STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(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 survey was conducted by Healthcare Licensing and Surveys on 7/29/19 through 7/31/19 at Cheyenne Health Care Center in Cheyenne, Wyoming. The survey was prompted by complaint intake WY00002891.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		8/24/19

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

Electronically Signed | 08/21/2019

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F 755	Continued From page 1 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of medication administration records and narcotics logs, the facility failed to develop a system for identifying and resolving inconsistencies in controlled medication administration records. This failure affected 1 of 8 residents (#9) reviewed for medication administration. The findings were: Review of the 1/28/19 quarterly Minimum Data Set assessment showed resident #9 had severe cognitive impairment, experienced pain every 1 -2 days, and required extensive assistance with all activities of daily living. Review of the January through March 2019 hospice notes showed hospice initiated palliative care on 1/15/19. Review of the January 2019 hospice comprehensive assessment and plan of care, showed the resident's needs assessment of the effectiveness of pain control/comfort measures. Review of the 2/5/19 physician's orders showed the physician renewed the order for hydrocodone/acetaminophen 5/325 milligrams (narcotic pain medication) every 6 hours as needed. Review of the February and March 2019 medication administration record showed the resident did not receive hydrocodone/acetaminophen. However, review of the narcotics log showed the nurses administered hydrocodone/acetaminophen to the resident two times on 2/15/19. On 7/31/19 at 4:15 PM, interview with the director of nurses verified the discrepancy and stated it had not been identified. She further stated the discrepancy had not been investigated to determine whether the resident	F 755	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. The plan of correction serves as the facility's allegation of compliance. F 755 Pharmacy CORRECTIVE ACTION The nurses who did not document the administration of the Norco were provided education related to documenting administration of medications on the Medication Administration record on 8/16/18. Resident #9 no long resides in the facility. IDENTIFICATION OF OTHERS An audit was conducted of the Medication Administration Record (MAR) of facility residents who have receive PRN narcotics for the last 30 days to identify any resident who received these medications as evidenced by the narcotic log, but not indicated as administered on the MAR. This audit was complete 8/7/19.	

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F 755	Continued From page 2 did or did not receive the pain medication. On 8/2/19 at 10 AM, interview with RN #1 revealed the facility did not have a system for auditing or reconciling medication administration records with the narcotics logs.	F 755	SYSTEMIC CHANGE In-service education was provided to the licensed nurses and completed prior to 8/24/19 by SDC related to ensuring that administration of narcotics is documented on the Narcotic Log as well as the Medication Administration Record. The licensed nurse reviews the Medication Administration Audit report prior to the end of each shift and compares it to the Narcotic Log to ensure that all PRN narcotics have been documented as administered. Any identified omissions to the MAR are corrected by the nurse with the appropriate documentation prior to the end of the shift. The DON/designee reviews the Medication Administration Audit Report 5 times per week (Monday-Friday) to ensure that the narcotics have been documented as administered on the Medication Administration Record. Identified areas of missed documentation will be addressed with the individual nurse. MONITORING The DON monitors the documentation of administration of PRN Narcotics on the MAR and reports any identified patterns or trends to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. This tracking will continue for 3 months unless the Quality Assurance	

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F 755	Continued From page 3	F 755	Performance Improvement Committee deems it prudent to continue.	