

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

PRINTED: 06/04/2008
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 R 05/29/2008
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 333} SS=E	<p>483.25(m)(2) MEDICATION ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to follow physician's orders to ensure that residents were free of significant medication error for 1 (Resident #4) of 8 residents case mix (Residents #1 thru #8) who received medications. This failed practice had the potential to affect all 53 residents who received medications. The findings are:</p> <p>Resident #4 had a diagnosis of History of Aneurysm.</p> <p>a. The physician orders dated 4/4/08 documented the resident was discharged back to the nursing home from the hospital with orders to "Cont (continue) meds (medications) per nrs (nursing) home MARS (Medication Administration Records) Add: Norvasc 5 mg (milligrams) PT (per tube) QD (every day)..."</p> <p>b. As of 5/29/08, there was no documentation on the April or May 2008 MAR of an order for Norvasc 5 mg or that it was administered.</p> <p>c. On 5/29/08 at 5:05 p.m. the ADON and Director of Nursing were asked, "Did you find any clinical records to show a discontinue of the Norvasc 5 mg?" The ADON and DON shook their head and stated, "No."</p> <p>d. This was a significant medication error due to the frequency of this medication error.</p>	{F 333}		5/9/08	

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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