STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	R-C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 revisit survey was conducted 11/8/18 for all previous deficiencies cited on 9/20/18. The following common abbreviations are used throughout this document: DON- Director of Nursing INR- international normalized ratio (laboratory test used to determine how well anticoagulant medication is working) MAR- medication administration record mg- milligrams Less commonly used abbreviations will be annotated in each deficiency.	{F 000}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure appropriate treatment and/or monitoring was provided for 2 of 3 sample residents (#2, #3) who received anticoagulant therapy. The findings were: 1. Review of a hospital discharge summary dated 10/5/18 revealed resident #2 was on Coumadin	{F 684}	1. Residents #2 and #3 were identified as being affected. Both residents #2 and #3 were checked to ensure PT/INR monitoring was being completed timely per orders and anticoagulant dosing was being given correctly. 2. No other residents were	11/28/18

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

Electronically Signed | 11/26/2018

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{F 684}	Continued From page 1 for atrial fibrillation. Review of a fax dated 10/15/18 showed the resident had an INR of 1.6. Review of a telephone order dated 10/15/18 showed "Coumadin 10 mg po [by mouth] today; then Coumadin 5 mg po once daily. Recheck INR on Friday (10/19/18)." The following concerns were identified: a. Review of a faxed notification form to the physician dated 10/22/18 and the October 2018 MAR showed the INR was not rechecked until 10/22/19 (it was 1.9); 3 days late. b. During an interview on 11/8/18 at 11:05 AM the staff development coordinator stated the nurse did not do the INR until 10/22/18 because the physician liked the INR to be done the day he made rounds at the facility, and he was not rounding until 10/22/19. On 11/8/18 at 11:05 AM the DON confirmed there was in fact an order for the INR to be done on 10/19/18, and the facility did not follow physician's orders. 2. Review of a 6/27/18 physician's progress note showed resident #3 was on Coumadin (anticoagulant) for "other pulmonary embolism and infarction." Review of a fax from the physician's office to the facility dated 10/8/18 showed the resident had an INR of 1.7. There was an order for the Coumadin to be "2.5 mg MW [Monday, Wednesday] and 5 mg the rest of the week. The following concerns were identified: a. Review of a "telephone encounter" form, between the physician's office and the facility, dated 10/16/18 showed "Patient had an INR on 10/8/18 of 1.7, Dr [physician last name] then gave order of 7.5 mg that day and to resume current dosing schedule. He was given wrong schedule of : 5 mg MWF and 2.5 mg Sun, Tu, Th, Sa. Patient's actual and current schedule is: 5 mg Su, Tu, Th, Fr and Sa and 2.5 mg MW and this is	{F 684}	identified as being affected. All residents receiving anticoagulant therapy requiring monitoring of PT/INR have the potential to be affected. All residents receiving anticoagulant therapy requiring montioring were checked to ensure PT/INR's were being drawn timely and anticoagulant medications are being administered accurately per orders. 3. All residents receiving anticoagulant therapy requiring monitoring will be audited with each ordered PT/INR draw. This audit will be conducted by the DON and/or designee. Audits will include verifying PT/INR labs are drawn per orders and that anticoagulant medication order changes are transcribed correctly to ensure accurate dose is given. 4. Results of the audits will be reported to the QAPI committee monthly for the next 60 days.	

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{F 684}	Continued From page 2	{F 684}		

what patient has been receiving." The action taken was listed as 7.5 mg that day and then increase to 5 mg daily with an INR recheck in one week.

b. Review of telephone orders showed an order dated 10/8/18 which read "Coumadin 7.5 mg po today; then Coumadin 5 mg po MWF and Coumadin 2.5 mg po S, T, Th, Sa. Recheck INR 2 wks."

c. However, review of the October 2018 MAR showed the order put on the MAR on 10/8/18 was Coumadin 2.5 mg Monday, Wednesday and 5 mg Sunday, Tuesday, Thursday, Friday and Saturday.

d. There lacked evidence in the medical record that nursing had clarified the conflicting orders for Coumadin. There was an order on a fax communication dated 10/8/18 for "2.5 mg MW and 5 mg the rest of the week" and a telephone order 10/8/18 for 7.5 mg that day and then 5 mg Monday, Wednesday, Friday and 2.5 mg Sunday, Tuesday, Thursday, and Saturday.

e. During an interview on 11/8/18 at 10:57 AM the DON stated "it was a medication error" when asked about the Coumadin for this resident.

f. Review of subsequent INRs showed 3.3 on 10/23/18 and 2.9 on 10/29/18.