DEPARTMENT OF HEALTH AND HUMAN S VICES on pages 1, 2, 10, 12, 13, 25, 26, PRINTED: 09/01/2006
CENTERS FOR MEDICARE & MEDICAID SERVICES 28 & 31 after discussion w/ 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 _____ Lucy Smith DON on 9/29/06 @ 4:30 pm Linda Brown RN	08/18/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	P O BOX 859 FORT WASHAKIE, WY 82514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 151 SS=E	483.10(a)(1)&(2) EXERCISE OF RIGHTS The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure an environment free from written reprisal and/or coercion. The facility census was 34. Observation on 8/15/06, 8/16/06, and 8/17/06, revealed signs posted above the thermostats in the resident lounge and near the centrally located nurses' station. The signs stated the following posted message: "If you keep on playing with this, I will fix it so you don't [word don't was underlined] have air." The signs were in large print; visible to residents, visitors, and staff. Thermostats at the end of each patient hall were specifically addressed to staff and stated, "Staff DO NOT adjust thermostats." Confidential interview with two staff members on 8/17/06 at 11:45 AM revealed the residents' would not speak up if their rights were being violated.	F 151	All resident will be free from interference or reprisal and able to freely exercise his or her rights. On 8/17/06 at approximately 1800 the signs above the thermostats were changed to read as follows: Please leave thermostats at 75 degrees. If thermostat is set lower, the air conditioner compressors freeze up and the air conditioner fails. Thank you for your kind cooperation. On 8/18/06 the maintenance department head received an in-service on resident right to be free of interference , coercion , discrimination, and reprisal from the facility in exercising his or her rights by the DON. Included in the in-service was how the residents might feel the wording of the sign is coercive and threatening B) All dept heads will monitor for any reprisal and / or coercion while performing specific job duties C) At stand-up meeting of all department heads 9-5-06 an in-service for all department heads regarding resident right to be free on interference, coercion, discrimination and reprisal from the facility in exercising his or her rights D) At stand-up meeting, 9-05-06 a new policy for all signage posted in the facility- All Signage must be approved by the DON or Administrator before being posted 9/5/06	

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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.

add E Administration of Lucy Smith DON on 9/29/06 by Linda Brown RN

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E) Results of monitoring will be evaluated by the QA Committee for the next 2 quarters.

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F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure least restrictive devices were use for one (#9) of three sample residents who utilized restraints. The findings were: Observation on 8/17/06 at 9:51 AM revealed resident #9 was seated in a wheelchair outside the activity room. The observation revealed the resident wore a "Wanderguard" and used a lap belt. A second observation at 10:18 AM on 8/17/06 revealed staff had released the lap belt in order to assist the resident to the toilet and then to bed. As staff prepared to leave the room, a full siderail was raised. Interview at that time with certified nurse aide (CNA) #11 revealed the resident could not release the lap belt. The CNA stated the side rail was used as a "precaution." The CNA further stated the resident's mental cognition had declined and the CNA was unsure whether or not the resident would try to get up. Observation from 6:04 PM to 6:18 PM on 8/17/06 revealed the resident had the lap belt on while eating at the assisted dining table. Observation on 8/18/06 at 8:11 AM revealed the resident was seated in a wheelchair at a table. A CNA assisted the resident with eating and the lap belt remained on. The following concerns were noted related to the use of the lap belt and side rail: a. Review of the medical record revealed a	F 221	All residents will be properly assessed for the need and use of restraints including : resident #9. Pre-restraint assessment was completed on resident #9 on Sept 5th. It was determined this resident does not require side rails so they are not being used. It was determined the resident does need the seatbelt. A) All other residents will have pre-restraint assessments prior to their use. (Assessment tool included). Pre-restraint assessment will be completed by nurse or therapist B) On Sept 12, 2006 a restraint committee will be in place consisting of the DON or designee, social services, and the MDS coordinator and meet to review monthly, all residents with physical restraints. C) This committee will ensure that least restrictive measures are being employed, adequate assessment for need has been documented, care planning for proper restraint utilization is in place and that family has been informed of these findings and has consented to their use. Minutes will be kept and attendance documented. D)The findings of this committee will be reviewed at each quarterly CQI meeting, next scheduled for the first week in October. Sept 12th and ongoing.	9/12/06

added per request of Lucy Smith DOB on 9/29/06 Lynda Brown RN

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F 221	Continued From page 2 resident assessment protocol (RAP) module dated 8/9/06 for restraints that documented the resident used the lap belt to prevent unsupervised ambulation and wandering. There lacked evidence that other methods were tried. Furthermore, the review failed to reveal any information related to the use of te siderail for this resident. b. Review of the most recent care plan and the previous care plan failed to reveal any documentation related to the restraints. . c. Interview and record review with the director of nursing (DON) on 8/17/06 at 6:40 PM revealed the siderail should no longer be used. After reviewing both the current medical record and purged record, the DON stated she was unable to find information or a care plan related to the use of the lap belt.	F 221		
F 224 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of the medical record, the facility failed to ensure resolution related to misappropriation of property for 1 (#28) of 9 sample residents. The findings were: Medical record review showed that according to the face sheet, resident #28 had diagnoses	F 22[illegible]	F 224 483.13 (c) Staff Treatment of Residents. The facility will ensure that all residents will be treated with respect and dignity. A) Staff will properly utilize written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. In regard to resident #28, resident's missing cane was found in the equipment storage garage on 8/17/06 and returned to his/her room for use. Resident was informed of finding his/her cane and given the cane.	

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F 224	Continued From page 3 including blindness and Parkinson's disease. Further review revealed the resident had undergone surgery to remove the second toe on the left foot on 3/10/06. Interview with resident #28 on 8/15/06 at 3:17 PM revealed the resident was missing his/her cane, and wanted it back. The resident, who had difficulty communicating, made a motion demonstrating the use of a cane to clarify the statement. Review of a physician's progress note dated 6/13/06 showed "PT [patient] states someone stole [his/her] cane would like another one." Review of th facility's policy on abuse reporting, reviewed on 9/99, showed "any alleged violations involving...misappropriation of resident property, must be promptly reported. The following concerns were noted with the facility's response regarding the missing cane: a. Interview with the social service director (SSD) on 8/16/06 at 4:05 PM revealed she was unaware the resident used a cane or that there was a missing cane. She further stated the resident was probably saying "keys," not "cane." b. Interview with the director of nursing on 8/17/06 at 10:40 AM revealed the resident had a cane, and a couple of months ago it was lost. She stated she remembered looking for it. However, it was never found or replaced. When asked if there was any documentation concerning the resident's missing property she responded that there was not. She further revealed the SSD should have been involved, and there was a form that should have been filled out. A blank copy of the form was provided, and it was titled "Theft/Loss Monitoring Report."	F 224	B) Direct care staff will be instructed to report missing resident property immediately to charge nurse and social services. Charge nurse will prepare appropriate report upon notification. C) An in-service will be presented to all staff on Sept 11, 2006 regarding misappropriation of resident property. The facility "Theft/Loss Monitoring Report" will be reviewed at that time and the criteria for its use and dispersal discussed. A social services communication book will be created in which all social service concerns among the residents will be entered on a PRN basis. This book will be available for daily inspection by the social services director. D) At quarterly CQI meeting all Theft/Loss Monitoring Reports will be reviewed for recovery or replacement of resident lost items.	10/2/06 ongoing

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F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, review of facility policy and procedure and medical record review, the facility failed to ensure policies and procedures were implemented for 2 (#22, #28) of 9 sample residents related to the misappropriation of resident property and reporting injuries of unknown origin. The findings were: Review of the facility policy and procedure on abuse reporting last reviewed 9/99 showed, "All personnel must promptly report any incident or suspected incident of resident abuse, including injuries of unknown source and misappropriation of resident property." In addition, the procedure for the person who discovered the injury showed they were to report the injury to the charge nurse and complete an incident report. The charge nurse then would provide an assessment of the resident and photograph the injuries. The nurse would then finish the incident report and provide the report to the director of nursing (DON). The DON was then responsible to notify the proper authorities, and conduct the investigation. The following concerns were noted with the implementation of this policy and procedure: 1. Medical record review showed that according to the face sheet, resident #28 had diagnoses	F 226	F 226 483.13 Staff Treatment of Resident. The facility will ensure that all residents will be treated with respect and dignity. A) Staff will properly utilize written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. In regard to resident #28 , resident 's missing cane was found in the equipment storage garage on 8/17/06 and returned to his /her room for use. Resident was informed of finding his/ her cane and given the cane. In regard of resident #22 an incident report was completed on 8/17/06 with family notification. B) Direct care staff will be instructed to report missing resident property and any injuries discovered immediately to charge nurse and social services. Charge nurse will prepare appropriate report upon notification	

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F 226	Continued From page 5 including blindness and Parkinson's disease. Further review revealed the resident had undergone surgery to remove the second toe on the left foot on 3/10/06. Interview with resident #28 on 8/15/06 at 3:17 PM revealed the resident was missing his/her cane, and wanted it back. The resident's left foot was observed to be bandaged. The resident, who appeared to have difficulty communicating, made a motion like using a cane to clarify the statement. Review of a physician's progress note dated 6/13/06 showed "PT [patient] states someone stole [his/her] cane would like another one." The following problems were noted: a. Interview with the social service director (SSD) on 8/16/06 at 4:05 PM revealed she was not aware the resident used a cane or that one was missing. b. Interview with the director of nursing (DON) on 8/17/06 at 10:40 AM revealed the resident had a cane, but it was lost a few months before. The DON said she remembered looking for it. However, it was never found or replaced. When asked if there was any other documentation concerning the resident's missing property, the DON responded that there was not. She further revealed the SSD should have been involved, and there was a form that should have been filled out. A blank copy of the form was provided, and it was titled "Theft/Loss Monitoring Report". 2. Medical record review showed according to the face sheet, resident #22 had diagnoses including quadriplegia and was totally dependant on staff for activities of daily living. Observation on 8/16/06 revealed the resident required staff assistance by CNA #11 and #14 for incontinence	F 226	C) An in-service will be presented to all staff on Sept.8 2006 regarding misappropriation of resident property and reporting injury/ bruising. The facility "Theft/Loss Monitoring Report" and Incident / Injury Report" will be reviewed at that time and the criteria for their use and dispersal discussed. A social services communication book will be created in which all social service concerns among the residents will be entered on a PRN basis. This book will be available for daily inspection by the social services director D) At Quarterly QA meeting all Theft/ Loss Monitoring Reports and Incident/ Injury reports will be reviewed E) Sept 8 and on-going	

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F 226	Continued From page 6 care and dressing. As the observation continued, staff removed the resident's shirt which was soiled. The observation revealed the resident had a large (approximately 3 X 2 inch) black/brown bruise to his/her left anterior upper arm. Interview with both CNAs at that time revealed neither had prior knowledge of the bruise. Interview with the director of nursing on 8/18/06 at 9:33 AM revealed she was unaware of the bruise on the resident's arm, and had not received any incident report. Interview with LPN #2 on 8/18/06 at 9:50 AM revealed she had been told about the bruise on either 8/14/06 or 8/15/06, but was just filling out the incident report on 8/16/06.	F 226		
F 246 SS=D	483.15(e)(1) ACCOMODATION OF NEEDS 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 interview, and medical record review, the facility failed to provide reasonable accommodations to locate or replace a personal mobility aide for 1 (#28) of 9 sample residents. The findings were: Medical record review revealed that resident #28 had diagnoses including blindness and Parkinson's disease. Furthermore, the resident had surgery to remove the second toe on the left	F 246	F246 483.15 (e) (1) Accommodation of Needs A) Staff will properly utilize written policies and procedures to assure reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered B) Staff will implement and follow written procedures to provide reasonable accommodation to locate or replace lost mobility aids or other items. In regard to resident #28, resident's missing cane was found in the equipment storage garage on 8/17/06 and returned to his/her room for use. Resident was informed of finding his/her cane and given the cane.	

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F 246	Continued From page 7 foot on 3/10/06, and the foot was still healing. The following concerns were noted: a. Interview with resident #28 on 8/15/06 at 3:17 PM revealed s/he was missing a cane, and wanted it back. The resident had difficulty communicating and made a motion as if using a cane to clarify his/her statement. b. Review of a physician's progress note dated 6/13/06 showed "PT [patient] states someone stole [his/her] cane would like another one." c. Interview with the social service director (SSD) on 8/16/06 at 4:05 PM revealed she was unaware the resident used a cane or that a cane was missing. d. Interview with the director of nursing on 8/17/06 at 10:40 AM revealed the resident had a cane and lost it a couple of months before. She remembered looking for it; however, the cane was never found or replaced. When asked if there was any documentation concerning the resident's missing property she stated there was none. She also stated the SSD should have been involved. e. Observation on 8/18/06 at 9:33 AM revealed the cane was leaning on a bedside table near the head of the resident's bed. At this time the resident stated s/he used the cane to transfer into and out of bed. According to the DON on 8/18/06 at 9:35 AM, the cane was located in the garage behind the facility.	F 246	. Direct care staff will be instructed to report missing resident property and any injuries discovered immediately to charge nurse and social services. Charge nurse will prepare appropriate report upon notification. C) An in-service will be presented to all staff on Sept 10, 2006 regarding misappropriation of resident property, reporting injury/bruising and accommodation of individual needs. The facility "Theft/Loss Monitoring Report" and "Incident/Injury Report" will be reviewed at that time and the criteria for their use and dispersal discussed. A social services communication book will be created in which all social service concerns among the residents will be entered on a PRN basis. This book will be available for daily inspection by the social services director. All resident personal items will be inspected for ownership marking and if not marked will be marked. D) At quarterly CQI meeting all Theft/Loss Monitoring Reports, Incident/Injury and reports of resident needs will be reviewed.	10/2/06

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F 250 SS=E	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to ensure communication and documentation was shared in order to enable medically-related social services to be provided for residents who required these services. As a result, social services were not provided for 3 (#8, #22, #28) of 9 sample residents with identified social service needs. The findings were: 1. Medical record review revealed resident #28 had diagnoses including blindness and Parkinson's disease. Further review revealed the resident had undergone surgery to remove the second toe on the left foot on 3/10/06. Interview with resident #28 on 8/15/06 at 3:17 PM revealed the resident was missing his/her cane, and wanted it back. At the time of the interview it was noted the resident had a bandaged left foot. The resident, who had difficulty communicating, made a motion as if using a cane to clarify his/her statement. Review of a physician's progress note dated 6/13/06 showed "PT [patient] states someone stole [his/her] cane would like another one." The following concerns were noted regarding the lack of social service's involvement: a. Interview with the social service director (SSD) on 8/16/06 at 4:05 PM revealed she had been working in the facility since November,	F 250	F 250 A) It is the policy of the facility to ensure all residents are provided medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. In regards to resident # 28 missing cane was found in the equipment storage garage on 8/17/06 and returned to room for use. In regard to resident #22 an assessment was done on wheel chair by OT and restorative nurse and deem safe for use at this time. In regard to resident #8 an assessment of psychosocial needs was done in regards to the loss of her granddaughter and no services needed at this time. B) Direct care staff will be instructed to report missing resident property and significant changes in psychosocial needs to social services and charge nurse immediately. Therapies will report specialize equipment needs to social services as they arise.	

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F 250	Continued From page 9 2005. The SSD stated that she was unaware the resident used a cane or that one was missing. She further stated the resident was probably saying "keys, not cane." b. Interview with the director of nursing (DON) on 8/17/06 at 10:40 AM revealed the resident had a cane, and a couple of months before it was lost. The DON stated she remembered looking for it; however, it was never found or replaced. She further revealed the SSD should have been involved. 2. Medical record review revealed resident #22 had diagnoses including quadriplegia and contractures of joints. Observation on 8/16/06 at 3:50 PM revealed the resident utilized a custom wheelchair. However, a lever was disconnected from the hydraulic mechanism under the seating platform of the wheelchair. Interview with CNA #3 and CNA #13 at the time of the observation revealed the wheelchair no longer reclined and was missing half of the lap belt. CNA #13 stated the wheelchair had been broken for approximately a year, and the resident needed the reclining option and lap belt since the resident had severe contractures and required specialized positioning. Interview and observation with the occupational therapist (OT) on 8/17/06 at 9:25 AM showed the resident used the wheelchair. The OT confirmed the wheelchair was broken. She further stated that due to the resident's weight gain, his/her positioning was no longer appropriate, and the chair was now too small. Interview with the resident's family on 8/16/06 at 4:45 PM revealed the custom wheelchair was several years old. The family member stated she was aware the facility was trying to get a new wheelchair because the resident's positioning was	F 250	C) An in-service will be presented to all staff by Sept.8 2006 regarding Theft /Loss monitoring report and the criteria for its use and dispersal Social services will provide grief consulting to all residents who experience losses in their personal life. A social service communication book will be created in which all social service concerns regarding the residents will be enter on a PRN basis. This book will be available for daily inspection by the social service director. A form for therapies will be created to report needed specialize equipment and submitted to social services PRN. D) At quarterly QA meeting Theft/ Loss monitoring reports, residents psychosocial needs, and specialize equipment needs will be discussed. E) Oct 2nd and on going. F) Discussions have occurred between the DON, social services, and nsg staff in regard to the conflict between social services & nsg and how to work & communicate collaboratively. Social Service job responsibilities was revised to be more defined & expectations outlined. Social services has been included in restraint committee and psychotropic committee along & nsg to increase collaboration & communication. added per request of Lucy Smith after discussion on 9/29/06 Linda Brown RN	

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	535050	A. BUILDING _____ B. WING _____	08/18/2006

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F 250	Continued From page 10	F 250		

not good. However, the family member was unaware the chair was broken, and had not heard anything regarding the new wheelchair, except that the facility still needed funding in order to purchase the new chair.

The following concerns were noted regarding the lack of involvement by social services in acquiring a new wheelchair for this resident:

a. Medical record review showed a physician's order for the new wheelchair was dated 3/28/06. However, there was no mention of the reason a new wheelchair was needed.

b. There was no evidence in the medical record that safety or positioning assessments were done, and no evidence that social services was involved. Interview with the DON on 8/17/06 at 10:40 AM verified safety and positioning assessments were not completed. As far as the progress toward a new chair, she stated the SSD was "working on it." Interview with the SSD on 8/16/06 at 5:08 PM confirmed she was working on getting funding for a new wheelchair for the resident, and so far was unsuccessful. She further confirmed there was no documentation regarding her efforts to get this resident a new wheelchair. She then stated "it should be documented."

3. Interview on 8/16/06 at 12:30 PM with RN #6, revealed resident #8 had lost her granddaughter two days prior in a "bad" motor vehicle accident. The nurse stated the resident's daughter who was the mother of the accident victim was a staff member at the facility. The mother was at work when notified about the accident.
Review of the medical record revealed no mention of the recent death. Interview with the SSD on 8/17/06 at 11:10 AM revealed she was

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	535050	A. BUILDING _____ B. WING _____	08/18/2006

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MORNING STAR CARE CENTER	P O BOX 859 FORT WASHAKIE, WY 82514

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F 250	Continued From page 11 "unaware" of the death in the family. When asked what her role would be to the resident in this situation, she responded she would provide grief counseling. She further stated there was conflict between herself and the nursing staff. The conflict resulted in poor communication, and at times, "keeps me from doing my job." She went on to say, the conflict was so great, when the evening staff came on at about 3 PM, she isolated herself to her office instead of being out with the residents. Interview with the director of nursing on 8/17/06 at 10:40 AM confirmed she was aware there was difficulty with communication between the SSD and nursing, and it was something they were working on. She further agreed this death of a close family member should have been documented in the medical record.	F 250		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE 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, resident interview, and staff interview, the facility failed to ensure routine housekeeping and maintenance. Light bulbs were burnt out, insects were accumulated in light fixtures, and seating surfaces needed repair and/or cleaning. The findings were: 1. Observation on 8/16/06 from 11 AM to 11:48 AM reveled an accumulation of dead insects in several overhead hallway plastic light covers in	F 253	Plastic light covers in the hallways (all) were cleaned by housekeeping. All burned out lightbulbs in the resident dining room and living room were replaced & new ones. The upholstered lounge chair in room 104 and in the activity room were cleaned. An inspection of all chairs was done and other chairs are scheduled for cleaning. Resident #26 wheelchair has been repair. an inspection was done of all wheelchairs and all needing repair will be done in 1 working day by maintenance. added per request of Lucy Smith DON on 9/29/06	

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MORNING STAR CARE CENTER	P O BOX 859 FORT WASHAKIE, WY 82514

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F 253	Continued From page 12 the following locations: a. in the east wing next to resident room #213 and next to the janitor's closet door. b. the entrance hallway next to the facility living room and next to the entrance to the public men's room. c. the back hallway next the clean linen storage door d. the west hallway next to resident rooms #106, #111, and #112. Interview with the facility director of housekeeping on 8/17/06 at 10 AM confirmed the ceiling lights should have been cleaned. 2. Observation on 8/16/06 from 1 PM to 1:48 PM revealed 4 burned out light bulbs in the overhead ceiling lights in the resident dining room. The observation revealed 8 burned out light bulbs in the overhead ceiling lights in the resident living room. Interview with the director of housekeeping on 8/17/06 at 10 AM revealed the light bulbs should have been replaced. Observation on 8/15/06 at 5:10 PM and 8/17/06 at 9:35 AM revealed the upholstered lounge chair in room #104 was soiled with a white colored substance. The soil was noted in three areas with the largest spot being approximately 3x4 inches in diameter. Interview with resident #18 on 8/17/06 at 9:35 AM, revealed s/he had noticed the chair in his/her room was dirty and was unaware of the last time it was cleaned. Observation on 8/16/06 at 9:30 AM revealed an upholstered chair in the activity room was soiled with several areas of a white colored substance. Observation at 3:25 PM on 8/15/06 revealed resident #26 utilized a wheelchair for mobility. The	F 253	Morning Star Care Center will ensure a clean, safe, and secure environment for all residents and employees. A)Housekeeping staff will monitor all overhead plastic light covers in the building bi-weekly and will clean the covers upon inspection. Light bulbs will also be checked weekly and replaced as they burn out. 8/25/06 8/18/06 C.N.A.s will monitor wheelchairs on a schedule night shift and clean chairs according to schedule. C.N.A. will report in the Maintenance log all resident's chairs needing repairs. All repairs will be completed the next working day. Maintenance director will report all potential problems regarding chairs to administrator if parts are unavailable. Replacement chair be offered.. C) Housekeeping Director will in-service housekeeping staff on procedures and schedules for light covers and the cleaning of the changing of light bulbs. Maintenance director will complete maintenance monitoring log of chairs needing repairs and report problems to Administrator. 9/30/06 D) Housekeeping report to administrator monthly and log problems to be reported in Safety Committee. The Safety Committee then reports results to the QA committee quarterly. added per request of Libby Smith, DON, on 9/29/06 Brenda RD	

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	535050	A. BUILDING _____ B. WING _____	08/18/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	P O BOX 869 FORT WASHAKIE, WY 82514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 253	Continued From page 13 observation revealed the right arm of the wheelchair had missing vinyl; exposing the interior foam.	F 253		

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F 272 SS=E	483.20, 483.20(b) 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 RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assure completion of comprehensive assessments in various areas for 5 (#8, #9, #22, #28, #29) of 9	F 272	F-272 A) Each resident will receive an initial and periodic comprehensive, accurate standardized and reproducible assessment of their functional capacity. Resident #22 will have a w/c safety and positioning assessment completed by therapies. Resident #8 will have a bowel and bladder assessment completed with a toileting plan develop. Resident #9 has had a restraint assessment completed. Resident #28 will have an accurate dental assessment completed. Resident #29 will have assessment for cognitive loss/ dementia and communication and care plans developed. B) RAI assessments for all residents will be reviewed by an RN for accuracy and corrections made at that time.	

The ADL assessment was reviewed by the DON and believed to be complete and accurate.

added per request of Libby Smith DON on 9/29/06 Linda Brown RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/S' IE A IDENTIFICAT. UM. R:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 15 sample residents. The findings were: 1. Medical record review showed resident #22 had diagnoses including quadriplegia and contractures of joints. The resident was totally dependant on staff for activities of daily living (ADLs). Observation on 8/15/06 at 3:50 PM revealed resident #22 utilized a custom wheelchair. A lever was observed to be disconnected from the hydraulic mechanism beneath the seating platform of the wheelchair. Interview with CNA #3 and CNA #13 at that time revealed the wheelchair no longer reclined and was missing half of the seatbelt. CNA #13 stated the wheelchair had been broken for approximately a year, but the resident needed the reclining option and seatbelt since the resident was severely contracted and required specialized postioning. Interview and observation with the occupational therapist (OT) on 8/17/06 at 9:25 AM confirmed the wheelchair was broken, and stated due to the resident's weight gain, the resident's positioning in the wheelchair was no longer appropriate. The OT stated she was unaware of an assessment for the positioning. Medical record review showed no evidence of a safety or positioning assessment. Interview with the DON on 8/17/06 at 10:40 AM confirmed neither a safety nor a positioning assessment was completed for the resident's use of the wheelchair. 2. According to the 1/10/06 significant change Minimum Data Set (MDS) assessment, resident #8 triggered for urinary incontinence. According to Section V of that MDS assessment, the comprehensive information was located in the 12/05 aide summaries. These aide summaries	F 272	C) The comprehensive assessment will be reviewed by an RN after completion by the MDS coordinator D) Random comprehensive assessments will be audited monthly and a report made to Quarter QA meeting E) Oct 2nd and ongoing	

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F 272	Continued From page 16 were not available; however, Resident Assessment Protocol (RAP) for the resident's urinary incontinenance was done. Review of this RAP revealed it was not a comprehensive assessment. Interview with the director of nursing (DON) on 8/16/06 at 10:40 AM verified that there was no additional assessment information. Futhermore the DON stated the facility should have developed a toileting plan for this resident. 3. Observation on 8/17/06 at 9:51 AM revealed resident #9 utilized a seatbelt while seated in a wheelchair. Other observations at 6:04 PM to 6:18 PM on 8/17/06 and at 8:11 AM on 8/18/06 revealed the resident had the seatbelt on while eating at the assisted dining table. In addition, a full side rail was used when the resident was assisted to bed on 8/17/06 at 10:18 AM. Interview at 10:18 AM on 8/17/06 with certified nurse aide (CNA) #11 revealed the resident was no longer able to release the seatbelt. The CNA stated the side rail was used as a "precaution." She further stated the resident's mental cognition had declined, and the CNA was unsure if the resident would even try to get up. Review of the medical record revealed a significant change RAI dated 7/28/06. Review of Section "V" revealed the resident triggered for additional assessment information for physical restraints. Review of a restraint RAP module dated 8/9/06 revealed the resident used the seatbelt to prevent unsupervised ambulation and wandering. A thorough assessment documenting alternative interventions or how to use the restraint in the least restrictive manner was not found. The review failed to reveal any information related to the side rail and its use. Interview and record review with the director of nursing (DON) on	F 272		

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F 272	Continued From page 17 8/17/06 at 6:40 PM revealed the side rail should no longer be used. Then, after reviewing both the current medical record and purged record, the DON stated she was unable to find further information related to the use of the lap belt and side rail. 4. According to the 7/14/06 annual MDS assessment, resident #28 triggered for ADL function, and dental care. According to Section V of that MDS assessment, there was no location listed for the ADLs or dental information. However, a RAP was done for ADL function but it was not comprehensive. Interview with the social service director on 8/18/06 at 12:15 PM revealed she was responsible for the area of dental care, and an assessment was not completed. 5. On 8/15/06 at 6:30 PM observation of resident #29 revealed s/he had a difficult time speaking and making his/her needs known. Review of the medical record revealed an annual assessment RAI dated 2/12/06 in which the resident triggered for additional assessment information for cognitive loss/dementia and communication on Section V. No location for additional assessment information was listed. However, a RAP summary was attached for the these two areas. Review of both RAP summaries revealed each was blank. Interview with the DON on 8/17/06 at 10:48 AM revealed the additional assessment information and summary would have been documented on the attached RAP summary.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278 SS=F	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview the facility failed to ensure the accuracy of information contained in the Minimum Data Set (MDS) assessments for 9 (#5, #8, #9, #16, #20, #22, #28, #29, #32) of 9 sample residents. The findings were:	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NO.	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 19 1. Review of the medical record for resident #16 revealed the resident was admitted to the facility on 5/1/06, and an admission MDS assessment was missing. Interview with the director of nursing (DON) on 8/17/06 at 5:15 PM stated the 5/16/06 14-day Medicare assessment should have also been coded as an admission assessment. Comparing the 5/16/06 Medicare 14-day, and the 6/2/06 Medicare 30-day MDS assessments (18 days apart) for resident #16 revealed the following concerns: a. The resident declined from having no memory problems, and being independent in cognitive skills and decision making to having memory problems and moderately impaired cognitive skills. b. The resident declined from needing limited assistance with activities of daily living (ADLs) to needing total dependence of staff for ADLs with the exception of eating. c. The resident declined from being continent of bowel to being frequently incontinent; the resident declined from "occasionally" incontinent of bladder to "frequently" incontinent. d. The resident declined from having adequate vision, to having highly impaired vision. Medical record review showed no acute medical problem or other indicators of decline in status during this period. Interview with the DON on 8/17/06 at 5:15 PM revealed a nurse who was no longer working at the facility, had completed the 6/2/06 assessment. She then confirmed it was grossly inaccurate. She stated she had never known the resident to be totally dependent on staff for any activities of daily living , and the resident had always had highly impaired vision. Review of the 8/11/06 quarterly MDS assessment showed the resident was mostly independent with	F 278	F 278 Resident Assessment: The facility will ensure that each resident receives an accurate assessment and a RN will certify its completeness. A) Each resident will receive an assessment that accurately reflects the resident's status. Resident #16 will have necessary correction made for ADL's, cognition, continence and vision. Resident # 28 will be accurately coded for existing surgical wound. Resident #22 will have location of assessment information listed and care planning decisions indicated. Resident #29 will have location of assessment information listed and care planning decisions indicated. Resident #8 will have location assessment information listed and care planning decisions indicated.	

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F 278	Continued From page 20 ADLs, requiring no more than "limited" assistance. This assessment revealed the resident was continent of both bowel and bladder. 2. Review of section M of the the 7/14/06 annual MDS assessment for resident #28 failed to code a surgical wound that was present at the time of the assessment. Interview with DON on 8/17/06 at 10:40 AM confirmed the resident still had a healing surgical wound from a 3/10/06 toe amputation, and the coding was inaccurate. 3. Review of section V for the following MDS assessments showed they were lacking the location of the information for the additional assessments that were triggered, and/or did not indicate care planning decisions for some of the triggered areas: a. The annual MDS assessment, dated 4/26/06, for resident #22. b. On 8/15/06 at 6:30 PM observation of resident #29 revealed s/he had a difficult time speaking and making his/her needs known. Review of the medical record revealed an annual RAI dated 2/12/06. Review of Section V revealed cognitive loss and communication were areas in need of further assessment. No location for additional assessment information was listed. In addition, Section V did not list a care planning decision for any of the triggered areas, including: cognitive loss/dementia, visual function, communication, ADL (activity of daily living) function, urinary incontinence and indwelling catheter, nutritional status, and pressure ulcers. c. The significant change MDS assessment, dated 1/10/06, for resident #8. d. Review of the medical record for resident #5 revealed an admission RAI, dated 6/10/06.	F 278	Resident #5 will have location of assessment information listed and care planning decisions indicated. Resident #32 will have location of assessment listed and care planning decision indicated. Resident #9 will have location of assessment information and care planning decisions indicated. Resident # 20 will have location of assessment information and care planning decisions indicated. B) RAI assessment for all residents will be reviewed by an RN for accuracy and corrections made at that time. C) The comprehensive assessments will be reviewed by an RN after completion by the MDS coordinator D) Random comprehensive will be audited monthly and a report made at the Quarterly QA meeting E) Oct 2nd and ongoing	

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F 278	Continued From page 21 Review of Section V revealed the care planning decision for cognitive loss was not determined. e. The significant change MDS assessment, dated 7/26/06, for resident #32 was missing locations for additional assessment information and care planning decisions. f. Review of the medical record for resident #9 revealed a significant change RAI, dated 7/28/06. Review of Section V revealed the resident required additional assessment information for nutrition. The location of the additional assessment information was blank. Further record review revealed a nutritional assessment in the dietary progress notes. Review of Section V revealed no documentation regarding a care planning decision for identified problem areas such as cognitive loss/dementia, communication, behavioral symptoms, nutrition, and activities. g. The annual MDS assessment, dated 7/6/06, for resident #20 was missing the location for additional assessment information for cognitive decline and care planning decisions.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING _____ B. WING _____	08/18/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	P O BOX 859 FORT WASHAKIE, WY 82514

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F 279 SS=D	483.20(d), 483.20(k)(1) 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 observation, medical record review and staff interview, the facility failed to develop a care plan that addressed a physical restraints for 1 (#16) of 3 sample residents who utilized physical restraints. The findings were: Observation on 8/17/06 at 4:24 PM revealed resident #16 wheeled out to the nurses' station. As LPN #5 passed the resident, the resident pulled on the lap belt restraint and said "Let me loose." The LPN reached down and unbuckled the restraint. The resident propelled the wheelchair back to the resident's room. Medical	F 279	F 279 483.20 (k)(1) Comprehensive Care Plans: It is the policy of the facility to ensure that the assessment will be used to develop the comprehensive plan care. A) All residents will have comprehensive plans of care developed, reviewed and revised based on the resident's assessments. Resident #16 care plan will be revised to reflect the use of restraints B) Care plans for all resident s will be reviewed by an RN for accuracy and completeness with corrections made at that time C) The resident care plans will be reviewed by an RN after completions by the MDS coordinator. An in-service on proper use of restraints will be conducted for all nurses and CNA's on Sept 25, 2006	

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F 279	Continued From page 23 record review showed an assessment for the lap belt was done on 5/20/06. The assessment showed the restraint was used to prevent the resident from getting up and walking without assistance. However, review of the resident's current care plan revealed the physical restraint was not mentioned. Interview with the director of nursing on 8/17/06 at 5:15 PM confirmed the use of the lap restraint should have been addressed in the care plan.	F 279	D) Random care plans will be audited monthly and a report made to the quarterly QA meeting E) Oct 2nd and ongoing	
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff and family interviews, the facility failed to ensure the safety of a wheelchair for one (#22) of one sample resident who utilized a specialized wheelchair. The findings were: Medical record review revealed resident #22 had diagnoses including quadriplegia and contractures of joints. The resident was totally dependant on staff for activities of daily living (ADLs). The following safety concerns were noted regarding the resident's wheelchair: a. Observation on 8/15/06 at 3:50 PM revealed resident #22 utilized a custom specialized wheelchair. A lever was disconnected from the hydrolic mechanism under the seating platform of the wheelchair. Interview with CNA #3 and CNA	F 323	F323 483.25 (h)(1) Accidents: It is the policy of the facility to ensure a accident free environment for all residents. A) The resident's environment will remain as free of accident hazards as is possible. Resident #22 received a safety evaluation for her w/c on 8/30/06 which included OT and restorative nurse. The lap belt was deemed intact and functional and is presently performing the task of intention which is to hold contacting thighs in seated position. The back of the w/c has been moved to a 90 degree position per OT evaluation. A side	

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F 323	Continued From page 24 #13 at that time revealed the wheelchair no longer reclined and was missing half of the lap belt. CNA #13 stated the wheelchair had been broken for approximately a year, and the resident needed the reclining option and seatbelt since the resident was had severe contractures and required special postioning. b. Interview and observation with the occupational therapist (OT) on 8/17/06 at 9:25 AM showed the resident used the wheelchair, and the OT confirmed the wheelchair was broken. She further stated, due to weight gain the resident's positioning in the wheelchair was no longer appropriate. c. Interview with the resident's family on 8/16/06 at 4:45 PM revealed the custom wheelchair was several years old. She was aware the facility was trying to get a new wheelchair because the positioning was not good. However, she was unaware the chair was broken. d. Further medical record review showed no evidence of a safety assessment. Interview with the DON on 8/17/06 at 10:40 AM confirmed a safety assessment was not completed for the resident's wheelchair.	F 323	support is in place to prevent right leaning. The chair is tightly secured at all junctures and deemed safe in all manners. The hydraulic mechanism to tilt entire chair is in the process of being repaired as a new cable must be obtained. OT still believes that resident #22 would benefit from a new chair and social services is in the process of procuring funding for it. Social services will keep family apprised of progress in this area B) Therapies will provide safety evaluations on all residents with custom w/c and in an ongoing capacity with new admissions C) Therapies will provide safety evaluations on all custom w/cs D) Completed safety assessment will be reviewed in Quarterly QA meetings E) Oct 2nd and ongoing an inspection of all w/c was done on 8/30/06 to see if others needed adjustments or had safety concerns added per request of Lucy Smith DON on 9/29/06. Linda Brown RN	
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure one	F 324		

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F 324	Continued From page 25 (#29) of one sample residents at risk for aspiration received timely care and services to prevent aspiration. The findings were: Observation of resident #29 on 8/15/06 from 6:11 PM to 6:35 PM revealed the resident was able to feed him/herself, consumed regular liquids, and had difficulty speaking short sentences. Observation of the lunch meal on 8/16/06 from 12:02 PM to 12:36 PM revealed the resident consumed regular liquids from cups or drinking glasses. Likewise, at the evening meal on 8/16/06 at 6:11 PM, the resident drank regular, unaltered, liquids out of a glass or cup. Medical record review revealed a physician's progress note dated 6/7/05 in which the physician noted the resident had slurred speech without weakness or paralysis, intact neurological system with "dysarthric" speech and questioned a mild stroke. ["Taber's" medical dictionary, 19th edition, describes dysarthria as impaired to clumsy uttering of words due to diseases that affect the oral, lingual, or pharyngeal muscles.] Further review of the medical record revealed nutritional progress notes dated 8/8/06 which documented reports by nursing that the resident was having coughing episodes while eating. The registered dietitian documented a request for a speech therapy (ST) screen. Review of physician's orders revealed that on 8/8/06 the physician requested therapies, including ST, to evaluate and treat the resident. Review of the speech evaluation revealed the resident was seen on 8/8/06 and ST was requested due to the resident had "coughing observed on, thin liquids". The evaluation showed the residents current diet was a mechanical soft diet with regular liquids and the ST recommended a change to "nectar" thick liquids. The ST	F 324	F324 483.25 (h)(2) It is policy of this facility to ensure that all residents receive assistance devices to prevent accidents. A) Each resident will receive adequate supervision and assistance devices to prevent accidents. Resident # 29 now has meal time plan being followed and monitored by restorative staff and the residents physician writ on order approving the plan. B) Therapies and restorative nurse will meet every Monday for a conference to ensure continuity of care, Same day f/up to MD for orders or phone call to request a telephone order for Tx will be implemented C) Charge nurse and restorative nurse will monitor meal times and ensure meal plans are followed. Therapies to notify charge nurse of nay changes or new orders requested from physician so that nursing may follow up for expedient implementation D) ST will provide spot checks and monthly audit at meals to verify follow thru and provide report of accuracy. Audit reports will be reviewed at quarterly QA E) Oct 2 and on going. added per request of Kathy Smith, RN on 9/29/06 Linda Beaumont	

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

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F 324	Continued From page 26 documented that the resident did better with a straw and had better control of intake. Further comments from the ST included reminding the resident to slow down and "cueing throughout the meal." The nectar thick liquids and comments were developed into a meal plan, dated 8/10/06, and found in the resident's medical record. Although the evaluation occurred on 8/8/06, the aforementioned observations (8/15/06 and 8/16/06, seven and eight days later) showed the resident continued to receive regular liquids despite the physician order for evaluation and "treat." A note in the medical record, dated 8/14/06, by the ST documented the resident was seen again on 8/14/06 and "...did much better [with] nectar thick liquids. Continue to follow the meal plan." Interview on 8/17/06 at 10:03 AM with a ST revealed that although speech therapy made the recommendations, a physician was required to order the recommendations. Further record review revealed a request for an order sent to the physician on 8/16/06, six days after the developed diet plan and eight days after the original order to treat. Record review of physician orders on the last day of the survey, 8/18/06 at 0800, revealed no orders for a change in diet.	F 324		

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F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must 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 that out-dated milk was not served. In addition, the food service window where trays were served was soiled. The findings were: 1. According to the National Dairy Council web site (www.nationaldairycouncil.org), "The "sell by" date refers to how long the grocery store can keep a product for sale in the dairy case. When properly refrigerated, milk generally stays fresh for 2 to 3 days after this date." The following concerns were noted: Observation on 8/15/06 at 2:05 PM revealed 4 gallons of fat-free milk in the walk-in refrigerator. Two of the gallons were unopened and had a sell by date of 8/2/06. One gallon was opened and had approximately three quarters remaining with a sell by date of 7/28/06, the last gallon was opened and had approximately one quarter remaining, this had a sell by date of 7/12/06. Observation on 8/16/06 at 11:30 AM revealed the milk was still in the walk-in refrigerator, and less of the 7/12/06 dated gallon remained. Interview with the dietary aide on 8/16/06 at 11:45 AM revealed only resident #26 used fat-free milk, and she received a glass every morning. When asked if she served the milk that morningm the dietary aide stated she had. The aide indicated the gallon	F 371	The facility will ensure that all residents receive safe, food and milk product thru a clean past thru window A) i) Sell by date of milk order will be noted and recorded on clip board of the walk-in refrigerator where the milk is stored at the time of delivery for each order. The dietary staff will rotate the milk, the oldest milk will be disposed of when 2 days past "sell by" date. ii) Dietary Manager will add cleaning of past thru window to daily cleaning task list B) Staff to be in-serviced on proper handling of Dairy Products by Register Dietitian 9/13/06 C) Dietary Manager will monitor milk and window pass thru to prevent potential illness from dairy products and the spread of germs from an unclean past thru window. D) Dietary Manager will report progress in Quarterly QA	

All expired milk discovered during the survey was discarded at that time.

added per request of Lucy Smith BON on 9/29/06 Kenda Brown RN

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F 371	Continued From page 28 of milk dated 7/12/06 (35 days past the sell by date) as the source for the milt served to resident #26 that day. Further interview with this aide and the dietary manager revealed they were not aware how far past the sell by date the milk was. The dietary manager then stated the milk was also used for cooking, and she usually checked dates once a week. 2. According to Food Code 2005, U.S. Public Health Service, 3-305.11: Food shall be protected from contamination by storing the food: (2) where it is not exposed to splash, dust, or other contamination... Observation on 8/16/06 at 1:50 PM revealed an accumulation of dirt, dust, and grime on the side of the food service tray window. Interview with the facility director of housekeeping on 8/17/06 at 10 AM confirmed the presence of the dirt and agreed the dirt represented a potential health hazard should it fall upon resident food being passed through the window at meal time.	F 371		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure staff followed proper handwashing technique after during two random observations. The findings were:	F 444	F 444 It is the policy of the facility to ensure that all residents are protected again possible infection. A) The facility staff will wash hands in accordance with accepted professional practice	

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	535060	A. BUILDING _____ B. WING _____	08/18/2006

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F 444	Continued From page 29 1. Observation on 8/17/06 at 9:41 AM revealed CNA #14 threw soiled items into the west hall soiled utility room. Without washing or sanitizing her hands, she went directly to assist another aide in transferring resident #22. When CNA #14 entered the resident's room she did not wash her hands or use hand sanitizer before touching the resident, getting a clean blanket from the closet, and moving the resident's drinking cup. 2. Observation of resident #9 on 8/17/06 at 10:18 AM revealed CNA #11 assisted the resident with incontinence care. After assisting, the CNA removed her gloves, and then without washing her hands, left the room and went to the clean linen closet, used hand sanitizer, opened the door, and retrieved a blanket. The CNA then returned to resident #9's room and washed her hands prior to leaving the room. 3. Interview with the director of nursing on 8/17/06 at 10:48 AM revealed the expectation was for staff to wash their hands after performing perineal care and prior to leaving the resident's room. In addition, staff should wash their hands prior to exiting the soiled utility rooms. 4. Review of the facility's handwashing policy (no date or number) revealed "the uses of gloves does not replace handwashing," and "waterless antiseptic solution may be used as an adjunct to routine handwashing."	F 444	B) Audit by charge nurse of 3 employees weekly for compliance with accepted professional practice beginning Sept 11, 2006. Immediate in service to anyone with deficient practice by auditing nurse. C) Hand washing in-service presented by infection control on Sept 8, 2006. Soiled utility room will be reequipped with containers that allow for access to the sink for hand washing D) Hand washing audits will be compiled on a monthly basis and reviewed at the Quarterly QA meeting E) Oct 2nd and ongoing	

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F 468 SS=B	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to securely attach a 4 foot section of handrail to the wall. The findings were: Observation on 8/16/05 at 10:48 AM revealed a section of handrail approximately 4 ft in length located opposite the central nurse's station and directly beneath a wall clock. The rail was loosely attached to the wall. Interview with the director of housekeeping on 8/17/06 at 10 AM verified the railing was loose. Interview with the administrator on 8/17/06 at 10:30 AM revealed all handrails should be firmly attached to the wall. The facility administrator also stated handrails should be able to support approximately 200 pounds.	F 468	F 468 It is the policy of this facility to ensure a safe environment for the residents A) The maintenance director will secure handrails 8/18/06 B) The maintenance director and housekeeping will check all handrails weekly and adjusted for safety C) The maintenance director will log any loose handrails and date the adjustment date. D) Will be reported to administrator and in the safety committee meeting.. then safety committee then provides a report to the QA committee. E) On going added per request of Lucy Stutts, DON, on 9/29/06 Linda Brown RN	
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure	F 492	F 492 It is the policy of this facility to follow all regulations and provide professional services. A) Licensed staff will perform job duties within the scope of their practice. Liter flow will be documented on the concentrator and O2 tank for resident #21.	

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F 492	Continued From page 31 licensed staff performed tasks for which they were qualified or that were within their scope of practice. One (#21) nonsample resident who required oxygen, had his/her oxygen adjusted by certified nurse aide (CNA) staff. The findings were: Observation on 8/15/06 at 3:18 PM revealed resident #21 had difficulty breathing and was attended to by licensed practical nurse (LPN) #5. At 5:25 PM on 8/15/06, observation of the resident revealed CNA #3 removed the resident's nasal oxygen tubing, which was connected to a concentrator, and applied nasal oxygen tubing connected to a portable oxygen tank. The CNA then adjusted the oxygen liter flow to 3 liters by adjusting the liter flow valve. Further observation revealed the liter flow was not marked on the tank. When interviewed on 8/15/06 at 5:25 PM, indicated she knew the resident was suppose to be on 3 liters of oxygen. Medical record review revealed an August 2006 physician order review which documented the resident's oxygen flow rate at 3 liters a minute or "as needed to keep the Sat (saturation level) > (greater than) 90%." Interview with the director of nursing on 8/17/06 at 10:48 AM revealed she was unaware of the Wyoming Board of Nursing (BON) decision related to CNAs adjusting oxygen. According to the May 2001 decision by the Wyoming BON, a CNA may be delegated the task of adjusting the oxygen liter flow if the liter flow is clearly marked by the nurse on the concentrator and/or oxygen tank.	F 492	B) All other residents receiving oxygen will have their tanks or concentrators marked in a like manner. In service on scope of practice for CNAs regarding adjusting the O2 liter flow on tanks and concentrators C) Charge nurse will monitor that liter flow is marked on O2 tank and/ or concentrator. If resident is admitted on O2 or O2 is started on current resident, liter flow will be marked D) Monthly checks by nurse will be included when O2 tubing is changed to ensure liter flow is marked. Staff development coordinator will monitor report and it be reviewed at the Quarterly QA meeting E) Oct 2nd and ongoing	