POC accepted 6/10/10

Wyoming Dept of Health
JUN 14 2010

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Office of Healthcare Licensing and Surveys
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 53A050 | A. BUILDING _____ B. WING _____ | 05/13/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STAR VALLEY CARE CENTER | 110 HOSPITAL LANE AFTON, WY 83110 |

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| F 000 | INITIAL COMMENTS<br><br>The following common abbreviations are used throughout this document:<br><br>DON - director of nursing<br><br>mg - milligrams<br><br>MARs - medication administration records<br><br>MRRs - medication regimen reviews<br><br>Less commonly used abbreviations will be annotated in each deficiency where used. | F 000 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure staff followed professional standards of practice related to clarification of physicians' orders for 2 of 9 sample residents (#5, #22). The findings were:<br><br>Review of Smith, Duell, and Martin "Clinical Nursing Skills Basic to Advanced Skills," 7th Edition, 2008, revealed that if an order is "questionable for any reason, the physician must be notified for clarification." Failure to follow this standard of practice was identified in the following instances:<br>a. Review of the medical record for resident #5 showed a verbal order from the physician to restart Wellbutrin SR 150 mg twice daily on | F 281 | F281 The facility will ensure that the physician's orders are clarified if questionable for any reason. This will be evidenced by:<br>* The computer software program (Accu-Care) has been updated as of May 21, 2010. When new computer software updates are sent, the DON will monitor technical support to make sure downloads are completed within five business days, this process will be monitored on the QA Calendar.<br>* The Recapitulation of Orders from June 2010 ongoing will no longer show "Cancel All Previous Orders." Recapitulation of Orders will be handed to physicians to be signed and returned by the 1st of each month (holidays/weekends) excluded. The date of physician signatures will be monitored on the QA Calendar by the DON.<br>*The DON or designee completing the Recapitulation of Orders will continue to update the orders throughout the end of the month. These will be updated by transferring new orders onto the Recapitulation of Orders between the time of review and the end of the month.<br>* The DON will in-service Nursing staff on the proper way to receive and document a verbal order from a physician by June 11, 2010.<br><br>**June 11, 2010**<br><br>*A quality monitoring tool will be implemented to ensure each physician has signed the Recapitulation of Orders by the 1st of each month. | |

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

Jean Porter RN CNO NHA — NHA — 03 June 2010

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.

Wyoming Dept of Health
JUN 07 2010

POC accepted. Message left for Michelle Oliver, DON on 6/10/10 @ 1:45pm

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: OIOC11 Facility ID: WY0039 If continuation sheet Page 1 of 4

Janice Corlett, RN, BSN

Office of Healthcare Licensing and Surveys

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| F 281 | Continued From page 1<br>4/30/10. However, the May 2010 recapitulation of orders, signed by the physician on 5/6/10, showed "Cancel previous orders." Further review revealed Wellbutrin was not included in these new orders. Since the May recapitulation of orders cancelled previous orders, the order for Wellbutrin should have been clarified with the physician. On 5/11/10 at 5 PM, the DON stated that receiving verbal orders during the time recapitulation of orders were out for the physicians' signatures was a problem. She confirmed the order should have been clarified.<br>b. Review of a physician's order dated 4/19/10 for resident #22 showed Tylenol 325 mg two tablets was ordered (total of 650 mg) three times per day. However, review of the recapitulation of orders for May 2010 showed the order was written as Tylenol 650 mg two tablets (total of 1300 mg) three times per day. The physician signed the recapitulation orders on 4/29/10, making this order the current one. Review of the May 2010 MAR showed the order was transcribed as 650 mg two tablets, but nursing staff had crossed out the two tablets, and were giving only 650 mg. There lacked evidence nursing staff had clarified the order. During an interview on 5/11/10 at 4:06 PM, the DON stated the order should have been written as 325 mg two tablets on the monthly recapitulation of orders. | F 281 | a) The order for Wellbutrin SR 150mg 1 po BID was clarified on 5/11/10. Resident expired 6/1/10.<br>The DON or designee completing the Recapitulation of Orders will continue to update the orders throughout the end of the month. These will be updated by transferring new orders onto the Recapitulation of Orders between the time of review and the end of the month.<br><br>b) The order for Tylenol 325mg 2 po TID was clarified on 5/25/10.<br>The DON or designee completing the Recapitulation of Orders will continue to update the orders throughout the end of the month. These will be updated by transferring new orders onto the Recapitulation of Orders between the time of review and the end of the month. | |
| F 428 SS=E | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of | F 428 | <u>F428</u> The facility will ensure that the pharmacist will report irregular medications to the attending physician and director of nursing monthly. This will be evidenced by: | |

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| F 428 | Continued From page 2<br>nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, staff interview, and interview with the consulting pharmacist, the facility failed to ensure irregularities were identified and reported as required for 2 of 10 sample residents (#1, #5). The findings were:<br><br>1. According to the physician's orders and the MARs, resident #1 had received the antidepressant, Lexapro, 20 mg daily since 9/22/08. Review of the monthly MRRs showed the pharmacist identified Lexapro as a medication of concern with the elderly. However, there was no evidence in the medical record that the continued use of Lexapro at the same dose had been identified and reported as an irregularity during the past year. On 5/12/10 at 4:20 PM the DON stated there were no reports from the pharmacist other than those in the medical record.<br><br>2. Medical record review showed resident #5 had received Paxil, an antidepressant, 30 mg daily since 12/17/08. Review of the monthly MRRs for the past year showed Paxil was identified by the pharmacist as a medication of concern for the elderly, but there was no evidence he had identified and reported it as an irregularity. On 5/12/10 at 4:20 PM the DON confirmed there had been no reports by a pharmacist of an irregularity related to the use of Paxil for this resident.<br><br>3. During an interview on 5/13/10 at 9:15 AM, the | F 428 | *Pharmacist will alert the Director of nursing and physicians monthly during Medication Reviews of the need for Gradual Dose Reduction (GDR) on all psychotropics, antidepressants, antianxiety, hypnotics and sedatives.<br><br>*During the monthly Chemical Review Meeting, consisting of the Administrator, Medical Director, Director of Nursing, Pharmacist and Social Services, will review and determine residents requiring a GDR.<br><br>*The Psychoactive Medication Management Policy has been reviewed and revised to meet the standards of care and to ensure that each resident is assessed in a timely manner.<br><br>*The Consideration of Gradual Dose Reduction for Psychopharmacological Medications form will be sent to the physician to be completed and returned with appropriate documentation. DON and Social Services will monitor monthly per QA Calendar.<br><br>*The Administrator will in-service the physicians at Med Staff meeting on the Psychoactive Medication Management Policy and the use of the Consideration of Gradual Dose Reduction for Psychopharmacological Medications form.<br><br>*GDR's will be documented as an approach on the comprehensive careplan.<br><br>*A quality monitoring tool will be implemented to ensure each resident taking irregular medications receives a GDR per standards of care.<br><br>1. GDR completed on 5/18/10 for Lexapro 20mg 1 po q day to Lexapro 10mg 1 po q day. Resident expired 5/27/10. | |

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| F 428 | Continued From page 3<br>current pharmacist stated he had not identified any irregularities for either of the aforementioned residents, and he confirmed there were no reported irregularities from the previous pharmacist. He further stated he had not been the consulting pharmacist very long and was unaware of the regulatory requirements. | F 428 | 2. Dr. Stibor documented on 5/12/10 that a GDR was not advisable at this time due to resident being clinically ill. He would consider it if her chronic medical condition improved. Resident expired 6/1/10.<br><br>3. Federal Regulations have been given to the pharmacist so he is better able to educate self on the long term care regulations for medication administration and documentation. Further education will conducted at the monthly Chemical Review meetings, the pharmacist regularly attends this meeting. DON will monitor pharmacist education on the Federal Regulations.<br>**June 18, 2010** | |