POC accepted 8/19/11
Janeele Cole, OHL

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

PRINTED: 08/08/2011
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
	560048	A. BUILDING _____ B. WING _____	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN'S NURSING HOME	625 EAST BROADWAY 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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: DON- Director of Nursing RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	**483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE.** An individual resident may self-administer drugs if the interdisciplinary team, as defined by 483.10(n)(2)(ii), has determined that this practice is safe. This will be accomplished by:	9-1-11
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, review of medical records, and staff interview, the facility failed to determine if 1 of 5 residents (#9) observed during medication passes was capable of self-administration of medications. This resident was observed to self-administer medications. The findings were: Observation on 7/25/11 showed RN #1 prepared and crushed medications for resident #9. Prior to administering the medications, the RN mixed them into a glass of Ensure, attached the lid, and shook them up. She then handed the glass to the resident at 5:37 PM and went out of the dining room. The RN stated she would watch the resident from the hallway, and that observing this way was permissible as long as the resident's tablemates were cognitively intact. However, the	F 176	A. Resident #9 has dementia and is not able to self administer medications according to policy. Nurses will administer medications to resident #9 as noted on the care plan. Nurses will observe resident while she is taking her medications. B. The Directors of Nursing will provide all nurses with a written reminder that they must directly observe residents taking medications unless the interdisciplinary team has care planned according to policy for self administration of medication. C. The Directors of Nursing and/or designee will monitor nurses administering medications correctly, specifically addressing that nurses are not having residents self administer medications without a specific care plan to self administer. Immediate feedback and inservicing will be provided if the med administration procedure is not followed. D. Results of these audits will be reported at the quarterly PI meeting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia Weber CNMSN NHA | TITLE: Administrator | (X6) DATE: 8-15-11

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.

POC accepted. Call to Pat Weber, WHA on 8/19/11 @ 3pm. je

JC 8/15/11

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

PRINTED: 08/05/2011
FORM APPROVED
OMB NO. 0938-1391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
1	536046	A. BUILDING _____ B. WING _____	07/28/2011

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

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F 178	Continued From page 1 RN immediately left the area and went to perform a task inside another resident's room. On 7/26/11 at 9:23 AM RN #2 stated the resident had severe dementia and did not ever self-administer medications. The RN further stated they did observe the resident from the corridor if s/he was sitting at the table immediately in front of the medication cart, and the observation was throughout the entire meal. Review of the medical record revealed no evidence of an assessment for self-administration of medications. Review of the care plan showed information was on the medication administration record (MAR). However, the only information on the MAR related to medication administration was to crush the medications and mix them with berry flavored Ensure. On 7/28/11 at 9:25 AM DON #1 confirmed the resident had severe dementia and was not assessed for self-administration of medications.	F 178		
F 285 SS=E	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental	F 285	483.20(m),483.20(e)PASRR REQUIREMENTS FOR MI AND MR. A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. This will be accomplished by: A. A PASRR for resident #15 was completed by the Social Worker. B. The admission policy has been revised to state that a PASRR Level I and if needed Level II will be completed prior to admission.	9-1-11

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	535048	A. BUILDING _____ B. WING _____	07/28/2011

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F 285	Continued From page 2 condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission— (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the PASRR (pre-admission screening and resident review) level I was completed prior to admission for 5 of 12 sample residents (#6, #9, #15, #42, #44). The findings were: 1. The following concerns were identified related	F 285	C. The Social Worker and/or designee will ensure that a PASRR Level I and if needed a Level II will be completed prior to any admission. D. The Social Worker will complete an audit of all admissions to ensure that a PASRR is completed on or before the day of admission. E. The findings of this audit will be reported at the Living Center quarterly PI meeting.	

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	535040	A. BUILDING _____ B. WING _____	07/28/2011

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ST JOHN'S NURSING HOME	625 EAST BROADWAY JACKSON, WY 83001

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F 285	Continued From page 3 to the completion of the PASRR level I: a. Review of the medical record revealed resident #15 was admitted on 6/28/11. Further medical record review showed no evidence the PASRR was completed. On 7/28/11 at 8:02 AM, the administrator stated the PASRR had not yet been done, one month after admission. b. Review of the PASRR for resident #9 showed the resident was admitted on 5/24/10, but the PASRR was not completed until 5/6/11. c. According to the PASRR, resident #6 was admitted on 7/1/11, but the PASRR was not completed until 7/5/11. d. According to the face sheet, resident #42 was admitted on 5/26/11. Review of the PASRR showed it was not completed until 6/2/11, four days after the resident's admission. e. Medical record review showed resident #44 was admitted on 6/9/11, but the PASRR was not completed until 8/10/11. 2. During an interview on 7/27/11 at 4:15 PM, the administrator stated the social worker was responsible for the completion of the PASRR on the residents. She stated the social worker was currently on vacation; therefore, she could not say why the PASRRs were not completed prior to admission.	F 285		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS. The facility must establish and maintain an Infection Control Program, designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. This will be accomplished by:	

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	535046	A. BUILDING _____ B. WING _____	07/28/2011

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F 441	Continued From page 4 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, review of manufacturer's instructions, and comparison of policies and procedures with nationally recognized standards for infection control activities, the facility failed to ensure compliance with infection control	F 441	Observation #1 A. The nurses will clean the glucometers after every use with a disinfectant cloth that will kill hepatitis B and C, and HIV. B. The policy on "Cleaning and Disposing of Equipment" has been rewritten to state that glucometers will be cleaned after every use with a disinfectant cloth. C. Written instructions were provided to all nurses on the revised policy for cleaning and disinfecting glucometers after each use. D. The Infection Control Nurse and the staff development nurse will monitor nurses for correct cleaning of glucometers. E. The results of these audits will be reported by the Infection Control Nurse at the Living Center quarterly PI meeting.	9-1-11

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F 441	Continued From page 5 practices. This lack of compliance involved failure to clean a glucometer after 1 of 1 observations of use (resident #44) and failure to clean equipment in 1 of 3 observations of wound care (resident #49). The findings were: 1. Observation on 7/26/11 showed RN #1 obtained blood sugar results from resident #44 at 5:45 PM. Prior to performance of the test, the RN placed the glucometer on the resident's bedside table and the case on the resident's bed. After completion of the test, the RN replaced the glucometer into the case without cleaning it, and returned the case to the nursing station. When questioned immediately after the observation, the RN stated that, unless blood was spilled on the glucometer or it was contaminated in some other manner, it was only cleaned at night. The RN specifically stated the glucometer was not cleaned between residents. Review of the manufacturer's instructions for the Precision PCx g ucometer showed daily cleaning of the exterior surface with a "water-moistened cloth or a sponge and a mild detergent" was recommended. Review of the facility's policy and procedure, "Cleaning and Disposing of Equipment", approved 7/14/11, showed "wipe...daily with a damp cloth." During an interview on 7/27/11 at 11:10 AM, the infection control practitioner (ICP) confirmed that neither the instructions nor the policy and procedure met the recommendations from the Centers for Disease Control & Prevention (CDC). Reference: The CDC: Frequently Asked Questions (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration, March 8, 2011:	F 441		

JE 8/19/11

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F 441	Continued From page 6 "Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared." 2. Observation on 7/27/11 showed, that between 4:40 PM and 5:30 PM, physical therapist #1 removed the old dressing, completed electrical stimulation, and applied a new dressing to the pressure ulcer for resident #49. Removal of the old dressing showed a greenish discharge on the packing in the wound. While changing the dressing, the therapist stated the resident had Pseudomonas, a pathogenic bacteria, in the wound, but it was improving as the drainage was now only light green instead of the blue-green previously found on the dressings. Review of laboratory results dated 5/11/11 confirmed the wound was positive for "heavy growth Pseudomonas aeruginosa...moderate growth Coagulase negative staphylococcus." While placing the electrodes for electrical stimulation, the therapist removed scissors from the equipment tote and cut a piece of foam to go under the clip. The therapist placed the scissors on a clean field and covered them before leaving the room. Upon his return, the therapist removed the electrodes, wrapped the electrical stimulation unit in plasticized paper, and placed it on the bedside table. The therapist then used the scissors to cut the new packing he inserted into the resident's wound. After applying the new dressing, the therapist picked up the paper containing the electrical stimulation unit, which fell out of the paper onto the bedside table and the	F 441	Observation #2. A. The Infection Control Nurse will provide an inservice to physical therapist #1 on infection control practices. B. The Infection Control Nurse will observe the physical therapist #1 do a dressing change on resident #49 to ensure that proper infection control practices are followed. If correct infection control practices are not followed, immediate feedback will be given to the Physical Therapist. C. The Infection Control Nurse will complete an inservice for nurses doing wound care on proper infection control practices. D. The Infection Control Nurse will monitor nurses and physical therapist #1 doing wound care on residents for proper infection control practices. If correct infection control practices are not followed, immediate feedback will be given to the provider.	9-1-11

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F 441	Continued From page 7 scissors and replaced the scissors and paper into the tote with the unused clean supplies. The following deficient practices were identified: a. The therapist did not cleanse the scissors after removing them from the tote nor prior to cutting either the foam or the packing. The therapist also failed to clean the scissors prior to replacing them in the tote. b. The therapist removed the plasticized paper from the tote but did not cleanse the electrical stimulation unit before wrapping and re-wrapping it in the paper and again placing it in the tote. c. When questioned immediately after the observation, the therapist stated he would clean the items later. He further stated he was the only person using the equipment in the tote so he knew it was clean. He demonstrated no understanding that placing dirty items in the tote potentially contaminated the clean supplies. d. Prior to leaving the room, the therapist failed to clean the bedside table which was potentially contaminated by the electrical stimulation unit. At 9:05 AM on 7/28/11, the ICP acknowledged that dirty items should never be put with clean items.	F 441	E. The Infection Control Nurse will report the findings of these observations at the Living Center quarterly PI meeting.	