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

PRINTED: 04/20/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535046	A. BUILDING _____ B. WING _____	04/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN'S NURSING HOME	P O BOX 428 JACKSON, WY 83001

(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 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and resident and staff interviews, the facility failed to complete a comprehensive assessment of needed areas for 5 of 13 sample residents (#9, #18, #31, #38,	F 272	The filing of this Plan of Correction is made pursuant to both state and federal requirements and does not constitute an admission to the allegations cited herein. The facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. A. The care coordinator will complete the pain assessment on resident #31. Licensed nurses assess resident's pain daily throughout shift and document assessment on the pain assessment sheet in the MARS. 5/31/07 Resident #9 was discharged on 4/10/07 and resident #50 was discharged on 1/9/07 ~~May 11 07~~ Residents #18 and #38 will have a comprehensive sleep assessment completed by the nursing staff 5/16/07 B. Nursing director will audit all charts to assure that a pain assessment has been completed. A pain assessment will be done on all residents who do not have a completed pain assessment in place. 5/16/07 MSW will assure that each resident who is on sedatives/hypnotics have a comprehensive sleep assessment completed by nursing staff. The MSW will ensure that there is an indication for use for each sedative/hypnotic. 5/16/07 C. An in-service on the admission process and completion of an admission pain assessment will be	

and will document other treatment tried

evaluate effect. plan

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

Accepted w/Changes Per Conversation w/Pat Weber pd on 5/2/07

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.

RECEIVED
APR 30 2007
Wyoming Dept of Health
Licensing and Surveys

Per Pat Weber's Request DOC = 5/31/07

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F 272	Continued From page 1 #50). The findings were: 1. According to the 10/16/06 admission and 1/11/07 quarterly Minimum Data Set (MDS) assessments, resident #31 had daily pain of moderate intensity. Review of the initial pain assessment dated 10/3/06 revealed it was incomplete. Interview with the director of nursing (DON) and the MDS coordinator on 4/4/07 at 9:35 AM verified the assessment was not completed. When questioned, the MDS coordinator stated she did not complete the form (including the level of pain acceptable to the resident, interventions other than medications which decreased pain, and activities which worsened pain) as the resident was capable of informing staff when s/he needed pain medications. During an interview on 4/3/07 at 9:55 AM, the resident stated s/he always had pain, even though using a pain pump. On 4/4/07 at 2:05 PM, when asked if his/her pain level was acceptable, the resident replied s/he felt the pain could be better controlled. 2. Review of the face sheet and the physician's orders showed resident #9 was admitted on 3/6/07 with an order for Ambien (sedative/hypnotic)10 mg (milligrams) at bedtime. Review of the medication administration records (MARs) for March and April 2007 showed nightly administration of the medication was attempted. Further review of the medical record showed no diagnosis of insomnia. Furthermore, there had been no comprehensive sleep assessment to determine the resident's usual sleep pattern/disturbance and possible reasons for insomnia (such as being a newly admitted resident, noise, pain, side effects of medication, stress). On 4/4/07 at 11:55 AM, the director of	F 272	completed for licensed nursing staff. This in-service will also cover orientation of how to complete a comprehensive sleep assessment prior to the initiation of any sedatives/hypnotics. 5/10/07 A pain assessment will be completed by nursing on all new residents on admission. Pain assessment was added to the admission paperwork packet and to the nursing admission checklist. 5/16/07 MSW and clinical coordinator will assure that a comprehensive sleep assessment will be completed by licensed nurse before initiation of a sedative/hypnotic. Residents admitted who are using a sedative/hypnotic will have a sleep assessment completed on admission. 5/10/07 D. The director of nursing (DON) or designee will do a chart audit to assure that pain assessments are completed on all new admissions. Any concerns will be reviewed with the admitting nurse. Follow-up findings will be reported at staff meetings and at the quarterly PI meeting. 5/16/07 The MSW will monitor sedatives/hypnotics and ensure that a comprehensive sleep assessment is completed before initiation of such medication. Lack of sleep assessments for residents receiving hypnotics/sedatives will be reported to the DON for feedback to the primary nurse. Aggregate findings and compliance with sleep assessments	5/31/07

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F 272	Continued From page 2 nursing (DON) confirmed a sleep assessment had not been completed for this resident. 3. Review of physician's orders dated 11/21/06 revealed resident #18 received temazepam (Restoril- a sedative/hypnotic) 7.5 mg at bedtime for insomnia. Review of a social service note dated 2/21/07 verified the resident had insomnia and took Restoril at bedtime. The current care plan (dated 2/12/07) showed the resident received Restoril at bedtime for sleep disturbance. However, review of the medical record revealed no evidence a comprehensive sleep assessment had been completed in order to determine the resident's usual sleep pattern/disturbance and possible reasons for insomnia such as noise, pain, side effects of medication, stress, etc. On 4/4/07 at 11:55 AM the DON stated there had been no sleep assessment done for this resident. 4. Review of physician's orders dated 1/23/07 showed resident #38 received Restoril 15 mg at bedtime for insomnia. Review of the 1/23/07 psychosocial resident assessment protocol (RAP) summary revealed the resident had a longstanding history of insomnia. The current care plan dated 1/30/07 showed the resident received Restoril 15 mg at bedtime for sleep disturbance and had a long history of sleep aid use. However, review of the medical record revealed no evidence that a comprehensive sleep assessment was completed for this resident in order to determine usual sleep patterns and possible reasons for insomnia such as noise, pain, side effects of medication, stress, etc. On 4/4/07 at 11:55 AM the DON verified there had been no sleep assessment for this resident.	F 272	for residents receiving hypnotics/ sedatives will be reported at the quarterly PI meetings.	5/16/07 5/31/07

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F 272	Continued From page 3 5. Review of the closed record revealed resident #50 was admitted on 12/29/06 with orders for Ambien 5 mg at bedtime as needed. On 1/5/07 the order was changed to Ambien CR 6.25 mg each night. Then on 1/9/07, the order was changed again to Ambien CR 12.5 mg nightly. Review of the MARs from 12/29/06 until 1/9/07 showed the resident had received Ambien every night since admission. Review of the 1/9/07 recapitulation of stay summary showed the resident continued to have sleep issues. A 1/5/07 social service note showed the resident had insomnia. Review of the medical record revealed no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep patterns and possible reasons for insomnia such as noise, pain, side effects of medication, stress, etc. On 4/4/07 at 11:55 AM the DON verified there had been no sleep assessment done for this resident.	F 272		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assure professional standards of practice related to clarification of orders were maintained for 1 non-sample (#6) and 1 of 12 (#31) residents who resided in the facility at the time of the survey. The findings were: 1. Observation on 4/3/07 at 11:30 AM showed	F 281	The services provided or arranged by the facility must meet professional standards of quality. The facility will assure professional standards of practice related to clarification of orders. A. Physician for resident #6 was contacted and the vitamin order was clarified. The monthly recap will also be corrected for resident #6. 4/25/07 The physician for resident #31 was contacted and was already aware of the abnormal lab results of 3/15/07 5/1/07 B. All residents' medication orders as noted on the most recent monthly recap and orders written since that	5/31/07

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F 281	Continued From page 4 registered nurse (RN) #8 prepared and administered medications including a multivitamin, Vitamin C 500 milligrams (mg), and one Preser Vision tablet (tablet containing multiple vitamins) for resident #6. Comparison of the labels revealed each medication contained several of the same vitamins. Reconciliation of the medication with the 2/28/07 recapitulation (recap) of orders showed the physician had originally written: "May take own vitamins," on 8/02/06. This order had been carried over to each recap of orders since then. When questioned on 4/4/07 at 9:32 AM, the director of nursing stated the physician saw the number of vitamins the resident received when he reviewed and signed each Recap of orders. However, the only place the name and number of vitamins was documented was the medication administration record and, according to the evidence, the physician only saw the order: "May take own vitamins." According to the sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, 2004, seven parts of medication orders include the name and dose of the medication as well as the time and frequency each is to be given. Further review of the same reference revealed "Nurses must not administer any drug without a specific physician order." On 4/4/07 at 1:30 PM, the administrator (also a nurse) acknowledged that medications should have been listed individually on the physician's orders. 2. According to nursing notes dated 3/14/07, the physician was notified when resident #31 complained of left-sided chest pain. Review of the orders showed the physician requested laboratory and radiographic tests for the resident.	F 281	recap will be reviewed by the DON and/or designee to assure that all medication orders include the name and dose of the medication, route, as well as the time and frequency each is to be given. The physician will be contacted by a licensed nurse for clarification of any medication that does not meet standards. 5/16/07 Nursing staff will review all resident charts for abnormal test results completed within the last month that do not provide indication that the physician was notified. The primary nurse will contact the physician and document communication that the physician was informed. 5/16/07 C. An in-service for licensed nursing staff and unit secretaries will review how to write a complete medication order to include: name, doese, as well as time and frequency of the medication to be given. 5/10/07 An in-service for licensed nursing staff will review accountability and appropriate communication of abnormal test results and/or findings to physicians. Nurses will provide documentation that the physician was aware of the abnormal test results and/or findings by the timely receipt of new orders or through a verbal or written response from the MD. 5/10/07 D. The clinical coordinator and DON will review all new medication orders daily to ensure they are	

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F 281	Continued From page 5 The requested tests were completed and, according to notes written on each result, faxed to the physician on 3/15/07. Review of the test results showed the laboratory tests were all abnormal. However, there was no indication the physician saw the results, that nursing staff assured the physician was aware of the results, or that nursing staff followed up on the abnormal test results. During an interview on 4/3/07 at 4:35 PM, RN #8 stated there was no way to know if the physician received the faxed results unless new orders were written. At that time, review of the physician's orders and the nursing notes with the RN verified that no new orders were received and there was no nursing documentation to indicate the physician was notified. When questioned further, the RN stated nursing called the physician during whatever shift the results were received if they had not heard from the physician. However, according to the evidence in this instance, although, the results were received 19 days ago, and the physician had not yet responded or been contacted regarding the abnormal test results. According to "Nursing and the Law" by Sheryl A. Feotz-Harter, 1997, "Accountability will be placed on the nurse for any information contained in the medical record...." and " 'Notification' of a physician does not merely mean that a phone call [or fax] is placed but rather that a physician is actually contacted and responds appropriately..." Review of "Nursing Malpractice: Sidestepping Legal Minefields" by Ann Helm RN, MS, JD, 2003 showed "it isn't the physician's responsibility to call you [the nurse]...It's the nurse's duty and responsibility to keep the physician informed..." According to an additional reference, the sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin,	F 281	specific. Any discrepancies will be addressed immediately. The nurse assigned to review the monthly recap of MD orders will audit for medication orders that do not meet standards which include an indication for use for each medication. Compliance for complete medication orders will also be reviewed at the monthly pharmacy drug review meeting. Orders that do not meet standards will be reported to the DON for follow-up. The findings will be reported at the quarterly PI meeting. 5/16/07 The DON will do a chart audit for documentation of nurse communication with the physician regarding abnormal test results/findings. This will be reported at the monthly staff meetings and at the quarterly PI meeting. 5/16/07	

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F 281	Continued From page 6 2004, nurses are responsible for "reporting abnormal laboratory findings to the appropriate health team member....Verbal communication is the most appropriate and efficacious method." On 4/4/07 at 5:15 PM, the DON acknowledged the facility lacked a method to assure physicians were aware of laboratory results.	F 281		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of competency expectations and requirements for quality assurance monitoring, the facility failed to ensure staff provided appropriate incontinence (perineal) care for 1 (#26) of 5 sample residents who required staff assistance with perineal care. The findings were: Observation on 4/3/07 at 7:30 AM showed certified nurse aides (CNAs) #5 and #10 assisted resident #26 out of bed with a sit-to-stand lift. When checked, the resident was incontinent of urine. While the resident was supported by the lift, the CNAs removed the disposable brief and provided perineal care by cleansing the resident's groin, inner thighs, and the anterior side of the exterior genitalia. The CNAs failed to cleanse remaining skin that was also in contact with urine. Interview with the director of nursing (DON) on 4/4/07 at 9:32 AM revealed the facility did not have a policy and procedure for perineal care.	F 312	The facility will assure that the resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. A. CNA's ~~#5 and #10~~ were in-serviced by clinical supervisor regarding providing appropriate incontinence care for Resident #26. 5/1/07 B. The nursing staff, nursing supervisor and the Director of Nursing will observe perineal care of residents and assure that proper care is provided. If standards are not being met, immediate feedback and in-servicing will be provided to the staff person. ~~5/16/07~~ C. Direct care staff will receive in-service education regarding appropriate incontinence (perineal) care. The DON and clinical supervisor will do random audits twice weekly during rounds and observe incontinence care to ensure it is done correctly. 5/10/07 D. The DON and clinical supervisor will monitor for compliance. Any concerns will be addressed immediately. Clinical supervisor	

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F 312	Continued From page 7 Instead, they utilized "Performance Expectations & Validation of Competency" forms and "Quality Assurance Monitor" forms. Review of these forms showed both listed "washes all areas of skin exposed to urine" as a requirement for completion of appropriate perineal care.	F 312	will report findings at the monthly staff meetings and at the quarterly PI meeting.	5/19/07
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a safe environment in the beauty shop. The findings were: During an interview on 4/5/07 at 9:25 AM, the beautician stated the entrance door to the beauty shop was not locked during the day when she was out for a short time. Observation showed the closet in the beauty shop was not locked, had a broken door knob, and was used to store hazardous chemicals used by the beautician. These chemicals included a half gallon bottle of Barbicide (disinfectant for combs and brushes) and a gallon bottle of fingernail polish remover. The labels on both of these products stated they were harmful if taken internally. At 9:30 AM the beautician was observed taking a resident back to the nurses' station; the door was shut, but it was unlocked. Upon returning to the shop, the beautician stated she had wanted a lock on the closet door "for eleven years."	F 323	The facility must ensure that the resident's environment remains as free of accident hazards as is possilbe. A. A lock was placed on closet door in beauty shop where hazardous chemicals are stored. Beautician will ensure that closet door is locked when she leaves beauty shop unattended. 4/24/07 B. The NHA will educate the beautician to lock the cabinet when she leaves beauty shop unattended. 5/4/07 C. The DON, Clinicial Supervisor, and NHA will make random rounds to ensure that the closet door in the beauty shop is locked when beautician leaves the beauty shop unattended. Any concerns will be addressed immediately with the beatuician and non-compliance will be reported to the NHA for follow-up. 5/19/07	5/31/07
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329	The facility will ensure that each resident's drug regimen must be free from unnecessary drugs. An	

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F 329	Continued From page 8 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure drug regimens were free of unnecessary drugs for four of 13 sample residents (#9, #18, #38, #50). The findings were: 1. Review of the face sheet and the physician's orders showed resident #9 was admitted on 3/6/07 with an order for Ambien (sedative/hypnotic)10 mg (milligrams) at bedtime. Review of the medication administration records (MARs) for March and April 2007 showed nightly administration of the medication was attempted.	F 329	unnecessary drug is any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the above. A. Resident #9 and resident #50 have been discharged from the facility. Resident #18 and #38 will have a comprehensive sleep assessment completed. Non-pharmacological interventions to address insomnia will also be attempted. ~~5/16/07~~ 5/31/07 B. The MSW will assure that each resident who is on sedatives/ hypnotics has a comprehensive sleep assessment completed by nursing staff. MSW, nursing staff and resident will identify and implement non-pharmacological interventions to address insomnia. 5/16/07 C. MSW and clinical coordinator will assure that a comprehensive sleep assessment will be completed by licensed nurses before intitiation of a sedtive/hypnotic. Residents admitted who are currently using a sedative/hypnotic will have a sleep assessment completed. 5/10/07 D. The MSW will monitor sedatives/ hypnotics and ensure that a comprehensive sleep assessment is completed before initiation of such medication. MSW will also	

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F 329	Continued From page 9 However, according to the MARs the resident frequently refused all medications (9 times in March and twice in April as of 4/4/07). Further review of the medical record showed no diagnosis of insomnia. or a comprehensive sleep assessment. On 4/4/07 at 11:55 AM, the director of nursing (DON) confirmed a sleep assessment that identified appropriate indications for use of the hypnotic had not been completed for this resident. 2. Review of physician's orders dated 11/21/06 showed resident #18 received temazepam (Restoril- a sedative/hypnotic) 7.5 mg at bedtime for insomnia. Review of a social service note dated 2/21/07 revealed the resident had insomnia and took Restoril at bedtime. The current care plan (dated 2/12/07) showed the resident received Restoril at bedtime for sleep disturbance. However, review of the medical record revealed no evidence a comprehensive sleep assessment was completed. In addition, there lacked evidence other non-pharmacological interventions (such as warm milk, a back rub, soothing music, a routine bedtime ritual) had been tried. On 4/4/07 at 11:55 AM the DON verified no sleep assessment had been completed for this resident. 3. Review of physician's orders dated 1/23/07 showed resident #38 received Restoril 15 mg at bedtime for insomnia. Review of the 1/23/07 psychosocial resident assessment protocol (RAP) summary revealed the resident had a longstanding history of insomnia. The current care plan dated 1/30/07 showed the resident received Restoril 15 mg at bedtime for sleep disturbance and had a long history of sleep aid use. However, review of the medical record	F 329	document use and effectiveness of non-pharmacologic interventions to address resident's insomnia. Lack of sleep assessments for residents receiving hypnotics/ sedatives will be reproted to the DON for feedback to the primary nurse. Aggregate findings and compliance with sleep assessments for residents receiving hypnotics/ sedatives will be reported at the quarterly PI meetings by MSW.	5/16/07

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	535046	A. BUILDING _____ B. WING _____	04/05/2007

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F 329	Continued From page 10 revealed no evidence a comprehensive sleep assessment was completed. In addition, there was no evidence other non-pharmacological interventions were attempted. On 4/4/07 at 11:55 AM the DON verified the facility had not assessed the resident to determine if there were appropriate reasons to use the hypnotic drug. 4. Review of the closed record revealed resident #50 was admitted on 12/29/06 with orders for Ambien (sedative/hypnotic) 5 mg at bedtime as needed. On 1/5/07 the order was changed to Ambien CR 6.25 mg each night. Then on 1/9/07, the order was changed again to Ambien CR 12.5 mg. Review of the medication administration records (MARs) from 12/29/06 until 1/9/07 showed the resident had received Ambien every night since admission. Review of the 1/9/07 recapitulation of stay summary showed the resident continued to have sleep issues. A 1/5/07 social service note showed the resident had insomnia. Review of the medical record revealed no evidence a comprehensive sleep assessment had ever been completed for this resident. In addition, there lacked evidence other non-pharmacological interventions had been tried. On 4/4/07 at 11:55 AM the DON verified the facility had not completed a sleep assessment prior to the resident's discharge on 1/9/07 to determine if use of the hypnotic drug was appropriate.	F 329		
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal	F 334	The facility must develop policies and procedures that ensure that i) before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects	

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F 334	Continued From page 11 representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the	F 334	of the immunization; ii) Each resient is offered an influenza immunization Oct 1-Mar31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; iii) the resident or the resident's legal representative has the opportunity to refuse immunization; and iv) the resident's medical record includes documentation that indicates, at a minimum, the following: A) that education was provided to the resident or resident's legal guardian; and B) that the resident either received or did not receive the influenza immunization due to medical contraindications. These same standards apply to the pneumococcal immunization. A. Residents #13, #18, and #38 or the resident's legal representative will be provided with eduction in regards to the influenza vaccine. This will be documented in the medical record. 5/16/07 B. The immunization records for all residents will be reviewed by the Infection Control nurse for pneumococcal immunization. Each resident or resident's legal representative who has not received this immunization will receive education on the benefits and potential side effects of the immunization and be offered the immunization. Documentation of the education and the administration	

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F 334	Continued From page 12 following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility immunization documentation and policies, and staff interview, the facility failed to assure the medical record contained documentation of education for 3 of 3 sample residents (#13, #18, #38) who received the influenza vaccination in the facility. The findings were: Review of a document on vaccination history of residents provided by the facility showed residents #13, #18, and #38 received the influenza vaccine on 10/20/06. Review of the October 2006 medication administration records (MARs) confirmed the residents received the influenza vaccination. However, further review of the three medical records showed no documentation that education was provided to	F 334	or refusal of the immunization will be documented on the immunization consent form. ~~5/16/07~~ Starting at or before Oct 1, 2007 until Mar 31, 2008 and annually thereafter, during this period, each resident or resident's legal representative who has not received the influenza immunization will recieve education on the benefits and potential side effects of the immunization and be offered the influenza immunization. Documentation of the education and the administratio or refusal of the immunization will be documented on the immunization consent form. C. The infection control nurse will implement policies and procedures that address the education, provision and documentation of influenza and pneumococcal immunization for residents. ~~5/16/07~~ The facility will ensure that all new admissions receive education in regards to influenza and pneumococcal immunizations and consents will be obtained. Annually between Oct 1 and Mar 31, all residents will be given education and offered the influenza immunization. This will be documented on the immunization consent form by the infection control nurse or the licensed nursing staff. Education will also be provided to residents and their legal representtive in the Living Center newsletter.	

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F 334	Continued From page 13 the resident or legal guardian prior to receiving the vaccine. On 4/5/07 at 8:21 AM, the infection control coordinator verified there was no documentation that education had been provided. Review of the facility's policy entitled. "Pneumococcal/Influenza Vaccine Administration," (6/8/06) showed education was not addressed.	F 334	Licensed staff will receive in-service education re: providing education to new admissions in regards to influenza and pneumococcal immunization policy and procedure. D. The infection control nurse will monitor for compliance. Any concerns will be addressed immediately. See attached sheet	5/16/07
F 386 SS=B	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure physicians signed progress notes as required for 4 (#9, #15, #22, #31) of 12 sample residents who resided in the facility at the time of the survey. The findings were: Review of progress notes showed physicians' signatures were lacking on notes written for the following residents: a. The progress note dated 3/2/07 for resident #9, b. The 10/16/06 progress note for resident #15, c. A note dated 3/26/07 for resident #22.	F 386	The physician must review the resident's total program of care, including medications, and treatements, at each visit required by paragraph C of this section; write, sign and date progress notes at each visit; and sign and date all orders. A. Resident #9 has been discharged. Progress note for visit 10/16/06 resident #15 will be signed. Progress note visit completed 3/26/07 for resident #22 will be signed. Progress notes dated 11/15/06, 12/14/06, 2/1/07, and 2/14/07 for resident #31 will be signed. B. Unit secretary will audit all resident records for signature and date on all progress notes. Unit secretary will flag all visits that require a signature and will report these delinquencies to the NHA. C. NHA and Living Center Medical Director will provide written communication on this standard to the medical staff. Unit secretaries will flag all dictated notes for	5/16/07 5/16/07

will be reported to QA & Unit States QA

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F 386	Continued From page 14 d. Progress notes dated 11/15/06, 12/14/06, 2/1/07, and 2/14/07 for resident #31. Interview with the director of nursing (DON) on 4/4/07 at 9:35 AM confirmed physician signatures were lacking. Interview with the unit secretary at 9:45 AM revealed the dictated notes arrived from the physicians' offices without signatures.	F 386	as a reminder to physicians that signature is required. ~~5/16/07~~ D. The unit secretary will audit physician visits for compliance with a progress note, date and signature. Non compliance will be reported to the NHA for follow-up with the medical director and the medical staff. Continued on attached sheet	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on review of medical records and staff interview, the facility failed to assure physician visits which evaluated the total program of care were provided every 60 days for 2 (#22, #44) of 12 open sample residents. The findings were: 1. According to the face sheet, resident #44 was admitted on 4/25/06. Review of physician's progress notes showed the resident's total program of care was evaluated by a physician on 10/18/06 and then, 77 days later, on 1/30/07. After researching physician's visits, the unit secretary stated on 4/5/07 at 9:30 AM that there had been no other visits. On 4/5/07 at 11:45 AM, the DON confirmed the unit secretary kept a log of all physician visits.	F 387	The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. A. There are signed progress notes in the medical record for resident #44 for 1/3/07 and 3/5/07. Resident #22 was seen on 3/26/07 and is due for her next MD visit on 5/26/07. B. Unit secretary will audit all resident records for compliance of physician visits that were not completed according to regulations. These visits will be reported to the NHA and to the Living Center Medical Director for follow-up. Physicians who do not comply with required visits will be referred to the Medical Staff Quality Committee for further follow-up. ~~6/16/07~~ 5/31/07 C. The unit secretaries will continue to track MD compliance with required visits and send out monthly reminders to physicians	

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F 387	Continued From page 15 2. Review of the physician's progress notes showed a physician evaluated the total program of care for resident #22 on 10/15/06, 10/29/06, 12/20/06, and 3/26/07. The last two visits were 95 days apart. After researching physician visits, the unit secretary stated on 4/5/07 at 9:30 AM that there were no other visits. On 4/5/07 at 11:45 AM, the DON confirmed the unit secretary kept a log of physician's visits.	F 387	about due dates. All MD visits that are five days late from scheduled due date will be reported to the NHA and to the Medical Director for follow-up. 5/16/07 D. The unit secretaries will audit visits as noted in item C. Delinquencies will be reported immediately to the NHA and the Living Center medical director for follow-up. Continued on Attached Sheet.	
F 442 SS=D	483.65(b)(1) PREVENTING SPREAD OF INFECTION When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of policies and procedures, the facility failed to demonstrate appropriate procedures were in place to maintain contact isolation for 1 (#44) of 1 residents who required contact isolation. The findings were: Review of laboratory (lab) results dated 3/31/07 revealed resident #44 was positive for methicillin resistant Staphylococcus aureus (MRSA) in a wound on his/her foot. Review of a physician's note dated 4/2/07 showed the resident had a fever with marked redness and pain in the lower extremity "...Culture MRSA..." Interview with licensed practical nurse (LPN) #6 on 4/4/07 at 1:10 PM revealed she was aware the resident had MRSA in the lower leg. She stated she notified her staff of the diagnosis, but did not know how other staff were informed. At that time,	F 442	When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. A. Over the door cabinet with PPE for staff was installed on door to room of Resident #44. Infection control nurse provided in-service education to staff regarding isolation precautions to be used. 4/5/07 B. The infection control nurse will identify all currently admitted residents to determine if isolation procedures are needed. Isolation procedures will be implemented for these residents. 4/16/07 C. Infection control nurse will provide direct care staff with in-service education on isolation precautions and PPE. 5/10/07 The Director of Nurses or designee and the infection control nurse will ensure that isolation precautions are initiated and PPE is provided for staff when caring for a resident who has been placed	

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F 442	Continued From page 16 the LPN stated staff used gloves, but did not use gowns, when caring for a resident who required contact isolation. Observation showed an isolation cart which contained personal protective equipment (PPE - gloves, gowns, goggles, masks) for staff and dedicated equipment (stethoscope, blood pressure cuff, thermometer, etc) for use with the resident was not available. Observation throughout the rest of that day and the next morning also showed staff entered the room without wearing gowns. Interview with the director of nursing (DON) on 4/5/07 at 7:30 AM revealed the infection control practitioner (ICP) told staff what precautions to institute for residents with MRSA. At that time (6 days after the positive culture), the DON stated she did not know if the ICP had provided instructions to staff related to caring for this resident. The DON further stated she did not know if staff knew to use gowns when anticipating contact with body fluids or contact with surfaces previously in contact with body fluids; nor did she know if gowns were used at all by the staff. Interview with the ICP on 4/5/07 at 8:02 AM revealed she received a weekly report from microbiology detailing laboratory results and a daily report if infections were identified. She stated the facility had over-the-door cabinets for storing PPE for staff and dedicated equipment for residents who required isolation. When questioned about resident #44, the ICP stated she "slipped" with that resident. She confirmed the cabinet was not in place and stated she had not yet educated staff on isolation precautions for the resident, even though positive MRSA results were received 6 days earlier on 3/31/07. Furthermore, the ICP stated her emphasis was on wearing gloves and practicing good	F 442	on isolation. Staff will be inserviced at that time by infection control nurse or designee regarding type of isolation precautions that are indicated for specific resident. 5/16/07 D. The DON or designee and infection control nurse will monitor for compliance. Any concerns will be addressed immediately. Findings will be reported by infection control nurse at quarterly Performance Improvement meeting. 5/19/07 5/31/07	

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F 442	Continued From page 17 handwashing; she did not necessarily stress the use of gowns when coming in direct contact with the wound or the resident's bed. According to the facility's undated policy and procedure entitled "Isolation Guidelines", contact precautions are for "patients [residents] known or suspected to be infected or colonized with multi-drug resistant organisms [such as MRSA] that can be transmitted by direct contact with the patient...or in direct contact (touching) with environmental surfaces or patient-care items in the patient's environment....Wear a gown when entering the room if you anticipate that your clothing will have substantial contact with the patient, environmental surfaces, or items in the patient's room...Dedicate the use of noncritical patient-care equipment to a single patient to avoid sharing between patients." F 444 SS=D 483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on random observation, staff interview, and review of guidelines from the Centers for Disease Control and Prevention (CDC), the facility failed to assure staff completed hand hygiene after direct contact for which hand hygiene was required. The findings were: 1. Observation with the director of nursing (DON) on 4/3/07 at 2:35 PM showed registered nurse (RN) # 3 donned non-sterile gloves and removed	F 44 F 444	The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. A. ~~Nurse (RN) #3~~ Nursing staff received in-service education regarding proper hand hygiene after removing soiled gloves and prior to donning sterile gloves as it relates to performing dressing change for resident #31. ~~Nurse (RN) #1~~ Nursing staff received in-service education regarding proper hand hygiene as it relates to medication administration. 4-5-07 B. The Director of Nursing and Clinical Supervisor will randomly audit direct care staff hand hygiene techniques for compliance during rounds. Policy and Procedure for "Packing a Wound" will be updated to include hand hygiene after removing soiled gloves and between glove changes. DON will observe licensed nurses who do dressing changes and medication administration to ensure hand hygiene is in compliance. Any concerns will be addressed immediately. ~~5/16/07~~ C. The facility will ensure that proper hand hygiene is completed to remove the transient microbial contamination acquired by contact with body fluids or excretions, mucous membranes, non intact skin, wound dressings, environmental sources and when removing gloves. The nursing staff will receive	

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F 444	Continued From page 18 the old dressing from resident #31. The RN then removed and discarded the gloves, but failed to wash her hands prior to donning sterile gloves and completing the dressing change. During an interview on 4/4/07 at 11:50 AM, the DON verified the RN failed to wash her hands when changing gloves and stated that she should have done so. Interview with the facility's infection control practitioner (ICP) on 4/5/07 at 8:02 AM revealed washing hands after removal of gloves "is crucial, especially with dressing changes." The ICP stated studies show that gloves can have micro-tears not visible to the human eye. Review of the facility's 2004 policy and procedure, "Packing a Wound," showed hand washing between glove changes was not addressed. Review of the CDC guidelines published in October 2002 showed, "Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact and wound dressings..." and "Decontaminate hands after removing gloves." 2. Observation on 4/3/07 at 7:46 AM showed RN # 1 closed the bottom drawer in the medication cart with her foot. The RN then reopened the drawer with her hand placed over the same surface as her foot, removed a bottle of medication, opened and poured it, returned it to the drawer, and shut the drawer with her hand. The RN proceeded to open another drawer and remove several unit doses of medications which she opened, poured into a cup, administered to an unidentified resident, and signed them out in the medication administration record. The RN never sanitized her hands during the entire procedure. According to the facility's 3/25/04 policy and	F 444	inservice education on handwashing and proper hand hygiene specifically in regards to: - Appropriate hand hygiene as it relates to medication administration. - Appropriate hand hygiene between golve changes as it relates to dreccing changes. - Review of the updated policy and procedure for "Packing a Wound". 5/10/07 D. The DON and designees will rnadomly audit licensed staff for hand hygiene during medication administration and dressing changes on daily rounds two times a week to ensure compliance. Any concerns will be addressed immediately. Findings will be reported at the quarterly PI committee meeting. 5/19/07	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535046	A. BUILDING _____ B. WING _____	04/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN'S NURSING HOME	P O BOX 428 JACKSON, WY 83001

(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 444	Continued From page 19 procedure entitled "Handwashing Technique for the Prevention of Nosocomial Infections" N-IC10, "employees will wash their hands in order to remove the transient microbial contamination acquired by contact with...environmental sources."	F 444		

St. John's Living Center
Health Recertification survey
Plan of correction 4.30.07

F334 continued

Findings will be reported quarterly at Performance Improvement meeting by the Infection Control Nurse.
5-19-07

F386 continued
This audit will be reported at the quarterly PI meeting and at appropriate SJMC medical staff meetings as needed.
5.16.07

F387 continued
Aggregate data on delinquent MD visits will be reported at the quarterly Living Center PI committee meeting.
5.16.07