

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

PRINTED: 04/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2008
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NAME OF PROVIDER OR SUPPLIER SEARCY HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SKYLINE DRIVE SEARCY, AR 72143
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F 000	INITIAL COMMENTS	F 000		
F 221 SS=E	<p>Complaint #13299 was unsubstantiated. Complaint #13400 was unsubstantiated.</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 Physical Restraint Informed Consent forms documented medical symptoms, specific target behaviors and that the least restrictive restraint was utilized for 6 (Resident # 1, # 2, # 4, # 9, # 10 and # 15), failed to ensure a restraint reduction was attempted for 1 (Resident # 4) and failed to ensure a pre restraining evaluation was completed for 2 (Resident # 1 and # 2) of 8 case-mix residents (Resident # 1, #2, # 4, # 5, # 8, # 9, # 10 and # 15) that had physical restraints. This failed practice had the potential to effect 33 residents that have restraints according to the Resident Census and Conditions of Residents form dated 3/15/08. The findings are:</p> <p>1. Resident # 10 had a diagnoses of Fractured Humerus, Anxiety Disorder, Dementia and Depressive Disorder. The Minimum Data Set (MDS) dated 2/29/08 documented the resident was moderately impaired in cognitive skills for daily decision making, had periods of restlessness, mental functions varied over the course of the day, had repetitive physical movements, wandered and had a trunk restraint.</p>	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 221	Continued From page 1 a. A Physician's Order dated 2/7/08 documented, "White locking table top to wheel chair at all times ..." b. A Physical Restraint Informed Consent form dated 2/7/08 documented a "white locking table top" was to be on the wheel chair at all times. The section for specific target behaviors was blank. 2. Resident #4 had diagnoses of Alzheimer's Dementia, Depressive Disorder and Diabetic Neuropathy. The Quarterly MDS dated 01/21/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive to total assistance for most ADLs and had a trunk restraint. a. A Physical Restraint Informed Consent form dated 01/23/07 documented the restraint type as a side release seat belt. The section for the less restrictive, alternative non restraint approach was blank. The sections for specific target behaviors and medical symptoms were blank. b. A Physician's Order dated 2/5/08 documented, "Push button seat belt with alarm to w/c." c. The Physical Restraint Elimination Assessment form documented on 04/16/07, 10/19/07 and 01/18/08 that the resident was a "good candidate" for restraint elimination with scores of 26, 26 and 31, respectively. The form documented a score of 21-35 was a good candidate for restraint reduction. d. On 03/16/08 at 3:10 p.m., the resident was	F 221		

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F 221	<p>Continued From page 2</p> <p>observed to have a pushbutton seat belt applied while up in her wheelchair.</p> <p>e. On 03/17/08 at 10:30 p.m., the resident was observed to have a pushbutton seat belt applied while up in her wheelchair.</p> <p>3. Resident #15 had diagnoses of Alzheimer's Dementia, Depressive Disorder and Anxiety Disorder. The Quarterly MDS dated 12/21/07 documented the resident was moderately impaired in cognitive skills for daily decision making and required extensive to total assistance for most ADLs and full bed rails were used daily.</p> <p>a. A Physician's Order dated 1/2/08 documented, "Continuous seat belt to w/c."</p> <p>b. A Physical Restraint Informed Consent form dated 01/2/08 documented the restraint type as a continuous seat belt to the wheel chair. The section for the less restrictive and alternative non restraint approach was blank. The section for medical symptoms was blank.</p> <p>c. On 03/15/08 at 2:19 p.m., the resident was observed to have a soft belt restraint applied while up in her wheelchair.</p> <p>d. On 03/16/08 at 10:45 a.m., the resident was observed to have a soft belt restraint applied while up in her wheelchair.</p> <p>4. Resident # 1 had diagnoses of Abnormal Posture, Parkinson's Disease, and Difficulty in Walking. The quarterly MDS dated 1/9/08 documented the resident was moderately in cognitive skills for daily decision making, required</p>	F 221			

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F 221	Continued From page 3 total staff performance for activities of daily living and had no restraints. a. A Physician's Order dated 1/23/08 documented, "Velcro seat belt with alarm to w/c (wheelchair)." b. On 3/16/08, the clinical record was reviewed. There was no documentation of a pre restraining evaluation. 5. Resident #2 had a diagnoses of Stage 6 Alzheimer's Disease and Ataxia. The Quarterly MDS dated 1/21/08 documented the resident was severely impaired in cognitive skills for daily decision making and was independent in transfers and ambulation. a. A Nurse's Note dated 2/12/07 documented the resident fell in the dining room and a Physician's Order was initiated for a white lap tray while up in the wheelchair for 24 hours until a therapy evaluation could be obtained. b. A Nurse's Note dated 2/13/08 documented, "Resident is very unsteady on her feet. OT (Occupational Therapy) is working with her and recommended Velcro seat belt with alarm when up in w/c r/t (related to) weakness and hx (history) of falls." c. A Physical Restraint Informed Consent form dated 2/13/08 documented, "Velcro seat belt with alarm at all [times] when up in w/c. Specific Target Behaviors: [Increased] confusion, [increased] wandering, unsteady gait. Medical Symptoms: hx of falls, [increased] weakness." d. An Occupational Therapy Progress Note dated	F 221			

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F 221	Continued From page 4 2/26/08 documented, "Prior Week Level: Velcro seatbelt with alarm. Current Week Level: Continuous seatbelt....for good safety, Updated Short Term Goals/Prognosis: Continue poc (plan of care), with emphasis on finalizing program for w/c seating safety, assessing w/c devices/as needed/appropriate." e. As of 3/17/08, there was no documentation in the clinical record of a pre restraining evaluation or initiation of a less restrictive measure. 6. On 3/18/08 at 11:00 a.m., the Director of Nursing (DON) was asked about documentation and reduction of restraints. The DON stated, " ... If the paperwork or documentation is not there (in the chart), we don't have it."	F 221		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a soft belt restraint was applied properly for 1 (Resident # 10) of 8 (Resident # 1, # 2, # 4, # 5, # 8, # 9, # 10 and # 15) case mix residents with physical restraints and failed to ensure harmful chemicals were properly secured on hall 5 to prevent possible injury. These failed practice had the potential to effect 33 residents with restraints	F 323		

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F 323	<p>Continued From page 5</p> <p>according to the Resident Census and Conditions of Residents form dated 3/15/08 and 5 confused, mobile residents that resided on hall 5 provided by the Director of Nurses on 3/19/08. The findings are:</p> <p>1. Resident # 10 had diagnoses of Dementia with behaviors, Fractured Arm and Anxiety Disorder. The Minimum Data Set (MDS) dated 2/29/08 documented the resident was moderately impaired in cognitive skills for daily decision making, had periods of restlessness, mental functions varied over the course of the day, had repetitive physical movements and wandered.</p> <p>On 3/17/08 at 8:20 a.m., the resident was observed sitting in a wheel chair with a soft belt restraint applied. The restraint was positioned around the resident's abdomen, the straps of the restraint was crisscrossed in the back of the resident's wheelchair and tied to the frame of the wheel chair with knots. The strap on the right side was secured with one knot. The strap on the left side was double knotted. Certified Nursing Assistant (CNA) # 1 noticed the restraint straps were secured with knots. The CNA struggled for 1 to 1 1/2 minutes to untie the restraint and stated, "One side was in a double knot and I had a hard time getting it undone."</p> <p>2. The facility policy and procedure documented, "Physical Restraint Application ... Methods of application for Soft Tie Belt ... Tie behind wheelchair ... with a slip knot to allow for speedy removal in an emergency."</p> <p>3. On 3/18/08 at 10:27 a.m., the Hall 5 supply box was not locked and the following patient care items were in the box:</p>	F 323			

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F 323	Continued From page 6	F 323		
F 329 SS=E	<p>a. 1 tube of Aloe Vesta Skin Protectant, and 3 bottles of Aloe Vesta Skin Protectant.</p> <p>b. 1 package of Lantiseptic Skin Protectant</p> <p>c. The warning labels on all 4 products documented, "If swallowed get medical help or consult a Poison Control Center right away."</p> <p>483.25(l) UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 329		

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F 329	<p>Continued From page 7</p> <p>Based on observation and record review, the facility failed to ensure a dose reduction was attempted in the absence of clinical rationale for continued use without clinical symptoms present and documented in the clinical record for 7 (Resident #1, #3, #8, #13, #18, #22 and #23) of 14 (Residents #1, #2, #4, #5, #6, #8, #9, #11, #12, #15, #18, #22, #23 and #24) case mix residents that received Proton Pump Inhibiting or psychoactive medications. These failed practices had the potential to effect 29 residents that received Proton Pump Inhibitors, 68 residents that received Antianxiety drugs and 28 residents that received Hypnotic drugs as documented on the lists provided by the Director of Nurses (DON) on 3/18/08. The findings are:</p> <p>1. Resident #8 had a diagnosis of Esophageal Reflux. The Minimum Data Set (MDS) dated 2/22/08 documented the resident was modified independent in cognitive skills for daily decision making.</p> <p>a. A Physician's Order dated 6/1/07 documented, "Prevacid 30 mg (milligrams) Solutab 1 per Peg (Percutaneous Enterogastrostomy) daily."</p> <p>b. The Drug Regimen Review from 8/5/07 thru 3/4/08 had no documentation regarding the Prevacid.</p> <p>b. The Medication Administration Records (MAR) dated June 2007 to March 2008 documented the resident received Prevacid daily.</p> <p>c. As of 3/18/08, there was no documentation in the clinical record that a dose reduction had been attempted and there was no physician's risk versus benefit statement to indicate if a dose</p>	F 329			

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F 329	<p>Continued From page 8 reduction would be clinically contraindicated.</p> <p>2. Resident #18 had diagnoses of Heartburn, Gastrointestinal Bleed and Peptic Ulcer Disease. The MDS dated 12/26/07 documented the resident was moderately impaired in cognitive skills for daily decision making.</p> <p>a. A Physician's Order dated 10/11/07 documented, "Prilosec OTC 20 mg (1) capsule by PO (by mouth) QD (every day)."</p> <p>b. As of 3/19/08, there was no documentation in the clinical record of any symptoms that required the extended use of Prilosec, a Proton Pump Inhibitor.</p> <p>c. A Consultant Pharmacist Communication form dated 02/22/08 documented a recommendation to taper the current dosage. The form documented the physician's response as follows, "Pt (patient) is stable with ...Prilosec. No Change. He is doing well." No further documentation was provided by the physician to explain why the continued need of Prilosec was warranted.</p> <p>3. Resident #23 had diagnoses of Gastroesophageal Reflux Disease. The MDS dated 1/14/08 documented the resident was moderately impaired in cognitive skills for daily decision making.</p> <p>a. A Physician's Order dated 9/17/07 documented, "Omeprazole (Prilosec) OTC 20 mg (1) capsule PO QD."</p> <p>b. A Consultant Pharmacist Communication form dated 10/05/07 documented a recommendation to taper the current dosage of Prilosec. There</p>	F 329			

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F 329	Continued From page 9 was no further documentation regarding the Prilosec thru 3/7/08. c. As of 3/19/08, there was no documentation in the clinical record of any symptoms that required the extended use of Omeprazole (Prilosec), a Proton Pump Inhibitor. There was no documentation in the clinical record to explain why the continued need of Prilosec was warranted. 4. Resident # 1 had a diagnosis of Gastroesophageal Reflux Disease. The quarterly MDS dated 1/9/08 documented the resident was moderately impaired in cognitive skills for daily decision making. a. A Physician's Order dated 6/29/07 documented, "Prilosec OTC (over the counter), 20 mg Bid (twice daily)." b. The Drug Regimen Review dated 8/4/07 thru 3/7/08 had no documentation regarding the Prilosec. b. As of 3/17/08, there was no documentation in the clinical record of symptoms that required the extended use of Prilosec, a Proton Pump Inhibitor. There was no documentation in the clinical record that a dose reduction had been attempted. There was no documentation in the clinical record to explain why the continued need of Prilosec was warranted. 5. Resident #22 had diagnoses of History of Gastroesophageal Reflux Disease. The Significant Change MDS dated 1/30/08 documented the resident was moderately	F 329			

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F 329	<p>Continued From page 10</p> <p>impaired in cognitive skills for daily decision making.</p> <p>a. A Physician's Order dated 12/31/07 documented, "Change Prilosec to Prilosec OTC 20 mg 1 po (by mouth) QD (daily)."</p> <p>b. As of 3/19/08, there was no documentation in the clinical record of symptoms that required the extended use of Prilosec, a Proton Pump Inhibitor. There was no documentation in the clinical record that a dose reduction had been attempted. There was no documentation to explain why the continued need of Prilosec was warranted.</p> <p>6. Resident # 13 had a diagnosis of Depression. The quarterly MDS dated 1/6/08 documented the resident was moderately impaired in cognitive skills for daily decision making.</p> <p>a. A Physician's order dated 4/17/07 documented "Lexapro 20 mg tab, 1 PO daily."</p> <p>b. As of 3/18/08, there was no documentation in the clinical record of symptoms that required the extended use of Lexapro for depression. There was no documentation in the clinical record that a dose reduction had been attempted. There was no documentation to explain why the continued need for Lexapro was warranted.</p> <p>7. Resident # 3 had diagnoses of Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. The Quarterly MDS dated 1/11/08 documented the resident was moderately impaired in cognitive skills for daily decision making.</p>	F 329			

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F 329	Continued From page 11 a. A Physician's Order dated 8/19/07 documented, "Ambien 10 mg at Hour of Sleep PRN (as needed) 5 days." b. The Medication Administration Records from December 2007 to March 18, 2007 documented the resident only received the medication twice in February. c. As of 3/17/08, there was no documentation in the clinical record that a dose reduction had been attempted. There was no documentation to explain why the continued need for Ambien was warranted. 8. The Nursing 2007 Drug Handbook page 715 documented: ". . . Prevacid . . . Indication & Doses: short term treatment of symptomatic gastroesophageal reflux disease (GERD) Adults: 15 mg. (milligrams) P.O. (by mouth) once daily for up to 8 weeks. 9. The Nursing 2007 Drug Handbook page 718 documented: ". . . Prilosec . . . Indications & Doses Symptomatic gastroesophageal reflux disease (GERD) with esophageal lesions. Adults: 20 mg. P.O. as delayed-release or oral suspension, daily for 4 weeks for patients who respond poorly to customary medical treatment, usually including an adequate course of H 2 receptor antagonists. Erosive esophagitis and accompanying symptoms caused by GERD. Adults: P.O. daily for 4 to 8 weeks. 10. The Geriatric Dose Handbook 12 th. Edition documented:	F 329			

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F 329	Continued From page 12 " . . . Lexapro . . . Special populations: Elderly: Use caution in elderly patients . . ."	F 329		
F 332 SS=E	11. The PharMerica Select: A Comparative Geriatric Drug Guide for Formulary Selection documented: " Ambien. . . Use Short-term treatment of insomnia . . . Warnings Closely monitor elderly or debilitated patients for impaired cognitive or motor performance. . . Usual Dosage Oral (duration of therapy should be limited to 7-10 days) . . ." 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 and record review of the 4:00 p.m. and 5:00 p.m. medication pass on 3/17/08 and the 9:00 a.m. medication pass on 3/18/08, the facility failed to ensure that the medication error rate was less than 5%. Physician's Orders were not followed on 3 (Resident #29, #30 and #31) of 12 residents observed during medication passes resulting in medication errors. Medication errors were made by 3 Licensed Practical Nurse (LPN) (LPN #1, #2 and #3) of 8 licensed nurses observed administering medications in the facility. This practice has the potential to affect 87 residents according to the Director of Nursing (DON) on 3/19/08. The medication error rate was 13.04% based on administration of 44 medications with 2 omissions for total of 46 with 6 medication errors observed. The findings are:	F 332		

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F 332	<p>Continued From page 13</p> <p>1. Resident #29 had a Physician's Order dated 9/12/07 for Calcium Carb 600 milligrams (mg) with vitamin D 1 tablet (tab) per mouth (po) twice a day (bid) with food. May crush and admin (administer) in applesauce, food, or liquid unless otherwise indicated and Depakote sprinkles 125 mg 1 (cap) capsule po three times a day (tid) with food. May open and admin in applesauce, food, or liquid unless otherwise indicated.</p> <p>a. On 3/17/08 at 4:15 p.m., LPN #1 administered Calcium Carb 600 mg with Vitamin D and the Depakote sprinkle 125 mg to the resident in their room with water.</p> <p>b. This resulted in two medications errors.</p> <p>2. Resident #30 had a Physician's Order dated 12/31/07 for Potassium Chloride 20 (mEq) milliequivalents /15 (ml) milliliters per PEG (percutaneous enteral gastrostomy) bid.</p> <p>a. On 3/17/08 at 5:25 p.m., LPN #2 administered medication to the resident via PEG tube. The LPN mixed all liquid medications and crushed medications together in a cup and poured it into a syringe. The LPN did not dilute the medication prior to administering.</p> <p>b. The Potassium Chloride 10% manufacturer bottle documented, "Must be diluted."</p> <p>c. The Tube Feeding Practical Guidelines and Nursing Protocols documented on pages 102 and 103, "General rules and written guidelines for medication administration can provide nurses with clear steps to take to avoid tube occlusion and to optimize therapeutic response of the medication ... Prepare medication by diluting liquid</p>	F 332			

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F 332	Continued From page 14 medication with 30 ml of water or by crushing tablet with a mortar and pestle to a fine powder and mix with water. 3. Resident #31 had a Physician's Order dated 11/12/07 for Depakote 125 mg SPR (Sprinkle) 2 (250 mg) po daily with food. May open and mix with food. On 3/18/08 at 9:50 a.m., LPN # 3 administered the resident's medications with a full glass of water. 4. Resident #31 had a Physician's Order dated 2/12/08 for Vitamin C 500 mg 1 po BID and Zinc 220 mg 1 po BID. There was no stop order. a. On 3/18/08 at 9:30 a.m., LPN # 3 did not administer the Vitamin C 500 mg or the Zinc 220 mg to the resident. b. On 3/19/08 at 9:30 a.m.. the DON stated, "There was no Doctor's telephone order to discontinue the Vitamin C or Zinc." c. This resulted in two medication errors.	F 332		
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425		

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F 425	<p>Continued From page 15</p> <p>administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record, review the facility failed to ensure medications were administered according to the manufactures specifications for 3 residents (Resident #29, #32 and #33). This failed practice has the potential to affect 12 residents observed during the 4:00 p.m. medication pass. The findings are:</p> <p>1. Resident #32 had a Physician's Order dated 3/7/08 for Pentoxifylline ER 400 mg (milligrams) give 1 by mouth two times a day. The resident had a diagnosis of Peripheral Vascular Disease and Esophageal Reflux.</p> <p>a. On 3/17/08 at 3:40 p.m., Licensed practice nurse (LPN) #4 administered the resident's medications with a glass of water.</p> <p>b. The Nursing 2008 Drug Handbook located at the nurse's station documented, " Indications and Dosages: . . . Adults: 400 (mg) milligrams per mouth (P.O.) three times a day (t.i.d.) with meals. . . Patient teaching: Advise patient to take drug with meals to minimize GI (gastrointestinal) upset ... "</p>	F 425		

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F 425	Continued From page 16 c. A patient transfer form dated 3/7/08, from the Medical Center the resident was discharged from, documented Pentoxifylline ER 400 mg UD (unit dose) twice a day (bid)-food. 2. Resident #33 had a Physician's Order dated 10/31/05 for Exelon 4.5 mg 1 po bid. May open and admin (administer) in applesauce, food, or liquid unless otherwise indicated. a. The bubble pack from the provider pharmacy dispensed to the resident documented, "Take with food." b. The Medication Administration Record for March 2008 documented, "... May open and admin (administer) in applesauce, food or liquid." b. On 3/17/08 at 3:55 p.m., LPN #4 administered the resident's medications by opening the capsule and mixing it with a teaspoon of applesauce. c. On 3/17/08 at 3:55 p.m., the LPN was asked, "Why do you use applesauce to give the resident their medications?" The LPN stated, "It just helps them go down easier." d. The Nursing 2008 Drug Handbook located at the Nurses Station documented, "Indications and dosage ... Adults: Initially, 1.5 mg P.O. b.i.d. with food ... Patient teaching: Tell caregiver to give rivastigmine (Exelon) with food in the morning and evening." 3. Resident #29 had a Physician's Order dated 9/12/07 for Advair 250/50 diskus inhaler 1 puff bid, clean diskus after each use.	F 425			

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F 425	Continued From page 17 a. On 3/17/08 at 4:15 p.m., LPN #1 administered the inhaler then gave the resident a glass of water and stated, "Here is some water to rinse your mouth with." No instructions to rinse and spit were given to the resident. b. The 2008 Physicians' Desk Reference documented, "... After inhalation, the patient should rinse the mouth with water without swallowing ..." c. The package insert for the Advair Diskus documented: Remember: >Never breathe into the Diskus. >Never take the Diskus apart. >Always ready and use the Diskus in a level, flat position. >Do not use the Diskus with a spacer device. >After each dose, rinse your mouth with water and spit the water out. Do not swallow. >Never wash mouthpiece or any part of the Diskus. Keep it dry. >Always keep the Diskus in a dry place. >Never take an extra dose, even if you did not taste or feel the medicine.	F 425			
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428			

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F 428	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to ensure the consultant pharmacist notified the physician and Director of Nursing (DON) of the need for a gradual dose reduction in the absence of documented clinical rationale for continued use and clinical symptoms for 3 (Residents #1, #8 and #22) of 5 (Resident #1, #8, #18, #22 and #23) case mix residents that received Proton Pump Inhibitors beyond the manufacturer's recommended time frame without evidence of therapeutic benefit. This failed practice had the potential to effect 29 residents that received Proton Pump Inhibitors as documented on lists provided by the DON on 3/18/08. The findings are:</p> <ol style="list-style-type: none"> 1. Resident #1 had a diagnosis of Gastroesophageal Reflux Disease (GERD). The quarterly Minimum Data Set (MDS) dated 1/9/08 documented the resident was moderately in cognitive skills for daily decision making. <ol style="list-style-type: none"> a. A Physician's Order dated 6/29/07 documented, "Prilosec OTC (over the counter) 20 mg (milligrams) Bid (twice daily).". b. The Drug Regimen Review dated 8/4/07 thru 3/7/08 had no documentation regarding the Prilosec. c. As of 3/17/08, there was no documentation in the clinical record of symptoms that required the extended or increased use of Prevacid, a Proton Pump Inhibitor. There was no documentation that a dose reduction had been attempted. There was no documentation to explain why the continued need for Prilosec was warranted. 	F 428			

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F 428	Continued From page 19 2. Resident #22 had a diagnosis of GERD. The Significant Change MDS dated 1/30/08 documented the resident was moderately impaired in cognitive skills for daily decision making. a. A Physician's Order dated 12/31/07 documented, "Change Prilosec to Prilosec OTC 20 mg 1 po (by mouth) QD (daily)." b. As of 3/19/08, there was no documentation in the clinical record of symptoms that required the extended or increased use of Prilosec, a Proton Pump Inhibitor. There was no documentation that a dose reduction had been attempted. There was no documentation to explain why the continued need for Prilosec was warranted. 3. Resident #8 had a diagnosis of GERD. The MDS dated 2/22/08 documented the resident was modified independent in cognitive skills for daily decision making. a. A Physician's Order dated 6/1/07 documented, "Prevacid 30 mg. Solutab 1 per PEG (Percutaneous Enterogastrostomy) daily. Dissolve in H2O (water)." b. The Drug Regimen Review from 8/5/07 thru 3/4/08 had no documentation regarding the Prevacid. c. As of 3/18/08, there was no documentation in the clinical record that a dose reduction had been attempted and there was no documentation to explain why the continued need for Prevacid was warranted.	F 428			