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

PRINTED: 02/25/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535046	A. BUILDING _____ B. WING _____	02/17/2005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 279 SS=D	483.20(k) RESIDENT ASSESSMENT 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 following: 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 s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(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 one (#37) of four sample residents who were incontinent of bowel. The findings were: Review of the bowel assessment dated 5/24/04 (updated 7/8/04, 10/6/04, and 1/4/05) revealed resident #37 was occasionally incontinent of bowel despite toileting throughout the day. The assessment documented the resident was on a toileting schedule. Review of the February 2005 nurse assistant care record showed the resident was incontinent thirteen times in fifteen days (through 2/15/05). During an interview on 2/17/05 at 9:30 AM, certified nurse aide (CNA) #1 stated the incidents of the care record reflected bowel	F 279	In accordance with the comprehensive assessment and the plan of care for bowel assessment, nursing will provide the highest practicable physical, mental and psychosocial care to promote the highest level of functioning for all residents including Resident #37. This will be accomplished by: 1. All residents with bowel incontinence, including Resident #37, will have a current comprehensive assessment of bowel function. The assessment will be written on the facility's bowel assessment form. To be completed by Clinical Coordinator,DON to monitor. 2. All bowel assessments on residents, including Resident #37, will be completed on admission, updated quarterly and when Clinical Assessments demonstrate that there has been a change in current bowel status.To be completed by Clinical Coordinator..DON to monitor. 3. All residents with bowel incontinence, including Resident #37, will have a toileting schedule written on the Certified Nursing Assistance Assignment sheet and the Nursing Care Plan. Individualized resident care plan will be oriented toward preventing avoidable decline in bowel function.	4/1/2005 4/1/2005

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Martha Cabrera — TITLE: NHA — (X6) DATE: 3/9/05

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 correction is requisite to continued program participation. POC was approved & corrections made by Jeanne Fris, DON & Karen Womack, RN, Health Surveyor on 3/14/05 @ 1340

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F 279	Continued From page 1 incontinence. Observation on 2/15/05 from 9:50 AM until 12:20 PM showed the resident was seated in a wheelchair. At 12:20 PM, CNA #2 and nurse aide (NA) #1 checked the resident for incontinence. The resident was incontinent of bowel. During an interview on 2/15/05 at 12:35 PM, CNA #2 and NA #1 stated the resident had been more incontinent of bowel lately. Review of the current care plan dated 1/4/05 showed bowel incontinence was not addressed. Furthermore, the care plan did not include a toileting plan for bowel incontinence. During an interview on 2/17/05 at 10:23 AM, the registered nurse clinical coordinator confirmed the care plan did not address bowel incontinence.	F 279	To be completed by Clinical Coordinators. DON to monitor 4. A Quality Assessment tool for Performance Improvement will be developed to assess and monitor accuracy in Care Planning. Clinical Coord. will develop this tool and initiate its use by 4/1/2005. Data will be presented at PI meeting on 4/26/05. 5. Facility staff will be in-serviced on bowel incontinence assessment. Education will include: Causes of bowel pattern changes; Reporting and documenting bowel incontinence; Promoting bowel continence with - see Sheet	4/1/2005
F 286 SS=C	483.20(d) Resident Assessment 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 staff interview and medical record review, the facility failed to ensure comprehensive assessments were readily accessible for 11 (#9, #14, #16, #17, #19, #22, #30, #34, #35, #36, #37) of 11 sample residents. The findings were: Review of the comprehensive Minimum Data Set (MDS) assessments for residents #9, #14, #16, #17, #19, #22, #30, #34, #35, #36, and #37 revealed they required comprehensive assessments in a variety of triggered areas. Review further revealed the required assessments were not in the medical record or readily accessible to staff. Interview with the Minimum Data Set (MDS) assessment	F 286	This facility will maintain all resident assessments completed within the previous 15 months in the residents active record. This will be accomplished by: 1. All resients, including Residents #9,14,16, 17, 19, 22, 30, 34, 35 and 37 will have a current comprehensive assessment completed which inlcudes Resident Assessment Protocol (RAP) summaries. The RAP summaries for all of the residents (including those listed) will be printed and placed in one of the team binders, which contain the residents care plans. These binders are available for all nursing staff 24/7 and are located at the nurses station. To be completed by Clinical Coordinator. DON to monitor.	3/31/05

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F 286	Continued From page 2 coordinators on 2/17/05 at 9:10 AM revealed they completed Resident Assessment Protocol (RAP) summaries as part of the assessment process. They confirmed the RAP summaries were kept in the computer, and not in the medical record, and required one of the MDS coordinator's passwords to access the information.	F 286	2. A comprehensive assessment which includes RAPS will be completed on all new residents by day 14 of admission. These assessments are updated annually and when clinical assessments demonstrate that there has been a significant change in status. These assessments will be available.....	
F 514 SS=E	483.75(l)(1) ADMINISTRATION The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policies, and staff interview, the facility failed to assure verbal orders were signed by the physician in accordance with facility policy for seven of eleven sample residents (#9, #14, #16, #22, #30, #35, #37). The findings were: 1. Review on 2/17/05 of physician's orders for resident #14 revealed the following verbal orders were not signed by the physician: a. A 7/1/04 verbal order for the approval of the Warfarin maintenance dosing protocol. b. A 2/9/05 verbal order for the initiation of an antibiotic, to order some laboratory tests, and to notify pharmacy of possible Coumadin interactions. 2. Review on 2/17/05 of physician's orders for resident #22 revealed a verbal order dated 9/15/04 for Hydrocortisone cream was not yet	F 514	This facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible, and systematically organized. This will be accomplished by: 1. The unsigned verbal orders cited for residents #9, 14, 16, 22,30,35, & 37 will be signed by their respective physician. DON to monitor. 2. All unsigned verbal orders will be flagged with "sign here" red arrow stickers by the secretary or nurse that transcribes the order. Charts are available 24/7 for physicians/practitioners. When physicians/practitioners are making rounds at the Living Center, they will be verbally prompted to sign the flagged verbal orders. Nursing and secretarial staff will be responsible for this intervention. Initiation date 3/14/05 DON to monitor.	4/3/05

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F 514	Continued From page 3 signed by the physician. 3. Review on 2/17/05 of physician's orders for resident #35 revealed a verbal order dated 2/8/05 regarding the medication Risterll was not yet signed by the physician. 4. Review on 2/17/05 of physician's orders for resident #37 revealed a verbal order dated 1/25/05 for the initiation of an antibiotic was not yet signed by the physician. 5. Review of the medical record for resident #9 revealed a verbal physician's order dated 2/8/05 at 10:30 AM for Levaquin (antiinfective) 500 mg for one day, Levaquin 250 mg for seven days, and for a follow-up urinalysis in nine days. Review further revealed the verbal orders were not signed by the physician. 6. Review of the medical record for resident #16 revealed a verbal physician's order dated 1/15/05 noted at 3:30 PM to discontinue the as needed morning Risperdal (antipsychotic) 0.5 milligrams (mg) dose because the resident had a regularly scheduled dose of Risperdal 5 mg ordered at 8 AM. Review further revealed the verbal order was not signed by the physician. 7. Review of the medical record for resident #30 revealed a verbal physician's order dated 1/21/05 at 1:50 PM was written for the following: complete blood count (CBC), complete metabolic panel (CMP), fasting lipid panel, total iron count, total iron binding capacity percentage saturation (TIBC%), inorganic phosphorous, and vitamin D level. Review further revealed the verbal orders were not signed by the physician.	F 514	3. Nursing staff will encourage physicians/practitioners to give orders in a written rather than verbal form. Initiation date: 3/14/05 DON to monitor. 4. A monthly audit will be conducted to assess compliance. The audit tool currently used to track "read-back of verbal orders" will be expanded to include tracking of sign off of verbal orders. Form to be completed by 3/14/05. First monthly audit to be completed by March 31, 2005. DON to monitor. 5. Follow-up reminders to physicians/practitioners not in in compliance with the prompt signing of verbal orders will take place in the following manner. a) Written reminders sent out with monthly notice of "MD visits". b) Phone follow-up by LC medical director as necessary. To be initiated 3/31/05. LC Administrator to monitor. Issues + trends will be reported to PI for review	

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F 514	Continued From page 4 Review of the facility policy on physicians' orders, section HW15, #5 revealed verbal orders must be signed by the physician or practitioner within 24 hours. Interview with the administrator on 2/17/05 at 11:10 AM confirmed physician verbal orders must be signed within 24 hours.	F 514	T	
F 520 SS=D	483.75(o)(1) ADMINISTRATION A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. This REQUIREMENT is not met as evidenced by: Based on review of quality assurance committee members and staff interview, the facility failed to ensure quarterly quality assurance committee meetings included a physician. The findings were: Interview with the facility administrator on 2/17/05 at 9:30 AM revealed quality assurance committee meetings were held quarterly. Interview further revealed the physician member did not attend regularly. Review of the quality assurance committee attendance sheets revealed the physician member was absent for the 2/3/04, 7/27/04, 10/26/04, and 1/25/05 meetings.	F 520	This facility will maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. This will be accomplished by: 1. The LC medical director will attend the quarterly Performance Improvement meeting of the LC. The medical director will be notified of each meeting at least one month in advance by the LC Administrator. In addition, the LC administration will prompt the medical director's attendance with a follow-up verbal reminder prior to the meeting. To be completed 3/28/05 LC Administrator to monitor. Trends will be reported to PI for review	

3/14/05

Section F279
5 continued
individualized program. Clinical Coordinator and DON to in-service. 3/29/05
DON to monitor documentation.

Section F286
2 continued
in printed form and placed with the corresponding care plan and put in the appropriate team care plan binder located behind the nurses station. To be completed by Clinical Coordinators. DON to monitor. Completion date: 4/1/05
The two Clinical Coordinators were instructed where to place assessment information.
Trends will be reported to the PI