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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	532304	A. BUILDING B. WING	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Hospital of Sweetwater County Dialysis Unit	1180 College Dr. , Rock Springs, Wyoming, 82902

(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
V0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/15/26 through 6/17/26. The following common abbreviations are used throughout this document: RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	V0000		
V0543	POC-MANAGE VOLUME STATUS CFR(s): 494.90(a)(1) The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is NOT MET as evidenced by: Based on medical record review and staff interview, the interdisciplinary team failed to provide the necessary care and services to manage the patient's volume status for 1 of 5 sample patients (#3) reviewed. The findings were: 1. Review of the physician orders for patient #3 showed 0.1 milligram of clonidine hydrochloride (a medication used in the treatment of hypertension) was to be administered 3 times per week if the patient's systolic blood pressure was greater than 160 millimeters of mercury (mmHg) following his/her dialysis treatment. The start date was 9/13/25. The following concerns were identified: a. Review of 20 dialysis treatment flow sheets from 5/2/26 through 6/16/26 showed patient #3's post dialysis standing systolic blood pressure was documented as being above 160 mmHg on 5/9, 5/12, 5/19, 5/21, 5/28, and 6/16. Review of the patient's medication administration record showed no evidence the clonidine hydrochloride had been administered or had been offered and refused.	V0543	V0543- See attached PoC	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jean M Hochberg	DIALYSIS DIRECTOR	7/8/2026

This plan of correction was accepted on 7/13/26. Jessica Lee Clinical Coordinator, was notified via telephone on 7/13/26 at 11:51 am.
Jean Hochberg MT/ASCP 7/13/26

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V0543	Continued from page 1 b. Interview with RN #1 on 6/16/26 at 2:30 PM confirmed she had not administered the medication as ordered. c. Interview with the facility director on 6/17/26 at 10:54 AM confirmed there was no documentation to show whether the medication was administered or if the patient had refused. In addition, the administrator stated he had instructed the clinical coordinator to start performing "flow sheet audits" to ensure the error was corrected.	V0543		

Memorial Hospital of Sweetwater County Dialysis Unit
1180 College Dr.
Rock Springs, WY 82901

CCN: 532304
Survey Date: 6/17/2026
PoC tag#: V0546

Plan of Correction (PoC)- V0546

Corrective Action for the Specific Deficiency

- **Immediate Action Taken:** A comprehensive clinical audit of the affected patient's medical record was immediately conducted by the Clinical Coordinator (CC).
- **Order Clarification:** The CC contacted the prescribing provider to clarify the existing Clonidine order. The order was successfully discontinued based on the provider's clinical assessment.
- **Systemic Audit:** The CC expanded the audit to include 100% of charts for patients with active PRN (as-needed) Clonidine orders, as well as all other parameter-dependent PRN medications, to identify and correct any outstanding documentation or ordering discrepancies.

Identification of Others at Risk & Systemic Changes

To prevent the recurrence of this deficiency and protect other patients with parameter-dependent PRN orders, the facility has re-engineered its ordering and Electronic Medical Record (EMR) workflows:

- **Hard-Stop EMR Restructuring:** The facility has eliminated the use of the easily missed PRN drop-down menu for parameter-dependent medications. These medications are now entered into the EMR template identical to scheduled medications, with "PRN" and specific parameters detailed in the free-text space. This creates a "hard stop" requiring staff to explicitly document "given" or "not given," along with required clinical parameters, before the daily treatment can be submitted.
- **Alternative Ordering Pathways:** At the provider's discretion, parameter-dependent PRN medications will be utilized as strict one-time orders (via written or verbal instruction) rather than active standing orders when appropriate.
- **Physical Cross-References:** To combat complacency and overlooked alerts, the Charge RN will print a weekly Treatment Alerts Report. This physical running list will serve as a daily baseline reference for the nursing shift leaders.

Training and Implementation Procedures

- **Staff In-Service Education:** A mandatory staff-wide in-service training was conducted. The curriculum specifically addressed the survey findings, identified EMR vulnerability gaps, the clinical dangers of complacency, and the vital importance of verifying printed treatment flow sheets and treatment alerts as well as the importance of adequate documentation.
- **Audit Integration:** The facility's standard Monthly Chart Audit tool was also updated to specifically include parameter-dependent PRN medications and corresponding treatment alerts.

JY
7/13/26

Quality Assurance & Performance Improvement (QAPI) Integration

- **Systemic Prevention Reporting:** The new EMR ordering protocols are being fully implemented with the provider and nursing staff. The results and data from the monthly chart audits will be printed and submitted directly to the Director and Clinical Coordinator for administrative oversight.
- **Monitoring and Tracking:** A dedicated Chart Audit Tracking Log that includes, but is not limited to PRN medications has been integrated into the facility's formal QAPI program. This log will track any identified documentation deficiencies, root causes, and immediate corrective actions taken.
- **QAPI Oversight:** The Clinical Coordinator and/or Director will present the tracking log data at the monthly QAPI committee meetings for an ongoing trend analysis and to determine if further systemic adjustments are required.

Staff Responsibilities

- **Clinical Coordinator (CC):** Responsible for executing initial retrospective audits, securing provider order clarifications, facilitating monthly chart audits, and presenting compliance data to the QAPI committee.
- **Charge RN:** Responsible for generating, printing, and cross-referencing the weekly Treatment Alerts Report for daily floor compliance.
- **Dialysis Director:** Responsible for administrative oversight, reviewing monthly audit trends, and ensuring facility-wide compliance with the QAPI plan.

Completion Date

- **Date of Full Compliance: August 1, 2026** *(Note: Since the processes will be changed by 8/1/2026, this serves as your official effective date of compliance, with ongoing auditing locked into the QAPI calendar).*

JY 7/18/26