Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	530015	07/13/2017
Name of Provider or Supplier	**Street Address, City, State**	
St Johns Medical Center	625 East Broadway, Jackson, WY	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
A0000	A complaint survey was conducted by Healthcare Licensing and Surveys on 7/13/17. The survey was prompted by complaint intake WY00002425. One standard level deficiency was cited.
A0166	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(4)(i) The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, the facility failed to modify the care plan for 1 of 2 patients (#14) with restraints or seclusion. The findings were: Review of the medical record showed patient #14 utilized soft wrist restraints on 6/20 /17 and 6/21/17 due to being intubated and attempts to self-extubate. Review of the care plan showed restraint use was not addressed. During review of the medical record on 7/13/17 at 10:15 AM the Quality and Accreditation Specialist confirmed the care plan did not address restraints.
A0171	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(8) Unless superseded by State law that is more restrictive-- (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1-hour for children under 9 years of age;

	This STANDARD is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure orders for seclusion were renewed within 4 hours for 1 of 1 adult patients (#16) who was in seclusion to manage self-destructive behavior. The findings were: Review of the medical record showed patient #16 had suicidal ideations and the physician wrote an order for a Title 25 hold and locked seclusion on 6/29/17 at 3:46 AM. The order was renewed on 6/29/17 at 7:59 AM (4 hours 13 minutes). The next renewal order was on 6/29/17 at 11:07 AM, but the following renewal was not until 4:13 PM (5 hours 6 minutes). The next renewal was 6/29/17 at 9:19 PM (5 hours 6 minutes). The next renewal was 6/29/17 at 11:42 PM, but the next renewal was not until 6/30/17 at 4:22 AM (4 hours 40 minutes). During an interview on 7/13/17 at 11:30 AM the associate director of nursing confirmed the renewal orders exceeded 4 hours. She stated the facility had identified that as a concern recently.
A0395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on medical record review, staff interview, and review of policies and procedures, the facility failed to ensure effective pain management for 6 of 20 sample patients (#1, #2, #3, #9, #10, #17). The findings were: 1. Review of the medical record showed patient #1 was admitted with diagnoses including hip pain and failure to thrive. Review of the care plan showed the patient experienced pain. The interventions included "Re-assess pain level within 30-60 minutes after comfort measures." Review of the MAR for July 2017 showed staff did not consistently document an assessment to determine the effectiveness of PRN pain medication. Examples included: a. The patient was medicated with PRN Norco 5-325 mg 1 tablet on 7/8/17 at 10:02 PM. Review of the Daily Focus Assessment Report (nursing documentation) showed a pain assessment was not conducted until 7/9/17 at 3:35 AM (5 hours 33 minutes), which documented the patient stated "feels pretty good." b. The patient received a PRN Norco 5-325 mg tablet on 7/9/17 at 12:31 PM for a pain score of 3. Review of the Daily Focus Assessment Report showed a pain assessment was not completed until 7/9/17 at 4:30 PM (3 hours 59 minutes), which documented the patient had no pain. c. The patient was medicated with a PRN Norco 5-325 mg tablet on 7/10/17 at 1: 11 AM because "it hurts." Review of the Daily Focus Assessment Report showed a pain assessment was not documented until 7/10/17 at 4:32 AM (3 hours 21 minutes) which only documented "Pain Assess Parameters. No change from previous assessment." d. The patient received a PRN Norco 5-325 mg tablet on 7/10/17 at 6:25 AM because "hurts some." Review of the Daily Focus Assessment Report showed a pain assessment was not completed until 7/10/17 at 9 AM (2 hours 35 minutes). The assessment documented the patient's pain level was "2" and did not require medication at the present time. 2. Review of the medical record showed patient #2 was admitted with a diagnosis of hip fracture. Review of the care plan showed the patient had pain and interventions included "Re-assess pain level within 30-60 minutes after comfort measures. Review of the MAR for July 2017 showed staff did not consistently document an assessment to determine the effectiveness of PRN pain medication. Examples included: a. The patient received PRN Hydromorphone 0.5 mg /0.5 ml intravenous on 7/7/17 at 10:51 PM for pain. The patient was medicated with another PRN dose at 1:30 AM. Review of the Daily Focus Assessment Report showed

no pain assessment documented between the 10:51 PM and 1:30 AM administrations. A pain assessment was not completed until 7/8/17 at 2:50 AM which documented pain was "5/10." b. The patient was medicated with PRN Hydromorphone 0.5 mg/0.5 ml intravenous on 7/10/17 at 9:41 PM for pain. Review of the Daily Focus Assessment Report showed a pain assessment was not completed until 7/11/17 at 4:10 AM (6 hours 29 minutes) which showed "pt wincing in pain with any type of movement." c. The patient was given PRN Acetaminophen 650 mg on 7/7/17 at 10:21 AM for pain. Review of the Daily Focus Assessment Report showed a pain assessment was not documented until 7/7/17 at noon (1 hour 39 minutes). d. The patient received PRN Acetaminophen 650 mg on 7/9/17 at 7:49 AM for pain. Review of the Daily Focus Assessment Report showed a pain assessment was not documented until 7/9/17 at 2:33 PM (6 hours 44 minutes) which showed the resident had a pain score of "6." 3. Review of the medical record showed patient #3 was admitted with a diagnosis of pancreatitis. Review of the care plan showed the patient had pain and interventions included "Re-assess pain level within 30-60 minutes after comfort measures." Review of the MAR for July 2017 showed staff did not consistently document an assessment to determine the effectiveness of PRN pain medications. Examples included: a. The patient received PRN Norco 5-325 mg 2 tablets on 7/10/17 at 7:14 PM. Review of the Daily Focus Assessment Report showed a pain assessment was not documented until 7/10/17 at 10:26 PM (3 hours 12 minutes). b. The patient was administered 2 tablets of PRN Norco 5-325 mg on 7/11/17 at 3:19 PM. Review of the Daily Focus Assessment Report showed a pain assessment was not completed until 7/11/17 at 8:56 PM (5 hours 37 minutes). 4. Review of the medical record showed patient #9 was admitted to the facility with diagnoses which included acute diverticulitis. Review of the care plan showed the patient had a plan for pain which included the following, "Re-assess pain level within 30-60 minutes after comfort measures." Review of the July 2017 MAR showed the patient received Tylenol 650 mg (non-narcotic analgesic) by mouth for pain on 7/10/17 at 1:14 PM. Medical record review showed the facility failed to assess the patient after the administration to determine if the medication was effective. In addition, the patient received Hydrocodone-APAP 7.5-325 mg (narcotic analgesic with non-narcotic analgesic) by mouth for pain on 7/11/17 at 12:34 AM. The facility did not assess the patient for effectiveness until 5:41 AM (5 hours and 7 minutes). 5. Review of the medical record showed patient #10 was admitted to the facility with diagnoses which included acute alcohol intoxication. Review of the care plan showed the patient had a plan for pain which included the following, "Re-assess pain level within 30-60 minutes after comfort measures." Review of the July 2017 MAR showed the patient received Tylenol 650 mg by mouth for pain on 7/9/17 at 8:41 PM. Medical record review showed the facility failed to assess the patient for effectiveness until 7/10/17 at 3:50 AM (7 hours and 9 minutes). 6. Review of the medical record showed patient #17 was admitted to the facility with diagnoses which included right pneumothorax. Review of the care plan showed the patient had a plan for pain which included the following, "Re-assess pain level within 30-60 minutes after comfort measures." Review of the July 2017 MAR showed the patient received Dilaudid 1 mg IV for pain on 7/4/17 at 8: 17 PM and was next assessed on 7/4/17 at 9:30 PM (1 hours and 13 minutes), on 7/5 /17 at 12:37 AM and was next assessed on 7/5/17 at 3:26 AM (2 hours and 53 minutes), on 7/5/17 at 3:26 AM and next assessed on 7/5/17 at 5:56 AM (2 hours and 30 minutes), and on 7/5/17 at 8:25 AM and next assessed on 7/5/17 at 11:08 AM (2 hours and 33 minutes). In addition, the patient received Hydrocodone-APAP 5-325 mg 2 tablets on 7/4/17 at 5:12 PM and was next assessed on 7/4/17 at 6:30 PM (1 hour and 18 minutes), on 7/4/17 at 9:30 PM and was next assessed on 7/5/17 at 12:37 AM (3 hours and 7 minutes), and 7/5/17 at 5:46 AM and was next assessed on 7/5/17 at 8:25 AM (2 hours and 39 minutes). 7. Interview on 7/13/17 at 2:25 PM confirmed

	the associate director of nursing expected nurses to document in a timely manner the patient's response to PRN pain medications that were administered. She also confirmed that nurses had failed to consistently assess and document the response for patients. 8. Review of the facility's policy "Pain Assessment and Management" (approved 12/4/2014) showed "...RN or LIP shall assess effectiveness of pharmacologic and non-pharmacologic interventions and document in the patient's medical record using the following guidelines: a. Oral medications: 1-2 hours after administration b. IV/IM medications: 30-60 minutes after administration c. Non-pharmacologic interventions: at appropriate intervals."
A0431	MEDICAL RECORD SERVICES CFR(s): 482.24 The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital. This CONDITION is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to protect medical records from unauthorized access in medical record storage areas (A441). This system failure resulted in the inability of the hospital to meet the necessary requirements for the Medical Record Services Condition of Participation.
A0441	PROTECTING PATIENT RECORDS CFR(s): 482.24(b)(3) The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released by the hospital only in accordance with Federal or State laws, court orders, or subpoenas. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to protect medical record information from unauthorized use in 2 of 3 locations (outdoor storage, basement storage) where medical records were stored. The findings were: 1. Observation on 7/11 /17 at 1:30 PM with HIM staff #1 in the facility basement showed medical records stored along metal shelving at 5 rows up at 10 feet high, and 6 separate sets of shelving 30 feet long. The shelving space was full with the records. HIM staff #1 confirmed at that time that the maintenance staff have a key to access the stored medical records. 2. Observation on 7/11/17 at 1:45 PM with HIM staff #1 in a storage building outside of the facility (on the facility grounds) showed medical records stored on shelving 10 feet up and 30 feet long. The shelving space was full with the records. At that time maintenance staff #1 had to unlock the storage building for access, and at that time HIM #1 confirmed that the maintenance staff have key access to the stored medical records. 3. Interview with the maintenance director on 7/12/17 at 12:40 PM confirmed the maintenance staff had key access to the stored medical records, and did not have a need to know the information contained in those records.
A1104	EMERGENCY SERVICES POLICIES CFR(s): 482.55(a)(3)

	[If emergency services are provided at the hospital --] (3) The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff. This STANDARD is not met as evidenced by: Based on review of policies and procedures, review of emergency medical services (EMS) documentation, and staff interview, the facility failed to develop comprehensive policies related to emergency services. The findings were: Review of EMS documentation showed on 6/7/17 an out-of-county ambulance crew contacted the emergency department (ED) by telephone. The crew told registered nurse (RN) #1 at the ED they had a 15 year old with a self-induced overdose who was stable enough for transport to their facility. However, prior to hanging up, the ED physician stated the patient needed to go [to a nearby] Clinic or a hospital in another county due to the patient being a pediatric psychiatric patient. The documentation showed the patient was then taken to a nearby clinic and was transported to a children's hospital via air ambulance. During an interview on 7/13/17 at 3:17 PM the ED director stated the EMS crew was told to the take the patient to a closer facility because it was an over-dose, and not because of the psychiatric component. On 7/13/17 at 3:25 PM RN #1 stated the ED physician told the EMS crew that maybe there was a better place to take the patient, and stated the MD never told the EMS crew not to come at all. The following concerns related to policy development were identified: a. Review of the facility's policies "Scope of Service- Emergency Department" (approved 8/6 /14) and "Juvenile Psychiatric Patients in the ED" (approved 9/7/16) showed both policies addressed what to do when a patient arrived at the facility, but did not address communication with EMS who wanted to transport a patient to the ED, including circumstances in which EMS would be told not to bring a patient, and who could make that decision. b. During an interview on 7/13/17 at 3:17 PM the ED Director stated the facility did not have a written policy to address communication with EMS. She stated what EMS was told depended on the condition of the patient. She stated the ED would take anybody and would never refuse.