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 08/30/2019

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 from 8/29/19 to 8/30/19. The survey was prompted by complaint intake WY00002932.	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, staff interview, quality assurance information review, and hospital record review, the facility failed to ensure residents were free of significant medication errors for 1 of 4 sample residents (#1) reviewed regarding their medication regimen. Corrective measures were implemented by the facility prior to the survey and compliance was determined to be achieved on 8/27/19. The findings were: Medical record review showed resident #1 was admitted to the facility on 4/22/15 with diagnoses which included catatonic schizophrenia, major depressive disorder, and generalized anxiety disorder. Review of physician orders showed the resident had a 7/1/19 order for olanzapine (antipsychotic agent) 5 mg (milligrams) by mouth at bedtime for catatonic schizophrenia, a 7/1/19 benztropine mesylate (anti-parkinson's agent) 0.5 mg by mouth twice a day for catatonic schizophrenia, a 6/30/19 order for venlafaxine HCL (anti-depressant) ER (extended release) 150 mg by mouth daily for depressive disorder, and a 7/14/19 order for Ativan (anti-anxiety agent) 0.5 mg by mouth twice a day for generalized anxiety	F 760	Past noncompliance: no plan of correction required.	9/14/19

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

Electronically Signed | 09/14/2019

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F 760	Continued From page 1	F 760		

disorder. A 7/22/19 order replaced olanzapine with Seroquel 200mg three times a day to treat catatonic schizophrenia. The following issues were identified:

a. Review of the July 2019 and August 2019 MAR (medication administration record) showed the facility failed to administer 6 doses of Ativan from 7/14/19 through 7/17/19, and 10 doses of Ativan from 8/22/19 through 8/26/19. Review of the corresponding nursing progress notes revealed the medication was not available.

b. Review of nursing progress notes showed the resident was sent to the local hospital and admitted on 6/26/19 at 3:06 PM and returned to the facility on 7/1/19 at 1:18 PM with a diagnosis of catatonic stupor. Review of nursing progress notes showed the resident was sent to the local emergency room on 8/26/19 at 8:15 PM for symptoms of possible catatonic state exacerbation. The resident was admitted to the local hospital and was readmitted to the facility on 8/29/19 at 11:17 AM. Several notes during that timeframe showed the facility had attempted to reach the physician who had ordered Ativan for the patient for a reorder, without success. Review of the entire medical record showed the only medication the resident had not received as ordered was Ativan, which was ordered for general anxiety disorder and not catatonic schizophrenia.

c. Review of the hospital medical record for the resident's June and August 2019 admissions showed no specific link between the residents exacerbation of catatonic schizophrenia and the facility failure to administer Ativan as ordered. The hospital record for the resident's first admission revealed the following: "Spoke with [individual name] with PART [psychological assessment response team] team...Her

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F 760	Continued From page 2	F 760		

impression is that the patient may be suffering from severe dementia and not necessarily purely catatonia."

d. Interview with the administrator and quality director on 8/29/19 at 3:30 PM revealed the facility quality team had identified an issue with getting the resident's Ativan reordered. The QAPI [quality assurance/ performance improvement] team had formulated a Corrective Action Plan on 8/26/19 and had educated nursing staff on the plan on 8/27/19.

e. Review of the 8/26/19 Corrective Action Plan showed that if difficulty arose with obtaining medications the medical director could not order, a specifically named physician had agreed to prescribe medications for residents at the facility. In addition, nursing staff were to receive the following, "Provide in-service education to the licensed nurses related to re-ordering medication, who to contact, if difficulties notify the DON and [medical director]."Further review showed the licensed nurses were educated on 8/27/19 concerning this process.

f. Interview with the medical director on 8/30/19 at 9:15 revealed the resident's catatonic schizophrenia was a chronic issue and continued exacerbations of catatonia would be the likely outcome. He stated the resident would more likely have an exacerbation of catatonia if s/he did not receive the ordered anti-psychotic and anti-depressant medications. He confirmed it was nevertheless important to ensure all ordered medications were administered as ordered, and in a timely manner.