

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

PRINTED: 09/22/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045143	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2008
NAME OF PROVIDER OR SUPPLIER CONCORDIA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7 PROFESSIONAL DRIVE BELLA VISTA, AR 72714	
(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	F 000		
F 329 SS=E	<p>Complaint #13844 was unsubstantiated.</p> <p>483.25(l) UNNECESSARY DRUGS</p> <p>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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure tapering of Zantac was attempted for 1 of 1 case mix resident with a physician order for Zantac (Residents #4) and tapering of Prevacid was attempted for 1 (Resident #1) of 3 case mix residents with physician orders for proton pump inhibitors (Residents #1, #7 and</p>	F 329		

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 329	Continued From page 1 #10). The failed practice had the potential to affect 3 residents with physician orders for Zantac and 11 residents with physician orders for proton pump inhibitors, as documented on lists provided by the Director of Nursing (DON) on 9/11/08 at 3:00 p.m. and 3:50 p.m. The findings are: 1. Resident #4 had a diagnosis of Gastroesophageal Reflux Disease (GERD). The Quarterly Minimum Data Set dated 7/23/08 documented the resident was moderately impaired in cognitive skills for daily decision making. a. The September 2008 Physician Orders sheets documented: "Ranitidine 150 mg [milligrams], Take 1 tab [tablet] po [by mouth] twice a day at lunch and bedtime. GERD." b. The April through September 2008 Medication Administration Records (MAR's) documented the resident had received Zantac 150 mg twice daily since 4/25/08. c. The Pharmacist's Monthly Chart Review form dated 7/16/08 documented a recommendation to reduce the Zantac to once per day. As of 9/10/08, there was no documentation in the Physician's Progress Notes, Physician Orders or elsewhere in the clinical record of a physician response to this recommendation. d. On 9/10/08 at 3:45 p.m., the DON was asked for documentation of recent clinical symptoms of GERD, a risk-versus-benefit statement from the physician for the continued use of Zantac in the absence of a dose tapering attempt and a response from the physician to the Pharmacist's recommendation to reduce the Zantac to daily.	F 329			

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F 329	Continued From page 2 The DON stated there was no documentation, but she would, "look some more." e. On 9/11/08 at 8:10 a.m., the DON confirmed there was no documentation in the clinical record of symptoms to justify the continued use of Zantac. 2. Resident #1 had a diagnosis of GERD. The Quarterly Minimum Data Set dated 6/17/08 documented the resident was moderately impaired in cognitive skills for daily decision making. a. A physician order dated 6/10/08 documented: "Prevacid 30 mg, Take 1 tab po every morning, GERD." b. The June through September 2008 Medication Administration Records (MAR's) documented the resident had received Prevacid 30 mg daily since 6/10/08 upon return from an inpatient stay at a Psychiatric Center. January through May 2008 MAR's documented that prior to the initiation of the Prevacid, the resident received another proton pump inhibitor medication (Protonix) from 1/29/08 through 5/15/08. c. The Pharmacist's Note to Attending Physician/Prescriber dated 6/4/08 documented: "...CMS [Centers for Medicare and Medicaid Services] has requested that all meds [medications] be assessed for reduction and or discontinuation. GI [gastrointestinal] meds such as PPI's [Proton Pump Inhibitors]... are getting tremendous attention presently. Surveyors in Arkansas have been writing tags pertaining to continuation of PPI's... without clinical justification from the attending physician. As the attending	F 329			

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F 329	Continued From page 3 physician, you may continue the above meds with a risk benefit statement or simply discontinue, if you agree. For example if a patient is on Coumadin therapy you may prefer to have patient on PPI... rather than risk a GI bleed..." As of 9/10/08, there was no documentation in the Physician's Progress Notes, Physician Orders or elsewhere in the clinical record of a physician response to this recommendation. d. On 9/10/08 at 3:45 p.m., the DON was asked for documentation of clinical symptoms of GERD, a risk versus benefit statement from the physician or a physician response to the Pharmacist's recommendations. The DON stated there was no documentation but that she would, "...look some more." e. On 9/11/08 at 8:10 a.m., the DON confirmed there was no documentation in the clinical record of symptoms to justify the continued use of PPI's.	F 329			
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 5:00 p.m. medication pass on 9/8/08 and the 8:00 a.m. medication pass on 9/9/08 and record review, the facility failed to ensure the medication error rate was less than 5%. Physician orders were not followed for 5 (Residents #4, #10, #11, #12 and #13) of 12 residents observed during the medication passes, which resulted in medication errors. Medication errors were made by 3 Licensed Practical Nurses	F 332			

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F 332	<p>Continued From page 4</p> <p>(LPN's #1, #2 and #3) of 5 nurses who administered medications. The failed practice had the potential to affect 43 residents who received medications from these nurses, as identified by Registered Nurse (RN) #1 on 9/9/08. The medication error rate was 9.26%, based on administration of 54 medications and a total of 5 errors detected. The findings are:</p> <p>1. Resident #4 had a physician order dated 8/23/08 for Quetiapine 25 milligrams (mg) 3 times a day.</p> <p>On 9/9/08 at 4:04 p.m., LPN #1 administered Quetiapine 50 mg to the resident, instead of 25 mg as ordered by the physician.</p> <p>2. Resident #10 had a physician order dated 9/5/08 for sliding scale insulin at 6:00 a.m., 12:00 p.m., 6:00 p.m. and 12:00 a.m. daily, according to the resident's blood glucose levels. The sliding scale order specified that for a blood glucose level of 176 to 200, a total of 4 units of insulin should be administered.</p> <p>On 9/8/08 at 6:05 p.m., the Accucheck reading was 187, which would require 4 units of insulin according to the physician order. LPN #1 did not administer insulin to the resident.</p> <p>3. Resident #11 had a physician order dated 8/2/08 for Symbicort inhaler 160/4.5, one puff twice a day.</p> <p>On 9/9/08 at 7:40 a.m., LPN #3 administered 2 puffs of the Symbicort inhaler to the resident, instead of 1 puff as ordered by the physician.</p> <p>4. Resident #12 had a physician order dated</p>	F 332			

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F 332	Continued From page 5 9/6/08 for Klonopin 2 mg at bedtime. On 9/9/08, LPN #3 administered the Klonopin 2 mg at 7:52 a.m., instead of at bedtime as ordered by the physician. 5. Resident #13 had a physician order dated 8/15/08 for Calcium Citrate 600 mg with Vitamin D twice a day. On 9/8/08 at 4:58 p.m., LPN #2 administered Calcium Carbonate 600 mg with Vitamin D, instead of Calcium Citrate with Vitamin D.	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 5:00 p.m. medication pass on 9/8/08 and the 8:00 a.m. medication pass on 9/9/08 and record review, the facility failed to ensure physician orders were followed to prevent significant medication errors for 1 (Resident #4) of 12 residents observed during the medication passes. A significant medication error was made by 1 Licensed Practical Nurse (LPN #1) of 5 nurses who administered medications. The failed practice had the potential to affect 29 residents who received medications from LPN #1, as identified by Registered Nurse (RN) #1 on 9/9/08. The findings are: Resident #4 had a diagnosis of Paranoid Schizophrenia. The Minimum Data Set (MDS) dated 7/23/08 documented the resident was moderately impaired in cognitive skills for daily	F 333			

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F 333	<p>Continued From page 6</p> <p>decision-making, exhibited verbally and physically abusive behaviors on 4 to 6 of the last 7 days, socially inappropriate/disruptive behavioral symptoms daily in the last 7 days and resisted care on 1 to 3 of the last 7 days.</p> <p>a. A physician order dated 7/14/08 documented the resident was to receive Quetiapine 50 milligrams (mg) 3 times daily. A physician order dated 8/23/08 documented the Quetiapine was reduced to 25 mg 3 times a day.</p> <p>b. On 9/8/08 at 4:04 p.m., LPN #1 administered Quetiapine 50 mg to the resident, instead of 25 mg as ordered by the physician. Quetiapine 50 mg was the only dose of the medication available for administration for this resident.</p> <p>c. From 8/23/08 through 9/8/08 at 4:04 p.m., the resident was administered Quetiapine 50 mg three times a day, instead of the physician-ordered Quetiapine 25 mg three times a day.</p> <p>d. This medication error was significant due to the resident's condition and the frequency of the error.</p>	F 333			