Banner Health.
Wyoming Medical Center

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	530012	A. _____ B. _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING MEDICAL CENTER	1233 EAST 2ND ST CASPER, WY 82601

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A 000	INITIAL COMMENTS	A 000		

An unannounced on-site survey, authorized by the Centers for Medicare and Medicaid Services (CMS), was conducted by Healthcare Licensing and Surveys on 4/14/25 through 4/21/25, which extended through 5/21/25. The Conditions of Participation for Hospitals reviewed for compliance were Quality Assessment and Performance Improvement Program, 482.21, Nursing Services, 482.23, Pharmaceutical Services, 482.25, and Emergency Services, 482.55. The survey was prompted by complaint intake WY00000358.
Noncompliance was identified in the following areas:

482.21 Quality Assessment and Performance
482.55 Emergency Services

On 5/16/25 a finding of Immediate Jeopardy (IJ) (immediate threat to the health and safety of patients) was identified in the area of 482.55 Emergency Services.

The hospital was notified verbally of this finding of IJ on 5/16/25 at 11:35 AM. The IJ removal plan was accepted, and the hospital was notified at 9:53 AM on 5/21/25.

The hospital's IJ removal plan included the following:
Immediate education to all staff via email, multidepartmental review and attestation, and during staff huddles (short, frequent impromptu meetings that occur with staff) focusing on the Standard of Practice related to monitoring the neonate on vasopressors which was developed and revised by the hospital on 05/19/25.

[signature] CEO 10/17/2025
(EXECUTIVE DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE) (TITLE) (DATE)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: WY00530012 Facility ID: WY530012 If continuation sheet Page 1 of 15

POC accepted. Spoke to Abby Bremer on 10/20/25 @ 3:14pm.
POC 11/20/25. [signature]

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A 000	INITIAL COMMENTS An unannounced on-site survey, authorized by the Centers for Medicare and Medicaid Services (CMS), was conducted by Healthcare Licensing and Surveys on 4/14/25 through 4/21/25, which extended through 5/21/25. The Conditions of Participation for Hospitals reviewed for compliance were Quality Assessment and Performance Improvement Program, 482.21, Nursing Services, 482.23, Pharmaceutical Services, 482.25, and Emergency Services, 482.55. The survey was prompted by complaint intake WY000004358. Noncompliance was identified in the following areas: 482.21 Quality Assessment and Performance 482.55 Emergency Services On 5/16/25 a finding of Immediate Jeopardy (IJ) (immediate threat to the health and safety of patients) was identified in the area of 482.55 Emergency Services. The hospital was notified verbally of this finding of IJ on 5/16/25 at 11:35 AM. The IJ removal plan was accepted, and the hospital was notified at 9:53 AM on 5/21/25. The hospital's IJ removal plan included the following: - Immediate education to all staff via email, intradepartmental review and attestation, and during staff huddles (short, frequent impromptu meetings that occur with staff) focusing on the Standard of Practice related to monitoring the neonate on vasopressors which was developed and revised by the hospital on 05/19/25.	A 000		

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

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A 000	Continued From page 1 - Development of a Standard of Practice for monitoring patients on vasopressors in the ED was approved by leadership to support existing policies which required monitoring of patients on vasopressors in the ED. - Date of the corrective actions was 05/20/25 with oversight of implementation by the Chief Nursing Officer. An onsite visit was conducted on 5/21/25, and based on the steps the hospital had taken, the surveyor determined that the IJ was removed on 5/21/25. The hospital was notified of this finding at 3:15 PM on 5/21/25. The following common abbreviations are used throughout this document: AD ED: Assistant Director of the Emergency Department DON: Director of Nursing ED: Emergency Department ESI: Emergency Severity Index IV: intravenous kg: kilogram mg: milligram ml: milliliter RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	A 000		
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.	A 263		

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A 263	Continued From page 2 The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on record review, staff interviews, and policy and procedure review, it was determined that the hospital failed to develop, implement, and maintain an effective, ongoing, hospital-wide, data driven quality assessment and performance improvement program that involved all hospital departments and services. Refer to A-283 regarding the facility's failure to appropriately investigate and implement systematic improvements after a neonatal septic shock (life-threatening condition in newborns where a severe infection causes the body's circulatory system to fail) event and interviews with staff revealed they felt reporting incidents could lead to retaliation. The findings resulted in the inability of the facility to meet the Condition of Participation for Quality Assessment and Performance Improvement Program.	A 263		
A 283	QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) (b) Program Data (2) [The hospital must use the data collected to -	A 283		

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A 283	Continued From page 3 .....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on record review, staff interviews, and policy and procedure review, it was determined that the hospital failed to identify an adverse patient event and implement preventive actions that included education for all staff. Specifically, the facility failed to identify a reported lack of adequate monitoring for a neonatal patient (#15) as an adverse patient event. In addition, interviews with staff revealed they felt reporting incidents could lead to retaliation. The findings were: 1. On 3/12/25 a neonatal septic shock event was reported. The verge/incident was reported to the management related to patient safety, missing blood pressure (BP) while the patient was	A 283		

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A 283	Continued From page 4	A 283		

considered stable, and was on vasopressors without cardiac monitoring. The employee submitted the verge anonymously on 3/13/25 at 1:16 PM. Review of the incident report showed the dayshift RN was told by management not to "verge" this and "it will be handled internally." Further, "Staff fears retaliation from management, so anonymous report being made on 3/13/25 at 1:19 PM." "The event reached the patient without harm" was noted by the AD ED on 3/13/25 at 2:21 PM. Further review showed under the section titled "What normally happens" it was written "When staff bring forward concerns, I listen to them and look for teaching opportunities and opportunities for improvement. A verge is encouraged when a pattern of behavior or concern is noticed or a safety concern."

2. Review of the medical record for patient #15 showed the patient was triaged as Emergency Severity Index (ESI) level 1 (Requires immediate life-saving interventions), "ESI 1 = Continuous observation and monitoring, with documented reassessments at a minimum of every 1 hour until hemodynamically stable, then minimally every 2 hours or per admitting unit guidelines of care." The diagnosis showed septic bacterial meningitis (bacterial meningitis is inflammation of the membranes surrounding the brain and spinal cord caused by bacteria. Sepsis is a life-threatening reaction to an infection). The following concerns were identified:

a. The facility failed to monitor the patient's BP within a 3.5-hour block (from 10:47 PM until 2:15 AM). The patient's BP during triage on 3/11/25 at 10:47 PM was 77/62 (normal neonate ranges are 60 to 70 systolic and 30 to 53 diastolic). There were no more documented BP

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A 283	Continued From page 5	A 283		

readings until 2:15 AM on 3/12/25 when the BP was 40/22 (low). The BP at 3:14 AM was 76/56 when norepinephrine (constricts blood vessels to increase blood pressure. Used to treat severe, acute low blood pressure in emergency situations) was ordered. Review of vital signs showed over the next four hours (until transfer to another facility) the blood pressures were up and down (the blood pressures varied from 29/19 at 4:48 AM to 71/55 at 7:16 AM). Epinephrine (used to treat low blood pressure) and cefepime (antibiotic) had been ordered at 3:53 AM.

b. Review of the medical record showed the physician ordered cardiac monitoring on the pediatric patient on 3/12/25 at 1:11 AM. Further review showed at the same time an order for "Discontinued: Cardiac Monitoring." Review of the medical record showed no evidence the patient was on a cardiac monitor throughout the stay. The record showed the patient had an EKG (electrocardiogram) twice (on 3/12/25 from 1:38:06 AM until 1:38:53 AM and again from 1:44:18 AM until 1:44:32 AM)

c. The medical records showed on 3/12/25 at 3:14 AM norepinephrine was ordered, and was discontinued at 3:46 AM. Then at 3:45 AM epinephrine (vasopressor) was ordered. There was no evidence cardiac monitoring was done on the patient while administering the vasopressors.

3. The following concerns were identified in interviews with staff:

a. Interview on 4/15/25 at 2:45 PM with employee #2 revealed s/he was fearful of reporting concerns to management, due to retaliation and potential loss of their job, and they stated they needed his/her job.

b. Interview on 5/22/25 at 11:39 AM with

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A 283	Continued From page 6	A 283		

employee #4 revealed if s/he had said anything about the management retaliating, it would have painted a big "X" on his/her back and they need their job. S/he stated that the managers retaliated on employees that voiced concerns.

4. Interview with the AD ED on 5/15/25 at 11 AM revealed "I did tell the nurse not to file a verge. I wanted to use it as a learning opportunity, instead of something punitive." Interview with the AD ED on 4/16/25 at 3:15 PM revealed the facility did not allow retaliation. She stated concerns could be reported on-line, in person or to human resources. She further stated there were employee representatives that staff could report a concern to without revealing themselves. She stated if staff felt they were retaliated against they could go to employee relations and the corporation would investigate.

5. Interview with quality assurance staff #1 on 5/15/25 at 11:35 AM revealed the case did not meet criteria for a risk assessment because they did not deviate from standard of care.

6. Review of the facility policy "Compliance: Reporting and Investigating Potential Compliance Issues" effective Date 12/2/21 included " ...IV. Procedure/Interventions ...b. If not a Potential Compliance Issue, assign to the appropriate individual or department based on the type of issue ... ii. Human Resources: Human resources issues (e.g., hostile work environment, employee relations, and staffing/scheduling issues ... iii. Clinical Risk Management / Patient Relations Service Center: Clinical risk management issues (e.g., certain patient safety issues, clinical care concerns, and potential or actual litigation matters) ...D. Investigating Potential Compliance

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A 283	Continued From page 7 Issues (INVESTIGATOR(S)) a. Make a preliminary, good faith inquiry into the Potential Compliance Issue to determine whether further investigation is warranted ... 6. Provide a response, if appropriate, to the Covered Person who initially reported the Potential Compliance Issue ..." 7. Review of the facility's policy "Event Reporting" effective date 3/29/25 included " ...I. Purpose and Population: A. To promote a culture of safety that supports internal reporting of errors and near misses. B. To prevent/reduce potential recurrence of similar events by: 1. Identifying patient care processes, systems, policies/protocols, and services that have opportunities for performance improvement and/or risk reduction. 2. To provide timely response to patient events ... III. Policy: A. Any employee/medical staff member who becomes aware of a safety event is responsible for reporting it. B. Banner Health is committed to utilizing Just Culture for reporting, investigating, and analyzing safety event."	A 283		
A1100	EMERGENCY SERVICES CFR(s): 482.55 The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on medical record review, staff interview, and policy review, the facility failed to meet the emergency needs of patients. Refer to A-1112 regarding the facility's failure to effectively monitor patient status to ensure emergency care needs were met for 1 of 20 sample patients (#15). On 5/16/25 a finding of Immediate Jeopardy (IJ)	A1100		

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A1100	Continued From page 8 (immediate threat to the health and safety of patients) was identified in the area of 482.55 Emergency Services. The hospital was notified verbally of this finding of immediate jeopardy on 5/16/25 at 11:35 AM. The hospital submitted an IJ removal plan and the plan was accepted. The hospital was notified at 9:53 AM on 5/21/25. An onsite visit was conducted on 5/21/25, and the surveyor determined that based on verification of a policy for monitoring neonates on vasopressors, staff education for all ED staff, verification of staff knowledge, and verification of adequate patient monitoring, the IJ was removed on 5/21/25. The hospital was notified of this finding at 3:15 PM on 5/21/25. The seriousness of the finding resulted in the inability of the facility to meet the Condition of Participation for Emergency Services.	A1100		
A1112	QUALIFIED EMERGENCY SERVICES PERSONNEL CFR(s): 482.55(b)(2) There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility. This STANDARD is not met as evidenced by: Based on medical record review, staff interview, policy review, and professional standards review, the facility failed to effectively monitor patient status to ensure emergency care needs were met for 1 of 20 patients (#15). The findings were: 1. Review of the medical record showed patient #15 was a 1-day old neonate who was brought to the ED on 3/11/25 and was triaged as an ESI 1	A1112		

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A1112	Continued From page 9	A1112		

(requires immediate life-saving intervention). Review of the physician's ED report showed the initial vital signs at 10:47 PM included a temperature of 38.8 Celsius (102 Fahrenheit) (normal temperature for neonate is typically between 97.7 F and 99.5 F). Further review of the medical record showed during the ED stay, the patient's blood pressure dropped critically low and they were started on vasopressors (medication to constrict blood vessels to increase blood pressure). In addition, testing of the patient's cerebrospinal fluid (CSF) showed bacterial growth and antibiotics were started. The patient was transferred to a specialty children's hospital by air. The following concerns were identified:

Related to blood pressure monitoring:

a. The facility failed to monitor the patient's BP within a 3.5-hour block (from 10:47 PM until 2:15 AM). The patient's BP during triage on 3/11/25 at 10:47 PM was 77/62. There were no more documented BP readings until 2:15 AM on 3/12/25 when the BP was 40/22 (normal neonate ranges are 60 to 70 systolic and 30 to 53 diastolic).

b. According to Emergency Severity Index Handbook, Fifth Edition, provided by facility administration on 5/15/25 at 11 AM showed "ESI 1 = Continuous observation and monitoring, with documented reassessments at a minimum of every 1 hour until hemodynamically stable [vital signs are within normal range and stable], then minimally every 2 hours or per admitting unit guidelines of care."

Related to Cardiac monitoring:

a. Review of the medical record showed the

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A1112	Continued From page 10	A1112		

physician ordered cardiac monitoring on the pediatric patient on 3/12/25 at 1:11 AM. Further review showed at the same time an order for "Discontinued: Cardiac Monitoring."

b. Review of the medical record showed no evidence the patient was on a cardiac monitor throughout the stay. The record showed the patient had an EKG (electrocardiogram) twice (on 3/12/25 from 1:38:06 AM until 1:38:53 AM and again from 1:44:18 AM until 1:44:32 AM)

c. The medical records showed on 3/12/25 at 3:14 AM norepinephrine (vasopressor; used to treat low blood pressure) was ordered and was discontinued at 3:46 AM. Then at 3:45 AM epinephrine (vasopressor; used to treat low blood pressure) was ordered. There was no evidence cardiac monitoring was done on the patient while administering the vasopressors.

2. Interview with the DON on 5/15/25 at 9:55 AM revealed the patient was triaged as an ESI 1. She stated there was no difference from the ESI level with vasoactive medication for pediatric patients. She stated vitals should be taken every 1 hour until hemodynamically stable.

3. Interview with the AD ED and ED Director on 5/14/25 at 4:30 PM revealed the ED orders were changed to the [hospital B] Clinical Pathway "Sepsis Pathway" during the patient stay as requested by the [hospital B] provider (they were unable to provide a time). Interview on 5/15/25 at 11 AM with the AD ED and ED Director revealed "we have no policy that states what the facility needs to monitor when a patient is on vasopressors. We follow the policy "ED patient Care" or physician's orders. The physician did not order cardiac monitoring."

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A1112	Continued From page 11	A1112		

4. Review of a written document from RN #5 dated 3/12/25 showed she had concerns regarding the neonatal patient because the patient was on two vasoactive drip medications (norepinephrine and epinephrine) to keep the patient alive. The nurse documented the patient had been in the emergency department for upwards for six hours without any cardiac monitoring and had not had a blood pressure taken in over two hours. Further, "these medications are required to have extremely close cardiac and blood pressure monitoring in order to ensure the safety of the patient and the efficacy of the medication."

5. Interview with RN #1 on 4/15/25 at 5:52 PM revealed she was the nurse taking care of patient #15 on the night of 3/11/25. She stated she had the BP machine set to take BPs every 5 minutes. She stated the BP machine would sometimes take the reading and sometimes it would not. Further, she stated she did not put the patient on the heart monitor; she just did not think of it.

6. Interview on 4/16/25 at 2 PM with the ED physician who provided the patient's care revealed the mother brought in the infant who had changes and "had popped a fever." The physician stated "the patient just went down quick and we did not think of putting [him/her] in a warmer or the heart monitor. We were just trying to save the patient."

7. Interview with RN #2 on 4/16/25 at 2:45 PM revealed she did have concerns with the turnover of care. She stated she had specialized training in pediatrics. When she took over care of the patient from the night nurse the baby was not on a warmer, the BP had not been done in over an

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	530012	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING MEDICAL CENTER	1233 EAST 2ND ST CASPER, WY 82601

(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
A1112	Continued From page 12	A1112		

hour, and the patient should have been on cardiac monitor since s/he was being given epinephrine.

8. Interview with pharmacist #2 on 5/16/25 at 10:40 AM revealed any patient on vasopressors should be put on a cardiac monitor and have blood pressure monitored.

9. Interview with the Assistant Director of OB and Nursery on 5/15/25 at 11:50 AM revealed the patient should have been on a cardiac monitor and vital signs including blood pressure, pulse respirations, and oxygen saturation taken every hour for that sick of a child. She further stated "We would have responded to the ED if called."

10. Interview with the AD ED on 5/15/25 at 10:30 AM revealed on 3/12/25 at 9 AM RN #2 had voiced concerns with the not monitoring the BP and no cardiac monitor on the patient while given vasopressors. Review of the 4/4/25 case review showed the staff talked through the case starting with triage nurse moving to the primary nurse, the primary doctor and the consulting doctor. The determination was that all care was deemed appropriate and timely and assessments were correctly performed. However, the OFI (Opportunity for Improvement) showed that staff could consult the labor and delivery nurse for help, that pediatric EKG stickers were available, the children's pathways were on-line, ensure vital signs transferred to the electric medical record and record vital signs more frequently. The AD ED stated they had not yet educated all staff and that the education would be provided during the May staff meetings.

11. Interview on 5/14/25 at 4 PM with quality

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A1112	Continued From page 13	A1112		

control staff #1 revealed there was no root cause analysis done due to it not being considered a safety event. Further, on 5/15/25 at 11:35 PM she revealed "the case did not meet criteria for a risk assessment, because we did not deviate from standard of care."

12. Review of the facility's policy "Emergency Department Patient Care" last revised 1/27/25 included for ESI 1 "Requires immediate life-saving interventions ...Continuous observation and monitoring, with documented reassessments at a minimum of every 1 hour until hemodynamically stable, then minimally every 2 hours or per admitting unit guidelines of care...Vital Signs 1. To be completed at a minimum with every ED assessment/reassessment and within 60 minutes of patient disposition from ED. 2. Vital signs include: Heart Rate, Blood Pressure, Respiratory rate, Temperature, Oxygen Saturation, Pain, and Fetal Heart Tones (if applicable). "

13. Review of the facility's policy "Safe Administration of Selected IV Medications" last revision was 4/3/24 showed no mention of monitoring vitals.

14. Review of the facility's policy "Neonates Presenting for Care in the Emergency Department effective 7/21/22 included " ...Following NRP (Neonatal Resuscitation Program), 2. Perform physical assessment: Vital signs ...Systems, including respiratory rate, heart rate, rhythm, and blood pressure, etc. ... Further, it showed "provide intravenous access, fluids, and medications as ordered ..."

15. Review of the facility's policy "Neonatal

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A1112	Continued From page 14 Patient Guidelines - NICU/CCN" effective 12/6/23 showed " ... F. Monitor all NICU and CCN neonates via continuous cardiac and respiratory monitors unless otherwise ordered. Cardiac monitoring includes at least 3 electrodes and 1 ECG wave form. Neonates will have a 6 second rhythm strip printed, mounted and scanned into the medical record with significant arrhythmias ..." 16. Review of the "Adrenalin-epinephrine injection" package insert by Endo USA, Inc showed " ...5.7 Cardiac Arrhythmias and Ischemia. Epinephrine may induce cardiac arrhythmias and myocardial ischemia in patients, especially patients suffering from coronary artery disease, or cardiomyopathy ..." 17. Review of the "Norepinephrine Bitartrate in Sodium Chloride- norepinephrine bitartrate injection, solution" package insert by WG Critical Care, LLC showed "5.3 Cardiac Arrhythmias. Norepinephrine Bitartrate in Sodium Chloride Injection elevates intracellular calcium concentrations and may cause arrhythmias, particularly in the setting of hypoxia or hypercarbia ..."	A1112		

Banner Health.
Wyoming Medical Center

This plan of correction is submitted to meet requirements established by state and federal law. This plan of correction constitutes this facility's demonstration of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that a deficiency existed or that one was correctly cited.

A263 & A283: QAPI and Quality Improvement Activities

CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3)

1. **Failure to identify an adverse patient event and implement preventive actions:**

Per the 2567: The facility failed to identify a reported lack of adequate monitoring for a neonatal patient as an adverse patient event.

The following was submitted as evidence of compliance during the survey:

This safety event was self-identified by bedside staff and reported verbally and through the event reporting system to department leadership for quality improvement as evidenced by:

The event occurred 3/12/2025, an incident report was submitted 3/13/2025, and this event was verbally reported to leadership. Additionally, the Associate Director ED set up a department event review meeting.

Plan of Correction:

Action 1: Department event review occurred 4/4/2025. The ED Associate Director, three bedside ED RNs, an ED Physician, and a Pediatric Hospitalist all participated in the Event Review. This information along with notes from the event review were provided to the State Agency during on-site review on 4/15/2025.

Opportunities for improvement based on the event review included: consulting labor and delivery nurse for additional support, re-education on use of infant warmer, ensuring neonatal EKG sticker availability, ensuring staff and providers are aware that Children's Hospital Clinical Pathways for emergency care are available online, verifying that all vital signs populate in the medical record and that vitals should be taken more frequently.

Action 2: Re-education on use of infant warmer occurred during Trauma Skills Day 4/10/2025. Additional education regarding the opportunities for improvement identified during the event review were provided to all applicable staff during staff meetings on 5/17/2025 and 5/21/2025.

Action 3: Policy review and education was sent by email to all staff and reviewed at department staff meetings for Event Reporting Policy #911, specifically that:

a. Any employee/medical staff member who becomes aware of a safety event is responsible for reporting it
b. Banner Health is committed to utilizing Just Culture for reporting, investigating and analyzing safety events

c. Complete an Event Report within 24 hours of the safety event when possible, using the online event reporting tool.

This education was reviewed with all nursing staff at clinical forums September 2, 3, and 4, 2025, and policy was sent to all ED staff 9/24/25. This information was also posted on the ED huddle board and will be discussed at department staff meeting 9/26/25.

Monitoring:

The volume of safety event reports will be monitored weekly by ED leadership and CNO. If there is a significant decrease in volume (>5% of average number of incidents reported by month), the reason for decreased reporting will be investigated. The CNO and ED Director will round in the ED as needed based on investigation and assess whether staff have concerns with reporting. Immediate action will be taken if staff verbalize concerns with safety event reporting.

Date of Corrective Actions Completed: October 10, 2025

2. **Staff revealed they felt reporting incidents could lead to retaliation:**

Per the 2567: Event and interviews with staff revealed they felt reporting incidents could lead to retaliation.

The following is submitted as evidence of compliance during the survey:

All staff complete compliance training annually that includes how to report concerns of retaliation. In this case, allegations of retaliation were not submitted using any of the multiple methods outlined in policy. Because this was not reported using the proper reporting method, the facility was unable to provide a response to the covered person who initially reported the potential compliance issue. Additionally, Policy #911 Event Reporting outlines when reporting a Safety Event (SE), "Description of SE should include a factual account of the SE describing specific details. Do not include subjective statements or opinions." As stated by the Associate Director of ED in the investigation, staff are encouraged to report concerns related to retaliation per policy. The allegation of retaliation was not investigated by the surveyor. This allegation was not substantiated by the facility.

Additional evidence that staff are comfortable reporting:
Over the past 3 years, the facility has nearly tripled in safety event reporting in the emergency department from 105 events reported in 2022 to 290 events YTD in 2025.

The emergency department has increased participation in annual employee engagement survey 66%-85% from 2024-2025.

Leadership effectiveness Scores have increased: 2024-68%, 2025-78.9%

On the Patient Safety Survey, question regarding: My supervisor, manager, clinical leaders take actions to address patient safety concerns brought to their attention was in the top 5% for favorability within the Banner Health System. Only 3% detractors within emergency services at BWYMC.

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Wyoming Medical Center

Plan of Correction:

Action 1: Policy review and education regarding Compliance ComplyLine policy #182 for all ED staff via email and at department staff meetings to include:

a. Banner strictly prohibits retaliation against any Banner Associated Staff or patient who engages in Protected Activity.
b. Banner Staff are protected from Prohibited Retaliation even if the allegation of illegal discrimination, harassment, or retaliation turns out to be without merit.
c. Banner Associated Staff are protected against Prohibited Retaliation even after any employment, contractual, or other relationship with Banner has ended.
d. Banner Associated Staff who feel that they have been subject to Prohibited Retaliation are encouraged to report the matter to a Banner Leader, the Human Resources Department, or the Ethics & Compliance Department, via the ComplyLine.

Education regarding compliance completed with annual required education by 6/1/2025. Email with above policy information was sent to all staff 9/24/25 and policy #182 will be reviewed and discussed at department meetings 11/19/25 and 11/20/25. The ED director and CNO will attend staff meetings.

Monitoring:

The volume of safety event reports will be monitored weekly by ED leadership and CNO. If a significant decrease in volume (>5% of average number of incidents reported by month) or concerns for retaliation are noted, the reason for decreased reporting will be investigated. The CNO and ED Director will round in the ED as needed based on investigation and assess whether staff have concerns with reporting. Immediate action will be taken if staff verbalize concerns with safety event reporting or concerns with retaliation related to reporting.

Date of Corrective Actions Completed: November 20, 2025

Banner Health
Wyoming Medical Center

A1100: Emergency Services, A1112: Qualified Emergency Services Personnel

CFR(s): 482.55, 482.55(b)(2)

The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice:

Per the 2567: The facility failed to effectively monitor patient status to ensure emergency care needs were met.

Related to Blood Pressure Monitoring:
The facility failed to monitor the patient's BP within a 3.5-hour block.
Per the medical record the following occurred between the hours of 10:47 p.m. and 2:15 a.m., the time the report outlines missing blood pressures.

- 11:41 p.m.-IV inserted
- 11:45 p.m.-Heart rate, respiratory rate, Oxygen saturation and temperature assessed and documented
- 11:50 p.m.-Acetaminophen administered
- 12:45a.m. -Pediatrician in ED-impression stable
- 12:58 a.m. -Pain Assessment
- 12:57 a.m. -Lumbar Puncture
- 12:59 a.m. -IV inserted
- 01:01 a.m. -Urinary Catheter inserted
- 01:10 a.m. -Newborn off monitor with mother, attempting to feed, warm blanket
- 01:30 a.m. -Newborn off monitor with mother, attempting to feed, warm blanket
- 01:38 a.m. -Nurse at bedside adjusting monitor
- 01:44 a.m.-Nurse at bedside adjusting monitor
- 01:47 a.m.-Gentamycin Administered
- 02:15 a.m. -Vital signs including blood pressure, heart rate, respiratory rate and oxygen saturation
- 02:25 a.m.-IV Fluids Administered

A clinician was in the room visually assessing and/or treating the patient at least hourly. Including ED physician, pediatrician, ED RN, ED Tech. Additionally, the patient's mother was in the room at bedside and/or holding the patient throughout the entirety of the patient's ED encounter. This patient was being monitored very closely, and interventions and treatment were occurring to ensure emergency care needs were met.

Related to Cardiac Monitoring:
The following items from the 2567 were found to be inaccurate or misleading; additional context is provided for each statement:

Statement: Interview 5/15/25 at 11 AM with the AD ED and ED director revealed, "We have no policy that states the facility needs to monitor when a patient is on vasopressors. We follow the policy 'ED patient Care' or physician's orders..."
Context: This statement did not include the context of the discussion that occurred during survey. As written, this statement implies that no monitoring was required, which is not an accurate representation of the conversation when asked specifically about cardiac monitoring.

Monitoring of patients is required based on 'ED Patient Care' policy but it does not specify that cardiac monitoring is required for vasopressors, which is what the AD ED and ED Director were specifically asked and specifically referred to.

Statement: Written document from RN #5 showed she had concerns regarding the neonatal patient because the patient was on two vasoactive drip medications... and that the patient was in the emergency department for upwards of six hours without any cardiac monitoring.

Context: The patient had two separate orders for vasoactive medications and was on norepinephrine and then transitioned to epinephrine. Norepinephrine started at 0314, discontinued at 0346. Epinephrine started at 0345 and continued through transfer. The flight team arrive at 0740 and took over care of newborn. No changes were made to the epinephrine infusion by the flight team. Per the IJ corrective action cardiac monitoring would only have been required while on vasopressors.

Statement: Review of 4/4/25 case review showed... "The determination was that all care was deemed appropriate and timely, and assessments were performed correctly."

Context: The intent of this statement during the case review was to reflect that the medical care provided and assessments done, i.e., antibiotics, procedures, lab, images, IVs, etc., were appropriate for the patient's medical condition and were timely.

This statement was not intended to reflect that no opportunities for improvement were identified as evidenced by the ED Case Review document given to the surveyor 4/15/25. The ED Case Review determination indicated the following opportunities for improvement: consulting labor and delivery nurse for additional support, additional education/refresh on use of infant warmer, ensuring neonatal EKG sticker were available, ensuring staff and providers are aware that Children's Hospital Clinical Pathways for emergency care are available online, verifying that all vital signs populate in the medical record when set to be taken automatically and that vitals should be taken more frequently.

Statement: Interview on 5/14/25 at 4 PM with quality control staff #1 revealed there was no root cause analysis done due to it not being considered a safety event.

Context: Per facility policy, this Safety Event (SE) did not require a root cause analysis (RCA). Per policy, all Safety Events (SEs) including those defined as a sentinel event per the Joint Commission and never events per the National Quality Foundation will be evaluated using the HPI Safety Event Taxonomy.

A Root Cause Analysis (RCA) is required when the event resulted in harm to the patient classified as a Serious Safety Event (SSE) 1-3. This safety event was rated as a Precursor Safety Event (PSE)

4 and did not meet the requirement for a RCA. Policy goes on to say, if SE does not meet the required RCA criteria, additional analysis is recommended, including Apparent Cause Analysis, Barrier Analysis, Density Analysis.
For this case, a Barrier Analysis occurred, which is an examination of barriers or safeguards within existing processes to determine if they were inadequate or missing altogether, in an effort to prevent a similar event from happening in the future. The facility did not deviate from policy.

Statement: Review of facility's policy "Neonatal Patient Guidelines- NICU/CCN neonate via continuous cardiac and respiratory monitors unless otherwise ordered...

Context: This information is not applicable. Department policies are written specifically for the nuances of the scope of care provided within their department. Departments cannot be held to the standards of other department policies due to various factors including staffing, resources, and scope of services.

Statement: Review of Adrenalin-Epinephrine injection...

- The package insert for epinephrine (Endo, USA) indicates it **"may"** induce arrhythmias and myocardial ischemia in patients, especially patients suffering from **coronary artery disease or cardiomyopathy**.
  - **CXR indicates cardiothymic silhouette is within normal limits**

Statement: Review of the Norepinephrine Bitartrate...

- The package insert for norepinephrine (manufactured by WG Critical Care) indicates it **"may"** cause arrhythmias-particularly in the setting of **hypoxia or hypercarbia**. Perform continuous cardiac monitoring of patient **"with" arrythmias**
  - **There was no evidence of hypoxia or hypercarbia**

Plan of Correction:

Action 1: Standard of Practice (SOP) created and implemented to support current policies and patient safety for monitoring patients on Vasopressors in the ED. The SOP outlines the purpose, population, policy, and required documentation for this patient type, and it cites learning materials from Lexicomp and Lippincott.

Action 2: Existing policies were reviewed. "Safe Administration of Selected IV Medications" and "Emergency Department Patient Care" provide requirements for monitoring patients on vasopressors in the ED, while "Neonates Presenting for Care in the Emergency Department" provides requirements for monitoring all neonates.

Both SOP and policy review completed using the following method: education was disseminated to all staff via email, placed in the department with 'read & sign' sheet upon completing review and education, and shared at staff huddles (ensuring team members were educated prior to next scheduled shift).

Monitoring:

A report will be run once per day to identify patients on vasopressors in the ED during the preceding 24 hours. Each chart will be reviewed to assess for compliance with the SOP and education. If a fall out is identified, 1:1 coaching will occur with the involved

team member. Continue to monitor until 100% compliance for 6 months and then spot check quarterly ongoing.

SOP includes continuous cardiac/telemetry monitoring, heart rate, blood pressure and oxygen saturation at a minimum of every hour or more frequently as indicated by patient condition.

Date of Corrective Actions Completed: May 20, 2025

Entire Plan of Correction Completion: November 20, 2025

Responsible Person: Chief Nursing Officer