| 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 _____ | C 06/18/2021 |

| 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 |
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| F 000 | INITIAL COMMENTS<br><br>A complaint survey was conducted by Healthcare Licensing and Surveys on 6/17/21 to 6/18/21. The survey was prompted by complaint intake WY00003076.<br><br>In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and Surveys on 6/17/21 to 6/18/21. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the infection control survey. | F 000 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, staff interview, and review of facility documentation, the facility failed to ensure neurological assessments were completed as required for 1 of 4 residents (#1) reviewed for falls. The findings were:<br><br>1. Review of the 4/22/21 quarterly Minimum Data Set (MDS) assessment showed resident #1 had two or more falls with injury since the last assessment. Review of the 4/22/21 Morse Fall | F 684 | 6/17/2021 Falls Complaint Survey POC<br><br>F000 – INITIAL COMMENTS<br>During the State Complaint Survey of 6/17/21, the surveyor reviewed 3 residents charting and found documentation was missing for a resident who had 2 falls in which the resident reported hitting their head. | 7/8/21 |

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

Electronically Signed | 07/08/2021

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| F 684 | Continued From page 1<br>Scale showed a score of 75, which indicated the resident was at high risk for falls.<br><br>2. During an interview on 6/17/21 at 3:45 PM the director of nursing (DON) stated the facility's policy on neurological assessments was not included in their policy for falls, but provided the surveyor with a typed sheet of paper. Review of the documentation showed "POLICY- If suspected head injury, chart VS [vital signs] and neuro assessment q [every] 6 hours x 24 hours, then q shift x 48 hours."<br><br>3. Review of a nursing note dated 6/4/21 showed the resident was found on the floor at 9 AM. The resident stated s/he hit his/her head. Review of neurological assessments in the electronic medical record showed neurological assessments were not completed as required. On 6/18/21 at 9:26 AM the DON provided the surveyor with additional documentation from the medical record pertaining to the 6/4/21 fall. Interview at that time with the DON revealed after looking at all of the documentation, there were four times when neurological assessments should have been completed, but were not documented. She stated the missing neurological assessments were on 6/4/21 at 7:30 PM, 6/5/21 at 7:30 AM, 6/6/21 on the night shift, and 6/7/21 on the day shift.<br><br>4. Review of the post-fall evaluation dated 6/14/21 showed the resident was found on the floor in the bathroom at 8:45 PM. The resident stated s/he bumped his/her head. Review of neurological assessments in the electronic medical record showed neurological assessments were not completed as required. On 6/18/21 at 9:26 AM the DON provided the | F 684 | F684 – QUALITY OF CARE<br>The policy for a resident who hits their head during a fall is this:<br>For a fall in which the resident reports hitting their head/staff suspect or observe resident hitting their head/there's an actual head injury, the nurse must perform and document vital signs and neuro assessment every 6 hours for the first 24 hours, then once each shift for the following 48 hours, then as needed for continued change in condition.<br><br>Procedure for Implementing POC - Staff Education:<br>As of 6/28/21 the Director of Nursing (DON) and/or RN Educator met with 100% of current nurses to review our policy for resident falls, the protocol for post-fall assessments, and how to document the assessment in the EMR. We had each staff member sign our Education Program Attendance sheet after receiving the education and emailed the Plan of Correction to all nurses.<br>The policy for resident falls will be discussed with all new nurses when they start at the Living Center.<br><br>Regarding Resident #1, with any future falls we will follow the policy on neuro assessments. The same is true for any resident who falls in our facility.<br><br>Monitoring Procedure - Quality Assurance and Performance Improvement:<br>The DON and/or RN Educator will perform documentation audits for falls and follow-up with nurses as needed. | |

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| F 684 | Continued From page 2<br>surveyor with additional documentation from the medical record pertaining to the 6/14/21 fall. Interview at that time with the DON revealed after looking at all of the documentation, there were four times when neurological assessments were missing or were late. She stated the 6/15/21 2:45 PM assessment was late, and not completed until 4 PM. She stated the missing neurological assessments were on 6/15/21 at 8:45 AM, 6/16/21 on the day shift, and 6/17/21 on the night shift. | F 684 | Results of those audits will be reviewed quarterly in our QAPI team meetings until evidence is established for consistent compliance.<br>Responsible Party for overseeing implementation of corrective action is the Director of Nursing. | |