DEPARTMENT OF HEALTH AND HUMAN SE' 'CES
CENTERS FOR MEDICARE & MEDICAID SER . .ES

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 53A051	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 2/11/05 1/12/2005
NAME OF PROVIDER OR SUPPLIER SOUTH LINCOLN NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE BOX 390, 711 ONYX KEMMERER, WY		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 283	483.20(l)(1)&(2) RESIDENT ASSESSMENT

When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay;

A final summary of the residents status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to assure a discharge summary was completed for one (#22) of one anticipated discharge. The findings were:

Review of the medical record for resident #22 revealed a care plan conference summary dated 12/14/04 that documented the resident was planning to be discharged by Christmas 2004. Review of the nurses' notes revealed the resident was discharged on 12/23/04. Review of the medical record with the executive nursing director on 1/12/04 at 10:30 AM revealed no discharge summary was done The executive nursing director stated during the review that the facility had no formal policy in place that documented the time frame for completion of a discharge summary, however, she stated the facility's expectation was that the discharge summary was completed within 14 days of discharge. At the time of the survey a total of 20 days had elapsed since the resident was discharged from the facility.

South Lincoln Nursing Center will do a discharge summary that includes a recapitulation of the resident's stay.

1)At the medical staff meeting on 02/08/05, the medical staff was informed of the requirement to do a discharge summary that includes a recapituation of the resident's stay within 14 days of discharge. 02/08/05

2) A policy will be put in place to document the time frame for completion of a discharge summary. 02/09/05 EXHIBIT #2

3) The discharge summary on resident #22 was completed on 01/12/2005.

4) The DON will do a random chart audit on a monthly basis of all discharged residents to assure that a discharge summary is done on discharged residents within 14 days of discharge. 03/07/05

5) On a monthly basis the DON will report the results of the chart audit at the Medical Director Meeting and to the South Lincoln Medical Center PQI/QA coordinator, starting at the next meeting. 03/07/05

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

The above isolated deficiencies pose no actual harm to the residents

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	53A051	A. BUILDING _____ B. WING _____	01/12/2005

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SOUTH LINCOLN NURSING CENTER	BOX 390, 711 ONYX KEMMERER, WY 83101

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F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT Within 14 days after the facility determines, or should have determined, that there has been a significant change in the residents physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the residents status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the residents health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure a significant change assessment occurred for one (#4) of three residents who had experienced a decline in physical and functional status. The findings were: Review of the 10/13/04 quarterly Minimum Data Set (MDS) assessment for resident #4 revealed the resident required extensive assistance in the following areas: bed mobility, transfer, hygiene, and bathing. The 10/13/04 assessment also documented the resident required limited assistance for ambulation and and locomotion, toilet use, was usually continent of bladder, and had mild pain less than daily. However, review of the 1/7/05 quarterly assessment revealed the resident had become totally dependent on staff for bed mobility, transfer, dressing, toilet use, hygiene, and bathing; the assessment also revealed the resident's bladder incontinence had declined from occasionally incontinent to frequently incontinent	F 274	South Lincoln Nursing Ctr. will within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. 1) The MDS coordinator has implemented a significant change checklist that will be completed to determine if a significant change should be filed. EXHIBIT #3 01/19/05 2) The MDS coordinator has been educated on what constitutes a significant change. 01/14/05 3) A significant change was filed on Resident #4. 01/19/05 4) The DON will do a random chart audit on a monthly basis to assure that a significiant change bas been filed within 14 days after we have determined or should have determined there has been a significant change in the resident's physical or mental condition. 03/07/05 5) On a monthly basis the DON will report the results of the chart audit at the Medical Director Meeting and to the South Lincoln Medical Center PQI/QA coordinator, starting at the next meeting.	03/07/05

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

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

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F 281	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure medications were administered in a manner that assured two residents (#20, #8) took medications as prescribed by a physician during two of twenty observations of the medication pass. The findings were: 1. Observation of the registered nurse (RN) on 1/11/05 at 11:30 AM revealed the RN prepared the following medications for resident #20: Lasix (diuretic); multivitamins with minerals; lysine (over the counter supplement), and calcium with vitamin D. The RN then proceeded to the dining room and placed the medications on the dining table next to the resident; the medications were contained in a paper souffle cup . The RN then left the dining room. During the observation, the RN stated she leaves the medications with the resident because the resident likes to set up his/her own medications. At 12 noon the surveyor observed the resident taking the medications that were left at the dining table. The observation revealed the RN did not return to observe the resident take the medications. 2. Observation of the RN on 1/11/04 at 11:45 AM revealed she prepared the following medications for resident #8: Fibercon (laxative), torsemide (antineoplastic), and potassium. The RN then proceeded to the dining room and placed a souffle cup that contained the medications next to the resident. The RN then left the dining area. At 11:50 AM the surveyor observed the resident take the medications. During the observation the RN did not return to the dining area to observe the	F 281	South Lincoln Nursing Center will provide services that meet the professional standards of quality. 1) At the January 13, 2005 staff meeting, the staff was instructed that proper medication administration is to include watching the resident take the medication. EXHIBIT #4 01/13/05 2) A formal medication policy has been written. EXHIBIT # 5 02/14/05 3) At the February staff meeting, the staff will be educated on the medication policy. 02/24/05 4) On a monthly basis the DON will randomly observe the RN and LPN staff during medication administration to assure appropriate medication administration. 03/01/05 5) On a monthly basis the DON will report the results of her observation at the Medical Director Meeting and to the South Lincoln Medical Center PQI/QA coordinator, starting at the next meeting.	03/07/05

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F 281	Continued From page 3 resident take the medications. Interview with the director of nursing (DON) on 1/11/04 at 11:30 AM revealed the facility had no formal medication policy. The DON stated during the interview her expectation was that staff who administer medication stay with the resident until the resident has swallowed all of the medication; otherwise, there was no assurance that the medication was taken. According to Nursing Interventions & Clinical Skills (Elkin, Perry & Potter, 2004) a nurse's responsibility when administering medications is to stay until the resident has completely swallowed each medication because the nurse is responsible for ensuring that residents receive the ordered dose, and if the resident is left unattended medication may not taken.	F 281		
F 385 SS=E	483.40(a)(1)&(2) PHYSICIAN SERVICES A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure six (#2, #3, #5, #8, #17, #20) of 10 sample residents were	F 385	South Lincoln Nursing Center will have a physician personally approve in writing a recommendation that an individual be admitted to the facility. SLNC will ensure that the medical care of each resident is supervised by a physician. 1) The SLNC administrator and the chief of staff met individually with the physicians, nurse practitioner and physician assistant to educate them that a physician must admit residents to SLNC. 01/04/05 2) At the February Medical Staff meeting, the medical staff was	

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F 385	Continued From page 4 admitted to the facility upon the recommendation of a physician and that medical care provided was under the supervision of a physician. The findings were: Review of medical records revealed the following residents were admitted to the facility and followed by a family nurse practitioner without physician oversight: Residents #2, #3, #5, and #20. Further medical record review revealed the following residents were admitted to the facility and followed by a physician's assistant without physician oversight: Residents #8 and #17. Interview with the director of nursing (DON) on 1/12/04 at 11:30 AM revealed she was not aware a nurse practitioner or physician's assistance required physician oversight in a nursing home, or that a physician was required to recommend admission to a nursing home. The interview confirmed the aforementioned residents' medical care was provided by either a nurse practitioner or a physician's assistant without physician oversight. Interview with the chief of staff on 1/12/04 at 2:40 PM confirmed no physician oversight was consistently done for the nursing home residents who were followed by either a nurse practitioner or a physician assistant. According to the Wyoming Board of Nursing, Chapter 4, Advanced Practitioners of Nursing, Section 7, Standards of Advanced Practitioners of Nursing Practice: (c)...the advanced practitioner of nursing shall maintain a current, written plan of practice and collaboration at the practice site... Furthermore Chapter 1 Section 6, Definitions of the Wyoming Board of Nursing, Standards of Practice, collaboration means a process which involves two or more health care professionals working together toward common goals, each	F 385	instructed that a physician must provide supervision of residents care when the resident is seen by the nurse practitioner and physician assistant. 02/08/05 3) A physician will provide oversight of residents #2, #3, #5, #20, #8 and #17. 02/14/05 4) The DON will do a random chart audit on a monthly basis to assure physician approves in writing admissions of an individual and provides oversight of the resident's care. 03/07/05 5) The DON will report the results of the chart audit at the monthly Medical Director Meeting and to the South Lincoln Medical Center PQI/QA coordinator, starting with the next meetings.	03/07/05

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F 385	Continued From page 5 contributing his or her respective area of expertise, in order to provide more comprehensive care than either one alone could offer. According to the Wyoming Board of Medicine practice guidelines, Article 5, 33-26-502. Scope of W.S. 33-26-501 through 33-26-511 (b) A physician assistant assists in the practice of medicine under the supervision of a licensed physician...The physician assistant may perform those duties and responsibilities delegated to him by the supervising physician when the duties and responsibilities are provided under the supervision of a licensed physician...	F 385		