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	535046	A. BUILDING _____ B. WING _____	05/04/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN'S NURSING HOME	625 E BROADWAY JACKSON, WY 83001

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F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure privacy for one (#1) non-sample resident during random observations of care. The facility census was 48. The findings were:	F 164	The facility will ensure personal privacy will be maintained for each resident, this will be accomplished by: A) The floor nurse and/or management team will observe the nurse aides as they provide perineal care and dressing of resident #1. They will observe for maintenance of personal privacy when resident #1 is given perineal care and being dressed 5/30/06 B) The floor nurse and/or management team will observe perineal care and dressing of residents and if privacy is not provided, immediate in-servicing and corrective action will be taken with the staff member. The Clinical Supervisor and Clinical Coordinators will randomly observe resident care and/or treatments and if resdient privacy is being violated, immediate in-servicing and corrective action will be taken. C) Education will be provided to the nursing staff on the resident's right to personal privacy and dignity with emphasis on pulling privacy curtains and/or closing doors while providing perineal care or dressing of residents. D)The Clinical Supervisor and Clinical Coordinators will report daily in Stand up meeting any observed violations of personal privacy. The DON or Clinical	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mardi Rohers — TITLE: NHA — (X6) DATE: 5/30/06

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JUN 02 2006
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HEALTH FACILITIES

Accepted w/ changes, Reviewed with Mardi Rohers administrator on 6/9/06 DOC - 6/30/06

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	This facility will insure that all alleged violations involving mistreatment, neglect or abuse are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures. This will be accomplished by: A. The administrator will immediately report any alleged violations involving mistreatment, neglect or abuse of a resident to the Department of Family Services or police and the WY Dept of Health, Office of Healthcare Licensing and Surveys in accordance with LC2M Abuse policy. A checklist has been developed to expedite and verify that all reporting is completed in a timely fashion. See Attachment 1 - 5/30/06 B. The administrator will inform immediately the CNO,CEO and Risk Manager, an abuse investigation has been initiated. The completed checklist will be sent to the CNO upon completion of the investigation (following the 5 working days framework). The CNO will review each checklist for timely compliance with reporting/investigation requirements. C. Education regarding abuse and reporting requirements will be provided to all Living Center employees as follows: 1. General new hire orientation: video on abuse and requirements	

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F 164	Continued From page 1 Observation on 5/3/06 at 10:56 AM of resident #1 revealed the resident required staff assistance with perineal care and dressing. As certified nurse aide (CNA) #4 assisted the resident, the CNA did not pull the privacy curtain. The resident's roommate was observed as he/she watch the CNA dress and provide perineal care to resident #1. At 10:58 AM, registered nurse #5 entered the room and assisted the CNA with care. The privacy curtain was not pulled as the resident was assisted to a standing position, and his/her disposable briefs and slacks were pulled up. The roommate had full visual view of the resident's care. Interview with the CNA as she finished caring for the resident revealed the aide was aware that the privacy curtain should be utilized during personal care. Medical record review for resident #1 revealed the resident's most recent assessment was a quarterly Minimum Data Set assessment dated 3/25/06 which assessed the resident with severely impaired cognition. Interview with the CNA coordinator on 5/3/06 at 2:07 PM revealed her expectation was for staff to close privacy curtains when caring for a resident.	F 164	Supervisor will track violations of personal privacy monthly and report findings quarterly at the Performance Improvement meeting. C. Continued DON and Clinical Supervisor are responsible for educating staff. Initial staff education was provided at 5/17/06 mandatory staff meeting.	5/16/06

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F 225	Continued From page 3 by: Based on review of facility investigation reports, and staff interview, the facility failed to immediately report allegations of abuse to the state survey and certification agency and other officials in accordance with State law for two of two allegations reviewed. In addition, the facility failed to send the written report of findings within five days for one of the two allegations reviewed. The findings were: On 5/2/06 at 4:40 PM, review of facility investigation reports and interview with the administrator revealed the following concerns regarding the timeliness of reporting: a. A report dated 2/15/06 showed numerous allegations against a male certified nurse aide (CNA #39), which included kissing and fondling the breasts of a female resident (resident #50). The report documented the facility became aware of the allegations on 2/6/06 and 2/9/06. The administrator stated the survey and certification agency was not notified, nor was the Department of Family Services (DFS) or law enforcement. Review of a fax cover sheet showed the written report was not submitted to the state survey and certification agency until 4/13/06. b. A report dated 2/17/06 showed an allegation of verbal abuse to resident #18 by licensed practical nurse (LPN) #18. The administrator stated the allegation was reported on 2/13/06. The report did not document that the state survey and certification agency, or DFS, was immediately notified of the allegation. During interviews on 5/4/06 at 9 AM and 11:45 AM, the chief nursing officer (CNO) stated there was not evidence the state survey agency or DFS was immediately notified.	F 225	for reporting. 2. During unit based orientation for Living Center employees: video on abuse and discussion. 3. Mandatory abuse/resident rights in-service is required at least yearly for all Living Center employees. The last in-service was February 28, 2006. In addition an inservice on abuse policy revisions and implementation of the investigation checklist will be provided to Living Center staff by June 16, 2006, D. The medical center's CNO will monitor Living Center compliance with the abuse policy.- reporting/ investigation process on a quarterly basis. LC DON, NHA and/or Clinical Supervisor will provide abuse in-services/unit based orientation on abuse.	6/16/06

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F 225	Continued From page 4 Review of the Rules and Regulations, Department of Family Services, Adult Protective Services, Chapter 2, Section 1, revealed "...any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused...exploited...shall report the information immediately to a law enforcement agency or the Department....Law enforcement agencies include, but are not limited to, the following: (i) Municipal police; (ii) County sheriff's department; (iii) Highway patrol; or (iv) Medicaid Fraud Control Unit of the Attorney General's Office..."			
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on policy review, review of facility investigation reports, and staff interview, the facility failed to implement its policies regarding reporting allegations of abuse for two of two allegations reviewed. The findings were: Review of the facility's policy "Abuse" (section: LC2M, revised 9/05, effective 10/11/05) revealed "...The Living Center Administrator will...report the alleged violation(s) and all substantiated incidents to the State Health Department, and the Department of Family Services...report to the	F 226	This facility will ensure that written policies and procedures that prohibit mistreatment, neglect or abuse of residents and misappropriation of resident property are developed and implemented. This will be accomplished by: A. The LC abuse policy will be reviewed and revised by the SJMC CNO. The revision addresses an additional group of people to whom reporting could be made internally (mandated reporting to DFS, State remains the same). The policy also includes a checklist which the LC administrator will use to expedite and verify that all reporting is completed in a timely fashion. The administrator will ensure that all alleged violations involving mistreatment, neglect or abuse are reported immediately to the administator of the facility and to other officials in accordance with state law through established procedures. B. The administrator will immediately inform the CNO, CEO & Risk Mgr that an abuse investigation has been initiated. The completed checklist will be sent to the CNO upon completion of the investigation (following the 5 working days framework). The CNO will review each checklist for timely compliance with reporting/investigation requirements.	6/10/06 5/30/06

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F 226	Continued From page 5 State Health Department...the results of the investigation within 5 working days of the incident..." On 5/2/06 at 4:40 PM, review of facility investigation reports and interview with the administrator revealed the following concerns regarding the facility's failure to follow its policies regarding reporting: a. A report dated 2/15/06 showed numerous allegations against a male certified nurse aide (CNA #39), which included kissing and fondling the breasts of a female resident (resident #50). The report documented the facility became aware of the allegations on 2/6/06 and 2/9/06. The administrator stated the survey and certification agency was not notified, nor was the Department of Family Services (DFS) or law enforcement. Review of a fax cover sheet showed the written report was not submitted to the state survey and certification agency until 4/13/06. b. A report dated 2/17/06 showed an allegation of verbal abuse to resident #18 by licensed practical nurse (LPN) #18. The administrator stated the allegation was reported on 2/13/06. The report did not document that the state survey and certification agency, or DFS, was immediately notified of the allegation. During interviews on 5/4/06 at 9 AM and 11:45 AM, the chief nursing officer (CNO) stated there was not evidence the state survey agency or DFS was immediately notified.	F 226	C. Education regarding the revised abuse policy and checklist will be provided to all LC employees as follows: 1. During unit based orientation for LC employees: video on abuse and discussion. 2. Mandatory abuse/resident rights in-service is required at least yearly for all LC employees. The last in-service was February 28, 2006 In addition, an in-service on abuse policy revisions and implementation of the investigation checklist will be provided to LC staff by June 16, 2006. D. The medical center's CNO will monitor LC complicance with the abuse policy, reporting/investigation process on a quarterly basis. The LC Medical Director will also be informed of any issues arising out of abuse investigations. 2 Contd. Abuse inservices/unit based orientation will be presented by LC DON, NHA and/or Clinical Supervisor	

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F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, the facility failed to ensure a dignified dining experience during two of two dining observations. The findings were: Observation of the east dining room of the noon meal on 5/2/06 at 12 PM revealed 11 non-sample residents had cold beverages in paper (disposable) cups. None of the residents in the dining room were served cold beverages in regular (non-disposable) drinking glasses. A second observation on 5/2/06 at 5:30 PM revealed cold beverages were served in disposable paper cups to the residents in both the East and Central dining rooms. In addition, all residents who received carrot cake at the noon meal on 5/2/06 were served their deserts on disposable Styrofoam plates. Interview with certified nurse aide #26 on 5/2/06 at 12 PM revealed disposable drinking cups were used on a daily basis to serve residents cold drinks. Interview with the dietitian on 5/3/06 at 11:25 AM revealed she did not know why disposable cups were being used, and all deserts should be served on china plates. When asked how long they had been using the disposable cups and plates, she was not sure but said, "It's been a while." During an interview on 5/3/06 at 2:10 PM, the	F 241	The facility will care for residents in a manner and in an environment that maintains or enhances dignity. This will be accomplished by: A) The Food & Nutrition Service department has china dessert plates and plastic cold beverage cups available for all resident meal services. The dietitian and food service manager talked with the baker who will from now on serve all desserts on china. 5/22/06 B) The dietitian will work with the LTC nursing and CNA staff to find regular plastic cold beverage cups that are appropriate for the residents as currently some residents are unable to grasp and lift the larger beverage cups. If under specific circumstances paper, disposable cups are the only appropriate alternative, the resident will have such use documented in his or her care plan. 6/10/06 C) The dietitian will conduct an inservice for all CNAs regarding the use of non disposable cups and dishes for all residents. 5/17/06 D) The dietitian will do monthly monitors of the dining rooms to assure that all residents are being served cold beverages in the appropriate cups and that food items are served on non disposable dinner ware. Results of above monitors will be discussed in the LTC PI Quarterly meeting.	

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F 241	Continued From page 7 administrator stated that paper cups were not acceptable for routine use with meal service. She further stated she, personally, did not like to drink from paper cups. Confidential resident interviews conducted on 5/3/06 at 10:30 AM revealed residents preferred to use durable tableware and not disposable picnic ware at meals.	F 241		

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F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure accurate completion of two Minimum Data Set (MDS) assessments for 2 of 12 sampled residents (#21 and #27). The findings were: Review of the 3/25/06 MDS quarterly	F 278 for	The facility will ensure that resident assessments will accurately reflect the resident's status a) A corrected MDS will be completed and care plan updated as needed for resident #27. Resident#21 quarterly assessment was redone using the appropriate time frames and was signed by the RN until completed. 5/15/06 B) All current resident MDS's were verified for accuracy and corrected as needed. 5/30/06 All current resident MDS's verified to ensure there were no predated MDS's. C) All MDS's will be reviewed at care plan conferences by a Clin. Coord accuracy and appropriate signature dates before being locked, submitted and placed in the chart. D) Clinical Coordinators will randomly audit a sample of each other's MDS's monthly to ensure accuracy and appropriate signature/ completion dates. The DON and Clinical Supervisor will review the results of the audits te and report at quarterly Performance Improvement meetings.	

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F 278	Continued From page 9 assessments for resident #27 revealed a significant weight loss was experienced by the resident over the reporting period. However, review of the dietary notes revealed a significant weight gain was experienced by the resident over the reporting period. Review of the resident's weight record for January 2006 revealed the resident's weight increased from 146 to 167 lbs. Interview with the Registered Dietician on 5/3/06 at 9:48 AM revealed the recorded weight gain was accurate. Interview with the registered nurse (RN) clinic coordinator on 5/3/06 at 3:30 PM revealed the entry in the 3/25/06 MDS was inaccurate. The RN stated the MDS should have documented a weight gain. Review on 5/4/06 of the most recent MDS quarterly assessment for resident #21 revealed a pre-dated ARD of 5/14/06. Section R2a was signed by the RN clinic coordinator as completed and section R2b was pre-dated for 5/14/06. Section AA9 was signed by the RN clinic coordinator and four other staff persons attesting completion of a portion of the accompanying assessment. All signatures were also dated 5/14/06. Interview with the MDS coordinator on 5/3/06 at 9:30 AM confirmed all signatures had been pre-dated. According to the December 2002, Centers for Medicare & Medicaid Services (CMS) Revised Long-Term Care Resident Assessment Instrument (RAI) User's Manual, Version 2.0, Section R2a is to be signed by the person coordinating the MDS assessments, and Section R2b is the date the coordinator signed the assessments as complete; completion of both the signature and date is required.	F 278		

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F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop a comprehensive care plan for 1 of 12 sample residents (#12). The findings were: Review of a 4/19/06 progress note by the Registered Dietitian (RD) for resident #12 showed the resident's weight on 4/18/06 was 134 pounds (#), which was a weight loss. The RD documented that Ensure (supplement) would be added to meals. Review of the current care plan	F 279	The facility will use the results of the assessment to develop review and revise the resident's comprehensive plan of care. A) Resident #12 care plan and CNA care plan sheets have been updated, recommended supplements will be added to the medication administration record for Resident #12 to ensure supplements are offered and observed by the floor nurse for accountability B) Care plans have been verified for accuracy and corrected as needed. Floor nurses will observe meals to ensure supplements are being distributed, if not immediate in-servicing and corrective action will be taken. C) Care Plans will be reviewed by a Clin.Cord for accuracy and completeness during care plan conferences. Clinical Coordinators will review all orders and update care plan and CNA care plan sheets as needed from these orders. A weekly Nutritionally at Risk committee has been implemented. Residents who meet the criteria for potentially being nutritionally at risk and unstable will be monitored weekly by the committee. The committee will make recommendations, implement and monitor resident status and ensure implementation of recommendations. D) Clincial Coordinators will randomly audit a sample of each other's care plans CNA care plan	5/30/06 5/30/06

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F 279	Continued From page 11 dated 3/27/06 showed the resident's weight loss was not addressed. The care plan did not identify that staff should provide Ensure at meals. During an interview on 5/3/06 at 8:45 AM, the RD stated she e-mailed the clinical coordinators on 4/20/06 and stated Ensure would be added to each meal, and that the care plan should be updated. Review of a copy of the e-mail confirmed this. During an interview on 5/3/06 at 11:55 AM, the clinical coordinator (registered nurse #19) confirmed the care plan and CNA care plan sheets did not include Ensure. Observation during meals at the following times revealed the resident was not provided with Ensure: On 5/2/06 at 8:28 AM, on 5/2/06 from 11:48 AM until 12:15 PM, and on 5/2/06 from 6 PM until 6:20 PM. Review of the April 2006 intake record showed no documentation of intake for supplements. During an interview on 5/3/06 at 8:45 AM, the RD stated if the resident had a supplement, it would be documented on the intake record in the place marked "supplement."	F 279	sheets to ensure accuracy and completeness and report at quarterly Performance Improvement meetings.	
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 review of the medical record, and staff interview, the facility failed to ensure one of 11 (#17)sample residents were weighed as ordered by the physician The findings were: Review of the medical record revealed	F 281	The services provided or arranged by the facility will meet professional standards of quality. A. The weight for Resident #17 has been obtained and physician orders for weights are being followed. B) Residents with ordered weights will be reviewed by the Nutritionally at Risk committee during their weekly meeting and obtained within 24 hours of needed. Staff will be in-serviced as needed to ensure compliance.	5/18/06 5/18/06

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	535046	A. BUILDING _____ B. WING _____	05/04/2006

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F 281	Continued From page 12 resident #17 had a history of weight loss, and was receiving a regular diet with supplements. Review of the signed recapitulations of physician's orders, dated 2/28/06 and 3/31/06, revealed, weights were to be done "weekly and PRN" [as needed] for this resident. Review of the certified nurse aide (CNA) flow sheets for March and April 2006, revealed the weekly weights were not completed. Interview with the clinical coordinator on 5/3/06 at 4:15 PM confirmed the weekly weights were not recorded on the CNA flow sheets, and the coordinator was unaware of any other place weights might have been documented. According to the July 2005, Wyoming Nurse Practice Act, nurses shall provide care according to the directions of a licensed physician.	F 281	C) A weekly Nutritionally at Risk committee has been implemented. Residents who meet the criteria for potentially being nutritionally at risk and unstable will be monitored weekly by the committee. The committee will monitor weights, and make recommendations, implement and monitor resident status and ensure implementation of recommendations. In-servicing will be done on the importance of following physician orders and obtaining weights. Clinical Coordinators will ensure MD orders are followed by reviewing monthly recaps. D) The DON or Clinical Supervisor will participate and monitor the weekly Nutritionally at Risk meetings and will randomly audit a sample of weight records for accuracy and completeness and report at quarterly Performance Improvement Meetings.	5/18/06
F 286 SS=E	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to keep 15 months of assessments in the active medical record for 4 of 11 sample residents (#12, #17, #26, #48). The findings were: During an interview on 5/2/06 at 11:30 AM, the administrator stated some assessments for current residents would be in the closed medical records located in the medical records department (in the hospital) because the facility	F 286	NUMBER 286 begins here. The facility will maintain all resident assessments completed within the previous 15 months in the active record. A) The previous 15 months of assessments have been placed in the active records for Residents #12, 17, 26 and 48. B) All resident active records were reviewed and 15 months of assessments were placed in the record per regulations.	5/30/06

F281C Continued
DON and/or Clinical Supervisor are responsible for inservicing RN/CNA staff

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F 286	Continued From page 13 "closed" the medical record when a patient was no longer on skilled services (Medicare). The administrator stated records kept in the medical records department were not accessible to staff during all hours. 1. Review of the active medical record for resident #12 showed the only assessment was a 3/28/06 quarterly Minimum Data Set (MDS) assessment. On 5/2/06 at 11:30 AM, the administrator stated previous assessments were located in the closed chart in the medical records department. The administrator then obtained the previous assessment, an admission assessment dated 12/28/05, from the medical records department. 2. Review of the medical record revealed the 5/29/05 admission MDS assessment for resident #17 was not available in the record. Interview with the clinical coordinator on 5/3/06 at 2:35 PM revealed the MDS was purged to medical records. 3. Medical record review revealed the May 2005 annual Minimum Data Set (MDS) assessment for resident #26 was not contained in the active medical record. Interview on 5/3/06 at 9:50 AM with the resident assessment RN coordinator revealed the assessment was purged from the current record and stored in the medical record office. The coordinator stated the purged record was not readily available to staff. 4. Review of the medical record revealed the 10/23/05 annual MDS assessment for resident #48 was not available in the record. Interview with the DON on 5/2/06 at 3:25 PM revealed the MDS	F 286	C) All appropriate personnel were instructed on the regulations of 15 months of assessments needing to remain in the active record regardless of payor source. Personnel included were Unit Secretaries, Social Services Dir, Medical Records & Clinical Supervisor and Clinical Coordinators. They all participated in reviewing the active medical records for 15 months of assessments. Random audits will be done monthly by the unit secretaries to ensure compliance. The DON or Clinical Supervisor will randomly audit charts for compliance. D) The DON or Clinical Supervisor will monitor the monthly audits and report at the quarterly Performance Improvement meeting the results of these audits and their own audits.	6/30/06

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F 286	Continued From page 14 was purged to medical records.	F 286		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure one (#8) of five sample residents with urinary incontinence received care according to assessed need and services to reduce urinary incontinence. The findings were: Random observations on 5/3/06 from 8:40 AM to 10:13 AM revealed resident #8 was asleep in his/her bed. At 10:13 AM, a strong odor of urine was noted in the resident's room. Continuous observation by two surveyors (from 10:13 AM to 12:01 PM) revealed the odor continued despite incontinence care provided to the resident's roommate at 10:56 AM. No staff were observed to check resident #8 for incontinence. At 11:49 AM, certified nurse aide (CNA) #4 entered the resident's room to provide personal care. Interview with the CNA at that time revealed the	F 315	The facility will ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. A) The floor nurse on day shift will observe the nurse aides to ensure they make rounds, turn, reposition, and provide incontinence care for resident #8 while in bed. (all residents who need it) 5/15/06 B) The floor nurse will observe and ensure that nurse aides are making their rounds and if not immediate in-servicing and corrective action will be taken with the aide. Clinical Coordinators and Supervisor will make daily rounds to ensure residents are turned, repositioned and given incontinence care as needed. C) In-servicing will be provided to the nursing staff on making rounds and giving appropriate perineal care to incontinent residents. Clinical Coordinators and Supervisor will report findings of daily rounds in daily Stand Up meeting. DON will randomly make rounds to ensure nursing staff are making rounds and giving appropriate perineal care to residents. 5/17/06 D) The DON or Clinical Supervisor will track and report findings	

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F 315	Continued From page 15 resident required staff assistance with toileting and perineal care. The CNA stated the resident was checked for incontinence and changed if needed when the resident was in bed, but ambulated to the bathroom during the day. The CNA stated the last time the resident was checked for incontinence was at 7:45 AM (four hours and four minutes prior to the current check). The observation revealed the resident's underpad was saturated with urine and had a brown circular stain which extended to the edges of the underpad. As the resident ambulated past the surveyor, the resident's gown was saturated with urine and had brown circular stains. The strong urine odor was observed as the resident passed by the surveyor. The following concerns were identified related to the resident's incontinence: a. Medical record review revealed the resident's most recent Minimum Data Set (MDS) assessment was a quarterly assessment dated 4/3/06 which assessed the resident as "totally incontinent" of urine. Review of the resident's current care plan, reviewed on 10/15/04, documented that when the resident was in bed at night, he/she required checking by staff for incontinence during rounds.Further review revealed the resident required turning or repositioning every two to three hours during the night and documentation showed staff was also to check the resident every two hours for bowel incontinence. b. Interview with registered nurse #5 on 5/3/06 at 1:42 PM revealed CNAs #2 and #4 were the CNAs responsible for resident #8's care. Interview with a CNA #2 at 1:45 PM on 5/3/06 revealed she was not assigned to check resident #8 and had not assisted the resident that	F 315	of the Clinical Coordinator, Supervisor and DON rounds at the quarterly Performance Improvement meeting. A. Continued Resident #8 is receiving appropriate incontinence care. C. Continued DON and Clinical Supervisor will be responsible for in-servicing nursing staff.	

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F 315	Continued From page 16 morning. The CNA identified CNA #4 as the CNA responsible for resident #8. c. Interview with the CNA coordinator on 5/3/06 at 2:07 PM revealed that residents were permitted to sleep in if they wished. The coordinator stated the expectation was that staff would continue to check residents for incontinence and turn residents every two hours, if required.	F 315		
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 ensure the environment was safe and chemicals were not accessible to residents during two random observations. The findings were: Observation of the resident bathing room opposite resident room #412 on 5/2/06 at 10:45 AM and again on 5/4/06 at 8:22 AM revealed doors leading into the room were open and no staff members were present. The key to the wall cabinet was inserted into the lock, but the cabinet was not locked. The cabinet contained a container of disinfectant cleaner #5. The label on the disinfectant cleaner indicated the container contained ammonium chloride as the active ingredient. According to the Columbia Encyclopedia 6th edition, 2004, ammonium	F 323	The facility will ensure that the resident environment remains as free of accident hazards as possible. A) The floor nurse will observe the shower rooms to ensure the cabinet is locked and the key is removed from the lock. B) The floor nurse will observe the shower rooms and if the cabinet is unlocked or the key is in the lock immediately make corrective action and in-service as necessary. C) Staff will be in-serviced on the importance of keeping this cabinet locked and not to leave the key in the lock and the need to keep the environment as free from accident hazards as possible. The DON, Clinical Supervisor, and Clinical Coordinators will make random rounds to ensure compliance with these cabinets not having the key left in and that they are being locked. They will report in daily Stand Up meeting any deficiencies found.	5/22/06 5/17/06

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F 323	Continued From page 17 chloride is harmful if swallowed and causes skin and eye irritation. Posted on the wall next to the cabinet was a sign stating: "Please remember to remove the key after locking the cabinet. Thank you." In addition, another sign posted on the door leading into the adjoining shower room stated: "Staff, do not ever leave disinfectant #5 cleaner in the shower. Lock it up. Poison!" Interview with the certified nurse aide training coordinator on 5/4/06 at 8:24 AM confirmed the cabinet doors should be locked at all times when staff is not in the room.	F 323	D) Results will be tracked monthly and presented at the quarterly Performance Improvement meeting. DON will track this and report at PI. DON and Clinical Supervisor are responsible for in-servicing staff.	
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to implement interventions to prevent further weight loss for 1of 8 sample residents (#12) with weight loss. The findings were: Review of the 12/10/05 history and physical showed resident #12 had a history of prostate cancer. Review of the 12/19/05 initial nutrition assessment revealed the resident was 68 inches tall and weighed 145.2 pounds (#). The resident's goal weight was documented to be140-150#.	F 325	This facility will ensure that a resident maintains acceptable parameters of nutritional status. This will be accomplished by: A) The DON, clinical coordinators and dietitian have initiated a Nutrition at Risk Committee. They will meet every week to discuss those residents at nutritional risk, possible interventions to correct the nutritional risk and monitor all interventions effectiveness. This will be documented in the NAR minutes. Also the dietitian will document the effectiveness of interventions in those resident's medical records. The dietitian has started fortifying the pureed soups for additional calories and protein for the pureed diets. She will continue to look at possible fortification of foods for residents on an individual basis.	5/18/06

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F 325	Continued From page 18 Review of the quarterly nutrition assessment dated 3/27/06 showed the resident's weights in March were 139.5 to 141.9#. Review of a 4/19/06 progress note by the dietitian showed the resident's weight on 4/18/06 was 134# (the resident's weight on 3/20/06 was 141.9#, so this was a 7.9# weight loss, or 5.6%, in one month). The dietitian documented that Ensure (supplement) would be added to meals. The following concerns were identified: a. Observation of the breakfast meal on 5/2/06 at 8:28 AM revealed the resident did not have Ensure or any other supplement. Observation of the lunch meal on 5/2/06 from 11:48 AM until 12:15 PM showed the resident was not offered Ensure or any other supplement. Observation of the evening meal on 5/2/06 from 6 PM until 6:20 PM showed the resident was not offered a supplement. Review of the April 2006 intake record showed no documentation of intake for supplements. During an interview on 5/3/06 at 8:45 AM, the Registered Dietitian (RD) stated if the resident had a supplement, it would be documented on the intake record in the place marked "supplement". During the same interview, the RD stated that Ensure was on the meal ticket for the resident, and her expectation was that the certified nurse aides (CNAs) would offer the resident Ensure at each meal. Review of the meal ticket showed Ensure was listed in bold writing for each meal. b. Review of the current care plan dated 3/27/06 showed the resident's weight loss was not addressed. The care plan did not identify that staff should provide Ensure at meals. During an interview on 5/3/06 at 8:45 AM, the RD stated she e-mailed the clinical coordinators on 4/20/06 and stated Ensure would be added to each meal, and	F 325	B) The dietitian will monitor resident's weights monthly and if a resident is identified to be at nutritional risk they will be added to the NAR list. Those residents will be monitored weekly until stable and felt able to be taken off the NAR list. Any such interventions will be documented in the resident's medical record and included in their care plan. C) The Dietitian meets with the clinical coordinators on a monthly basis to assure that the meal tickets, care plans and diet orders are all in compliance. This is done at the beginning of each month and will continue to occur each month. This will assure that all items discussed at the NAR meetings are included in the care plans and meal tickets etc. D) The results of the NAR meetings will be summarized at the quarterly LTC PI meeting. A. Continued Resident #12 care plan and CNA care plan sheets have been updated, recommended supplements will be added to the medication administration record for Resident #12 to ensure supplements are offered and observed by the floor nurse for accountability.	5/30/06

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F 325	Continued From page 19 that the care plan should be updated. Review of a copy of the e-mail confirmed this. During an interview on 5/3/06 at 11:55 AM, the clinical coordinator (registered nurse #19) confirmed the care plan and CNA care plan sheets did not include Ensure. c. On 5/3/06 at 1:40 PM, RN #19 stated the resident's weight that day was 132.4#. In addition, general concerns related to the management of weight loss for residents were as follows: a. Interview with the dietitian on 5/4/06 at 8:15 AM about fortifying foods for residents with weight loss revealed she did not really do any fortifying of foods, and was not sure why. b. Interview with residents on 5/3/06 at 10:30 AM revealed snacks were not routinely offered at night, but snacks were available if residents asked for them. Interview with the registered nurse #13 assigned to work evenings revealed residents were not offered snacks at bedtime. Refer to F368 for additional information regarding evening snacks at this facility.	F 325		

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F 368 SS=B	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to routinely offer bedtime snacks to residents. The findings were: Observation at 7:08 AM on 5/2/06 revealed some of the residents eating their meal in the restorative dining area. Interview at that time with the restorative certified nurse aide (CNA) revealed the facility had recently started an alternative care philosophy that include open dining for the morning meal. The CNA stated residents could sleep in and come to breakfast as late as 10 AM. Observation of the evening meal revealed on 5/2/06 at 5:36 PM revealed meal service started approximately 5:15 PM. Interview with the CNA coordinator on 5/3/06 at 2:07 PM revealed some residents preferred to sleep in and	F 368	This facility will ensure that each resident receives and the facility provides at least three meals daily and that snacks will be offered at bedtime daily. This will be accomplished by: A) The CNAs and nursing staff will offer all residents a snack at bedtime between the hours of 7:30 and 8:30pm 5/22/06 B) RNs will observe the passing of bedtime snacks to assure all residents are offered a snack. The bedtime snack procedure will be discussed at the next CNA staff meeting. C) Nursing will be in-serviced on the need to offer all residents a bedtime snack. 5/17/06 D) Clinical supervisor will monitor to ensure the passing of bedtime snacks. DON and Clinical Supervisor inserviced all staff on 5/17/06	

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F 368	Continued From page 21 not eat breakfast. Confidential interview with residents on 5/3/06 at 10:30 AM revealed snacks were not routinely offered at night, but snacks were available if residents asked for them. Interview with evening registered nurse #13 revealed residents were not offered snacks at bedtime. During an interview on 5/3/06 at 5:40 PM, evening shift certified nurse aide (CNA) #30 stated residents were not offered snacks at night, but could have a snack if they requested one.	F 368		
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to ensure the walk-in freezer, laundry room, and dry food storage room floors were maintained in good condition. In addition, the food storage room had open rodent bait stations. The findings were: 1. Observation on 5/2/06 at 7:05 AM revealed the floor of the walk-in freezer had an accumulation of food particles and spills. In addition, there were several areas of ice accumulated on the floor in front of shelves toward the back of the freezer approximately 3 feet long by 2 inches wide. The condenser unit directly above this area also had	F 465	The facility will provide a safe functional, sanitary and comfortable environment for residents, staff and the public. This will be accomplished by: 1. A. The floor of the walk-in freezer was cleaned on May 5, 2006. In addition, the accumulation of ice build up on the floor in front of the shelves toward the back of the freezer was removed on May 5, 2006. B. The cleaning of the floor of the walk-in freezer and removal of any ice accumulation has been added to the weekly food service cleaning schedule. This is done at night. The cook coming in the day following the scheduled night freezer cleaning/ice removal will check the cleaning schedule to determine that it has been completed	5/12/06

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 _____	05/04/2006

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F 465	Continued From page 22 frost and ice accumulation. Interview with the food service manager on 5/3/06 at 8:55 AM confirmed the floor in the walk-in freezer needed to be cleaned and was expected to be cleaned once a week. However, she revealed a cleaning schedule was no longer utilized and didn't know the last time the floor in the walk-in freezer had been done. Additionally she stated the ice build-up had been a problem for approximately six months, and she was not aware if maintenance knew of the problem. 2. Observation in the dry food storage room on 5/2/06 at 3:05 PM revealed three mouse traps located under separate shelving units. The traps were not covered or enclosed and utilized a snapping bar mechanism. The floors under the shelves had build up of food particles and debris. Interview with the food service manager on 5/3/06 at 8:55 AM revealed a pest control company supplied the traps, and she was not aware the traps were supposed to be enclosed. She further stated the storeroom floors should be swept daily including under the shelves. According to Food Code 2005, U.S. Public Health Service, 7-206.12 Rodent Bait Stations: Rodent bait shall be contained in a covered, tamper-resistant bait station. 3. Observation on 5/4/06 at 10: AM revealed a 2 ft x 2 ft missing piece of linoleum on the floor between the facility's washing machine room and the dryer room. The edges of the remaining linoleum were elevated from the concrete floor surface, creating an uneven walking surface. In addition, the exposed concrete was starting to crumble. Interview with the facility maintenance supervisor on 5/4/06 at 10:10 AM confirmed the	F 465	C. The food services manager will monitor the weekly cleaning check off sheets on a monthly basis. D. The SJMC Environmental Rounds committee will inspect the food service freezers for cleanliness and absence of ice build-up. 2. A. The mouse traps have been removed from the dry storage area. 5/5/06 B. The food service manager will notify Dean's pest control company of the inappropriateness of such traps in the food service area and assure that only closed rodent bait stations are used in future. 5/30/06 C. The food service manager or designee will routinely inspect the food service area to assure that all of the floors are kept clean and that there are no open rodent bait stations in the food service area. D.The SJMC Environmental Rounds committee will inspect the dietary department for compliance with Food Code 2005, U.S.P.H.S. 7-2 06. 3. A. The vinyl on the floor between the facility's washing machine room and dryer room was completely removed. This cement in this area was patched and smoothed out. The cement was then sealed with an epoxy reinforced latex enamel. 5/16/06 B. The environmental services supervisor will inspect the floor	

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 _____	05/04/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN'S NURSING HOME	625 E BROADWAY JACKSON, WY 83001

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F 465	Continued From page 23 above.	F 465	in this area on a monthly basis and report any need for repair to maintenance, staff. C. The maintenance supervisor will ensure that all repairs are made in a timely fashion. D. The SJMC Environmental Rounds committee will inspect the laundry room to ensure a safe environment is present.	