

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

PRINTED: 01/20/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04A145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
NAME OF PROVIDER OR SUPPLIER YELL COUNTY NURSING HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 502 WEST PENNINGTON OLA, AR 72853		
(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 157 SS=H	<p>483.10(b)(11) NOTIFICATION OF CHANGES</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the physician was immediately consulted regarding a large abrasion to the lower extremity for 1 of 1</p>	F 157			

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 157	<p>Continued From page 1</p> <p>case-mix resident (Resident #7) with a history of venous ulcers. This failed practice resulted in actual harm to Resident #7 who had deterioration and additional venous ulcers noted and the potential to affect 1 other resident who had venous ulcers according to the Director of Nursing on 1/8/09. The findings are:</p> <p>1. The Policy and Procedure for Skin Inspection received from the ADON on 1/8/08 documented, "...Area will be monitored closely by licensed personnel and physician notified if treatment not effective... When recorded in the skin book a weekly entry will be done to show if current treatment is effective. If ineffective the Physician will be contacted for any change of orders or continuation."</p> <p>2. Resident #7 had diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Ischemic Cardiomyopathy, and Atherosclerosis. The Change of Condition Minimum Data Set dated 10/27/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, totally dependent on staff for all Activities of Daily Living and had no ulcers.</p> <p>a. The Care Plan last reviewed on 10/27/08 documented the resident had a history of stasis ulcers on the lower extremities. A handwritten note dated 12/3/08 documented, "Necrotic Ulcer right lower extremity and top of foot." A handwritten note dated 12/29/08 documented Wound Clinic Appt ASAP (as soon as possible)." The Goal documented "Will be monitored for signs and symptoms of stasis ulcers with Treatment provided if occur thru out quarter on 12/3/08 No Problems will go Unnoticed thru out</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>quarter." with approaches of: Treatment as ordered, Monitor for Breakdown, Meds as ordered, Notify MD (Medical Doctor) prn (as needed)."</p> <p>b. The Wound Documentation form received from the ADON (Assistant Director of Nursing) on 1/8/09 started with 8/1/08 and did not document any ulcers thru 9/4/08.</p> <p>c. The next Wound Documentation was dated 11/24/08 and documented, "Location...: right lower leg abrasion... Size 50 X 45 mm (millimeters),... date observed: today" and on 11/27/08 "Location: right lower leg, abrasion, Size: 52 X 50 mm." There was no documentation in the clinical record that the physician was notified of the large abrasion.</p> <p>d. The Wound Documentation dated 12/3/08 documented, "Location...: right lower leg,... Size 58 X 63 mm. NEW ULCER 12/3/08 Right lower leg, Stasis Ulcer Size 10 mm X (by)10 mm. 12/3/08 NEW ULCER : Right top of foot, stasis ulcer, size: 13 mm X 4 mm. 12/3/08 NEW ULCER Left top of foot, stasis ulcer 15 mm X 10 mm.</p> <p>A physician order dated 12/3/08 documented, "Clean wounds on both feet and legs with betadine, apply silvadene cream to open areas qd (everyday) till healed. Cover with protective drsg (dressing).</p> <p>e. The Wound Documentation Progress Notes dated 12/10/08 documented the size on the right foot increased to 50 mm X 60 mm and 12 mm X 10 mm, the top of the right foot increased to 14 mm X 6 mm and the top of the left foot 10 mm X 6 mm.</p>	F 157			

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F 157	Continued From page 3 f. Wound Documentation Progress Notes dated 12/25/08 documented the sizes increased on the right leg to 70 mm X 40 mm and 10 mm X 10 mm, top of the right foot 10 mm X 12 mm and left foot 10 mm X 12 mm. As of 1/6/09, there was no documentation received from the facility that the physician was notified from 12/3/08 to 12/29/08 of changes and increased sizes with new ulcers. g. Physician Progress note dated 12/29/08 documented, "...Has 1 cm (centimeter) ulcer dorsum left foot and 2 inch superficial ulcer lower right leg... continue same treatment and refer to wound care [in near by town]. h. The Wound Documentation Progress Notes dated 1/5/08 documented, the right leg had a new ulcer that measured 10 mm X 8 mm, the 2 original ulcers on the right leg measured 33 mm X 80 mm and 30 mm X 42 mm and a new ulcer on the left great toe measured 15 mm X 10 mm with 3 mm X 3 mm with center open. i. The Post-Procedure Wound Care Instructions received on 1/6/09 documented the Wound Care clinic identified 7 Wounds: "1. Right lower shin... Type/Stage Venous... 7.5 X 4.5 cm , 2. Right Lat. (lateral) Dorsal Foot, Type: Venous, Size 1.0 X 1.0 cm., 3. Left medial shin, Type: Venous Size: 1.0 X 1.0 cm. X 0, 4. Left Lateral dorsal foot, Type: Venous Size 1.4 cm X 1.0 cm, #5. Right great toe: Type: Venous 0.5 cm X 0.5 cm X 0. 6. Right distal shin, Type Venous Size: 4.0 cm X 2.5 cm, 7. Left Latera great toe: Blister 0.4 cm X 0.4 cm X 0." The physician orders included: Cleanse and rinse wound with normal saline, Dermagran wound cleanser, apply Silage to wound bed and cover with Gauze and Kerlix.	F 157		

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F 157	Continued From page 4	F 157		
F 221 SS=D	<p>On 1/7/08 observation of Resident Dressing change done by the Director of Nursing and Assistant Director of Nursing, the observations were approximately the same as the wound clinic documentation.</p> <p>j. On 1/7/08 at 11:00 a.m., the DON stated the right lower leg was the major one the rest of the wounds were just minor. "We tried to send the resident to the wound clinic sooner and they cancelled." She also stated there were no calls made between 12/3/08 and 12/29/08 to inform the physician and that was all the documentation that was done and the wounds got worse so fast.</p> <p>483.13(a) PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure there was a physician order and a signed consent for the use of a seat belt restraint for 1 (Resident # 6) of 2 case mix residents (Resident #6 and #2) who used a physical restraint. This failed practice had the potential to affect 2 residents who used a restraint according to a list provided by the Minimum Data Set Coordinator dated 1/8/09. The findings are.</p> <p>1. The facility's policy and procedure titled "Restraints" documented, "A. Restraints should be applied only upon a physician written and</p>	F 221		

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F 221	Continued From page 5 signed order. The consent form is to be signed by the resident or authorized person." 2. Resident #6 had a diagnosis of General Anxiety Disorder, Depression, Vascular Dementia and Bipolar Disorder. The Admission Minimum Data Set dated 12/4/08 documented the resident had long and short term memory problems, was moderately impaired in cognitive skills for daily decision making, and did require the use of a restraint. a. A "Pre-Restraining Assessment" documented the resident had a short attention span and was disoriented. The section "Referrals/Recommendation" documented, "Interdisciplinary team evaluation Date __/__/__ (no date was written in) Recommendations: Seat belt in w/c (wheelchair) for security and to enable to be oob (out of bed). " The form was signed by License Practical Nurse #3 and dated 11/25/08. b. The Plan of Care dated 12/1/08 did not document the use of a seat belt restraint. c. The January 2009 Physician Orders sheet did not document an order for a seat belt restraint. d. On 1/5/09 at 1:40 p.m., the resident was sitting in a wheelchair with a seat belt restraint in place. The resident was asked if she could remove or release the belt and the resident was unable to release the belt. e. On 1/5/09 at 1:40 p.m. the Assistant Director of Nursing was asked if the resident could release the belt and stated, "Apparently not." f. As of 1/6/09 there was no documentation in	F 221		

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F 221	Continued From page 6 the clinical record of a signed physical restraint consent.	F 221			
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the Foley catheter and urethral meatus was cleaned during catheter care for 1 (Resident # 7) and the catheter tubing was secured to prevent the potential for trauma to the urinary meatus for 1 (Resident #3) of 6 (Resident #3, 4, 7, 8, 11, and 13) case mix residents who had an indwelling catheter. This failed practice had the potential to affect 8 residents who had an indwelling catheter according to a list provided by the MDS (Minimum Data Set) Coordinator on 1/8/09. The findings are: 1. Resident #3 had diagnoses of Urine Retention and Decubitus. The Annual MDS dated 12/31/08 documented the resident was severely impaired in cognitive skills for daily decision making and incontinent of bowel and had an indwelling catheter. a. The "Physician Orders" sheet dated 1/1/09 through 1/31/09 documented, "May change or irrigate Foley catheter if occluded, dislodged or	F 309			

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F 309	Continued From page 7 draining improperly. Cath (catheter) care q (every) shift. Change urinary drainage bag q month. Check cath strap q shift." b. The Plan of Care dated 1/7/09 documented, "Requires Foley catheter due to Dx (diagnosis) of Urinary Retention: 3. Position catheter tubing and drainage bag to allow for proper drainage." There was no documentation to secure tubing with a leg strap to prevent trauma to the urinary meatus. c. On 1/5/09 at 1:50 p.m., the Assistant Director of Nursing removed the resident's covers and the Foley catheter was not secured with a leg strap to prevent trauma to the urinary meatus. d. The facility's policy and procedure, "Routine Foley Catheter Care" documented, "2. Position the catheter using a leg strap as needed to secure against trauma..." 2. Resident #7 had diagnoses of Urinary Retention and Neurogenic Bladder. The Change of Condition MDS dated 10/27/08 documented the resident was moderately impaired in cognitive skills for daily decision making, had an indwelling Foley catheter and was incontinent of bowel. a. A physician order dated 7/12/05 documented, "Foley catheter DX: Retention of Urine." A physician order dated 3/7/08 documented, "Cath (catheter) care every shift." A physician order dated 3/18/08 documented, "Change urinary drainage bag every month, Check catheter strap every shift." b. The Plan of Care reviewed/updated on 9/1/08 and 10/27/08 documented, "6. Potential for	F 309			

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F 309	Continued From page 8 problems r/t (related to) Foley catheter - Diagnosis: Neurogenic bladder with retention. Chronic Urinary Tract Infections... Approaches 5. Catheter care every shift and as needed (PRN)." c. On 1/7/09 at 10:30 a.m., CNA (Certified Nursing Assistant) # 8 and 9 provided catheter care. CNA #9 cleaned all areas of the perineum and then pulled the foreskin back on the penis and wiped around the foreskin, then the resident was rolled to the right side and the rectal area was cleaned and dried. CNA #9 did not clean the urethral meatus or the catheter. d. The facility policy and procedure received from the Assistant Director of Nursing (ADON) on 1/8/09 at 5:30 p.m. Titled: Catheter Care (Indwelling Catheter) Procedure#5. Cleanse area well at catheter insertion, taking care not to pull on catheter or advance further into urethra. #6. All debris must be removed from catheter at insertion site. # 7. Rinse well with warm water and pat dry gently with clean towel. e. The Incontinent and Catheter Care Observation Checklist received from the ADON on 1/8/09 at 5:30 p.m. documented : Procedural Steps: # 8. Male: Wipe urinary meatus first in a circular motion, pull back foreskin of the uncircumcised male, wipe in a circular motion around the head of penis, if drying, change gloves and dry, return foreskin over head of penis, working down the shaft of penis, scrotum, and thighs changing areas on cloth for each wiping stroke. #9. Secure catheter at insertion site, wiping away from body and down the catheter 3-4 inches	F 309			
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION	F 323			

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F 323	<p>Continued From page 9</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure staff were properly trained in the use of a lift pad for transfers and the geri chair functioned properly for 1 (Resident #14) and a bed sheet was not utilized for transfers for 1 (Resident #12) of 3 case mix residents (Resident #8, 12 and 14) who were non-weight-bearing and required total assistance of staff with transfers. These failed practices had the potential to affect 16 residents who were non-weight bearing and required total assistance with transfers and 19 residents who required Geri chairs as documented on a list provide by the Director of Nurses (DON) on 1/8/09. The findings are:</p> <ol style="list-style-type: none"> 1. The facility Policy and Procedure for Lifting/transferring last reviewed/revised dated 8/26/04 documented, "If the resident is extremely heavy or difficult to handle with transfers, the lift can be used." 2. Resident #14 had diagnoses of Dementia and Obesity. The Annual Minimum Data Set (MDS) dated 1/5/09 documented the resident was severely impaired in cognitive skills for daily decision making, had short and long term memory problems, required total assistance of 2 	F 323		

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F 323	<p>Continued From page 10 staff for transfers and was lifted manually.</p> <p>a. The Care Plan revised 10/6/08 documented, "(#4) Problem: Resident requires low bed to prevent injury from rolling out of bed and reclining geri-chair when out of bed..." The approach for mechanical lift for all transfers had a line drawn through it and two to assist with transfers was hand written in.</p> <p>b. On 1/7/09 at 3:35 p.m., CNA (Certified Nursing Assistant) #1 and 2 finished dressing the resident. CNA #3 and 4 entered the room to assist with transferring the resident from the bed to the geri chair. CNA #3 stated they needed 4 CNA's because the lift won't fit under the bed. The resident was in a Pipe low bed. Two CNA's stood on each side of the bed. A dark blue lift pad with handles was placed under the resident. The bed was moved from against the wall and the Geri chair was placed by the side of the bed. The 2 CNA's by the wall stepped onto the mattress and lifted with the other 2 CNA's. The 2 CNA's walked across the mattress then stepped to the floor causing an unsteady gait. The head of the Geri chair was elevated. The resident was transferred into the chair in a laying position and then repositioned to a sitting position.</p> <p>c. On 1/8/09 at 12:05 p.m., the surveyor asked CNA #2 and #4 how they were taught to lift this resident. CNA #4 stated, "That dark blue lift pad is for 4 or 6 people to lift, going down to the low bed is easier but going up to the Geri chair, it's easier to walk the mattress because you have to lift him higher. Our DON and ADON (Assistant Director of Nursing) taught us how to lift him."</p> <p>d. On 1/8/09 at 12:05 p.m., the surveyor asked</p>	F 323		

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F 323	<p>Continued From page 11</p> <p>who determined the type of transfer for this resident. CNA #4 stated, "We decide which ever is more comfortable." (The care plan documented 2 person assist with transfers and did not address a lift pad.)</p> <p>e. On 1/8/09 at 2:40 p.m., CNA #2, #3, #5, #6 and #7 were observed at the bedside. The resident was in the Pipe low bed. The bed was turned with the head of the bed out in the floor. The Geri chair was placed at the head of the bed. The head of the Geri chair was elevated. A dark blue lift pad with handles was placed under the resident. CNA #3 stated, "this will be the first time we've tried it this way so we don't walk on the mattress". CNA #5 stated, "I'm going to stand behind the chair while the other 4 transfer him." There were 2 CNA's on each side of the low bed. A 4 person lift and transfer was performed to the G- chair. The G-chair rolled backwards. CNA #5 was unable to hold the G-chair in place. The resident was transferred in a laying position to the G-chair and repositioned to a sitting position. CNA #3 stated, "The chair is broke. It won't lock. It's been broke for a while. The chair behind you is broke too (Resident #12). We've told them they won't lock."</p> <p>3. Resident #12 had diagnoses of Dementia. The Quarterly MDS dated 1/5/09 documented the resident was severely impaired in cognitive skills for daily decision making, had short/long term memory problems and required 2 person assistance with transfer.</p> <p>a. The Care Plan revised on 10/6/08 documented a problem of being at risk for falls with an approach of "All transfers by 2 assist. Reclining geri-chair for position and comfort while out of</p>	F 323			

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PRINTED: 01/20/2009
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04A145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2009
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F 323	<p>Continued From page 12</p> <p>bed." The Care Plan did not address the type of transfer.</p> <p>b. On 1/8/09 at 12:15 p.m., CNA #2, #4, #10 and #11 were at the bedside. The resident was in a Geri chair by the side of the bed. A bed sheet was in the chair under the resident. There were 2 CNA's on each side of the bed. Two CNA's reached across the bed to the Geri chair to reach and grab the sides of the bed sheet. A 4 person transfer to the bed was provided. The resident's weight was documented at 157 pounds resulting in an inappropriate device for support/safety during the transfer.</p> <p>c. On 1/8/09 at 12:05 p.m., the surveyor asked CNA #4 who determined the type of transfer. CNA #4 stated, "We decide which ever is more comfortable, like a sheet or a blanket."</p> <p>4. On 1/8/09 at 3:30 p.m., the surveyor asked the DON and the ADON who was responsible to assess and determine the type of transfer for a resident. The ADON stated, "The Interdisciplinary team (IDT). We bought light blue and dark blue sheets with handles. I guess the CNA's didn't understand what to use." The surveyor also asked the DON and ADON if they were observing how the CNA's transferred Resident #14. The ADON stated, "One time. There is no easy way to transfer him and the 4 person lift is not an easy transfer." The surveyor asked have you re-evaluated to determine a different technique. The DON stated, "No, we just decided to continue using the same thing." The DON and ADON was asked who was responsible to ensure resident Geri chairs were in good repair. The ADON stated, "The maintenance man. We were not aware they were broken." The DON stated, "We</p>	F 323			

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F 323	Continued From page 13 have him on it right now." The surveyor asked what system was in place to inform the maintenance man of needed repairs. The DON stated, "The aides come and tell us or they write notes." The DON and ADON were asked who was responsible to supervise and monitor transfers. The ADON stated, "We all are."	F 323			
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 8:00 a.m. and 11:00 a.m. and 12:00 p.m. medication passes on 1/6/08 the facility failed to ensure that the medication error rate was less than 5%. Physicians orders were not followed on 3 residents (Resident #8, #9, and #10) of 13 residents observed during medication passes. Medication errors were made by 2 Licensed Practical Nurse (LPN) (LPN #1 and #2) of 2 licensed nurses observed administering medications. The medication error rate was 6.81% based on administration of 43 medications with 1 omission for a total of 44 medications with 3 medication errors observed. This failed practice had the potential to affect all 46 residents according the Assistant Director of Nursing (ADON) on 1/5/08. The findings are: 1. Resident #8 had no physician order for Colace 100 mg (milligrams). a. On 1/6/08 at 9:06 a.m., LPN #1 administered Colace 100 mg.	F 332			

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F 332	Continued From page 14 b. On 1/6/08 at 10:27 a.m., the surveyor asked LPN #1 if there was a physician order for the Colace 100 mg. LPN #1 looked in the clinical record and stated, "It's not there." 2. Resident #9 had a physician order dated 8/27/01 for Folic Acid 1 mg 1 tablet po (by mouth) every day. On 1/6/08 at 9:21 a.m., LPN #2 set up all the resident's medication except the Folic Acid 1 mg. LPN #2 put the medications back in the medication cart, locked the cart, and turned to go into the resident's room. The surveyor asked LPN #2 to identify the medications in the cup. There were 7 medications in the cup instead of 8 medications. LPN #2 rechecked the medications and the Folic Acid 1 mg was not popped out of the pharmacy provider bubble package. 3. Resident #10 had a physician order dated 8/1/08 for Valproic Acid 250 mg/ (per) 5 ml (milliliters) Give 2 teaspoonfuls or 10 ml po tid (three times a day). On 1/6/08 at 11:50 a.m., LPN #2 poured the Valproic Acid 250 mg/5 ml in a medication cup. LPN #2 place the Valproic Acid 250 mg/5 ml back in the medication cart and locked it. The surveyor asked LPN #2, "Does the resident have seizures?" LPN #2 stated, "Yeah." The surveyor asked LPN #2 to measure the Valproic Acid 250 mg/5 ml in a oral syringe. LPN #2 drew the medication into the syringe and there was 7.7 ml out of 10 ml., a shortage of 23%.	F 332		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of	F 333		

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F 333	Continued From page 15 any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, facility failed to ensure physician orders were followed for 1 of 1 case mix resident (Resident #10) who received Valproic Acid for seizures. This failed practice resulted in a significant medication error that had the potential to affect only 1 resident who received Valproic Acid 250 mg (milligrams)/ 5 ml (milliliters) according to the Assistant Director of Nursing (ADON) on 1/6/09. The findings are: Resident #10 had a diagnosis of Seizures. a. A physician order dated 8/1/08 documented Valproic Acid 250 mg (milligrams)/5 ml (milliliters) Give 2 teaspoonfuls or 10 ml po tid (three times a day). b. On 1/6/09 at 11:50 a.m., LPN #2 poured the Valproic Acid 250 mg/ 5 ml in a medication cup. LPN #2 place the Valproic Acid 250 mg/5 ml back in the medication cart and locked it. The surveyor asked LPN #2, "Does the resident have seizures?" LPN #2 stated, "Yeah." The surveyor asked LPN #2 to measure the Valproic Acid 250 mg/5 ml in a oral syringe. LPN #2 drew the medication into the syringe and there was 7.7 ml out of 10 ml a shortage of 23%. c. This was a significant medication error due to the class of medication (antiepileptic).	F 333			
F 458 SS=C	483.70(d)(1)(ii) RESIDENT ROOMS Bedrooms must measure at least 80 square feet	F 458			

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F 458	<p>Continued From page 16</p> <p>per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure multiple resident rooms provided at least 80 square feet of living space for each resident. This failed practice had the potential to affect all 46 residents. The findings are:</p> <p>On 1/20/09 at 8:45 a.m., the Administrator stated that the rooms required for a waiver were the same as previous years.</p> <p>a. Semi-private Resident Room #1, #3, #5, #7, #9 and #10 through #15 on the North Hall and semi-private Resident Room #1, #3, #5 #7, #9 and #10 through #15 on the South Hall measured 14.2 feet by 10.2 feet each for a total of 144.84 square feet (divided by 2 residents per room would provide a total of 72.42 square feet per resident).</p> <p>b. Semi-private Resident Room #2, #4 and #6 on the North Hall and semi-private Resident Room #2, #4 and #6 on the South Hall measured 16 feet by 9.5 feet each, for a total of 152 square feet (divided by 2 residents per room would provide 76 square feet per resident).</p> <p>c. The 4 bed ward rooms #16 and #17 on the North and South Halls measured 16 feet by 17 feet each, minus 7.8 square feet of closet space for a total of 264.2 square feet (divided by 4 residents per room would provide a total of 66.05 square feet per resident .</p>	F 458			