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

PRINTED: 07/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING _____ B. WING _____	C 07/12/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide ADON- Assistant Director of Nursing DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set CAA- Care Area Assessment RN- Registered Nurse MAR- Medication Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000	F000 No deficiency was listed. F164 (SS=E) A. No Resident was listed in section leaving no direct POC. B. Education: In-service with staff to remind them of the HIPPA regulations and Resident Rights. Nursing staff are reminded of HIPPA regulation at "stand up" meetings held 3 or more times M-F. Residents are aware that the social worker is their personal advocate and if they feel their rights are being violated the social worker is their advocate. At which time the social worker will make sure to address the issue with staff and/or resident. Facility: MSCC's Nurse's Station is the hub located right in the center of the facility. All information is exchanged at this location. MSCC does not have the financial means at this time to enclose the nurse's station therefore alternative solutions are necessary. Alternative: MSCC has a records room/staff room for nursing staff to use to consult in privacy with each resident, resident family member, or staff member about personal information. For phone calls that require personal consultation with physician, family, ect. can be conducted in the records room. C. Each resident is disclosed "Resident Rights and MSCC Privacy Practices" at time of admission. Each resident signs a release of information of medical records at time of admission. System changes: no system change is needed – education	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/11/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
SEP 11 2012
Healthcare Licensing and Surveys
WY Dept of Health

POC emailed. Call to Marc Martin, Administrator on 9/14/12 @ 1:45 pm.
Janelle Carlson RC

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 25UR11 Facility ID: WY0017 If continuation sheet Page 1 of 46

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and review of council minutes, the facility failed to ensure privacy was maintained for residents, including sample resident #16. The census was 36. The findings were: 1. Review of the resident council meeting minutes from 6/14/12 showed "Residents also feel that HIPPA is being violated by some of the nurses when they are giving out information about a resident, as this is done in front of other residents who are sitting in the halls or walking by and they can hear what is being said." Confidential interview with nine residents on 7/10/12 at 9:30 AM verified they have heard nurses talk about personal and private resident information when they were out and about in the facility. Interview with the DON on 7/10/12 at 9:20 AM revealed discussing residents and their personal information where others could hear was not acceptable. 2. Observation on 7/10/12 at 9:40 AM showed the social worker was having a conversation with resident #16 concerning the resident's hospice care in his/her room. The door was wide open to the hallway and the resident's roommate was	F 164	and strict enforcement of MSCC Resident Rights and Privacy Practices. D. Monitor PCC: Administrative Nursing Staff will be on the floor more interacting with residents and staff. Any information shared about residents or staff not done in confidentiality will be addressed and corrected. DON's office will be moved to the former Beauty Shop across from the Nurse's Station. This will allow for more visibility of Administrative Nursing Staff and allow DON to hear what is happening on the floor. If sharing of privet information is heard then DON will correct the issue. Continued education with staff and residents during in-service at least once annually and weekly "stand-up" meetings. Any Grievance/Complain Forms filled out by residents or mention of HIPPA infractions by staff or residents during Resident Council Meetings will be investigated, addressed, and corrected. Staff found violating HIPPA will be verbally corrected 1 time, formal write up the 2nd time, and terminated the 3rd time. The quality assurance on HIPPA is to continue to offer annual refreshers of HIPPA during in-service and weekly reminders during "stand-up". Review of quality assurance will be the sign in sheet of those employees that attending in-service and stand-up meetings. Staff found violating HIPPA regulations by DON will be documented and reviewed at weekly RISK/QA Committee Meeting. Administrative Nursing Staff will make sure all staff have HIPPA training within	

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and review of council minutes, the facility failed to ensure privacy was maintained for residents, including sample resident #16. The census was 36. The findings were: 1. Review of the resident council meeting minutes from 6/14/12 showed "Residents also feel that HIPPA is being violated by some of the nurses when they are giving out information about a resident, as this is done in front of other residents who are sitting in the halls or walking by and they can hear what is being said." Confidential interview with nine residents on 7/10/12 at 9:30 AM verified they have heard nurses talk about personal and private resident information when they were out and about in the facility. Interview with the DON on 7/10/12 at 9:20 AM revealed discussing residents and their personal information where others could hear was not acceptable. 2. Observation on 7/10/12 at 9:40 AM showed the social worker was having a conversation with resident #16 concerning the resident's hospice care in his/her room. The door was wide open to the hallway and the resident's roommate was	F 164	30 days of hire and triggered on Silverchair Learning annual refreshers. Audit of these trainings not completed by staff will be conducted by Administrative Nursing Staff monthly. Audit reports can be found in Administrative Nursing office. Staff found to be out of compliance with refresher courses will be reported at weekly RISK/QA Committee meetings. E. Completion Date: 8/24/2012. 2. a. Resident #16: No POC is needed considering the event has since passed and social worker was addressed by survey staff of found deficiency. b. Social Worker has been reminded of the MSCC privacy policies and is aware that meetings with residents need to be held in privacy. Administrator asked the social worker to review the NASW Code of Conduct. c. No system changes are needed just a reminder of the privacy practices of MSCC. d. Administrator and Administrative Nursing Staff will address any violations of HIPPA by the social worker. Any Grievance/Complain Forms filed out by residents or mention of HIPPA infractions by staff or residents during Resident Council Meetings will be investigated, addressed, and corrected. Staff found violating HIPPA will be verbally corrected 1 time, formal write up the 2nd time, and terminated the 3rd time. The quality assurance on HIPPA is to continue to offer annual refreshers of HIPPA during in-service and weekly reminders during "stand-up". Review of quality assurance will be the sign in sheet of those employees that attending in-service and stand-up meetings. Audit of Grievance/Complaint Forms will be conducted	

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F 164	Continued From page 2 present in the room. From the hallway this surveyor could hear the conversation as they discussed changing from hospice services/care. Interview with the social worker on 7/11/12 at 4:26 PM revealed the conversation should have been held in a private area.	F 164	by Administration monthly. The number of Grievance/Complaint Forms plus investigation will be documented and reviewed during weekly RISK/QA Committee Meeting. e. Completion Date: 8/24/2012.	
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of	F 203	F203 (SS=D) a. Resident #37 was properly notified on 7/13/2012 by social worker with a discharge letter and a list of grievances/complaints. b. As of 7/13/2012 MSCC has implemented a discharge policy created by the social worker. Residents discharging because they have met their rehabilitation requirements will meet with the interdisciplinary team, family, and any other linked service providers. At this time it will be asked what expectations are needed once the resident matriculates back into the community. If discharge is reachable then a discharge date is established. For those residents that are involuntarily being discharged from MSCC because they meet 1 of the 5 requirements (example: residents has not paid their bill, MSCC cannot offer the level of care they need, or the facility closes) then a Discharge Letter is sent to the resident's responsible party. At this time the family can appeal within the 30 days allowed. The social worker will confirm placement at another facility if needed prior to sending out the discharge letter. c. System Changes: Interdisciplinary Team must meet prior to any discharge to confirm discharge is best for the resident. If there is a consensus on discharge then a discharge date will be established. If there isn't a consensus then a plan for exhausting all resources/interventions will be put in place and evaluated in 30 days.	

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F 203	Continued From page 3 this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a discharge notice was provided for 1 of 1 sample resident (#37) who the facility discharged. The findings were: Review of the medical record for resident #37 showed s/he was transferred to another facility for a psychological evaluation on 6/11/12. Interview with the administrator on 7/12/12 at 10:46 AM verified the resident was not admitted back to the facility due to safety concerns for staff and other residents. At that time, the administrator also verified a notice of discharge with the required elements had not been sent to the resident. The	F 203	d. MSCC records clerk will audit each resident file that was discharged after 7/13/2012 to confirm discharge documents are in the file and all discharge dates have been achieved. If there are documents missing or dates that have not been met then the records clerk will address the issue during RISK/QA Committee meeting which is held weekly with all administrative staff and medical director. The quality control will be the audits conducted by the records clerk and any deficiencies will be collected and placed in the medical records. All audits and confirmation that discharge process has been implemented can be found in the medical records of any residents discharged after 7/13/2012. A report of discharged residents will be presented during weekly RISK/QA Committee meetings and any files missing proper discharge documents will be reported by records clerk. e. Completion Date: 8/24/2012	

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F 203	Continued From page 4 administrator also acknowledged that she was not aware of these specific requirements.	F 203		
F 225 SS=E	483.13(c)(1)(i)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225	F225 (SS=E) a. The state survey indicated that 3 of 3 allegations involved abuse or misappropriation of funds but no resident numbers were referenced for MSCC to address POC. b. The policy for reporting abuse and negligent has been updated to show all reporting agencies. Each incident is documented, investigated, reported to all correct agencies, and filed for review to be signed off by medical director at each weekly RISK meeting. Each report that is faxed to specific agency will have a copy of the fax confirmation attached to the incident report. c. No system changes are needed. Education from survey staff as to what agencies needed to be notified helped to revise current policy. It was indicated by survey staff that we were doing the right steps but could not verify State Agency was notified of incidents. This has since been corrected. d. All incidents are reviewed at weekly RISK/QA Committee meetings and verified by medical director's signature that incidents have been reviewed and sent to the right agencies. The quality assurance would be the signature from the medical director that he has confirmed each incident was completed on time and submitted to the correct agencies. Since MSCC Administrative Nursing Staff was notified of the error this was corrected and sustained consistent corrective action. Verification of incidents reported to the correct agencies would be found in the DON's office with all the other incident reports. Results	

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F 225	Continued From page 5 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility investigations and staff interview, the facility failed to ensure that 3 of 3 allegations involving abuse or misappropriation of funds were reported to the State Survey Agency. The findings were: In review of three allegations, (a resident to resident altercation dated 5/31/12, a report of misappropriation of resident funds dated 5/3/12, and an alleged physical abuse by staff to a resident dated 4/20/12) there was no evidence that any of the allegations were reported to the State Survey Agency. The investigations were completed and there were reports made to other agencies that included the State Board of Nursing, the Department of Family Services and law enforcement. Interview with the DON and the social worker on 7/11/12 at 2 PM revealed there had been a turn over in staff and they could not find any evidence these allegations/investigations were reported to the State Survey Agency. In addition, the record maintained at the State Survey Agency related to received reports failed to show the information was reported by the facility.	F 225	will be reviewed during weekly RISK/QA Committee meetings. e. Completion date: 8/24/2012	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	F226 (SS=E) a. The state survey indicated that 3 of 3 allegations involved abuse or misappropriation of funds but no resident numbers were referenced for MSCC to address POC. b. The policy for reporting abuse and negligent dated 4/27/2012 has been revised to show all	

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F 226	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on review of facility investigations, policy and procedure review, and staff interview, the facility failed to develop and implement their policies and procedures related to reporting requirements for 3 of 3 allegations of abuse and misappropriation of resident property. The findings were: Review of the updated policy and procedures for abuse and neglect prevention, showed the reporting requirements were to have all alleged mistreatment, neglect, misappropriation of resident's property (exploitation), physical, mental , verbal, or sexual abuse of a resident reported to all "local/state/federal agencies within 24 hours of the allegation." The policy and procedure did not specifically identify the State Survey Agency, rather just "the state" as a required agency to have these allegations reported to. In review of three allegations, (a resident to resident altercation dated 5/31/12, a report of misappropriation of resident funds dated 6/3/12, and an alleged physical abuse by staff to a resident dated 4/20/12) there was no evidence that any of the allegations were reported to the State Survey Agency. The investigations were completed and there were reports made to other agencies that included the State Board of Nursing, the Department of Family Services and law enforcement. Interview with the DON and the social worker on 7/11/12 at 2 PM revealed there had been a turn over in staff and they could not find any evidence these allegations/investigations were reported to the State Survey Agency. In	F 226	reporting agencies, including the state survey agency. Each incident is documented, investigated, reported to all correct agencies, and filed for review to be signed off by medical director at each weekly RISK meeting. Each report that is faxed to specific agency will have a copy of the fax confirmation attached to the incident report. c. No system changes are needed. Education from survey staff as to what agencies needed to be notified causing revised policy. It was indicated by survey staff that we were doing the right steps but could not verify State Survey Agency was notified of incidents. This has since been corrected. d. All incidents are reviewed at weekly RISK/QA Committee meetings and verified by medical director's signature that incidents have been reviewed and sent to the right agencies. The quality assurance would be the signature from the medical director that he has confirmed each incident was completed on time and submitted to the correct agencies. Since MSCC Administrative Nursing Staff was notified of the error this was corrected and sustained consistent corrective action. Verification of incidents reported to the correct agencies would be found in the DON's office with all the other incident reports. Results will be reviewed during weekly RISK/QA Committee meetings. e. Completion date: 8/24/2012	

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F 226	Continued From page 7 addition, the record maintained at the State Survey Agency related to received reports failed to show the information was reported by the facility.	F 226	F241 (SS=D)	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on review of council minutes and resident and staff interviews, the facility failed to ensure dignity was maintained for residents. The census was 36. The findings were: Review of the 6/14/12 resident council meeting minutes showed "Nurses need to stop complaining about inter-facility problems at the nursing station and stop discussing issues about their problems in front of the residents and guests. Nurses need to take their issues to the proper department head and discuss it with them." Confidential interview with nine residents on 7/10/12 at 9:30 AM verified staff was complaining about their work problems instead of focusing on resident needs and care. The residents said it made them feel discounted and staff should pay attention to them. One resident stated "we live, feel and hear what goes on in the facility." Interview with the DON on 7/12/12 at 9:20 AM revealed she was working with staff on this issue and hoped to have the resident concerns resolved soon.	F 241	a. The survey does not note specific resident numbers but states what was listed in resident council meeting minutes and a census of 36. MSCC is unable to address any resident with a direct POC. b. This deficiency is an opportunity for our administrative nursing staff to educate staff and residents about the facilities' policies about inter office gossip and professional behavior in the workplace. Education: In-service with staff to remind staff of professional behavior in the workplace. Administrative Nursing staff will encourage nursing staff that our facility is an open door facility and at any time the staff needs to express a concern, vent, or vocalize frustrations they are welcome to do so behind closed doors with a supervisor or manager. c. MSCC nursing staff have completed necessary training and certification to know the professional behavior in the workplace. This will be standard practice at our facility. d. Monitor POC: Administrative Nursing Staff will be on the floor more interacting with residents and staff. Any staff gossiping or complaining on the clock in front of residents is not acceptable professional behavior and should be done behind closed doors. DON's office will be moved to the former Beauty Shop across from the Nurse's Station. This will be allow for more visibility of Administrative Nursing Staff and allow DON to hear what is happening on the floor. Continued education with staff and residents during in-service at least once a month and "stand-up" meetings about professionalism in the work place. Staff	

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PRINTED: 07/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING _____ B. WING _____	C 07/12/2012

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

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F 226	Continued From page 7 addition, the record maintained at the State Survey Agency related to received reports failed to show the information was reported by the facility.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on review of council minutes and resident and staff interviews, the facility failed to ensure dignity was maintained for residents. The census was 36. The findings were: Review of the 6/14/12 resident council meeting minutes showed "Nurses need to stop complaining about inter-facility problems at the nursing station and stop discussing issues about their problems in front of the residents and guests. Nurses need to take their issues to the proper department head and discuss it with them." Confidential interview with nine residents on 7/10/12 at 9:30 AM verified staff was complaining about their work problems instead of focusing on resident needs and care. The residents said it made them feel discounted and staff should pay attention to them. One resident stated "we live, feel and hear what goes on in the facility." Interview with the DON on 7/12/12 at 9:20 AM revealed she was working with staff on this issue and hoped to have the resident concerns resolved soon.	F 241	found gossiping or exhibiting unprofessional behavior in the workplace will be documented by DON. Review of Resident Council minutes reflective of any signs of staff unprofessional behaviors will be documented and addressed by DON. Report of incidents will be reviewed during weekly RISK/QA Committee meeting. e. Completion Date: 8/24/2012.	

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F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to accommodate the needs of 2 of 9 sample residents (#5, #16) who made their needs known related to the operation of the air conditioning units in their rooms. The findings were: 1. Observation on 7/10/12 at 10:25 AM showed the spouse of resident #16 had to use a grabber extension tool to adjust the vent of the air conditioner, located above the roommate's bed. The temperature could not be adjusted because the control for the thermostat was looked in a box mounted to the wall. The resident stated s/he could not get into the locked box with the remote. Interview with CNA #3 on 7/12/12 at 12:55 PM revealed nursing staff did not have keys to access the remotes, only maintenance could unlock the remote to adjust the temperature. 2. Observation on 7/12/12 at 8:40 AM showed the remote control for the air conditioner unit was located in a locked box mounted on the wall in the room of resident #5. Observation of the air conditioner unit showed it was located on the wall	F 246	F246 (SS=D) a. Resident #5 and #16 was furnished with a remote so they could control their room air conditioning unit. b. MSCC is a 50 bed facility with 2 resident per room, in most cases. The social worker attempts to match up each resident with a compatible roommate. Example: Will the resident have a tv, has to have a silent room for sleeping, likes to be warm or cool, ect. MSCC cannot please every resident's desired temperature. Maintenance keeps the common areas temperature at 72 degrees while each room has their own heating and air conditioning room thermostat. It was decided to have the remotes in the locked box in each room because the number of remotes misplaced/lost and the cost factor to replace. With that said maintenance will over in-service to all nursing staff on how to use the air condition remotes by showing them the user operating manual. A key for each box will be made available for all nursing staff so the remotes are easily accessible to make temperature changes. Residents that are cold can request additional blankets located in the staff break room or electronic heater blankets (based off availability). c. Maintenance will no longer be the only department with a key to the remotes. Nursing staff will have access to the key so accessibility to the remotes is made easily. d. Audits will be done by QA committee member and reported to the QA committee. Audits can be reviewed at any time through maintenance manager. e. Completed on 8/10/2012	

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F 246	Continued From page 9 near the ceiling. When measured, the power button was 7 feet, 2 inches from the ground. Interview with the resident at that time revealed s/he was able to turn the air conditioner unit on and off only by reaching it with a grabber extension tool. The resident stated it would be much easier to use the remote control.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure 1 of 9 sample residents (#5) who were reviewed for activities received an ongoing individualized program of activities during a period of confinement to his/her room. The findings were: 1. Review of the 6/4/12 admission MDS assessment for resident #5 showed s/he was understood and had a clear comprehension of understanding others. When the resident was interviewed related to activity preferences for this MDS assessment, reading materials, music, animals/pets, the news, being outdoors, and religious services were shown to be very important to him/her. Review of a 6/26/12 timed at 12:25 AM nurses note showed the resident had been placed on antibiotics and isolation due to a positive lab for infection. The following concerns	F 248	F248 (SS=D) a. Resident #5 had an updated care plan with activities and social networking that MSCC could offer when a resident is on isolation. The resident indicated he did not want any activities but to watch tv (he has his own tv and cable in his room) and have his family come visit him. Social Worker contacted the family and his wife and daughter came to visit. MSCC staff visited with the resident throughout each day of isolation. b. Policy written on 8/1/2012 "Activity Program for Residents in Isolation" breaks down the activities department role when offering services to residents in isolation. Currently, MSCC does not have any residents in isolation. However, if a resident is placed on isolation status then the activities director will be notified by nursing staff that a change in care plan is needed. The activities staff will follow the policy to make sure that any available activities for isolated residents are offered and implemented then noted on the care plan. c. The system changes would be that nursing staff communicate to activities staff of change in status with any residents on isolation. At that point the activities staff will meet with residents the same day (unless isolation is done after 5pm then it will be the next day) to offer a list of MSCC activities for isolated residents. Interdisciplinary staff will meet to go over the care plan and make any suggestion/revisions to care plan for the resident. Care plan will then be updated to show offered/accepted activities and services. d. MDS coordinator will follow up with activities to collect updated information to be added to the care	

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F 248	Continued From page 10 were identified related to a lacking activity program for this resident: a. Interview with the resident on 7/10/12 at 8:15 AM revealed s/he stayed in his/her room most of the time, and wished there was more to do. The resident expressed wanting to be able to read; however, his/her eyesight was not good. The resident also enjoyed music and wished there was a way s/he could listen to music. b. Interview with the activity director on 7/12/12 at 8:50 AM revealed the resident initiated most all of his/her own activities. She verified while the resident had been on isolation for about a week, there were no additional activities offered for the resident to do in the room. The activity director said she had visited with him/her one on one; however, this was not documented. During this interview, the activity director verified there was no care plan related to activities for this resident, and audio books or large print books and music had not been made available to the resident.	F 248	plan. Once the care plan has been updated by the MDS coordinator then the care plan is reviewed and signed by interdisciplinary staff. Care plans are then audited by DON and placed in the care plan book at the nurse's station. Significant changes are addressed at weekly RISK/QA Committee meetings at what point medical director can offer additional insight to additional care we may have missed. Records clerk will be auditing resident files to make sure updated care plans are updated timely and placed in the correct sections. If the audit shows care plan is missing vital information a report will be presented of findings during weekly RISK/QA Committee meetings. Corrective action will then take place to update and correct care plan. Audit reports are made available in the DON's office. Results of the audit will be reviewed at weekly RISK/QA Committee meeting. e. Date Completed: 8/24/2012	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure reasonable upkeep of the environment. Doors, furniture, and walls in a variety of areas were in need of maintenance and cleaning. The findings were:	F 253	F253 (SS=E) a. No residents were listed for MSCC to address POC. However, room numbers 102, 103, 104, 106, 207, and 208 have had all repairs and painting completed. Living room recliners and couches have been pulled from the floor and cleaned. b. In-service with housekeeping staff on housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. c. No system change is needed. d. Monthly audits will be completed by maintenance and housekeeping managers of all the facility to ensure reasonable upkeep of the environment. All audits can be located and are made available through the maintenance manager. Maintenance and housekeeping will report audits to the QA committee. e. Date completed 8/24/2012	

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F 253	Continued From page 11 Observation on 7/12/12 at 8:30 AM showed resident rooms 102, 103, 104, 106, 207, and 208 had damage to the closet doors and the wall next to the closets. The areas were scraped with paint chipped off and the wooden doors were gouged. The gouged area covered the entire width of the doors and extended 17 inches up from the floor. In addition, there was a long section greater than 8 feet, of the radiator heater in the dining room that was marred with paint chipped off. Finally, the living room near the front entrance of the facility had an upholstered recliner and sofa that had multiple areas of dried on spills. Interview with the maintenance director on 7/12/12 at 10:30 AM verified the closet doors and walls as well as the furniture was in need of cleaning and or repair. The director said the plan was to complete the painting by fall.	F 253		
F 266 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to ensure lighting was adequate for reading in 1 non-sample resident's room (#1). The findings were: Review of the 4/2/12 significant change MDS assessment for resident #1 showed reading books, newspapers, magazines and keeping up with the news was very important. Interview with the resident on 7/10/12 at 9:45 AM revealed s/he had always enjoyed reading in his/her room at	F 266	F266 (SS=D) a. Resident #1 was offered and installed in room additional lighting. In fact at time of interview with State Survey Staff the resident had lighting above her headboard and also a reading lamp on her night stand. Resident is not in acceptance to her visual impairment. The optometrists from Indian Health Services indicated no matter how many surgeries this resident goes through it would only slow down the process of complete blindness which runs in the resident's family. Care plan was updated to show additional lighting was requested and installed in the resident room. b. Nursing staff will notify the maintenance manager when there is a significant change on the MDS Care Plan that requires maintenance assistance. Maintenance will offer in-service on adequate and comfortable lighting levels.	

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F 256	Continued From page 12 bedtime. However, the resident further said the lighting in his/her room was not bright enough so s/he was unable to read. Interview with the maintenance director on 7/10/12 at 3:05 PM revealed the resident had spoken with another maintenance staff about the lighting, and that staff member had cleaned the plastic cover on the light. However, no additional lighting such as a reading lamp had been offered or provided.	F 256	Requests for additional lighting will be noted on the care plan and relayed to maintenance for install. c. Change in system would be communication from nursing staff after care plan meeting to maintenance staff making the request for maintenance services. Communication can be written or verbal for additional lighting or other related maintenance services. d. Maintenance requests will be audited by a QA committee member and report taken to the QA committee to be reviewed. e. Completed by 8/10/2012	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;	F 272	F272 (SS=E) a. Residents # 9, #19, and #27 have been reviewed and updated CAA summaries and all necessary assessments have been completed. The MDS sections have been updated and updated care plans have been reviewed, printed, signed, and filed. b. At time of admission the resident will have several assessments conducted. Social Worker will complete sections C (Cognitive Assessment) and D (Mood Assessment) at time of admission and gather information from the resident to pass on to the nursing staff. Activities staff will meet with the resident the same day of admission to collect information about activity involvement. Dietary will meet with resident on the first day of admissions to collect information about food allergies and favorite foods the resident may like. Nursing Staff will complete all assessments upfront at time of admissions and any follow up assessments required by facility/state/federal guidelines. All information collected at time of admission will be relayed to MDS coordinator to enter in the computer.	

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F 272	Continued From page 13 Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide comprehensive assessments in a variety of areas for 3 of 8 sample residents (#9, #19, #27). The findings were: According to the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, "Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions...This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in the MDS data...Use the information gathered thus far to make a clear issue or problem statement." Failure to complete comprehensive assessments of triggered areas was identified as follows: 1. Review of the 7/9/12 admission MDS assessment showed resident #27 triggered for a problem in activities. Continued review of the	F 272	c. System changes would include strengthening communication among interdisciplinary team members to make sure all necessary assessments are completed on time and correctly. The MDS Coordinator will make sure all assessments have been completed and if any are missing or incomplete then MDS Coordinator will have staff members complete in a timely manner. d. All the work the MDS coordinator completes will be reviewed and signed by the interdisciplinary staff and DON. Quality Assurance will be completed by records clerk when audits are completed on each medical record. MDS coordinator will make sure all CAA are completed on time and done correctly. As a backup, the records clerk will be verifying that all CAA's are in the file. If any CAA's are missing during this audit the MDS Coordinator will be notified. Findings from the audit will be presented during weekly RISK/QA Committee meeting in which corrective action will be established. All audits will be available for review in the DON's office. e. Date Completed 8/24/2012	

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F 272	Continued From page 14 MDS assessment showed, although the resident triggered for comprehensive review of activities, the accompanying CAA was not completed. Interview with the activities director on 7/12/12 at 8:55 AM revealed she was still learning how to do MDS assessments. 2. Review of the 11/1/11 annual MDS assessment, section V, for resident #9 showed several areas triggered for additional assessments and the location and date of the care area assessments (CAA) information was found in the CAA summaries. Review of the CAA summaries showed they did not indicate the location of the information that was used for the assessment. In addition, the area of the CAAs to provide an analysis of the findings was lacking a description of the problem, causes and contributing factors and risk factors to the care areas. 3. Review of the 2/26/12 annual MDS assessment, section V, for resident #19 showed the location and date of the CAA information was found in the CAA summary. Review of the CAA summaries showed they did not indicate the location of the information that was used for the assessment. In addition, the area of the CAAs to provide an analysis of the findings was lacking a description of the problem, causes and contributing factors and risk factors to the care areas. 4. Interview with the DON on 7/12/12 at 3:15 PM revealed she and others would be attending a workshop for the MDS assessment process, because more training was needed.	F 272		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 15 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a comprehensive care plan to include measurable objectives to meet the resident's needs for 2 of 9 sample residents (#9, #19). The findings were: 1. Review of the physician notes dated 3/3/10 showed resident #9 was prescribed Lexapro (for depression) 10 mg daily. Review of the 7/9/12 physician's orders showed the resident remained on the medication. Review of the 11/1/11 annual MDS assessment, section V, showed a care plan	F 279	F279 (SS=D) a. Resident #9 and #19 Section V was reviewed and updated on the care plan. This has been updated, reviewed, signed, and filed in the resident's charts. b. The MDS Coordinator will notify interdisciplinary team to update their section V when flagged by the system. Each interdisciplinary team member who has information to update in this section will then update when is needed. Once the section has been complete then each interdisciplinary team member will review and sign the updated care plan. c. System changes would be that the MDS Coordinator communicate to interdisciplinary staff of needed information for section V. If a plan is to be created then the staff has to follow through with the change. This would be reflected on the updated care plan produced by the MDS Coordinator. The team as a whole will meet and make sure all areas are addressed so the care plan can be updated. Once the care plan has been updated then the team will review and sign off on the care plan. The updated care plan will then be filed in the care plan binder at the nurses station. d. Interdisciplinary staff will review and sign the MDS Coordinators updated care plan. Final review will be completed by the DON. The Records Clerk will complete audits to show updated/revised care plans are in the residents files. If the audit shows a discrepancy the findings will be presented at the weekly RISK/QA Committee meetings in which corrective action will be planned. All audits will are available for review in the DON's office. Results from audit will be reviewed during weekly RISK/QA Committee meeting. e. Date Completed: 8/16/2012	

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F 279	Continued From page 16 was to be developed for psychotropic drug use. Review of the care plan dated 5/8/12 showed no care plan had been developed for the use of psychotropic medication. 2. Review of the care plan for resident #19 identified the following concerns: a. Review of the psychoactive medication consent form showed the resident signed the consent on 3/29/06 for the medication trazodone (an antidepressant). In addition, the consent form for the medication clonazepam (used for agitation) was signed on 10/15/07. Review of the July 2012 MAR showed the resident remained on these medications. Review of the 2/28/12 annual MDS assessment, section V showed a care plan was to be developed for psychotropic drug use. However, review of the resident care plan showed psychotropic medications were not included. b. Review of the 2/28/12 annual MDS assessment, section V showed a careplan related to dental care would be developed because the resident did not have teeth. However, review of the 6/5/12 care plan showed no care plan was developed for dental care. 3. Interview with the DON on 7/12/12 at 3:15 PM, verified care plans need to be developed as indicated in section V of the MDS assessments.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	F280 (SS=E) a. Residents #5, #7, #9, and # 19 care plans have been reviewed and revised to reflect the corrective action needed. #9 care plan incontinence care and pressure ulcers was revised to show daily whirlpool baths to help with pressure ulcers sores, check resident hourly, toileted every 2 hours, and dressing change to toe. Since then sores have	

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F 280	Continued From page 17 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure staff reviewed and revised the care plan to accurately reflect the resident's status for 4 of 9 sample residents (#5, #7, #9, #18). The findings were: 1. Review of the care plan showed the following concerns were identified for resident #9: a. Review of the 7/3/12 physician referral form showed the resident had a decubitus ulcer on her left toe and a stage II pressure ulcer on the labia. Observation on 7/12/12 at 9:55 AM showed the resident still had the ulcer on the left toe. Review of the 7/6/12 physician orders showed the physician was aware of the ulcer on the labia and wrote orders for staff to check the resident every hour, because the resident was known to pad the area with a paper towel. Review of the care plan for pressure ulcers dated 6/8/12	F 280	been found to be cancerous and toe has healed, #18 care plan pressure ulcers was revised to show the seat cushion was given to the resident and a pressure reducing device for the bed. Revised care plan for bladder incontinence to reflect updated information for resident's incontinence. #5 care plan was updated to show activities offered for residents in isolation. Activities staff showed resident how to locate music stations on his DISH network so he could enjoy music when he wanted. Activities staff updated/revised activity log to show the number of times staff interacted with resident while on isolation. #7 care plan was revised to show toileting program was identified and implemented. Care plan was also revised to show interventions for the falls: gate belt, floor mates, lowering of bed, neural checks, ect. b. The MDS Coordinator will be notified by interdisciplinary team an update is needed for significant change with resident. Each interdisciplinary team member who has information to update in their sections will then update. Once their section has been complete then each interdisciplinary team member will review and sign the updated care plan. c. System changes would be that the MDS Coordinator communicate to interdisciplinary staff of needed information is required to complete sections for care plan. The team as a whole will meet and make sure all areas are addressed so the care plan can be updated. Once the care plan has been updated then the team will review and sign off on the care plan. The updated care plan will then be filed in the care plan binder at the nurses station.	

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F 280	Continued From page 18 failed to show the resident had any pressure ulcers and did not show the current treatments being provided. It also failed to mention checking for paper towels. b. Review of the 7/6/12 physician orders showed the resident was to be toileted every two hours to include perineum care. Review of the care plan for incontinence care dated 5/8/12 failed to show the resident was to be toileted every two hours. 2. Observation on 7/9/12 at 9:40 AM showed resident #19 had a cushion on the seat of his/her wheelchair. Review of the 5/20/12 quarterly MDS assessment, section M, showed the resident was at risk for developing pressure ulcers and skin treatment included a pressure reducing device for the bed. Review of the 6/5/12 care plan for skin integrity did not include any pressure reducing devices to be used for the bed or the wheelchair. In addition, the MDS assessment showed the resident was occasionally incontinent of urine. The 6/5/12 care plan for bladder incontinence showed the resident had no recent episodes of incontinence and only had a history of rare incontinent episodes. 3. Review of the 6/4/12 admission MDS assessment for resident #5 showed s/he was understood and had a clear comprehension of understanding others. When the resident was interviewed related to activity preferences for this MDS assessment, reading materials, music, animals/pets, the news, being outdoors, and religious services were shown to be very important to him/her. Review of a 6/26/12 timed at 12:25 AM nurses note showed the resident had been placed on antibiotics and isolation due to a	F 280	d. Interdisciplinary staff will review and sign the MDS Coordinators updated care plan. Final review will be completed by the DON. The Records Clerk will complete audits to show updated/revised care plans are in the residents files. If the audit shows a discrepancy the findings will be presented at the weekly RISK/QA Committee meetings in which corrective action will be planned. All audits will are available for review in the DON's office. Results from the audit will be reviewed during the weekly RISK/QA Committee meeting. e. Date Completed: 8/16/2012	

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F 280	Continued From page 19 positive lab for infection. The following concerns were identified: a. Interview with the resident on 7/10/12 at 8:15 AM revealed s/he stayed in his/her room most of the time, and wished there was more to do. The resident expressed wanting to be able to read; however, his/her eyesight was not good. The resident also enjoyed music and wished there was a way s/he could listen to music. b. Interview with the activity director on 7/12/12 at 8:50 AM revealed the resident initiated most all of his/her own activities. She verified while the resident had been on isolation for about a week, there was no additional activities offered for the resident to do in the room. The activity director said she had visited with him/her one on one however, this was not documented. During this interview, the activity director verified there was no care plan related to activities for this resident, and audio books or large print books and music had not been made available to the resident. c. Review of the care plan showed it failed to address activities. 4. The following care plan issues were identified for resident #7: a. Review of the 6/20/12 quarterly MDS assessment for the resident showed s/he was frequently incontinent of bowel and bladder. Review of the care plan dated 6/19/12 showed incontinence was identified as a problem. However, there was no evidence a toileting program was identified or implemented, only to answer the call light promptly and to assess and document the resident's voiding pattern. Interview with the DON on 7/12/12 at 9:20 AM revealed the care plan should have been updated to reflect a	F 280		

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F 280	Continued From page 20 toileting plan for this resident. b. Review of incident reports revealed the resident experienced a fall on 2/4/12, 3/11/12, and 3/19/12. Further review showed the care plan was not updated to reflect the recommendations made after the fall assessments were completed. Interventions recommended included using a gait belt, checking to make sure the brakes were locked on the wheelchair, and placing a fall mat beside the bed. Interview with the DON on 7/12/12 at 9:20 AM revealed the care plan should have been updated to include these recommendations.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff followed physician's orders regarding bowel management for 1 of 4 sample residents (#7) with bowel issues. In addition, staff did not follow physician orders in regard to monitoring the vital signs for 1 of 9 sample residents (#7). The findings were: In regard to bowel management: 1. Review of the medical record showed resident #7 was admitted with diagnoses including constipation. Review of the 6/19/12 care plan showed constipation was identified as a problem. Review of the physician's orders for June and July 2012 showed orders written on 6/29/11 for	F 281	F281 (SS=D) a. Resident # 7 physician orders are being followed, recorded, and reviewed by administrative nursing staff. Vital signs are being collected every 12 hours and bowel management is being followed accordance to MSCC Bowel Management Policy. b. In accordance to Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulation of November 2003, page 3-6, nursing must function under the direction of a licensed physician. MSCC nursing staff will follow the physician orders with the direction of the administrative nursing staff to supply the necessary tools to complete the job tasks. MSCC administrative nursing staff have created and implemented two polices to insure these issues do not recur; revised Bowel Management and Procedure of Obtaining Routine Vitals. What is clear is that following the physician orders are needed to be transposed to MSCC computerized systems so triggers will be posted for the nursing staff. This will insure physician orders are followed. c. System changes would be that when a physician order is received that this information is	

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F 281	Continued From page 21 management of constipation. These orders included Milk of Magnesia 30 cc (cubic centimeters) as needed, Colace 100 mg PRN (as needed), Dulcolax 10 milligrams (mg) suppository PRN if there was no bowel movement after laxatives were administered, and soap suds or fleets enema PRN if there were no results from the laxatives. Also included in the orders was Bran food supplement (natural fruit laxative) PRN. The following concerns with bowel management were identified: a. Review of the June 2012 bowel flow sheet showed the resident had no bowel movement from 6/7/12 through 6/13/12 (6 days), from 6/14/12 through 6/17/12 (4 days), and 6/26/12 through 6/30/12 (5 days). Review of the June MAR and nursing notes showed no evidence the resident was administered any of the laxatives or enema ordered as needed. b. Interview with the DON on 7/12/12 at 9:20 AM revealed physician orders should always be followed or if questioned, clarified. In regard to vital sign monitoring: Review of the June and July 2012 physician's orders for resident #7 showed an order to check his/her pulse, respirations and pulse oximetry (measures oxygen saturation) every twelve hours at 9 AM and 9 PM daily. Review of the flow sheets, nursing notes, MARs and treatment administration records showed no evidence these vital signs were obtained or monitored on a twice daily basis as ordered. According to the vital sign flow sheet, the vitals were obtained only on 6/8/12. Review of the CNA flow sheet for July 2012 showed the resident's oxygen saturation was obtained twice, on 7/9/12 and 7/12/12. No	F 281	entered by staff nurse into MSCC computer system. Administrative Nursing staff will then check that the physician orders have been transposed correctly. Reports created by the administrative nursing staff will show all orders have been completed or not. d. Administrative Nursing staff will have to check all orders and make sure they are entered correctly in MSCC computer tracking system. If orders are done incorrectly the administrative nursing staff needs to show nursing staff how to enter correctly. The QA will come from the DON who will then check both administrative nursing staff and nursing staff have entered orders correctly into MSCC computerize system using a daily (Monday – Friday) computerize report from MSCC computer system. Computerized reports of missing vitals and BM reporting/tracking will be reviewed by DON daily in which will be addressed with nursing staff and DON. 1st offense will be a verbal, 2nd offense will be a written and 3rd offense will be termination. Review of audit will be presented during weekly RISK/QA Committee meeting. e. Completion date 8/24/2012	

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F 281	Continued From page 22 other vital signs were recorded for the resident. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to provide appropriate interventions for 2 of 4 sample residents (#7, #19) with constipation. In addition, the facility failed to ensure staff monitored the vital signs for 1 of 9 sample residents (#7). The findings were: 1 .Review of the medical record showed resident #7 was admitted with diagnoses including constipation. Review of the 6/19/12 care plan showed constipation was identified as a problem. Review of the physician's orders for June and July 2012 showed orders written on 8/29/11 for management of constipation. These orders included Milk of Magnesia 30 cc (cubic centimeters) as needed, Colace 100 mg PRN (as needed), Dulcolax 10 milligrams (mg) suppository	F 309	F309 (SS=D) a. Resident # 7 physician orders are being followed, recorded, and reviewed by administrative nursing staff. Vital signs are being collected every 12 hours and bowel management is being followed accordance to MSCC Bowel Management Policy. Resident #19 physician orders are being followed, recorded, and reviewed by administrative nursing staff. b. In accordance to Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulation of November 2003, page 3-6, nursing must function under the direction of a licensed physician. MSCC nursing staff will follow the physician orders with the direction of the administrative nursing staff to supply the necessary tools to complete the job tasks. MSCC administrative nursing staff have created and implemented two polices to insure these issues do not recur; revised Bowel Management and Procedure of Obtaining Routine Vitals. What is clear is that following the physician orders are needed to be transposed to MSCC computerized systems at which triggers will be posted for the nursing staff. This will insure physician orders are followed.	

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F 309	Continued From page 23 PRN if there was no bowel movement after laxatives were administered, and soap suds or fleets enema PRN if there were no results from the laxatives. Also included in the orders was Bran food supplement (natural fruit laxative) PRN. The following concerns with bowel management were identified: a. Review of the June 2012 bowel flow sheet showed the resident had no bowel movement from 6/7/12 through 6/13/12 (6 days), from 6/14/12 through 6/17/12 (4 days), and 6/26/12 through 6/30/12 (5 days). Review of the June MAR and nursing notes showed no evidence the resident was administered any of the laxatives or enema ordered as needed. b. Interview with the DON on 7/12/12 at 9:20 AM said she thought it was just a documentation error. However, review of the documents showed multiple daily entries which indicated the resident had "None Bowel 0." The DON then talked with the CNAs and nurses on duty 7/12/12 but they were unable to provided additional information. 2. Review of the 6/5/12 care plan for resident #19 showed s/he had a potential for constipation due to the prescribed medication. The care plan further showed, if the resident did not have a bowel movement (BM) in two days, the licensed staff were to assess diet and activity. If s/he did not have a BM in three days the nursing staff were to administer an oral laxative and assess the abdomen for bowel sounds and discomfort. The following concerns were identified: a. Review of the June 2012 bowel and bladder report showed the resident did not have a BM from 6/1/12-6/5/12 (4 days), 6/6/12-6/14/12 (7 days), 6/15/12-6/20/12 (5 days) and from 6/26/12-7/1/12 (5 days). Review of the nurses notes	F 309	c. System changes would be that when a physician order is received that this information is entered by staff nurse into MSCC computer system. Administrative Nursing staff will then check that the physician orders have been transposed correctly. Reports created by the administrative nursing staff will show all orders have been completed or not. "None Bowel 0" was found to be that the computer places this entry when nurse does not complete their assessment. This is being followed closely by administrative staff. d. Administrative Nursing staff will have to check all orders and make sure they are entered correctly in MSCC computer tracking system. If orders are done incorrectly the administrative nursing staff needs to show nursing staff how to enter correctly. The QA will come from the DON who will then check both administrative nursing staff and nursing staff have entered orders correctly into MSCC computerize system using a daily (Monday – Friday) computerize report from MSCC computer system. Computerized reports of missing vitals and BM reporting/tracking will be reviewed by DON daily in which will be addressed with nursing staff and DON. 1st offense will be a verbal, 2nd offense will be a written and 3rd offense will be termination. Review of audit will be presented during weekly RISK/QA Committee meeting. e. Completion date 8/24/2012	

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F 309	Continued From page 24 showed no documentation indicating an assessment was completed or medications were administered for constipation. b. Review of the the July 2012 bowel and bladder report showed the resident did not have a BM from 7/2/12-7/5/12 (3 days). Review of the July nurses' notes did not show documentation the resident was assessed for constipation. Further, review of the July 2012 MAR did not show the resident received any laxatives for constipation. In regard to vital sign monitoring: Review of the June and July 2012 physician's orders for resident #7 showed an order to check his/her pulse, respirations and pulse oximetry (measures oxygen saturation) every twelve hours at 9 AM and 9 PM daily. Review of the flow sheets, nursing notes, MARs and treatment administration records showed no evidence these vital signs were obtained or monitored on a twice daily basis as ordered. According to the vital sign flow sheet, the vitals were obtained only on 6/8/12. Review of the CNA flow sheet for July 2012 showed the resident's oxygen saturation was obtained twice, on 7/9/12 and 7/12/12. No other vital signs were recorded for the resident. Interview with the DON on 7/12/12 at 9:20 AM revealed she spoke with nursing staff and asked if the vital signs would be documented any place other than the vital sign flow sheet and they said no. The DON then verified there was no evidence these vital signs were obtained as ordered.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		

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F 314	Continued From page 26 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the facility's policies and procedures, the facility failed to ensure assessments and monitoring of interventions were ongoing for 1 of 1 sample residents (#9) with pressure ulcers. The findings were: Review of the physician's notes dated 7/3/12 showed resident #9 had a large area of skin breakdown on the right labia and early breakdown noted on the left side. The physician ordered treatments of the area to include keeping the area covered with ointment and discourage use of paper towels as a pad. Review of the 7/4/12 plan of care for rehabilitation services document, completed by physical therapy, showed the resident had three different areas where wounds were located to include two stage II wounds in the vaginal area and each measured approximately 3x2 centimeters with no depth. The document further showed the nursing staff was to provide care of the these wounds. The following concerns were identified: a. Review of the nurses' notes from 7/4/12-7/11/12 showed there was a "sore on vaginal area" and the wound was being cleaned	F 314	F314 (SS=D) a. Resident #9 care plan was updated to show nursing staff was offering provided care for the wounds. Assessment of the wounds are being completed daily by nurses and physical therapy staff. b. Going forward care plans will note any signs of wounds that need provided care. In these care plans a breakdown of what provided care will be offered. Those residents identified with sores will be assessed to determine the level of care needed to heal. Following the physician orders the nursing staff will work within the care plan to ensure sores are assessed and healing properly. c. MSCC policy has been updated to include all missing assessment data pointed out in the survey. The revised policy was submitted to MSCC nursing staff and in-service on how to change dressing for wounds was provided by administrative nursing and physical therapy staff. d. Skin assessments will be conducted weekly by LPN or RN along with bath aids reports. (Each resident receives a bath at least 2 times a week minimum.) Reports from bath aids and from nursing staff will then be submitted to administrative staff for review. Stand-up meetings will also allow nursing staff to vocalize any change in skin conditions. The quality assurance will be the administrative nursing staff review the reports and determining if skin condition needs to be added to the care plan. Serious change in condition from skin assessments will be addressed during weekly RISK/QA Committee meetings. Medical director can then review and determine if additional care is needed from already established intervention. Skin assessment reports are	

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	535060	A. BUILDING _____ B. WING _____	C 07/12/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 26 throughout the day and ointment was being applied. However, there was no documentation to show a comprehensive assessment was completed to include the current size of the wound, evidence of any drainage, the color of the wound beds or an evaluation how the of wounds were healing. b. Review of the care plan for pressure ulcer/skin integrity last reviewed on 6/8/12 showed it did not address any of the wounds the resident currently had, nor did it include any treatment plans. c. Review of the policies and procedures for wound care dated 6/19/12 showed after care was provided, documentation of the procedure should be completed. Assessment data such as wound bed color, size, drainage, and any odor should be included. Further, the documentation should show how the resident tolerated the procedure and any problems or complaints made by the resident. d. An interview with the ADON on 7/12/12 at 11 AM, verified the nurses' notes did not show a comprehensive assessment of the wounds. She also stated the nurses notes were where such assessments would be documented.	F 314	available for review in the DON's office. Review of the audit will be conducted during weekly RISK/QA Committee meeting. e. Date of Completion 8/24/2012	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	F329 (SS=D) a. Resident #18 and # 19 physician was notified and asked if any changes are needed and to justify with clinical rational. Behavior Log was implemented to assess change in behavior and the effectiveness. Care plans have been updated to reflect any changes by physician. b. All resident files have been audited to make sure any resident on psychotropic medications have been evaluated by the physician to determine	

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F 329	Continued From page 27 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary medications related to a lack of monitoring for 2 of 9 sample residents (#18, #19). The findings were: 1. Review of the medical record for resident #18 showed s/he had orders dated 2/14/12 for clonazapam 2 mg twice a day as needed (PRN) for agitation. Review of the controlled drug administration record showed the resident received 18 doses of the PRN medication from 6/1/12 to 7/5/12. However, with the exception of 6/19/12 and 6/20/12, there was no monitoring recorded as to why the medication was needed or if it was effective once administered. Interview with the DON on 7/11/12 at 4:55 PM verified the reasons and effectiveness of the medication needed to be documented.	F 329	If any change is needed and to justify with clinical rational. Behavioral Logs are being completed to determine if there is a change in behavior and the effectiveness of the medication for both continued and PRN residents. Those residents who are PRN of psychotropic medications will also be tracked on the behavioral sheets and nursing staff are triggered through the computerized system to check the resident every 30 minutes for behavioral change. Care plans have been updated to reflect any changes made by physician. c. The system change was to build a strong communication relationship with admitting physicians to make sure assessments are being completed quarterly when residents are on psychotropic medications. Some physicians have indicated they would like our residents to be seen by specialist who can better monitor the behavioral changes. MSCC nursing staff is following the physician orders and making sure to complete behavioral logs. Behavioral Logs can be used as evidence the medication is either working or not and at quarterly review the physician can make determination to increase or decrease medication dosage. d. Pharmacy consultant will be checking all residents on psychotropic medications to flag nursing staff it is time for assessment by physician. Behavioral Logs will be reviewed by nursing staff for accuracy. Stand-up meetings with nursing staff will be helpful insight as to the changes with the resident daily. Social Worker will be brought in for assessments and recommendation if the resident should be seen by outside provider in extreme behavioral changes. The quality assurance with be the administrative staff for the behavioral logs. Records Clerk will audit to make sure behavioral logs have been completed and assessment from	

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F 329	Continued From page 28 2. Review of the psychoactive medication consent form for resident #19 showed a consent was signed for medications to include trazodone 50 milligrams (antidepressant) on 3/29/06. Review of the July 2012 MAR showed the resident remained on the medication and the dose of the medication had been increased to 100 mg. Further review of the medical record showed a request for psychopharmacological medication change that included the trazodone on 6/8/12. The physician indicated he did not want to attempt to taper the medication but did not give a clinical rationale. No other documents were found in the medical record to show a dose reduction was attempted or considered from 2006 to 6/8/12. In addition, there was no documentation to show the rationale for the dose increase of the medication. An interview with the DON on 7/11/12 at 10:40 AM revealed dose reductions for the medication may have been attempted but were not documented. Further, she stated she would look for evidence to show dose reductions had been attempted or considered before 6/8/12. As of 7/12/12, no additional documents or information were presented.	F 329	physician has been completed so the care plan can be updated. All audits can be reviewed and located in the DON's office. Audits will be reviewed during weekly RISK/QA Committee meeting. e. Date of Completion: 8/16/2012	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a significant medication error did not occur, for 1 of 9 sample	F 333	F333 (SS=D) a. Resident #19 Behavioral Log are being completed. Notes are being updated in the system to show change in resident behavior, the physician is being notified of any missed medication, and with the new policy all medications within 15 days of empty will be ordered by MSCC nursing staff. b. Any medications that are needing a hard script are being ordered 15 days prior to empty status. New policy in place has implemented a check list from night nursing staff for morning nursing staff to order any medications needed. Medication errors are being reported to physicians by DON. Nursing staff missing medication and not documenting are given 1 verbal warning, then a written warning, and then termination of employment. Medication errors will not be acceptable practice at MSCC. c. Administrative Nursing Staff are pulling reports daily to review medication distribution. If there are medication errors the DON is notifying physician and then working with nursing staff to correct the issue. DON is more involved in the daily activity of nursing staff becoming more visible and hold nursing staff responsible for their actions.	

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F 333	Continued From page 29 residents (#19). There were no significant medication errors during the medication pass which had 47 opportunities for a medication error. The findings were: Review of the medical record for resident #19 showed s/he had diagnoses to include depression, anxiety and possible Parkinson's disease. Further, review of the 7/9/12 physician orders showed the resident had orders for the medication Klonopin 0.5 mg twice daily. Review of the 5/17/12 psychopharmacological medication change document showed s/he received the medication for anxiety. The following concerns were identified: a. Review of the April 2012 MAR showed the resident did not receive Klonopin for six consecutive doses from 4/4/12-4/7/12. Review of the nurses' notes dated 4/6/12 showed the resident stated; "I don't feel good." Further, the note showed the Klonopin was not available and the pharmacy was notified. Review of the 4/7/12 nurses' notes showed the resident was "...in constant motion-moving chair back and forth... Klonopin arrived and given at 1115 [11:15 AM] and resident calmed down and not as nervous acting after receiving medication." Further review of the notes did not show the physician was notified of the unavailable medication or the resident's possible side effects. b. Review of the July 2012 MAR showed the resident did not receive the Klonopin for seven consecutive doses from 7/6/12-7/9/12. Review of the nurses' notes during that time did not show any documentation referring to the missing medication, the resident's symptoms, whether the physician was notified or if the pharmacy was contacted.	F 333	d. Administrative Nursing staff will pull the reports for review by DON. DON will then review to determine if any medication was missed and why. DON will then contact physician if needed. More involvement from Administrative Nursing staff to make sure medication distribution is being completed correctly. Quality Assurance will come from the DON's review of the medication distribution reports. All reports and corrective actions can be found in the DON's office. Audits will be reviewed during weekly RISK/QA Committee meeting. e. Date of completion: 8/23/2012	

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F 333	Continued From page 30 c. An interview on 7/12/12 at 9:25 AM with LPN #1 revealed the resident became more agitated when s/he did not receive the Klonopin. d. Review of the nurses' notes with the ADON on 7/12/12 at 11 AM confirmed there was no documentation to show the physician was notified the medication was unavailable. Further, in her interview at that time, she stated communication with the physician would be documented in the nurses' notes. e. According to Turkoski, Lance, and Tomsik, in the Drug Information Handbook for Nursing, 11th Edition, 2010; Abrupt discontinuation after sustainable use of Klonopin (generally greater than 10 days) may cause withdrawal symptoms.	F 333		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure food sanitation requirements were met in a variety of areas in the facility kitchen. The findings were: 1. Observation on 7/9/12 at 3 PM and again on 7/10/12 at 11:30 AM showed there was a	F 371	F371 (SS=F) a. No resident was listed in this section. b. Maintenance will do a full deep clean and sanitizing of ice machine immediately and there after every six months or sooner when needed per manufacture guidelines. Basic cleaning of the ice machine will be completed monthly. Dietary staff will be in-serviced on cleaning ice machine by Dietary Manager. Dietary with the help of housekeeping will clean the two convection ovens, hood vent filters above range, and the four exhaust vents in kitchen immediately. Dietary Manager will in-service dietary staff on cleaning and sanitizing dietary equipment. Registered Dietitian will in-service dietary staff on hand washing, cross contamination, and glove usage. Registered Dietitian will in-service dietary staff on correct way of sanitizing counter tops, the usage of the sanitation buckets, storage of wet wiping clothes and proper food storage. c. Dietary Manager will work closely with Registered Dietitian to make sure all POC have been addressed and corrected. Dietary Staff will receive continuous education as refresher and logs of cleaning for kitchen equipment will be maintained.	

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F 371	Continued From page 31 brownish pink substance on the interior of the ice machine. The substance was located on a white plastic part where the ice dropped down into the bin. Interview with the dietary manager on 7/11/12 at 9:05 AM revealed she was new to the position and did not know the last time the machine was cleaned and sanitized. Interview with the maintenance director on 7/12/12 at 10:30 AM revealed he sanitized the machine every 6 months per the manufactures directions, and it was due to be done. He further verified build up should not occur and if there is a need for more frequent cleaning it should be done by dietary staff or he would need to be notified. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. 4-701.10 "Equipment food-contact surfaces and utensils shall be sanitized." 2. Observation on 7/9/12 at 3 PM and on 7/10/12 at 11:30 AM showed two convection ovens that were in need of cleaning. The ovens had burned on food inside and were visibly soiled with dried food and grease on the exterior. In addition, the hood vents located above the range and the convection ovens were visibly soiled with accumulated grease and dust. Also, above the preparation and service areas in the kitchen there were four separate ceiling vents that had visible accumulated black dust and grease. Interview with the dietary manager on 7/11/12 at 9:05 AM revealed the cleaning schedule was in the process of being developed. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and	F 371	d. Dietary Manager will perform random audits weekly for 3 months to ensure ice machine is cleaned sanitized. Dietary Manager will conduct random audits weekly for 3 months to ensure that equipment is cleaned, sanitized, and in working condition. Dietary Manager will monitor dietary staff to ensure that dietary staff are exhibiting and practicing good glove and hand washing, techniques. Dietary Manager will report to weekly RISK/QA committee of finding of the monitoring. e. Date of completion: 8/10/2012	

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F 371	Continued From page 32 pans shall be kept free of encrusted grease deposits and other soil accumulations.'(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 3. Observation of staff working with food on 7/10/12 from 11:30 AM to 12:10 PM showed the following concerns: a. Hand washing was lacking when dietary aide #1 was observed to go from preparing food in the kitchen to the dish room. In the dish room the aide loaded dirty dishes into the dish machine and without removing the soiled gloves proceeded to put away clean dishes. According to Food Code 2009, U.S. Public Health Service, 2-301.14 When to Wash: "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS...(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands." b. Counters were not sanitized prior to preparing food. Observation showed dietary aide #1 and the cook failed to use any sanitizer when wiping down the counters in their work areas. The wet wiping cloths were not held in any sanitizer solution, they were left on counters or draped over the edge of the sink. Interview with the cook at 11:40 AM revealed there was a spray bottle with sanitizer solution that was to be used for the counters. She pointed out the spray bottle of solution in the dish room area, and left it there without using it. She also stated she was unaware	F 371		

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F 371	Continued From page 33 of the need to have wet towels held in a sanitizer solution. Interview with the dietary manager on 7/11/12 at 9:05 AM verified the sanitizer solution needed to be used for food surfaces, and she too was unaware that the wet towels needed to be held in solution. According to Food Code 2009, U.S. Public Health Service: 3-304.14. "...(B) Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114;" According to Food Code 2009, U.S. Public Health Service: 4-702.11, "Utensils and food-contact surfaces of equipment shall be sanitized before use after cleaning."	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure progress notes were written, signed, and dated after each physician visit and placed in the medical record for 2 of 10 sample residents (#9, #31). The findings were:	F 386	F386 (SS=D) a. Resident # 9 and # 31 had updated progress noted while survey staff was still at the facility. Survey staff indicated progress notes had been received and reviewed. b. Records Clerk will follow up with physician on all progress notes from each physician visit. Records Clerk will do continuous follow up with physician's office to obtain any missing progress notes every 30 days until progress notes have been obtained. Notes from Records Clerk as to an ETA of progress notes will be noted in the residents file. c. Records Clerk and Nursing Staff have to work together to obtain progress notes. Ultimately the Records Clerk is the person responsible for making sure the file is in compliance but can rely on Nursing Staff to help obtain needed progress notes. d. Records Clerk will audit the files monthly to make sure all necessary progress notes have been received. If progress notes are missing then the Records Clerk will contact the physician requesting a copy. If the Records Clerk is having difficulty receiving progress notes from a particular physician then during weekly RISK/QA Committee meetings the medical director can contact the physician directly to get needed progress notes.	

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F 386	Continued From page 34 1. Review of the medical record for resident #9 showed there were physician progress notes written on 3/3/10 and 3/30/12. Further review showed there was one additional note from the physician that was not dated or signed. Review of the resident's chart and interview with the ADON on 7/12/12 at 11 AM, revealed there were no other physician notes available in the chart. Further, she confirmed the physician had not signed and dated one entry. The ADON contacted the physician's office and obtained two additional notes written by the physician dated 4/4/12 and 7/3/12. 2. Review of the medical record for resident #31 showed there were physician visits made on 3/28/12 and on 5/16/12; however, the record failed to include the referred to "dictated notes." Interview with the ADON on 7/11/12 at 4:50 PM verified the dictated progress notes had not been filed in the resident's record, she had to call and have them faxed over from the physician's office.	F 386	Audit findings will be presented during weekly RISK/QA Committee meeting. e. Date of completion: 8/24/2012	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425	F425 (SS=D) a. Resident #19 and #18 now have a back up medications. Medication for #19 was receiving while survey staff was still at the facility. For both #18 and #19 the physician was notified of missed medication. Medication charts are being reviewed by administrative nursing staff daily to make sure there are no more missed medications. b. Any medications that are needing a hard script are being ordered 15 days prior to empty status. New policy in place has implemented a check list from night nursing staff for morning nursing staff to order any medications needed. Medication errors are being reported to physicians by DON. Nursing staff missing medication and not documenting are	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535060	A. BUILDING _____ B. WING _____	C 07/12/2012

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

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F 425	Continued From page 36 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure pharmacy services were obtained to meet the medication needs for 2 of 9 sample residents (#18, #19). The findings were: 1. Review of the medical record for resident #18 showed s/he had orders dated 2/14/12 for clonazepam 2 mg twice a day as needed (PRN) for agitation. Review of the controlled drug administration record showed the resident received 18 doses of the PRN medication from 6/1/12 to 7/5/12, and as of 7/6/12 there were no more tablets remaining. The following concerns were identified: a. Observation of the medication cart and interview with LPN #1 on 7/12/12 at 9:10 AM revealed there was no clonazepam available for the resident if needed. During the interview with the LPN, she stated the system was for the nurse to fax the physician to re-order the medication prior to it being totally out. Review of the fax communication log revealed there was no evidence found related to a request to re-order this medication. b. Interview with the ADON on 7/12/12 at 9:40 AM revealed when she called the pharmacy they	F 425	given 1 verbal warning, then a written warning, and then termination of employment. Medication errors will not be acceptable practice at MSCC. MSCC will make sure to have back up medication but with new policy to order medication 15 days prior to empty will help the facility from being without medication for their residents. c. Administrative Nursing Staff are pulling reports daily to review medication distribution. If there are medication errors the DON is notifying physician and then working with nursing staff to correct the issue. DON is more involved in the daily activity of nursing staff becoming more visible and hold nursing staff responsible for their actions. d. Administrative Nursing staff will pull the reports for review by DON. DON will then review to determine if any medication was missed and why. DON will then contact physician if needed. More involvement from Administrative Nursing staff to make sure medication distribution is being completed correctly. Quality Assurance will come from the DON's review of the medication distribution reports. All reports and corrective actions can be found in the DON's office. Audit finding will be presented during weekly RISK/QA Committee meeting. e. Date of completion: 8/23/2012	

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F 426	Continued From page 36 reported having received the re-fill order for clonazapam on 7/11/12, and it was being filled and would be sent to the facility before the end of the day (7/12/12). Continued interview with the ADON on 7/12/12 at 9:55 AM revealed there was no written policy and procedure related to ordering and reordering medications. She verified the resident did not have the ordered medication available for the past 7 days and that was not acceptable. 2. Review of the April 2012 MAR for resident #19 showed s/he was to receive Klonopin 0.5 mg twice daily. Further review showed the resident did not receive Klonopin for six consecutive doses from 4/4/12-4/7/12. Review of the July 2012 MAR showed again the resident did not receive the Klonopin for seven consecutive doses from 7/6/12-7/9/12. Interview on 7/12/12 at 9:25 AM with LPN #1 revealed the facility had a back-up supply of medications available but Klonopin was not included. Further, she stated the nursing staff has periodically had difficulty obtaining medication in a timely manner.	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	F441 (SS=E) a. Resident #7, #16, #25, #12, and #13 incidents could not be corrected because the incident happened and no immediate correction was implemented accept for State Survey Staff questing MSCC staff about infection control and hand washing policies. Each staff did acknowledge their mistake and knew the correct procedure but did not follow policy. b. Hand washing is a serious infection control prevention. The proper policy was in place but was not being followed accurately. MSCC is conducting	

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F 441	Continued From page 37 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of facility policies and procedures, the facility failed to ensure staff followed the accepted standards of practice in regard to hand washing and infection control practices. These failures were captured during 4 random observations which effected 2 of 9 sample residents (#7, #16) and 3 non-sample residents (#25, #12, #13). The findings were:	F 441	In-service with all staff to make sure hand washing policy is being followed. All new hires will be going through a hand washing observation and self demonstration. Twice annually MSCC staff will go through in-service on hand washing policy and techniques. As for the glucometer, a policy was put in place explaining the proper way to disinfect the machine. (Using diluted bleach solution or an environmental protection agency (EPA) registered disinfectant effective against hepatitis and human immunodeficiency viruses. Alcohol is not an EPA registered disinfectant for blood-borne pathogens. c. No system changes are needed. Staff needs to remember to follow proper infection control polices set by MSCC. d. Administrative nursing staff will conduct random checks with each nursing staff twice quarterly to insure staff is following correct infection control policies. In-service will be conducted twice annually on correct infection control policies. Administrative nursing staff will be more visible on the floor to observe nursing staff which should help decrease infectious control incidents. Those staff members not following the policy will be verbally warned the first time, 2nd time written warning, and 3rd termination of employment. MSCC is serious about infection control and will not tolerate staff not following the written policies. Quality assurance will be from the random check with each staff and in-service provided by administrative staff. Reports can be found in the DON's office. Result from audit will be presented and reviewed during weekly RISK/QA Committee meeting. e. Completion Date: 8/23/2012	

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F 441	Continued From page 38 1. Observation of the noon meal on 7/10/12 at 12:16 PM showed CNA #1 placed trash into a trash can, placed a used tray into the dirty dish room then proceeded to pick up and deliver a fresh meal tray to resident #7 without cleansing her hands between dirty and clean. Additionally, CNA #2 placed his hands into his pockets, around his waist on his clothing and then picked up a fresh tray to deliver to a resident without cleansing his hands. Interview with the infection control nurse on 7/12/12 at 11:30 AM revealed staff should always cleanse their hands between meal trays. 2. Observation on 7/10/12 at 9 AM showed LPN #2 completed a glucose finger stick on sample resident #16. After the procedure, she cleaned the glucometer with an alcohol wipe and set it aside. Interview with the LPN on 7/11/12 at 2:15 PM revealed she was not aware the glucometer was not to be cleaned with alcohol. In addition, the LPN revealed the glucometer was used for multiple residents. Review of the manufacturer's instructions for the OptiumEZ glucometer used by the facility showed: "Healthcare professionals performing blood tests with this system on multiple patients...should follow the infection control policies and procedures approved by the facility." Interview with the ADON on 7/11/12 at 1 PM, revealed there was not a policy on how to appropriately clean the glucometer after its use. According to the Association for Professionals in Infection Control & Epidemiology (APIC) recommendations for disinfecting point-of-care devices are published in the American Journal of Infection Control, April 2010. The APIC guideline recommends glucometers be disinfected with a dilute bleach solution or an Environmental	F 441		

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F 441	Continued From page 39 Protection Agency (EPA)- registered disinfectant effective against hepatitis and human immunodeficiency viruses. Alcohol is not an EPA-registered disinfectant for blood-borne pathogens. 3. Observation on 7/11/12 at 4:45 PM showed RN #1 prepare medications for non-sample resident #25. The RN went to the sink for a glass of water located in the dining room, touching the faucet with her unprotected hand. She then proceeded to give the medications to the resident. The RN then prepared medications for resident #13 without first cleansing her hands. Continued observations at that time showed the RN assisted residents with obtaining coffee and water and moving furniture during the medication pass and did not cleanse her hands between tasks and preparing medication. During an interview with the RN immediately following the observation, she acknowledged she should have washed her hands between residents and before preparing medications. Review of the policy and procedure for hand washing dated 4/22/12 showed; "When to Wash Hands:...Before and after each resident contact, after touching a resident or handling their belongings,..." 4. Observation on 7/10/12 at 9:20 AM showed LPN #2 clean and dress a wound for resident #16. The LPN applied her gloves prior to the dressing change. After completing the task, she removed her gloves then touched her hair. The LPN then continued to prepare medications for resident #12 without first cleansing her hands. Review of the policy and procedure for hand washing dated 4/22/12 showed; "When To Wash Hands: ...And before and after glove use."	F 441		

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F 441	Continued From page 40 Further, hands are to be cleansed after touching hair.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medical record notations were accurate in regard to medication administration for 2 of 9 sample residents (#27, #31) and 1 non-sample resident (30). The findings were: Review of the March 2012 MARs for residents #27, #31, and #30 showed on 3/4/12 LPN #3 administered their morning medications. Review of the LPN's personnel file showed s/he did not have a Wyoming LPN license to pass medications or perform any nursing duties. Interview with the LPN on 7/12/12 at 8:55 AM verified she did not yet have a Wyoming nursing license and therefore was not allowed to perform	F 514	F514 (SS=D) a. Resident #27, #31, and #30 will not have a direct POC considering the incident has already occrued and staff who administered the medication has already been terminated. b. Based off the findings the POC is as follows: MSCC has a outside computer technology firm that maintains our server. This provider will issue new computer passwords twice annually to decrease the possibility of unauthorized staff use of another staff's commuter log-in. c. The system change would be that Administrator will contact tech support to change passwords twice annually. A list of the updated password's will be given to Administrator who will then pass out to each staff member. This list will be kept with the Administrator and DON only. d. The Administrator will have a calendar with reminders to contact tech support for password change. Copies of the changed passwords will be kept with the Administrator and DON as record that the passwords have been changed twice annually. MARS report will be printed daily (Monday – Friday) and reviewed by DON or Administrative Nursing Staff to confirm medication was dispensed correctly and dispensed by approved nursing staff. Audit findings will be presented and reviewed during weekly RISK/QA Committee meeting. e. Completion Date: 8/24/2012	

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F 514	Continued From page 47 any nursing duties, including passing medications. When asked about the day in question, 3/4/12, she stated she did not work that day, and "absolutely" did not and would not pass medications because she had no license to do so. Review of the nursing schedule for that day, 3/4/12, showed the LPN was not scheduled to work. Review of the daily staffing sheet verified the LPN did not work on that date. Interview with the DON on 7/12/12 at 9:20 AM revealed, "it appears [another nurse] falsified the MAR for those residents to make it look like the LPN worked when she did not." The DON further verified the nurse she suspected of entering the inaccurate information had computer access codes for all nursing staff. The DON stated this nurse was no longer employed by the facility.	F 514		
F 516 SS=E	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 516	F516 (SS=E) a. No resident number was listed for direct POC corrective action. b. All discharged and over flow medication records have been removed from the records office and placed in locked file cabinets in a privet locked room of the social worker's office. The only staff with access to this room would be pre-approved staff needing such necessary information. Any files that are in the records office should be in locked file cabinets or returned to the correct location at the end of the business day. c. System changes was to locate a place for the discharged and overflow files that would be secure. The social worker's office has a locked room with cabinets which would provide the maximum security for these files.	

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F 516	Continued From page 42 facility failed to ensure medical records were securely stored in one (room 112) of three medical record storage areas. The findings were: Observation on the days of survey from 7/9/12 to 7/12/12 showed resident discharge records and thinned resident records were stored on shelves in an unlocked closet in room 112. The closet, located just inside the entrance to the room, had no doors that could be closed or locked. Interview with the medical records director on 7/11/12 at 12:45 PM verified the medical records should be in a locked area where they were secured. She stated the room was her office and was usually left open or unlocked on weekends. Interview with the DON on 7/12/12 at 3:06 PM verified room 112 with the resident closed/thinned records was usually kept open all day even if there was not medical records staff present.	F 516	d. DON to monitor Records Clerk to make sure that files are being securely filed away. No files should be left unattended by any staff. Offices should be closed and doors locked if there isn't a staff present to secure resident files. All files should be placed in locked file cabinets at the end of each business day. Computers should go to screen saver after 5 minutes of no use and systems should be logged out when not in use to make sure all computerized data is secure. All of this will be monitored by DON and Administrator during end of the day walk troughs to each staff office. Documentation of infractions will be addressed with staff. If there are files that have not been placed in secure areas or offices left open and unattended the DON and Administrator will issue a verbal warning. A second offence will result in a written warning and the third offence will result in termination. Audit findings will be	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require	F 520	reviewed during weekly RISK/QA Committee meeting. e. Completion date: 8/24/2012 F520 (SS=E) a. No resident number was listed for direct POC corrective action. b. Weekly RISK meetings are held every Thursday with the following quality assessment and assurance committee members: Administrator, Social Worker, DON, ADON, Maintenance Manger, Dietary Manager, House Keeping Manager, and Medical Director. All audits from the week will be reviewed and discussed. New policies that need to be reviewed and signed by the medical director will be presented to all staff. Incident reports will be discussed, reviewed, and signed by medical director and administrative staff. Monthly and Year	

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F 520	Continued From page 43 disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of CMS-2567 (Centers for Medicare and Medicaid Statement of Deficiencies), and review of facility documents, the facility failed to ensure the quality assurance and performance improvement (QAPI) program was effective in resolving identified concerns. The findings were: 1. Interview with the quality assurance coordinator on 7/12/12 at 12 noon revealed data was collected on privacy, catheters, falls, and skin issues. Review of the quality data verified these areas were audited. However, there was no evidence the data was analyzed or used to improve processes. In addition, review of the CMS-2567 for last year's survey, dated 9/15/11 revealed the following deficiencies were written: a. F272 related to lack of comprehensive assessments; b. F280 related to inaccurate care plans; c. F314 related to pressure sores; d. F329 related to unnecessary medications; e. F371 pertaining to clean and sanitary conditions; and f. F520 related to quality assurance and performance improvement.	F 520	to Date reports showing the number of incidents, residents with sores, residents in isolation, medication errors, and any staff not in compliance with updated training will be presented at each weekly RISK meeting. This report is a visual aide for our staff to show we are either improving or declining our level of care. If we are declining then we need to create performance improvement plan that is agreed and implemented by all staff. Each RISK Meeting must have a sign in sheet to show who was in attendance. If a committee member is absent then minutes from the meeting must be issued, reviewed, and signed by absent committee member. If medical director is absent then meeting must be propone until the next week. The medical director has to be present for RISK Meetings to give his stamp of approval on information presented by committee members. c. System changes would be that meeting be structured with line items of each topic presented so we can get through all audits, reports, and incidents in a timely manner. MSCC committee members will utilizing the medical director's education and experience to help build a strong facility. d. ADON and Records Clerk will be presenting the bulk of the information in the meeting. Their audits and reports will be reflective in the weekly RISK minutes. Sign in sheet will show all that attended. The minutes of the meeting along with the sign in sheet will be in a folder with the Administrator available for review. e. Completion Date: 8/24/2012	

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F 520	Continued From page 44 These same issues were identified as concerns during the current survey conducted 7/9/12 through 7/12/12. 2. Review of the meeting attendance rosters for the past year showed no evidence a physician was in attendance and participated in the QAPI meeting four times. Interview with the quality assurance coordinator on 7/12/12 at 12 noon revealed the facility did not consistently record attendance at the meetings until October of 2011 so she was unable to determine if a physician attended the July 2011 meeting or not.	F 520		