STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rawlins Rehabilitation and Wellness	542 16th Street Rawlins, WY 82301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44506 Based on medical record review, staff and physician interview, and policy review, the facility failed to provide CPR in accordance with a resident's advance directive for 1 of 1 sample resident (#36) who expired. The emergency happened shortly after admission. The facility had not identified the issue, which left all new admits at risk and a determination of immediate jeopardy. The census was 35 and there were two new admits in the last 30 days. The findings were: 1. Medical record review for resident #36 showed an admission and discharge date of [DATE]. Further review showed the resident signed the admission paperwork, including a POLST [physician orders for life-sustaining treatment] dated [DATE] that indicated the resident chose to be a full code. The POLST was signed by the physician on [DATE]. The nurse admission evaluation was completed by LPN #1 on [DATE] at 2:43 PM and the resident was alert and oriented. The following concerns were identified: a. Review of a progress note on [DATE] at 6:15 PM showed two RN's (RN #1 and RN #2) were providing care to the resident when s/he became unresponsive and lost signs of life. The note did not show that CPR was done on the resident. b. Interview with the administrator (RN #1) on [DATE] at 5:03 PM revealed she had heard the resident was a DNR/DNI in the hospital and did not start CPR on the resident. She was unaware that in the event of a cardiopulmonary arrest the resident and physician had signed a POLST that requested CPR. An additional interview on [DATE] at 11 AM revealed the resident showed signs of mottling to the extremities just prior to the resident becoming unresponsive and the physician was notified. However, further review of progress notes showed no documentation of mottling or notification of the physician prior to notification of the death. c. Interview with LPN #1 on [DATE] at 9:05 AM revealed he admitted the resident and did not recall the resident stating a code status. d. Interview with social worker #1 on [DATE] at 9:12 AM revealed when a new resident arrived at the facility, medical records personnel met with the resident to process the admission paperwork, including the POLST. (continued on next page)

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. Interview with CNA #1 on [DATE] at 9:20 AM verified the residents' POLST and code status documents were kept in the disaster recovery binder at the nurses station. A random check of two residents verified the information in the binder was correct and there was a tab with resident #36's name on it but the POLST was no longer in the binder. f. Interview with the DON (RN #2) on [DATE] at 9:30 AM revealed she was providing care to the resident when s/he lost consciousness and did not have a pulse. She had heard that while hospitalized the resident chose a DNR/DNI status and she was not aware the resident had signed a POLST earlier in the day requesting CPR in the event of a cardiopulmonary arrest. g. Interview with physician #1 on [DATE] at 12:50 AM revealed he had signed the resident's POLST and was aware of the resident's pending admission to the facility but had not yet seen the resident. He further revealed he had not been notified of any concerns the facility had regarding the resident until the notification of the resident's death. 2. Review of the personnel files for the DON and the administrator showed both were currently certified in CPR. 3. Review of the admission packet, last revised [DATE], showed .The center will abide by any instructions provided in your Advance Directive, Living Will, Health Care Power of Attorney, other Directive, or any POLST/POST issued by your physician. If you have not provided an Advance Directive or if a POLST/POST has not been issued, the Center will take all appropriate actions during an emergency, including administering CPR, calling 911 and sending you to a hospital. 4. Review of the facility's Code Blue (Resident found without vital signs) policy, published [DATE], showed . The resident's code status is established immediately by the nearest Licensed Nurse (LN) using the POLST/POST/Advance Directives .CPR is initiated by the LN for those residents who: a. Have requested, through advance directive or POLST/POST, to have CPR initiated when cardiac or respiratory arrest occurs. b. Have not formulated an advanced directive nor have a POLST in their medical record. c. Do not have a valid DNR order. 5. Review of the facility's Advance Directive policy, updated [DATE], showed .The Center follows each advance directive that has been provided to it in accordance with State and Federal Law .In the absence of an Advanced Directive, the Center provides full treatment to the resident in the event of an emergency of health change. 6. On [DATE] at 8:30 AM the administrator was informed of the immediate jeopardy related to lack of CPR in accordance with advance directives. 7. The facility submitted a removal plan which included: a. Education to all staff regarding POLST forms and code blue. b. 100% audit of all POLST forms for all current residents. c. Audit of all licensed nurses for verification of up to date CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. A mock Code Blue drill was conducted on [DATE], and would occur on every shift for the next 24 hours. 8. The removal plan was accepted on [DATE] at 11:50 AM. 9. The implementation of the removal plan was verified and immediacy was removed on [DATE] at 12:34 PM; however, deficient practice remained at a scope and severity of G.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 44506 Based on observation, medical record review, and staff and physician interview, the facility failed to ensure the medication error rate was 5% or less. There were 2 errors out of 25 medications administered, for an error rate of 8%. The findings were: 1. Observation of RN #1 on 5/1/23 at 9 AM showed administration of folic acid 2 tablets of 400 mcg and 20 ml of liquid potassium to resident #24. Interview with the nurse at that time revealed the MAR showed the resident's order for folic acid was 2-400 MG tablets and the folic acid was dispensed in micrograms (not milligrams) so she corrected the MAR from mg to mcg to prevent the error and gave a total of 800 mcg of folic acid to the resident. In addition, the potassium chloride bottle showed the concentration as 20 mEq/15 ml give 20 ml's and the nurse confirmed there was 20 ml in the resident's medication cup. 2. Review of the medication orders in resident #1's medical record showed an order for folic acid 400 mg tablets, 2 tablets, twice a day and for liquid potassium chloride 15 mEq with a concentration of 20 mEq/15 mls. 3. Interview with the ordering physician (physician #1) on 5/2/24 at 12:55 PM confirmed the order should have been written in mEq not mls; the pharmacy should have calculated the dose based on the concentration of the liquid (mEq/ml) and 20 ml was not equal to 15 mEq as ordered.