STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	**3128 BOXELDER DRIVE 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 8/19/19 to 8/21/19. The survey was prompted by complaint intakes WY00002912 and WY00002922.	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, medication error report review, staff interview, and quality assurance information review, the facility failed to ensure residents were free of significant medication errors for 2 of 11 sample residents (#1, #3) reviewed for medication regimen. Corrective measures were implemented by the facility prior to the survey and substantial compliance was determined to be achieved on 7/17/19. The findings were: 1. Review of the 6/27/19 admission orders for resident #1 showed an order for enoxaparim (Lovenox, an anticoagulant) 40 mg into skin (subcutaneous injection) BID (twice a day). The resident also had an order for Coumadin (an anticoagulant) 2.5 mg via PEG (percutaneous gastrostomy) tube daily. Review of the 5/22/19 admission orders for the resident showed s/he had an order for baclofen (antispasmodic) 20 mg PO (by mouth) TID (three times a day). The following concerns were identified: a. Review of the July 2019 MAR (medication administration record) showed the resident did not receive scheduled Lovenox for the 8 AM dose	F 760	Past noncompliance: no plan of correction required.	9/16/19

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

Electronically Signed | 09/16/2019

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F 760	Continued From page 1	F 760		

on 7/4/19, 7/5/19, and 7/6/19. In addition, the resident did not receive the scheduled Lovenox for the 8 PM dose on 7/1/19, 7/3/19, 7/5/19, and 7/6/19. The review showed no documented explanation for the omitted medication. Review of the corresponding medication error report dated 7/8/19 and timed 7:36 AM showed "Upon review of MAR and MD orders = noted a total of 7 doses of Lovenox missed since 7/1/19."

b. Review of an order communication from the nurse practitioner on 7/6/19 at 4:21 PM showed "Is [the resident] still on Lovenox? Increase Coumadin to 7.5 mg tonight and Tuesday, recheck next Saturday." Review of an interdisciplinary progress note dated 7/7/19 and timed 6AM-6PM showed "Clarification order written for coumadin order. Spoke with [nurse practitioner]. " Review of the July 2019 MAR showed the order to increase the resident's Coumadin to 7.5 mg was not started until 7/7/19 at 4 PM, 23 hours and 39 minutes after the order was written. Review of the corresponding medication error report dated 7/7/19 timed 2:30 PM showed "When going thru faxes on the desk found orders that hadn't been taken off regarding new coumadin orders from pt/inr results from 7/5/19. This nurse also found Lovenox had not been given. This nurse called on call relayed what I had found and obtained new orders and carried them out."

c. Review of the 6/27/19 admission orders showed the resident was ordered "Baclofen 10 mg 1 PO TID Spasms." Review of a 7/9/19 interdisciplinary progress note timed 6 AM-6 PM revealed the nurse discovered an order for the resident's baclofen to be increased to 10 mg QID (four times a day) on 7/5/19. Review of a medication error report dated 7/9/19 and timed at 4:35 PM showed the nurse discovered an order

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F 760	Continued From page 2 dated 7/5/19 to increase the resident's baclofen to 10 mg QID. Review of the July 2019 MAR showed the facility failed to increase the baclofen to 10 mg QID until 7/9/19 at 12 AM. d. Interview with the administrator and the director of nursing (DON) on 8/20/19 at 10:40 AM confirmed the facility failed to administer all doses of Lovenox as ordered, and failed to follow the nurse practitioner's order to increase the resident's Coumadin in a timely manner. In addition, they confirmed the resident's baclofen order was not revised to reflect the increase in dosage in a timely manner. 2. Review of a fax from a nurse practitioner dated 6/13/19 and signed at 11:48 AM for resident #3 showed Rocephin (antibiotic) 1 gm for two doses was ordered. The following concerns were identified: a. Review of an interdisciplinary progress note dated 6/19/19 and signed at 11:20 AM showed "Order clarified and received to give Rocephin 1 gm IM [intramuscular injection] times 2 doses. First dose given today for UTI [urinary tract infection] with no adverse reactions..." Review of the June 2019 MAR showed the Rocephin was administered on 6/19/19 and 6/20/19. b. Interview with the administrator and DON on 8/20/19 at 10:40 AM confirmed the facility failed to administer the resident's Rocephin in a timely manner. 3. Interview with the administrator and DON on 8/20/19 at 10:40 AM confirmed the facility had identified issues with the medication system. On 7/15/19 the facility addressed the issue with a Quality Assurance Performance Improvement (QAPI) Action Plan. The actions taken were as	F 760		

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follows:

a. Review of the 7/15/19 QAPI Action Plan to address medication errors showed transcription of medication from fax orders to telephone orders to the MAR/treatment administration record (TAR) was identified as the main issue. The plan identified "specific staff members" as having issues with orders, and the DON would address these issues with specific staff members, and also provide general staff education. The DON and the unit managers, along with other staff members designated by the DON, would be responsible for conducting audits.

b. Review of the 7/17/19 "Mandatory Nurses Meeting" documentation showed nurses were educated on issues regarding medication errors and delay of transcription of orders. Nineteen nurses signed the attendance form.

c. Review of the completed "Medication Errors Audit" forms showed a variety of nurses participated in the audits and all units were included. The audit dates were from 7/17/19 to 8/22/19. The 3 categories on the form included, "Medication orders include dosage, route, time, and diagnosis," "Medication transcribed to MAR/TAR," and "Medication signed as given on the MAR/TAR." At the top of the forms the requirement was, "10 residents 3 times per week."

4. Review of the medical record for 11 sample residents showed no medication issues were identified after the 7/17/19 education was provided to nurses and the audit process began.