

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

PRINTED: 07/18/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2008
NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE SEARCY, AR 72143	
(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 Complaint # 13551 substantiated (all or in part) with deficiency cited at F312. Complaint # 13506 substantiated (all or in part) with deficiencies cited at F312 and F329. Complaint #13638 was unsubstantiated.	F 000		
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Complaint # 13551 and # 13506 substantiated all or in part by these findings. Based on observation, interview and record review, the facility failed to ensure that planned interventions were implemented during feeding to minimize the risk for aspiration for 1 (Resident # 7) and failed to ensure resident's dentures were in place during a meal for 1 (Resident # 1) of 4 (Resident #'s 1-3 and 7) case mix residents who were dependent on staff for eating. The facility failed to ensure all areas were cleansed during incontinent care for 2 (Resident # 2 and #5) and failed to provide incontinent care after each episode of urinary incontinence for 1 (Resident # 4) of 6 (Resident #'s 1-5 and 7) case mix residents who were incontinent of bladder and/or bowel. The failed practices had the potential to affect 40 residents who required assistance with eating and 104 residents who required assistance	F 312		

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 312	Continued From page 1 with incontinent care as identified by lists provided by the Director of Nursing on 7/2/08. The findings are: 1. Resident # 7 had diagnoses of Alzheimer's Disease and Feeding Problem. The Minimum Data Set (MDS) dated 6/18/08 documented the resident had severely impaired cognitive skills for daily decision making, was dependent on staff for eating and had chewing problems. a. The Plan of Care dated 6/8/08 documented, "Total assist. Practice safety precautions during care". b. On 7/1/08 at 7:30 a.m., a sign posted on the wall above the head of the bed documented, "Patient up at 90 degree angle for all PO (oral) intake. Hold head up with slight chin down posture during feeding. Provide verbal/tactile cues to increase timely swallow. Provide oral care after all meals. No straws. The paper was dated 5/15/08 and was signed Speech Therapy. c. On 7/1/08 at 7:45 a.m., CNA (Certified Nursing Assistant) #3 was feeding the resident. The head of the bed was elevated approximately 45 degrees or less. There was no pillow behind the resident's head and the resident ' s head was tipped back with the chin up. The resident was drinking the milk and juice offered through a straw. The resident cleared her throat and coughed frequently during the meal. When the meal was completed, the CNA left the room without providing oral care for the resident. d. On 7/2/08 at 12:30 p.m., the resident's daughter stated she had brought the instructions back to the facility with her when the resident	F 312			

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F 312	Continued From page 2 returned from the hospital. She stated the resident had gotten choked while eating in the hospital and they had Speech Therapy evaluate her. She stated she discussed the feeding instructions with the resident's nurse and was instructed by the facility to post them on the wall in the resident's room so the CNAs would be aware of safe feeding techniques. 2. Resident # 1 had diagnoses of Alzheimer's Disease and Cerebrovascular Accident (CVA). The MDS dated 5/15/08 documented the resident had moderately impaired cognitive skills for daily decision making, was dependent on staff for transfers, required extensive assistance with Activities of Daily Living and received Hospice care. a. The Plan of Care dated 5/15/08 documented, "At risk for weight loss, depression and overall decline due to cancer process. Diet per orders. Observe intake. Will encourage food preferences within diet." b. On 7/1/08 at 7:50 a.m., CNA # 1 brought the resident's breakfast tray into the room. The resident stated he just wanted a piece of toast and jelly. The CNA stated, "This toast is too hard (and rapped it against the side of the plate), I'm just going to feed him his (Raisin Bran) cereal. A handwritten sign above the head of the resident's bed read, "Please put [name of resident]'s teeth in and at night take them out." The resident was not wearing his dentures. The upper and lower plate dentures were in a cup in the bathroom. The CNA was asked if he would be able to eat better if he had his teeth in and the CNA stated, "Probably, but the night shift is supposed to put them in and they didn't". The CNA did not	F 312			

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F 312	<p>Continued From page 3</p> <p>attempt to put the resident's teeth in at any time during the breakfast meal. The resident consumed less than 25 % of the meal.</p> <p>3. The Policy and Procedure for Assisting the resident with in room meals provided by the Director of Nursing on 7/2/08 documented, "Provide mouth care as necessary. If dentures are worn, assist resident in inserting them. The resident should be positioned so his or her head and upper body are as upright as possible and with the head tipped slightly forward. If the resident is served in bed, use wedges and pillows to achieve a nearly upright position. Be alert to the dangers of residents choking while they are eating".</p> <p>4. Resident #2 had diagnoses of Abdominal Aortic Aneurysm, Osteoarthritis, Alzheimer's Disease, and Muscle Weakness. The quarterly MDS dated 4/9/08 documented the resident had severely impaired cognitive skills for daily decision making, had multiple daily episodes of bladder incontinence, was incontinent of bowel all of the time, and was totally dependent on two or more staff members for incontinent pad changes and cleansing.</p> <p>a. The Plan of Care dated 4/9/08 documented, "Problem: Resident is at risk for skin breakdown and [Urinary Tract Infection] [due to] incontinence of [bowel and bladder]. ... Approaches: ... Incont (incontinent) care after each incont episode with protective barrier as needed and q (every) 2 hrs (hours)."</p> <p>b. On 6/30/08 at 6:05 p.m., CNA #4 and CNA #5 entered the room to get the resident ready for supper. CNA #5 checked the resident's</p>	F 312			

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F 312	Continued From page 4 incontinent brief and stated, "He's wet." The resident was rolled to the right side and CNA #5 cleansed the peri-rectal area and left buttock. The wet incontinent brief was rolled inward toward the resident. The resident was turned supine and CNA #4 cleansed the penis and scrotum area. The resident was rolled to the left side; the soggy incontinent brief was removed, and a clean incontinent brief was tucked under the resident's hip. The resident was turned supine and the new incontinent brief was fastened around the waist. The right buttock and hip that had been lying on the soggy incontinent brief was not washed. c. On 6/30/08 at 6:30 p.m., CNA #4 was asked, "Did you wash the resident's right buttock?" CNA #4 stated, "No, I was concentrating on cleaning his front side." 5. Resident #4 had diagnoses of Fractured Humerous, Fractured Femur, Dementia with Behaviors, and Cerebrovascular Accident. The initial MDS dated 5/22/08 documented the resident had moderately impaired cognitive skills for daily decision making, had multiple daily episodes of bladder incontinence, daily bowel incontinence, and was totally dependent on one staff member for incontinent pad changes and cleansing. a. The Plan of Care dated 5/22/08 documented, "Problem: Resident is at risk for complications d/t (due to) incont of B&B (bowel and bladder). ... Approaches: Incont care q 2 hrs and prn (as needed)." b. On 6/30/08 at 4:06 p.m., the resident was lying in the bed in the room. CNA #5 entered the resident's room and stated, "I'm going to take you	F 312			

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F 312	<p>Continued From page 5</p> <p>to the bathroom." The resident was ambulated to the bathroom by CNA #5. The resident's pants and incontinent brief were pulled down. CNA #5 stated, "We're going to have to change this." CNA #5 was asked, "Is this (incontinent brief) wet?" CNA #5 stated, "Yes." CNA #5 pulled the soggy incontinent brief down the resident's legs while the resident sat on the toilet. A new incontinent brief was placed over the resident's feet and slid up the legs, then the pants were placed on the resident's lower legs. The resident was handed a roll of toilet paper. The resident took a piece of toilet paper approximately 8 inches long, folded the paper, then wiped the labia area once. CNA #5 then stood the resident up, pulled up the dry incontinent brief, and then pulled the resident's pants in place. The CNA did not cleanse the resident's skin, inner labia, or meatus that had been in contact with the soggy incontinent brief. As the resident was ambulated by CNA #5 back to the room, a package of "Prevail Wash Cloths" was on a nightstand outside the bathroom door. CNA #5 took one of the cloths out of the package and wiped the resident's hands. CNA #5 was asked, "What are those for?" CNA #5 stated, "We use them to clean, you know, bottoms."</p> <p>6. Resident # 5 had diagnoses of Cerebrovascular Accident and Congestive Heart Failure. The MDS dated 05/21/08 documented the resident had modified independence in cognitive skills for daily decision-making, was incontinent of bowel and bladder and required extensive assistance from staff for toileting and personal hygiene.</p> <p>a. The Care Plan dated 05/21/08 documented: Problem: Resident at risk for complications due to</p>	F 312			

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F 312	Continued From page 6 bowel and bladder incontinence. Approach: Provide incontinent care every 2 hours and as needed after each incontinent episode. b. On 07/01/08 at 1:40 p.m., the resident was lying in bed on her back. CNA # 6 and CNA # 7 was observed providing incontinent care for the resident. CNA # 6 lowered the front part of the resident brief. CNA #7 cleansed the front pubic/labia area with 1 wipe. Using a clean wipe the CNA cleansed the right groin area and with a clean wipe cleansed the left groin area. The CNA the spread and cleansed the inner labia and meatus with 1 wipe. The resident was then positioned on her right side and CNA # 7 cleansed the rectal area. A dark brown stain was on the wipe that was used to cleanse the rectal area. CNA # 7 then cleansed the left buttock and rectal area again. The resident was positioned on her back and CNA # 6 removed the wet brief that was soiled with a dark brown stain. The CNAs positioned the resident on her left side and a clean brief was placed and secured on the resident. While incontinent care was provided the resident right buttock was never cleansed and urine was left on her skin.	F 312			
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. This REQUIREMENT is not met as evidenced by:	F 323			

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F 323	<p>Continued From page 7</p> <p>Rohde, Freda K</p> <p>Based on observation, interview and record review, the facility failed to ensure that a resident was cognitively and physically able to assist in the use of the Sara 2000 mechanical lift as per manufacturers recommendations for 1 (Resident # 2) of 4 (Resident #'s 1, 2, 5, and 7) case mix residents who required mechanical lift transfers. The facility failed to ensure that a sensor pad alarm was implemented according to the plan of care for 1 (Resident # 4) of 4 (Resident #'s 1-4) case mix residents who had physician orders for a sensor alarms and a history of falls. The failed practices had the potential to affect 41 residents requiring mechanical lift transfers and 55 residents requiring alarms according to lists provided by the Director of Nursing on 7/2/08. The findings are:</p> <p>1. Resident #2 had diagnoses of Abdominal Aortic Aneurysm, Osteoarthritis, Alzheimer's Disease, and Muscle Weakness. The quarterly Minimum Data Set (MDS) dated 4/9/08 documented the resident had severely impaired cognitive skills for daily decision making and was totally dependent on one staff member for transfers.</p> <p>a. On 6/30/08 at 6:05 p.m., Certified Nursing Assistant (CNA) #4 and CNA #5 entered the room to get the resident ready for supper. CNA #5 left the room and returned with a Sara 2000 Lift, a mechanical sling lift. CNA #4 and CNA #5 swiveled the resident into a sitting position on the side of the bed. CNA #4 supported the resident in a seated position, while CNA #5 positioned a sheepskin sling around the resident's lower back and fastened the safety belt around the resident's waist. CNA #5 straightened the resident's legs</p>	F 323			

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F 323	Continued From page 8 out and placed the resident's feet on the foot rest of the mechanical lift. The resident did not hold to the bars of the mechanical lift. The lift was raised by CNA #5. As the lift elevated the resident from the bed, the resident stated, "Whoa, Hey," and lifted both feet off the foot rest of the mechanical lift, as the sling slid up the resident's back and caught under both armpits. Both arms were thrust upward and the weight of the resident was supported by the resident's armpits, upper back and upper arms. No support was given to the arms to lower them or to lower the sling on the back of the resident. The resident's legs were bent at the knees, and the knees were resting against the frame of the lift above the knee rest area. With the resident dangling by the upper arms, the lift was moved across the room to the wheelchair, and the resident was lowered into the wheelchair. CNA #5 stated, "This lift is a lifesaver. We use it on everyone who can kinda stand." b. The Sara 2000 instruction manual provided by the Director of Nursing (DON) on 7/2/08 at 11:05 a.m. documented, "... F. ... 11. Residents who have suffered a "stroke", who can only hold with one hand, or residents who cannot hold on at all may still be lifted by the Sara 2000, but it will be necessary for the attendant, (or a second attendant) to hold the resident's arm/arms down in front of the body during the lift. Note: Only use this method after a satisfactory professional assessment has been carried out on the individual resident. Note: residents wearing nylon nightclothes/ dressing gowns are prone to be "slippery" - the sling may ride up the back causing slight pressure under the arms. It may be necessary to hold the sling in position when lifting or lowering."	F 323		

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F 323	Continued From page 9 c. On 7/2/08 at 11:40 a.m., the DON was asked, "How do CNA's know which lift to use on a resident?" The DON stated, "It should be documented on the ADL (Activities of Daily Living) plan for the CNAs " The "Plan of Care Kardex" [no date] for the CNAs documented, "Transfer: Assistance of 2." No documentation of the use of a lift was on the plan. The DON stated, "Then it must be on the ADL sheet." The June 2008 ADL sheet was reviewed, and no documentation of the type of transfer was noted. The DON stated, "Sometimes the aides keep their own notebook. They assess the resident and write down whether they need total assist; whether they're mobile or not." The Assistant Director of Nursing (ADON) was asked, "Who assesses residents for the use of a mechanical lift, and which lift would be appropriate?" The ADON stated, "We assess residents when they are admitted and document." The ADON was asked, "Do you assess the resident for the type of lift, which sling, and the size of the sling?" The ADON stated, "No." The ADON was asked, "For the use of the Sara 2000 with a sit to stand sling, should a resident be cognitive enough to hold to the lift bars?" The ADON stated, "Yes." 2. Resident #4 had diagnoses of Fractured Humerus, Fractured Femur, Dementia with Behaviors, and Cerebrovascular Accident. The initial MDS dated 5/22/08 documented the resident had moderately impaired cognitive skills for daily decision making, had an unsteady gait and had fallen within the past 30 days. a. Physician's Orders dated 5/12/08 documented, "Pull type alarm to w/c (wheelchair). Check fxn (function) and placement q (every	F 323			

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F 323	<p>Continued From page 10 shift. Sensor alarm to bed. Check fxn and placement q shift. ..."</p> <p>b. The Plan of Care dated 5/13/08 documented, "Problem: Resident is at risk for falls d/t (due to [history] of falls with fxs and the use of antianxiety Ativan prn (as needed) and antidepressant Lexapro. Approaches ... Pull type alarm in w/c and sensor alarm to bed. Check function and placement q shift and prn"</p> <p>c. On 6/30/08 at 4:06 p.m., the resident was in the bed in the room. CNA #5 entered to toilet the resident. The resident was ambulated to the bathroom by CNA #5. There was no alarm that sounded when the resident was raised off the bed. There was not a sensor alarm on the resident's bed.</p> <p>d. On 7/1/08 at 7:50 a.m., the resident was not in the room. The bed was made, and a sensor alarm was lying on top of the bedspread unconnected. The Assistant Director of Nursing (ADON) was in the hall outside the resident's room, and called to a CNA down the hall, "I found a sensor alarm for [resident's name] so we can get it put on the bed."</p> <p>e. On 7/1/08 at 8:00 a.m., an incident report was seen on the nursing desk that documented, "7/1/08 0230 (2:30 a.m.) Resident climbed out of bed. Side rails up - sat on floor. Pulled call light for assistance to bathroom. Gait steady. No visible injury. Able to move all extremities. No complaints of discomfort." The ADON was asked, "Did the resident fall last night?" The ADON stated, "Yes, well, she sat in the floor and put her shoes on to go to the bathroom. She didn't really fall, but we filled out an incident report</p>	F 323			

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F 323	Continued From page 11 anyway." The ADON was asked, "Did the resident have a sensor alarm on the bed.?" The ADON stated, "She had the chair alarm on, but she took it off. We've implemented the sensor alarm today."	F 323			
F 329 SS=E	483.25(I) UNNECESSARY DRUGS 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. 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. This REQUIREMENT is not met as evidenced by: Complaint # 13506 was substantiated (all or in part) with these findings: Based on observation, interview and record	F 329			

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F 329	Continued From page 12 review, the facility failed to ensure that gradual dose reductions were attempted or that documentation was provided in the clinical record as to why a dose reduction was clinically contraindicated for 1 (Resident #5) of 4 (Resident #'s 2, 4, 5, and 7) case mix residents receiving antidepressants and 1 (Resident # 1) of 4 (Resident #'s 1-4) case mix residents receiving antianxiety medications. The facility also failed to attempt to assess cause of behavior and develop/implement interventions that would decrease the need for antianxiety medications. These failed practices had the potential to affect 69 residents receiving antianxiety medications and 87 residents receiving antidepressant medications as identified by lists provided by the Director of Nursing on 7/2/08. The findings are: 1. Resident # 1 had diagnoses of Alzheimer's Disease and Cerebrovascular Accident (CVA). The MDS dated 5/15/08 documented the resident had moderately impaired cognitive skills for daily decision making, exhibited sad, pained, worried facial expressions, required extensive assistance with Activities of Daily Living, had fallen in the past 31-180 days, received antipsychotic, antianxiety and antidepressant medications 7 out of 7 days and received Hospice care. a. The Nurse's Note dated 4/1/08 and timed 1750 (5:50 p.m.) documented, "Ativan 1 mg given PO for increased anxiety. Trying to climb out of bed nervousness." b. The Nurse's Note dated 4/2/08 at 2000 (10:00 p.m.) documented, "Spoke with son. Concerned about resident's increased anxiety and does he need to get an order to have us get him up more often because he thinks he's "going crazy" lying in	F 329			

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F 329	<p>Continued From page 13</p> <p>bed. Told son that we will get him up as often as he wishes and we don't need an order. Stated I would pass on his concerns to nurse and DON (Director of Nursing)."</p> <p>c. The Hospice Nurse's Note dated 4/11/08 at 1315 (1:15 p.m.) documented, "Spouse called and stated husband is restless and trying to get out of bed. States Nursing Home called her to come see him and see if she could settle him down. Called LPN (Licensed Practical Nurse) for report - states had Ativan at 1300 (1:00 p.m.), 2 Percocet and an Albuterol updraft. Explained spouse wants anxiety medication given on schedule."</p> <p>d. The Physician's order dated 4/11/08 documented, "Ativan 1 mg. (milligram) tablet 1 PO (by mouth) q (every) 6 hours on schedule for anxiety."</p> <p>e. The Plan of Care dated 5/15/08 documented, "At risk for hypotension, balance disturbances, Adverse drug Reactions and drug interaction due to use of antianxiety med."</p> <p>f. The Consultant Pharmacist Communication form dated 5/22/08 documented, "The resident has been receiving Ativan 1 mg q 6 hr (hours) since 5/1/08. Anxiolytic medications may increase risk of confusion, sedation and falls. Please consider a dose reduction at this time to find the optimal dose for this resident or provide documented evidence why this dose is necessary to maintain or improve the resident's function or quality of life. As of 7/2/08, the physician had not addressed this request.</p> <p>g. On 7/1/08 at 7:20 a.m., the resident stated, "I</p>	F 329			

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F 329	<p>Continued From page 14</p> <p>want to get up for a few minutes. Can I? "CNA # 2 stated, "No, not right now."</p> <p>h. On 7/1/08 at 12:05 p.m., LPN # 2 entered the resident's room to administer Ativan. The resident asked, "Can I get up for a while?" The LPN stated, "No, someone has to watch you when you're up. Maybe when your family gets here."</p> <p>i. On 7/1/08 from 12:30 p.m. until 1:00 p.m., the resident's family was in the room visiting. The resident was in bed.</p> <p>j. On 7/1/08 at 1:30 p.m., the resident told Hospice RN (Registered Nurse) # 1, "They won't let me out of bed. Just 30 minutes, I would like to be out of bed for 30 minutes". RN # 1 stated, "You wiggle too much and might fall. You just need to rest"</p> <p>k. On 7/1/08 at 1:45 p.m., the Hospice RN stated, "The Ativan is scheduled four times a day to keep him from climbing out of bed."</p> <p>l. As of 7/3/08 no documentation could be found in the physician progress notes or physician order sheet to indicate a gradual dose reduction had been attempted for the Ativan. There was no risk versus benefit statement from the physician regarding the use of the medication to indicate why a dose reduction would be clinical contraindicated.</p> <p>2. Resident # 5 had diagnoses of Cerebrovascular Accident, Congestive Heart Failure, Anxiety State, and Depression. The Annual MDS dated 05/21/08 documented the resident had modified independence in cognitive</p>	F 329			

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F 329	Continued From page 15 skills for daily decision making and required antidepressant medication. a. The July 2008 Physician Order Sheet documented: Lexapro 10 mg (milligrams) one half tablet (5 mg) daily [order date 3/06/07] for Depressive Disorder. b. The Pharmacist Consultant Communication form dated 4/22/07 documented to the physician: "This resident has been receiving LEXAPRO 5 MG (milligram) QD (every day) since 03/06/07. Please consider tapering the dose of this medication or documenting in your progress notes why the benefits of continued use outweigh any and all potential risks." c. The Physician Response to the Pharmacist Consultant Communication dated 04/25/07 documented, "Please continue all medications." d. As of 7/2/08 no documentation could be found in the physician order sheet or progress notes to indicate a gradual dose reduction had been attempted for the Lexapro. There was no risk versus benefit statement from the physician regarding the use of the medication to indicate why a dose reduction would be clinically contraindicated.	F 329			
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514			

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F 514	<p>Continued From page 16</p> <p>resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure accurate clinical records were maintained to monitor the use of a Narcotic analgesic medication in order to evaluate effectiveness of pain management program and minimize the potential for diversion for 1 (Resident # 1) of 2 (Residents #1, and 4) case mix residents. The failed practice had the potential to affect 58 residents in the facility receiving PRN (as needed) narcotics as identified by a list provided by the Director of Nursing on 7/3/08. The findings are:</p> <p>Resident # 1 had diagnoses of Alzheimer's Disease and Cerebrovascular Accident (CVA). The Minimum Data Set dated 5/15/08 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance with Activities of Daily Living , had fallen in the past 31-180 days, experienced moderate pain less than daily and received Hospice care.</p> <p>a. The Physician's order dated 5/1/08 documented, "Percocet 5/325 mg (milligram) 1 PO (by mouth) q (every) 4 hours PRN (as needed) for breakthrough pain."</p> <p>b. The Medication Administration Record for June 2008 documented the resident received the Percocet 1 time in June on 6/20/08 at 4 p.m. for</p>	F 514			

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F 514	Continued From page 17 generalized pain. c. The Nurse's Note dated 6/4/08 documented Percocet was given at 1:00 p.m. for complaints of pain all over and the Nurse's note dated 6/5/08 documented Percocet was given at 1:30 p.m. for complaint of "I'm hurtin". There was no other documentation of the drug being administered in June in the nurse's notes or on the medication administration record. d. The Narcotic sign out sheet for Percocet documented the medication was signed out on 6/1/08 at 11:30 a.m., 6/4/08 at 11:30 a.m., 6/5/08 at 11:30 a.m. and 7:30 p.m., 6/8/08 at 9:00 a.m. and 2:00 p.m., 6/12/08 at 9:00 a.m., 6/13/08 at 7:00 p.m., 6/14/08 at 8:00 a.m. and 2:00 p.m., 6/15/08 at 2:00 p.m., 6/18/08 at 11:00 a.m., 6/19/08 at 11:30 a.m., 6/23/08 at 11:00 a.m., 6/24/08 at 1:00 p.m., 6/26/08 at 1:30 p.m., 6/28/08 at 11:00 a.m., 6/29/08 at 10:45 a.m. There was no documentation available to indicate why the medication was administered or the effectiveness of the medication for the relief of the resident ' s pain.	F 514			