

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

PRINTED: 07/28/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045267</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/30/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEGACY HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3310 NORTH 50 STREET</b> <b>FORT SMITH, AR 72904</b>	
(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 333 SS=E	<p>Complaint #11805 was unsubstantiated.</p> <p>483.25(m)(2) MEDICATION ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation of the 6:30 a.m. medication pass on 6/29/06, record review and interview, the facility failed to ensure Physician orders were followed to ensure that residents were free of significant medication errors. 1 (Resident #6) of 6 case-mix residents observed during the medication pass was found to have a significant medication error. A significant medication error was made by 1 (Licensed Practical Nurse [LPN] #1) of 5 Nurses observed during the medication pass. This failed practice had the potential to affect 14 residents who receive medications from this nurse, according to a list provided by the acting Director of Nurses on 6/30/06 at 11:26 a.m. The findings are:</p> <p>1. Resident #6 was admitted to the facility on 5/8/06 and had diagnoses of Non-Insulin Dependent Diabetes and Vertigo. The Minimum Data Set dated 5/26/06 documented the resident had severely impaired cognitive skills for daily decision making.</p> <p>a. A Physician order dated 5/8/06 documented Glipizide 5 mg. (milligrams) tabs 2 po (by mouth) q (every) am and Glipizide 5 mg 1 po q p.m.</p>	F 333		7/30/06

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 333	<p>Continued From page 1</p> <p>b. On 6/29/06 at 6:25 a.m., LPN #1 administered Glipizide 5 mg. 1 tablet to the resident.</p> <p>c. On 6/29/06 at 2:30 p.m., the Pharmacy Tech stated, "We dispensed 60 tablets [Glipizide 5 mg] on 5/9/06 and 60 tablets on 6/5/06, a total of 120 tablets."</p> <p>d. On 6/29/06 at 1:30 p.m., during reconciliation of the 6:30 a.m. medication pass a blister pack dated 5/9/06, from the morning medication administration cart, contained 17 Glipizide 5 mg tablets; 13 spaces were empty where tablets had been punched out of the card.</p> <p>Another blister pack dated 6/5/06, from the morning medication administration cart, contained 24 Glipizide 5 mg tablets; 6 spaces were empty where tablets had been punched out of the card.</p> <p>On 6/29/06 at 2:55 p.m., a blister pack dated 6/5/06, from the evening medication cart, contained 7 Glipizide 5 mg tablets; 23 spaces were empty where tablets had been punched out of the card.</p> <p>e. Of the 120 tablets sent by the pharmacy, there were still 48 tablets remaining in the resident's blister packs. The resident had been administered 72 tablets since admission on 5/8/06, but should have been administered approximately 152 tablets since admission; a difference of 80 tablets the resident did not receive as ordered.</p> <p>f. This was a significant medication error due to the frequency of the error and the antidiabetic agent classification of the drug.</p>	F 333			