

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Methodist Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 7425 Euper Lane Fort Smith, AR 72903	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview, record review, facility document review, and facility policy review, it was determined the facility failed to ensure administration of correct medication to correct resident for 1 (Resident #76) of 1 sample mix residents for medication administration.</p> <p>The findings are:</p> <p>Review of Resident #76's Care Plan with an initiated date of 04/28/2024 noted the resident had an allergy to statin medications.</p> <p>Review of Resident #76's Medication Administration Records (MAR) dated June 2024 noted, the physician ordered the following medications:</p> <p>Amlodipine 5 (milligrams) mg for high blood pressure</p> <p>Fenofibrate 54mg for high cholesterol</p> <p>Aricept 5mg for dementia</p> <p>Melatonin 6mg for insomnia</p> <p>Namenda XR Extended Release (ER) 24- hour (HR) 28mg (memantine) for dementia</p> <p>Fenofibrate 54mg for cholesterol due to the allergy to statins.</p> <p>Review of the Medication Error Report dated June 1, 2024, revealed Certified Medication Assistant (CMA) #13 reported that both Resident #76 and Resident #47's medication were taken to the secured unit dining room where both residents had their dinner trays. Both residents take their medications better crushed and with their meal. CMA #13 labeled each medication cup with first names of each resident. CMA #13 called Resident #76 by first name; Resident #76 responded. CMA #13 gave Resident #76 a bite of the medication. Resident #76 had already swallowed the medication. CMA #13 then immediately realized the medications were mixed up and Resident #76 received Resident #47 medication. CMA #13 notified the nurse who then called the chain of command. CMA #13 checked Resident #76 blood pressure which was 140/80. The medications that Resident #76 received were:</p> <p>Atorvastatin 20 mg</p> <p>Amlodipine 5mg</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Buspirone 7.5mg</p> <p>Aricept 10mg</p> <p>Hydralazine</p> <p>Melatonin 6mg</p> <p>Mirtazapine 7.5mg</p> <p>Namenda 10mg</p> <p>Resident #76 was given a lower dose than prescribed by the physician, Namenda XR ER 24HR 28MG (memantine).</p> <p>Review of the Resident #47 Physician Orders with a start date of 5/1/2024 noted:</p> <p>Atorvastatin 20 mg</p> <p>Amlodipine 5mg</p> <p>Buspirone 7.5mg</p> <p>Aricept 10mg</p> <p>Hydralazine 100mg</p> <p>Melatonin 6mg</p> <p>Mirtazapine 7.5mg</p> <p>Namenda 10mg.</p> <p>On 10/23/2024 at 10:03AM, during an interview with the Assistant Director of Nursing (ADON), ADON confirmed, when Resident #76 was given the wrong medication, the vital signs were monitored. When the blood pressure dropped Resident #76 was then sent to the Emergency Room. CMA #13 received one on one training.</p> <p>During an interview with the Director of Nursing (DON) on 10/23/2024 at 10:10AM, DON confirmed, the CMA #13 pulled Resident #47 and Resident #76's medications at the same time. Both residents receive crushed medications. Some of the medications were the same for each resident. CMA #13 received counseling with action plan of one-on-one training with four weeks of supervised medication pass (June 14, 22, 25 and July 5, 2024) and 30 days of probation.</p> <p>During an interview with DON on 10/23/2024 at 4:19PM, she confirmed not all staff that administered medication were provided in-service training at that time. CMA #13 did not follow protocol. A skill check off was completed with other medication technicians and nurses.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with CMA #13 on 10/23/2024 at 4:10PM, she confirmed Resident #76 was provided the wrong medication. CMA #13 was rushing to get the medications to Resident #76 and Resident #47 before they ate. CMA #13 carried both residents initialed medication cups into the secured unit dining room, in the same hand. CMA # 13 grabbed the spoon from Resident #47's cup and gave Resident #76 the medicine. CMA #13 knew Resident #47 had lots of blood pressure medications. CMA #13 took Resident #76's blood pressure while the nurse contacted the chain of command. Resident #76 and Resident #47 prefer their medications during mealtime. CMA #13 stated medications need to be pulled for one resident at a time, so a medication error is not made, to ensure the right medication is given to the right resident and do the five rights of medication administration. After my one-on-one training, I was watched for four weeks, and I am on probation for three months.</p> <p>During an interview with CMA #14 on 10/24/2024 at 8:55AM, she confirmed they (the staff) are to ensure residents receive correct medication by asking their name and birthday. Only one medication at a time should be pulled so you don't get them mixed up or make a medication error.</p> <p>During an interview with CMA #15 on 10/24/2024 at 8:57AM, she confirmed they are to ensure residents receive correct medication and compare medication cards to the Medication Administration Record. Only one medication at a time is pulled so you do not make a mistake, a medication error or give the wrong medication to the wrong resident.</p> <p>During an interview with Licensed Practicing Nurse #16 on 10/24/2024 at 9:35AM, she confirmed they are to ensure residents receive correct medication, verify the resident's medication orders against the Medication Administration Record, and verify name and date of birth by asking resident. Only one medication at a time should be pulled so you do not get them mixed up and to decrease the risk of a medication error.</p> <p>During an interview with Licensed Practicing Nurse #17 on 10/24/2024 at 9:40AM, he confirmed they are to ensure residents receive correct medication, double check the resident ' s Medication Administration Record against the medication card. Check the name, date of birth and picture against the Medication Administration Record. Only one medication at a time is pulled so you do not make a medication error.</p> <p>Review of the facility policy and procedure titled Medication Administration with a revision date of 5/29/2024 noted, check Electronic Medication Administration Record and verify resident, greet and identify the resident. Do not crush or manipulate extended-release medications.</p>		