 a.m., LPN #2 did not administer the Citroma Oral.  b. Resident #12 had a physician order dated 11/2/05 for Artificial Tears to administer 2 drops in each eye 3 times a day.  On 7/11/06 at 8:15 a.m., LPN #2 did not administer the Artificial Tears.	F 332		
F 333 SS=E	<b>483.25(m)(2) MEDICATION ERRORS</b>  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by:  Based on observation and record review, the facility failed to ensure physician orders were followed to prevent a significant medication error for 1 of 1 case mix resident (Resident #12) who received eye drops. This failed practice had the potential to affect all 80 residents. The findings are:  Resident #12 had a physician order dated 11/2/05 for Artificial Tears to administer 2 drops in each eye 3 times a day.  a. On 7/11/06 at 8:15 a.m., the Artificial Tears were not administered by Licensed Practical Nurse (LPN) #2.  b. On 7/11/06 at 12:13 p.m., Registered Nurse (RN) #1 stated the resident was admitted to the hospital on 6/29/06 and re-admitted to the nursing home on 7/4/06 with orders to resume all	F 333		

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F 333	Continued From page 10 previous orders.  c. The July 2006 Medication Administration Record (MAR) did not document that the Artificial Tears had been administered after the resident was readmitted to the facility.  d. This was a significant medication error due to the frequency.	F 333			
F 364 SS=D	483.35(d)(1)-(2) FOOD  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by:  Based on observation and record review, the facility failed to ensure food was prepared by methods that conserves the nutritive value, flavor and appearance. This failed practice had the potential to affect 75 residents who took meals from the kitchen according to the Diet List dated 7/10/06. The findings are:  Resident #13 had diagnoses of Renal Failure, Type 2 Diabetes Mellitus, and Dialysis Encounter The Minimum Data Set (MDS) dated 5/12/06 documented that the resident was independent in decision making skills.  a. A physician order dated 4/13/06 documented a regular, low concentrated sweet, add extra eggs diet.	F 364			

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F 364	Continued From page 11 b. On 7/10/06 at 2:00 p.m., a long pan with water in the bottom had small pans of rice, mashed potatoes, ground meat, smoked sausage and turnip greens left from the lunch meal that were cooking on the stove.  c. On 7/10/06 at 3:07 p.m., the water in the long pan had evaporated from the bottom and Dietary Employee #2 added more water. The foods continued to cook until 3:25 p.m. for a total of 1 hour and 25 minutes.  d. On 7/10/06 at 3:25 p.m., the ground meat had dried out with a brown ring around the edge of the pan. The turnip greens had turned a dark green color and were crunchy on top. The mashed potatoes were dried, cracked and had turned brown around the edges. The sausage link had wrinkled and turned darker in color.  e. On 7/10/06 at 3:25 p.m., Resident #13 returned from dialysis and was served a smoked sausage, mashed potatoes and turnip greens from the foods on the stove.	F 364			
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE  The facility must store, prepare, distribute, and serve food under sanitary conditions.  This REQUIREMENT is not met as evidenced by:  Based on observation and record review, the facility failed to ensure stored food was labeled and dated, refrigerator temperatures were	F 371			

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

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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>07/14/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKE VILLAGE HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653</b>		
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F 371	<p>Continued From page 12</p> <p>maintained at or below 41 degrees Fahrenheit (F), freezer temperatures were maintained at or below 0 degrees F, the temperature of the rinse cycle in the dish machine was 180 degrees F or higher, cold food on the serving line was 41 degrees or below and dietary staff did not eat food in the kitchen. These failed practices had the potential to affect 75 residents who received a tray from the kitchen according to the Diet List dated 7/10/06. The findings are:</p> <ol style="list-style-type: none"> <li>1. On 7/10/06 at 2:00 p.m., a tray on a top shelf in the walk-in refrigerator had 7 bowls of yellow pudding and 2 bowls of butterscotch pudding covered with a sheet of clear plastic wrap on top with no label or date.</li> <li>2. On 7/10/06 at 2:00 p.m. the temperature in the walk-in refrigerator registered 48 degrees F.</li> <li>3. On 7/10/06 at 2:00 p.m. and 7/11/06 at 8:25 a.m. and the temperature in the walk-in freezer registered 15 degrees F.</li> <li>4. On 7/10/06 at 2:00 p.m., the rinse cycle on the hot water dish machine reached 179 degrees F. <ol style="list-style-type: none"> <li>a. On 7/11/06 at 8:25 a.m., the rinse cycle on the hot water dish machine reached 177 degrees F after running the cycle 5 times.</li> <li>b. On 7/11/06 at 8:50 a.m. the Dish Machine Temperature Log for July 2006 already documented a temperature of 183 degrees F for the rinse cycle for 7/11/06 and 183 degrees F for the rinse cycle at dinner on 7/11/06.</li> </ol> </li> <li>5. On 7/10/06 at 5:22 p.m., the temperatures on the steam table registered:</li> </ol>	F 371			

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F 371	Continued From page 13  a. Cold pureed tuna, 50 degrees F.  b. Cold pureed potato salad, 50 degrees F.  6. On 7/11/06 at 8:25 a.m., Dietary Employee #3 stood in the dish room with food in her hand as she chewed food in her mouth. When the surveyors walked in, she threw the food in her hand into the trash can.  The facility's dietary policy under "Additional Hygiene Regulations" documented "Eating, drinking and gum chewing are not permitted in the department."	F 371		
F 445 SS=C	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, record review and interview, the facility failed to ensure clean linen and supplies were not stored on the dirty side of the laundry room. This failed practice had the potential to affect all 80 residents. The findings are:  On 7/12/06 at 10:30 a.m., the entrance to the laundry room was on the dirty side. There were 3 barrels of laundry and a four tier, mesh covered rack to the immediate left, crowding the entrance area. The lids to all 3 barrels were unfastened and the contents of the rack and barrels were exposed and hanging outside of the containers.	F 445		

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F 445	Continued From page 14  a. The maintenance supervisor stated all 3 barrels contained clean supplies; one contained mechanical lift slings, one contained mop heads, the third contained rags used by housekeeping for cleaning and the rack contained various clean cushions. When asked why clean supplies were stored on the dirty side, the maintenance supervisor stated, "there is no room for them on the clean side."  b. On 7/12/06 at 10:35 a.m., the laundry worker was asked why clean supplies were stored on the dirty side and the laundry worker stated, "There is no room on this (clean) side and they (clean supplies) should be on the floor (halls) for use."  c. The facility Laundry/Linen Policy documented, "...to provide a process for the safe and aseptic handling, washing, and storage of linen." The "General Guidelines" also documented, "1. Separate soiled and clean linen at all times." The "Steps in the Procedure" documented, "....5. Keep soiled linen and clean linen, and their respective hampers and laundry carts, separate at all times."	F 445			