POC accepted 10/20/11

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

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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 09/15/2011

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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- certified nursing assistant DON- director of nursing LPN- licensed practical nurse MDS- Minimum Data Set RD- registered dietitian Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, and staff and resident interview, the facility failed to ensure the survey results were readily accessible to residents and others. The findings were: Observations on 9/13/11 at 9:30 AM and on 9/14/11 at 1:30 PM revealed a notice posted on the wall opposite the nursing station stating "The survey information can be viewed at the nurses'	F 167	Survey results have been placed in the hall outside the Activity Room. Survey results will be kept in the hall outside the Activity Room. Activity Director and staff will ensure daily that the Survey results are available. Residents will be informed of the location during Resident Council meeting. Random audit will be preformed by Staff Development to ensure that all staff are aware of the requirement of F167. The result of the audit will be taken to the Risk Management meeting weekly (Thursday 10:30 am) and to the QA meeting quarterly.	10/30/11

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.

RECEIVED
WyomingDeptofHealth

POC accepted 10/20/11. Case to Zoey Nordell, SSD @ 1:10pm.

OCT 19 2011
Office of Healthcare Licensing and Surveys

RECEIVED
WyomingDeptofHealth

OCT 25 2011

Office of Healthcare Licensing and Surveys

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F 167	Continued From page 1 station." During an interview on 9/14/11 at 1:30 PM, LPN #1 stated the survey results were located behind the nurses station. She stated they were available to residents if they asked to see them. A confidential interview with 11 residents on 9/13/11 at 10:15 AM revealed the residents would prefer to have access to the survey results without having to ask staff.	F 167		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding	F 272	F272 The comprehensive nutrition assessment for Residents # 19, 24, 38, have been completed by the Dietary Manager and Registered Dietician. All resident records will be reviewed to assure that the Nutritional History is complete. The Dietary Manager will review records and discuss with all new admissions to complete her portion of the Comprehensive Nutritional History. All new admissions will have an assessment by the Registered Dietician. The computations for ideal body weight, ideal body weight range, usual body weight and BMI along with clinical observation and resident food	

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F 272	Continued From page 2 the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed in needed areas for 3 of 10 sample residents (#19, #24, #38). The findings were: The following concerns were identified related to nutritional assessments: a. Medical record review revealed the 6/15/11 nutritional assessment for resident #19 was incomplete. The resident's ideal body weight, ideal body weight range, usual body weight, and BMI was not listed. In addition, the caloric needs, protein needs, and fluid needs were not calculated. b. Review of the 6/14/11 nutritional assessment for resident #24 revealed it was incomplete. The first page was almost entirely blank, which included the sections for ideal body weight, usual body weight, BMI, clinical observations, and food preferences. c. The 3/1/11 nutritional assessment for resident #38 was incomplete. The resident's usual body weight, ideal body weight range, and BMI was not listed.	F 272	preferences will be done by the Dietary Manager. The computation for Caloric, protein, and fluid needs will be completed by the Registered Dietician. Health Information Management wil do an audit of the Dietary section of charts upon admission, significant change, quarterly and readmission to assure that the nutrition history is complete. Results of audits will be presented to the weekly Risk committee and the quarterly Quality Assurance Committee. 10/28/2011	

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F 272	Continued From page 3 d. During an interview on 9/14/11 at 2:50 PM, the dietary manager stated she was responsible for completing the front page of the assessment (including the usual weight, ideal body weight, and BMI). She stated the RD was responsible for reviewing the first page and completing the second page. When asked about the incomplete assessments for residents #19, #24, and #38, she stated "those must have been missed."	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the	F 280	**F280** Resident #19 The dietary care plan has been updated to reflect dietary orders for meal fortification. All care plans will be reviewed by Director of Nursing Services and The MDS Coordinator. Any changes will be communicated to Dietary Manager for changes. All future orders will be verified by the Director of Nursing Services or Designee. Orders will then be sent to Health Information Management. Orders for dietary changes will be communicated to Dietary Manager and MDS coordinator by Health Information Management.	

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F 280	Continued From page 4 care plan was updated as needed for 1 of 10 sample residents (#19). The findings were: Review of a progress note dated 6/14/11 revealed the RD recommended meal fortification three times per day for resident #19. According to physician orders, on 6/14/11 the physician ordered meal fortification three times per day. However, review of the care plan dated 9/6/11 showed the meal fortification was not addressed. Observation on 9/13/11 at 6:45 PM revealed the resident's meal was not fortified. Interview with cook #1 at that time revealed the resident did not receive meal fortification because it was not written on his/her dietary card.	F 280	Health Information Management will do a random audit of 4 charts weekly to assure that Physician orders match the care plans and dietary cards for each Resident Results of audits will be presented to the weekly Risk committee and the quarterly Quality Assurance Committee.	10/28/2011
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 by: Based on observation, review of dietary cards, staff interview, and medical record review, the facility failed to ensure the care plans were followed for 2 of 9 (#1, #19) sample residents. The findings were: 1. Review of the care plan dated 9/6/11 for resident #19 revealed the resident was to receive protein powder three times per day. However, observation on 9/13/11 at 6:45 PM of the evening meal revealed the resident did not receive protein powder. Interview with cook #1 at that time	F 282	**F282** Resident #1 and # 19 Dietary cards have been updated to reflect the plan of care as prescribed by the Physician's orders. The Dietary Manager will review the dietary care plan and cards at admission, readmission, quarterly and significant change. The MDS coordinator will assure the accuracy of the Care plan and dietary card. The MDS Coordinator and Dietary Manager will receive a communication note from HIM reflecting any changes in dietary intake or new dietary order as noted by DON when checking orders. MDS will be responsible to verify	

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F 282	Continued From page 5 revealed the resident did not receive protein powder because it was not written on his/her dietary card. 2. Medical record review for resident #1 revealed a dietary care plan that was last updated on 9/13/11. The care plan showed the resident was to be offered meal fortification three times a day. Review of the resident's dietary card showed meal fortification was not listed. Observation on 9/13/11 at 5:45 PM of the evening meal revealed the resident did not receive meal fortification.	F 282	updating of plan of care and Dietary Manager will update dietary cards. A weekly audit of four (4) charts by Health Information Management will reflect verification in that all changes in diet or intake have been updated on plan of care. Results of audits will be presented to the weekly Risk committee and the quarterly Quality Assurance Committee.	
F 286 SS=C	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS 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 medical record review and staff interviews, the facility failed the ensure 15 months of MDS assessments for 9 of 9 (#1, #10, #19, #20, #21, #22, #24, #31, #38) sample residents were accessible to all professional staff. The findings were: Medical record review for residents #1, #10, #19, #20, #21, #22, #24, #31, and #38 revealed only the most recent MDS assessments were kept in the resident records at the nurses' station. Interview on 9/13/11 at 4:25 PM with the person responsible for medical records revealed all other resident MDS assessments were kept in the medical records office. She stated only herself and the MDS coordinator had keys to access the office. Interview on 9/14/11 at 4:30 PM with the	F 286	10/28/2011 **F286** A file cabinet has been moved into the report room next to the nurses' station. The most current MDS is located in the Resident's medical record. The balance of the 15 months of MDS has been placed in the file cabinet. When the facility has electronic records will be accessed electronically. With each MDS report the most recent MDS will be placed in the Medical Record. The past MDS will be removed from the Medical Record the thinned assessments will be placed in the File Cabinet. With each MDS assessment Health Information Management will do an	

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F 286	Continued From page 6 DON revealed the nurses did not have access to a computer where they could review past MDS assessments.	F 286	audit to assure all past records for 15 months are available. The past records have been placed in the MDS overflow file cabinet and the most current MDS is in the Medical Record.	
F 314 88=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL 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, review of the dietary cards, and staff interview, the facility failed to provide nutritional interventions for 1 of 2 sample residents (#19) with a pressure sore. The findings were: Review of laboratory results dated 6/14/11 showed resident #19's albumin level was low at 2.1 gm/dL (range 3.2 to 5.0), and the total protein was low at 5.5 gm/dL (range 6.4 to 8.4). Review of nursing notes showed on 6/10/11 the resident was admitted with open areas to the coccyx. Review of physician orders showed on 6/14/11 the physician ordered meal fortification three times daily based on the recommendation of the RD. On 7/5/11 the RD recommended protein powder three times per day, which the physician ordered. Review of nursing documentation dated 8/8/11 showed the wounds to the buttocks were	F 314	Weekly audits will be presented at the weekly Risk Meetings and quarterly at the QA meeting **F314** Dietary card for Resident #19 has been updated to reflect changes. Wound care nurse has reviewed lab results and updated care plan. All new wounds will be referred to the Wound Care Nurse or designee for review by appropriate disciplines. Wound care nurse or designee will monitor Lab changes and dietary consultant recommendations. Wound care nurse will monitor interdisciplinary progress notes to assure nursing documentation. All future dietary orders will be verified by the Director of Nursing Services or Designee. Orders will then be sent to Health Information	10/28/2011

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F 314	Continued From page 7 closed. The following concerns were identified: a. Review of the care plan dated 9/8/11 showed the protein powder was addressed, but the meal fortification was not. Review of the dietary card used by kitchen staff showed the meal fortification and protein powder was not listed. During an interview on 9/14/11 at 2:50 PM, the dietary manager stated if a resident was receiving meal fortification or protein powder, it would be listed on the card. b. Observation on 9/12/11 at 5:45 PM of the evening meal revealed the resident did not receive meal fortification or protein powder. Interview with cook #1 at that time revealed the resident did not receive the fortification or protein powder because it was not listed on his/her dietary card. c. Review of nursing notes showed on 9/8/11 the CNA reported to the nurse the resident had a small open area to the right buttock. Observation on 9/13/11 at 9 AM revealed the resident had a 2 centimeter (cm) Stage II pressure ulcer on the right buttock.	F 314	Management. Orders for dietary changes will be communicated to Dietary Manager and MDS coordinator by Health Information Management. This will ensure dietary card and care plans are current. Wound care nurse will conduct a weekly audit of 2 records randomly selected for residents with pressure ulcers. At weekly risk meetings all Residents with pressure ulcers will be reviewed for accuracy of dietary cards and care plan interventions. Audit results will be presented at weekly Risk meetings and quarterly Quality Assurance Meeting.	10/28/2011
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	**F325** Resident #19 weight changes and lab changes have been communicated with the Physician. Documentation reflects the Physician changes. Nutritional Assessment has been completed and updated to reflect the physician orders. Dietary card has been updated to reflect the physician orders.	

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F 325	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of dietary cards, the facility failed to ensure interventions were implemented to maintain nutritional status for 3 of 3 sample residents (#19, #24, #38) with weight loss. The findings were: 1. Review of the admission nutritional assessment revealed resident #19 weighed 167.2 pounds. An RD note dated 7/19/11 revealed the resident's weight was 168.2 pounds, which was a significant weight decline. The RD stated that nursing reported fluid and edema loss was planned due to diuretic use. Review of the weight record showed on 9/12/11 the resident's weight was 136.6 pounds. Review of laboratory results dated 6/14/11 showed the resident's albumin level was low at 2.1 gm/dL (range 3.2 to 5.0), and the total protein was low at 5.5 gm/dL (range 6.4 to 8.4). The following concerns were identified: a. Medical record review revealed the 6/15/11 nutritional assessment was incomplete. The resident's ideal body weight, ideal body weight range, usual body weight, and BMI was not listed. In addition, the calorie needs, protein needs, and fluid needs were not calculated. During an interview on 9/14/11 at 2:50 PM, the dietary manager stated it "must have been missed." b. Review of physician orders showed on 6/14/11 the physician ordered meal fortification three times daily based on the recommendation of the RD. On 7/5/11 the RD recommended protein powder three times per day, which the physician ordered. However, observation on 9/13/11 at 5:45 PM of the evening meal revealed	F 325	Resident #24 weight change concerns had been communicated with Resident's Physician and addressed with changes in Resident's orders. The Nutritional Assessment has been completed. Weekly weight issue has been resolved by reassignment of daily weight orders to Resident care CAN and weekly weight orders to bath aide and they will provide weight directly to Licensed Nurse. Licensed Nurse will report significant changes to Director of Nursing Services Dietary Manager will review daily and weights and report to Risk Committee	

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F 325	Continued From page 9 the resident did not receive meal fortification or protein powder. Interview with cook #1 at that time revealed the resident did not receive the fortification or protein powder because it was not written on his/her dietary card. Review of the dietary card confirmed the interventions were not listed. 2. Review of the weight record showed resident #24 weighed 141 pounds on 6/15/11 and 138.6 pounds on 8/8/11. The following concerns were identified: a. Review of the 6/14/11 nutritional assessment revealed it was incomplete. The first page was almost entirely blank, which included the sections for ideal body weight, usual body weight, BMI, clinical observations, and food preferences. During an interview on 9/14/11 at 2:50 PM, the dietary manager stated it "must have been missed." b. Review of physician orders showed on 6/14/11 the physician ordered weekly weights. However, review of the weight record showed the last recorded weight was 8/8/11 (138.6 pounds). Upon the surveyor's request, the resident was weighed on 9/13/11. The resident weighed 130 pounds, which was a loss of 8.6 pounds (or 6%) in one month. c. During an interview on 9/14/11 at 2:50 PM, the dietary manager stated she used the weight record to monitor weights, and would notify the RD if a resident had weight loss. The last RD note for this resident was on 6/21/11. On 9/14/11 at 4:16 PM and 4:36 PM, the DON stated he was aware of the problem with weekly weights not being done. In addition, he stated resident #24 was recently refusing more meals, therefore he received an order to start Megace on 9/7/11 to	F 325	Resident #38 Nutritional assessment has been completed. Registered Dietician was made aware of Resident 38 weight loss issues. Assessment and evaluation was completed. RD was informed of use of diuretic. Reassignment of daily weight orders to Resident care Certified Nurse Aide and weekly weight orders to bath aide and they will provide weight directly to Licensed Nurse. Licensed Nurse will report significant changes to the Director of Nursing Services. DON will report to Registered Dietician and Physician. All daily weights are to be done by resident care CNA. Staff Education will educate staff on the importance of identifying weight loss and gain. The importance of report weight changes immediately. All weight changes will be reported to the Licensed Nurse. Licensed Nurse will report these changes to Director of Nursing serves. DON will report	

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(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 326	Continued From page 10 increase the resident's appetite. 3. Review of the nutritional assessment dated 3/1/11 revealed resident #38 weighed 207.6 pounds. Review of the weight record showed the resident weighed 193 pounds on 7/9/11 and was down to 174.4 pounds on 7/22/11. The most recent weight on 9/11/11 was 160.4 pounds. The following concerns were identified: a. The 3/1/11 nutritional assessment for resident #38 was incomplete. The resident's usual body weight, ideal body weight range, and BMI was not listed. During an interview on 9/14/11 at 2:50 PM, the dietary manager stated it "must have been missed." b. During an interview on 9/14/11 at 4:16 PM, the DON stated the resident did lose about 20 pounds because of edema/fluid loss. On 9/14/11 at 2:50 PM, the dietary manager stated she monitored weights and would notify the RD of any weight loss. However, the last RD note that mentioned the resident's weight was dated 6/25/11. There lacked evidence the RD was aware of the weight loss, or had re-evaluated the resident's nutritional status.	F 325	to Registered Dietician, Dietary Manager and Physician. Electronic charting of ADL's and weight have include an alert system that notifies Licensed Nurse and Director of Nursing Services of any significant weight changes. This will be monitored by the Director of Nursing Services. Director of Nursing Services will print a weekly weight report to identify alerts and any changes in weight. Weight issues will be an ongoing audit. Documentation will support unavoidable weight loss or planned weight changes.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	Director of Nursing Services will present weight change report to weekly Risk Committee and Quarterly Quality Assurance Committee.	10/28/2011

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	535060	A. BUILDING _____ B. WING _____	C 09/15/2011

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F 329	Continued From page 11 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary medications for 1 of 10 sample residents (#31). The findings were: Review of physician orders showed resident #31 was ordered Trazodone (antidepressant)12.6 milligrams (mg) three times per day and Zyprexa (antipsychotic) 2.5 mg at bedtime on 8/3/10. Further review of the medical record showed no evidence a dose reduction had been attempted for either medication since they were ordered on 8/3/10. There also lacked documentation by the physician why a dose reduction would be contraindicated. During an interview on 9/14/11 at 4:10 PM, the social services director confirmed a dose reduction had not been attempted. She also stated there lacked documentation by the physician why a dose reduction would be	F 329	**F329** The Physician and Director of Nursing Services have reviewed the information from Psychiatric services. The request for reduction of dose has been completed for Resident # 31 After review of the Medical Record including mood and behavior documentation the Physician has requests that Resident medication should not be reduced at this time. Resident #31 is stable at current dose. Director of Nursing Services or designee will initiate the evaluation and request forms for all Residents on psychotropic medications. Forms will be complete by October 28, 2011. PCP or Psychiatric care provider will be given the evaluations and request forms by Director of Nursing Services or designee. A log will be kept of all requests sent and return date. An audit of all Residents with psychotropic medications will be completed by the Director of	

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	535050	A. BUILDING _____ B. WING _____	C 09/16/2011

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F 329	Continued From page 11	F 329	Nursing Services or his/her designee in conjunction with the MDS assessment reference date. All Resident receiving psychotropic medications will be reviewed by the Director of Nursing Services and forms updated quarterly and with Significant Change in Condition. Results of evaluations and decisions will be taken to the Risk Management Meeting weekly and to the quarterly Quality Assurance Committee.	10/28/2011

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F 329	Continued From page 12 contraindicated.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	1. The seal for the freezer door has been ordered. The ice build up around the door has been removed. As soon as the seal arrives the maintenance department will repair. 2. The four ceiling air vents have been cleared of dust and dirt on 9/29/11.	10/28/11
	This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to prevent resident food from exposure to possible contamination. The findings were: 1. Observations on 09/12/11 at 4:49 PM, on 09/13/11 at 9 AM and on 09/14/11 at 9:30 PM revealed the freezer door had an approximate 2 inch accumulation of ice around the door seal preventing the door from closing. In addition, an approximate 2 square foot thin sheet of ice had accumulated on the floor of the freezer and ice droplets had accumulated on the freezer ceiling. Interview with the dietary manager on 09/14/11 at 2:48 PM revealed she was aware that the freezer door did not form a tight seal. According to the 2009 Food Code, U.S. Public Health Service, Equipment 4-501.11: Good Repair and Proper Adjustment. (B) Equipment components such as doors, seals, hinges shall		The Dietary manager will include a pre/post checklist for staff to document the condition of equipment on a weekly basis. This information will be reported to Risk Management committee. F371 This information will be presented weekly at the Risk Meeting and quarterly at the Quality Assurance meeting	

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F 371	Continued From page 13 be kept intact, tight and adjusted in accordance with manufacturer's specifications. 2. Observations on 09/12/11 at 4:48 PM, on 09/13/11 at 9:00 AM and on 09/14/11 at 9:30 PM revealed four ceiling air vents in the kitchen had a visible accumulation of dirt and dust. The vents were directly over the food preparation table and over the coffee preparation area. Interview with the dietary manager on 09/14/11 at 2:48 PM revealed she was not aware the ceiling air vents were dirty and stated the maintenance department is responsible for cleaning the vents. According to the 2009 Food Code, U.S. Public Health Service, 4-601.11, Equipment, Nonfood-Contact Surfaces. (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris.	F 371		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 2 of 10 (#20, #21) sample residents were seen by their	F 387	F387 The Physician has visited Residents #20 and 21. For Resident #20 and 21, the regulation for Physician visits was presented to both Physicians and the need for compliance was discussed with the Physician by the Director of Nursing Services. All Physicians with Residents at the facility will receive a copy of the requirements for Physician visits.	

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F 367	Continued From page 14 physician every 60 days. The findings were: 1. Medical record review for resident #20 revealed a physician progress note for a physician visit on 4/15/11, but there was not another note for a visit until 7/27/11, three and a half months later. 2. Medical record review for resident #21 revealed a physician progress note for a physician visit on 1/11/11, but then no further notes for another visit until 6/23/11, five months later. 3. Interview on 9/13/11 at 11:10 AM with LPN #1 revealed the physician for resident #21 often dictated during his visits, but the facility didn't always get a copy of his dictated notes. Interview on 9/16/11 at 10 AM with the DON revealed he had contacted the clinics of the physicians and requested copies of notes from when the physicians visited residents #20 and 21, but the clinics did not have any additional notes.	F 367	All Residents will be reviewed for timeliness of Physician visits and Physician visit will be scheduled for any Resident out of compliance by 10/28/2011 Physician visits will be monitored by Health Information Management. A log of Physician visits will be maintained by Health Information Management. The log will be reviewed by Director of Nursing Services weekly. The Director of Nursing Services will be notified of impending visits 2 weeks in advance. The Director of Nursing Services will notify the Physician that the Resident's Physician evaluation is due. Health Information will report to the weekly risk committee and quarterly quality improvement committee the timeliness of Physician visits. The weekly risk committee will assure that no visits are missed.	10/28/2011
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431		

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F 387	Continued From page 14 physician every 60 days. The findings were: 1. Medical record review for resident #20 revealed a physician progress note for a physician visit on 4/15/11, but there was not another note for a visit until 7/27/11, three and a half months later. 2. Medical record review for resident #21 revealed a physician progress note for a physician visit on 1/11/11, but then no further notes for another visit until 6/23/11, five months later. 3. Interview on 9/13/11 at 11:10 AM with LPN #1 revealed the physician for resident #21 often dictated during his visits, but the facility didn't always get a copy of his dictated notes. Interview on 9/15/11 at 10 AM with the DON revealed he had contacted the clinics of the physicians and requested copies of notes from when the physicians visited residents #20 and 21, but the clinics did not have any additional notes.	F 387		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431	**F431** For Resident #37 Pamida was contacted and expiration dates were provided for the medications that had been supplied by them. Staff Education completed to nursing staff to ensure checking for all agents of current labeling of medications received from local pharmacy not supplied by Emissary pharmacy.	

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F 431	Continued From page 16 appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1978 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications in 1 of 2 medication carts contained expiration dates. The findings were: Observation on 9/15/11 at 7 AM of the east wing medication cart revealed 2 bottles of medications for non-sample resident #37. One bottle was labeled Triamterene/HCTZ 37.5-25 (milligrams) mg and contained 28 tablets. The other bottle was Enalapril 10 mg and contained 30 tablets. The labels on the 2 bottles did not contain expiration dates for the medicines. Interview at that time with LPNs #2 and #3 confirmed the 2	F 431	An audit tool will be developed by the Director of nursing services. Audits will be done weekly by the Medication Nurse for any medications not received by Emissary to assure all labeling is complete and correct. Results of audits will be presented weekly to the Risk Committee and to the quarterly Quality Assurance Committee. 10/28/2011	

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F 431	Continued From page 16 bottles of medications did not have expiration dates listed on the labels.	F 431		
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide outside ventilation to resident bathrooms in 2 of 2 resident hallways. The findings were: During the facility tour on 9/14/11 between 11:30 AM and 2:10 PM, the resident bathrooms in the west wing hallway and half of the bathrooms from rooms 207 to the end of the hall in the east wing did not have operating ceiling air vents. All nonfunctioning bathroom vents were tested with tissue paper, and none of them moved air out of the bathroom. None of the bathrooms had exterior windows. Interview with the maintenance staff on 9/14/11 at 1:48 PM revealed he did not know why the ventilation system was not working and stated he would contact the maintenance manager to initiate repairs.	F 467		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		

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F 520	Continued From page 17 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. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of quality assurance (QA) minutes, staff interview, and review of previous survey results, the facility failed to ensure there was an effective QA committee, which included all of the required members. The findings were: During an interview on 9/15/11 at 10:15 AM, the administrator and DON stated a physician had not been attending their QA meetings. The DON stated a new Medical Director started two weeks ago. During the interview, the QA meeting minutes were reviewed. Review of the minutes and staff interview revealed the QA process was	F 520	The Quality Assurance Committee for the Morning Star Care Center consists of the Medical Director, Administrator, DON, Staff Development, MDS Coordinator and Social Services. The next scheduled quarterly QA meeting is scheduled for 10/20/11 at 9:00am. The QA meeting will consist of nursing, MDS, financial, dietary, housekeeping, maintenance, infection control, falls, medical record and social services reports. The goal of this QA committee is to identify risks and develop goals for corrective action plans. A template format of the minutes will be used and available for review.	10/20/11

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F 520	Continued From page 18 informal; goals were not established and action plans were not developed. Review of the previous survey results (CMS-2567) dated 11/18/10 showed F 371 was written for the walk-in freezer door not closing because of ice. Refer to F 371 for details of the same issue being cited during this survey. During the QA interview on 9/15/11 at 10:15 AM, the DON stated there was no evidence of monitoring that issue in the QA minutes.	F 520		

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WDH - Office of Healthcare Licensing and Surveys

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SNH	LIC REGS FOR NURSING HOMES This State Rules and Regulations is not met as evidenced by: Rules and Regulation for Program Administration of Nursing Care Facilities Chapter 11. Section 11. Dietetic Services (a) Dietary Supervision. Overall supervisory responsibility for the dietetic service shall be assigned to a full-time qualified dietetic supervisor. (i) If the qualified supervisor is not a Registered Dietician, she/he shall be a graduate of a dietetic technician program approved by the American Dietetic Association or a dietary manager's educational program approved by the Certifying Board for Dietary Managers. Training and experience in food service supervision and nutrition equivalent in content to the approved educational programs are acceptable. This standard is not met as evidenced by: Based on staff interview, the facility failed to ensure the dietary manager met the minimum qualifications. The findings were: Interview with the dietary manager on 09/12/11 at 3:48 PM revealed she was hired as the dietary manager in June 2011. She also stated she enrolled in an online certified dietary managers' program through the University of North Dakota shortly after being hired as manager and had finished one lesson. Interview with the facility's consultant RD on 09/13/11 at 2:14 PM confirmed the manager was enrolled in the CDM coursework and making progress in completing the course.	SNH	SNH Intervention regarding the dietary manager's curriculum consist of changing the process of class work submittals. This was changed on 09/29/2011 to help expedite her module completions. The dietary manager is currently waiting for her books to arrive. The Dietary Manager will complete her Dietary Managers' course no later than May 31, 2012. The Dietary Manager is currently enrolled in the Dietary Managers Correspondence Course offered through the University of North Dakota. The Administrator will monitor her progress by having a weekly one-on-one meeting where course work can be reviewed. A monthly progress report will be faxed to Wyoming Department of Health Completion Date: 05/12/2012 Currently the Registered Dietician is providing consulting at the facility for four (4) hours per week. She is also available by phone for any questions or concerns. Currently an employment ad has been placed for a CDM in two local newspapers. 11/15/2011	

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marla Martin TITLE: Administrator (X6) DATE: 10/6/11

POC accepted 10/20/11. Call to [illegible] Pendall, SSD at 1:10pm Janelle Con[illegible], OHLS