



Complaint Summary for Public Viewing Reports for:  
NORTHERN COLORADO REHABILITATION HOSPITAL

Intake ID: CO00007677

Facility: NORTHERN COLORADO REHABILITATION HOSPITAL

Date of Complaint: 12/16/2005

Date of Investigation: 4/11/2006

Total Number of Allegations for Complaint: 7

Allegation: 2

Type: Nursing Services

Findings: Unsubstantiated

Allegation Detail: The complainant alleges that the staff failed to assess the patient after she had a significant deterioration in her condition.

Findings Detail: According to the Interdisciplinary Progress Notes of 11/23/05, the occupational therapist, --- ----, documented "completed therapy in room following as patient felt some relief from dizziness initially. As time elapsed, patient nauseous and vomited ". On 11/23/05, the physician ordered Antivert 12.5 mg orally (6 a.m., 12 noon and at bedtime). This medication is used in the management of nausea, vomiting, and dizziness associated with motion sickness.

The Physician Progress Notes dated 11/25/06 state, "family noticed some shaking of the RUE (right upper extremity) while at Thanksgiving meal on 11/24/05". Physical and occupational therapies were cancelled on 11/25/05 and the physician --- ---- was alerted to her changes by staff. The physician ordered laboratory studies, --- ----, and medication changes, --- ----. On 11/26/05, it was documented at 4:25 p.m. that the registered nurse, --- ----, "notified the physician," --- ----, of poor oral intake, decrease in urination, and declining neurological status. The oncoming registered nurse, --- ----, was in contact with the physician, --- ----, and the patient was transported per ambulance to the hospital, --- ----, at 7:30 p.m.

In summary the allegation is unsubstantiated as the nursing and multidisciplinary staff reported resident changes in a timely and appropriate manner. No deficient practice cited.

Allegation: 5

Type: Pharmaceutical Services

Findings: Unsubstantiated

Allegation Detail: The complainant alleges that Pharmacy Services failed to assess the patient's medications for poly-pharmacy and drug interactions.

Findings Detail: An interview was conducted with the Director of Pharmacy --- ---- on 4/11/06. Policies and procedures were reviewed. He explained the processes he had implemented throughout the facility. One of those actions had been the development of a --- - --- form --- ----. He explained it was a written method to formally confirm the patient's pre-admission and current medications with the physician. The physician would address the issue of whether to continue or discontinue the medications listed on the form. This was done in response to concerns that the Director of Pharmacy, --- ----, had in communicating with the Physician, --- ----. The pharmacist did recall having a conversation with the physician about a medication dosage --- ---- during the patient's hospitalization --- ----. However, at that time the discussion between the pharmacist and physician was not documented.

The Director of Pharmacy, --- ----, when interviewed stated the Automatic Medication Stop Policy was followed in review of the patient's medication administration record (MAR). --- ----. All Schedule II medications would automatically be discontinued in 14 days. The pharmacist explained that he reviews medications daily and fills the orders. He provided information from October 2005 through March 2006 documented on the --- ----, which showed the medication error at less than 1% each consecutive month. The pharmacist explained that staff is encouraged and educated to report any adverse or side effects that may be concerning in patient care. Regular meetings were conducted by the Director of Pharmacy with Interdisciplinary care staff members, and included Pharmacy and Therapeutics.

In summary, the allegation is unsubstantiated due to lack of sufficient evidence. No deficient practice cited.

Allegation: 7

Type: Physician Services

Findings: Unsubstantiated

Allegation Detail: The complainant alleges that the facility failed to ensure that the patient's physician communicate with the family about the patient's treatment plan, medication and particularly about her declining condition prior to being transferred to an acute care hospital.

Findings Detail: An interview was conducted with the physician, --- ----, on 4/12/06. The Physician Progress Notes revealed that the physician, --- ----, assessed the patient daily. His written notes indicated communication with the family. --- ----. On 11/15/05, the physician wrote "daughter updated at bedside". Another physician had written on 11/19/05, --- ---- "patient and family request follow up with SCP (Speech Therapy) with regards to her swallowing status". During the interview, the physician, --- ----, stated that he was in "regular contact" with the family members as they were usually at the patient's bedside. He explained that it was difficult to know whom to communicate with due to family dynamics. --- ----. The physician documented that he did notify the patient's husband --- ---- about the decision to send the patient to the emergency room at --- ---- for further evaluation. --- ----.

In summary, the allegation is unsubstantiated. No deficiencies cited.