STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045327	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIDGECREST HEALTH AND REHABILITATION	5504 E JOHNSON AVE JONESBORO, AR 72401

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)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 772) was substantiated, all or in part, with these findings. Based on record review and interviews, the facility failed to ensure the physician was notified promptly when the pharmacy no longer filled the medication [MEDICATION NAME], resulting in a resident not receiving medication for approximately 11 days for 1 (Resident #1) of 1 resident. The findings are: Resident (R) #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 3/15/20 documented the resident scored 7 (0 - 7 indicated severe impairment) on the Brief Interview for Mental Status (BIMS) and exhibited wandering behaviors daily. 1. The Care Plan dated 5/20/19 documented, .The resident lacks capacity to understand and make decisions regarding healthcare due to [MEDICAL CONDITION] . 2. A physician's orders [REDACTED]. [MEDICATION NAME] Capsule 20-10 MG ([MEDICATION NAME]-[MEDICATION NAME]) Give 1 capsule by mouth one time a day related to [MEDICAL CONDITION], unspecified . 3. The May 2020 Medication Administration Record, [REDACTED].[MEDICATION NAME] Capsule 20-10 mg give 1 by mouth one time a day for [MEDICAL CONDITION], unspecified . 4. The May 2020 Chart Code on page 17 of the MAR indicated [REDACTED]= other see progress notes . 5. A Progress Note dated 5/5/20 at 8:18 a.m. and signed by Licensed Practical Nurse (LPN) #2, documented, . [MEDICATION NAME] Capsule 20-10 MG Give 1 capsule by mouth one time a day related to [MEDICAL CONDITION], UNSPECIFIED Cannot get this drug any more per pharmacy. (Pharmacy #1) Faxed doctor . 6. A Progress note dated 5/6/20 at 8:54 a.m. and signed by LPN #1, documented, . [MEDICATION NAME] Capsule 20-10 MG Give 1 capsule by mouth one time a day . ordered from pharmacy . 7. A Progress Note dated 5/9/20 at 8:45 a.m. and signed by LPN #2, documented, . [MEDICATION NAME] Capsule 20-10 MG Give 1 capsule by mouth one time a day . Can no longer get this medication . There was no documentation of attempts to notify the Physician. 8. A Progress Note dated 5/10/20 at 8:46 a.m. and signed by LPN #2, documented, . [MEDICATION NAME] Capsule 20-10 MG Give 1 capsule by mouth one time a day . No medication available . 9. A Progress Note dated 5/11/20 at 8:41 a.m. and signed by LPN #3 documented, . [MEDICATION NAME] Capsule 20-10 MG Give 1 capsule by mouth one time a day . waiting on pharmacy . 10. A Progress Note dated 5/13/20 at 9:13 a.m. and signed by LPN #2, documented, . [MEDICATION NAME] Capsule 20-10 MG Give 1 capsule by mouth one time a day . Can no longer get this medication . There was no documentation of attempts to notify the Physician. 11. A Progress Note dated 5/14/20 at 8:40 a.m. and signed by LPN #2 documented, . [MEDICATION NAME] Capsule 20-10 MG Give 1 capsule by mouth one time a day . No medication to give . 12. A Progress Note dated 5/15/20 at 8:48 a.m. and signed by LPN #2 documented, . [MEDICATION NAME] Capsule 20-10 MG Give 1 capsule by mouth one time a day . Not available . 13. A Progress Note dated 5/16/10 at 8:21 a.m. and signed by LPN #3 documented, . [MEDICATION NAME] Capsule 20-10 MG Give 1 capsule by mouth one time a day . not available . 14. A Progress Note dated 5/17/20 at 8:27 a.m. and signed by LPN #3 documented, . [MEDICATION NAME] Capsule 20-10 MG Give 1 capsule by mouth one time a day . unavailable . 15. A Progress Note dated 5/18/20 at 2:56 p.m. and signed by LPN #4 documented, . Spoke with nurse at physician's office regarding an order change for [MEDICATION NAME]. Awaiting call back from (Physician) at this time . 16. A Progress Note dated 5/18/20 at 5:23 p.m. and signed by LPN #4 documented, . [MEDICATION NAME] Capsule 20-10 MG Give 1 capsule by mouth one time a day . on order . 17. A Progress Note dated 5/20/20 at 3:23 p.m. and written by ADON #1, documented, . Charge nurse had confirmed medications had arrived from new pharmacy including [MEDICATION NAME]. Social has assisted with transitioning resident to new pharmacy . 18. On 6/3/20 at 8:40 a.m., Clinic Nurse #1 (from the physician's office) was asked if the facility notified their office that they were unable to obtain the medication [MEDICATION NAME] from the pharmacy on any day from May 5 through May 18th. She stated, We received a phone call on May 18th for the first time, notifying us that the pharmacy was no longer able to fill that medication. The nurse reported that she had been off for 2 weeks and was unsure how long the resident had been without the medication. On that day I contacted the resident's daughter and suggested that she find an alternate pharmacy that would be able to fill the prescription. On May the 20th we received a call from the facility stating that the daughter had chosen (Pharmacy #2). They asked us to send the resident's orders to the pharmacy and they let us know that all of her medications - including the [MEDICATION NAME] - had been filled by (Pharmacy #2). She was asked if their office received a fax on May 5th notifying them that the resident did not have any [MEDICATION NAME]. She answered, I do not see a fax regarding that. It could have come, and I just didn't see it. There is nothing documented about a fax. To my knowledge, May 18th was the first time we were informed about the [MEDICATION NAME]. 19. On 6/3/20 at 11:00 a.m., LPN #1 was asked, did you give Resident#1's [MEDICATION NAME] on May 6th? The MAR indicated [REDACTED]. She answered, I marked on the MAR indicated [REDACTED]. But if I wrote a progress note then I did not give the med. I shouldn't have marked that I gave it on the MAR. She was asked, what do you do if you notice a resident is out of a medication? She answered, All I know is that you remove the sticker from the card and place it on a refill sheet and fax to the pharmacy. If the sticker is already gone, I document that it has been ordered. 20. On 6/3/20 at 11:30 a.m., LPN #3 was asked, Are you familiar with R#1's [MEDICATION NAME]? She answered, Yes. She was asked, Did you give this medication on May 7 and 8? She answered, Yes. She was asked, there is documentation from the 5th and 6th that the facility was out of the medication. How were you able to give it? She answered, There was a card in the med (medication) room. I gave it on the 7th and 8th . On the 17th I gave report to our ADON (Assistant Director of Nursing) that something needed to be done about this. .I did call the doctor and I also sent a message to the DON (Director of Nursing). I didn't make a progress note when I called the doctor and I never got a return call . 21. On 6/3/20 at 1:40 p.m., LPN #2 was asked are you familiar with R#1? She answered, With the [MEDICATION NAME] that we did not have? Yes, I am. I worked that cart while LPN #4 was on vacation. She was told, on May 5th you documented that you faxed the doctor about the medication not being available. She answered, I meant to say I called the doctor. I left a message, and no one called me back. I don't know who I talked to. It wasn't the nurse. I just left a message asking for them to call me back and no one ever did. She was asked, What do you do when you realize you don't have a medication for a resident? She answered, I fax to refill it. And that is what I did with this medicine. When we never got it, I called the pharmacy to find out why it hadn't come. I was told that (Pharmacy #1) would no longer be dispensing that medication to our facility. I don't know why they didn't let us know this. We usually call the doctor and try to get an order for [REDACTED]. I didn't see it. 22. On 6/4/20 at 10:00 a.m., Pharmacist #1 from (Pharmacy #1) contacted and was asked if we could discuss a resident from this facility's medication regimen. The pharmacist stated, I have documentation where we notified the facility on more than one occasion that we were not going to be able to fill this medication. I asked the pharmacist if she would like for me to give her the name of the resident or the name of the medication. She stated, I already know who and what you are talking about. 23. On 6/4/20 at 12:30 p.m., LPN #4 was asked are you familiar with Resident #1 and the [MEDICATION NAME] order? She answered, Yes. I was off on vacation for 12 days. I'm not sure when she ran out. When I got back to work on the 18th I ordered it from (Pharmacy #1). It did not show up, so I called (Pharmacy #1) to check on it. They told me that there was some sort of lawsuit and they won't be filling that

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) medication anymore. I spoke to her daughter and talked to her about possibly finding another pharmacy for the [MEDICATION NAME]. I ordered the medication from (Pharmacy #3) as a stat order and I went home for the day. When I came back to work the next day it wasn't there. I called (Pharmacy #3) and they had it in the bin to be picked up instead of delivery. But apparently, they didn't deliver it that day either. So, the next day our old DON - called me and asked me which pharmacy I had ordered from and I told her the 24-hour (Pharmacy #3). When I got back to work on that Saturday it was there. She was asked, Do you know if the doctor was notified that the resident did not receive the medicine? She answered, I was on vacation, so I really don't know. I did not notify the doctor. 24. On 6/3/20 at 10:00 a.m., the DON was asked, What do you do if you are unable to obtain a medication from the pharmacy? She answered, It depends on the medication. We can try to get it from another pharmacy. If it's in the ER (emergency) box, we can get it from there. She was asked, Is it appropriate for a resident to go from May the 5th to May the 18th without a medication? She answered, Well it depends on what the medication is and whether harm was done. She was asked, Should the facility notify the doctor if they can't get a medication? She answered, Yes.