

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

PRINTED: 09/27/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045158	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/13/2007
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER - HEBER SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 1040 WEDDINGFORD RD HEBER SPRINGS, AR 72543	
(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 332 SS=E	<p>Complaint #12776 was substantiated (all or in part) with deficiencies cited at F332 and F333.</p> <p>483.25(m)(1) MEDICATION ERRORS</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #12776 was substantiated (all or in part) with these findings.</p> <p>Based on observation of the 8:00 p.m. medication pass on 9/12/07 and the 8:00 a.m. medication pass on 9/13/07, record review and interview, the facility failed to ensure the medication error rate was less than 5%. Physician orders were not followed for 4 (Residents #1 through #4) of 10 residents observed during the medication passes, which resulted in medication errors. Medication errors were made by 2 of 5 Licensed Practical Nurses (LPN's) observed administering medications in the facility. The medication error rate was 10.9%, based on observation of 51 medications administered, 4 medications ordered but not administered and a total of 6 medication errors detected. The failed practice had the potential to affect 79 residents who received 8:00 p.m. medications, as documented on a list provided by the Administrator on 9/13/07. The findings are:</p> <p>1. Resident #1 had a physician order dated 10/19/06 for Zocor 40 milligrams (mg) 1 at bedtime (HS). The September 2007 Medication Administration Record (MAR) documented the</p>	F 332		

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 332	<p>Continued From page 1</p> <p>Zocor 40 mg was scheduled to be administered at 8:00 p.m. each evening.</p> <p>On 9/12/07 at 7:30 p.m. during the 8:00 p.m. medication pass, LPN #1 administered all of the resident's scheduled 8:00 p.m. medications, with the exception of the Zocor 40 mg.</p> <p>2. Resident #3 had a physician order dated 6/30/05 for Glucophage XR (extended release formulation) 500 mg 1 tablet by mouth (po) daily every evening.</p> <p>On 9/12/07 at 7:38 p.m. during the 8:00 p.m. medication pass, LPN #1 administered regular Glucophage 500 mg., instead of Glucophage XR.</p> <p>3. Resident #3 had a physician order dated 6/30/05 for Exelon 6 mg 1 po two times a day (bid). The September 2007 MAR documented the Exelon 6 mg was scheduled to be administered at 8:00 a.m. and 8:00 p.m. daily.</p> <p>On 9/12/07 at 7:38 p.m. during the 8:00 p.m. medication pass, LPN #1 administered the resident's 8:00 p.m. medications, but did not administer the Exelon 6 mg.</p> <p>4. Resident #3 had a physician order dated 3/8/06 for Risperdal 0.25 mg 1 bid. The September 2007 MAR documented the Risperdal 0.25 mg was scheduled to be administered at 8:00 a.m. and 8:00 p.m. daily.</p> <p>On 9/12/07 at 7:38 p.m. during the 8:00 p.m. medication pass, LPN #1 administered the resident's 8:00 p.m. medications, but did not administer the Risperdal 0.25 mg.</p>	F 332			

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F 332	Continued From page 2 5. Resident #2 had a physician order dated 8/14/07 for Pred-Forte 1% Suspension 1 drop to the left eye four times a day (qid) for 4 weeks then bid for 2 weeks. a. On 9/12/07 at 8:00 p.m., LPN #2 administered Pred-Forte 1% suspension, 1 drop to the resident's left eye. The LPN did not shake the ophthalmic suspension before it was administered. b. The manufacturer's label on the Pred-Forte suspension documented: "Shake Well." 6. Resident #4 had a physician order dated 7/10/07 for Colace 100 mg 1 po at bedtime. The September 2007 MAR documented the Colace 100 mg was scheduled to be administered at 8:00 p.m. each evening. On 9/12/07 at 8:17 p.m. during the 8:00 p.m. medication pass, LPN #2 administered all of the resident's scheduled 8:00 p.m. medications with the exception of the Colace 100 mg.	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: Complaint #12776 was substantiated (all or in part) with these findings. Based on observation, record review and interview, facility failed to ensure physician orders were followed in order to prevent significant medication errors for 1 (Resident #3) of 5 case	F 333			

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F 333	<p>Continued From page 3</p> <p>mix residents with physician orders for medication administration (Residents #1 through #5). The failed practice had the potential to affect 82 residents who received medications, as identified by the Interim Administrator on 9/12/07. The findings are:</p> <p>Resident #3 had a diagnosis of Diabetes Mellitus and a physician order dated 6/30/05 for Glucophage XR (Extended-release formulation) 500 milligrams (mg) 1 tablet by mouth (po) daily every evening.</p> <p>a. On 9/12/07 at 7:38 p.m. during the 8:00 p.m. medication pass, Licensed Practical Nurse (LPN) #1 administered regular Glucophage 500 mg. to the resident, instead of Glucophage XR as ordered by the physician.</p> <p>b. On 9/13/07 at 11:10 a.m., the Interim Director of Nursing (DON) stated, "As far back as 2/11/05, the Glucophage [order] was XR."</p> <p>c. On 9/13/07 at 11:10 a.m., the bubble pack of Glucophage for this resident had a label dated 8/15/07. Twenty-seven of the tablets had been removed and administered to the resident. The tablets were regular Glucophage, instead of Glucophage XR.</p> <p>d. This medication error was significant due to the frequency of the error and the classification of the drug, which was an antidiabetic medication.</p>	F 333			