STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted by Healthcare Licensing and Surveys on 10/11/18. The survey was prompted by complaint intake WY00002700.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to administer an antibiotic in a timely manner to 1 of 4 sample residents (#1). The findings were: Review of the medical record face sheet showed resident #1 was admitted on 8/13/18 with diagnoses which included a feeding tube with swallow impairment, nontraumatic hemorrhage of right cerebral hemisphere, left sided paralysis, chronic renal failure, and hypertension. Review of the physician progress notes dated 9/11/18 showed the resident had taken an antibiotic for a urinary tract infection from 8/22/18 to 8/28/18 with instructions to repeat a urinalysis. The urinalysis results showed a continued urinary tract infection which could be treated with linezolid (an antibiotic). The following concerns were identified: a. Review of the medication administration incident report dated 9/18/18 showed an order for linezolid was faxed to the facility on 9/11/18, but the nursing staff did not receive the order. The antibiotic was ordered from the pharmacy once the error was detected on 9/18/18, and was to be started as soon as possible. b. Review of the nursing progress notes	F 760	F760 1. Douglas Care Center (DCC) will ensure that our residents are free of any signiant medication errors. 2. Resident #1 has passed away. 3. All residents are at risk for having a significant medication error. 4. A fax machine was put into the acting DON□s office so that she receives all orders faxed to DCC. 5. Faxed orders are then compared to hard (original) orders weekly to ensure no orders are missed. Once the faxed and hard (original) are compared the faxed orders are shredded. 6. Acting DON and MDS nurse will be educated the importance of ensuring all residents have received orders and are receiving medication to prevent any	11/11/18

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

Electronically Signed | 11/03/2018

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.

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F 760	Continued From page 1 dated 9/19/18 and timed 8 AM showed the resident was not responding to verbal or physical stimulation, and the nurse contacted the resident's family. Family told the nurse the resident had been that way for several days and family had talked with the nurse practitioner. The nurse practitioner told the family the resident had been treated 7 times for the recurrent urinary tract infection without resolve and the resident was probably at the end of life. Family wanted the resident to have comfort care measures placed but wanted the antibiotic started as soon as it arrived. c. Review of the nursing progress notes dated 9/20/18 and timed 8 AM showed the antibiotic arrived, but when the nurse went to administer it, the resident had passed away. d. Interview on 10/11/18 at 2:14 PM with the acting DON confirmed the physician's office faxed the order for the antibiotic on 9/11/18, but the office staff missed the order and it got mixed up in other paper work. She revealed the facility did not know about the order until the nurse practitioner asked about it the following week. She stated they ordered the antibiotic but it took a couple days to come in from the pharmacy. She also stated the facility changed the process for faxed orders to ensure no future orders would be missed.	F 760	significant medication errors. 7. Acting DON or designee will audit monthly and bring to QAPI on a monthly basis for a minimum of three months or until the issue is resolved. 11/11/18	