

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER Center at Lincoln, Llc, The		STREET ADDRESS, CITY, STATE, ZIP CODE 12230 Lioness WY Parker, CO 80134	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135</p> <p>Based on record review and interviews, the facility failed to provide pharmaceutical services to meet the needs of one (#1) of three residents out of three sample residents.</p> <p>Specifically, the facility failed to ensure two inhaler medications for Resident #1 were ordered and delivered to the facility as ordered by the physician.</p> <p>Findings include:</p> <p>I. Facility policy and procedures</p> <p>The Medication Ordering From Pharmacy policy, reviewed 4/2/24, was provided via email on 10/9/24 at 1:21 p.m. by the director of nursing (DON). It revealed in pertinent part,</p> <p>The purpose of this policy is to assure that patients receive their medication delivery when admitted to the facility in a timely manner.</p> <p>Standard Process:</p> <p>All medications will be faxed to the pharmacy once the medications have been verified with the provider when a patient admits to the facility or when a new RX (prescription) is received and patient(s) need a medication refill.</p> <p>If medications are on the delivery manifest but were not delivered the provider pharmacy should be contacted for a correction and nurse management should be notified.</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age 85, was admitted on [DATE] and discharged on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnosis included COVID-19, sepsis, acute respiratory failure with hypoxia (low levels of oxygen in the body tissues), anemia, unspecified atrial fibrillation (AFIB), hypertension (high blood pressure) and depression.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The minimum data set (MDS) admission assessment was not completed because the resident discharged before it could be completed.</p> <p>The 7/9/24 admissions functional ability assessment revealed the resident required maximum assistance with oral hygiene. The resident was dependent on staff for toileting, sitting to lying down, sitting to stand, and chair to bed transfers. The resident required staff supervision or touch assistance with eating.</p> <p>B. Record review</p> <p>Resident #1 was admitted to the hospital on 6/27/24 with a diagnosis of COVID-19 pneumonia and was admitted to the facility 11 days later, on 7/7/24.</p> <p>The comprehensive care plan, initiated 7/8/24, revealed Resident #1 was at respiratory risk related to respiratory conditions and/or deficiencies/abnormalities in pulmonary function, acute respiratory failure with hypoxia, deconditioning with hospital stay/acute medical condition, metabolic encephalopathy, COVID-19, sepsis, pleural effusion and elevated white blood count. The goal was that respiratory risks related to pulmonary conditions/function would be minimized with interventions over the next 90 days. Interventions included administering medications per physician orders.</p> <p>Review of Resident #1's July 2024 CPO revealed the following physician's orders:</p> <p>Fluticasone-Salmeterol Inhalation Aerosol PowderBreath (steroid medication inhaler) Activated 113-14 MCG (micrograms)/ACT (activation) (one) puff inhale(d) orally two times a day, ordered 7/7/24.</p> <p>Spiriva HandiHaler Inhalation (medication used to treat shortness of breath) Capsule 18 MCG (micrograms) (Tiotropium Bromide Monohydrate) one puff inhale(d) orally at bedtime, ordered 7/7/24.</p> <p>Review of the July 2024 medication administration treatment record (MAR) revealed the following:</p> <p>The Fluticasone-Salmeterol Inhalation Aerosol PowderBreath was not administered on the evening of 7/7/24, the morning of 7/8/24 or the evening of 7/8/24 (for a total of three doses).</p> <p>The Spiriva HandiHaler Inhalation Capsule 18 MCG was not administered on the evening of 7/7/24 or 7/8/24 (for a total of two doses).</p> <p>The nursing progress note on 7/7/24 at 8:48 p.m. documented the Fluticasone-Salmeterol inhalation aerosol powder and the Spiriva Handihaler inhaler were not available.</p> <p>The pharmacist progress note on 7/8/24 at 10:27 a.m. documented an admission review of medications was completed and there were no clinically significant medication issues identified.</p> <p>The nursing progress note on 7/8/24 documented the Fluticasone-Salmeterol inhalation aerosol powder and the Spiriva Handihaler inhaler were not available.</p> <p>III. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON was interviewed on 10/8/24 at 2:00 p.m. The DON said the pharmacy decided, on 7/7/24 at 2:30 p.m., that the medication list in the medical record system was Resident #1's medication current list, however, she said that was incorrect. The DON said the facility always ensured the physician, as well as two nurses, read and signed off on a medication order before the order went to the pharmacy to be filled.</p> <p>The DON said the facility sent the correct medication list to the pharmacy on 7/7/24 at 3:40 p.m. The DON said she spoke with the pharmacy today (10/8/24) and the pharmacy representative told her the medication list which had been sent to the pharmacy on 7/7/24 at 3:40 p.m. was deleted and put into the computer trash bin with the assumption that what was read by the pharmacy on 7/7/24 at 2:30 p.m. was the correct medication list for Resident #1. The DON said the pharmacy never did get the order correctly done for Resident #1's stay in the facility from 7/7/24 through 7/9/24. She said today (10/8/24) the pharmacy representative told her the pharmacy would do a plan of correction with the pharmacy employees so this type of situation would never occur again.</p> <p>The DON said the pharmacy threw away the facility's correct medication list for Resident #1. She said the particular medications in this situation were not carried in their emergency medication kit to be retrieved. She said with all Resident #1 had been through with her health, the inhalers would have benefited the resident. The DON said she was not informed of the medication situation for Resident #1 by the nursing staff.</p> <p>Registered nurse (RN) #1 was interviewed on 10/8/24 at 3:17 p.m. RN #1 said she called the pharmacy on 7/8/24 to request them to send over the missing medications. RN #1 said she assumed the pharmacy would comply with her request. RN #1 said she did not document the conversation with the pharmacy and she did not report the situation to the DON.</p> <p>The DON was interviewed again on 10/8/24 at 3:35 p.m. The DON said the facility had started a training (during the survey) for all of the facility nursing staff about how to ensure pharmacy orders were to be followed through on if a medication was not delivered. The DON said the training contained information to let the DON know when the pharmacy did not comply with the physician's medication orders. The DON said the training reminded the nursing staff to document in the residents' medical records when a call to the pharmacy took place to correct a pharmacy order.</p> <p>IV. Facility follow-up</p> <p>On 10/9/24 at 9:04 a.m. (after the survey) the DON provided an email written by the pharmacy representative on 10/8/24 at 4:27 p.m. The email read in pertinent part,</p> <p>Admission orders faxed on 7/7/2024 for Resident #1 for Spiriva and Fluticasone were misinterpreted by pharmacy staff as duplicate orders. Facility did not report missing these or any medications. The incident has been reviewed and pharmacy staff has been counseled. We have updated our process to include a review of duplicate orders to prevent further incident(s).</p>