11/13/09

NOV 04 2009

Office of Healthcare Licensing and Surveys

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

PRINTED: 10/26/2009
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
	535050	A. BUILDING _____ B. WING _____	C 10/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	4 NORTH FORK ROAD FORT WASHAKIE, WY 82514

(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 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications; personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another health care institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to provide privacy during personal care for 1 of 9 sample residents (#22). The findings were: Review of the quarterly Minimum Data Set (MDS)	F 164	This plan of correction is the facility's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of truth of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared because it is required by the provision of federal and state law. F164 Director of Nursing and/or designee will conduct inservice for staff concerning completely closing the window curtains when providing care to Resident #22. Director of Nursing and/or designee will conduct inservice for staff concerning completely closing the window curtains when providing care to all Residents. Director of Nursing and/or designee will audit for privacy while delivering care twice a week for three weeks, once a week for three weeks and randomly thereafter.	11-12-09 11-12-09 11-13-09

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

[signature] | NHA | 11-5-09

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 JoAnn Cedrich, NHA on 11/13/09 @ 9:30 AM

Janelle Conlin, IOM RC

11/3/09

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F 164	Continued From page 1 assessment dated 8/17/09 showed resident #22 was cognitively impaired, had difficulty understanding, and was completely incontinent of bowel and bladder. Observation on 10/14/09 at 1:30 PM revealed certified nurse aide (CNA) #1 transferred the resident from a wheelchair to a bed in order to change the resident's disposable brief. Observation showed that while the CNA changed the resident's brief and performed perineal care, the curtain on the window next to the resident's bed was open 6-8 inches. There was a clear view from the street and the facility's parking lot into the resident's room. Interview at that time with the CNA revealed she usually closed the window curtains when she provided perineal care for the resident.	F 164	F164 cont'd: Director of Nursing will bring results of audit to the weekly risk meeting and to the quarterly Quality Assurance meeting.	11-13-09
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure nutrition assessments were completed by a qualified professional for 1 of 9 sample residents (#28) who were assessed as needing a nutrition assessment. The findings were: According to the 2008 Standards of Practice for Registered Dietitians in Nutrition Care, published by the American Dietetic Association, Standard 1: Nutrition Assessment, The registered dietitian (RD) uses accurate and relevant data and information to identify nutrition-related problems. Rationale: Nutrition Assessment is the first of four steps of the Nutrition Care Process. Nutrition	F 281	F281: 1. The Resident Assessment Protocol (RAP) summary for nutritional status for Resident #28 will be reviewed and signed by the Registered Dietitian (RD). The RD will complete a current nutritional assessment for Resident #28. 2. The RD will "assign certain tasks" to the Dietary Manager "for the purpose of providing the RD with needed information or communicating with and educating patients" for Resident #28 and all other Residents. The RD will complete RAPs for nutritional status for Residents using the information from the "assigned certain tasks" The Dietary Manager will obtain the schedule of required assessments and ensure the needed information is	11-03-09 11-03-09 11-03-09 11-03-09

jc 11/3/09

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F 281	Continued From page 2 Assessment is a systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. It is initiated by referral and/or screening of individuals ...for nutrition risk factors. ..It provides the foundation for Nutrition Diagnosis, the second step of the Nutrition Care Process. Further, the 2008 Standards of Practice specifically state: "The RD does not delegate the nutrition care process, but may assign certain tasks for the purpose of providing the RD with needed information (e.g., screens, gathering of data and other information) or communicating with and educating patients." 1. Review of the 2/25/09 annual Resident Assessment Instrument (RAI) for resident #28 revealed the Resident Assessment Protocol (RAP) summary for nutritional status was not signed by the registered dietitian (RD). Further medical record review revealed no nutritional assessment was completed by the RD during the assessment timeframe. 2. During an interview on 10/14/09 at 2 PM, the dietary manager verified the RD did not complete RAPs for nutritional status for residents. She stated she was unaware nutritional assessments were to be completed by the RD.	F 281	F281 Cont'd: given to the RD for the RD to complete the nutritional assessments and complete the nutritional care process for the RAPs for all Residents in a timely manner. The Dietary Manager will report the following of the schedule at the weekly Risk meeting and at the quarterly Quality Assurance meeting. F282 All direct care staff will be inserviced by the Director of Nursing and/or designee to follow the plan of care for incontinence for Resident #22. All direct care staff will be inserviced by the Director of Nursing and/or designee to follow the plan of care for incontinence for all Residents. The Director of Nursing and/or designee will conduct audits of Residents with incontinence care plans three times per week for three weeks and randomly thereafter for three months.	11·03·09 11·12·09 11·12·09 11·13·09
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		

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F 282	Continued From page 3 by: Based on observation, staff interview, and medical record review, the facility failed to provide care in accordance with the written care plan for 1 of 9 sample residents (#22). The findings were: Refer to F315 for details regarding the facility's failure to follow the plan of care to promote continence for resident #22.	F 282	F282 cont'd: The Director of Nursing and/or designee will bring results of the audits to the weekly Risk Meeting and the quarterly Quality Assurance Meeting.	11-13-09
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to ensure wound care was completed as ordered for 1 of 1 sample resident (#26) who had pressure ulcers. The findings were: Medical record review for resident #26 revealed a physician reconciliation order dated 9/4/09 for daily dressing change to all decubiti. A weekly wound rounds tracking sheet dated 10/8/09 revealed the resident had three decubiti on that date. Observation on 10/14/09 at 2:15 PM confirmed the resident had a Stage III decubiti on the right scapula, a Stage IV decubiti on the right hip, and a Stage III decubiti on the coccyx. The	F 314	F314 The Director of Nursing and/or designee will inservice licensed nurses regarding documentation of dressing changes and/or Resident refusal of care for Resident #26. The Director of Nursing and/or designee will inservice licensed nurses regarding the documentation of dressing changes and/or Resident refusal of care for all Residents with ordered dressing changes. The Director of Nursing and/or designee will audit treatment sheets and charts for documentation of either treatment being completed and/or refusal of care for all Residents two times per week for one month and randomly once a week thereafter.	11-12-09 11-12-09 11-13-09

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F 314	Continued From page 4 following concerns were noted: a. Review of the resident's September and October 2009 treatment sheets revealed a physician's order for daily dressing changes. The September treatment sheet revealed no documentation that the dressing changes were done on 9/15/09, 9/25/09, and 9/27/09. Further record review revealed no nurses' notes on those dates that explained why the dressing changes were not done. Review of the October treatment sheet also revealed no documentation the dressing changes were done on 10/2/09, 10/3/09, and 10/10/09. Again, there were no nurses' notes explaining why the dressing changes were not done on those dates. b. Interview on 10/14/09 at 4:15 PM with licensed practical nurse (LPN) #1 revealed the days there was not any documentation on the treatment sheets meant the resident refused the dressing changes. However, he stated the nurses should have documented in the nurses' notes if the resident refused. Interview on 10/14/09 at 3:40 PM with the director of nursing (DON) confirmed the nurses should document refusals in the nurses' notes or other reasons why dressing changes were not done. c. Review of the admission Minimum Data Set (MDS) assessment dated 7/24/09 revealed the resident had minimal cognitive impairment with no memory deficit. Interview on 10/14/09 at 4:20 PM with the resident revealed dressing changes to the decubiti sites could be done while the resident was standing or while s/he was lying in bed. The resident stated s/he had never refused a dressing change.	F 314	F314 cont'd: The Director of Nursing and/or designee will bring the results of audits to the Risk meeting and the quarterly Quality Assurance meeting. F315 All direct care staff will be inserviced by the Director of Nursing and/or designee to follow the plan of care for incontinence for Resident #22. All direct care staff will be inserviced by the Director of Nursing and/or designee to follow the plan of care for incontinence for all Residents. The Director of Nursing and/or designee will conduct audits of Residents with incontinence care plans three times per week for three weeks and randomly thereafter for three months. The Director of Nursing and/or designee will bring results of the audits to the weekly Risk Meeting and the quarterly Quality Assurance Meeting.	11·13·09 11/2/09 11·12·09 11·13·09 11·13·09
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a	F 315		

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F 315	Continued From page 5 resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and observation, the facility failed to provide care to promote continence for 1 of 4 sample residents (#22) who were incontinent of bladder. The findings were: Review of the quarterly Minimum Data Set (MDS) assessment dated 8/17/09 showed resident #22 was cognitively impaired, had difficulty understanding, and was completely incontinent of bowel and bladder. Review of the resident's urinary and bowel incontinence care plan last reviewed on 8/26/09 revealed the resident was to be checked and changed approximately every two hours and prn (as needed) for incontinence. However, continuous observation for four hours of the resident on 10/14/09 from 9:30 AM until 1:30 PM revealed the resident was not checked for incontinence. Observation of incontinence care at 1:30 PM revealed the resident's incontinence brief was soaked with urine. Interview with certified nurse aide (CNA) #1 at that time revealed she thought the resident was to be checked three to four times a shift (eight hour shift). The CNA stated this usually included after breakfast and before lunch.	F 315		

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