STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045125	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Butterfield Trail Village	1923 East Joyce Blvd Fayetteville, AR 72703

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50924 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to dispense a pharmacy bubble packaged pain medication according to professional standards for 1 (Resident #3) of 3 residents reviewed for pharmacy services. Findings include: During an observation of a medication administration pass on 01/09/2025 at 7:54 AM, Licensed Practical Nurse (LPN) #1 pulled a pain medication card for Resident #3 and questioned why the pharmacy packaged two tablets in each bubble pouch when the order was for one. One bubble pouch was opened, and one tablet was gone, but one tablet remained. LPN #1 unsuccessfully attempted to call pharmacy and investigate. A review of the Admission Record indicated the facility admitted Resident #3 with diagnoses that included dementia, cognitive communication deficit, age-related physical debility, and osteoarthritis. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/02/2024, revealed Resident #3 had a Staff Assessment of Mental Status (SAMS) score of 3 which indicated the resident had severe cognitive impairment. A review of Resident #3's Care Plan, initiated 04/27/2017, revealed the resident was at risk for pain. Interventions included: administer pain medication per physician's orders. A review of Physician's Orders revealed, Resident #3 had a pain medication dose of 325mg by mouth every 12 hours for pain and the same medication 650mg by mouth every 4 hours as needed for pain. A review of January Medication Administration Record, revealed Resident #3 had received 8 doses of the 325mg dose of pain medication at 8:00 AM and 8 doses of the 325mg dose of pain medication at 8:00 PM in January. No doses of the 650mg, as needed dose, were administered. During a concurrent observation and interview on 01/09/2025 at 8:25 AM, LPN #1 stated a staff member had written on the top of the card indicating to only administer one tablet. LPN #1 stated I'm not sure. I'm going to check with pharmacy. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 01/09/2025 at 8:50 AM, LPN #1 successfully reached the packaging pharmacy, it was revealed the card was associated with Resident #3's 650 milligram (mg) as needed pain medication order, and not the 325mg scheduled medication order. No card was found for the 325mg scheduled order. The pain medication card had been delivered on 01/06/2025. The Director of Nursing (DON) stated, nurses may have been pulling the scheduled dose from a stock bottle on the cart and showed an open pain medication bottle with the correct scheduled dose. During a concurrent observation and interview on 01/09/2025 at 9:05 AM, a blue dot sticker was noted at the top left corner of the card. The Director of Nursing (DON) stated, the facility used a colored sticker system, a blue dot was for scheduled medications and a yellow dot was for as needed medications. The card was mislabeled as a scheduled medication (blue dot sticker). The DON agreed the 40 and 45 bubble package was opened and empty, but 44 bubble package was opened with one tablet gone and one remaining. No other bubble packages had been opened. During an interview, on 01/09/2025 at 11:51 AM, LPN #3 stated she usually pulled one tablet out of the bubble packaging with two tablets and left one in the open bubble package for the next shift to use. LPN #3 was aware of Residents #3's as needed order of pain medication, but stated it never comes up. LPN #3 did not know why the pharmacy packaged the medications with two tablets in one pouch and thought they were wasting medication. She stated the medication could get overdosed if someone was unfamiliar with the cart. LPN #3 stated the last card she used for Resident #3's scheduled 325mg pain medication was also packaged with two tablets in it. During an interview, on 01/09/2025 at 11:58 PM, LPN #2 stated Resident #3 was scheduled to take one of the tablets for the scheduled dose and does not know why the pharmacy was packaging them this way. He stated you should not leave pills in an open package, so he gives one pill and wastes the other in the sharps container. He stated some nurses give one tablet and leave the other in the open bubble packaging, but he never gives those. LPN #2 stated he uses the bubble packaging to administer the scheduled dose and does not pull it from the stock medication. He stated the process was not best practice because you do not know what the pill was in the open package.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 50924 Based on interviews, record review, facility document review, facility policy review, it was determined that the facility failed to a resident was free from a significant medication error for 1 (Resident #1) of 3 residents reviewed for medication administration. Findings include: A review of a facility policy titled, Documentation of Medication Administration, revised in April 2007, indicated, all medications administered to a resident should be documented on the resident's Medication Administration Record (MAR) immediately after (never before) it is given with the signature and title of the person administering the medication. A review of a facility policy Medication Record for 08/2024, revealed Resident #1 had an order for an anticonvulsant to be given at 8:00 AM and 6:00 PM which was started on 12/18/2022. The 08/25/2024 8:00 AM dose was signed off by Licensed Practical Nurse (LPN) #3. The 08/27/2024 6:00 PM dose was not signed of as administered. A review of Resident #1's anticonvulsant medication's page in the facility's narcotic book revealed, on 08/25/2024 no medication was signed out by LPN #3. A review of a Progress Note dated 08/29/2024 at 10:43 AM, revealed Resident #1 had seizure like activity in the dining room and Emergency Medical Services (EMS) were called. A review of Resident #1 ' s hospital records revealed, Resident #1 was diagnosed with a seizure. Written education provided by the hospital stated common causes of seizures were fever, infection, brain tumors, head injuries, bleeding in the brain and low levels of sugar or salt. Resident #1 ' s temperature was 97.2 Fahrenheit, no elevated white blood cell count indicating an infection, Resident #1 Computed Tomography (CT) of the head and neck was negative for any abnormalities, Resident #1's glucose level was elevated at 172 and Sodium level was within normal range at 138. Resident #1's seizure was controlled with an anticonvulsant medication. During an interview on 11/19/2024 at 1:41 PM, LPN #1 stated, Resident #1 had not had a seizure in the previous years they had worked here. During an interview on 11/20/2024 at 11:55 AM, Director of Nursing (DON) stated, on 08/25/2024 LPN #3 probably documented the 8:00 AM dose on the MAR prior to retrieving the dose and forgot to go back and do it or documented the 8:00 AM dose for another nurse who never gave it. DON stated there were no discrepancies reported during the narcotic count, so the tablet had not been pulled. If the tablet had been pulled without being signed out a discrepancy would have been noted during the narcotic count. The result was no dose was administered to Resident #1 on 08/25/2024 at 8:00 AM. The DON stated no dose was documented and administered on 08/27/2024 at 6:00 PM. The DON explained when a second nurse comes to help administer medications the nurses pull and sign out medications for each other, this results in nurses forgetting to administer medications or documenting them. The DON agreed Resident #1 most likely did not receive two doses of the anticonvulsant medication. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/20/2024 at 12:27 PM, LPN #3 stated he did not remember the exact occurrence, but they most likely documented the medication and never gave it. LPN #3 stated there were no issues with a discrepancy in the narcotic counts that week.