STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. BUILDING _____ B. WING _____	03/02/2006

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F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined, that the facility did not ensure that Minimum Data Set (MDS) assessments accurately reflected resident's status for 5 of 16 sample residents. Resident identifier 1, 4, 5, C1 and C3.	F 278	F278 The Interdisciplinary Team has reviewed and /or corrected the MDS's of residents numbered 1,4,5 C1 and C3 to accurately reflect the resident's current status. This will be completed by 04/01/2006. The Resident Assessment Coordinator will provide each discipline representative with a copy of the appropriate portion of the MDS manual for training and education of the MDS components. Each discipline representative will interview the resident, staff members and family members when gathering information to complete their portion of the MDS. All discipline representatives will enter information for their portion of the MDS into the facility system. Care plans will be derived from the information put into the MDS by the discipline representative. Information that is not consistent will be corrected prior to transmittal if possible. If not corrected prior to transmittal to the State, a Correction Request will be instituted. Each MDS will be completely reviewed	

3/29/06 POC acceptable Completion date 5/1/06 Ubusenbaugh RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/24/06

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.

Utah Department of Health
7005 1160 0004 1311 6787

MAR 27 2006
3/24/06
Bureau of Health Facility Licensing

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F 278	Continued From page 1 Findings include: 1. Resident C1 was admitted on 10/25/05 with diagnoses that included, asthma, chronic obstructive pulmonary disease, hypoxia, gastrointestinal reflux disease, arthritis, and macular degeneration. Resident C1's medical record was reviewed on 3/1/06. Resident C1's assessment, dated 12/23/05, documented under section N. Activity Pursuit Patterns, 1. Time Awake, none of the above was marked, which indicated the resident was not awake during morning, afternoon or evening. The average time involved in activities was documented at a 1, from 1/3 to 2/3 of time. There was documentation that any activities were conducted during the night time hours. Another assessment, dated 1/22/06, documented under section N. that resident was only awake during the evening hours, and the average time involved in activities was documented as a 1, from 1/3 to 2/3 of time. Resident C1's assessment, dated 1/22/06, documented under section E. Mood and Behavior Patterns, 4. Behavior Symptoms was incomplete. Area e. Resist Cares (A) 3 (behavior occurred daily) (B) was left blank. 2. Resident C3 was admitted to the facility November 2005. Resident C3's medical record was reviewed 3/2/06. Resident C3's medical record included a MDS Re-Entry Tracking sheet dated 11/29/05. The	F 278	(Continued 278...) by the discipline representative prior to signing for accuracy. At monthly Quality Assurance meetings, a randomly selected currently active MDS will be reviewed for accuracy in each Section to assure compliance with F278 requirements. This will be initiated at the April 18, 2006 meeting. The Administrator is responsible to ensure compliance to this plan of correction. In that the Administrator is a member of the Quality Assurance Committee, this will be accomplished through the monthly report and review of the plan by the committee. 3/29/06 - completion date for Tag F278 changed to 5/1/06 per surveyor Rosenbaum RN	5/1/06 ~~05/15/06~~ Cgl

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F 278	Continued From page 2 Re-Entry Tracking indicated resident C3 had returned following a temporary leave of absence from the facility. The comprehensive MDS assessment for resident C3, dated 12/12/05, revealed the resident had not been in the facility prior to 11/29/05. 3. Resident 4 was admitted to the facility 5/25/04. On 2/27/06, resident 4's medical record was reviewed, including the MDS assessments that had been completed by the facility's interdisciplinary team (IDT). Mood and Behavior Patterns, Section E: Resident 4's quarterly MDS assessments, dated 11/16/05 and 2/15/06, revealed the resident had a persistent angry mood. The same assessments revealed resident 4 had no moods. Physical Functioning, Section G: Resident 4's comprehensive MDS assessment and quarterly MDS assessment, dated 5/18/05 and 8/17/05, revealed the resident independently transferred between surfaces. The same MDS assessments revealed the resident had needed physical assistance to be manually lifted by staff during the same observation periods. If the resident needed weight bearing assistance for 1 or 2 days, the assessments should have been coded to indicate he required limited assistance to transfer. Health Conditions, Section J: The nurse's notes and X-ray results revealed that resident 4 had fallen and sustained a hip/pelvic fracture on 9/21/05. The quarterly MDS assessment for resident 4, dated 2/15/06 revealed the resident had fallen within 180 days of the assessment. The MDS had been	F 278		

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F 278	Continued From page 3 documented that resident 4 had not sustained any type of fracture within 180 days of the assessment. Activity Pursuit Patterns, Section N: Resident 4's quarterly MDS assessments, dated 8/17/05 and 11/16/05, revealed the resident slept all or most of the time through the mornings, afternoons and evenings. The MDS assessments revealed that resident 4 spent 1/3 to 2/3 of his time in activities. The most recent comprehensive MDS assessment for resident 4, dated 5/18/05, revealed the resident preferred activities in his room rather than outside or in other areas of the facility. It had been documented in the assessment that resident 4 enjoyed two activities, gardening or plants and wheeling or walking outdoors. 4. Resident 5 was admitted to the facility 11/7/05 Resident 5's medical record included a MDS Re-Entry Tracking sheet dated 11/7/05. The Re-Entry Tracking indicated resident 5 had returned following a temporary leave of absence from the facility. The comprehensive MDS assessment for resident 5, dated 11/20/05, revealed the resident had not been in the facility prior to 11/7/05. Demographic Information, Section AB: The comprehensive MDS assessment for resident 5, dated 11/20/05, revealed the highest level of education attained by the resident was a Bachelor's degree. The social services history revealed resident 5's level of education was high school graduate.	F 278		

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F 278	Continued From page 4 Oral/Nutritional Status, Section K: The comprehensive MDS assessment for resident 5, dated 11/20/05, revealed the resident was 67 inches tall and weighed 166 pounds. The quarterly MDS assessment for resident 5, dated 2/1/06, revealed the resident was 61 inches tall and weighed 178 pounds. The weight tracking record for resident 5 revealed the resident weighed 159 pounds on 2/2/06. Nutrition notes, dated 11/8/05, revealed resident 5 was 67 inches tall. 5. Resident 2 was admitted to the facility 11/6/05 Oral/Nutritional Status, Section K: The comprehensive MDS assessment for resident 5, dated 11/19/05, revealed the resident was 60 inches tall and weighed 107 pounds. The quarterly MDS assessment for resident 2, dated 2/15/06, revealed the resident was 66 inches tall and weighed 120 pounds.	F 278		
F 371 SS=E	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on interview and observation of the kitchen it was determined that the facility did not store, prepare, distribute and serve food under sanitary	F 371	F371 The Dietary Manager (in her absence the dietary cook on shift) will ensure that: All foods that are leftovers or not stored in original packaging will be labeled with content of package and current date.	

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F 371	Continued From page 5 conditions. Findings include: The following observations were made on 2/27/06 from 1:00 PM until 1:30 PM. 1. In the freezer: a. Eight packages of unknown meat not labeled or dated. b. Twenty-five packages of an unknown fruit not labeled or dated. 2. In the Dry Storage area: a. Onion shavings on the floor next to a mouse trap. 3. General Kitchen area a. A cup in the dry sugar bin. b. Paint peeling away from wall above the stove. c. Rust along the pipe above the stove which caused rust like stains to drip down the wall. d. The oven had a black charred material on the inside door of the oven and on the bottom of the oven. On 2/27/06 the dietary manager was interviewed. She stated the material in the oven was from a cobbler that had bubbled over that morning and that the oven was scheduled to be cleaned that	F 371	(Continued 371...) Items to be stored in freezer will have special labels, (ones that will resist moisture and cold and will not fall off packaged items). Dry bulk foods will not have scoops or other serving utensils stored in them. Paint peeling away from wall to be repaired and rust removed from pipes and area painted by maintenance by May 1, 2006. Spills and boil overs to be cleaned up as they happen, whether on cooking equipment or floors, (oven has been cleaned). Gloves, (disposable) will be used when handling actual food items, but will not be used when serving foods where utensils are to be used. Staff to be inserviced on proper storage, cleaning, and serving procedures, in an inservice scheduled for March 28, 2006.	

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F 371	Continued From page 6 day, on 2/27/06. On 2/28/06 at 8:30 AM the oven was observed. The oven had the same black charred material on the door and bottom of the oven that was there on 2/27/06. 4. On 2/28/06 at 8:30 AM the refrigerator contained a gallon of Fat Free milk with the best used by date as 2/27/06. 5. On 3/1/06 the tray line was observed at 8:00 AM. Prior to tray line the cook was observed to touch her apron with her gloved hands and then begin serving food without changing her gloves. During tray line the cook was observed to leave the tray line on three seperate occasions to handle equipment, make toast, and retrieve food out of the refrigerator and then return back to the tray line and continue serving food without changing her gloves. The cook was observed to place two pieces of toast into a sectioned plate and pour warm milk over the toast. The milk spilled into one of the sections of the plate and the cook was observed to take a dish rag, which she had been wiping her hands on and wiping the counters with, and mop up the spilled milk out of the sectioned plate. The cook then went over and spooned scrambled eggs into that section of plate that she had mopped the spilled milk out of. 6. One dietary staff member was observed during tray line to touch the rim of the cereal bowls with un-gloved hands prior to putting the lid on the cereal bowl.	F 371	(Continued 371...) Dietary Manager is responsible to see procedures are in place and are followed by checking these areas of concern twice weekly. The manager will also provide new employee orientation on the procedures and quarterly inservice review. The Quality Assurance Committee will review and monitor progress and compliance to this plan of correction on a monthly basis. The Administrator is responsible for the plan of correction compliance by meeting with Dietary Manager monthly to review progress and participating in monthly Q. A. meetings.	05/01/06
F 429 SS=D	483.60(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities to the attending physician and the director of nursing.	F 429	F429 The Consulting Pharmacist has revised the Pharmacist Consultant	

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F 429	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the pharmacist did not report medication irregularities to the Directors of Nursing for 2 of 17 sample residents. Residents 4 and 6. Findings include: 1. Resident 4's medical record was reviewed by the surveyor on 2/28/06. The medication administration records for resident 4, dated February and March 2006, revealed the resident had been taking valproic acid for dementia with aggressive features. Valproic acid is a medication that acts on the central nervous system and it's level needs to be monitored to prevent toxicity. During November 2005, the pharmacist reviewed resident 4's medications. The pharmacist documented in resident 4's medical record that the last valproic acid level check for the resident was completed in February 2005. On 3/1/06, the DON was informed by the surveyor of the pharmacist's comments regarding the November 2005 review for resident 4. The DON called resident 4's physician. The physician ordered a valproic acid level to be checked. 2. Resident 6's medical record was reviewed by the surveyor on 3/1/06.	F 429	(Continued 429...) Service policy statement, devised a Monthly Consulting Worksheet, purchased GeriMed Profiles software program for generating custom recommendations with outcome tracking, developed a Pharmacy Consultation Report form, Chart Review Summary form, Drug Irregularity form, Chart Review Summary form, Drug Irregularity form, MD Recommendation Review form and Irregularity tracking form. Please refer to attached documents. This was completed on 03/09/2006. The GeriMed Profile software was installed at the Pharmacy on 03/20/2006 with input of resident data. Database development will allow for utilization of the resident specific drug information for generation of recommendations regarding irregularities to the physician and Directors of Nursing with the monthly review for March 2006. The Directors of Nursing will receive the Pharmacy	

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F 429	Continued From page 8 Resident 6's medication administration records revealed the resident had a major depressive disorder and was taking Cymbalta and Celexa, two antidepressants that work similarly. During a psychotropic drug review for resident 6, on 3/9/05, an interdisciplinary team had recommended Cymbalta be tapered down and then discontinued due to ineffectiveness in treating resident 6's depression. A nurse noted that she had felt the medication was effective and disagreed with the interdisciplinary team's recommendation. On 3/25/05, Celexa was added to resident 6's medications. A pharmacy review, dated June 2005, revealed the pharmacist questioned the administration of Cymbalta and Celexa due to therapeutic duplication. Another pharmacist had recommended in July, August, September and October 2005 that Cymbalta be discontinued for resident 6. The pharmacist documented that Wellbutrin was more compatible with Celexa. On 2/7/06, the pharmacist noted an irregularity in resident 6's medication regimen. The pharmacist documented, "Cymbalta : Celexa ?" There was no documentation that the DONs or physician were aware of the pharmacist's findings. 3. On 3/1/06 at 1:10 PM, a Director of Nursing (DON 1) was interviewed. The DON stated that a pharmacist performed medication reviews for the residents. The DON stated that she thought the pharmacist notified the physicians of his findings, but she stated she had no way of knowing for	F 429	(Continued 429...) Consultation Report (recommendations) and the Review of Pharmacist's Recommendations. The Physician will receive the Pharmacy Consultation Report for their individual residents. Medical Records will monitor for completion of monthly chart reviews during their monthly audits by review of the Chart Review form (florescent red form currently in use) in the resident's chart. The Directors of Nursing will monitor recommendations and ensure they were acted upon through review of the monthly Pharmacy Consultation Report and Review of Pharmacist's Recommendation forms as well as Medical Records monthly chart review audits. The Administrator and QA Committee will ensure compliance with plan of correction implementation.	04/18/06

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F 429	Continued From page 9 certain. DON 1 stated the pharmacist documented in the residents' medical records, but that the DONs did not know the pharmacist's schedule. DON 1 stated that the DONs were aware they needed to know which residents were reviewed and what the pharmacist found in his reviews. Don 1 stated that she and DON 2 were not notified of the results of the pharmacist's medications reviews. The DON stated they needed to get a system working for the pharmacist to notify the DONs of the pharmacist's findings so the DONs could ensure any recommendations were acted upon.	F 429		

PHARMACIST CONSULTANT SERVICE

I. REGULATIONS

PHARMACY SERVICE-STAFF

A. FACILITY SHALL RETAIN A CONSULTING PHARMACIST WHO DEVOTES A SUFFICIENT NUMBER OF HOURS DURING A REGULARLY MONTHLY VISIT, FOR THE PURPOSE OF COORDINATING, SUPERVISING AND REVIEWING THE MEDICATION NEEDS OF THE PATIENTS AND FACILITY. THERE SHALL BE AN AGREEMENT BETWEEN THE PHARMACIST AND FACILITY WHICH INCLUDES DUTIES AND RESPONSIBILITIES OF BOTH.

B. A PHARMACIST SHALL SERVE ON THE QUALITY ASSURANCE COMMITTEE.

C. A PHARMACIST SHALL REVIEW THE DRUG REGIMEN OF EACH PATIENT AT LEAST MONTHLY AND PREPARE APPROPRIATE REPORTS. THE REVIEW OF THE DRUG REGIMENT OF EACH PATIENT SHALL INCLUDE ALL DRUGS CURRENTLY ORDERED, INFORMATION CONCERNING THE PATIENT'S CONDITION RELATION TO DRUG THERAPY, MEDICATIONS ADMINSTRATION RECORDS, AND WHERE APPROPRIATE, DOCTOR'S PROGESS NOTES, NURSE'S NOTES, LABORATORY TESTS, PYSCHOLOGY SERVICE NOTES, PAIN MANAGEMENT NOTES, AND UTAH STATE F429 AND F430 (INCLUDING ALL BEER'S CRITERIA MEDICATIONS) REPORTS.

D. THE PHARMACIST SHALL BE RESPONSIBLE FOR REPORTING IN WRITING AND VERBALLY, IRREGULARITIES IN THE DISPENSING, MANAGEMENT, AND ADMINSTRATION OF DRUGS AND OTHER MATTERS RELATIONG TO THE REVIEW OF THE DRUG REGIMEN TO THE PHYSICIAN AND DIRECTOR OF NURSING. THE PHARMACIST WILL ALSO REPORT VERBALLY TO NURSING STAFF ALL PLAN OF ACTIONS CONCERNING ABOVE IRREGULARITIES MONTLY. A COPY OF ALL ABOVE REPORTING WILL BE KEPT IN THE FACILITY FOR REVIEW FOR 12 MONTHS.

E. ALL UTAH STATE F429 AND F430 REGULATION MEDICATIONS (INCLUDING ALL BEER CRITERIA MEDICATIONS) WILL BE NOTED AND A PLAN OF ACTION INCLUDING CONFIRMATION OF PHYSICIAN INVOLVEMENT WILL BE KEPT IN THE PATIENTS CHART FOR THE PERIOD OF12 MONTHS.

II. POLICY

A. THE FACLITY SHALL RETAIN A CONSULTANT PHARMACIST

B. THE PHARMACIST SHALL SERVE ON THE QUALITY ASSURANCE COMMITTEE, PYSCHOTROPIC REVIEW COMMITTE, PAIN MANAGEMENT COMMITTEE AND ON INFECTION CONTROL COMMITTEE

C. THE CONSULTANT PHARMACIST SHALL PERFORM DRUG REGIMEN REVIEWS MONTHLY AND REPORT RECOMMENDATIONS AND/OR IRREGULARITIES TO THE DIRECTOR OF NURSING AND PHYSICIAN.

III. PROCEDURE

A. PATIENT DRUG REGIMEN REVIEWS

1. DEFINITIONS:

A. THE TERM DRUG REGIMEN OR MEDICATION REGIMEN SHALL MEAN ALL THOSE DRUGS WHICH ARE CURRENTLY ORDERED FOR THE PATIENT.

B. THE TERM ECAH PATIENT SHALL MEAN ANY PATIENT WHO IS RECEIVING CARE THAT IS REIMBURSED FROM ANY SOURCE, INCLUDING MEDICARE AND/OR MEDICAID PROGRAM.

C. THE TERM IRREGULARITY MEANS ANY DEPARTURE FROM WHAT IS PROPER, ACCEPTED OR RIGHT, AND SIGNIFICANTLY SO. TO INCLUDE BUT NOT LIMITED TO ALL MEDICATIONS LISTED ON "EXPLICIT CRITERIA FOR DETERMINING INAPPROPRIATE MEDICATION USE BY THE ELDERLY"

2. THE PHARMACIST SHALL REVIEW EACH PATIENT'S AVAILABLE DRUG REGIMEN AND ASSOCIATED FACTORS IN SUFFICIENT DETAIL TO DETERMINE IF ANY IRREGULARITIES EXIST. IN PERFORMING THE REVIEW IT IS NECESSARY THAT THE PHARMACIST HAVE ACCESS TO THE PATIENT, HAVE AN UP-TO-DATE RECORD OF ALL MEDICATIONS ON ORDER FOR THE PATIENT, BE AWARE OF ANY PHYSICAL OR MENTAL CONDITIONS OF THE PATIENT WHICH ARE LIKELY TO AFFECT HIS DRUG THERAPY, AND HAVE ACCESS TO LABORATORY TESTS, DOCTOR'S PROGESS NOTES, NURSE'S NOTES, AND OTHER DOCUMENTATION WHICH WILL ASSIST IN MAKING A PROFESSIONAL JUDGEMENT AS TO WHETHER OR NOT IRREGULARITIES EXIST IN THE DRUG REGIMEN.

3. EACH PATIENT'S DRUG REGIMEN SHOULD BE REVIEWED IN THE FACILITY DIRECTLY FROM THE PATIENT'S HEALTH RECORD.

4. THE PHARMACIST SHALL PROVIDE THE FACILITY WITH DOCUMENTATION THAT HE/SHE HAS REVIEWED EACH PATIENT'S REGIMEN AT LEAST MONTHLY. THE PHARMACIST SHALL RECORD IN THE PATIENT'S HEALTH RECORD THAT HE/SHE HAS PERFORMED THE REVIEW, SHALL SIGN AND DATE THE ENTRY. IN ADDITION THE PHARMACIST SHALL KEEP RECORD OF ALL REVIEWS IN A ESTABLISH PHARMACY RECORD BOOK TO BE EASILY REFERENCED.

5. WHEN IRREGULARITIES ARE IDENTIFIED, THE PHARMACIST SHALL PREPARE A DRUG IRREGULARITY REPORT AND SUBMIT THE REPORT TO THE DIRECTOR OF NURSING AND THE ADMINSTRATION AND WILL BE MADE AVAILABLE TO THE MEDICAL DIRECTOR. THESE REPORTS SHALL BE STORED AND MAINTAINED IN THE FACILITY FOR AT LEAST ONE YEAR. IN ADDITION THE PHARMACIST WILL VERBALLY REPORT IRREGULARITIES IN A MONTHLY MEETING. ALL REPORTS WILL BE STORED IN THE PATIENTS HEALTH RECORD AND IN THE PHARMACY RECORD BOOK FOR EASY REFERENCE.

B. PHARMACIST'S REPORTS AND REPORT: THE DOCUMENTATION OF PHARMACIST'S ACTIVITY IN THE FACILITY SHALL BE BY WRITTEN REPORTS OF HIS/HER FINDINGS.

1. DRUG REGIMEN REVIEW AND REPORT: WILL DOCUMENT THE PHARMACIST'S FINDINGS WHILE CONDUCTING THE REVIEW OF EACH PATIENT'S ORDERS AND GENERAL OBSERVATIONS CONCERNING PATIENT CARE. DOCUMENTATION IN THE PATIENT'S RECORD THAT THE DRUG REGIMEN REVIEW WAS PERFORMED SHALL MEAN THAT NO SIGNIFICANT IRREGULARITIES EXIST. **ANY IRREGULARITIES NOTED WILL BE DOCUMENTED IN THE PHARMACISTS REPORTS,** IN THE PATIENT'S HEALTH RECORD, GIVEN TO THE DIRECTOR OF NURSING, AND IN THE PHARMACY RECORD BOOK FOR QUICK REFERENCE.

F429

marla

MONTHLY CONSULTING WORKSHEET

1. CHART REVIEW USING GERI-MED OF ALL PATIENTS ON SITE.

2. RECORD IN PATIENT'S HEALTH RECORD CHART REVIEW

3. RECORD ALL F429 AND F430 MEDICATIONS INCLUDING EXPLANTION FOR USE AND RECOMMENDATIONS IN "DRUG IRRIGULARITY SUMMARY FORM". INCLUDE IN PATIENT'S HEALTH RECORD.

4. STORE MONTHLY "DRUG IRREGULARITY FORM" IN PHARMACY RECORD BOOK. STATING ALL IRREGULARITIES FOR THE FACLITY'S FOR THE MONTH.

5. FILL OUT "PHARMACIST CONSULTING REPORT" FOR EACH INDIVIDUAL PATIENT. INCLUDE REFERENCES AND RECOMMENDATIONS FOR EACH IRREGULARITY.

6. COPY EVERY "PHARMACIST CONSULTING REPORT" INTO PHARMACY RECORD BOOK.

7. PRESENT ALL RECOMMENDATIONS AT MONTHLY PYCHOTROPIC MEETING.

8. FILL OUT AND RECIEVE SIGNATURE ON "REVIEW OF RECOMMENDATIONS" BY THE DIRECTOR OF NURSING AT THE MEETING. DELIVER ALL "PHARMACIST CONSULTING REPORTS" AT TIME OF PRESENTATION.

9. FOLLOW UP ON ALL RECOMMENDATIONS FROM PREVIOUS MEETING RECORD ON THE "REVIEW OF RECOMMENDATIONS" INSURING PHYSICIAN'S INVOLVEMENT

10. STORE "REVIEW OF PHARMACIST'S RECOMMENDATION" FORM IN PHARMACY RECORD BOOK.

IN PATIENT'S RECORD (CHART)

Form # 2 *CHART REVIEW FORM* - current form
6 *DRUG IRREGULARITY FORM*
1 *PHARMACY CONSULTATION REPORT* (PHYSICIAN RECORDS)

IN PHARMACY RECORD BOOK
3 *CHART REVIEW SUMMARY*
4 *MONTHLY DRUG IRREGULARITY SUMMARY*
5 *REVIEW OF PHARMACIST'S RECOMMENDATION*

TO DIRECTOR OF NURSING
1 *PHARMACY CONSULTATION REPORT*
5 *REVIEW OF PHARMACIST'S RECOMMENDATION*

TO PHYSICIAN
1 *PHARMACY CONSULTATION REPORT*

IN PYSCOTROPIC MEETING
5 *REVIEW OF PHARMACIST'S RECOMMENDATION* (CURRENT MONTH)
5 FOLLOW UP WITH *REVIEW OF PHARMACIST'S RECOMMENDATION* (PAST MONTH)

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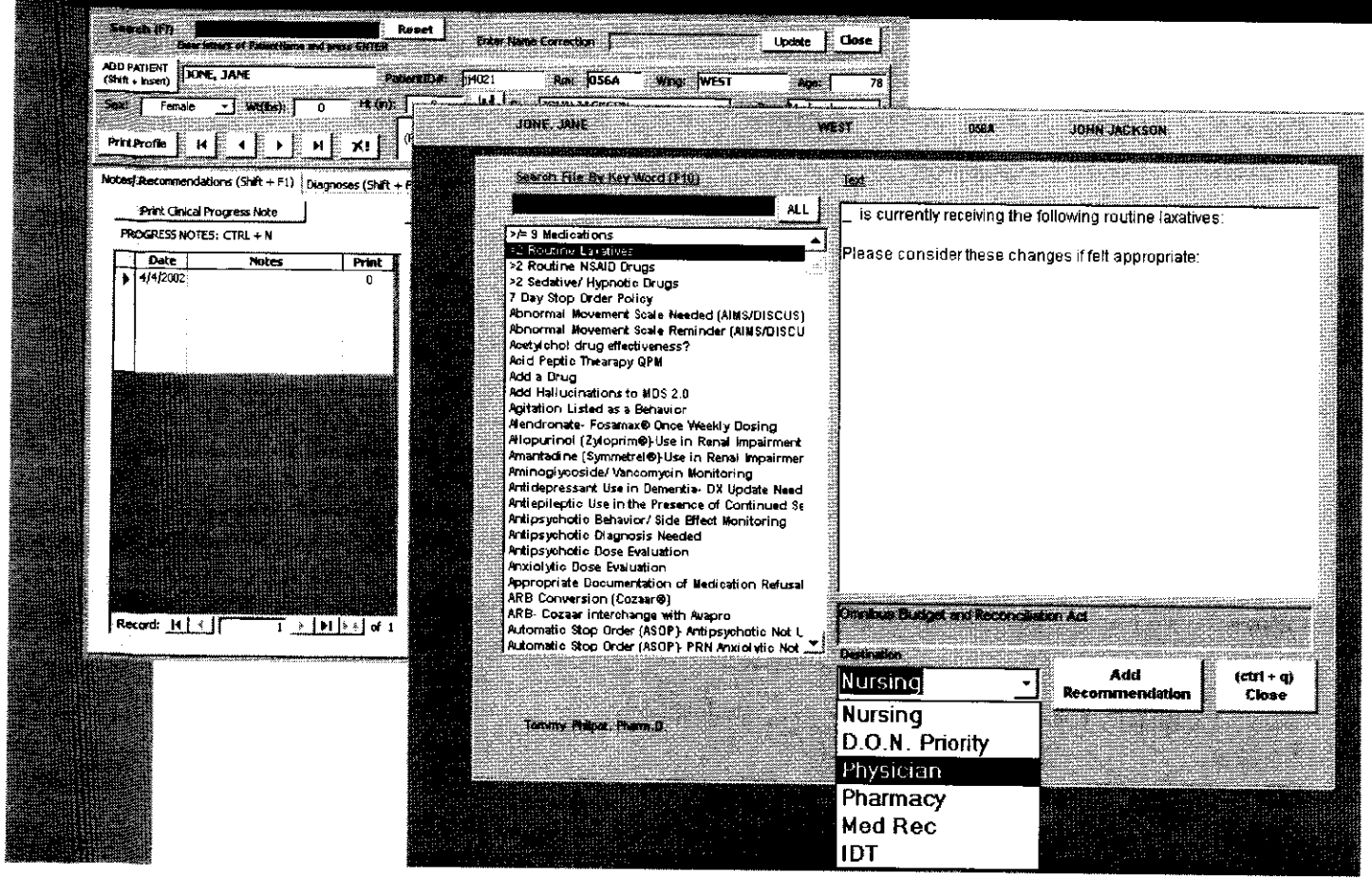
GeriMed Profiles

Consultant Pharmacist Software and Database

Features

- Complete patient database capabilities
- Outcome-based reports relating to drug cost, nursing time, and recommendation acceptance rates
- Facility compliance reporting related to consultant activities
- Detailed facility reports and communications
- Custom recommendation generation with outcome tracking
- Detailed psychotropic usage reporting and comparisons
- Facility Lab-monitoring worksheet
- On-screen clinical tools
- Data warehouse and benchmarking capabilities
- Other specialty reports

Recommendations



The recommendation area provides unlimited macro additions that are coded allowing for data warehouse tracking of activity.

Each recommendation generated allows for outcome tags related to drug cost and nursing time

Pharmacy Consultation report (1)
TO ID and DON

MONTH _____

PHARMACY CONSULTATION REPORT
LOGAN NURSING AND REHAB

DATE _____

PATIENT _____

PHYSICIAN _____

SUBJECT _____

COMMENT:

RECOMMENDATION:

PHARMACIST _____ **DATE** _____

PLAN OF ACTION:

DIRECTOR OF NURSING _____ **DATE** _____

REQUEST:

PHYSICIAN ACCEPTANCE _____ **DATE** _____

PHYSICIAN DENIAL _____ **DATE** _____

Order received by Phone___ Visit___	to pharmacy by fax_____ phone___	Nurses note	Signature of Nurse Noting Order	Date/time

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Cache Valley Pharmacy Drug Regimen Review

ACTION
NI = No Irregularities I = Irregularity R = Recommendation NA = No Action Taken

Month/Date	Pharm	Findings	Comments
JAN		NI R I NA	
FEB		NI R I NA	
MAR		NI R I NA	
APR		NI R I NA	
MAY		NI R I NA	
JUNE		NI R I NA	
JULY		NI R I NA	
AUG		NI R I NA	
SEPT		NI R I NA	
OCT		NI R I NA	
NOV		NI R I NA	
DEC		NI R I NA	
JAN		NI R I NA	
FEB		NI R I NA	
MAR		NI R I NA	
APR		NI R I NA	
MAY		NI R I NA	
JUNE		NI R I NA	
JULY		NI R I NA	
AUG		NI R I NA	
SEPT		NI R I NA	
OCT		NI R I NA	
NOV		NI R I NA	
DEC		NI R I NA	

PHARMACIST CONSULTANT: _____ INITIALS:_____

PHARMACIST CONSULTANT: _____ INITIALS:_____

PATIENT: _____ DOCTOR: _____

ALLERGIES:_____

PLEASE DO NOT THIN

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CHART REVIEW SUMMARY
CACHE VALLEY PHARMACY
LOGAN NURSING AND REHAB

DATE	# OF PATIENTS	# OF IRREGULARITIES	RPH	EXCEPTIONS

F429

monthly Drug irregularity summary ④
Pharmacy book
all recommendation
(nurse and MD)

CACHE VALLEY PHARMACY
DRUG IRREGULARITY F429 F430 AND BEER'S CRITERIA

LOGAN NURSING AND REHAB

DATE	PATIENT	IRREGULARITY	PLAN OF ACTION	COMPLETED

PHARMACIST_____

DATE _____

PRESENTED DATE_____

REVIEWED BY _____

DATE _____

F429

review Phar records summary

Pharmacy Book (MD recommendation review)

REVIEW PHARMACIST'S RECOMMENDATIONS
CACHE VALLEY PHARMACY
DRUG IRREGULARITY F429 F430 AND BEER'S CRITERIA

LOGAN NURSING AND REHAB

DATE	PATIENT	IRREGULARITY	PLAN OF ACTION	COMPLETED

PHARMACIST_____

DATE RECOMMENDED_____

PRESENTED DATE_____

REVIEWED BY _____

DATE _____

F429

Patient irregularity form in chart's (6)

Cache Valley Pharmacy Consulting Services

DATE	RPH	FINDINGS	COMMENTS	DOCTOR RESPONSE
JAN				
FEB				
MAR				
APR				
MAY				
JUNE				
JULY				
AUG				
SEPT				
OCT				
NOV				
DEC				

NI=NO IRRIGULARITY I=IRREGULAR R=RECOMMENDATIONS NA=NO ACTION

Pharmacy consultant._____ INITIALS: _____
JASON BIRCH PHARM D.

Pharmacy consultant_____ INITIALS:_____
PHILLIP COWLEY Rph

PATIENT:_____ AGE _____ HT_____ WT _____

Allergies _____ DOCTORS _____

ROUTINE LABS _____

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