

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

PRINTED: 05/02/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/25/2005</b>
NAME OF PROVIDER OR SUPPLIER  <b>SEARCY HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 SKYLINE DRIVE</b> <b>SEARCY, AR 72143</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  Complaint #10511, substantiated (all or in part) with deficiencies cited at F333 and F426  Complaint #10399, unsubstantiated.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS  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.  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).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated	F 225		9/19/05

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	<p>Continued From page 1</p> <p>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> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and interview the facility failed to ensure an allegation of verbal abuse was thoroughly investigated, reported to the Office of Long Term (OLTC) and local law enforcement for 1 (Resident #3) who was allegedly verbally abused. This failed practice had the potential to affect 181 resident currently residing in the facility as per the Roster Matrix furnished by the facility on 8/22/05. The findings are:</p> <p>1. Resident #2 had diagnoses of Depressive Disorder. The Quarterly Minimum Data Set (MDS) dated 8/10/05 documented the resident had no short/long term memory problems, was independent in cognitive skills for daily decision making skills and was dependent on staff for activities of daily living with the exception of eating and she required set up help only.</p> <p>2 . Resident #3 had diagnoses of Neurotic Disorders and Cerebral Palsy. The Annual MDS dated 4/13/05 and the Quarterly MDS dated 7/11/05 documented the resident had short/long term memory problems, was severely impaired in cognitive skills for daily decision making, had a sad, pained worried facial expression up to 5 days per week and repetitive physical movements daily that were easily altered and was totally</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>dependent on staff for all activities of daily living.</p> <p>a. Resident #2 [mother] and Resident #3 [son] lived in the same room until 7/15/05 when the facility moved the son to another room on 500 hall.</p> <p>b. Nurses notes from Resident #2's record dated 7/7/02 at 9:00 a.m. documented, "CNA (Certified Nursing Assistant) reported that r (resident) had stated she wanted son removed from room for the day so she could sleep. R stated she needed tape to tape his mouth shut for awhile. Explained to r that son had to remain in room until he could be supervised as he requires. R now resting quietly. No trouble resting noted. Will cont (continue) to monitor."</p> <p>c. A letter dated 7/10/05 signed by the mother (Resident #2) and 2 witnesses documented, " I acknowledge that I have been provided a copy of the Resident's Rights on this day and have been counseled that my son, [Resident #3] is entitled to all the rights listed. I have been encouraged to view my parental role in my son's life as one of encourage and maximize his health and emotional well-being. I further acknowledge that I have been cautioned against restricting my son's rights or well being in any manner, which includes seclusion, name-calling, yelling, threatening statements, and physical aggression,. I have been counseled that any verbal or physically abusive behaviors could result in my son being placed in an alternate room."</p> <p>d. Resident #3's care plan comments/concerns form dated 7/15/05 documented Concerns: "Re-concerns of verbal abuse from mother [Resident #2] toward son [Resident #3] who was</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>sharing a room with resident. Family &amp; (and) staff had overheard [mother had also stated to others] that she needed "some duct tape to put on his mouth to keep him quite." Facility concern re: general cleanliness of room. Mother's [Resident #2] monopolizing the TV entire time &amp; generally yelling at son all of the time. [Resident #3] son has seemed to be withdrawn &amp; keeps his head covered most of the time." General discussion of mothers violation of son's rights. Plan to move [Resident #3] son to another room with different roommate - i.e.: back to room where he was prior to his mothers admission to this facility. [name of business office manager] will pursue Legal Guardian Status."</p> <p>f. As of 8/22/05 there was no documentation in the nurses notes, social service notes, activities notes or plan of care of the verbal abuse alleged in the plan of care meeting.</p> <p>g. On 8/22/05 at 3:15 p.m., the social worker for this resident stated that on 7/15/05 the Business office Manager called her and said the Nurse consultant wanted an Emergency Care Plan Meeting. She stated that she was not in the meeting but was told prior to that of the issue with the television. She was also asked if she had ever witnessed the mother being abusive to the son and she stated, "No" She was asked "Do you have any knowledge of the mother abusing the resident and she stated, "Some of the aides have said things but it mostly comes for [name of business office manager].</p> <p>h. On 8/22/05 at 3:40 p.m., the Director of Nursing and Nurse consultant were asked for information regarding Resident #3 being moved. The Nurse consultant stated that he was moved</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>for his own protection. She was then asked for the evidence that the alleged abuse was investigated and that the resident was protected from further abuse before moving him on 7/15/05. She stated "You do not have to report when it is resident to resident." She was then asked for the internal investigation. At 4:05 p.m. after looking through the I (Incident) &amp; A's (Accident) reports the nurse consultant stated "Well that's it." She was asked "Did you find one?" and she stated, "No."</p> <p>i. On 8/23/05 at 8:45 a.m., the nurse consultant stated they could not find any documentation related to why the notice was given to the mother on 7/10/05 or that any alleged verbal abuse had been investigated or that the resident was protected from further abuse from 7/7/05 until 7/15/05 when he was moved from the room.</p> <p>j. On 8/23/05 at 11:00 a.m., CNA #1 was asked the following questions:</p> <p>1) Have you ever witnessed Resident #2 being abusive to Resident #3 and she stated, "Yes. One day I was in there taking care of her [Resident #2], he [Resident #3] was noisy &amp; she told me to put a sock in his mouth and duct tape it [mouth]. Another time, she told me to roll him out the sliding door so she could sleep. Another time she told him to shut up."</p> <p>4. "When did this occur and did you report it?" She stated, "She has been making these remarks for 2-3 months and I reported each one to my Charge Nurses."</p> <p>5. "Have you ever been asked to fill out a witness statement?" She replied " Only one and Social</p>	F 225			

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F 225	Continued From page 5 Worker has it." (Dated 1/6/05)	F 225			
F 226 SS=E	<p>483.13(c) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, and interview the facility failed to implement the abuse policy and procedure concerning an allegation of verbal abuse for 1 (Resident #3) by not ensuring an allegation of verbal abuse was thoroughly investigated, reported to the Office of Long Term (OLTC) and local law enforcement. This failed practice had the potential to affect 181 as per the Roster Matrix furnished by the facility on 8/22/05. The findings are:</p> <p>1. The facility Policy for Abuse documented the procedure as follows:</p> <p>"PROCEDURE: The facility shall take the following steps to prevent, detect and report</p>	F 226		9/19/05	

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F 226	<p>Continued From page 6</p> <p>abuse, neglect, injuries of unknown source and the misappropriation of resident property ("alleged violations").</p> <p>PROTECTIONS: a. If the circumstances require it, the DNS (Director of Nursing Services) or his/her designee shall remove as [a] resident suspected of being the subject of an alleged violation to an environment where the residents's safety can be protected. If the suspected perpetrator is another resident, the DNS shall separate the residents so they do no have access to each other until the circumstances of the alleged incident can be determined. Where the circumstances of the alleged violation warrants, the DNS or his/her designee shall initiate a physical and mental assessment of the resident and document, no assumptions. The DNS shall also notify the attending physician regarding the alleged violations and findings and document contact.</p> <p>REPORTING: Any associate who suspects an alleged violation shall immediately notify the ED (Executive Director) or his/her designee. The ED shall also notify the appropriate state agency in accordance with state agency in accordance. The results of all investigations must be reported to the ED or his/her designee and to the appropriate stated agency as required by state law, with in five (5) working days of the alleged violation.</p> <p>INVESTIGATION: All investigations shall be conducted by the ED or DNS. In the event an alleged violation occurs when neither of these people are in the facility, the charge nurse is responsible for initiating the investigation procedure. The investigation shall include</p>	F 226			

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F 226	<p>Continued From page 7</p> <p>interviews of associates, visitors, or residents who may have knowledge of the alleged incident. The documentation of the investigation shall be kept in the ED office in an administrative file. Federal law requires the facility to have evident of investigation of alleged violations. The attached "Verification of Investigation" form shall be completed after the investigation is complete and provide to survey agencies when requested or required by state or federal law. "</p> <p>2. Resident #2 had diagnoses of Depressive Disorder. The Quarterly Minimum Data Set (MDS) dated 8/10/05 documented the resident had no short/long term memory problems, was independent in cognitive skills for daily decision making skills and was dependent on staff for activities of daily living with the exception of eating and she required set up help only.</p> <p>3 . Resident #3 had diagnoses of Neurotic Disorders and Cerebral Palsy. The Annual MDS dated 4/13/05 and the Quarterly MDS dated 7/11/05 documented the resident had short/long term memory problems, was severely impaired in cognitive skills for daily decision making, had a sad, pained worried facial expression up to 5 days per week and repetitive physical movements daily that were easily altered and was totally dependent on staff for all activities of daily living.</p> <p>a. Resident #2 [mother] and Resident #3 [son] lived in the same room until 7/15/05 when the facility moved the son to another room on 500 hall.</p> <p>b. Nurses notes from Resident #2's record dated 7/7/02 at 9:00 a.m. documented, "CNA (Certified Nursing Assistant) reported that r (resident) had</p>	F 226			

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F 226	<p>Continued From page 8</p> <p>stated she wanted son removed from room for the day so she could sleep. R stated she needed tape to tape his mouth shut for awhile. Explained to r that son had to remain in room until he could be supervised as he requires. R now resting quietly. No trouble resting noted. Will cont (continue) to monitor."</p> <p>c. A letter dated 7/10/05 signed by the mother (Resident #2) and 2 witnesses documented, " I acknowledge that I have been provided a copy of the Resident's Rights on this day and have been counseled that my son, [Resident #3] is entitled to all the rights listed. I have been encouraged to view my parental role in my son's life as one of encourage and maximize his health and emotional well-being. I further acknowledge that I have been cautioned against restricting my son's rights or well being in any manner, which includes seclusion, name-calling, yelling, threatening statements, and physical aggression,. I have been counseled that any verbal or physically abusive behaviors could result in my son being placed in an alternate room."</p> <p>d. Resident #3's care plan comments/concerns form dated 7/15/05 documented Concerns: "Re-concerns of verbal abuse from mother [Resident #2] toward son [Resident #3] who was sharing a room with resident. Family &amp; (and) staff had overheard [mother had also stated to others] that she needed "some duct tape to put on his mouth to keep him quite." Facility concern re: general cleanliness of room. Mother's [Resident #2] monopolizing the TV entire time &amp; generally yelling at son all of the time. [Resident #3] son has seemed to be withdrawn &amp; keeps his head covered most of the time." General discussion of mothers violation of son's rights. Plan to move</p>	F 226			

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F 226	<p>Continued From page 9</p> <p>[Resident #3] son to another room with different roommate - i.e.: back to room where he was prior to his mothers admission to this facility. [name of business office manager] will pursue Legal Guardian Status."</p> <p>f. As of 8/22/05 there was no documentation in the nurses notes, social service notes, activities notes or plan of care of the verbal abuse alleged in the plan of care meeting.</p> <p>g. On 8/22/05 at 3:15 p.m., the social worker for this resident stated that on 7/15/05 the Business office Manager called her and said the Nurse consultant wanted an Emergency Care Plan Meeting. She stated that she was not in the meeting but was told prior to that of the issue with the television. She was also asked if she had ever witnessed the mother being abusive to the son and she stated, "No" She was asked "Do you have any knowledge of the mother abusing the resident and she stated, "Some of the aides have said things but it mostly comes for [name of business office manager].</p> <p>h. On 8/22/05 at 3:40 p.m., the Director of Nursing and Nurse consultant were asked for information regarding Resident #3 being moved. The Nurse consultant stated that he was moved for his own protection. She was then asked for the evidence that the alleged abuse was investigated and that the resident was protected from further abuse before moving him on 7/15/05. She stated "You do not have to report when it is resident to resident." She was then asked for the internal investigation. At 4:05 p.m. after looking through the I (Incident) &amp; A's (Accident) reports the nurse consultant stated "Well that's it." She was asked "Did you find one?" and she stated,</p>	F 226			

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F 226	<p>Continued From page 10</p> <p>"No."</p> <p>i. On 8/23/05 at 8:45 a.m., the nurse consultant stated they could not find any documentation related to why the notice was given to the mother on 7/10/05 or that any alleged verbal abuse had been investigated or that the resident was protected from further abuse from 7/7/05 until 7/15/05 when he was moved from the room.</p> <p>j. On 8/23/05 at 11:00 a.m., CNA #1 was asked the following questions:</p> <p>1) Have you ever witnessed Resident #2 being abusive to Resident #3 and she stated, "Yes. One day I was in there taking care of her [Resident #2], he [Resident #3] was noisy &amp; she told me to put a sock in his mouth and duct tape it [mouth]. Another time, she told me to roll him out the sliding door so she could sleep. Another time she told him to shut up."</p> <p>4. "When did this occur and did you report it?" She stated, "She has been making these remarks for 2-3 months and I reported each one to my Charge Nurses."</p> <p>5. "Have you ever been asked to fill out a witness statement?" She replied " Only one and Social Worker has it." (Dated 1/6/05)</p> <p>k. On 8/24/05 at 11:45 a.m., CNA #2 was asked if she had witnessed the mother being abusive to the son? She stated she was in the room when the mother stated, "I done threw a book at him &amp; points to grabber &amp; says if I could have hit him with that I would have." She went on to say that she believed it to be true because a book was on the floor and she had reported this to the social</p>	F 226			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/25/2005</b>
NAME OF PROVIDER OR SUPPLIER  <b>SEARCY HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 SKYLINE DRIVE</b> <b>SEARCY, AR 72143</b>		
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F 226	Continued From page 11 worker and it occurred over a week before they moved him.	F 226			
F 250 SS=H	483.15(g)(1) SOCIAL SERVICES  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interview, the facility failed to assess causative factors for increased depression and behavioral symptoms and develop/implement effective interventions for 1 case mix resident (Resident # 2) who had identified indicators of depression and who later developed behavioral symptoms after loss of guardianship of her son. This failed practice resulted in actual harm to Resident #2 and had the potential to affect 152 residents who had a history of depression according to the Roster Matrix received 8/22/05. The findings are:  Resident #2 was admitted to the facility on 5/8/04 and had diagnoses of Hypertension, Degenerative Disc Disease and Depressive Disorder. The Annual Minimum Data Set (MDS) dated 5/12/05 documented the resident was independent in cognitive skills for daily decision-making, had depression indicators of sad, pained, worried facial expressions, crying and tearfulness exhibited up to 5 days a week that were easily altered; had no behavioral symptoms and received an antidepressant medication.	F 250		9/19/05	

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F 250	Continued From page 12  a. Nurse notes dated 5/12/04 documented the resident shared a room with her 51 year old son (Resident #3). The Admission Information form documented Resident #3 was admitted to the facility on 8/5/97 with a diagnosis of Cerebral Palsy. Resident #3's legal guardian was his mother, Resident #2.  b. A Physician's order dated 06/07/05 documented Ativan 0.5 mg Give 1 PO (by mouth) Q (every) 8 HRS (hours) PRN (as needed) Anxiety.  c. A Petition for Appointment of Guardian of the Person and Estate was filed in the Circuit of XXX County on 6/10/05 for Resident #3 by a non-family member who was an employee of the facility.. There was no documentation to indicate the exact date that Resident # 2 was notified of the intent to petition or the filing of the petition.  d. A statement signed by Resident #2 on 7/10/05 documented, "...I further acknowledge that I have been cautioned against restricting my son's rights or well-being in any manner... I have been counseled that any verbal or physically abusive behaviors could result in my son being placed in an alternate room."  e. The Nurses's Note dated 07/15/05 and timed 1000 (10 a.m.) documented "[Name of PCP (Primary Care Physician)] made rounds and no new orders given."  f. Nurses notes for Resident #3 dated 7/15/05 at 2:45 p.m. documented, "Care plan team met & (and) agreed that [resident] will be moved to another rm (room) to facilitate activities & conflict	F 250			

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F 250	<p>Continued From page 13</p> <p>[with] rmmate over TV. Mother controlling TV in rm &amp; not wanting any noise in rm. Moved to XXX room."</p> <p>g. A physician order dated 7/15/05 at 3:30 p.m. documented, "Ativan 2 mg (milligrams) PRN (as needed) Anxiety" which was a 4 times increase in the strength of the Anti-anxiety medication. There was no documentation in the clinical record as to why the physician was contacted and the dose for the Ativan was increased.</p> <p>h. Nurses Note, with no date but with a time of 11:00 a.m. documented, "Resident is very dissatisfied with current situation. Foster-daughter questioned son's removal from mother's room into another room. Referred her to social services and explained that the decision was made in the resident's [Resident #3] best interest."</p> <p>i. Nurses Note dated 7/30/05 at 12:15 p.m. documented, "Resident crying and c/o (complains of) leg pain. Appite (sic) poor today. refusing lunch tray. She states quote 'I want my son back.' DCN 100 1 po (by mouth) and Ativan 0.5 mg 1 po given per request. Will continue to monitor."</p> <p>j. The Quarterly MDS dated 8/5/05 documented a decline in the resident's psychosocial status with depression indicators that were not easily altered and a new behavior of resisted care.</p> <p>k. On 8/23/05 at 10:03 a.m., the Social Service Designee was asked the following questions:</p> <p>1) "What type of interventions are you doing to assist this resident through this difficult period"</p>	F 250			

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F 250	Continued From page 14 and she stated, "When she calls, I come down and talk to her about memories and the past. It gets her mind off of other things."  2) " Have you at any time made an appointment or referral to her psychiatrist to get her some help?" and she stated, "No, I haven't."  3) "Were you aware that her Anti-Anxiety medications had been increased?" and she stated, "No."  4) "Have you noticed any changes in her behavior since her son was moved out?" and she stated, "Yes. She is more tearful."  5. " At what point do you recommend a plan of care meeting or a referral?" Reply " If they talk about suicide, I would."  l. Nurses notes dated 8/23/05 at 10:15 a.m. documented, "TC (telephone call) made to Dr. [psychiatrist] in request for him to see [Resident #2] due to reports from staff on increased depression.  m. Psychiatric Evaluation dated 8/23/05 documented in current history "In her stressful environment without a room mate, reports is sad about failing health of son, sad he has been moved in a different room." In the space provided for plan documented, "...Also frustrated with court awarding guardianship of son. Trial of [increase] Cymbalta to 30 mg iii (3) PO q am [with] food. Monitor for ADE (adverse drug event), therapeutic benefit."	F 250		
F 319 SS=H	483.25(f)(1) MENTAL AND PSYCHOSOCIAL FUNCTIONING	F 319		9/19/05

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F 319	Continued From page 15  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interview, the facility failed to assess causative factors for increased depression and behavioral symptoms and develop/implement effective interventions to prevent a decline in the resident's mental/psychosocial status for 1 case mix resident (Resident # 2) who had identified indicators of depression and who later developed behavioral symptoms after loss of guardianship of her son. This failed practice resulted in actual harm to Resident #2 and had the potential to affect 152 residents who had a history of depression according to the Roster Matrix received 8/22/05. The findings are:  Resident #2 was admitted to the facility on 5/8/04 and had diagnoses of Hypertension, Degenerative Disc Disease and Depressive Disorder. The Annual Minimum Data Set (MDS) dated 5/12/05 documented the resident was independent in cognitive skills for daily decision-making, had depression indicators of sad, pained, worried facial expressions, crying and tearfulness exhibited up to 5 days a week that were easily altered; had no behavioral symptoms and received an antidepressant medication.	F 319		

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F 319	<p>Continued From page 16</p> <p>a. Nurse notes dated 5/12/04 documented the resident shared a room with her 51 year old son (Resident # 3). The Admission Information form documented Resident #3 was admitted to the facility on 8/5/97 with a diagnosis of Cerebral Palsy. Resident #3's legal guardian was his mother, Resident #2.</p> <p>b. A Physician's order dated 06/07/05 documented Ativan 0.5 mg Give 1 PO (by mouth) Q (every) 8 HRS (hours) PRN Anxiety.</p> <p>c. A Petition for Appointment of Guardian of the Person and Estate was filed in the Circuit of XXX County on 6/10/05 for Resident #3 by a non-family member who was an employee of the facility. There was no documentation to indicate the exact date that Resident # 2 was notified of the intent to petition or the filing of the petition.</p> <p>d. A statement signed by Resident #2 on 7/10/05 documented, "...I further acknowledge that I have been cautioned against restricting my son's rights or well-being in any manner....I have been counseled that any verbal or physically abusive behaviors could result in my son being placed in an alternate room."</p> <p>e. The Nurses's Note dated 07/15/05 and timed 1000 (10 a.m.) documented "[Name of PCP (Primary Care Physician)] made rounds and no new orders given."</p> <p>f. Nurses notes for Resident #3 dated 7/15/05 at 2:45 p.m. documented, "Care plan team met &amp; (and) agreed that [resident] will be moved to another rm (room) to facilitate activities &amp; conflict [with] rmmate over TV. Mother controlling TV in rm &amp; not wanting any noise in rm. Moved to XXX</p>	F 319			

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F 319	<p>Continued From page 17 room."</p> <p>g. A physician order dated 7/15/05 at 3:30 p.m. documented, "Ativan 2 mg (milligrams) PRN (as needed) Anxiety" which was a 4 times increase in the strength of the Anti-anxiety medication. There was no documentation in the clinical record as to why the physician was contacted and the dose for the Ativan was increased.</p> <p>h. Nurses Note, with no date but with a time of 11:00 a.m. documented, "Resident is very dissatisfied with current situation. Foster-daughter questioned son's removal from mother's room into another room. Referred her to social services and explained that the decision was made in the resident's [Resident #3] best interest."</p> <p>i. Nurses Note dated 7/30/05 at 12:15 p.m. documented, "Resident crying and c/o (complains of) leg pain. Appite (sic) poor today. refusing lunch tray. She states quote 'I want my son back.' DCN 100 1 po (by mouth) and Ativan 0.5 mg 1 po given per request. Will continue to monitor."</p> <p>Nurses Note at 1:15 p.m. documented, "Resident continues to cry stating she wants her son."</p> <p>j. The Quarterly MDS dated 8/5/05 documented a decline in the resident ' s psychosocial status with depression indicators that were not easily altered and a new behavior of resisted care.</p> <p>k. The Social Services Quarterly Progress Note dated 8/17/05 documented, "[Resident #2] does not have a roommate at this time due to the resident's son being moved to another room</p>	F 319			

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F 319	<p>Continued From page 18</p> <p>recently. The resident's son has a new guardian now which upsets this resident. [Resident #2] has become more tearful and often requests to have her son back in the room with her. Her son's new guardian does not want the resident and the son together due to her actions before he was moved. She was refusing to allow him to have his television on or would turn hers up loud over his. She wanted him to be quiet and would request staff to pull curtains to make it dark in the room for him to go to sleep. Resident is historically very pleasant and friendly, however since her son has been moved she has been more tearful, angry, and resistive to care. She has refused to allow them to change her at times even though she is wet. She refuses to get out of bed. No outside referrals are indicated at this time."</p> <p>I. On 8/22/05 at 8:00 p.m., a family interview was conducted with Resident # 2's family member. The family member stated, "My [family member] and I were in the facility when they had that care plan meeting and we didn't know anything about it. We had just gotten back home from there when [Resident # 2] called crying and said they had moved [Resident # 3] to another room. I called the facility and they told me [Resident #2] was saying mean things to him like 'I'm gonna jump down your throat and gallop your guts.' Our family always says that to each other. It's just something we say. [Resident # 2] has gone completely downhill since they moved him. She cries all the time and says "I want to die." The family member was asked if these statements had been reported to the facility staff and the family member stated, "She has said those things to staff in front of us so I know they know it. The staff don't have any sympathy for [Resident # 2]."</p>	F 319			

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F 319	<p>Continued From page 19</p> <p>Everybody is going along with [name of facility employee who is Resident # 3's new guardian]. They'll be asking us to move [Resident # 2] in another 2 or 3 weeks."</p> <p>m. The Care Plan dated 5/7/05 and updated on 8/7/05 did not identify the residents psychosocial adjustment difficulty of dealing with the loss of the resident's son as a roommate and did not document the initiation of interventions to assist this resident to cope with the adjustment.</p> <p>n. On 8/23/05 at 10:03 a.m., the Social Service Designee was asked the following questions:</p> <p>1) "What type of interventions are you doing to assist this resident through this difficult period" and she stated, "When she calls, I come down and talk to her about memories and the past. It gets her mind off of other things."</p> <p>2) " Have you at any time made an appointment or referral to her psychiatrist to get her some help?" and she stated, "No, I haven't."</p> <p>3) "Were you aware that her Anti-Anxiety medications had been increased?" and she stated, "No."</p> <p>4) "Have you noticed any changes in her behavior since her son was moved out?" and she stated, "Yes. She is more tearful."</p> <p>5. " At what point do you recommend a plan of care meeting or a referral?" Reply " If they talk about suicide, I would."</p> <p>o. Nurses notes dated 8/23/05 at 10:15 a.m. documented " TC [telephone call] made to Dr.</p>	F 319			

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F 319	Continued From page 20 [name of psychiatrist] in request for him to see [name of resident] due to reports from staff on increased depression.  p. Psychiatric Evaluation dated 8/23/05 documented in current history " In her stressful environment without a room mate, reports is sad about failing health of son, sad he has been moved in a different room." In the space provided for plan documented " Frustrated with court awarding guardianship of son and Trial of increase antidepressant to 90 mg in am with food- Monitor for ADE, therapeutic benefit."	F 319		
F 333 SS=J	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 #10511, substantiated (all or in part) in these findings.  Based on observation, record review and interview the facility failed to ensure the correct dose of medication was dispensed for 1 case mix resident (Resident #1) who received morphine for pain. This failed practice resulted in Immediate Jeopardy for Resident #1 and had the potential to affect only this one resident who received morphine according to the Director of Nursing on 8/22/05. The Immediate Jeopardy was removed and the scope/severity reduced to "E" when the resident expired on 8/17/05 and there were no other residents identified in immediate jeopardy at the time of the survey, but the underlying deficient practice remained uncorrected. The facility failed	F 333		9/19/05

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F 333	<p>Continued From page 21</p> <p>to ensure physician orders were followed for 1 case mix resident (Resident #2) who had a physician order for Ativan. This failed practice had the potential to affect 76 residents who received a psychoactive medication according to the Roster Matrix received 8/22/05. The findings are:</p> <p>Resident #1 had diagnoses of Malignant Neoplasm Skin/Arm, Diabetes with Ketoacidosis, Colon Cancer and Alzheimer's type Dementia. A Significant Change Minimum Data Set dated 8/10/05 documented the resident was moderately impaired in cognitive skills for daily decision-making and had no symptoms of pain.</p> <p>a. Nurses Notes dated 8/17/05 at 12:00 p.m., signed by RN (Registered Nurse) #1 documented, "resident has severe changes severe body jerking eyes dilated unresponsive to verbal question temp 98.1 Ax (axillary) B/P (blood pressure) 115/60 at best unable to be more accurate due to body jerking, color white notified brother and sister in law to see what they wanted done &amp; (and) they said to just leave him here &amp; try to keep him comfortable as much as we can. We are notifying hospice for medication for comfort."</p> <p>b. Nurses Notes dated 8/17/05 at 12:30 p.m., signed by LPN (Licensed Practical Nurse) #1 documented, "Call placed to [Doctor] about above named problem. Order for Roxanol 20 mg (milligrams)/ml (milliliter) 10 mg. = 0.5 ml. SL (sublingual) q (every) 4 hours PRN (as needed) for pain and air hunger. Call placed to [Drug Store]. Medication ordered. Resident continues to be actively dying he is having periods of apnea lasting 5-10 sec. (seconds). [Doctor] is aware of this also."</p> <p>c. A Physician Telephone Order dated 8/17/05 at</p>	F 333			

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NAME OF PROVIDER OR SUPPLIER  <b>SEARCY HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 SKYLINE DRIVE</b> <b>SEARCY, AR 72143</b>		
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F 333	<p>Continued From page 22</p> <p>12:30 p.m. and signed by LPN #1 documented, "Roxanol 20 mg./ml. give 5 mg 0.25 ml to 10 mg 0.5 ml SL (sublingual) q (every) 4 hours prn severe pain."</p> <p>d. A faxed copy of the prescription sent to the Pharmacy from the attending physician dated 8/17/05 documented, "Morphine Sulfate 30 ml. 20 mg/ml Sig: Give 5 mg. (0.25 ml) to 10 mg. 0.5 ml) sublingual every 4 hours prn severe pain."</p> <p>e. The August 2005 Physician Orders sheet had a hand written entry dated 8/17/05 and signed by LPN #1 that documented, "Roxanol 20 mg./ml give 10 mg = 0.5 ml SL q 4 [hours] PRN. T.O. [doctor]/(LPN #1)." The 5 mg 0.25 ml was omitted when transferred from the telephone order to the physician's order.</p> <p>f. Nurses Notes dated 8/17/05 at 2:30 p.m. and signed by LPN #2 documented, "Resting quietly in bed eyes glazed over and staring @ (at) ceiling. HR (heart rate) reg (irregular). Esp (Respirations) uneven, labored with periods of apnea lasting up to 5 sec. MD (doctor) &amp; family notified &amp; aware of situation. Some family at BS (bedside) @ this time. Lower ext. (extremities) cold &amp; pare with weak peripheral pulses. Non-responsive to verbal stimuli. Will cont to monitor."</p> <p>g. Nurses Notes dated 8/18/05 and signed by LPN #3 documented, "This is a late entry of Nurse's Notes on [Resident #1]. 8/17/05 - 1445 (2:45 p.m.) - Assessed resident with [LPN #2]. Resident's family requested pain medication. At 1500 (3:00 p.m.) Roxanol drawn up, witnessed by [LPN #2]. Medication given with most spilled out on front of gown. Resident stopped breathing. Notified [LPN #2] who assessed resident and</p>	F 333			

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F 333	<p>Continued From page 23</p> <p>stated no pulse, no respiration. Family present, MD notified, Hospice Notified."</p> <p>h. On 8/22/05 at 1:00 p.m. the bottle of medication documented Lot # 63848, MDC 58177-886-01, the name of the pharmacy, Rx# 69873, the resident's name, the physician's name, and the date of 8/17/05. The directions for administration entered by the pharmacy inaccurately documented directions as follow: "Take 5 ml by Mouth (0.25 ml) to 10 ml (0.5 ml) sublingually every 4 hours as needed for severe pain. Morphine Sulfate 20 mg/ml." The bottle contained approximately 24 ml per the scale on the side of the bottle.</p> <p>i. On 8/22/05 at 1:00 p.m., the Narcotic Sign-out Log documented:</p> <ol style="list-style-type: none"> <li>1) Patient: (Resident #1)</li> <li>2) Drug/Str (strength): Roxanol</li> <li>3) Directions: 10 ML SL Q 4 hours PRN</li> <li>4) Doctor: XXX</li> <li>5) Date [date received]: 8/17/05</li> <li>6) Time [time received]: 1445 (2:45 p.m.)</li> <li>7) RCD (Received) From Pharm (Pharmacy): 30 ML</li> <li>8) Nurse's Signature: XXX LPN #2</li> </ol> <p>The information on the Narcotic sign out log did not document the correct milligrams and milliliters to be dispensed.</p>	F 333			

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F 333	Continued From page 24  j. The Narcotic Sign-out Log documented the following:  1) Date [date given]: 8/17/05  2) Time [time given]: 1500 (3:00 p.m.)  3) Qty (quantity) On Hand: 30 ml  4) Amount Used: 10 ml  5) Total Rem (remaining): 20 ml  6) Nurse's Signature: XXX LPN #2  k. The August 2005 Medication Administration Record (MAR) had a handwritten entry dated 8/17/05 that documented, "Roxanol 20 mg/ml, give 10 ml = 0.50 mg SL q 4 hrs PRN pain, air hunger." There was no documentation on the MAR that Roxanol had been administered to the resident on 8/17/05 at 3:00 p.m.  l. On 8/22/05 at 3:00 p.m., LPN #1 stated that on 8/17/05 she had been assigned to work Hall 10 and Resident #1 was on Hall 2. The LPN stated she had received a telephone call from the nurse working Hall 2 due to a problem with a Hospice Aide. While attending to the problem on Hall 2 the nurse of that unit asked her if Hospice could get some pain medication for Resident #1 as the resident had recently been admitted to Hospice. LPN #1 stated, "I told the nurse that the next step after oral medication in the Hospice Protocol is usually Roxanol (liquid Morphine Sulfate)." LPN #1 stated that she had told the other nurse that "the protocol is usually 20 mg/ml and to give 5 mg. (0.25 ml) and increase to 10 mg. (0.5. ml.)"	F 333			

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F 333	<p>Continued From page 25</p> <p>every 3 to 4 hours." LPN #1 stated she then went back to her assigned unit. The nurse on Hall 2 called her later and told her that she had contacted the resident's physician and the physician had ordered the Roxanol. LPN #1 stated she asked the other nurse if she had told the physician to fax the prescription to the pharmacy as the pharmacy would not fill the prescription without a hard copy. LPN #1 stated that the other nurse had asked her to call the resident's physician and request that he send the prescription to the pharmacy. LPN #1 stated that she had contacted the physician about this matter and while on the telephone the physician told her that the resident would probably need 10 mg but he would write the prescription per the Hospice protocol. LPN #1 stated, "I wrote the telephone order - (LPN #2) put it on the MAR." LPN #1 was asked why she had documented 5 to 10 mg (milligrams) on the telephone order and 10 mg only in the Nurses Notes. LPN #1 reviewed the Nurses Notes and stated, "I messed up in the Nurses Notes."</p> <p>m. On 8/22/05 at 3:22 p.m. LPN #3 stated he was scheduled to be on duty at 3:00 p.m. on 8/17/05 and had arrived at the facility at about 15 to 20 minutes before 3:00 p.m. LPN #2 told LPN #3 that "Resident #1 is in the act of dying." LPN #3 stated that LPN #2 had signed in the narcotic (Roxanol) from the pharmacy into the Narcotic Sign-out Log when it arrived to the facility. LPN #3 stated that he had offered to help LPN #2 by giving the medication to the resident. LPN #3 was asked "Did you look at the physician's order before administering the Roxanol?" He stated "No, I looked at the bottle and a note written on a piece of paper lying on the top of the med cart." He was then asked, "Where is that piece of</p>	F 333			

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F 333	<p>Continued From page 26</p> <p>paper?" and he stated, "I don't know." He was then asked "Did the note say 10 ml or 10 mg.?" and he stated, "I can't remember for sure." LPN #3 stated that he could not tell how much was actually in the bottle as it was a colored bottle, therefore, he poured the full 30 ml into a medication cup then poured the medication back into the bottle until there was 10 ml in the cup, instead of pulling the medication into a syringe for a more accurate dosage. LPN #3 stated that he poured approximately 5 ml into the resident's mouth and the resident began "gurgling so I sat him up and most of medicine came out on gown." The LPN then stated, "I eased him back and used a dropper from the medication bottle to administer the remaining 5 ml." The LPN was asked if he had ever administered Roxanol before and he stated that he had never seen Roxanol before. The LPN stated the resident quit breathing almost immediately and "another nurse said she heard another heart beat or two." The LPN stated that he did not realize a medication error had been made until he called into the facility the next morning (8/18/05). LPN #3 stated, "I gave the medication, (LPN #2) signed it out. I know that was wrong too."</p> <p>n. On 8/22/05 at 3:45 p.m., the Director of Nursing (DON) stated she was notified of a problem on 8/18/05 at approximately 8:15 a.m. The DON stated she was called to the medication room and saw that the "label on the medication bottle was controversial" as the bottle documented milliliters per milliliter rather than milligrams per milliliter. The DON stated she looked at the chart for the actual order then called the nurse (LPN #1) who took the order. She stated LPN #1 didn't take the order, that RN #1 took the order and LPN #1 took the clarifying</p>	F 333			

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F 333	<p>Continued From page 27</p> <p>order. The DON was asked what LPN #3 had looked at before he gave the medication. The DON stated that he had looked at the Narcotic Book and the Label on the bottle.</p> <p>o. The Plan of Correction attached to the facility's DMS-7734 dated 8/18/05 relative to the medication error documented, Item #4, "All licensed nurses on duty will be in-serviced immediately and the remainder will be in-serviced this afternoon at 2:00 p.m., - - - - ." Item #5 documented, " - - - - No licensed nurse will be allowed to return to work before being inserviced on this matter." The in-service sign-in sheet attached to the Plan of Correction did not contain the signatures of 4 nurses that worked on 8/19/05, 8/20/05, and/or 8/21/05.</p> <p>p. On 8/23/05 at 3:00 p.m., the DON was asked if the professional staff of the facility had been observed administering medications and/or checked off on the procedure. The DON stated that the facility had planned to hire an independent pharmacy consultant to do inservices, medication passes, and in-depth training with the staff in the future but this had not been started yet.</p> <p>q. The facility policy/procedure entitled "Administering Oral Medication" dated March, 2005, documented:</p> <p>"1. General Guidelines:</p> <p>i. Item 1: Always verify the "5 Rights" before administering medications - the right medication; the right dose; the right resident; the right route; and the right time.</p>	F 333			

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F 333	<p>Continued From page 28</p> <p>ii. Item 2: Be familiar with the resident's medical diagnosis and reason for administering the drug, as well as contraindications, usual dosages, side effects, and intended outcome of the drug.</p> <p>iii. Item 3: Double check the Medication Administration Record (MAR) against physician orders before administering medications.</p> <p>2. Steps in the Procedure</p> <p>i. Item 6: Check the label on the medication and confirm the medication name and dose with the MAR.</p> <p>ii. Item 8: Check the medication dose. Re-check to confirm the proper dose.</p> <p>3. Documentation: The following information should be recorded in the resident's medical record:</p> <p>i. Item 1: The drug name, dose, time, date, and route of administration. (Note: Such information should be documented on the resident's medication administration record immediately after the drug is given).</p> <p>ii. Item 2: The name and title of the individual administering the medication.</p> <p>iii. Item 6: The name and title of the individual documenting the administration of the medication."</p> <p>2. Resident #2 had a diagnosis of Depressive Disorder. The Quarterly MDS dated 8/10/05 documented the resident was independent in cognitive skills for daily decision making and received antidepressant medications.</p>	F 333			

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F 333	Continued From page 29 a. A physician order dated 7/15/05 at 3:30 p.m. documented, Ativan 2 mg. PRN Anxiety. There was no clarification as to how often the resident could receive the PRN medication.  b. The July 2005 MAR documented, "Ativan 1-2 mg po PRN Anxiety." There was no physician's order for 1 mg of Ativan.  c. The Pharmacy label for the Ativan 1 mg documented, "Take 1 or 2 tablets by mouth every 8 hours as needed - should no exceed 4 mg/day."  d. The August 2005 MAR documented, "Ativan 1-2 mg po PRN Anxiety." The MAR also documented the resident was administered "Ativan 1 mg or 2 mg" on 8/10/05, 8/11/05, 8/12/05, 8/13/05, 8/14/05, 8/21/05 and 8/22/05. There was no physician order in the clinical record for 1 mg of Ativan.	F 333		
F 426 SS=J	483.60(a) PHARMACY SERVICES - PROCEDURES  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.  This REQUIREMENT is not met as evidenced by:  Complaint #10511, substantiated (all or in part) in these findings.  Based on observation, record review and interview the facility failed to ensure the correct dose of medication was dispensed for 1 case mix	F 426		9/19/05

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F 426	<p>Continued From page 30</p> <p>resident (Resident #1) who received morphine for pain. This failed practice resulted in Immediate Jeopardy for Resident #1 and had the potential to affect only this one resident who received morphine according to the Director of Nursing on 8/22/05. The Immediate Jeopardy was removed and the scope/severity reduced to "E" when the resident expired on 8/17/05 and there were no other residents identified in immediate jeopardy at the time of the survey, but the underlying deficient practice remained uncorrected. The facility failed to ensure physician orders were followed for 1 case mix resident (Resident #2) who had physician order for Ativan. This failed practice had the potential to affect 76 residents who received a psychoactive medication according to the Roster Matrix received 8/22/05. The findings are: Resident #1 had diagnoses of Malignant Neoplasm Skin/Arm, Diabetes with Ketoacidosis, Colon Cancer and Alzheimer's type Dementia. A Significant Change Minimum Data Set dated 8/10/05 documented the resident was moderately impaired in cognitive skills for daily decision-making and had no symptoms of pain.</p> <p>a. Nurses Notes dated 8/17/05 at 12:00 p.m., signed by RN (Registered Nurse) #1 documented, "resident has severe changes severe body jerking eyes dilated unresponsive to verbal question temp 98.1 Ax (axillary) B/P (blood pressure) 115/60 at best unable to be more accurate due to body jerking, color white notified brother and sister in law to see what they wanted done &amp; (and) they said to just leave him here &amp; try to keep him comfortable as much as we can. We are notifying hospice for medication for comfort."</p> <p>b. Nurses Notes dated 8/17/05 at 12:30 p.m., signed by LPN (Licensed Practical Nurse) #1</p>	F 426			

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F 426	<p>Continued From page 31</p> <p>documented, "Call placed to [Doctor] about above named problem. Order for Roxanol 20 mg (milligrams)/ml (milliliter) 10 mg. = 0.5 ml. SL (sublingual) q (every) 4 hours PRN (as needed) for pain and air hunger. Call placed to [Drug Store]. Medication ordered. Resident continues to be actively dying he is having periods of apnea lasting 5-10 sec. (seconds). [Doctor] is aware of this also."</p> <p>c. A Physician Telephone Order dated 8/17/05 at 12:30 p.m. and signed by LPN #1 documented, "Roxanol 20 mg./ml. give 5 mg 0.25 ml to 10 mg 0.5 ml SL (sublingual) q (every) 4 hours prn severe pain."</p> <p>d. A faxed copy of the prescription sent to the Pharmacy from the attending physician dated 8/17/05 documented, "Morphine Sulfate 30 ml. 20 mg/ml Sig: Give 5 mg. (0.25 ml) to 10 mg. 0.5 ml) sublingual every 4 hours prn severe pain."</p> <p>e. The August 2005 Physician Orders sheet had a hand written entry dated 8/17/05 and signed by LPN #1 that documented, "Roxanol 20 mg./ml give 10 mg = 0.5 ml SL q 4 [hours] PRN. T.O. [doctor]/(LPN #1)." The 5 mg 0.25 ml was omitted when transferred from the telephone order to the physician's order.</p> <p>f. Nurses Notes dated 8/17/05 at 2:30 p.m. and signed by LPN #2 documented, "Resting quietly in bed eyes glazed over and staring @ (at) ceiling. HR (heart rate) irreg (irregular). Resp (Respirations) uneven, labored with periods of apnea lasting up to 5 sec. MD (doctor) &amp; family notified &amp; aware of situation. Some family at BS (bedside) @ this time. Lower ext. (extremities) cold &amp; pare with weak peripheral pulses.</p>	F 426			

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F 426	<p>Continued From page 32</p> <p>Non-responsive to verbal stimuli. Will cont to monitor."</p> <p>g. Nurses Notes dated 8/18/05 and signed by LPN #3 documented, "This is a late entry of Nurse's Notes on [Resident #1]. 8/17/05 - 1445 (2:45 p.m.) - Assessed resident with [LPN #2]. Resident's family requested pain medication. At 1500 (3:00 p.m.) Roxanol drawn up, witnessed by [LPN #2]. Medication given with most spilled out on front of gown. Resident stopped breathing. Notified [LPN #2] who assessed resident and stated no pulse, no respiration. Family present, MD notified, Hospice Notified."</p> <p>h. On 8/22/05 at 1:00 p.m. the bottle of medication documented Lot # 63848, NDC 58177-886-01, the name of the pharmacy, Rx# 69873, the resident's name, the physician's name, and the date of 8/17/05. The directions for administration entered by the pharmacy inaccurately documented directions as follow: "Take 5 ml by Mouth (0.25 ml) to 10 ml (0.5 ml) sublingually every 4 hours as needed for severe pain. Morphine Sulfate 20 mg/ml." The bottle contained approximately 24 ml per the scale on the side of the bottle.</p> <p>i. On 8/22/05 at 1:00 p.m., the Narcotic Sign-out Log documented:</p> <p>1) Patient: (Resident #1)</p> <p>2) Drug/Str (strength): Roxanol</p> <p>3) Directions: 10 ML SL Q 4 hours PRN</p> <p>4) Doctor: XXX</p>	F 426			

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F 426	<p>Continued From page 33</p> <p>5) Date [date received]: 8/17/05</p> <p>6) Time [time received]: 1445 (2:45 p.m.)</p> <p>7) RCD (Received) From Pharm (Pharmacy): 30 ML</p> <p>8) Nurse's Signature: XXX LPN #2</p> <p>The information on the Narcotic sign out log did not document the correct milligrams and milliliters to be dispensed.</p> <p>j. The Narcotic Sign-out Log documented the following:</p> <p>1) Date [date given]: 8/17/05</p> <p>2) Time [time given]: 1500 (3:00 p.m.)</p> <p>3) Qty (quantity) On Hand: 30 ml</p> <p>4) Amount Used: 10 ml</p> <p>5) Total Rem (remaining): 20 ml</p> <p>6) Nurse's Signature: XXX LPN #2</p> <p>k. The August 2005 Medication Administration Record (MAR) had a handwritten entry dated 8/17/05 that documented, "Roxanol 20 mg/ml, give 10 ml = 0.50 mg SL q 4 hrs PRN pain, air hunger." There was no documentation on the MAR that Roxanol had been administered to the resident on 8/17/05 at 3:00 p.m.</p> <p>l. On 8/22/05 at 3:00 p.m., LPN #1 stated that on 8/17/05 she had been assigned to work Hall 10 and Resident #1 was on Hall 2. The LPN stated</p>	F 426		

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F 426	<p>Continued From page 34</p> <p>she had received a telephone call from the nurse working Hall 2 due to a problem with a Hospice Aide. While attending to the problem on Hall 2 the nurse of that unit asked her if Hospice could get some pain medication for Resident #1 as the resident had recently been admitted to Hospice. LPN #1 stated, "I told the nurse that the next step after oral medication in the Hospice Protocol is usually Roxanol (liquid Morphine Sulfate)." LPN #1 stated that she had told the other nurse that "the protocol is usually 20 mg/ml and to give 5 mg. (0.25 ml) and increase to 10 mg. (0.5. ml.) every 3 to 4 hours." LPN #1 stated she then went back to her assigned unit. The nurse on Hall 2 called her later and told her that she had contacted the resident's physician and the physician had ordered the Roxanol. LPN #1 stated she asked the other nurse if she had told the physician to fax the prescription to the pharmacy as the pharmacy would not fill the prescription without a hard copy. LPN #1 stated that the other nurse had asked her to call the resident's physician and request that he send the prescription to the pharmacy. LPN #1 stated that she had contacted the physician about this matter and while on the telephone the physician told her that the resident would probably need 10 mg but he would write the prescription per the Hospice protocol. LPN #1 stated, "I wrote the telephone order - (LPN #2) put it on the MAR." LPN #1 was asked why she had documented 5 to 10 mg (milligrams) on the telephone order and 10 mg only in the Nurses Notes. LPN #1 reviewed the Nurses Notes and stated, "I messed up in the Nurses Notes."</p> <p>m. On 8/22/05 at 3:22 p.m. LPN #3 stated he was scheduled to be on duty at 3:00 p.m. on 8/17/05 and had arrived at the facility at about 15 to 20</p>	F 426			

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F 426	Continued From page 35 minutes before 3:00 p.m. LPN #2 told LPN #3 that "Resident #1 is in the act of dying." LPN #3 stated that LPN #2 had signed in the narcotic (Roxanol) from the pharmacy into the Narcotic Sign-out Log when it arrived to the facility. LPN #3 stated that he had offered to help LPN #2 by giving the medication to the resident. LPN #3 was asked "Did you look at the physician's order before administering the Roxanol?" He stated "No, I looked at the bottle and a note written on a piece of paper lying on the top of the med cart." He was then asked, "Where is that piece of paper?" and he stated, "I don't know." He was then asked "Did the note say 10 ml or 10 mg.?" and he stated, "I can't remember for sure." LPN #3 stated that he could not tell how much was actually in the bottle as it was a colored bottle, therefore, he poured the full 30 ml into a medication cup then poured the medication back into the bottle until there was 10 ml in the cup, instead of pulling the medication into a syringe for a more accurate dosage. LPN #3 stated that he poured approximately 5 ml into the resident's mouth and the resident began "gurgling so I sat him up and most of medicine came out on gown." The LPN then stated, "I eased him back and used a dropper from the medication bottle to administer the remaining 5 ml." The LPN was asked if he had ever administered Roxanol before and he stated that he had never seen Roxanol before. The LPN stated the resident quit breathing almost immediately and "another nurse said she heard another heart beat or two." The LPN stated that he did not realize a medication error had been made until he called into the facility the next morning (8/18/05). LPN #3 stated, "I gave the medication, (LPN #2) signed it out. I know that was wrong too."	F 426			

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F 426	<p>Continued From page 36</p> <p>n. On 8/22/05 at 3:45 p.m., the Director of Nursing (DON) stated she was notified of a problem on 8/18/05 at approximately 8:15 a.m. The DON stated she was called to the medication room and saw that the "label on the medication bottle was controversial" as the bottle documented milliliters per milliliter rather than milligrams per milliliter. The DON stated she looked at the chart for the actual order then called the nurse (LPN #1) who took the order. She stated LPN #1 didn't take the order, that RN #1 took the order and LPN #1 took the clarifying order. The DON was asked what LPN #3 had looked at before he gave the medication. The DON stated that he had looked at the Narcotic Book and the Label on the bottle.</p> <p>o. The Plan of Correction attached to the facility's DMS-7734 dated 8/18/05 relative to the medication error documented, Item #4, "All licensed nurses on duty will be in-serviced immediately and the remainder will be in-serviced this afternoon at 2:00 p.m., - - - - ." Item #5 documented, "- - - - No licensed nurse will be allowed to return to work before being inserviced on this matter." The in-service sign-in sheet attached to the Plan of Correction did not contain the signatures of 4 nurses that worked on 8/19/05, 8/20/05, and/or 8/21/05.</p> <p>p. On 8/23/05 at 3:00 p.m., the DON was asked if the professional staff of the facility had been observed administering medications and/or checked off on the procedure. The DON stated that the facility had planned to hire an independent pharmacy consultant to do inservices, medication passes, and in-depth training with the staff in the future but this had not been started yet.</p>	F 426			

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F 426	Continued From page 37  q. The facility policy/procedure entitled "Administering Oral Medication" dated March, 2005, documented:  "1. General Guidelines:  i. Item 1: Always verify the "5 Rights" before administering medications - the right medication; the right dose; the right resident; the right route; and the right time.  ii. Item 2: Be familiar with the resident's medical diagnosis and reason for administering the drug, as well as contraindications, usual dosages, side effects, and intended outcome of the drug.  iii. Item 3: Double check the Medication Administration Record (MAR) against physician orders before administering medications.  2. Steps in the Procedure  i. Item 6: Check the label on the medication and confirm the medication name and dose with the MAR.  ii. Item 8: Check the medication dose. Re-check to confirm the proper dose.  3. Documentation: The following information should be recorded in the resident's medical record:  i. Item 1: The drug name, dose, time, date, and route of administration. (Note: Such information should be documented on the resident's medication administration record immediately after the drug is given).	F 426			

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F 426	Continued From page 38 ii. Item 2: The name and title of the individual administering the medication.  iii. Item 6: The name and title of the individual documenting the administration of the medication."  2. Resident #2 had a diagnosis of Depressive Disorder. The Quarterly MDS dated 8/10/05 documented the resident was independent in cognitive skills for daily decision making and received antidepressant medications.  a. A physician order dated 7/15/05 at 3:30 p.m. documented, Ativan 2 mg. PRN Anxiety. There was no clarification as to how often the resident could receive the PRN medication.  b. The July 2005 MAR documented, "Ativan 1-2 mg po PRN Anxiety." There was no physician's order for 1 mg of Ativan.  c. The Pharmacy label for the Ativan 1 mg documented, "Take 1 or 2 tablets by mouth every 8 hours as needed - should no exceed 4 mg/day."  d. The August 2005 MAR documented, "Ativan 1-2 mg po PRN Anxiety." The MAR also documented the resident was administered "Ativan 1 mg or 2 mg" on 8/10/05, 8/11/05, 8/12/05, 8/13/05, 8/14/05, 8/21/05 and 8/22/05. There was no physician order in the clinical record for 1 mg of Ativan.	F 426			
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness	F 502		9/19/05	

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F 502	<p>Continued From page 39 of the services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure laboratory services were performed in a timely manner for 1 (Resident #2) case mix resident who required diagnostic laboratory services for an acute condition. This failed practice had the potential to affect all 181 residents. The findings are:</p> <p>Resident #2 had diagnoses of Hypertension, Degenerative Disc Disease and Depressive Disorder. The Annual Minimum Data Set (MDS) dated 5/12/05 documented the resident was independent in cognitive skills for daily decision-making, totally dependent on staff for transfers and toileting and had abnormal lab values during the past 90 days.</p> <p>a. Nurses Note dated 8/18/05 at 3:00 p.m. documented, "R (resident) was reported as saying she was pregnant this a.m. R stated people had been hiding in her bathroom @ night. Confused to time &amp; (and) place. CNA's (Certified Nursing Assistant) report [decreased] urinary output. Saturated pad X (times) 2 this shift. Encouraging fluids. Urine amber [with] strong odor. Orders received for cath UA (urinalysis obtained through a catheter), CBC (complete blood count), CMP (complete metabolic profile) &amp; Levaquin 500 mg (milligrams) 1 PO (by mouth) q (every) d (day) X 6 days. [name of primary care physician] notified [with] orders to start ABT (antibiotic treatment) and complete blood work in a.m."</p>	F 502			

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F 502	Continued From page 40  b. Nurses Note dated 8/24/05 documented, "at 0700 (7:00 a.m.) V punc (venipuncture) performed on R (right) hand for CBC & CMP" and was signed by lab technician.  c. On 8/24/05 at 8:30 a.m., the lab technician was asked "Were the lab tests you drew blood for this morning the lab tests that were ordered on to be done on 8/19/05?" and the lab technician stated "Yes, I just got a copy of that order today."	F 502			