

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

PRINTED: 01/26/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045203	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2009
NAME OF PROVIDER OR SUPPLIER BATESVILLE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1975 WHITE DRIVE BATESVILLE, AR 72501		
(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 309 SS=D	<p>483.25 QUALITY OF CARE</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure the labia was separated and cleaned during Foley catheter care to prevent the potential for Urinary Tract Infections (UTI) for 1 (Resident #10) of 2 (Residents #10 and #12) case mix residents who a Foley catheter. This failed practice had the potential to affect 4 residents who had a Foley catheter according to the Resident Census and Conditions of Residents report dated 1/10/09. The findings are:</p> <p>1. The facility Catheter Care, Urinary Policy and Procedure received from the Director of Nurses on 1/14/09 documented, "The purpose of this procedure is to prevent infection of the resident's urinary tract... Steps in the Procedure: 13. With nondominant hand separate the labia of the female resident... 15. cleanse around the urethral meatus."</p> <p>2. Resident #10 had diagnoses of Renal and Ureteral Disease, a history of a Right Sided Nephrectomy and Morbid Obesity. The Admission Minimum Data Set dated 12/11/08 documented the resident was independent in cognitive skills for daily decision making, had an indwelling catheter and a UTI in the last 30 days.</p>	F 309			

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 309	Continued From page 1 a. A Physician Order dated 12/11/08 documented, "Routine Foley cath care, cleanse q (every) shift with soap & (and) water." b. The Resident Care Plan dated 12/16/08 documented, "Potential for urinary tract infection due to presence of indwelling catheter with poor kidney function. h/o (history of) urinary retention and UTI... Use proper hygienic practices." c. A Physician telephone order dated 12/29/08 documented, "Levaquin 500 mg (milligrams) 1 po (by mouth) qd (every day) x (times) 3 days for UTI." d. A hospital History and Physical/Medical Consultation dated 12/30/08 documented, "67 year old female admitted with hematuria, UTI." e. A Physician Order dated 1/5/09 documented, "Admit to... [facility]... Dx (diagnosis) UTI... Cipro 500 mg BID (twice daily) x 7 days/UTI ([1] po)." f. On 1/12/09 at 9:45 a.m., Certified Nurses Assistant (CNA) #1 provided catheter care for the resident. The CNA cleansed the catheter from the point that it was visible on the outside of the labia but did not separate the labia to begin cleansing at the catheter insertion area.	F 309		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure resident room doors were in good repair and metal ground post were not broken from electrical plugs and protruding from electrical outlets. These failed practices had the potential to affect 71 mobile residents as identified on a Census List provided by the Administrator on 1/14/09 at 11:23 a.m. The finding are: 1. On 1/12/09 at 9:56 a.m., the door to Resident Room 107 had a rough, hook-like jagged area of damage to the front facing of the door about 2 feet from the floor on the hinge side. 2. On 1/12/08 at 10:45 a.m., a metal ground post which had broken away from an electrical cord plug protruded from the wall outlet on the left side of the hall near the activity room at the end of 500-hall. The sharp, jagged edges of the metal post extended approximately 1/2-inch from the outlet approximately 16 inches from the floor.	F 323		
F 328 SS=E	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328		

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F 328	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that oxygen was administered at a rate ordered by the physician for 1 (Resident #3) and the oxygen tubing and nasal canula were changed as ordered to prevent a possible upper respiratory infection and maintain cleanliness for 2 of 2 case mix residents (Residents #3 and #10) who had orders for continuous oxygen administration. These failed practices had the potential to affect 2 residents who had orders for continuous oxygen administration and 14 residents who had orders for oxygen administration on an as needed basis as identified by a list provided by the Director of Nurses on 1/14/09 at 9:00 a.m. The findings are: 1. Resident #3 had diagnoses of Upper Respiratory Disease and a Complete Cervical 1 through 4 Quadriplegic. The Quarterly Minimum Data Set (MDS) dated 10/15/08 documented the resident was severely impaired in cognitive skills for daily decision making and received oxygen (O2) therapy. a. A Physician Order dated 5/23/07 documented, "O2 (oxygen) @ (at) 3L (liters)/Min (per minute) via nasal canula." b. The Resident's Plan of Care updated on 7/18/08 documented, "Potential for complications R/T (related to) use of O2 via nasal canula continues... O2 per MD (Medical Doctor) orders." c. A January 2009 Treatment Record documented, "Change O2 tubing q (every) week... start date: 5/23/07."	F 328			

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F 328	Continued From page 4 d. On 1/10/09 at 1:47 p.m. and 1/11/09 at 9:12 a.m., 11:15 a.m., 11:50 a.m. and 2:30 p.m., the resident's oxygen administration rate was set on 2L/Min via nasal canula during use and the oxygen nasal canula and tubing were dated 12/28/08. e. On 1/14/09 at 10:20 a.m., LPN #4 was asked what the oxygen rate was suppose to be for this resident and she stated, "Between 2 to 3 (l/m)." 2. Resident #10 had a diagnosis of Heart Failure. The Admission MDS dated 12/11/08 documented the resident was independent in cognitive skills for daily decision making and received oxygen therapy. a. A Physician Order dated 12/11/08 documented, "O2 @ 2 liters via nasal canula continuously for SOB (shortness of breath)... change O2 tubing q week." b. A December 2008 and January 2009 Treatment Record documented, "Change O2 tubing q week." c. On 1/10/09 at 2:30 p.m.; 1/11/09 at 9:20 a.m., 12:55 p.m. and 5:55 p.m.; 1/12/09 at 9:05 a.m. and 9:45 a.m. and 1/13/09 at 9:15 a.m., the O2 nasal canula and tubing was dated 12/28/08. d. On 1/13/09 at 10:10 a.m., after being informed of the multiple observations of the nasal canula and tubing dated 12/28/08 being used on the resident, the Assistant Director of Nurses stated, "I'm changing it now. It should be changed every week. We missed one."	F 328		
F 329	483.25(l) UNNECESSARY DRUGS	F 329		

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F 329 SS=E	<p>Continued From page 5</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 observation, record review and interview, the facility failed to ensure a dose reduction was attempted or the clinical rationale for the continued dose of the medication was completed for 1 of 1 (Resident #4) case mix resident who had a physician order for Temazepam. These failed practices had the potential to affect 2 residents who had a physician order for Temazepam as per a list provided by the DON (Director of Nursing) on 1/14/09. The</p>	F 329			

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F 329	Continued From page 6 findings are: Resident #4 had diagnoses of Manic Depression and Insomnia. The Minimum Data Set (MDS) dated 10/12/08 documented the resident had problems with short and long term memory, was moderately impaired in cognitive skills for daily decision making, had periods of altered perception or awareness of surroundings, periods of disorganized speech, indicators of depression of insomnia/change in sleep pattern that were not easily altered over the past 7 days, received a hypnotic daily for the past 7 days, had an unsteady gait, and fell in the past 30 days and 31 - 180 days. a. The August 2008 MAR (Medication Administration Record) documented, Temazepam 15 mg (milligrams) PO (by mouth) Q hs (at bedtime) and was dated 2/16/07. b. The Consultant Pharmacist Communication dated 8/22/08 documented, "This resident is receiving Temazepam 15 mg QHS (at bedtime) for Insomnia since 2/16/07. Please consider tapering this medication in order to find the optimal dose (to minimize the risk of adverse consequences) or determine whether continued use of this medication is benefiting the resident. If you feel that the benefits of continued use medication at this dose outweigh the risks involved (i.e. increased sedation and potential for falls or tolerance dose), please document this in your progress notes and/or space provided below." Under "Your Response" was documented, [Decrease] to 7.5 mg QHS" and was signed by the physician, but not dated. c. The September MAR documented	F 329			

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F 329	<p>Continued From page 7</p> <p>Temazepam 7.5 mg 1 capsule at bedtime with a start date of 8/27/08 and increased back to 15 mg on 9/3/08.</p> <p>d. A physician order dated 9/3/08 documented, "[Change] Temazepam 7.5 mg to Temazepam 15 mg. There was no documentation in the nurses notes or physician order as to why the medication was increased.</p> <p>e. The October and November 2008 MAR documented, "Temazepam 15 mg Q PM R/T (related to) Insomnia." and nurses initials indicated the medication was administered at 5:00 p.m. daily.</p> <p>f. The Consultant Pharmacist Monthly Report dated 11/26/08 documented, "This resident has diagnosis of Insomnia and is currently taking Temazepam 15 mg PO Q PM (every evening). Routine use of Temazepam is discouraged for geriatrics (> (greater than) 65 y/o [years old]) due to increased sedation and falls. Please evaluate the continued need/benefit of the current medication and consider alternatives. If this medication maintains functional status and you feel that the benefits of continued use (i.e. greater control of insomnia) outweigh the risks involved (i.e. increase in the number of falls in the elderly, potential for addiction, and/or development of tolerance) for this resident, please document to that effect in your progress notes." The physician checked, "Decrease Temazepam to 7.5 mg PO (by mouth) Q PM." A hand-written note on the bottom of the report dated 12/4/08 documented by a facility RN the resident's granddaughter refuses for the medication to be changed.</p> <p>g. A Quarterly Review Nursing Summary</p>	F 329		

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F 329	<p>Continued From page 8</p> <p>Additional Comments Related to Care Plan (Continued) dated 10/13/08 documented, "Awake and alert but disoriented x (times) 2... in room between meals, in recliner."</p> <p>h. A Quarterly Progress Note completed by the Social Services Director dated 10/14/08 documented, "Resident is alert and oriented to person only. He has short and long term memory problems, confusion, forgetfulness... his mental function varies over the course of the day... He is at risk for falls due to his medications, poor trunk balance,... an unsteady gait and history of falls... He continues to be quiet and reserved... He spends most of his time in his room..."</p> <p>i. The Fall Risk Assessment form documented the resident had falls on 10/13/08, 12/5/08, and 12/22/08.</p> <p>j. Annual Review Nurses Notes dated 1/11/09 documented, "...stays in room, watches TV (television) or naps in recliner..."</p> <p>k. On 1/10/09 at 3:59 p.m., 1/11/09 at 9:29 a.m., 10:30 a.m., 2:35 p.m., and 1/12/09 at 9:15 a.m., the resident was in bed with his eyes closed and sleeping or in the recliner sleeping.</p> <p>l. The January 2009 MAR documented the resident received Temazepam 15 mg Q hs for Insomnia from 1/1/09 through 1/12/09 at 5:00 p.m.</p> <p>m. On 1/13/09 at 10:10 a.m., the DON was asked for the notification to the physician that the Temazepam was not decreased from 15 mg to 7.5 mg as ordered by him on the Consultant Pharmacist Recommendation form dated</p>	F 329			

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F 329	Continued From page 9 11/26/08. The DON said, "I don't see where the physician was told." n. On 1/13/09 at 11:20 a.m., the DON and the ADON (Assistant Director of Nursing) were asked for the clinical justification that's required to be documented by the physician concerning the resident's continued use of Temazepam 15 mg at bedtime for such a long duration. o. As of 1/13/09 at 6:15 p.m., the resident's clinical record did not contain the clinical rationale for the continued use of Temazepam 15 mg Q hs, and the DON and ADON were unable to provide this information. p. On 1/14/09 at 9:20 a.m. CNA (Certified Nursing Assistant) #3 was asked if the resident sleeps most of the time during the day. She said she usually works on another hall, but, "We couldn't get him out of bed this morning for breakfast. He was beginning to become angry for trying to get him up, so we had to let him be. He does sleep or rest in a recliner or bed if he's not in the dining room for meals."	F 329			
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 record review and interview, the facility failed to ensure a physician order to decrease the dosage of Risperdal was followed for 1 (Resident #6) of 2 (Residents #6 and #7) case mix residents who received Risperdal on a scheduled basis. The facility failed to ensure a physician order to	F 333			

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F 333	<p>Continued From page 10</p> <p>decrease the dosage of Temazepam was followed for 1 of 1 case mix resident (Resident #4) who had a physician order for Temazepam. These failed practices had the potential to affect 13 residents who had orders for Risperdal and 2 resident who had orders for Temazepam as identified by a list provided by the Director of Nurses on 1/14/09 at 9:00 a.m. The findings are:</p> <p>1. Resident #6 had a diagnosis of Dementia. The Quarterly Minimum Data Set dated 1/11/08 documented the resident was moderately impaired in cognitive skills for daily decision making, had behaviors of wandering and resisting care and received an antipsychotic 7 days in the past week.</p> <p>a. A Physician Order dated 7/27/07 documented, "Risperdal Sol (solution) 0.25 mg (milligram) po (by mouth) q (every) am (morning) and hs (hour of sleep)."</p> <p>b. A Consultant Pharmacist Monthly Report dated 10/17/08 documented, "This resident has been receiving Risperdal solution 0.25 mg po q am and q pm... Please consider a small reduction on this resident to see if it is tolerable." The selection, "Reduce Risperdal to 0.25 mg po q am" was checked and the physician signed the form but did not date it.</p> <p>c. The November 2008 Physician Order Sheet documented the hand written entry of, "11/7/08... Time 0800 (8:00 a.m.)... Risperdal Sol 0.25 mg po qd (every day)." The original order had a single line drawn through it and documented, "changed 11/7/08."</p> <p>d. The November 2008 Medication Administration</p>	F 333			

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F 333	<p>Continued From page 11</p> <p>Record (MAR) documented Risperdal Sol 0.25 mg was administered at 8:00 a.m. daily from 11/7/08 through 11/30/08 as initialed by the nurses .</p> <p>e. The December 2008 and January 2009 Physician Orders Sheet documented, "Order date 7/27/07... Risperdal 0.25 mg po q am and q pm."</p> <p>f. The December 2008 and January 2009 MAR documented, "Risperdal Sol 0.25 mg po q am and q pm.. 8 am... 5 pm." and was administered twice a day from 12/1/08 through 01/11/09 as initialed by the nurses.</p> <p>g. The Risperdal medication pharmacy label dated 11/8/08 documented, "Risperdal 1 mg/ml (milliliter) solution... give 0.25 ml every morning... each dose = 0.25 mg."</p> <p>h. On 1/13/09 at 1:45 p.m., the Director of Nursing stated, "It (the Risperdal medication order on 11/7/08) wasn't processed correctly. If it was, then it wouldn't have shown up again on the order sheet or the MAR."</p> <p>i. On 1/13/09 at 3:40 p.m., Licensed Practical Nurse (LPN) #3 was asked if she administered an evening Risperdal medication to the resident. LPN #3 stated, "I believe so," the LPN turned to the resident's January 2009 MAR and stated, "Yeah."</p> <p>2. Resident #4 had diagnoses of Manic Depression and Insomnia. The Minimum Data Set (MDS) dated 10/12/08 documented the resident had problems with short and long term memory, was moderately impaired in cognitive skills for daily decision making, had periods of</p>	F 333			

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F 333	Continued From page 12 altered perception or awareness of surroundings, periods of disorganized speech, indicators of depression of insomnia/change in sleep pattern that were not easily altered over the past 7 days, received a hypnotic daily for the past 7 days, had an unsteady gait, and fell in the past 30 days and 31 - 180 days. a. The August 2008 MAR (Medication Administration Record) documented, Temazepam 15 mg (milligrams) PO (by mouth) Q hs (at bedtime) and was dated 2/16/07. b. The September MAR documented Temazepam 7.5 mg 1 capsule at bedtime with a start date of 8/27/08 and increased back to 15 mg on 9/3/08. c. A physician order dated 9/3/08 documented, "[Change] Temazepam 7.5 mg to Temazepam 15 mg. d. The Consultant Pharmacist Monthly Report dated 11/26/08 documented, "This resident has diagnosis of Insomnia and is currently taking Temazepam 15 mg PO Q PM (every evening). Routine use of Temazepam is discouraged for geriatrics (> (greater than) 65 y/o [years old]) due to increased sedation and falls. Please evaluate the continued need/benefit of the current medication and consider alternatives. If this medication maintains functional status and you feel that the benefits of continued use (i.e. greater control of insomnia) outweigh the risks involved (i.e. increase in the number of falls in the elderly, potential for addiction, and/or development of tolerance) for this resident, please document to that effect in your progress notes." The physician checked, "Decrease Temazepam to 7.5mg PO	F 333			

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F 333	Continued From page 13 (by mouth) Q PM." A hand-written note on the bottom of the report dated 12/4/08 documented by a facility RN the resident's granddaughter refuses for the medication to be changed. e. The January 2009 MAR documented the resident received Temazepam 15 mg Q hs for Insomnia from 1/1/09 through 1/12/09 at 5:00 p.m. f. On 1/13/09 at 10:10 a.m., the DON was asked for the notification to the physician that the Temazepam was not decreased from 15 mg to 7.5 mg as ordered by him on the Consultant Pharmacist Recommendation form dated 11/26/08. The DON said, "I don't see where the physician was told." g, This was a significant medications due to the frequency of the error.	F 333			
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure chemicals were not stored in the kitchen and the rinse cycle of a low temperature dish machine was tested for	F 371			

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F 371	<p>Continued From page 14</p> <p>the correct amount of sanitizer and that the sanitizer was dispensing correctly. This failed practice had the potential to affect 86 residents who received their meals from the Dietary Department as documented on the Diet Roster dated 1/10/09. The findings are:</p> <ol style="list-style-type: none"> 1. On 1/10/09 at 1:49 p.m., there was a container of high temperature grill cleaner stored open beneath the kitchen sink. 2. On 1/13/09 at 12:15 p.m., the January 2009 Dish Machine Temperature chart did not document litmus test results for testing the sanitizer. <ol style="list-style-type: none"> a. On 1/13/08 at 12:30 p.m., Dietary Employee #1 stated, "I take the temperature for the wash, rinse, sanitizer each meal and mark it on the 'Dish Machine Temperatures' Sheet". The January 2009 sheet was filled out for the 13 days, 3 temperatures for each meal. I asked her for the litmus test strip to check the amount of sanitizer on the dish surface. She stated she had been an employee for 2 weeks and had never seen that. There were no available test strips in the dish room. Employee #1, Employee #2 and the Administrator searched for 20 minutes and found the litmus sheets in the dietary office at 12:50 p.m. b. On 11/13/08 at 12:50 p.m., Dietary Employee #2 tested the sanitizer on the dish surface and the strip was clear with no color change, indicating that the sanitizer was not registering above 0% in the machine. The Dietary Manager asked if the Sanitizer bucket was empty. Employee #2 stated that the bucket was full but the tubing was not in the bucket to dispense. 	F 371		

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F 425 SS=E	<p>483.60(a),(b) PHARMACY SERVICES</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure medications were administered as ordered for 3 (Resident #13, 14 and 15) of 9 case mix residents (Resident #3, 5, 9, 10, 11, 13, 14, 15 and 19) who received medications on the 300 and 600 halls. These failed practices had the potential to affect 44 residents who received medications on the 600 and 300 Halls as identified by the Administrator on 1/13/09. The findings are:</p> <p>1. Resident #13 had a diagnosis of Hyperlipidemia.</p>	F 425		

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F 425	<p>Continued From page 16</p> <p>a. A physician order dated 8/20/07 documented Zocor 40 mg (milligrams) 1 po (by mouth) every day with supper.</p> <p>b. On 1/12/08 at 4:30 p.m., LPN (Licensed Practical Nurse) #1 administered Zocor 40 mg with 3 ounces of water.</p> <p>2. Resident #14 had a diagnosis of Dementia.</p> <p>a. A physician order dated 9/14/06 documented Namenda 10 mg 1 bid (twice a day) with food.</p> <p>On 1/12/09 at 4:32 p.m., LPN #1 give the Namenda 10 mg with water.</p> <p>b. A physician order dated 2/15/07 documented Oyster Shell Calcium 500 mg 1 bid (twice a day).</p> <p>On 1/12/09 at 4:30 p.m., LPN #1 stated, "This should be given with meals, so I'm going to hold this." LPN #1 came and got the surveyor to administer the Oyster Shell Calcium 500 mg with Vit D at 5:53 p.m. with the resident sitting at the supper meal.</p> <p>3. Resident #15 had a diagnosis of Congestive Heart Failure.</p> <p>a. A physician order dated 11/14/08 documented Klor Con 10 mEq (milliequivalents) 1 tablet po every day.</p> <p>b. On 1/13/09 at 8:04 a.m., LPN #2 administered the Klor Con 10 mEq to the resident and the resident chewed the medication. The resident had white powder around the outside of the mouth.</p>	F 425		

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F 425	Continued From page 17 c. On 1/13/09 at 8:08 a.m., the surveyor asked LPN #2, "Does the resident usually chew her medications?" LPN #2 stated, "Yes." d. The January 2009 Medication Administration Record (MAR) documented LPN #2 administered the Klor-Con 10 mEq 9 times from 1/1/09 through 1/13/09. e. The Lexi-Comp's Drug Information Handbook for Nursing 2007 on page 1010 documented, "Nursing Actions Patient Education: Long-acting and wax matrix tablets should be swallowed whole; do not crush or chew."	F 425			
F 468 SS=D	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure hand rails were secured to the walls. These failed practices had the potential to affect 9 mobile residents who resided on the 500 hall unit as identified on a Census List provided by the Administrator on 1/14/09 at 11:23 a.m. The findings are: On 1/12/09 at 10:40 a.m., the hand railing at the far end of the 500-hall in the locked unit, on the right side of hall nearest the dining area was pulled away from the wall leaving an approximately 5/8-inch to 3/4-inch gap.	F 468			