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Wyoming Dept of Health
NOV 26 2008
Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	C 11/06/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to perform comprehensive assessments in various areas for 3 (#101, #111, #127) of 21 sample residents. The	F 272	**PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF STATE AND FEDERAL LAW** **<u>272 – COMPREHENSIVE ASSESSMENTS</u>** **This plan of correction is the facility's credible allegation of compliance.** **<u>Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:</u>** A comprehensive bowel assessment for resident #101 will be completed with care plan updates as indicated. A comprehensive assessment for psychotropic medications and bowel assessment for resident #111 will be completed with care plan updates as indicated. A comprehensive bowel assessment for resident #127 will be completed with care plan updates as indicated.	pp 12/21/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 11-28-08

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. 12/5/08 POC accepted & amended per telephone call with administrator. pp

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F 272	Continued From page 1 findings were: 1. According to the 8/27/08 significant change Minimum Data Set (MDS) assessment, resident #101 was totally incontinent of bowel. Review of the entire medical record failed to reveal a comprehensive bowel assessment. After reviewing the medical record on 11/4/08, registered nurses (RN) #1 and #2 confirmed at 10:20 AM that a comprehensive bowel assessment had not been completed for this resident. 2. Review of the 8/27/08 quarterly MDS assessment showed resident #111 received a daily antidepressant and was incontinent of bowel. Review of physician's orders showed an antidepressant was first ordered for the resident on 5/28/08. Review of the entire medical record revealed, and interview with corporate nurse #1 on 11/6/08 at 12:15 PM confirmed, the facility had not completed a comprehensive assessment for psychotropic medications. Additionally, a comprehensive bowel assessment was lacking. On 11/5/08 at 9:35 AM the director of nursing (DON) stated the facility lacked an actual bowel assessment which identified causative and contributing factors related to bowel incontinence for any resident who was incontinent of bowel. The director of nursing (DON) confirmed the information on the nursing assessment was only data; it did not provide an analysis of any of the information. 3. Review of the significant change MDS for resident #127 showed s/he triggered for incontinence of bowel [a level 4 under H1a]. Further review revealed the resident's care plan	F 272	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** A facility audit will be conducted by the DON or designee to determine other residents in need of comprehensive bowel or psychotropic medication assessments. Identified issues will be corrected as needed including conducting the appropriate assessment(s) and updates, if needed, to the resident's care plan. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur:** An in-service will be conducted by the DON or designee for licensed nurses on bowel assessments and psychotropic medication assessments being completed according to facility procedure with care plan updates as indicated. Routine audits will be conducted by the DON or designee for 90 days to confirm assessments are completed. Identified issues will be corrected as indicated.	

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F 272	Continued From page 2 addressed bowel incontinence with a toileting plan. Review of the resident's record failed to show a bowel assessment was done to determine the cause of the incontinence. Interview with the DON on 11/5/08 at 4 PM confirmed the facility did not have a bowel assessment form, and staff had not been conducting bowel assessments.	F 272	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The DON or designee will report outcomes of the audits to the Performance Improvement Committee for the next 90 days. The Performance Improvement Committee will review, evaluate and provide recommendations or direction as needed and to assure ongoing compliance. 12/5/08 PP Date of compliance is December 21, 2008.	
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to follow the care plan for one (#127) of twenty-one sample residents who had care plans. The findings were: Observation of resident #127 on 11/3/08 from 1:55 PM through 6:20 PM, a period of four hours and twenty-five minutes, revealed the resident had not been to the toilet. Review of the resident's care plan showed it instructed staff to provide prompted toileting for the resident "...upon rising, between meals, at bedtime and as needed with extensive assist of one." Interview with certified nurse aide (CNA) #1 on 11/3/08 at 6:10 PM confirmed resident #127 was routinely incontinent of urine and needed to be toileted. The CNA confirmed this resident was to be toileted every two hours. The CNA stated she "forgot", as she was concentrating on other duties.	F 282	**F-282 – COMPREHENSIVE CARE PLANS** **This plan of correction is the facility's credible allegation of compliance.** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #127 was toileted at the time of identification and continues to be toileted according to the care plan. Resident #127 has no identified skin issues. No	
F 314 SS=D	483.25(c) PRESSURE SORES	F 314		

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F 314 SS=D	483.25(c) PRESSURE SORES	F 314		

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F 314 SS=D	483.25(c) PRESSURE SORES	F 314		

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F 314	Continued From page 3 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to consistently apply pressure sore dressings as ordered by the physician for one of two residents who had pressure sores. The findings were: Review of resident #5's November 2008 physician's order sheet revealed orders to change the dressing on the resident's sacral pressure sore twice daily with a thin strip of calcium alginate packed into the wound and secured with Telfa. Observation on 11/03/08 at 5:35 PM of CNA #2 during the provision of incontinence care revealed the resident was lying on urine and fecal soiled incontinent pads, without a dressing on his/her stage II sacral pressure sore. Interview with CNA #2 revealed the resident was frequently incontinent of urine and the CNA did not know whether or not a dressing should be applied to the open pressure sore. Continued observation revealed the the CNA completed the incontinence care, dressed the resident, and used the call light to request assistance with transferring the resident from the bed to the wheelchair. RN #3	F 314	**F-314 PRESSURE SORES** **This plan of correction is the facility's credible allegation of compliance.** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #5 was assessed on 11-4-08 following identification of a lack of a dressing on the wound. No negative effects were identified for this resident. A new dressing was applied to the wound. C.N.A. #2 was counseled on the need to alert the assigned nurse when a wound dressing is identified as not intact. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** A facility audit will be conducted by the DON or designee to confirm that resident's wound dressings are applied appropriately.	

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F 314	Continued From page 3 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to consistently apply pressure sore dressings as ordered by the physician for one of two residents who had pressure sores. The findings were: Review of resident #5's November 2008 physician's order sheet revealed orders to change the dressing on the resident's sacral pressure sore twice daily with a thin strip of calcium alginate packed into the wound and secured with Telfa. Observation on 11/03/08 at 5:35 PM of CNA #2 during the provision of incontinence care revealed the resident was lying on urine and fecal soiled incontinent pads, without a dressing on his/her stage II sacral pressure sore. Interview with CNA #2 revealed the resident was frequently incontinent of urine and the CNA did not know whether or not a dressing should be applied to the open pressure sore. Continued observation revealed the the CNA completed the incontinence care, dressed the resident, and used the call light to request assistance with transferring the resident from the bed to the wheelchair. RN #3	F 314	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur:** The DON or designee will in-service nursing staff regarding the expectation of communication to licensed nurses when it is found that resident's dressings are not present. Random audits will be conducted by the DON or designee for 90 days to confirm that wounds requiring dressings have the appropriate dressing present.	

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F 314	Continued From page 4 responded to the call light, followed by CNA #3. Both CNAs transferred the resident to the wheelchair and pushed the resident to the dining room without ever telling the RN that the resident's pressure sore did not have a dressing. Interview on 11/5/08 at 5:19 PM with the third floor nursing unit manager and RN #3 revealed their expectations were that direct care staff should always report to a nurse when a resident's pressure sore lacked a dressing. The unit manager and RN #3 stated that this resident's pressure sore should have been covered at all times. They also said they did not know how long the resident's pressure sore had been without a dressing on 11/03/08.	F 314	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The DON or designee will report outcomes of audits to the Performance Improvement Committee for the next 90 days. The Performance Improvement Committee will review and provide recommendations and direction based on the outcome of the audits and ongoing sustained compliance. Date of compliance is December 21, 2008.	
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure staff provided toileting in a timely manner in order to promote dryness for one (#127) of eleven sample residents who were incontinent of urine. The findings were:	F 315	**F-315-URINARY INCONTINENCE** **This plan of correction is the facility's credible allegation of compliance.** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #127 was toileted at the time of identification and continues to be toileted according to the care plan. Resident #127 has no identified skin issues. No negative outcome was identified for resident #127. Staff will be trained on the need to follow the care plan for resident #127.	

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F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure staff provided toileting in a timely manner in order to promote dryness for one (#127) of eleven sample residents who were incontinent of urine. The findings were:	F 315	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The facility will conduct an audit by the DON or designee to determine if other residents are not being toileted according to their care plan. Corrective action will be taken if residents are not toileted according to their care plan.	

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F 315	Continued From page 5 Review of the 10/5/08 significant change Minimum Data Set (MDS) assessment for resident #127 revealed s/he was incontinent of urine (coded as a 4 on H1b). Review of the resident's care plan showed it instructed staff to follow a specifically documented toileting plan. Observation of resident #127 on 11/3/08 from 1:55 to 6:20 PM, a period of four hours and twenty-five minutes, revealed the resident was not toileted, checked for incontinence, or prompted to use the toilet. Observation when s/he was toileted on 11/3/08 at 6:20 PM revealed the resident's incontinent brief was saturated with urine. This was confirmed with CNA #1 at that time. Interview with CNA #1 on 11/3/08 at 6:10 PM confirmed the expectation was to toilet resident #127 a minimum of every two hours. The CNA stated she "forgot", because she was concentrating on other duties.	F 315	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The DON or designee will report outcomes of the audits to the Performance Improvement Committee for the next 90 days. The Performance Improvement Committee will review, evaluate and provide recommendations or direction as needed and to validate ongoing compliance. 12/5/08 PP Date of compliance is December 21, 2008 .	
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interviews, and review of reference material, the facility failed to maintain an error rate under 5%. Five errors occurred out of 48 opportunities for error, resulting in an error rate of 10.41%. The findings were: 1. Observation on 11/4/08 at 7:44 AM showed licensed practical (LPN) #2 prepared and administered medications for resident #8. Reconciliation of the medications with physician	F 332	**F-332 – MEDICATION ERRORS** **This plan of correction is the facility's credible allegation of compliance.** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The medication for resident #8 was administered upon receipt from the backup pharmacy. Resident #8 is no longer in the facility. No negative outcome was identified from the delay in medication administration. The Medication Administration Record (MAR) for resident #22	

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F 332	Continued From page 6 orders revealed the resident should also have received Lexapro 10 milligrams (mg) with that medication pass. Interview with the LPN on 11/4/08 at 12:48 PM revealed the medication had not been delivered by the pharmacy. 2. Observation on 11/4/08 showed RN #4 prepared and administered medications for resident #22. After priming the new bottle at 8:05 AM, the RN administered one spray of Fortical Nasal Spray 200 units in each of the resident's nostrils. Reconciliation of the medication pass showed the physician's order was for staff to administer one spray daily, and to alternate nostrils. During preparation of the medications, the RN stated the resident should receive an inhalation of Advair, but after looking through the medication cart at 8 AM, she stated it was "not available." She further stated she could get the inhaler "from backup" and that it would take "approximately one hour." At 10:53 AM that day, the resident stated s/he had not received the medication, and at 10:58 AM the RN confirmed it had not arrived from pharmacy. Reconciliation with the orders confirmed the resident should have received the medication. Two errors occurred during this medication pass. 3. On 11/6/08 at 9:09 AM, RN #5 was observed preparing medications for resident #26. At this time the RN stated the resident was "out of" Albuterol for the nebulizer treatment, but it was supposed to "arrive today." The RN further stated the resident received the nebulizer treatment every four hours while awake, but today s/he "probably won't receive four doses," a total of 12 hours without the medication. Review of the	F 332	will be changed to indicate right or left nostril for alternating days of administration of Fortical Nasal Spray. RN #4 was alerted to the need to alternate nostrils on administration of Fortical Nasal Spray. Medication for resident #22 was administered upon receipt from the backup pharmacy. Resident #22 is no longer in the facility. No negative outcome was identified from either of the noted errors. The medication for resident #26 was administered upon receipt from the backup pharmacy. RN #5 was alerted to the need to wait at least one minute between inhalations of Symbicort. The MAR will be updated to include an alert on the need to wait one full minute between inhalations of Symbicort. Resident #26 is no longer in the facility. No negative outcome was identified from either of the noted errors.	

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F 332	Continued From page 6 orders revealed the resident should also have received Lexapro 10 milligrams (mg) with that medication pass. Interview with the LPN on 11/4/08 at 12:48 PM revealed the medication had not been delivered by the pharmacy. 2. Observation on 11/4/08 showed RN #4 prepared and administered medications for resident #22. After priming the new bottle at 8:05 AM, the RN administered one spray of Fortical Nasal Spray 200 units in each of the resident's nostrils. Reconciliation of the medication pass showed the physician's order was for staff to administer one spray daily, and to alternate nostrils. During preparation of the medications, the RN stated the resident should receive an inhalation of Advair, but after looking through the medication cart at 8 AM, she stated it was "not available." She further stated she could get the inhaler "from backup" and that it would take "approximately one hour." At 10:53 AM that day, the resident stated s/he had not received the medication, and at 10:58 AM the RN confirmed it had not arrived from pharmacy. Reconciliation with the orders confirmed the resident should have received the medication. Two errors occurred during this medication pass. 3. On 11/6/08 at 9:09 AM, RN #5 was observed preparing medications for resident #26. At this time the RN stated the resident was "out of" Albuterol for the nebulizer treatment, but it was supposed to "arrive today." The RN further stated the resident received the nebulizer treatment every four hours while awake, but today s/he "probably won't receive four doses," a total of 12 hours without the medication. Review of the	F 332	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be conducted by the DON or designee to confirm availability of medications according to physician orders. An audit will be conducted by the DON or designee to identify medication administration alerts that should be added to the MAR. Corrections to the MAR will be completed as necessary. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur:** An in-service will be conducted by the DON or designee regarding the proper ordering of medications for refill; utilization of the back-up pharmacy to obtain medications; and the involvement of the DON and ED when medications are not readily available. An in-service will be conducted by the DON or designee regarding administering medications according to MD order and manufacturer recommendations.	

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F 332	Continued From page 7 medical record showed the resident was admitted with diagnoses which included pneumonia and exacerbation of chronic obstructive pulmonary disease. The physician's order was for Albuterol nebulizer treatments every four hours while awake. Observation of the medication pass showed the RN administered inhaled Symbicort at 9:13 AM. The resident completed two inhalations 15 seconds apart. The RN did not instruct the resident to wait at least one minute between inhalations. Review of the facility's reference, "Geriatric Drug Information Handbook" 2007, showed "Allow 1 full minute between inhalations." At 9:25 AM that day, the RN reviewed the reference and confirmed she should have waited one minute between inhalations. Two errors occurred during this medication pass.	F 332	Random audits will be conducted by the DON or designee for 90 days to confirm that medications are administered as ordered and in accordance with manufacturer recommendations. **Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The DON or designee will report outcomes of the audits to the Performance Improvement Committee for the next 90 days. The Performance Improvement Committee will review, evaluate and provide recommendations or direction as needed and to validate ongoing compliance. 12/16/08 PP Date of compliance is December 21, 2008.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the	F 334	**F-334-INFLUENZA AND PHEUMOCOCCAL IMMUNIZATIONS** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #101 received the influenza and pneumococcal immunization on November 28, 2008.	

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F 334	Continued From page 8 following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal	F 334	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** A facility audit will be conducted by the Infection Control Nurse or designee of medical records to identify residents in need of influenza and pneumococcal immunizations. Information regarding the vaccines will be provided to the resident or the resident's legal representative. Vaccines will be offered to those residents as indicated. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur:** The DON or designee will educate Nursing staff regarding the requirement to offer influenza and pneumococcal immunizations to residents upon admission A facility audit of new admission records will be conducted by the Infection Control Nurse or designee to confirm that immunizations are offered and administered according to resident or resident's legal representative's preference.	

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F 334	Continued From page 9 immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to provide education and offer influenza and pneumococcal immunizations for one (#101) of 5 sample residents reviewed for immunization status. The findings were: Medical record review showed resident #101 was admitted on 2/21/08. Further review showed the record lacked evidence the resident was offered information about the influenza and pneumococcal immunizations or provided with the opportunity to consent to or refuse them. On 11/6/08 at 12 PM, corporate nurse #2 confirmed the information was not provided and the immunizations were not offered.	F 334	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Infection Control Nurse or designee will report outcomes of the audits to the Performance Improvement Committee for the next 90 days. The Performance Improvement Committee will review, evaluate and provide recommendations or direction as needed and to validate on going compliance. Date of compliance is December 21, 2008.	12/5/08 PP
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425	**F-425 –PHARMACY SERVICES** **This plan of correction is the facility's credible allegation of compliance.** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #105 received prn pain medications during the time referenced. Resident #105 received her lexapro when it became available. No negative	

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F 425	Continued From page 10 the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interviews, and review of pharmaceutical contracts, the facility failed to provide an effective method for obtaining routine and emergency medications in a timely manner for 4 (#22, #105, #129, #138) of 21 sample and 2 non-sample residents (#8, #26). The findings were: 1. During an observed medication pass on 11/3/08 at 4:05 PM, licensed practical nurse (LPN) #1 questioned resident #105 about pain relief from a previous medication. The resident stated it had helped "a little bit." The LPN informed the resident that the ordered Vicodin would not be delivered until 9 or 10 PM that night. During an interview at 4:48 PM the resident rated his/her pain as 8 on a scale of 0 to 10. (The rating given by the resident later that afternoon was 4.) The resident stated s/he normally took two Vicodin at 8 AM, 2 PM and 8 PM. However, s/he had not had any that day as the pharmacy had not delivered it. The resident further stated s/he was given Motrin (800 milligrams [mg]), but when s/he requested more s/he was told it was too soon and s/he was given Tylenol (650 mg) instead. Review of the physician's orders verified	F 425	outcome was identified from the noted error. Medication for resident #22 was administered medication upon receipt from the backup pharmacy. Resident #22 is no longer in the facility. No negative outcome was identified from either of the noted errors. The medication for resident #26 was administered upon receipt from the backup pharmacy. Resident #26 is no longer in the facility. No negative outcome was identified from the noted error. Resident #129 is currently receiving her medication as prescribed. No noted negative outcome was identified as a result of the noted error. Resident #138 received prescribed medication in accordance with the physician order, which read, "Tonight with NO exceptions start Lovenox 75mg daily". The medication was administered within the parameters of the physician order. Resident #138 is no longer in the facility. There was no noted negative outcome from the medication being administered at the time it was received from the pharmacy.	

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F 425	Continued From page 11 the resident could receive two tablets of Vicodin every six hours for pain. On 11/5/08 at 11:33 AM the resident reported she received Vicodin at 8 AM on 11/4/08. S/he stated s/he was sleeping when it was delivered on the night of 11/3/08. When asked how often Vicodin had not been available, the resident replied that it "occasionally happens." 2. Observation on 11/4/08 at 7:44 AM showed LPN #2 prepared and administered medications with physician orders revealed the resident should also have received Lexa pro 10 milligrams (mg) with that medication pass. Furthermore, the order for the medication was dated 10/30/08. Interview with the LPN on 11/4/08 at 12:48 PM revealed the medication was unavailable as it was never delivered by the pharmacy. 3. During preparation of medications on 11/4/08, RN #4 stated resident #22 should received an inhalation of Advair. However, after looking through the medication cart at 8 AM, the RN stated it was "not available." The RN further stated she could get the inhaler "from backup" and that it would take "approximately one hour." At 10:53 AM that day, the resident stated s/he had still not received the medication. At 10:58 AM the RN confirmed it had not yet arrived from pharmacy. Reconciliation with the orders showed the resident should have received the medication during the AM medication pass. 4. On 11/6/08 at 9:09 AM, RN #5 was observed preparing medications for resident #26. At this time the RN stated the resident was "out of " Albuterol for the nebulizer treatment, but that it should "arrive today." When questioned, the RN calculated that the resident probably would not receive four doses that day (a total of 12 hours	F 425	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be completed by the DON or designee to identify any delay in receipt of medications as ordered. For medications identified as being unavailable, the pharmacy or back up pharmacy will be contacted immediately. Physician's will be notified if medications are not administered in accordance with the physician order.	

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F 425	Continued From page 12 without the medication). Review of the medical record showed the resident's diagnoses included pneumonia and exacerbation of chronic obstructive pulmonary disease. The physician's order was for Albuterol nebulizer treatments every four hours while awake. Review of the pharmaceutical agreements showed the facility had arrangements in place with two pharmacies in Denver and two local "back-up" pharmacies. On 11/6/08 at 2:15 PM, the DON stated she was unaware these arrangements were inadequate to ensure residents received their medications. 5. Review of the medication administration record (MAR) for resident #129 revealed s/he had a physician's order dated 7/7/08 for 25 mg hydrochlorothiazide 25 milligrams to be administered orally every day for hypertension. On 9/14/08 and 9/15/08, the medication was not administered to the resident with a documented reason of "unavailable/ ordered." Further review of the resident's September 2008 MAR revealed s/he had a physician's order dated 8/11/08 for Ativan 0.25 milligrams to be administered by mouth three times daily for anxiety. On 9/19/08 at 4 PM the medication was not administered to the resident with a documented reason of "ordered." Interview with the third floor until manager on 11/6/08 at 8:45 AM confirmed the resident did not receive the medications because they were not available. 6. Review of the closed record for resident #138 revealed s/he had an ultrasound performed on 10/14/08 at 1 PM to rule out a deep vein thrombosis (DVT) in the left leg. Review of the 10/14/08 nurses note timed at 4 PM revealed the results showed the resident was positive for a	F 425	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur:** The contracted pharmacy has been notified of identified concerns. The residents affected were communicated with the contracted pharmacy for internal investigation. A review of the contract with the pharmacy has been completed. An in-service will be conducted by the DON or designee regarding the proper ordering of medications for refill; utilization of the back-up pharmacy to obtain medications; and the involvement of the DON and ED when medications are not readily available. Routine audits will be conducted by the DON or designee for 90 days to confirm that medications are available in accordance with physician orders.	

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F 425	Continued From page 13 DVT, and the physician was notified. Review of the physician's order dated 10/14/08 and timed 5:34 PM showed: "Tonight with NO exceptions" start Lovenox 75 mg subcutaneous daily and Coumadin 7.5 mg daily. Further review of nursing notes showed the pharmacy was called at 5:37 PM to order the medication, and the nurse called the pharmacy to follow up at 11:15 PM because the correct dose of Lovenox had not yet arrived. Review of the medication administration record for that day showed the Lovenox was administered at 11:50 PM, 6 hours and 13 minutes after the order was placed to the pharmacy. Interview with the DON on 11/6/08 at 2:20 PM revealed she did not know what pharmacy was called, or why there was a delay in getting the medication for this resident.	F 425	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The DON or designee will report outcomes of the audits to the Performance Improvement Committee for the next 90 days. The Performance Improvement Committee will review, evaluate and provide recommendations or direction as needed and to validate ongoing compliance. Date of compliance is December 21, 2008.	