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

Printed: 12/16/2009
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 _____ | 12/04/2009 |

| 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 |
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| F 226 SS=E | 483.13(c) STAFF TREATMENT OF RESIDENTS<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This Requirement is not met as evidenced by:<br>Based on record review and staff interview, it was determined that the facility failed to implement their current abuse policies and procedures when new staff members were not oriented to the facility's abuse policies/procedures, one newly hired employee did not have evidence of a background check, and two new employees did not have their licensure/certification verified. The findings included:<br><br>1. On 12/3/09, a sample review of 7 staff of 15 hired from 9/1/2009 - 11/30/2009, revealed that the facility failed to implement screening and verification of 2 of 4 staff requiring licenses / certifications; that the licenses/certifications were active and that there were no reported histories of abuse or neglect.<br><br>a. On 12/3/09 at 9:00 AM, an interview with staff (M) revealed that an online background check is completed and that several names may be returned with similar birthdates. The "Department Heads are responsible to verify that the applicant is not one that would be ineligible for hire. Department Heads do not provide me documentation that they have completed this verification."<br><br>2. On 12/3/09, a review of sampled staff hired from 9/1/09 - 11/3/09, revealed that 7 of 7 staff could not be verified as having completed training on abuse prohibition practices, prior to resident contact. | F 226 | 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.<br><br>F226:<br>1. The 15 observed staff hired from 9/1/09 – 11/30/09 will be screened for verification of licenses/certifications; licenses/certifications are active; and that here are no reported histories of abuse or neglect by Office Manager.<br>a. All Department Heads will be trained in documenting verification of birthdates for newly hired staff by Office Manager.<br><br>2. All staff hired between 9/1/09 and 11/30/09 will complete training on abuse prohibition practices by the Administrator and/or Social Services and/or designee. | X<br>1-13-10<br>1-13-10<br>1-13-10 |

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

X _____ X UHA X 12-23-09

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.

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| F 226 | Continued From page 1<br><br>a. On 12/3/09 at 9:00 AM, an interview with staff (A) revealed that she is unable to demonstrate that newly hired staff receive training through orientation on the abuse prohibition practice. "I do not have a record that is signed that they receive orientation." | F 226 | F226 cont'd:<br>All new hire files will be reviewed by the NHA prior to new staff member working with Residents to | 1-13-10 |
| F 241 SS=E | 483.15(a) DIGNITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This Requirement is not met as evidenced by:<br>Based on observation and resident and staff interview, it was determined that the facility failed to provide care for one sample resident (#7) and nine supplemental residents (#12, #13, #14, #15, #17, #18, #19, #24, and #26) in a manner which enhanced the residents' self worth and individuality while they were eating their meals in the dining room. The findings included:<br><br>On 12/1/09 during the evening meal observation from 5:00 PM to 7:00 PM, the following observations were made:<br><br>1. Residents #2, #23, and #24 were seated at table (1) (facility identified as table 1).<br><br>Resident #2 received the first tray which was served for the evening meal at 5:48 PM. The resident ate some of his/her food and left the table at 6:08 PM. Then the resident returned to the room at 6:20 PM and stayed until 6:32 PM.<br><br>Resident #23 was served his/her meal at 5:50 PM. The resident ate one bite of the fish | F 241 | ensure all verifications are documented, all required training is given.<br><br>Results of the review of personnel files will be taken to the quarterly Quality Assurance meeting by the NHA. Any such personnel file review results will be taken to the weekly Risk Meeting by the NHA.<br><br>F241<br>All observed Residents will be monitored in the dining room by the Director of Nursing (DON)/Staff Development Coordinator (SDC)/ the Administrator (NHA) and/or other designated staff member to ensure Residents sitting at one table will be served their meal before serving another table.<br><br>All observed Residents will be monitored in the dining room by the Director of Nursing (DON)/Staff Development Coordinator (SDC)/ the Administrator (NHA) and/or | 1-13-10<br><br>1-13-10<br><br>1-13-10 |

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| F 241 | Continued From page 2<br>sandwich and then started to eat the ice cream sandwich. She offered resident #24 part of the ice cream sandwich.<br><br>Resident #24 watched the other residents eat their meals. At 5:55 PM, this resident talked to the nurse and commented that he/she was getting scared. The resident appeared anxious and upset and this continued until the resident was served his/her meal at 6:15 PM (27 minutes after resident #2 was served).<br><br>2. Residents #25, #9, #5, and #26 were seated at the u-shaped tables (2) and (3). These tables were arranged in an oval shape with an aisle between them.<br><br>Resident #25's food was placed on the table to the left side of the resident at 6:02 PM. Certified Nurse Aide (CNA) (G) commented that the resident would "dump the plate" if it was placed in front of him/her. The CNA began assisting the resident at 6:05 PM.<br><br>Resident #9's food was served at 6:13 PM.<br><br>Resident #5's food was placed on table (2), out of reach of the resident who was seated at table (3) at 6:04 PM.<br><br>Resident #26 was observed to remove his/her shoes and socks. The resident moved his/her wheelchair away from the table several times. When he/she tried to pick up the socks/shoes, the tab alarm was set off. Staff came and encouraged the resident to sit down but did not obtain food for him/her. This resident was served at 6:27 PM (25 minutes after the resident #25).<br><br>3. Resident #7, #18, and #19 were seated in | F 241 | F241 cont'd:<br>other designated staff member to ensure each Resident is being offered the necessary assistance.<br><br>Dietary Staff will be Inserviced by the Dietary Manager relating to serving order to ensure observed Residents are given meals in a timely manner.<br><br>All monitoring records will be taken to the quarterly Quality Assurance meeting by the appropriate staff. Monitoring records will be taken to the weekly Risk meeting to be reviewed.<br><br>F253<br>a. Resident room #103 bathroom tiles till be replaced by the Maintenance Director..<br><br>b. Resident rooms #5, #102 and #201 curtains will be fixed to hang properly on the rod by the Maintenance Director.<br><br>c. Toothbrushes in Resident rooms #101,#107, #201, #209 and #210 will be disposed of and replaced with | 1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10 |

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| F 241 | Continued From page 3<br>their wheelchairs and positioned in front of a U-shaped table. The table was identified by the facility on a seating chart as table (4). The facility had also identified these residents as needing extensive assistance with eating. The meal service began at 5:53 PM. However, the residents at table (4) were not served until 6:34 PM. The residents had been seated at the table over an hour and thirty four minutes before being fed. It was also noted that the residents were still being fed at 7:00 PM when the observation ended. These resident were across the table from resident #16 who had been served at 6:00 PM. Residents #7, #18 and #19 had been brought into the dining room before 5:00 PM and were not served their meal in a timely dignified manner.<br><br>4. At table (5) four residents were seated at a U-shaped table. Resident #16 was served at 6:00 PM. The other three residents #13, #14 and #15 were not served until 6:35 PM. Resident #13 had been watching resident #16 eat and repeatedly asked and motioned to staff for food or drink. The resident asked the surveyor for help. Staff was asked to assist the resident and reported she was waiting for food.<br><br>Resident #12 was seated at another table watching resident #13 and repeatedly asked staff and the surveyors to help resident #13. Resident #12 stated, "I feel so bad for her (resident #13). They need to get her something to eat. They should sit her by me and I would help her eat. She can't feed herself and they need to help her." As resident #12 was leaving the dining room she again asked to get resident #13 help.<br><br>5. Resident #17 had been placed at table (6) with two other residents #21 and #22. Residents #21 and #22 had been served at 5:53 PM. | F 241 | F253 cont'd:<br>new and labeled appropriately by CNA staff.<br><br>d. Refrigerator in Resident room #106 will be defrosted and the fan in Resident room #106 will be cleaned by Housekeeping staff.<br><br>All Resident rooms will be audited to ensure sited observations are not present by Housekeeping Supervisor/Maintenance Director/DON and/or designee.<br><br>Results of audit will be brought to the quarterly Quality Assurance meeting and the weekly Risk meeting.<br><br>F280<br>1. Resident Care Coordinator will update the plan of care for Resident #1 to address the issues with MRSA and ongoing upper respiratory infections as well as the new pressure areas.<br><br>2. Resident Care Coordinator will update the plan of care for Resident #7 to address ongoing problems with | 1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10 |

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| F 241 | Continued From page 4<br>Resident #17 was not served until 6:38 PM, forty-five minutes after the other two residents. One resident had finished eating and left the table before resident #17 had been served. | F 241 | F280 cont'd:<br>pneumonia and recurring pressure sores to the coccys. | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING/MAINTENANCE<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This Requirement is not met as evidenced by:<br>Based on observation, it was determined that the facility failed to provide maintenance/housekeeping services to ensure a safe and sanitary environment for the residents. The findings included:<br><br>On 12/1/09 at 8:30 AM, during the facility initial tour the following observations were made:<br><br>a. Resident room #103 bathroom tiles were observed to be stained yellow.<br><br>b. Resident rooms #5, #102 and #201 were observed to have curtains that were unhooked or had missing hooks and were hanging down from the curtain rod.<br><br>c. Resident rooms #101, #107, #201, #209 and #210 were observed to have toothbrushes that were either not identified, laying in the sink, placed in a container and in contact with another resident's toothbrush.<br><br>d. Resident room #106 was observed to have a refrigerator that contained a significant amount of frost and a floor standing fan that was dirty . | F 253 | The Resident Care Coordinator along with the Care Plan team will review all plans of care to ensure all ongoing issues are addressed on the care plans.<br><br>Resident Care Coordinator will present the results of the reviews/updates to the care plans to the Quality Assurance committee at least quarterly.<br><br>F281<br>1. The MAR for Resident #26 will be corrected to reflect Atenolol one half of a 25 mg tablet. DON will verify correction.<br><br>2. The MAR for Resident #9 will be corrected to reflect full physician order concerning route. DON will verify correction. | 1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10 |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS | F 280 | FOLLOW PHYSICIAN ORDERS AND PLAN OF CARE: | |

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| F 280 | Continued From page 5<br><br>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.<br><br>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.<br><br>This Requirement is not met as evidenced by:<br>Based on record review and staff interview, it was determined that the facility failed to update the care plans in a timely manner for two of 11 sample residents (#1 and #7) as their individual needs changed. The findings included:<br><br>1. Resident #1's medical record review revealed the resident was admitted to the facility on 7/21/06. The resident's multiple diagnoses included quadriplegia, colostomy, constipation, chronic UTI (urinary tract infection), neurogenic bladder, open wounds/pressure ulcers on buttock, and pain.<br><br>Resident #1 was readmitted to the facility on 10/17/09 from the hospital with diagnoses which | F 280 | F281 cont'd:<br>1. System for ordering over the counter (OTC) medications will be reviewed by the DON and/or designee to ensure timely ordering system in place.<br><br>DON and/or designee will inservice staff relating to timely ordering of OTC medications.<br><br>2. DON and/or designee will review all medication errors to ensure medication error report is completed.<br><br>NHA will review all medication error reports.<br><br>DON and/or designee will inservice professional nursing staff relating to completing a medication error report.<br><br>3. DON and/or designee will review Resident #6 MAR for appropriate documentation of pulse.<br><br>DON and/or designee will inservice professional nursing staff relating to | 1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10 |

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| F 280 | Continued From page 6<br>included pneumonia. The pneumonia was identified as MRSA (methicillin resistant staphylococcus aureus). The resident was also identified as having additional pressure areas to the left buttock.<br><br>Review of the "Interdisciplinary Progress Notes" dated 10/17/09 showed the resident was placed in isolation with "Droplet Precautions". The resident's sputum was recultured on 10/27/09 and was not identified as MRSA. However, a different organism was identified and an antibiotic was ordered.<br><br>Review of the resident's plan of care revealed the plan of care had not been updated to address the resident's issues with MRSA and ongoing upper respiratory infections. Additionally, the new pressure areas were not updated in the plan of care.<br><br>2. Resident #7's medical record review revealed the resident was admitted to the facility on 5/24/02 with diagnoses including Parkinson's disease, diabetes, PVD (peripheral vascular disease), post foot amputation, blindness and pain.<br><br>The resident had been readmitted to the facility from the hospital 11/1/09. The resident had diagnoses of pneumonia and hypoxia. The resident was also readmitted with a pressure sore to the right heel and a Stage II pressure sore on the coccyx.<br><br>Review of the resident's plan of care revealed the plan of care had not been updated to address the resident's ongoing problems with pneumonia and recurring pressure sores to the coccyx. | F 280 | F281 cont'd:<br>appropriate documentation and appropriate place to document pulse.<br><br>The DON and/or designee will review system for obtaining lab draws and lab results to ensure system is appropriate.<br><br>DON and/or designee will inservice professional nursing staff on system structure.<br><br>Medical Record Director will review log to ensure lab draws completed timely and that lab results are obtained timely.<br><br>4. DON and/or designee will review system ordering of class of controlled medications relating to new DEA regulations regarding refilling this class of medications.<br><br>If Primary Care Physician cannot complete hard copy prescription, the Medical Director will be contacted to ensure medication can be filled by the Pharmacy. | 1-15-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10 |

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| F 280 | Continued From page 7<br>3. Interview with Nurse (B) on 12/4/09 confirmed that the care plans had not been updated to address the issues identified as stated above for residents #1 and #7. | F 280 | F281 cont'd:<br>DON and/or designee will inservice professional nursing staff relating to documenting level of pain, interventions attempted and results of interventions. | 1-13-10 |
| F 281 SS=E | 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This Requirement is not met as evidenced by:<br>Based on record review, observation, and staff interviews, it was determined that the facility failed to follow professional standards and facility policies when administering medications and failed to ensure that physician orders were followed for 6 of 11 sample residents (#2, #3, #5, #6, #7, and #9) and one supplemental resident (#26). The findings included:<br><br>TRANSCRIPTION:<br><br>1. On 12/2/09 during the observation of the medication pass at 8:40 AM, nurse (H) was observed to administer several oral medications to resident #26. One of the medications was Atenolol one half of a 25 mg (milligram) tablet.<br><br>a. Review of the resident's most current summary of physician orders and 12/09 Medication Administration Record (MAR) evidenced an order for Atenolol 25 mg, dated 2/4/09. This order was verified as 25 mg by nurse (A).<br><br>b. The Director of Nursing (DON) confirmed that the medication card from the pharmacy was labelled Atenolol 25 mg give 1/2 tablet (12.5 mg).<br><br>c. The DON was requested by the surveyor to call the pharmacy to determine what they had been | F 281 | RESTORATIVE PLAN<br><br>Restorative Care Coordinator will review the restorative program for Residents #6, #2 to ensure accuracy of restorative plan of care.<br><br>Restorative Care Coordinator will review all restorative plans of care to ensure accuracy of restorative plans of care.<br><br>Restorative Care Coordinator will review restorative plans of care with all restorative CNA staff DON and/or designee will review to ensure understanding of all restorative plans of care.<br><br>Restorative Care Coordinator will review documentation for accuracy for all restorative plans of care. | 1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10 |

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| F 281 | Continued From page 8<br>sending for the resident. On 12/2/09 at 4:45 PM, the DON called the facility's pharmacy and spoke with a pharmacy staff member (I), who asked to speak with the surveyor. Staff (I) was asked about the dosage of Atenolol which the pharmacy provided for resident #26. The Pharmacy staff member (I) confirmed that they had been sending 25 mg in the form of 1/2 tablets of Atenolol since 2/4/09 as that was the admission order for the resident.<br><br>d. Review of the resident's admission orders confirmed the order to be 12.5 mg. This appeared to be a transcription error which was not caught on the double check of the transcription. It was not clear why any of the nurses had not questioned the information as listed in the MAR when the medication card was labelled differently for ten months.<br><br>2. Record review for resident #9 evidenced the resident's physician order for MS (Morphine Sulfate) was not completed transcribed onto the MAR. The resident's admission physician order dated 10/30/09 stated "Morphine Sulfate IR (immediate release) or soln (solution): 20 mg/ml solution sublingual 0.25 - 0.5 ml every hour prn pain/air hunger, eff (effective) 06/18/09."<br><br>The MAR notation dated 11/2/09 was written "Morphine Sulfate 0.25-0.5 PO (oral) QH (every hour) PRN." This was not transcribed completely and was inaccurate (route was sublingual, not oral).<br><br>FOLLOW PHYSICIAN ORDERS AND PLAN OF CARE:<br><br>1. On 12/3/09 at 8:52 AM, in an interview with the Administrator and nurse (A), the medications not | F 281 | F281 cont'd:<br>Restorative Care Coordinator will review and/or inservice restorative CNA staff relating to program implementation, appropriate documentation including restorative care progress notes and explanations of services not being given.<br><br>PAIN ASSESSMENT<br><br>1. b. Resident #3 will have pain assessment completed by the Charge Nurse with each medication given.<br><br>c. DON and/or designee will review Pain Management Flowsheets for Resident #3 to ensure prn doses and pain assessments are documented appropriately.<br><br>d. DON and/or designee will review the narcotic sign out sheets and MARs for Resident #3 to ensure dosage documentation is clear. | 1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10 |

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

Printed: 12/16/2009
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 |
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| | 535050 | A. BUILDING _____ B. WING _____ | 12/04/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| F 281 | Continued From page 9<br>being available was discussed. The Administrator revealed that recently the facility had changed suppliers for over the counter (OTC) medications, so the facility pharmacy was no longer providing these medications.<br><br>2. Record review for resident #2 revealed that on 8/3/09 a potassium level was ordered/drawn due to a medication error.<br><br>On 12/3/09 at 11:14 AM, in an interview with the DON and nurse (A), they confirmed that they had no evidence that a medication error report was written. They indicated that the previous DON might have done the report but they were not aware of where the report would have been placed, if one was actually done.<br><br>3. Record review for resident #6 revealed a physician order to hold the resident's Digoxin for a pulse lower than 60.<br><br>Review of the resident's 11/09 MAR evidenced that on 11/11/09 the resident's pulse was 56. The medication was charted as given. Additionally, no pulses were documented on the MAR for 11/7, 11/8, 11/10, and 11/22. Without the pulse being taken prior to the medication administration, the nurse could not accurately determine if the Digoxin should be held.<br><br>Review of the resident's physician orders revealed a verbal order dated 9/25/09 for fasting blood tests on 10/12/09. No laboratory results were found for this date. The DON confirmed that no blood testing had occurred on 10/12/09. The resident had another order via fax for blood work dated 10/26/09 based on behavior reported to the physician via fax. The DON obtained a copy of these results from the hospital on 12/3/09. | F 281 | F281 cont'd:<br>DON and/or designee will review documentation on the MAR for all Residents to ensure pain assessments for all Residents receiving pain medication to ensure pain assessments are being completed.<br><br>DOCUMENTATION<br><br>DON and/or designee will review documentation on the MAR for Resident #5 to ensure appropriate documentation for medications not given is present.<br><br>DON and/or designee will review documentation on the MARS for all Residents for medications not given to ensure documentation is appropriate.<br><br>DON and/or designee will inservice all professional nursing staff relating to appropriate pain assessments, documentation of medications not given and clear documentation of medication given.<br><br>DON and/or designee will complete audits of completeness of pain | 1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10 |

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| | 535050 | A. BUILDING _____ B. WING _____ | 12/04/2009 |

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

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| F 281 | Continued From page 10<br><br>4. Record review for resident #7 revealed a physician order for Oxycodone 2 tabs PO BID (twice a day) for chronic pain started 5/13/08.<br><br>Review of the resident's 10/09 MAR evidenced that on 10/16/09, 10/17/09, and 10/18/09 the Oxycodone was circled as "not given". The Medication Administration Comments sheet on 10/16/09 and 10/17/09 stated, "Oxycodone Not Available".<br><br>Review of the 9/09 MAR evidenced that on 9/10/09 and 9/12/09 the Oxycodone was circled as "not given". The Medication Administration Comments sheet on 9/10/09 and 9/12/09 stated, "Oxycodone Not Available".<br><br>There was no documentation of assessment of the resident's pain, other interventions used for pain or that the physician was notified that the medication was not available for administration.<br><br>RESTORATIVE PLAN:<br><br>1. On 12/3/09 at 8:52 AM, in an interview with the Administrator and nurse (A), the provision of restorative care was discussed. The Administrator indicated that they had added another person to do restorative and now they were working on accurate documentation of the services provided. She said that they were not taking credit for these services on the Minimum Data Set (MDS) because of the concern about actual provided care and the accuracy of what amount of time was documented.<br><br>2. During the above interview, the documentation for resident #6's restorative services was used as an example of the lack of provision of services as | F 281 | F281 cont'd:<br>assessment, documentation of medications not give and clear documentation of medication given two times per week for two months and randomly thereafter.<br><br>Results of the audits will be presented to the Risk Committee weekly and the Quality Assurance Committee at least quarterly.<br><br>F309<br>DON and/or designee will review Resident #11 plan of care concerning goal "...will not experience adverse effects of hemodialysis..." and the approaches and compare with nursing documentation to ensure plan of care is being implemented.<br><br>DON and/or designee will review all Residents' plans of care relating to hemodialysis to ensure plan of care is being implemented. | 1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10 |

DEPARTMENT OF HEALTH AND HUMAN S VICES
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Printed: 12/10/2009
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OMB NO. 0938-0391

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| | 535050 | A. BUILDING _____ B. WING _____ | 12/04/2009 |

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

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| F 281 | Continued From page 11<br>ordered and/or inaccurate documentation of those services.<br><br>a. On 12/2/09 at 9:03 AM, in an interview with a restorative aide (RA) (L), she revealed that resident #6 was care planned to ambulate twice a day.<br><br>b. Review of the list of residents on the facility's Restorative Program evidenced that resident #6 was care planned to receive ambulation with a front wheeled walker 165 feet 2 times a day 5 times a week.<br><br>c. Review of the resident's 10/9 and 11/09 Restorative Care Flow Records evidenced that restorative services were not furnished as planned for this resident. In 11/09, the resident was ambulated on 11/1 (one time), 11/2 (one time), 11/5 (twice), 11/6 (twice), 11/7 (once), 11/9 (twice), 11/13 (twice), 11/14 (once), 11/15 (twice), 11/19 (twice), 11/20 (once), 11/21 (twice), 11/22 (once), 11/26 (once), 11/27 (twice), 11/28 (?), 11/29 (twice), and 11/30 (once).<br><br>3. Review of the list of residents on the facility's Restorative Program evidenced that resident #2 was care planned to receive upper and lower extremity exercises three times a week.<br><br>a. On 12/2/09 at 9:03 AM, in an interview with the RA (L), she verified that resident #2 was planned to receive upper and lower extremity exercises.<br><br>a. Review of the resident's 10/09 and 11/09 Restorative Care Flow Records evidenced a frequency of 3 - 5 times per week. The restorative aides charted the following dates when they provided restorative services to this resident: | F 281 | F309 cont'd:<br>Resident Care Coordinator will develop a diabetic management plan for Resident #11 and implement in the plan of care.<br><br>Resident Care Coordinator will develop and implement a diabetic management plan for all Residents with a diagnosis of Diabetes.<br><br>Care Plan Team will develop and implement a system to ensure tracking, follow-up and audits are completed to ensure plan of care is being implemented.<br><br>DON and/or designee will present audit results at the weekly Risk meeting and to the quarterly Quality Assurance Committee.<br><br>DON and/or designee will audit insulin documentation for Resident #4 daily for one week and two times per week for three weeks and randomly thereafter to ensure professional nurses are completing documentation appropriately. | 1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Printed: 12/15/2009
FORM APPROVED
OMB NO. 0938-0391

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

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| F 281 | Continued From page 12<br>10/09 - 10/2, 10/8, 10/13, 10/17, 10/19, 10/22, 10/25, and 10/30.<br><br>11/09 - 11/6, 11/8, 11/13, 11/15, 11/19, 11/21, and 11/29. "Company" was noted on 11/2 and 11/26.<br><br>There were no restorative care progress notes written for this resident and no explanations about why the resident did not receive the planned restorative services.<br><br>PAIN ASSESSMENT:<br><br>1. Record review for resident #3 revealed that the resident was admitted on 7/10/09 with diagnoses that included end stage liver disease (ESLD), fractured hip, open wounds, pneumonia, depressive disorder, abdominal pain, loss of weight, and insomnia. The resident was receiving services from Hospice.<br><br>a. Review of the resident's 11/09 MAR evidenced that he/she was receiving the following pain medications:<br><br>MS (Morphine Sulfate) Contin 100 mg every 6 hours (to be given at the same time as the MSIR)<br><br>MSIR (Morphine Sulfate Instant Release) 30 mg every 6 hours<br><br>MS 30 mg 1 or 2 tablets every 4 to 6 hours prn (as needed)<br><br>Levsin SL 0.125 mg four times a day prn (anticholinergic for abdominal pain).<br><br>b. Review of the resident's 10/09 and 11/09 | F 281 | F309 cont'd:<br>DON and/or designee will audit insulin documentation for all Residents receiving insulin daily for one week and two times per week for three weeks and randomly thereafter to ensure professional nurses are completing documentation appropriately.<br><br>DON and/or designee will inservice professional nursing staff relating to the appropriate documentation of insulin.<br><br>All audit results will be presented to the weekly Risk meeting and the quarterly Quality Assurance Committee.<br><br>F311<br>Resident #3, #9, #20 and #28 will receive necessary meal time assistance from staff.<br><br>All Residents will be given necessary meal time assistance from staff. | 1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10 |

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| F 281 | Continued From page 13<br>Medication Administration Comments forms showed that the pain scale for pain assessment was not consistently being used.<br><br>c. Review of the resident's 10/09 Pain Management Flowsheets evidenced that some but not all of the prn doses of MS were charted on these forms and/or had pain assessments documented.<br><br>d. Review of the resident's narcotic sign out sheets and MARs revealed that the narcotics were not documented so that dosage could be determined. There were numerous sign out sheets, labelled MS 100 mg, MSIR, and/or MS 30 mg.<br><br>On 11/24/09 there was a notation on the MSIR Controlled Drug Administration Record that 30 tablets were taken from the ER box; this was crossed off and changed to read 60.<br><br>Since the dosage on the MAR for the MS 30 mg one or two tablets was not consistently charted with the amount (one or two), the nurses' initials did not coincide with the numbers, and there were no times noted, it was not possible to determine what doses the resident had received or the effect of these on the resident's pain level.<br><br>e. Further review of the resident's 11/09 and 10/09 MARs revealed that when medications were circled as omitted and/or initial spaces were left blank, there was no explanation of why the resident was not given the medications. Examples included:<br><br>i. MS Contin 100 mg on 11/5/09 at 6:00 PM and midnight, 11/12/09 at 6:00 AM, 11/19/09 at 6:00 AM, and 11/30/09 at 6:00 PM. | F 281 | F311 cont'd:<br>Staff Development Coordinator will inservice the Domestic Assistant staff relating to offering the Residents necessary assistance at each meal.<br><br>DON and/or designee will complete audits for appropriate meal assistance for all Residents for each meal time two times per week for one week, one time per week for three weeks and randomly thereafter.<br><br>Results of audit will be presented at the weekly Risk meeting and at the quarterly Quality Assurance Committee meeting.<br><br>F312<br><br>Staff Development Coordinator will inservice CNA staff relating to proper techniques for giving peri care to Residents #7 and #26.<br><br>DON and /or designee will audit all CNA staff giving peri care to all Residents requiring such care to | 1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10 |

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| F 281 | Continued From page 14<br><br>ii. Neurontin on 11/3/09 at 10:00 PM, 11/6/09 at 8:00 AM and 2:00 PM, 11/30/09 at 2:00 PM and 10:00 PM.<br><br>iii. Magnesium Oxide on 11/22/09 at 8:00 AM and 6:00 PM.<br><br>f. On 12/2/09 at 3:15 PM, in an interview with the DON, she confirmed that the nurses should be using the 1 to 10 pain scale to assess pain. She verified that the nurses were not always using this pain scale to assess resident #3's pain.<br><br>DOCUMENTATION:<br><br>1. On 12/2/09 at 8:30 AM, during a medication pass observation with nurse (C) administering medications to resident #5, the resident was not given his/her multiple vitamin (MVI). The nurse revealed that the MVI had not come from the pharmacy yet, but that it would be given later in the day when the medication arrived.<br><br>On 12/2 09 at 4:55 PM, in an interview with nurse (C), the nurse verified that resident #5's multiple vitamin (MVI) had not arrived with the medications which came from the pharmacy.<br><br>Review of the resident's MAR evidenced that the medication was circled as omitted but there was no explanation noted to explain why the medication was not given.<br><br>2. On 12/3/09 at 9:35 AM, in an interview with the consultant Pharmacist, he verified that the two types of oral Morphine Sulfate (MS) are sustained release and instant release. He clarified that resident #3 was receiving 100 mg sustained release and 30 mg MS or as noted MSIR (MS | F 281 | F312 cont'd:<br>ensure proper techniques are used while giving peri care. Audits will include correction, if necessary, at the time of an improper technique used.<br><br>Staff Development Coordinator will inservice all CNA staff on proper techniques for giving peri care. CNA staff will demonstrate peri care to the Staff Development Coordinator to ensure knowledge of proper technique.<br><br>Results of audit will be presented at the weekly Risk meeting and at the quarterly Quality Assurance Committee meeting.<br><br>F314<br><br>The wound tracking log for Resident #3 will become part of the permanent medical record.<br><br>Assessments will be completed by the Charge Nurse for Resident #3 relating to skin conditions including but not limited to measurement, color, odor, drainage present, etc. | 1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10 |

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| F 281 | Continued From page 15<br>instant release). He stated that the ER (emergency) medication box, supplied by his pharmacy, contained only ten 15 mg MS tablets.<br><br>3. The Pharmacist was asked about residents whose medications (prescribed) were charted as not available. He stated that if the order was for a new medication, he had contracts to have that medication delivered the same day. He said that the medications not available were narcotics for which they had not received signed orders for. He stressed that the DEA was enforcing the regulations which required signed orders. So the pharmacy would no longer send the narcotics without physician signed orders.<br><br>4 | F 281 | F314 cont'd:<br>DON and/or designee will audit medical record for all Residents with changes in skin condition to ensure wound tracking log is part of each Resident's permanent medical record.<br><br>DON and/or designee will audit medical record for all Residents to determine is assessments are present in the chart. | 1.13.10<br><br>1.13.10 |
| F 309 SS=E | 483.25 QUALITY OF CARE<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This Requirement is not met as evidenced by:<br>Based on record review and staff interview, it was determined that the facility failed to provide care/services for residents with end stage renal disease, to monitor/manage residents' bowel movements, and to manage diabetic residents based on physician orders and current standards of practice for three of 11 sample residents (#4, #8, and #11). These failures affected the residents' abilities to reach their highest practicable level of physical, mental, and/or | F 309 | DON and/or will inservice all professional nursing staff relating to the assessment schedule, tracking and properly documenting skin conditions including but not limited to measurement, color, odor, drainage present, etc.<br><br>All audit results will be presented to the weekly Risk committee and the quarterly Quality Assurance Committee.<br><br>Resident #7 will have a skin assessment completed by the Charge | 1.13.10<br><br>1.13.10<br><br>1.13.10 |

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| F 309 | Continued From page 16<br>psychosocial functioning. The findings included:<br><br>Resident #11's medical record review revealed the resident was admitted to the facility on 9/8/08 with diagnoses including: diabetes, hypertension, glaucoma, blindness, pain, insomnia, constipation and end stage renal disease. The resident left the facility to get dialysis three times per week (Monday, Wednesday, and Friday).<br><br>a. Review of the significant change MDS (Minimum Data Set) assessment dated 9/13/09 identified the resident as being independent with decision making, and limited assistance with dressing and bathing. It also identified the resident as having moderate pain less than daily, having falls in past 31-180 days and being on dialysis.<br><br>b. Review of the "Interdisciplinary Progress Notes" revealed the following concerns:<br>8/3/09 3:45 "Nsg. Bruising on L (left) hip et R (right) arm. tender to touch - refused pain med. MD notified per fax of incident. 1300 (1:00 PM) returned from dialysis bleeding from port with clamp on. 1320 (1:20 PM) clamp removed."<br><br>8/3/09 "LATE ENTRY 1300 (1:00 PM) Nsg. bleeding has stopped drsg. applied (sign for no) further bleeding noted."<br><br>8/3/09 "2045 (8:45 PM) Nsg. Aides report res. did not eat very much at mealtime due to increased pain. C/O (complained of) pain at this time. Requests pain med. Tylenol #3 given. 2200 (10:00 PM) Resting in bed with eyes closed. Resp | F 309 | F314 cont'd:<br>Nurse and Resident Care Coordinator.<br><br>DON and/or designee will audit medical record for all Residents to determine is assessments are present in the chart.<br><br>Resident Care Coordinator will inservice professional nursing staff relating to completing such assessments for new admissions, readmissions and as scheduled.<br><br>DON and/or designee will audit after admissions, after readmissions and per schedule the medical records for all Residents to ensure skin assessments are completed as necessary.<br><br>Results of audits will be presented to the weekly Risk committee and the quarterly Quality Assurance Committee.<br><br>F371<br>1.a. The garbage disposal in the dishwashing room will have a cover | 1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10 |

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Printed: 12/16/2009
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 |
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| | 535050 | A. BUILDING _____ B. WING _____ | 12/04/2009 |

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

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| F 309 | Continued From page 17<br>(respirations) even non-labored. (sign for no) s/s (signs and symptoms) of distress noted."<br><br>[There was no documentation of vital signs, inspection of the dialysis port and recheck for bleeding, pain assessment including pain rating, type and location of pain from 1:00 PM on 8/3/09 to 9:00 AM on 8/4/09.]<br><br>The next entry was 8/4/09 at 9:00 AM (11 hours later) when the resident complained of chest pain and shortness of breath. The note reported that vital signs were checked oxygen applied at 3 liters and the resident was sent to the ER (emergency room) at 8:40 AM.<br><br>On 8/5/09 "10:00 Late Entry for 8/4/09" reported the resident returned from the ER at 11:30.<br><br>The next entry from nursing was 8/19/09 (15 days later). There was no evidence the resident was reassessed and monitored or care provided following transport to the ER for complaints of chest pain and shortness of breath.<br><br>10/20/09 the notes identified the resident as having a "very hard BM (bowel movement)- when the resident stood nurses aide noted red blood in toilet and got this writer. Resident states she feels fine has hx (history) of hemorrhoids with bleeding at this time refusing to lay down to let me look... will have evening shift nurse ck (check) when she lays down"<br>[There was no documentation by the evening shift that the resident was assessed for bleeding, hemorrhoids and constipation.]<br><br>The next entry was 10/23/09 (three days later) which noted the the resident had received multiple laxatives and enemas with ineffective | F 309 | F371cont'd:<br>gasket installed by the Maintenance Director.<br>Maintenance Director will add the garbage disposal to the list of audits he/she completes.<br><br>1.b. Dry storage area will be free of boxes on the floor and open and/or unsealed products;<br><br>1.c. Dietary staff will clean the floor under and behind equipment and shelving;<br><br>1.d. The narrow slot between the hood sections above the stove will be cleaned by the dietary staff;<br><br>1.e. Observed refrigerator in the dining room will be defrosted by the Maintenance Director and cleaned by the Housekeeping Aides<br><br>2. The box of crackers in the medication storage room will be disposed of by the Charge Nurse.<br><br>3. Dietary Manager will inservice observed dietary staff relating to | 1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10 |

DEPARTMENT OF HEALTH AND HUMAN S /ICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 309 | Continued From page 18<br>results and physician being notified. There was no further documentation on the resident's ongoing issues with constipation or bleeding from hemorrhoids.<br><br>The facility failed to provided timely care and monitoring to meet this resident's needs and changes in condition.<br><br>c. Review of the resident's plan of care dated 9/23/09 identified:<br>1) Problem- "Hemodialysis client related to renal disease."<br>Goals- "...will not experience adverse effects of hemodialysis such as fluid volume unbalance and/or infection."<br>Approaches: "1. Monitor access for patency and s/s infection daily,<br>2. Monitor for s/s hypo/hypervolemia,<br>3. Monitor for hypotension such as c/o dizziness, ringing in the ears, etc...<br>4. Notify MD for temp of 100 or greater as increased temp can signify infection.<br>5. Arrange for transportation as notified by the dialysis center.<br>6. Monitor for s/s of electrolyte imbalance (especially potassium levels) such as muscle weakness, confusion."<br>However the documentation evidenced that the approaches for dialysis care were not being implemented.<br><br>2) Additionally the plan of care it did not address diabetic management for this diabetic resident. Review of the resident's MAR (Medication Administrative Record) revealed the resident was on Lantus insulin 5 units subq (subcutaneous) QD (everyday) and Accu-chek finger sticks twice a day to monitor the resident's blood sugar. | F 309 | F371 cont'd:<br>touching hair without changing gloves prior to serving meals.<br><br>Dietary manager will add the dry storage area storage, the cleaning of the floor, cleaning of the hood sections to the dietary cleaning schedule.<br><br>Dietary Manager will inservice dietary staff relating to the items on the cleaning schedule.<br><br>Dietary Manager will audit the observed items once a week for four weeks and randomly thereafter to ensure cleaning schedule is followed.<br><br>DON and/or designee will audit the medication storage room to ensure open containers/packages of food items are not stored in this area.<br><br>Audit results will be presented by the Maintenance Director, the Dietary Manager and the DON and/or designee to the quarterly Quality Assurance Committee. | 1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10 |

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| F 309 | Continued From page 19<br><br>d. Interview with the Administrator and DON on 12/4/09 confirmed the the facility did not have a current policy and procedure addressing care of residents receieving dialysis.<br><br>DIABETIC MANAGEMENT:<br>1. Resident #4 was identified as not being provided diabetic care and monitoring in accordance nursing practice, facility policy and procedure, and physician orders.<br><br>a. Resident #4's medical record review revealed the resident was admitted to the facility on 7/12/09 with diagnoses including: diabetes, hypertension, PVD (peripheral vascular disease), cardiovascular disease, arthritis, COPD (chronic obstructive pulmonary disease), pain, and wound infection with partial amputation of the left foot.<br><br>b. Review of the resident's MAR (Medication Administrative Record) revealed the resident was on routine insulin and sliding scale insulin.<br><br>c. Review of the MAR and the Blood Glucose Data Sheet for 11/2009 and 10/2009 showed the following orders:<br>Order date 7/28/2009 Novolog 8 units sub-q everyday AC + Sliding scale,<br><br>Order date 10/21/09 Lantus 60 units Sub-q Q HS (at bedtime) increased from 55 units,<br><br>Order date 7/17/2009 units/ml insulin sub-q per sliding scale as directed:<br>"Sliding Scale Sub-Q QID (four times per day) AC Novolog<br>0-70 orange juice;<br>71-120 NONE<br>121-150=1U (one unit), | F 309 | F441<br>WOUND CARE<br>1. Infection Control Person will inservice the observed professional nurse in appropriate infection control protocol for dressing changes.<br><br>Infection Control Person will inservice all professional nursing staff on appropriate infection control protocol for dressing changes.<br><br>DON and/or Infection Control Person and/or designee will observe dressing changes to ensure appropriate infection control protocol is followed for all dressing changes for one week and randomly thereafter for one month.<br><br>Results of the observations of dressing changes will be presented to the weekly Risk committee and the quarterly Quality Assurance committee.<br><br>2. The DON inserviced the Physical Therapist relating to the appropriate protocol for wound treatment. Contracted agency will be contacted by NHA to ensure staff is | 1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-15-10<br><br>1-13-10 |

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| F 309 | Continued From page 20<br>151-200=2U,<br>201-250=3U,<br>250-300=4U,<br>301-350=5U,<br>351-400=6U<br>>400 = 8 Units and CALL MD.<br><br>d. Review of the Blood Glucose Data Sheet for October 2009 identified the following errors with no documentation of sliding scale insulin being given:<br><br>10/2/09 5:00 AM BS (blood sugar) 277 "Insulin Amount" blank (no indication sliding scale insulin was given as per physician orders),<br><br>10/3/09 5:00 AM BS 139 "Insulin Amount" blank,<br><br>10/06/09 no BS documented,<br><br>10/7/09 5:00 AM BS 372 "Insulin Amount" blank,<br><br>10/8/09 5:00 AM BS 229 "Insulin Amount" blank, (MAR also blank)<br><br>10/9/09 5:00 AM BS 155 "Insulin Amount" blank,<br><br>10/13/09 5:00 AM BS 181 "Insulin Amount" blank,<br><br>10/14/09 one BS documented (three blood sugars not done or documented),<br><br>10/1609 5:00 AM BS 155 "Insulin Amount" blank,<br><br>10/21/09 2100 BS "Does not register 'HI' physician notified 10 units Novolog " given and HS insulin order increased,<br><br>10/22/09 5:00 AM BS 194 "Insulin Amount" blank, | F 309 | F441 cont'd:<br>knowledgeable in appropriate infection control protocols.<br><br>DON and/or designee will observe contract therapists to ensure knowledge of appropriate infection control protocols.<br><br>Results of DON and/or designee observations will be presented to the appropriate weekly Risk committee and the quarterly Quality Assurance Committee.<br><br>CLEANING OF EQUIPMENT<br><br>1.2. DON and/or designee will clean all Glucometers using the manufacturer guidelines.<br><br>Infection Control Person will inservice all professional nursing staff on cleaning Glucometers using the manufacturer guidelines<br><br>3. Housekeeping will clean fan in room of Resident #7. | 1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10 |

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| F 309 | Continued From page 21<br>10/22/09 2100 (9:00 PM) AM BS 400 "Insulin Amount" blank,<br><br>10/28/09 5:15 AM 161 "Insulin Amount" blank,<br><br>10/28/09 9:00 PM BS 171 "Insulin Amount" blank,<br><br>10/29/09 5:00 AM BS 199 "Insulin Amount" blank,<br><br>10/29/09 9:00 PM BS 364 "Insulin Amount" blank,<br><br>10/30/09 5:00 AM BS 197 "Insulin Amount" blank,<br><br>10/30/09 11:30 AM BS 335 "Insulin Amount" blank,<br><br>10/30/09 4:30 PM BS 191 "Insulin Amount" blank,<br><br>10/31/09 4:30 PM BS 264 "Insulin Amount" blank,<br><br>e. On 12/2/09 at 4:00 PM Nurse (A) was asked to review the MAR with the corresponding Blood Glucose Data Sheet for October 2009. Nurse (A) confirmed the documentation on the Blood Glucose Data Sheet was incomplete. Nurse (A) reported that there had been issues with not getting insulin documented on the MAR so the facility started the "Blood Glucose Data Sheet" to improve documentation and tracking of blood sugars.<br>There was no evidence that showed diabetic care was provided consistently, to ensure physician orders being followed and sliding scale insulin being given as ordered.<br><br>2. Review of the medical record for resident #8 revealed the resident was admitted to the facility on 11/19/08 with diagnoses that included malignant neoplasm of bronchus and lung, chronic kidney disease, diabetes mellitus, and | F 309 | F441 cont'd:<br>Maintenance Director will clean filter in oxygen concentrator in room of Resident #7.<br><br>Charge Nurse will clean the nebulizer in room of Resident #7<br>Maintenance Director, Housekeeping Supervisor and/or Infection Control Person will inspect all Resident rooms to ensure observed items are properly cleaned.<br><br>Staff Development Coordinator will inservice housekeeping staff, professional nursing staff relating to proper cleaning of above observed items.<br><br>Maintenance Director and/or Housekeeping Supervisor and/or Infection Control Person will conduct audits weekly for one month and randomly thereafter to ensure equipment is properly cleaned.<br><br>Results of audits will be taken to the weekly Risk committee and the quarterly Quality Assurance Committee. | 1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10<br><br>1-13-10 |

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| F 309 | Continued From page 22<br>congestive heart failure.<br><br>a. November physician orders included;<br>ACCU-CHEK Easy Test F-stick QD (every day) AC (before meals), (Prescribed 4/1/09);<br><br>Lantus insulin 30 units subq (subcutaneous) (QD (every day) (ordered 4/1/09);<br><br>Insulin reg (regular) 3 units subq BID (twice each day) (ordered 4/21/09);<br><br>Insulin reg 4 units subq PRN If blood sugar >400 (Prescribed 2/4/09).<br><br>b. Review of the Medication Administration Record instructions, revealed the following instructions:<br><br>A.) Initial appropriate box at time medication administered.<br>B.) Circle initials when medication refused.<br>C.) State reason for refusal on NURSES Notes.<br>D.) State reason PRN MEDICATION GIVEN and Results<br>E.) Date and initial all DC-Changes ME.<br>F.) Indicate site of injection with appropriate number on medication record.<br><br>c. Review of the Medication Administration Record for November 2009 revealed incomplete documentation.<br><br>1. Under the Medication area for ACCU-CHEK EASY TEST scheduled at 05:00, 11:00 and 17:00:<br><br>There was no documentation for 11/10/09 at 17:00. | F 309 | F441 cont'd:<br>PERINEAL CARE<br><br>1. Staff Development Coordinator will inservice CNA staff relating to proper techniques for giving peri care to Residents #7 and #26.<br><br>DON and /or designee will audit all CNA staff giving peri care to all Residents requiring such care to ensure proper techniques are used while giving peri care. Audits will include correction, if necessary, at the time of an improper technique used.<br><br>Staff Development Coordinator will inservice all CNA staff on proper techniques for giving peri care. CNA staff will demonstrate peri care to the Staff Development Coordinator to ensure knowledge of proper technique.<br><br>Results of audit will be presented at the weekly Risk meeting and at the quarterly Quality Assurance Committee meeting. | 1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10 |

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| F 309 | Continued From page 23<br>There was no documentation for 11/11/09 at 11:00 and 17:00.<br><br>There was no documentation for 11/12/09 at 11:00 and 17:00.<br><br>There was no documentation for 11/27/09 at 17:00.<br><br>2. Under the Medication area for Lantus Insulin 30 Units Subq QD 8:00<br><br>There was no documentation under site for 11/6, 8, 11, 17, 18, 22, 24, 26 and 27.<br><br>3. Under the Medication area for Insulin Reg 3 Units subq BID 9:00 and 13:00<br><br>There was no documentation under site for 9:00 on 11/3, 6, 8, 9, 10, 12, and 22.<br><br>There was no documentation under site for 13:00 on 11/6, 7, 8, 9, 10, 21, 22, 24, 25 and 26.<br><br>4. Under the Medication area of Insulin Reg 4 Units Subq PRN<br><br>There was no documentation regarding the units administered and the time on 11/5, 20 and 25. | F 309 | F441 cont'd:<br>HANDLING OF LINEN<br><br>Infection Control Coordinator will inservice all CNA staff relating to appropriate handling of soiled linen and use of gloves<br>All CNA staff will demonstrate to the Infection Control Coordinator ability appropriately handle soiled linen.<br><br>Infection Control Coordinator and/or designee will conduct audits to ensure linen is handled appropriately.<br><br>Results of audits will be presented to the weekly Risk Committee and the quarterly Quality Assurance Committee. | 1-13-10<br><br>1-13-10<br><br>1-13-10 |
| F 311 SS=E | 483.25(a)(2) ACTIVITIES OF DAILY LIVING<br><br>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.<br><br>This Requirement is not met as evidenced by:<br>Based on observation and staff interview, it was determined that the facility failed to provide adequate meal assistance to two of 11 sample | F 311 | F467<br><br>a. The Maintenance Director will repair the mechanical ventilation system for the 100 wing. | 1-13-10 |

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| F 311 | Continued From page 24<br>residents (#3 and #9) and two supplemental residents (#20 and #28). These residents were facility assessed and/or observed to be able to feed themselves all or part of his/her meals, but required supervision, cueing, and/or physical assistance to eat. The findings included:<br><br>1. During observations of the evening meal on 12/1/09 from 5:00 PM to 7:00 PM concerns with the residents who needed cueing and assistance were identified.<br><br>Resident #20 was seated at table (7) in a wheelchair. The resident was served a pureed diet at 5:55 PM. The resident was observed to take two bites of food and made no further attempt to eat. The resident then left the table at 6:12 PM propelling self in the wheelchair. The resident was not cued or offered assistance during the meal. The staff available in the dining room were passing meal trays. There was no staff available to cue and further assist the residents who had already been served their meals.<br><br>2. On 12/1/09 and 12/2/09, observations during meal services revealed that residents with varying degrees of independence seated at tables 10,11,12,13 and 14 received little or no assistance after meals were served. Staff did not return or ask if there were other requests or additional needs.<br><br>Residents did not receive additional fluids or other limited assistance with food. Resident #28 exhibitied symptoms of frustation in locating and eating food items. Resident #9 did not receive any assistance until the end of the meal service. Resident #3 was often observed to be asleep at the table and to be qued by tablemate. This | F 311 | F467 cont'd:<br>b. Maintenance Director will repair the ventilation system in the Resident smoking room.<br><br>Maintenance Director will include verifying the ventilation system for all areas of the facility in the maintenance checks done weekly.<br><br>Results of audits will be presented to the weekly Risk Committee and the quarterly Quality Assurance Committee.<br><br>F514<br>DON and/or designee will audit insulin documentation for Resident #4 daily for one week and two times per week for three weeks and randomly thereafter to ensure professional nurses are completing documentation appropriately.<br><br>DON and/or designee will audit insulin documentation for Resident #8 daily for one week and two times per week for three weeks and randomly thereafter to ensure professional nurses are completing documentation appropriately. | 1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10 |

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| F 311 | Continued From page 25<br>resident was observed to carry a very full bowl of hot mashed potatos and gravy along with other hot items, after going to the serving window to obtain these items. No staff were available in the area to assist the resident.<br><br>3. During observations of the noon meal on 12/2/09 from 12:00 PM to 1:00 PM, it was observed that once the meals were served, the nursing staff sat down to assist the dependent residents eat. No staff were observed to assist, cue, or ask the other residents if they needed help or wanted other food/drinks.<br><br>4. On 12/3/09 at 8:52 AM, in an interview with the Administrator and nurse (A), the meal observations made on 12/1/09 and 12/2/09 were discussed. This discussion included the lack of assistance, cueing, or offering of additional or different food items for residents who could eat independently during the entire or part of the meal. | F 311 | F514 cont'd:<br>DON and/or designee will audit insulin documentation for all Residents receiving insulin daily for one week and two times per week for three weeks and randomly thereafter to ensure professional nurses are completing documentation appropriately.<br><br>2. DON and/or designee will review Resident #11 plan of care concerning goal "...will not experience adverse effects of hemodialysis..." and the approaches and compare with nursing documentation to ensure plan of care is being documented.<br><br>DON and/or designee will review all Residents' plans of care relating to hemodialysis to ensure plan of care is being documented.<br><br>3. Resident #7 will have a skin assessment completed by the Charge Nurse and Resident Care Coordinator. | 1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10 |
| F 312 SS=D | 483.25(a)(3) ACTIVITIES OF DAILY LIVING<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This Requirement is not met as evidenced by:<br>Based on observation, record review, and staff interview, it was determined that the facility failed to assist one of 11 sample residents (#7) and one supplemental residents (#26) with appropriate and adequate peri-care. These residents were facility assessed and/or were observed to be unable to perform this Activity of Daily Living (ADL), requiring extensive/total assistance. The | F 312 | | |

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

Printed: 12/16/2009
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 _____ | 12/04/2009 |

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

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| F 312 | Continued From page 26<br>findings included:<br><br>1. On 12/2/09 at 1:55 PM, Certified Nurse Aide (CNA) (J) was observed in the presence of nurse (H) assisting resident #26 with toileting. The resident was taken into the bathroom, stood up, and transferred to the toilet. The CNA removed the resident's brief, which she verified was wet and fecal soiled. The CNA touched the resident's wheelchair handles, items in the resident's bathroom, and rubbed the resident's back. The resident used the toilet and was provided peri-care by the CNA. The CNA wiped the resident from the back side, reaching between his/her legs. The resident's front perineal area, groin, and buttocks were not cleaned. The CNA indicated that the resident had urinated and had a bowel movement in the toilet. The CNA pulled the clean brief and pants up and transferred the resident to his/her wheelchair. The CNA did not change her gloves or do handwashing until this entire observation was done.<br><br>2. Resident #7's medical record review revealed the resident was admitted to the facility on 5/24/02 with diagnoses which included: Parkinson's disease, diabetes, above knee amputation of the left leg, PVD (peripheral vascular disease), CVD (cardiovascular disease), blindness, insomnia and pain.<br><br>a. Review of the significant change MDS (Minimum Data Set) assessment dated 8/23/09 identified the resident as being total care and as having skin ulcers. The assessment included: Total dependence (full staff performance) with two staff persons physical assistance for bed mobility, transfers, and toilet use, Total dependence with one staff person physical | F 312 | F514 cont'd:<br>DON and/or designee will audit medical record for all Residents to determine is assessments are present in the chart.<br><br>Resident Care Coordinator will inservice professional nursing staff relating to completing such assessments for new admissions, readmissions and as scheduled.<br><br>DON and/or designee will audit after admissions, after readmissions and per schedule the medical records for all Residents to ensure skin assessments are completed as necessary.<br><br>4. DON and/or designee will review the medical records for Residents #2, #3, #5, #6, #9 and #26 to ensure documentation is present and accurate and complete with medication administration, transcription errors, pain assessment and restorative care.<br><br>DON and/or will review medical records for all Residents to ensure documentation is present and | 1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10<br><br>1.13.10 |

DEPARTMENT OF HEALTH AND HUMA[illegible]ERVICES
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| F 312 | Continued From page 27<br>assistance for dressing and personal hygiene.<br><br>b. Observations and staff interviews for resident #7 included:<br><br>1) 12/1/09 at 8:25 AM on the initial tour of the facility with Nurse (A), resident #7 was identified as having skin breakdown after return from the hospital with pneumonia. Staff identified the resident as having an area of black eschar to the right heel and recurring skin issues on the coccyx.<br><br>2) 12/2/09 at 9:35 AM CNA (F) and the PT (physical therapist) were observed transferring resident #7 into bed by using a two person lift. The resident was positioned on his back in bed. Staff (F) donned gloves to do perineal care. The resident was noted to have a large yellow liquid stool. Staff (F) used a disposable wipe down each side of the resident's groin and one wipe over the penis. The CNA did not retract resident's foreskin over the penis when peri-care was provided.<br><br>The resident was then turned on to his right side. Staff was observed to touch the soaker pad, sheets, and disposable wipes container with soiled gloves. Staff (F) used multiple wipes over the buttock to remove the liquid stool. The resident was noted to have an open area over the coccyx. The CNA had used multiple wipes over the open area to removed the liquid stool before being asked to check if the area was open.<br><br>The DON(director of nursing) who was also observing the care confirmed the area was open and applied a dressing to the area before care ended. The CNA was noted to continue with care by applying a new brief on the resident while touching the resident's pants and bedding with | F 312 | F514 cont'd:<br>accurate and complete with medication administration, transcription errors, pain assessment and restorative care.<br><br>DON and/or designee will audit the medical records to ensure documentation is present and accurate and complete with medication administration, transcription errors, pain assessment and restorative care two times per week for two months and randomly thereafter.<br><br>Results of audits will be presented to the weekly Risk committee and the quarterly Quality Assurance Committee. | 1/13/10<br><br>1/13/10 |

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| F 312 | Continued From page 28 | F 312 | | |

1) 12/1/09 at 8:25 AM on the initial tour of the facility with Nurse (A), resident #7 was identified as having skin breakdown after return from the hospital with pneumonia. Staff identified the resident as having an area of black eschar to the right heel and recurring skin issues on the coccyx.

2) 12/2/09 at 9:35 AM CNA (F) and the PT (physical therapist) were observed transferring resident #7 into bed by using a two person lift. The resident was positioned on his back in bed. Staff (F) donned gloves to do perineal care. The resident was noted to have a large yellow liquid stool. Staff (F) used a disposable wipe down each side of the resident's groin and one wipe over the penis. The CNA did not retract resident's foreskin over the penis when peri-care was provided.

The resident was then turned on to his right side. Staff was observed to touch the soaker pad, sheets, and disposable wipes container with soiled gloves. Staff (F) used multiple wipes over the buttock to remove the liquid stool. The resident was noted to have an open area over the coccyx. The CNA had used multiple wipes over the open area to removed the liquid stool before being asked to check if the area was open.

The DON(director of nursing) who was also observing the care confirmed the area was open and applied a dressing to the area before care ended. The CNA was noted to continue with care by applying a new brief on the resident while touching the resident's pants and bedding with the same soiled gloves. The CNA then picked up the wipes container and placed it back into the dresser before removing the gloves and washing hands. The CNA did not change her gloves or do

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| F 312 | Continued From page 29<br>handwashing until this entire observation was done.<br><br>3) Interview with the DON following the care observed confirmed perineal care was not done in a manner to ensure proper perineal care of a male resident and staff did cross contaminate multiple items with soiled gloves. | F 312 | | |
| F 314 SS=D | 483.25(c) PRESSURE SORES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and staff interview, it was determined that the facility failed to provide a system/procedure to assure skin/wound assessments were timely and appropriate and interventions were implemented, monitored, and revised as appropriate for three of 11 sample residents (#3, #4, and #7). These residents were facility assessed to be at risk for the development of pressure ulcers. The findings included:<br><br>1. Record review for resident #3 revealed that the resident was admitted on 7/10/09 with diagnoses that included end stage liver disease (ESLD), fractured hip, open wounds, pneumonia, depressive disorder, abdominal pain, loss of | F 314 | | |

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| F 314 | Continued From page 30<br>weight, and insomnia. The resident was receiving services from Hospice.<br><br>a. The Director of Nursing (DON) was requested to provide evidence of wound tracking for this resident's pressure ulcers. The wound assessments were not kept in the resident's record, but were in a separate book which she indicated did not become part of the resident's permanent record.<br><br>b. Review of the resident's pressure ulcer tracking as copied from the facility's tracking book and documented on the Wound/Skin Record or the Skin Condition Record, included:<br><br>12/29/08 - 1/6/09: Site A which was ongoing and located on the coccyx and Site B which was ongoing and located on the back of the right thigh<br><br>Undated page of tracking for three Sites on the coccyx<br><br>1/13/09: Site A and B<br><br>7/16/09 (time of readmit to the facility): coccyx noted as present on admit - size 2.5 x 1.8 with no depth<br><br>7/23/09: 2.8 x 2.3 no depth - deteriorated<br><br>8/5/09: 3.4 x 3.0 x 0.7 - deteriorated - air overlay coming from hospice<br><br>8/13/09: 5.0 x 6.5 x 0.5 - deteriorated with moderate drainage, strong odor, wound bed black<br><br>8/20/09: 6.5 x 5.3 x 0.7 - deteriorated with moderate drainage, strong odor, black eschar, | F 314 | | |

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| F 314 | Continued From page 31<br>some slough.<br><br>9/28/09 - Rt scapula: L (length) 5 1/2 cm, W (width) 3 1/2 cm, D (depth) 1/2 cm; Coccyx: L 4 3/4 cm, W 5 1/4 cm, D 1/8 - 1/4 cm; Rt hip: L 6.5 cm, W 4 1/8 cm, D 2 1/4 cm. These were listed as Stage IV. (Note: This was the first Staging assessment found for these wounds.)<br><br>10/8/09 - R scapula, Stage III, 3.8 cm X 2.7 cm; R hip, Stage IV, 5.8 cm x 3.3 cm x 2.0 cm; coccyx, Stage III, 5.0 cm x 4.5 cm x 0.4 cm. no drainage.<br><br>11/2/09 - R scapula, Stage II, 3.5 cm x 2 cm x 1/2 cm; coccyx 4 cm x 5 cm x .25 cm; hip 3 cm x 4 cm x 1(?) cm; ankle (new) 1/2 x 1/2. Clear drainage from coccyx and serous from hip.<br><br>11/13/09 - R scapula, Stage II, .5 x .4 cm; R hip, Stage IV, 1 cm x 1 1/2 cm, yellowish serous drainage; coccyx, Stage IV, 1.5 x 1.1, no drainage.<br><br>11/23/09 - R scapula, no Stage noted, 1.5 x 1.5; R hip, no Stage noted, 3.5 x 3.5; coccyx, no Stage noted, 3 x .5 , yellow slough. No drainage noted.<br><br>c. Review of the Interdisciplinary Progress Notes (IPNs) revealed the following:<br><br>9/11/09: wounds on coccyx (5.5 cm x 5 cm with 0.8 cm deep), right hip (6.0 cm x 4.0 cm with 2 cm deep), and right scapula (5.5 cm x 3.5 cm with 0.5 cm deep). Also right malleolus 0.7 cm x 0.4 cm, haloed by 1.5 cm. (Note: A nurse's note indicated that the resident left on pass on 9/5/09 and would return on Tuesday, or 9/8/09. The 9/11/09 note was the next documentation in the | F 314 | | |

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| F 314 | Continued From page 32<br>IPNs so it was not clear when the resident returned to the facility or what his/her skin condition at that time.)<br><br>Several IPNs noted drainage from the wounds. However, the next IPN which related to the wound size was dated 10/9/09 from wound rounds. It revealed "Wound on R (right) scapular region measures 3.8 cm length, 2.7 cm width and approximately 0.4 cm depth. ... R hip measures 5.8 cm length, 3.3 cm width and 2.5 cm deep. ... Coccyx wound measures 5.0 cm in length by 4.5 cm with x 0.4 cm deep. ..."<br><br>11/19/09: (next IPN related to wound measurement) - R scapular 5 x 2.5 depth 0.5 .... coccyx wound 3 x 3.5 .... R hip 3 x 3 depth 1".<br><br>No additional IPNs related to wound size through 12/1/09.<br><br>d. On 12/2/09 at 11:38 AM, nurse (H) was observed doing wound care for resident #3. The resident was standing in the shower room while the dressing change was done. The following observations were made:<br><br>When the dressing on the right hip was removed, there was a moderate amount of greenish drainage on the dressing. This drainage had soaked through the dressing. The wound appeared to be a Stage IV. When the nurse was questioned about the Stage of wound, she agreed it was probably a Stage IV based on the appearance of the wound. The wounds were not measured during this dressing change.<br><br>After the resident showered, the nurse put Calcium Alginate in the open pressure ulcers on | F 314 | | |

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| F 314 | Continued From page 33<br>the coccyx and hip and covered these with dressings.<br><br>The facility failed to track/assess the resident's changes in his/her skin condition and failed to maintain the assessments that were reportedly done in the resident's permanent medical record.<br><br>2. Resident #7's medical record review revealed the resident was admitted to the facility on 5/24/02 with diagnoses which included: Parkinson's disease, diabetes, above knee amputation of the left leg, PVD (peripheral vascular disease), CVD (cardiovascular disease), blindness, insomnia and pain.<br><br>a. Review of the significant change MDS (Minimum Data Set) assessment dated 8/23/09 identified the resident as being total care and as having skin ulcers. The assessment included: Total dependence (full staff performance) with two staff persons physical assistance for bed mobility, transfers, and toilet use, Total dependence with one staff person physical assistance for dressing and personal hygiene.<br><br>b. On 12/2/09 at 9:35 AM CNA (F) was observed providing perineal care for resident #7. The resident was noted to have an open area over the coccyx. The DON who was also observing the care confirmed the area was open and applied a dressing to the area and reported it as a reoccurring area of breakdown.<br><br>c. Review of the record identified the resident as being admitted to the hospital for acute respiratory infection 9/28/09 and for pneumonia on 10/28/09. The resident returned to the facility | F 314 | | |

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| F 314 | Continued From page 34<br>on 11/1/09. Review of the hospital the discharge instructions for PT (physical therapy) to see resident for pressure ulcer on the right heel.<br><br>d. Review of the "Pressure Ulcer Risk Assessment/Prevention Intervention Protocol" sheet identified the last assessment date of 8/21/09 which identified the resident at 18 (high risk) for pressure ulcers.<br><br>e. Review of the "Interdisciplinary Progress Notes" dated 11/09 documented the residents return to the facility but did not address the resident's skin assessment or skin breakdown.<br><br>On 11/3/09 the RD noted, "RD informed resident has open wounds on his body upon readmit from the hospital."<br><br>On 11/5/09 nursing noted superficial open areas on buttocks peeling.<br><br>There was no documentation in the resident record by nursing of a complete skin assessment upon readmit to the facility for a resident at high skin risk.<br><br>At the time of survey 12/2/09 the resident was observed to have an open area on the coccyx, and an unstageable area of eschar to the right heel identified by PT as "4.2 cm x 2.4 cm".<br><br>f. Review of a "Skin Reference Sheet (to be completed weekly and PRN by a licensed nurse)" dated 10/8/09 identified an area on the right hip. However the sheets had not been completed weekly to address the skin issues the resident had on readmission to the facility. | F 314 | | |

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| F 314 | Continued From page 35<br>g. Interview with the DON, Nurse (A) and Nurse (B) confirmed skin documentation had been an issue and there had been changes in the assessment forms. The DON confirmed that she had been doing weekly skin rounds and provided a "Weekly Wound Rounds Tracking Sheet" with documentation on all residents identified with skin issues. They also confirmed that the documentation from the "Weekly Wound Rounds Tracking Sheet" did not get put in or become part of the individual resident's medical record.<br><br>This sheet did identify resident #7 with an open area to the coccyx. However there was no documentation of interventions done to address the area.<br><br>2. Resident #4 medical record review revealed the resident was admitted to the facility on 7/12/09 with diagnoses including: diabetes, hypertension, PVD, peripheral vascular disease, cardiovascular disease, arthritis, COPD (chronic obstructive pulmonary disease), pain and wound infection with partial amputation of the left foot. The resident had been admitted to the hospital on 7/3/09 and returned on 7/12/09.<br><br>a. Review of the "Interdisciplinary Progress Notes" dated 7/21/09 include a skin assessment. Then on 7/24/09 during wound rounds the resident was identified as having three open areas on the coccyx. The physician was notified and treatment discussed with the resident. The resident reported the areas had developed in the hospital.<br><br>There was no documentation of a complete skin assessment on return from the hospital for this high risk resident to ensure timely care and follow | F 314 | | |

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| F 314 | Continued From page 36<br>up for skin breakdown.<br><br>Reference: Professional Standards of Practice:<br><br>According to the CMS (Centers for Medicare and Medicaid) RAI (Resident Assessment Instrument) Version 2.0 Manual, revised last in June, 2005, Chapter 3, page 3-160: "If necrotic eschar is present, prohibiting accurate staging, code the skin ulcer as Stage '4' until the eschar has been debrided (surgically or mechanically) to allow staging."<br><br>According to the "Clinical Practice Guidelines, Pressure Ulcer Treatment" (pages 12-13) used by the facility as a treatment reference, a stage I pressure area is an area of erythema of "intact" skin. AA Stage II is a partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial & presents clinically as an abrasion, blister, or shallow crater. Inconsistent or inaccurate staging of ulcers has the potential for implementation of inappropriate or inadequate treatment. A stage III pressure ulcer is a full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. When eschar is present, a pressure ulcer cannot be accurately staged until the eschar is removed. Eschar is described as thick, leathery, frequently black or brown in color, necrotic (dead) or devitalized tissue that has lost its usual physical properties & biological activity. Eschar may be loose or firmly adhered to the wound.<br><br>According to "Pressure Ulcers in Adults: Prediction and Prevention", U.S. Department of | F 314 | | |

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| F 314 | Continued From page 37<br>Health and Human Services, Clinical Practice Guideline, Number 3, "Any person at risk for developing a pressure ulcer should avoid uninterrupted sitting in any chair or wheelchair. The individual should be repositioned, shifting the points under pressure at least every hour or be put back to bed if consistent with overall patient management goals."<br><br>According to "Pressure Ulcer Treatment", U.S. Department of Health and Human Services, Clinical Practice Guideline, Number 15, the resident should have an individually prescribed seat cushion which will relieve or reduce pressure on bony prominences. Support surface and positioning needs should be assessed and reviewed regularly and determined by results of skin inspection, patient comfort, ability, and general state. Covering these support services with bed linens, towels or incontinent pads decreases their effectiveness for pressure relief. | F 314 | | |
| F 371 SS=E | 483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE<br><br>The facility must store, prepare, distribute, and serve food under sanitary conditions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined that the facility failed to store, prepare, and distribute food in a manner that minimized the potential for the spread of food-borne illness. The findings included:<br><br>1. On 12/1/09 at 9:10 AM, during the initial dietary | F 371 | | |

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| F 371 | Continued From page 38<br>tour in the presence of the Dietary Manager (DM), the following observations were made:<br><br>a. The garbage disposal in the dishwashing room did not have a cover gasket to prevent garbage from splattering out when the disposal was operating. The wall behind the garbage disposal was observed to have splatters on it. The DM indicated that the staff use a tray to cover it.<br><br>b. In the dry storage area, there were two boxes sitting on the floor, a 25 pound sack of bread crumbs was standing open, and a bag of cheesecake mix was open and not sealed or placed in another closed container.<br><br>c. Throughout the kitchen, the floor under and behind equipment and shelving was dirty and in need of cleaning.<br><br>d. The narrow slot between the hood sections above the stove was very greasy and sticky to touch.<br><br>e. In the dining room, the small refrigerator located under the counter was observed to be dirty with spills. The freezer section had an ice build-up of up to three inches thick and there were spills inside this section of the refrigerator.<br><br>2. On 12/3/09 at 11:30 AM during an observation in the medication storage room located behind the nurses station, there was an open undated case of crackers. The outside of the box was grease stained. Inside the box, there were open packages of crackers. The Director of Nursing was present during this observation and indicated that she was not aware of the crackers being stored open. She commented that these crackers | F 371 | | |

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| F 371 | Continued From page 39<br>were kept for residents who might be hungry.<br><br>3. On 12/3/09 at 12:02 PM, during an observation of the meal service for the noon meal, dietary staff member (K) was observed to touch his/her hair with gloved hands. Staff member (K) touched each resident's tray and glasses of liquid. The gloves were not changed throughout the entire meal. | F 371 | | |
| F 441 SS=F | 483.65(a) INFECTION CONTROL<br><br>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined that the facility failed to ensure that staff techniques during cares minimized the potential for cross contamination and the spread of infections. Additionally, the facility failed to maintain resident care equipment in a clean, sanitary manner. The findings included:<br><br>WOUND CARE:<br><br>1. On 12/2/09 at 11:38 AM, nurse (H) was observed doing wound care for resident #3. The resident was standing in the shower room while | F 441 | | |

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| F 441 | Continued From page 40<br>the dressing change was done. The following observations were made:<br><br>When the dressing on the right hip was removed, there was a moderate amount of greenish drainage on the dressing. This drainage had soaked through the dressing.<br><br>The nurse placed the spray bottle of wound cleaner on a towel which was already lying on the floor in the shower. Then she used 4 x 4 gauze pads moistened with the wound cleaner to clean the area. When a soiled 4 x 4 was held under the wound, the spray bottle was used to spray the wound. The edge of the bottle touched the soiled 4 x 4. The bottle was placed back on the towel on the floor and then it was moved onto the cart with the package of 4 x 4 s.<br><br>At 12:08 PM, after the resident showered, the nurse put Calcium Alginate in the open pressure ulcers and covered these with dressings.<br><br>The resident touched the remaining Calcium Alginate and closed the package. He/she put the Calcium Alginate, the package of 4 x 4 s, and the contaminated wound cleaner bottle in the cabinet in the shower room.<br><br>2. On 12/2/09 at 10:00 AM the PT (Physical Therapist) was observed providing wound care for resident #7. The resident had a pressure sore on the right heel. The PT reported that the resident had been seen by PT for sharps debridement of the wound. The DON (director of nursing) was also present and had washed her hands and donned gloves to hold the resident's right ankle. The PT had washed her hands, donned gloves and removed the dressing from | F 441 | | |

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| F 441 | Continued From page 41<br>the resident's right heel. There was a small amount of drainage noted on the dressing as it was placed in a plastic bag. The PT then opened a single use "Debridement Kit". A wrapped tray which contained gloves and instruments was opened and set up on the bed. This set up was done with the same dirty gloves used to removed the dressing.<br><br>After the set up was done the PT removed her gloves and used hand sanitizer before putting on the gloves from the kit and proceeded to peel back and cut small pieces of black tissue from the wound. The PT was observed to use her left gloved hand to push back her hair around her ear and continued with wound care. The DON then left the room to get a dressing for the wound. The dressing was opened by the DON and removed by the PT. The dressing was cut to shape around the resident's heel. Before the dressing was applied an applicator was used to cover the wound with Hydrogel.<br><br>Interview with the DON on 12/3/09 at 10:20 AM confirmed she had concerns with the wound care observed on 12/2/09 with resident #7.<br><br>CLEANING OF EQUIPMENT:<br><br>1. On 12/2/09 at 11:20 AM nurse (C) was observed to pick up a tray identified as a "blood sugar tray" and entered resident #4's room to check the resident's blood sugar. The nurse placed the tray on the bedside stand, donned gloves, wiped the resident's finger tip with an alcohol wipe and poked the resident's finger with a lancet. The Glucometer was then picked up, scan strip placed into the machine and strip was | F 441 | | |

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| F 441 | Continued From page 42<br>touched to blood on the finger. The scan identified the blood sugar at 224. The strip was removed from the machine and with the gloved hand the Glucometer was placed back into the "blood sugar tray" on top of other supplies including gloves and alcohol wipes. Nurse (C) then left the room with the tray and returned the tray to the nurses station. The nurse did not clean the glucose monitor after resident use.<br><br>2. On 12/2/09 at 1:48 PM, nurse (H) was preparing to use the Glucometer to check resident #8's blood sugar. Due to the earlier observation of the use of the Glucometer which was returned to the tray without being cleaned, the Director of Nursing was asked how the Glucometer was cleaned. She revealed that it was cleaned with alcohol. The earlier observation was discussed with her. She said that she had seen the nurses clean the instrument with alcohol (in the past). The surveyor asked her if the facility had the manufacturer's instructions for how to clean it.<br><br>Nurse (H) waited to do resident #8's blood sugar until the cleaning protocol could be determined.<br><br>Nurse (A) printed the manufacturer's instructions for "Precision Scan" off the Internet. The instructions stated: "Healthcare professionals: Acceptable cleaning solutions include 10% Bleach, 70% Alcohol, or 10% Ammonia."<br><br>The DON, nurse (H), and the surveyor discussed the need to clean the instrument and the contaminated tray. This cleaning was completed and nurse (H) was observed to check the resident's blood sugar. | F 441 | | |

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| F 441 | Continued From page 43<br>3. On 12/1/09 at 9:00 AM during the initial tour of the facility issues were identified with resident equipment. Resident #7 was noted to have a fan in his/her room. The fan was dirty and in need of cleaning. The oxygen concentrator had a filter which had a build up of dust and was in need of cleaning. There was also a nebulizer set up on a small dresser. The nebulizer was noted to have moist and residue left in the cup. Nurse (A) reported that the nebulizer was supposed to be cleaned after each use.<br><br>PERINEAL CARE:<br><br>1. On 12/2/09 at 1:55 PM, Certified Nurse Aide (CNA) (J) was observed in the presence of nurse (H) assisting resident #26 with toileting. The resident was taken into the bathroom, stood up, and transferred to the toilet. The CNA removed the resident's brief, which she verified was wet and fecal soiled. The CNA touched the resident's wheelchair handles, items in the resident's bathroom, and rubbed the resident's back. The resident used the toilet and was provided peri-care by the CNA. The CNA wiped the resident from the back side, reaching between his/her legs. The resident's front perineal area, groin, and buttocks were not cleaned. The CNA indicated that the resident had urinated and had a bowel movement in the toilet. The CNA pulled the clean brief and pants up and transferred the resident to his/her wheelchair. The CNA did not change her gloves or do handwashing until this entire procedure was completed.<br><br>2. On 12/2/09 at 9:35 AM CNA (F) was observed providing perineal care for resident #7.<br>Care was not done in a manner to ensure proper | F 441 | | |

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| F 441 | Continued From page 44<br>perineal care of a male resident and prevent cross contamination of multiple items with soiled gloves. (Cross refer to F 312)<br><br>HANDLING OF LINENS:<br><br>On 12/2/09 at 1:50 PM CNA (E) was observed coming out of a resident room with gloved hands carrying a plastic bag in one hand and clothing in the other. The CNA was observed to take a key to open the door to the soiled utility room on the 200 wing with gloved hands. The CNA identified the clothing as being soiled. The CNA then returned the key to the hook and returned to the resident's room.<br><br>Interview with Nurse (A) the infection control coordinator confirmed that staff was to bag soiled linen before taking it out of the resident's room. Staff failed to handle linens in a manner to limit the potential spread of infection.<br><br>REFERENCES: CDC MMWR 2005 / 54 (09); 220-223,<br>Recommended Infection-Control And Safe Injection Practices to Prevent Patient To Patient Transmission of Bloodborne Pathogens:<br>Diabetes Care Procedures & Techniques<br>"...Environmental surfaces such as glucometers should be decontaminated regularly and anytime contamination with blood or body fluids occurs or is suspected. Glucometers should be assigned to individual patients. If a glucometer that has been used for one patient must be reused for another patient, the device must be cleaned and disinfected..." | F 441 | | |
| F 467 SS=E | 483.70(h)(2) OTHER ENVIRONMENTAL CONDITIONS - VENTILATION | F 467 | | |

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| F 467 | Continued From page 45<br>The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined that the facility failed to ensure that the ventilation system was adequate to remove the smoke from the smoking room and to provide functioning ventilation in resident bathrooms on the 100 hallway in order to minimize odors. The findings included:<br><br>During the environmental tour on 12/3/09, starting at 10:40 AM, with the Administrator and the Maintenance Supervisor, the following issues with mechanical ventilation were identified:<br><br>a. The mechanical ventilation was checked in resident room 103 and was found to not work. The Maintenance Supervisor reported that all residents' bathroom ventilation on the 100 wing ran off one unit and the 200 wing ran off a separate unit or system. The ventilation system on the 100 wing not working affected 11 resident rooms and 17 residents. The 200 wing was checked and found to be working.<br><br>b. The facility had a "Smoking Room" which was checked on tour. At the time the room was checked, there were no residents smoking. However, the odor of smoke was strong and pervasive. The room had three mechanical vents which were checked. The small square vent had no pull of air from the room when it was checked with a tissue by maintenance. The large square vent had no draw of air or smoke from the room. | F 467 | | |

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| F 467 | Continued From page 46<br>The third vent was a round unit attached to a light. The vent did draw the tissue up but it was not sustained. The Maintenance Supervisor confirmed that the mechanical ventilation or exhaust in the "Smoking Room" was not sufficient. During the observation of this room, it was also noted that the room had a sliding window which was opened two to three inches. The outside temperature was approximately 10 degrees. Even though the cold air was noted coming into the room, the strong odor of smoke remained. The facility failed to ensure the "Smoking room" was well ventilated to accommodate those residents who wished to smoke. | F 467 | | |
| F 514 SS=E | 483.75(l)(1) CLINICAL RECORDS<br><br>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.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, it was determined that the facility failed to ensure that medical records were accurate and complete. The findings included: | F 514 | | |

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| F 514 | Continued From page 47<br>1. The facility failed to maintain accurate, complete and organized clinical information for residents needing diabetic management for resident #4 and #8. An example included:<br><br>Review of the medical record for resident #8 revealed the resident was admitted to the facility on 11/19/08 with diagnoses that included malignant neoplasm of bronchus and lung, chronic kidney disease, diabetes mellitus, and congestive heart failure.<br><br>a. November physician orders included; ACCU-CHEK Easy Test F-stick QD (every day) AC (before meals), (Prescribed 4/1/09);<br><br>Lantus insulin 30 units subq (subcutaneous) (QD (every day) (ordered 4/1/09);<br><br>Insulin reg (regular) 3 units subq BID (twice each day) (ordered 4/21/09);<br><br>Insulin reg 4 units subq PRN If blood sugar >400 (Prescribed 2/4/09).<br><br>b. Review of the Medication Administration Record instructions, revealed the following instructions:<br><br>A.) Initial appropriate box at time medication administered.<br>B.) Circle initials when medication refused.<br>C.) State reason for refusal on NURSES Notes.<br>D.) State reason PRN MEDICATION GIVEN and Results<br>E.) Date and initial all DC-Changes ME.<br>F.) indicate site of injection with appropriate number on medication record. | F 514 | | |

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| F 514 | Continued From page 48<br>c. Review of the Medication Administration Record for November 2009 revealed incomplete documentation.<br><br>1) Under the Medication area for ACCU-CHEK EASY TEST scheduled at 05:00, 11:00 and 17:00:<br><br>There was no documentation for 11/10/09 at 17:00.<br><br>There was no documentation for 11/11/09 at 11:00 and 17:00.<br><br>There was no documentation for 11/12/09 at 11:00 and 17:00.<br><br>There was no documentation for 11/27/09 at 17:00.<br><br>2) Under the Medication area for Lantus Insulin 30 Units Subq QD 8:00<br><br>There was no documentation under site for 11/6, 8, 11, 17, 18, 22, 24, 26 and 27.<br><br>3) Under the Medication area for Insulin Reg 3 Units subq BID 9:00 and 13:00<br><br>There was no documentation under site for 9:00 on 11/3, 6, 8, 9, 10, 12, and 22.<br><br>There was no documentation under site for 13:00 on 11/6, 7, 8, 9, 10, 21, 22, 24, 25 and 26.<br><br>4). Under the Medication area of Insulin Reg 4 Units Subq PRN<br><br>There was no documentation regarding the units | F 514 | | |

| 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 _____ | 12/04/2009 |

| 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 |
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| F 514 | Continued From page 49<br>administered and the time on 11/5, 20 and 25. Cross refer to F309<br><br>2. The facility failed to maintain accurate, complete and organized clinical information for residents following dialysis. There was no docuemtation to show residents returning from dailysis recieved timely assessment of access site, monitoring of access site for infection, potential adverse effects and dialysis care. This was identified for resident #11. Cross refer to F309<br><br>3. Review of the medical records for resident #7 and #4 identified the residents with skin breakdown. There was no documentation of a complete skin assessment on return from the hospital for these residents at high risk for skin breakdown to ensure timely care and follow up. Additionally, resident #3 was identified with chronic wounds and had a lack of documentation to show monitoring and follow-up. Cross refer to F314<br><br>4. The facility failed to ensure documentation was accurate and complete with medication administration, transcription errors, pain assessment and restorative care for 6 of 11 sample residents (#2, #3, #5, #6, #7, and #9) and one supplemental resident (#26).<br>Cross refer to F281<br><br>STANDARD OF PRACTICE:<br>A. ADMINISTRATION of MEDICATIONS<br>According to "Fundamentals of Nursing," by Harkreader & Hogan, 2nd Edition, (2000), pages 409 and 411, "Use a systematic method of checking medications during preparation to | F 514 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 514 | Continued From page 50<br>prevent possible errors. The new gold standard system of checking used by nurses is called the "six rights" (the original five rights plus a sixth)---right drug, right dose, right client, right route, right time, and right documentation."<br>Standards for nursing practice for administration of medication provide, in pertinent part that: The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's order unless they believe the orders are in error or would harm clients.<br>Medications must be accurately administered and documented. Accurate administration includes, in the first instance, a physician order authorizing the administration of the medication; if an order is not clear, the nurse should communicate with the physician to seek clarification. Thereafter, accurate administration includes transcribing the drug order correctly, delivering the correct drug, to the correct resident, by the correct route, in the correct dose. Accurate documentation involves recording information on the drug administered, including the client's response to the medication. The physician may order a drug on a PRN basis (when a client requires it). The nurse uses objective assessments, subjective assessments, and discretion in determining the client's need. When medications are administered, the nurse documents the assessment made and the time of drug administration. The nurse should make frequent evaluation of the effectiveness of the drug and record findings in the appropriate place.<br>See generally: Lippincott, Nursing Drug Guide, 1998 (Lippincott) and Perry & Potter, Clinical Nursing Skills & Techniques; 1998, (Perry & Potter). | F 514 | | |