Accepted 3/30/06 Received by Tina Griffith, manager. DOC = 4/1/06

Wyoming Department of Health
Office of Healthcare Licensing and Surveys

NAME OF FACILITY	FACILITY ADDRESS	DATE OF SURVEY
COUNTRY CLUB LIVING	52 16TH STREET WHEATLAND, WY. 82201	2/10/06

SUMMARY OF DEFICIENCY	FACILITY PLAN OF CORRECTION	FACILITY COMPLETION DATE
An onsite State licensing survey was conducted by the Office of Health Facility on 2/10/06. The survey revealed that the facility was out of compliance with the Rules and Regulations for Program Administration of Boarding Home Facilities. Please submit a Plan of Correction for the deficiencies. Your response to each deficiency needs to specifically state how the correction has been or will be accomplished, and its completion date. Deficiencies must be corrected by 60 days from the date of the survey. You are subject to follow-up survey actions related to deficiencies after the 60 day period. The deficiencies are as follows: 1. Section 12: Medications (b) The manager or staff shall be responsible for providing necessary assistance to the resident in taking his medications; including but not limited to: (i) Reminding the resident to take medications; (ii) Removing medications containers from storage; (iii) Assisting with the removal of the medication cap; (iv) Assisting with the removal of the medication from a container for residents with a disability which prevents independence in this act; and (v) Observing the resident take the medication. This REGULATION was not met as evidenced by: Interview with a personal care assistant (PCA) on 2/10/06 at 7:25 AM revealed PCAs would pour PRN (as needed; examples: Tylenol, Advil/Motrin, cough syrups) medications and take them to the residents. The PCA stated that was how she was taught to give PRN medications. Interview with the manager on 2/10/06 at 7:34 AM confirmed PCAs obtained PRN medications from the bottle, placed them in a medication (med) cup, and took them to the resident. The manager further stated a registered nurse (RN) came in weekly and "set up" routine medications for each resident. The RN would place the medications in individual cassettes and the PCAs would hand the cassettes to each resident. The resident would then pour the medications into a med cup or his/her hand prior to taking them. The following concerns with medication administration were identified for two of three (#1, #2) sample residents:	1. a. The facility will ensure that medications will be self-administered with assistance to the resident. The bottle of Advil will be presented to resident #2 so she can be sure to get her correct medicine. All medications locked in storage for the resident, will be presented to them when asked, in the original container so the resident can verify the medication requested by them. Medication cups will no longer be used. Management will monitor medication help to ensure policy is being followed. b. Staff will no longer be able to help resident #2 with any prescription ointments. The resident had not been using the prescription ointment because he felt it didn't help so he was using Vaseline Intensive Care lotion and mineral oil – this is what the staff was assisting him with. Manager will monitor staff to be sure no resident is being assisted with prescription ointments.	4/1/06 3/2/06

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WYOMING DEPT OF HEALTH
HEALTH FACILITIES

Bob Stumpf
Administrator's Signature

2-3-06
Date

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a. On 2/10/05 at 7:45 AM observation showed a PCA obtained two tablets of Advil 200 milligrams from the medication bottle kept in a locked drawer, poured it into a med cup, and took it to resident #1. Interview with that PCA on 2/10/06 at 10:15 AM revealed the Advil was a routine med which was not available when the RN set up the medications; therefore, it was not in the med cup. However, the PCA did verify she obtained the medication and gave it to the resident.

b. Interview with resident #2 revealed staff applied a medicated ointment to his/her back twice daily because the resident "can't reach" the area. Review of the resident's "Full Time Meds" sheet verified the resident received Clobetasol ointment twice daily "for itching."

According to the facility's undated policy, "Section 9 Medications and Administration," "Drugs shall be self-administered." Further review of the policy manual, "Section 4 Admission, Transfer and Discharge, Changes in Resident Status, Resident Records and Reports," showed residents "shall not be accepted, nor retained, if: g) They are incapable of self-administration of medications."

2. Section 12: Medications
(a) Drugs shall be self-administered.

Review of the Full Time Meds sheets revealed the following medication errors for three of three (#1, #2, #3) sample residents:

a. Review of the Full Time Meds sheet showed resident #1 received one half tablet of Zocor 40 mg (or 20 mg) from January 2005 through 2/10/06. The order on the yearly Health Status and Medications Form, dated and signed by the physician on 5/26/05, was for the resident to receive 40 mg, but the physician did not specify a frequency. In addition, the physician ordered Buspar 10 mg (no frequency) on 5/26/05, but the resident received 1/2 of a tablet three times a day since 11/3/03, a total of 15 mg. Furthermore, the physician ordered Meclizine 25 mg (no frequency) on 5/26/05, but the resident received 1/2 of a 25 mg tablet as needed. Finally, the facility lacked orders for Boniva (for increased bone density), Lopressor (to decrease blood pressure), Colace (stool softener), Advil (for pain), and Omeprazole (to decrease acid production in gastric ulcers). However, the resident received all those medications.

b. According to review of the Full Time Meds sheet, resident #2 received three tablets of Isosorb Mon. (Imdur - for chest pain) 60 milligrams (mg) once in the morning, for a total of 180 mg at one time. According to the most recent physician's order dated 8/7/05, the resident should have received 60 mg three times a day. However, according to the label on the prescription bottle, the resident was to take three tablets of 60 mg Isosorb Mon. ER (extended release) every morning and one tablet each evening. The fill date on the bottle was 11/9/05. Interview with the manager on 2/13/06 at 9:20 AM revealed she did not know which amount of the medication the physician wanted the resident to

2.

a. Manager contacted the Medical Clinic regarding the medications. The med form was correct – all medications were being taken as directed. — 2/13/06

Any residents being helped by facility with medication assistance will have "Medication Change Form" completed and signed by their physician for new or changed orders. RN will change their medications as ordered by their physicial.

b. Manager contacted the Medical Clinic and Doctor to verify resident #2 is currently taking the correct medication and doses – this was verified to the manager over the phone. — 2/13/06

Any residents being helped by facility with medication assistance will have "Medication Change Form" completed and signed by their physician for new or changed orders. RN will change their medications as requested.

c.Resident #3 was taken to the doctor by her family on 12/16/05. The med form shows those changes made by her doctor – Fosamax was not ordered by her new doctor nor was Metamucil. Manager checked with the Medical Clinic regarding the DC of Digoxin – was listed on med form as Digitek – has been discontinued. — 2/13/06

Any residents being helped by facility with medication assistance will have "Medication Change Form" completed and signed by their physician for new or changed orders. RN will change their medications as requested.

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receive. In addition, the resident received Plavix (blood thinner) and Hydroxyzine HCl (for itching), but the facility lacked orders for these medication. Furthermore, the resident did not receive the Lidoderm patch, ordered on 8/7/05.

c. Review of a physician's script dated 12/16/05 showed the physician discontinued Protonix, Potassium, Digoxin, Furosemide, Multivitamin, Vitamin C, Iron, and Colace. These discontinued medications were listed on the Discontinued Meds sheet. However, according to the Full Time Meds sheet, the resident continued to receive Digitek 0.125 mg daily. Interview with a pharmacist on 2/13/06 at 10:45 AM confirmed Digitek is a generic form of Digoxin. In addition, Fosamax (for bones) and Metamucil (for constipation) were ordered on the Health Status and Medications Form, which was signed and dated by the physician on 10/27/05. However, the resident did not receive these medications at all.

3. Section 12: Medications
(a) Drugs shall be self-administered.

This REGULATION was not met as evidenced by:

a. On 2/10/06 at 7:34 AM, interview with the manager revealed the physician completed the "Health Status and Medication Form" (the order sheet) before a resident was admitted and yearly thereafter. The physician determined whether the resident could keep medications in his/her room and whether the "medication should be controlled by Manager/MedicationTech." If the physician determined the resident could not keep medications in his/her room and the manager should control them, an RN would fill a cassette with the resident's routine, daily medications. The RN filled all the cassettes weekly, and the PCAs handed them to the each resident at the appropriate time.

Further interview with the manager on 2/13/06 at 9:20 AM revealed a resident would see a physician, receive a prescription, and then the resident or family would send the prescription to the pharmacy. The facility might or might not see the prescription and order the medication, but the usual practice was for the resident or family to obtain the medication. In addition, the manager stated she changed the information, if notified by the resident or family of the change, on the Full Time Meds sheet which was used by the RN to set up the routine medications. The manager stated she was not a nurse and did not know the abbreviations which might be used on the yearly Health Status and Medication Form or on any prescription she might be given. Furthermore, the manager stated the RN did not have written orders for any new medications added by the manager, and the RN did not call the physician for verbal orders. According to the manaher, the RN went by the manager's documentation on the Full Time Meds sheet.

The 2004, sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin documented, "A medication must have

3.

a. A Medication Change Form will be provided to the residents for their physician to make changes to their medications during the year. This will provide a written order for the RN to set up weekly medication containers for the residents asking for assistance. — 4/1/06

All PRN medications will be kept by the resident in her or his room.

The facility will provide the necessary assistance to the resident in taking his medications; including but not limited to:

1. Remind the resident to take medications.
2. Removing medications containers from storage,
3. Assisting with the removal of the medication cap,
4. Assisting with the removal of the medication from a container for residents with a disability which prevents independence in this act,
5. Observing the resident take the medication

The facility will provide a locked cabinet for medications. If the resident requests the medications to be locked in the cabinet, the Personal Care Attendant will give the resident their daily pill container first thing in the morning.

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physician's order or prescription before it can be legally administered..." During an interview on 2/13/06 at 12 PM, the assistant executive director of the Wyoming State Board of Nursing (BON) stated that if a nurse gives medications, s/he must have a physician's order. The assistant executive director also stated she expected residents of boarding homes to be capable of giving medications to themselves with a sufficient knowledge base (of what each medication did, when to take it, and how much to take) to do so safely. She further stated that having an RN set up the medications and a PCA give them to the residents was not "self-administration."		