

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

PRINTED: 07/30/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/18/2008
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF BENTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 ALCOA ROAD BENTON, AR 72015	
(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 225 SS=E	<p>Complaint #13708. substantiated (all or part) with deficiencies cited at F333 and F425.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225		

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 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure allegation of neglect was reported to OLTC (Office of Long Term Care) and local law enforcement in accordance with State law for 13 (Residents #1 through #13) of 13 case mix residents who did not receive medications per Physician Orders. This failed practice had the potential to affect 30 residents who resided on 300 hall according to the Census List dated 7/18/08. The findings are: 1. A Facility Action Plan dated 7/13/08 documented, "Problem: Multiple medications not given on 3-11; dates seem to be primarily Monday through Friday on 300 hall - DON (Director of Nursing) notified by ADON (Assistant Director of Nursing)." Under column titled Action documented, "Meet with LPN #2 and place on suspension until the investigation is complete..." 2. On 7/17/08 at 1:00 p.m., review of the Medication Administration Records and medication blister packs revealed 13 residents did not receive medications as ordered from 7/7/08 through 7/11/08. 3. On 7/18/08 at 8:25 a.m., the Administrator was asked if the facility reported the allegation of neglect to OLTC and local law enforcement in accordance with State law. She stated, "No." 483.13(c) STAFF TREATMENT OF RESIDENTS	F 225		
F 226 SS=E	The facility must develop and implement written policies and procedures that prohibit	F 226		

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F 226	<p>Continued From page 2</p> <p>mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure their Abuse/Neglect Policy and Procedure was implemented for reporting an allegation of neglect to OLTC (Office of Long Term Care) and local law enforcement in accordance with State law for 13 (Residents #1 through #13) of 13 case mix residents who did not receive medications per Physician Orders. This failed practice had the potential to affect 30 residents who resided on 300 hall according to the Census List dated 7/18/08. The findings are:</p> <p>1. The facility's Abuse/Neglect Policy and Procedure documented, "Reporting/Investigation/Response: Policy: Any complaint of, allegation of, observation of or suspicion of resident abuse, mistreatment or neglect... is to be thoroughly reported, investigated and documented... The Administrator or designee shall call local Police when... neglect is suspected and/or confirmed by investigation... Verbal notification to... other regulatory agencies per individual state reporting requirements..."</p> <p>2. A Facility Action Plan dated 7/13/08 documented, "Problem: Multiple medications not given on 3-11; dates seem to be primarily Monday through Friday on 300 hall - DON (Director of Nursing) notified by ADON (Assistant Director of Nursing)." Under column titled Action documented, "Meet with LPN #2 and place on suspension until the investigation is complete..."</p>	F 226			

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F 226	Continued From page 3 3. On 7/17/08 at 1:00 p.m., review of the Medication Administration Records and medication blister packs revealed 13 residents did not receive medications as ordered from 7/7/08 through 7/11/08. 4. On 7/18/08 at 8:25 a.m., the Administrator was asked if the facility reported the allegation of neglect to OLTC and local law enforcement in accordance with State law. She stated, "No."	F 226		
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: Complaint #13708, substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure medications were administered as ordered for 13 of 13 case mix residents (Resident #1 - 13) who had physician orders for medication. This failed practice had the potential to affect 30 residents who resided on the 300 hall according to the Director of Nursing on 7/18/07 at 9:00 a.m. The findings are: 1. Resident #1 had diagnoses of Alzheimer's Disease, Edema and Weight Loss. The Quarterly Minimum Data Set (MDS) dated 7/4/08 documented the resident was moderately impaired in cognitive skills for daily decision-making and required extensive assistance with activities of daily living (ADLs). a. A Physician Order dated 2/29/08 documented	F 333		

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F 333	<p>Continued From page 4</p> <p>Megestrol Acetate (Megace) 40 mg (milligrams) 1 PO (by mouth) BID (twice daily).</p> <p>b. A Physician Order dated 2/29/08 documented Aricept 5 mg 2 PO at HS (bedtime).</p> <p>c. A Physician Order dated 3/9/08 documented Lasix 40 mg 1 PO BID.</p> <p>d. The July 2008 Medication Administration Record (MAR) was initialed by nursing staff that the 5:00 p.m. dosage of Megace and Lasix was administered from 7/8/08 through 7/11/08, and the bedtime dosage of Aricept was administered from 7/8/08 through 7/12/08.</p> <p>e. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the Megace and Lasix were not administered from 7/8/08 through 7/11/08 and the Aricept was not administered from 7/8/08 through 7/11/08.</p> <p>f. These were significant medication errors due to the frequency of the error.</p> <p>2. Resident #2 had diagnoses of Edema and Presenile Dementia. The Quarterly MDS dated 7/4/08 documented the resident had modified independence in cognitive skills for daily decision-making and required extensive assistance with ADLs.</p> <p>a. A Physician Order dated 4/12/08 documented Namenda 10 mg 1 PO BID.</p> <p>b. A Physician Order dated 5/26/08 documented Lasix 20 mg PO BID.</p> <p>c. A Physician Order dated 6/27/08 documented</p>	F 333			

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F 333	<p>Continued From page 5</p> <p>Coreg 3.125 mg PO every 8 hours.</p> <p>d. The July 2008 MAR was initialed by the nursing staff that the 5:00 p.m. dosage of Namenda was administered on 7/10/08 and 7/11/08, the 5:00 p.m. dosage of Lasix was administered on 7/10/08 and 7/11/08, and the 4:00 p.m. dosage of Coreg was administered on 7/9/08.</p> <p>e. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the Namenda and Lasix were not administered on 7/10/08 and 7/11/08 and the Coreg was not administered from 7/8/08 through 7/11/08.</p> <p>f. These were significant medication errors due to the frequency of the error.</p> <p>3. Resident #3 had a diagnosis of Alzheimer's Disease. The Quarterly MDS dated 4/18/08 documented the resident had modified independence in cognitive skills for daily decision-making and required limited assistance with some ADLs.</p> <p>a. A Physician Order dated 1/4/07 documented Namenda 10 mg 1 PO BID.</p> <p>b. The July 2008 MAR was initialed by the nursing staff that the 5:00 p.m. dosage of Namenda was administered on 7/9/08, 7/10/08 and 7/11/08.</p> <p>c. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the Namenda was not administered from 7/9/08 through 7/11/08.</p> <p>f. This was a significant medication error due to the frequency of the error.</p>	F 333			

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F 333	Continued From page 6 4. Resident #4 had diagnoses of Osteoarthritis, Benign Hypertension, Weight Loss and Pruritic Disorder. The Quarterly MDS dated 5/20/08 documented the resident had modified independence in cognitive skills for daily decision-making and required limited to extensive assistance with ADLs. a. A Physician Order dated 2/10/06 documented Norvasc 5 mg 1 PO BID and Desyrel 50 mg 1 PO HS. b. A Physician Order dated 9/27/07 documented Hydrocodone 7.5/325 mg 1 PO every 8 hours. c. A Physician Order dated 1/10/08 documented Vistaril 25 mg 1 PO TID (three times daily). d. A Physician Order dated 3/28/08 documented Megace 40 mg 1 PO BID. e. A Physician Order dated 4/1/08 documented Micro K 10 mEq (milliequivalents) 1 PO BID. f. The July 2008 MAR was initialed by nursing staff that the 5:00 p.m. dosage of Norvasc was administered on 7/11/08, the 8:00 p.m. dosage of Desyrel was administered from 7/7/08 through 7/11/08, the 10:00 p.m. dosage of Hydrocodone was administered on 7/8/08 and 7/9/08, the 5:00 p.m. dosage of Vistaril was administered from 7/8/08 through 7/11/08, the 5:00 p.m. dosage of Megace was administered from 7/8/08 through 7/11/08 and the 5:00 p.m. dosage of Micro K was administered from 7/8/08 through 7/11/08. g. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the Norvasc, Vistaril,	F 333			

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F 333	<p>Continued From page 7</p> <p>Micro K and Megace were not administered from 7/8/08 through 7/11/08, the Desyrel was not administered from 7/7/08 through 7/11/08. There was no documentation in the narcotic book that the resident was administered the 10:00 p.m. dosage of Hydrocodone was administered from 7/7/08 through 7/11/08.</p> <p>h. These were significant medication errors due to the frequency of the error.</p> <p>5. Resident #5 had diagnoses of Dementia and Insomnia. The Annual MDS dated 5/1/08 documented the resident was severely impaired in cognitive skills for daily decision-making and totally dependent on staff for ADLs.</p> <p>a. A Physician Order dated 4/27/06 documented Trazodone 100 mg 2 HS.</p> <p>b. A Physician Order dated 1/10/08 documented Ativan 0.5 mg 1 PO every evening</p> <p>c. A Physician Order dated 6/19/08 documented Zyprexa 2.5 mg 1 PO every evening.</p> <p>d. The July 2008 MAR was initialed by nursing staff that the 8:00 p.m. dosage of Zyprexa was administered on 7/10/08, the 8:00 p.m. dosage of Trazodone was administered on 7/10/08 and 7/11/08, and the 5:00 p.m. dosage of Ativan was administered on 7/8/08 and 7/10/08.</p> <p>e. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Trazodone and Zyprexa on 7/10/08 and 7/11/08. The narcotic sign out book documented the resident did not receive the 5:00 p.m. dosage of Ativan from 7/8/08 through</p>	F 333			

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F 333	Continued From page 8 7/10/08. f. These were significant medication errors due to the frequency of the error. 6. Resident #6 had diagnoses of Hypertension, Cardiac Dysrhythmia and Deep Vein Thrombosis. The Quarterly MDS dated 5/19/08 documented the resident was independent in cognitive skills for daily decision-making and required limited assistance with most ADLs. a. A Physician Order dated 11/6/07 documented Quinaglute 324 mg 1 PO every 8 hours and Verapamil 80 mg 1 PO TID. b. A Physician Order dated 11/7/07 documented Coumadin 4 mg 1 PO every day except Wednesday and Saturday. c. A Nurse's Note dated 7/13/08 documented, "Received order for Stat PT Prothrombin)/INR (International Ratio) due to missed doses of Coumadin." d. Lab work dated 7/13/08 documented the PT as 10.1 (normal range 20.8 - 30.3) and INR as 1.00 (normal range 2.0 - 3.0). e. The July 2008 MAR was initialed by nursing staff that the 5:00 p.m. dosage of Verapamil and Coumadin were administered on 7/10/08 and 7/11/08, and the 4:00 p.m. dosage of Quinaglute was administered on 7/10/08 and 7/11/08. f. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Verapamil, Coumadin and Quinaglute on 7/10/08 and 7/11/08.	F 333		

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F 333	Continued From page 9 g. These were significant medication errors due to the frequency of the error and classification of one medication (anticoagulant). 7. Resident #7 had diagnoses of Hypertension and Headaches. The Annual MDS dated 5/22/08 documented the resident was moderately impaired in cognitive skills for daily decision-making and required limited assistance with ADLs. a. A Physician Order dated 5/10/07 documented Coreg 3.125 mg 1 PO BID and Lortab 5/325 mg 1 PO BID. b. The July 2008 MAR was initialed by nursing staff that the 5:00 p.m. dosage of Coreg was administered on 7/9/08 and 7/11/08. c. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Coreg on 7/9/08 and 7/11/08. There was no documentation in the narcotic book that the resident was administered the 8:00 p.m. dosage of Lortab on 7/8/08 and 7/10/08. d. This was a significant medication error due to the frequency of the error. 8. Resident #8 had a diagnosis of Alzheimer's Disease. The Medicare 14 day MDS dated 5/7/08 documented the resident was moderately impaired in cognitive skills for daily decision-making and required supervision with ADLs. a. A Physician Order dated 4/23/08 documented Namenda 5 mg 1 PO BID.	F 333			

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F 333	Continued From page 10 b. On 7/17/08 at 1:00 p.m., the July 2008 MAR was initialed by nursing staff that the 8:00 p.m. dosage of Namenda was administered on 7/9/08. c. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Namenda on 7/9/08 and 7/11/08. d. This was a significant medication error due to the frequency of the error. 9. Resident #9 had diagnoses of Dementia, Hypertension and Congestive Heart Failure. The Annual MDS dated 5/27/08 documented the resident was severely impaired in cognitive skills for daily decision-making and totally dependent on staff for ADLs. a. A Physician Order dated 4/23/08 documented K-Dur 10 mEq 1 PO BID, Labetalol 200 mg 1 PO BID, Seroquel 100 mg 1 PO at HS. b. A Physician Order dated 5/23/08 documented Lortab 5/500 mg TID. c. On 7/17/08 at 1:00 p.m., the July 2008 MAR was initialed by nursing staff that the 8:00 p.m. dosage of Seroquel was administered on 7/11/08, the 5:00 p.m. dosage of K-Dur and Labetalol was administered on 7/11/08, and the 4:00 p.m. and 10:00 p.m. dosage of Lortab was administered on 7/9/08. d. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Labetalol on 7/11/08. There was no documentation in the narcotic book that the resident was administered Lortab from 7/9/08	F 333			

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F 333	<p>Continued From page 11 through 7/11/08.</p> <p>e. These were significant medication errors due to the frequency of the error.</p> <p>10. Resident #10 had diagnoses of Alzheimer's Dementia with Behavioral Disturbance and Delusions. The Medicare 5 day MDS dated 7/7/08 documented the resident had modified independence in cognitive skills for daily decision-making and required limited assistance with ADLs.</p> <p>a. A Physician Order dated 7/3/08 documented Aricept 5 mg 1 PO HS and Seroquel 25 mg 1 PO BID.</p> <p>b. The July 2008 MAR was initialed by nursing staff that the 8:00 p.m. dosage of Seroquel and Aricept were administered from 7/9/08 through 7/11/08.</p> <p>c. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Seroquel and Aricept from 7/9/08 through 7/11/08.</p> <p>d. This was a significant medication error due to the frequency of the error.</p> <p>11. Resident #11 had a diagnosis of Alzheimer's Disease. The Quarterly MDS dated 4/14/08 documented the resident was moderately impaired in cognitive skills for daily decision-making and required extensive assistance with ADLs.</p> <p>a. A Physician Order dated 6/13/07 documented Namenda 5 mg 1 PO BID.</p>	F 333			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/18/2008
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F 333	Continued From page 12 b. The July 2008 MAR was initialed by nursing staff that the 5:00 p.m. dosage of Namenda was administered on 7/9/08 and 7/10/08. c. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Namenda from 7/9/08 through 7/11/08. d. This was a significant medication error due to the frequency of the error. 12. Resident #12 had a diagnosis of Atrial Fibrillation. The Quarterly MDS dated 7/8/08 documented the resident was moderately impaired in cognitive skills for daily decision-making and required extensive assistance with some ADLs. a. A Physician Order dated 7/9/08 documented Coumadin 3 mg one day and 1.5 mg the next, alternating. b. A Nurse's Note dated 7/13/08 at 2:04 p.m. documented, "Received Stat PT/INR order due to missed doses of Coumadin." c. Lab work dated 7/13/08 documented the PT as 10.8 (normal range 20.8 - 30.3) and INR as 1.08 (normal range 2.0 - 3.0). d. The July 2008 MAR was initialed by nursing staff that the 5:00 p.m. dosage of Coumadin was administered on 7/9/08 and 7/10/08. e. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Coumadin on 7/9/08 and 7/10/08.	F 333			

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

PRINTED: 07/30/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/18/2008
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F 333	Continued From page 13 f. This was a significant medication error due to the frequency of the error and drug classification (anticoagulant). 13. Resident #13 had a diagnosis of Pain. The Medicare MDS dated 7/3/08 documented the resident had modified independence in cognitive skills for daily decision-making and was independent in some ADLs. a. A Physician Order dated 1/3/07 documented Tramadol 50 mg 1 PO BID. b. The July 2008 MAR was initialed by nursing staff that the 8:00 p.m. dosage of Tramadol was administered on 7/9/08. c. On 7/17/08 at 1:05 p.m., there was no documentation in the narcotic book that the resident was administered Tramadol on 7/9/08 and 7/11/08. d. This was a significant medication error due to the frequency of the error. 14. A handwritten witness statement by Licensed Practical Nurse (LPN) #2 dated 7/13/08 documented, "I have been randomly punching meds on cards, I have borrowed meds from other cards if I could not find med for patient. Was not aware that this shouldn't be done and was not allowed. Have also punched meds from previous shift cards if did not have a card on patient in my drawer. Was not aware that there should be a card in each drawer for BID meds." 15. On 7/17/08 at 1:27 p.m., LPN #1 stated during a telephone interview, "The pills were there	F 333			

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

PRINTED: 07/30/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/18/2008
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F 333	<p>Continued From page 14</p> <p>in the blister packs. I worked Saturday. At the 5:00 p.m. med pass the pills were still in the blister pack from 3-11 shift Monday through Friday the previous week. I'm a stickler; when I see something like that I'm going to do something about it. I work 300 hall. I know the residents. I counted the pills Saturday. Ninety five pills were not given. I counted them - 80 pills of the regular long term care residents and 15 scheduled narcotics were not given, all off 300 hall... It was [LPN #2]; she's the only LPN who worked 300 hall Monday through Friday." LPN #1 was asked if any of the residents who didn't receive their medications complained to her about it. She stated, "She gave it to the ones who knew better. She told [Assistant Director of Nursing] and [Director of Nursing] she popped pills from other cards. If she did, the other cards would be off. If she did, why didn't she give the scheduled narcotics?"</p> <p>16. On 7/18/08, the schedule and time card information documented LPN #2 worked the 3-11 shift from 7/7/08 through 7/11/08 on 300 hall.</p> <p>17. On 7/17/08 at 6:40 a.m., Registered Nurse #1 was asked if medications were punched out of the blister packs by date. He stated, "Yes."</p> <p>18. On 7/17/08 at 6:45 a.m., LPN #3 was asked if medications were punched out of the blister packs by date. She stated, "Yes.."</p> <p>19. On 7/17/08 at 3:30 p.m., the Administrator provided information to indicate the facility had conducted an inservice on 7/13/08 for all nurses on medication administration. On 7/18/08 at 9:25 a.m., the Assistant Director of Nursing (ADON) was asked if the facility was monitoring the</p>	F 333			

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

PRINTED: 07/30/2008
FORM APPROVED
OMB NO. 0938-0391

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F 333	Continued From page 15 effectiveness of their inservice. She stated, "No, but we have the same nurses working Monday through Friday, same nurse working the same cart with the same group of meds." The ADON was asked if the facility was monitoring to ensure the medications were being given. She stated, "As far as me going back through, no I haven't."	F 333			
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES 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. 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. 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. This REQUIREMENT is not met as evidenced by: Complaint #13708, substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure there were procedures developed to ensure medications were administered as	F 425			

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

PRINTED: 07/30/2008
FORM APPROVED
OMB NO. 0938-0391

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F 425	Continued From page 16 ordered for 13 of 13 (Residents #1 through #13) case mix residents who had physician orders for medications. This failed practice had the potential to affect 30 residents who resided on the 300 hall according to the Director of Nursing on 7/18/07 at 9:00 a.m. The findings are: 1. Resident #1 had diagnoses of Alzheimer's Disease, Edema and Weight Loss. The Quarterly Minimum Data Set (MDS) dated 7/4/08 documented the resident was moderately impaired in cognitive skills for daily decision-making and required extensive assistance with activities of daily living (ADLs). a. A Physician Order dated 2/29/08 documented Megestrol Acetate (Megace) 40 mg (milligrams) 1 PO (by mouth) BID (twice daily). b. A Physician Order dated 2/29/08 documented Aricept 5 mg 2 PO at HS (bedtime). c. A Physician Order dated 3/9/08 documented Lasix 40 mg 1 PO BID. d. The July 2008 Medication Administration Record (MAR) was initialed by nursing staff that the 5:00 p.m. dosage of Megace and Lasix was administered from 7/8/08 through 7/11/08, and the bedtime dosage of Aricept was administered from 7/8/08 through 7/12/08. e. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the Megace and Lasix were not administered from 7/8/08 through 7/11/08 and the Aricept was not administered from 7/8/08 through 7/11/08. f. These were significant medication errors due to	F 425			

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

PRINTED: 07/30/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/18/2008
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F 425	<p>Continued From page 17 the frequency of the error.</p> <p>2. Resident #2 had diagnoses of Edema and Presenile Dementia. The Quarterly MDS dated 7/4/08 documented the resident had modified independence in cognitive skills for daily decision-making and required extensive assistance with ADLs.</p> <p>a. A Physician Order dated 4/12/08 documented Namenda 10 mg 1 PO BID.</p> <p>b. A Physician Order dated 5/26/08 documented Lasix 20 mg PO BID.</p> <p>c. A Physician Order dated 6/27/08 documented Coreg 3.125 mg PO every 8 hours.</p> <p>d. The July 2008 MAR was initialed by the nursing staff that the 5:00 p.m. dosage of Namenda was administered on 7/10/08 and 7/11/08, the 5:00 p.m. dosage of Lasix was administered on 7/10/08 and 7/11/08, and the 4:00 p.m. dosage of Coreg was administered on 7/9/08.</p> <p>e. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the Namenda and Lasix were not administered on 7/10/08 and 7/11/08 and the Coreg was not administered from 7/8/08 through 7/11/08.</p> <p>f. These were significant medication errors due to the frequency of the error.</p> <p>3. Resident #3 had a diagnosis of Alzheimer's Disease. The Quarterly MDS dated 4/18/08 documented the resident had modified independence in cognitive skills for daily</p>	F 425			

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

PRINTED: 07/30/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/18/2008
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F 425	<p>Continued From page 18</p> <p>decision-making and required limited assistance with some ADLs.</p> <p>a. A Physician Order dated 1/4/07 documented Namenda 10 mg 1 PO BID.</p> <p>b. The July 2008 MAR was initiated by the nursing staff that the 5:00 p.m. dosage of Namenda was administered on 7/9/08, 7/10/08 and 7/11/08.</p> <p>c. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the Namenda was not administered from 7/9/08 through 7/11/08.</p> <p>f. This was a significant medication error due to the frequency of the error.</p> <p>4. Resident #4 had diagnoses of Osteoarthritis, Benign Hypertension, Weight Loss and Pruritic Disorder. The Quarterly MDS dated 5/20/08 documented the resident had modified independence in cognitive skills for daily decision-making and required limited to extensive assistance with ADLs.</p> <p>a. A Physician Order dated 2/10/06 documented Norvasc 5 mg 1 PO BID and Desyrel 50 mg 1 PO HS.</p> <p>b. A Physician Order dated 9/27/07 documented Hydrocodone 7.5/325 mg 1 PO every 8 hours.</p> <p>c. A Physician Order dated 1/10/08 documented Vistaril 25 mg 1 PO TID (three times daily).</p> <p>d. A Physician Order dated 3/28/08 documented Megace 40 mg 1 PO BID.</p> <p>e. A Physician Order dated 4/1/08 documented</p>	F 425			

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

PRINTED: 07/30/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/18/2008
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F 425	<p>Continued From page 19</p> <p>Micro K 10 mEq (milliequivalents) 1 PO BID.</p> <p>f. The July 2008 MAR was initialed by nursing staff that the 5:00 p.m. dosage of Norvasc was administered on 7/11/08, the 8:00 p.m. dosage of Desyrel was administered from 7/7/08 through 7/11/08, the 10:00 p.m. dosage of Hydrocodone was administered on 7/8/08 and 7/9/08, the 5:00 p.m. dosage of Vistaril was administered from 7/8/08 through 7/11/08, the 5:00 p.m. dosage of Megace was administered from 7/8/08 through 7/11/08 and the 5:00 p.m. dosage of Micro K was administered from 7/8/08 through 7/11/08.</p> <p>g. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the Norvasc, Vistaril, Micro K and Megace were not administered from 7/8/08 through 7/11/08, the Desyrel was not administered from 7/7/08 through 7/11/08. The narcotic sign out book documented the 10:00 p.m. dosage of Hydrocodone was not administered from 7/7/08 through 7/11/08.</p> <p>h. These were significant medication errors due to the frequency of the error.</p> <p>5. Resident #5 had diagnoses of Dementia and Insomnia. The Annual MDS dated 5/1/08 documented the resident was severely impaired in cognitive skills for daily decision-making and totally dependent on staff for ADLs.</p> <p>a. A Physician Order dated 4/27/06 documented Trazodone 100 mg 2 HS.</p> <p>b. A Physician Order dated 1/10/08 documented Ativan 0.5 mg 1 PO every evening</p> <p>c. A Physician Order dated 6/19/08 documented</p>	F 425			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/18/2008
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF BENTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 ALCOA ROAD BENTON, AR 72015		
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F 425	Continued From page 20 Zyprexa 2.5 mg 1 PO every evening. d. The July 2008 MAR was initialed by nursing staff that the 8:00 p.m. dosage of Zyprexa was administered on 7/10/08, the 8:00 p.m. dosage of Trazodone was administered on 7/10/08 and 7/11/08, and the 5:00 p.m. dosage of Ativan was administered on 7/8/08 and 7/10/08. e. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Trazodone and Zyprexa on 7/10/08 and 7/11/08. The narcotic sign out book documented the resident did not receive the 5:00 p.m. dosage of Ativan from 7/8/08 through 7/10/08. f. These were significant medication errors due to the frequency of the error. 6. Resident #6 had diagnoses of Hypertension, Cardiac Dysrhythmia and Deep Vein Thrombosis. The Quarterly MDS dated 5/19/08 documented the resident was independent in cognitive skills for daily decision-making and required limited assistance with most ADLs. a. A Physician Order dated 11/6/07 documented Quinaglute 324 mg 1 PO every 8 hours and Verapamil 80 mg 1 PO TID. b. A Physician Order dated 11/7/07 documented Coumadin 4 mg 1 PO every day except Wednesday and Saturday. c. A Nurse's Note dated 7/13/08 documented, "Received order for Stat PT Prothrombin)/INR (International Ratio) due to missed doses of Coumadin."	F 425			

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

PRINTED: 07/30/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/18/2008
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F 425	Continued From page 21 d. Lab work dated 7/13/08 documented the PT as 10.1 (normal range 20.8 - 30.3) and INR as 1.00 (normal range 2.0 - 3.0). e. The July 2008 MAR was initialed by nursing staff that the 5:00 p.m. dosage of Verapamil and Coumadin were administered on 7/10/08 and 7/11/08, and the 4:00 p.m. dosage of Quinaglute was administered on 7/10/08 and 7/11/08. f. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Verapamil, Coumadin and Quinaglute on 7/10/08 and 7/11/08. g. These were significant medication errors due to the frequency of the error and classification of one medication (anticoagulant). 7. Resident #7 had diagnoses of Hypertension and Headaches. The Annual MDS dated 5/22/08 documented the resident was moderately impaired in cognitive skills for daily decision-making and required limited assistance with ADLs. a. A Physician Order dated 5/10/07 documented Coreg 3.125 mg 1 PO BID and Lortab 5/325 mg 1 PO BID. b. The July 2008 MAR was initialed by nursing staff that the 5:00 p.m. dosage of Coreg was administered on 7/9/08 and 7/11/08. c. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Coreg on 7/9/08 and 7/11/08. The narcotic sign out book documented the resident	F 425			

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

PRINTED: 07/30/2008
FORM APPROVED
OMB NO. 0938-0391

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F 425	<p>Continued From page 22</p> <p>did not receive the 8:00 p.m. dosage of Lortab on 7/8/08 and 7/10/08.</p> <p>d. This was a significant medication error due to the frequency of the error.</p> <p>8. Resident #8 had a diagnosis of Alzheimer's Disease. The Medicare 14 day MDS dated 5/7/08 documented the resident was moderately impaired in cognitive skills for daily decision-making and required supervision with ADLs.</p> <p>a. A Physician Order dated 4/23/08 documented Namenda 5 mg 1 PO BID.</p> <p>b. On 7/17/08 at 1:00 p.m., the July 2008 MAR was initialed by nursing staff that the 8:00 p.m. dosage of Namenda was administered on 7/9/08.</p> <p>c. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Namenda on 7/9/08 and 7/11/08.</p> <p>d. This was a significant medication error due to the frequency of the error.</p> <p>9. Resident #9 had diagnoses of Dementia, Hypertension and Congestive Heart Failure. The Annual MDS dated 5/27/08 documented the resident was severely impaired in cognitive skills for daily decision-making and totally dependent on staff for ADLs.</p> <p>a. A Physician Order dated 4/23/08 documented K-Dur 10 mEq 1 PO BID, Labetalol 200 mg 1 PO BID, Seroquel 100 mg 1 PO at HS.</p> <p>b. A Physician Order dated 5/23/08 documented</p>	F 425			

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

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF BENTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 ALCOA ROAD BENTON, AR 72015		
(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 425	Continued From page 23 Lortab 5/500 mg TID. c. On 7/17/08 at 1:00 p.m., the July 2008 MAR was initialed by nursing staff that the 8:00 p.m. dosage of Seroquel was administered on 7/11/08, the 5:00 p.m. dosage of K-Dur and Labetalol was administered on 7/11/08, and the 4:00 p.m. and 10:00 p.m. dosage of Lortab was administered on 7/9/08. d. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Labetalol on 7/11/08. The narcotic sign out book documented the resident did not receive the Lortab from 7/9/08 through 7/11/08. e. These were significant medication errors due to the frequency of the error. 10. Resident #10 had diagnoses of Alzheimer's Dementia with Behavioral Disturbance and Delusions. The Medicare 5 day MDS dated 7/7/08 documented the resident had modified independence in cognitive skills for daily decision-making and required limited assistance with ADLs. a. A Physician Order dated 7/3/08 documented Aricept 5 mg 1 PO HS and Seroquel 25 mg 1 PO BID. b. The July 2008 MAR was initialed by nursing staff that the 8:00 p.m. dosage of Seroquel and Aricept were administered from 7/9/08 through 7/11/08. c. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Seroquel and Aricept from 7/9/08	F 425			

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

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F 425	<p>Continued From page 24 through 7/11/08.</p> <p>d. This was a significant medication error due to the frequency of the error.</p> <p>11. Resident #11 had a diagnosis of Alzheimer's Disease. The Quarterly MDS dated 4/14/08 documented the resident was moderately impaired in cognitive skills for daily decision-making and required extensive assistance with ADLs.</p> <p>a. A Physician Order dated 6/13/07 documented Namenda 5 mg 1 PO BID.</p> <p>b. The July 2008 MAR was initialed by nursing staff that the 5:00 p.m. dosage of Namenda was administered on 7/9/08 and 7/10/08.</p> <p>c. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Namenda from 7/9/08 through 7/11/08.</p> <p>d. This was a significant medication error due to the frequency of the error.</p> <p>12. Resident #12 had a diagnosis of Atrial Fibrillation. The Quarterly MDS dated 7/8/08 documented the resident was moderately impaired in cognitive skills for daily decision-making and required extensive assistance with some ADLs.</p> <p>a. A Physician Order dated 7/9/08 documented Coumadin 3 mg one day and 1.5 mg the next, alternating.</p> <p>b. A Nurse's Note dated 7/13/08 at 2:04 p.m.</p>	F 425			

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F 425	Continued From page 25 documented, "Received Stat PT/INR order due to missed doses of Coumadin." c. Lab work dated 7/13/08 documented the PT as 10.8 (normal range 20.8 - 30.3) and INR as 1.08 (normal range 2.0 - 3.0). d. The July 2008 MAR was initialed by nursing staff that the 5:00 p.m. dosage of Coumadin was administered on 7/9/08 and 7/10/08. e. On 7/17/08 at 1:05 p.m., review of the medication cards revealed the resident did not receive the Coumadin on 7/9/08 and 7/10/08. f. This was a significant medication error due to the frequency of the error and drug classification (anticoagulant). 13. Resident #13 had a diagnosis of Pain. The Medicare MDS dated 7/3/08 documented the resident had modified independence in cognitive skills for daily decision-making and was independent in some ADLs. a. A Physician Order dated 1/3/07 documented Tramadol 50 mg 1 PO BID. b. The July 2008 MAR was initialed by nursing staff that the 8:00 p.m. dosage of Tramadol was administered on 7/9/08. c. On 7/17/08 at 1:05 p.m., review of the narcotic sign out book revealed the resident did not receive the Tramadol on 7/9/08 and 7/11/08. d. This was a significant medication error due to the frequency of the error.	F 425			

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F 425	<p>Continued From page 26</p> <p>14. A handwritten witness statement by Licensed Practical Nurse (LPN) #2 dated 7/13/08 documented, "I have been randomly punching meds on cards, I have borrowed meds from other cards if I could not find med for patient. Was not aware that this shouldn't be done and was not allowed. Have also punched meds from previous shift cards if did not have a card on patient in my drawer. Was not aware that there should be a card in each drawer for BID meds."</p> <p>15. On 7/17/08 at 1:27 p.m., LPN #1 stated during a telephone interview, "The pills were there in the blister packs. I worked Saturday. At the 5:00 p.m. med pass the pills were still in the blister pack from 3-11 shift Monday through Friday the previous week. I'm a stickler; when I see something like that I'm going to do something about it. I work 300 hall. I know the residents. I counted the pills Saturday. Ninety five pills were not given. I counted them - 80 pills of the regular long term care residents and 15 scheduled narcotics were not given, all off 300 hall... It was [LPN #2]; she's the only LPN who worked 300 hall Monday through Friday." LPN #1 was asked if any of the residents who didn't receive their medications complained to her about it. She stated, "She gave it to the ones who knew better. She told [Assistant Director of Nursing] and [Director of Nursing] she popped pills from other cards. If she did, the other cards would be off. If she did, why didn't she give the scheduled narcotics?"</p> <p>16. On 7/18/08, the schedule and time card information documented LPN #2 worked the 3-11 shift from 7/7/08 through 7/11/08 on 300 hall.</p> <p>17. On 7/17/08 at 6:40 a.m., Registered Nurse</p>	F 425			

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F 425	Continued From page 27 #1 was asked if medications were punched out of the blister packs by date. He stated, "Yes." 18. On 7/17/08 at 6:45 a.m., LPN #3 was asked if medications were punched out of the blister packs by date. She stated, "Yes." 19. On 7/17/08 at 3:30 p.m., the Administrator provided information to indicate the facility had conducted an inservice on 7/13/08 for all nurses on medication administration. On 7/18/08 at 9:25 a.m., the Assistant Director of Nursing (ADON) was asked if the facility was monitoring the effectiveness of their inservice. She stated, "No, but we have the same nurses working Monday through Friday, same nurse working the same cart with the same group of meds." The ADON was asked if the facility was monitoring to ensure the medications were being given. She stated, "As far as me going back through, no I haven't."	F 425			