STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	R-C 06/01/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	**706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560**

(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 328} SS=E	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that respiratory treatment equipment was stored in a manner to prevent possible contamination for 2 (Residents # 9 and # 8) of 3 (Residents # 9, # 8 and # 5) case mix residents in the facility who received scheduled or PRN (as needed) updraft treatments (respiratory) and had updraft treatment machines in the resident's rooms. This failed practice had the potential to affect 25 residents who had documented physician orders for updraft treatments in the facility as documented by the Administrator on 6/1/07. The findings are: 1. Resident #9 had diagnoses of Congestive Heart Failure, Asthma and Diabetes. The Annual Minimum Data Set (MDS) dated 4/24/07 documented the resident had independent skills for daily decision making and had received oxygen therapy during the last 14 days. a. A physician order dated 5/16/07 ,upon return	{F 328}		

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 328}	Continued From page 1 from the hospital, documented "Albuterol UD (updraft) 0.083 % q (every) 6 h (hour) w/a (while awake) and q 4 hrs (hours) prn (as needed) SOB (shortness of breath)." b. The resident's May 2007 Medication Administration Record (MAR) documented that on 5/29/07 at 9:00 a.m., LPN (Licensed Practical Nurse) #3 administered an updraft treatment to the resident. c. On 5/29/07 at 11:30 a.m. during initial rounds of the facility, the resident's updraft medication tubing and mouthpiece were observed unbagged with the mouthpiece touching the resident's bedside table top. The tubing was dated 5/29/07. d. The resident's May 2007 MAR documented that on 5/29/07 at 2:00 p.m., LPN #3 administered an updraft treatment to the resident. e. On 5/29/07 at 2:50 p.m., the resident's updraft medication tubing and mouthpiece were observed unbagged with the mouthpiece touching the resident's bedside table top. The tubing was dated 5/29/07 f. On 5/30/07 at 3:00 p.m., when asked about the updraft equipment storage, stated " I don't do any of that. They (staff) take care of all of that." g. On 4/13/07, an inservice sign in sheet for oxygen and updraft policy and procedure documented that LPN #3 had signed as attended. h. On 6/1/07 at 10:40 a.m., the Administrator stated, "We have searched and can't find a policy for the storage of the updraft equipment."	{F 328}		

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{F 328}	Continued From page 2 2. Resident #8 had diagnoses of Asthma, Emphysema/Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Allergic Rhinitis. The Annual Minimum Data Set dated 4/21/07 documented the resident was independent in cognitive skills for daily decision making, and received oxygen therapy in the last 14 days. a. A Physician's order dated 9/8/06 documented....."Albuterol Inhl (Inhaler) Soln (Solution), 0.083% Updraft BID (Twice a day). b. On 5/29/07 at 11:10 a.m. during initial rounds of the facility, the resident's nebulizer mouthpiece and tubing was lying on a chair beside the resident. The mouthpiece and tubing was not bagged.	{F 328}		
{F 332} SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview of the 12:00 p.m., 4:00 p.m. and 8:00 p.m. medication passes on 5/31/07 the facility failed to ensure that the medication error rate was less than 5%. Physicians orders were not followed on 4 (Residents #11, #12, #13, and #14) of 20 residents observed during medication passes resulting in medication errors. Medication errors were made by 2 Licensed Practical Nurses (LPN), (LPN #1, LPN#2) of 6 licensed nurses observed administering medications in the facility.	{F 332}		

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{F 332}	Continued From page 3 This failed practice had the potential to affect 24 residents on the 400 and 500 hall, and 30 residents on the 100 and 200 hall according to a list provided by the Administrator on 06/01/07. The medication error rate was 9.52% based on observation of 41 medications and 1 omission for a total of 42 opportunities with 4 medication errors observed. The findings are: 1. Resident #11 had a physician order dated 4/24/07 for Dicyclomine Tab 10 mg (milligrams) 1 p.o. (by mouth) Q.I.D. (four times a day) with food. On 05/31/07 at 11:27 a.m. during the 12:00 p.m. medication pass the LPN #1 administered Dicyclomine 10 mg 1 tablet with water. 2. Resident #12 had a physician order dated 03/29/07 for Abilify 5 mg tablet; give 1 tablet p.o. daily at lunch. a. On 5/31/07 at 11:38 a.m. during the 12:00 p.m. medication pass the LPN #1 administered Abilify 5 mg 1 tablet with water. b. On 5/31/07 at 1:15 p.m. the surveyor asked LPN #1 "What would you consider at lunch to mean?". LPN #1 replied "With food." 3. Resident #13 had a physician order dated 11/26/02 for Humulin Insulin 70/30 10 units S.Q. (subcutaneous) daily Q.(every) p.m. at dinner. The time schedule column of the physician's order documented the time of administration to be at 5:00 p.m. a. On 5/31/07 at 4:06 p.m. the LPN #1	{F 332}		

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{F 332}	Continued From page 4 administered Novolin (Humulin) 70/30 10 units S.Q. . b. On 5/31/07 at 4:05 p.m. LPN #1 asked the resident "Are you going to the dining room for supper tonight?". The resident responded "I don't know". c. On 5/31/07 at 6:20 p.m. the surveyor asked what time supper was served to the 400/500 hall. Dietary Staff # 1 replied "I didn't look at the clock, but it had to be roughly about 5:30 p.m.". 4. Resident #14 had a physician order dated 5/7/07 for Citalopram 20 mg Q. H.S. (hour of sleep). 5/31/07 at 7:40 p.m. LPN #2 administered all scheduled medications except for Citalopram 20 mg. ("Insulin being held due to low blood sugar").	{F 332}		
{F 333} SS=D	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: Based on observation, record review, and interview facility failed to follow physician's orders to ensure that residents were free of significant medication error for one (Resident #13) of 1 case mix residents who received insulin medications. This failed practice had the potential to affect 15 residents who received Insulins according to a list provided by the Administrator on 6/1/2007. The findings are: Resident #13 had a physician order dated	{F 333}		

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{F 333}	Continued From page 5 11/26/02 for Humulin Insulin (antidiabetic medication) 70/30 10 units S.Q. (subcutaneous) daily Q.(every) p.m. at dinner. The time schedule column of the physician's order documented the time of administration was 5:00 p.m. a. On 5/31/07 at 4:06 p.m. Licensed Practical Nurse (LPN) #1 administered Novolin (Humulin) 70/30 10 units S.Q. . b. On 5/31/07 at 4:05 p.m. LPN #1 asked the resident, "Are you going to the dining room for supper tonight?". The resident responded, "I don't know." c. On 5/31/07 at 6:20 p.m. Dietary Staff #1 was asked what time supper was served to the 400/500 hall. Dietary Staff # 1 replied "I didn't look at the clock, but it had to be roughly about 5:30 p.m." d. This medication error was significant due to the classification of the medication (antidiabetic).	{F 333}		