

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER Chapel Woods Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1440 East Church Warren, AR 71671	

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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>37925</p> <p>Based on observation, record review, interview and facility policy review, the facility failed to ensure the medication error rate was less than 5 percent (%) during the medication administration observation of 1 (Resident #7) of 2 (Residents #1 and #7) sampled residents, and one (Resident #8) non-sampled resident who received medications from 1 Registered Nurse (RN) and 2 Certified Med Techs (CMT). Observed 25 opportunities of medication administration and 2 of the 25 medications were not administered in accordance with the physician's orders, resulting in a medication error rate of 8.00%.</p> <p>The findings are:</p> <p>1. On 03/11/2025 at 9:06 AM, CMT #2 entered Resident #7's room to administer the medication she had prepared. CMT #2 gave the resident a cup of pills with a cup of water. Once the resident took the pills, CMT #2 administered one drop of [Name brand - Polyethylene Glycol 440 / Propylene Glycol] ophthalmic (eye) drops in each of the resident's eyes. CMT #2 did not take [brand name] laxative to the resident with the other medications.</p> <p>Resident #7's Order Summary Report was reviewed and indicated the resident was to receive [brand name] Powder (Polyethylene Glycol 3350) 17 grams by mouth one time a day for constipation and [brand name - carboxymethylcellulose sodium] Solution instill 1 drop in both eyes in the morning related to dry eye syndrome of unspecified lacrimal gland (a small organ that produces tears). There was no active order for [brand name - Polyethylene Glycol 440 / Propylene Glycol] eye drops.</p> <p>The electronic Medication Administration Record (eMAR) was reviewed and indicated the [brand name] laxative powder was last administered at 0800 (8:00 AM) on 03/11/2025 by CMT #2. The eMAR indicated [brand name - carboxymethylcellulose sodium] solution was last administered at 0800 (8:00 AM) by CMT #2.</p> <p>On 03/11/2025 at 9:53 AM, CMT #2 was interviewed and stated she did not give [brand name] laxative powder to Resident #7 with the other medication this morning. She stated the resident refuses this medication and would ask for this medication when the resident feels constipated. She stated she signed the [brand name] laxative medication as being administered this morning in error.</p> <p>On 03/11/2025 at 10:04 AM, Resident #7 was interviewed and stated [brand name] laxative powder was not taken this morning. The resident stated [pronoun] asks for the laxative medication when constipated.</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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/11/2025 at 3:40 PM, the Unit Manager was in the medication stock room restocking medication. There was a box of [carboxymethylcellulose sodium] Lubricant eye drops on the top shelf. The Unit Manager was interviewed and stated she ordered the medication, and the delivery came today.</p> <p>On 03/11/2025 at 3:59 PM, the Advanced Practice Nurse (APN) was interviewed by telephone and stated she was not made aware by staff that Resident #7 was not taking the [name brand] laxative medication. She stated [brand name - Polyethylene Glycol 440 / Propylene Glycol] eye drops, and [brand name - carboxymethylcellulose sodium] Tears were different but worked the same. She stated what the practitioner ordered needed to be sent to the pharmacy because [brand name - carboxymethylcellulose sodium] Tears was ordered for a reason.</p> <p>On 03/12/2025 at 10:14 AM, CMT #2 was interviewed and stated she looked for [brand name - carboxymethylcellulose sodium] eye drops, and the facility did not have any. She stated it was on a Saturday, and the LPN who was working that day told her it was ok to use the [brand name - Polyethylene Glycol 440 / Propylene Glycol] eye drops. The LPN she asked is no longer an employee at the facility.</p> <p>On 03/12/2025 at 10:26 AM, the Director of Nursing (DON) was interviewed and stated nurses and med techs were placed on orientation with a nurse who has been at the facility for a while to train with until they were comfortable passing medications at the facility. She stated if a resident was refusing to take a scheduled medication, the doctor should be notified of the refusal and the reason should be charted. She stated if a medication was not available, the nurse/med tech should mark the medication as not given and call the provider. She stated the nurse/med tech should not substitute a medication order without notifying the provider.</p> <p>An Adverse Consequences and Medication Errors policy, dated as revised April 2014, was reviewed and indicated a medication error was defined as the preparation or administration of drugs or biological which was not in accordance with the physician's orders, manufacture's specifications, or accepted professional standards of the professional providing services. Examples of medication errors included: a drug ordered but not administered, wrong drug, and wrong time.</p> <p>An Administering Oral Medications policy with a revision date of October 2010, was reviewed and indicated for preparation, a physician's medication order should be verified. Steps in the procedure indicated check the label on the medication and confirm the medication name and dose with the MAR (Medication Administration Record).</p>