

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

PRINTED: 08/14/2007
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 07/23/2007
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 425 SS=E	<p>Complaint #12738 substantiated (all or in Part) with a deficiency cited at F425. Complaint #12767 unsubstantiated</p> <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: Complaint #12738 substantiated (all or in Part) with these findings:</p> <p>Based on observation, record review and interview, the facility failed to ensure medications were acquired and dispensed in a timely manner for 4 (Resident #1, #5, #3 and #6) of 7 casemix residents who received medications. This failed practice had the potential to affect all 100</p>	F 425		7/27/07

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 425	Continued From page 1 residents in the facility who had physician's orders for medications according to the Director of Nursing (DON) on 7/19/07 at 2:00 p.m. The findings are: 1. Resident #1 had diagnosis of Chronic Obstructive Pulmonary Disease (COPD). The Admission Minimum Data Set (MDS) dated 6/30/07 documented the resident had modified independence cognitive skills for daily decision making and required limited to extensive assistance with activities of daily living (ADLs). a. The nurse's notes dated 7/8/07 (no time given) documented, "C/O (complains of) "cough" this am - non-productive - Temp. (temperature) 100.8 - Dr. [name] notified for Dr. [name], orders received for Z pack as directed - Robitussin DM 1 or 2 tsp (teaspoon) every 4 hours PRN (as necessary) - cough." b. A physician's order dated 7/8/07 (no time given) documented, "Z-pack as directed..." c. A "Prescription Order and Receipt Form" for Pharmacy #1 documented the Z-pack was ordered for the resident on 7/8/07 at 11:36 a.m. d. The medication delivery form from Pharmacy #1 documented the facility received the Z-pack at 7:24 p.m. on 7/9/07 and the Z-pack was "sent back, wrong pharmacy." e. On 7/18/07 at 8:11 p.m., the pharmacist at Pharmacy #2 stated Dr. [name] called the Z-pack into them on 7/9/07. The prescription was filled on 7/9/07 at 7:34 p.m. by Pharmacy #2 and delivered to the nursing home.	F 425			

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F 425	<p>Continued From page 2</p> <p>f. The July 2007 Medication Administration Record (MAR) documented the first dose of the Z-pack was not administered until 8:00 p.m. on 7/9/07, approximately 32 1/2 hours after the order was originally faxed to the wrong Pharmacy.</p> <p>2. Resident #5 had diagnoses of Urinary Tract Infection and Anorexia. The Quarterly MDS dated 4/11/07 documented the resident had moderately impaired cognitive skills for daily decision-making and was incontinent of bowel and bladder.</p> <p>a. A Physician Order dated 7/5/07 at 1:30 p.m. documented Macrobid 100 mg (milligrams) 1 PO (by mouth) BID (twice daily) after meals x 10 days.</p> <p>b. A Pharmacy Fax Sheet documented the order was not faxed to the pharmacy until 6:43 a.m. on 7/6/07.</p> <p>c. The July 2007 Medication Administration Record (MAR) documented the first dose of the Macrobid was not administered until 8:00 p.m. on 7/6/07, approximately 30 1/2 hours after the order was received from the physician.</p> <p>d. On 7/19/07 at 10:10 a.m., Licensed Practical Nurse (LPN) #1 was asked when she ordered the medication from the pharmacy. She stated, "I ordered it on 7/5/07 at 1:30 p.m. I always fax it as soon as I get it or at least by the end of my shift."</p> <p>1. A Transmission verification report dated 7/6/07 documented that the time of transmission for new medication order for the above physician order was 06:43 (6:43 a.m.).</p>	F 425			

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F 425	Continued From page 3 e. On 7/19/07 at 10:30 a.m., a representative from the provider pharmacy stated they received the order for the Macrobid on 7/6/07 at 6:43 a.m. 3. Resident #3 had diagnoses of Psychosis and Dementia. The Medicare 30 day MDS dated 5/8/07 documented the resident exhibited persistent anger and was verbally abusive and socially inappropriate 1 to 3 days in the last 7 days. a. A Physician Order dated 7/17/07 at 4:05 p.m. documented, "Risperdal 0.25 mg 1 PO BID to treat psychosis." b. A Pharmacy Prescription Order and Receipt Form documented the order was faxed to the pharmacy at 23:07 (11:07 p.m.) on 7/17/07. c. The July 2007 MAR documented the first dose of the Risperdal was not administered until 8:00 a.m. on 7/19/07, approximately 40 hours after the order was received from the physician. The bubble packed medication cards also revealed the first dose of medication was administered on 7/19/07. 4. Resident #6 had diagnoses of Acute Sinusitis and Cough. The Quarterly MDS dated 4/24/07 documented the resident had moderately impaired cognitive skills for daily decision-making and required limited assistance from staff for most activities of daily living. a. A Nurse's Note dated 7/16/07 on the 3-11 shift documented, "Received order for Biaxin XL 500 mg BID x 7 days, Medent DM 1 BID x 7 days, CXR [chest x-ray]."	F 425			

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F 425	Continued From page 4 b. A Physician Order dated 7/17/07 documented, "Biaxin XL 500 mg BID x 7 days, Medent DM 1 BID x 7 days, CXR." c. A Transmission Verification Report documented a Prescription Order and Receipt Form was faxed to the pharmacy on 7/17/07 at 15:37 (3:37 p.m.). d. On 7/18/07 at 7:40 p.m. during the 8:00 p.m. medication pass, the Biaxin XL and Medent DM were not available for administration. e. On 7/18/07 at 8:15 p.m., the Medicare MDS Coordinator called the provider pharmacy. A pharmacy representative stated to her that they did not receive the medication order.	F 425			