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

RECEIVED
WY Dept of Health
SEP 20 2013
Healthcare Licensing and Surveys

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 ____	08/01/2013

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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CAA: Care Area Assessment CNA: Certified Nurse Assistant DON: Director of Nursing INR: International Normalized Ratio LPN: Licensed Practical Nurse MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	F176 • Resident # 3 and #15 will be assessed with the new Briggs Form CFS1-144H "Assessment for Self-Administration of Medication by September 20, 2013. • MSCC adopted new policy: Self-Administration of Medication. The inter-disciplinary team will determine resident's ability to self-administrate medications. All current/future residents will be assessed with the new form CFS1-144H. MDS Coordinator will update Care Plan accordingly. All new admissions will have assessment completed within 7 days with a re-assessment every quarter or PRN. • Medical Records will confirm that assessment form CFS144H was completed at time of admission, quarterly, and PRN during chart review monthly. An in-service will be held with all nursing staff by September 20, 2013 about proper medication distribution and self-administration assessment requirements. • DON will create a running current list of any residents approved to	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to determine that self-administration of medications was a safe practice for 1 of 1 non-sample residents (#3) and 1 of 1 sample residents (#15) observed self-medicating. The findings were: 1. Observation on 7/29/13 at 5:17 PM showed residents #15 and #3 had medications sitting next to their dinner plates. The nurse was passing medications to other residents and did not observe the residents take their medication.	F 176		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 9/17/13

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.

Reviewed and accepted. 10/17/13. Latest DOC = 11/1/13 J. VanDyke, RN
10/18/13 8:39 AM left message that PoC was accepted. [signature]

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F 176	Continued From page 1 2. Observation on 7/31/13 at 12:20 PM showed LPN #1 gave a medication to resident #3, sitting it next to his/her lunch plate. The LPN did not wait for the resident to take the medication. The nurse stated at that same time the medication was Carafate (an antiulcer agent) and added the resident takes his/her own medication. 3. Interview with LPN #1 on 8/1/13 at 11 AM revealed she was not aware residents were to be evaluated for self-administration of medications. An interview with the MDS coordinator at that same time revealed the facility did not have a policy and procedure for the evaluation of residents self-administering their medications.	F 176	self-administrate medications and update weekly. The assessment audit will be incorporated into the Quality Improvement Plan and the team will verify Care Plans are reflective of inter-disciplinary team's findings. This audit will be two parts; 1) Medication Administration assessment/care plans by the outside RN; 2) visual audit of nursing staff passing medications will be performed randomly twice a week over the next twelve months. • Creation of policy, assessment of residents, and inter-disciplinary team approvals will be completed by September 20, 2013. 09/20/2013	
F 226 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility documentation review, State agency record review and staff interview, the facility failed to investigate an incident of resident to resident physical abuse documented in the medical record for 1 of 9 sample residents (#8). In addition, the facility failed to check the CNA abuse registry for 1 of 1 sample CNA for whom the registry should have been checked prior to resident contact. The findings were:	F 226	F226 • A complete investigation around the incident reported for Resident #8 was completed by the Administrator on August 12, 2013. MSCC Human Resources completed and verified all MSCC CNA staff have been cleared through the Abuse Registry.	

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F 226	Continued From page 2 1. Review of nursing notes dated 5/17/13, timed at 3:05 PM, revealed "1300 [the resident] was slapped on L [left] side of face by another. No redness noted states she's OK." The facility was unable to produce any documentation of an investigation into this incident. Review of State agency records revealed no evidence the incident was reported to the agency as required. Interview with the social worker on 7/30/13 at 3:05 PM confirmed that the incident documented in the nursing notes had indeed occured. The social worker further revealed that no investigation of the incident was completed, there was no incident report for the incident, and the incident had not been reported to the State agency. 2. Review of facility employee records revealed CNA #1 was most recently hired on 7/10/13. The facility was unable to produce any evidence the CNA abuse registry had been checked prior to the CNA having resident contact. The facility administrator confirmed in interview on 8/1/13 at 10:10 AM that he was unaware of the requirement to check the CNA abuse registry stating, "If we're supposed to be checking that, I'm sorry, but we're not."	F 226	• Adverse/Incident Report policy will be revised to designate a point person to coordinate all abuse adverse/incidents and ensure appropriate staff are notified, safety of staff and residents are met, and determine type of investigation needed. All abuse incidents will be kept in a secure binder with point person. All CNAs who are hired by MSCC with a current license will be screened prior to employment through the Abuse Registry. All CNAs waiting for a license will be screened immediately when license number is available. All documentation will be placed in appropriate personnel files. • MSCC staff will follow the Abuse and Neglect Policy and Procedure. The abuse adverse/incident reporting procedure point person will be responsible to educate all current and future staff on the proper steps and procedures to report any abuse of residents or staff. Bi-annual in-service and face-to face orientation processes will be coordinated with Human	
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by:	F 247		

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F 247	Continued From page 3 Based on medical record review, resident and family interviews, and staff interview, the facility failed to provide notice and support to 1 of 1 sample residents (#8) with a facility-initiated room change before the room change was effected. The findings were: Resident #8 was admitted to the facility on 5/14/13 with diagnoses that included non-Alzheimer's dementia and amputation of the left leg. Interview with the resident on 7/30/13 at 9:15 AM, revealed s/he was confused, but repeatedly expressed distress about a recent room change. Review of the resident's medical record revealed s/he had recently been moved from a room where s/he had a roommate to a room where s/he resided alone. The medical record contained no assessments related to the room change, and no rationale for the move. Interview with a family member on 8/1/13 at 11:33 AM revealed the room change occured prior to resident and family notification. The family member expressed concern about the resident's fear of being alone. S/he stated had s/he known about the move ahead of time s/he would have expressed his/her concerns about the resident being in a room alone to the facility. She also stated the resident felt "safe and secure with someone [s/he] knows." Review of nursing notes dated 7/17/13, timed 1:45 PM, revealed "Resident was moved to another room. [His/her] new room is [room number]. Resident is confused and upset about the move. I notified all of the family about the move." Interview with the social worker on 7/30/13 at	F 247	Resources. All documentation will be included in personnel file. • All abuse incidents will be monitored through monthly risk management meetings. MSCC will utilize the Memorandum of Agreement with Eastern Shoshone Tribe Human Resources to include the verification of the Abuse Registry in their quarterly personnel file audits. The first audit will be scheduled to occur before October 30, 2013 for the prior quarter. • One abuse and neglect in-service was conducted on August 28, 2013. The next Abuse and Neglect In-service will be September 12, 2013. All CNA staff must have verification their name was submitted to the abuse registry by September 15, 2013. o 10/15/2013 F247 • Resident #8 has made the adjustment to the room change. Consideration was made to move #8 in with another roommate, however the interdisciplinary team determined another room	

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F 247	Continued From page 4 2:35 PM revealed that although when moving a resident to a new room the normal process was to notify family before the move, "in this case it was after."	F 247	change would not be in the resident's best interest. Wyoming Counseling Services continue to follow-up with resident to verify adjustment.	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	• Revise the "Resident Room Change" policy. MSCC staff will follow the policy, "Resident Room Change" when moving a resident. The Social Worker is the key person involved in the room change. An assessment by the interdisciplinary team/resident/resident family will be completed 24 hours before a room change occurs. • MSCC Social Worker must have the assessment completed before a room change. An audit process will developed by September 20, 2013. Audit will be on-going for the next twelve months. • A list of moved residents will be provided to the Mock Survey RN to verify the policy was followed and results provided to the Quality Improvement/risk management team. • Resident Room Change policy revised on August 19, 2013. The	

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F 247	Continued From page 4 2:35 PM revealed that although when moving a resident to a new room the normal process was to notify family before the move, "in this case it was after."	F 247	Audits will begin on any residents moved September 20, 2013. o 9/30/2013	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F272 • Resident #15 Care Plan has been updated to reflect a compressive over view with the involvement from the Care Plan Team. All interdisciplinary team members participated to reflect all of the needs for Plan of Care. • A newly developed Care Plan Team was implemented on 8/7/2013. The Purpose of the interdisciplinary care plan team will be to meet weekly to ensure all resident care plans are comprehensively detailed and individualized for each resident. • Each Team Member is required to provide substantial input during the Care Plan Team Meeting. Care Plan/MDSs will not be signed off by the MDS Coordinator until all team members have completed their sections. • Quarterly Mock Survey RN will review a sample selection of Care Plans to verify each one is meeting the purpose of the Care Plan Team Meeting. An audit on	

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F 272	Continued From page 5 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 1 of 9 sample residents (#15). The findings were: Review of the 2/7/13 significant change MDS assessment showed resident #15 triggered for delirium, falls, psychotropic medication use, and urinary incontinence. Review of the CAAs for these areas showed the information was obtained from the MDS summary, admission assessment and the medication administration record. The CAA did not include the reason the care area was selected and it did not show causes or contributing factors related to the identified problems. In addition, the analysis of findings did not include any risk factors associated with the care areas. An interview with the MDS coordinator on 8/1/13 at 8:45 AM revealed she referred to the MDS assessment for the data included in the CAA rather than obtaining the information from other sources such as the medical record and staff input.	F 272	all care plans reviewed by the Care Plan Team will be compiled in a binder with proper signatures of all who attended weekly. A report will be provided to the Risk Management Team. • All scheduled residents who have care plans pending will be reviewed during Care Plan Review Team Meetings weekly. Care Plan Team Review Meetings was initiated on 8/8/2013. Team will review care plans for the week ahead/month to make sure all care plans are updated correctly. All current residents will have their care plans reviewed and updated accordingly based off the Care Plan Review Team recommendations. All residents care plans will be updated correctly by November 1, 2013. o 11/01/2013 F278 • Resident #16 – On 8/20/2013 had the Care Plan Meeting. The MDS section Z0500B was signed by the MDS Coordinator after all disciplines completed and signed their sections. Resident #12 - 9/10/2013 had the Care Plan	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

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F 278	Continued From page 6 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 medical record review, staff interview and observation, the facility failed to ensure MDS assessments were accurate for 5 of 10 sample residents (#10, #12, #15, #16, #28). The findings were: 1. Review of the 2/11/13 annual MDS assessment section Z, for resident #16 showed	F 278	Meeting. The MDS section Z0500B was signed by the MDS Coordinator after all disciplines have completed and signed their sections. Resident #15 –Care Plan meeting occurred on 8/20/2013. MDS and Care Plan for #15 have been modified to reflect correct information. Resident #10 – Care Plan was updated from 7/30/2013 to reflect current information. Resident #28 – On 8/13/2013 had the Care Plan meeting – care plan is updated and reflects all MDS CAA's. • A newly developed Care Plan Team was implemented on 8/7/2013. The team will meet weekly to ensure all resident care plans are comprehensively detailed and individualized. • Each Team Member is required to give substantial input during the Care Plan Team Meeting. Care Plan/MDS will not be signed off by the MDS Coordinator until all team members have completed their sections. • Quarterly Mock Survey RN will review a sample selection of Care Plans to verify each one is	

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F 278	Continued From page 7 the RN MDS assessment coordinator signed section Z0500B indicating all assessments were completed as of 2/11/13. However, review of section Z0400 showed the following sections were not signed as completed by the discipline that performed the assessments: sections H, I, J, K, L, M, N, O, and P. Interview with the MDS coordinator on 8/1/13 at 8:40 AM verified not all disciplines had signed indicating their individual assessments were performed prior to her signing section Z0500B verifying the MDS assessment was completed. 2. Review of the 3/1/13 quarterly MDS assessment section Z for resident #12 showed the RN MDS assessment coordinator signed section Z0500B indicating all assessments were completed as of 3/1/13. However, review of section Z0400 showed the following sections were not signed as completed by the discipline that performed the assessments: sections B,F,H, I, J, K, L, M, N, O, and P. Interview with the MDS coordinator on 8/1/13 at 8:40 AM verified not all disciplines had signed indicating their individual assessments were performed prior to her signing section Z0500B verifying the MDS assessment was completed. 3. Review of the 2/7/13 significant change MDS assessment for resident #15 revealed s/he had no history of falls prior to his/her admission. The following concerns were identified: a. Review of the incident report dated 1/21/13 showed resident #15 fell in his/her room. Review of the neurological assessment flowsheet dated 1/21/13 showed the resident had fractured his/her left hip and was transferred to the hospital. Review of the MDS assessment, section A, showed the resident returned to the facility on	F 278	meeting the purpose of the Care Plan Team Meeting and report findings to Quality Improvement/risk management team. • All scheduled residents who have care plans pending will be reviewed during Care Plan Review Team Meetings weekly. Care Plan Team Review Meetings was initiated on 8/8/2013. Team will review care plans for the week ahead/month to make sure all care plans are updated correctly. All current residents will have their care plans reviewed and updated accordingly based off the Care Plan Review Team recommendations. All residents care plans will be updated correctly by November 1, 2013. o 11/01/2013	

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F 278	Continued From page 8 1/24/13. Review of section J did not show s/he had a fall within the last month prior to the resident's admission. In addition, it did not show the resident had sustained any fractures related to a fall within the last 6 months prior to his/her admission. The MDS assessment also did not show the resident had sustained any falls since his/her admission or prior assessment. c. An interview with the MDS coordinator on 8/1/13 at 10 AM stated she was uncertain how to code the MDS assessment for the resident's fall. 4. Review of the 7/18/13 quarterly MDS assessment showed resident #10 had no behaviors exhibited to include wandering. In addition, section H showed the resident was always continent for both bowel and bladder. The following concerns were identified: a. Review of the weekly/monthly [nursing] summary dated 7/16/13 showed for mood and behaviors, the resident made negative statements, was verbally abusive and wandered. Review of the care plan for behaviors, last reviewed on 7/16/13, showed the resident was at risk for wandering from the facility. b. Review of the weekly/monthly [nursing] summary dated 7/16/13 for continence showed the resident was frequently incontinent of bowel and was usually continent of bladder. Review of the care plan, last reviewed 7/16/13, for incontinence showed s/he was incontinent of both bowel and bladder. 5. Review of medical records revealed that resident #28 was admitted to the facility on 5/22/12 with diagnoses including heart failure, hypertension, diabetes mellitus and depression. Periodic observation of the resident on 7/30/13 from 9:08 AM to 2:22 PM revealed the resident	F 278		

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F 278	Continued From page 9 was alert and oriented to person, place and time. Interview with the resident on 7/33/13 at 4 PM revealed the resident was cognitively intact. The following concerns were identified: a. Review of the resident's most recent MDS assessment, a quarterly assessment dated 4/28/13, revealed the resident was assessed as being severely cognitively impaired, with a brief interview of mental status (BIMS) score of 0 (a score of 0-7 indicates severe cognitive impairment). BIMS scores on previous MDS assessments, dated 7/2/12 and 1/26/13, were both 15 (the maximum score, indicating intact cognition). b. Interview with the social worker on 7/31/13 at 9:55 AM revealed at the time of the 4/28/13 quarterly MDS assessment the resident had experienced a decline in his/her health status, family was present at the resident's bedside, and the social worker did not want to intrude on the family. The social worker further revealed she had received no training on MDS assessments, and was unaware there were alternate methods for assessing a resident's cognitive status.	F 278	F279 • Resident #10 – Care Plan has been corrected and updated, perimeters are in place for acceptable limits. Monitoring of behaviors will continue for the next 90 days and will be documented. Behaviors and interventions are listed on the Behavior Sheet. Resident #15 – Care Plan has been corrected and updated, all triggers and diversional activities have been addressed in the Care Plan. Monitoring of behaviors will continue for the next 90 days and will be documented and evaluated on Behavior Sheet. Resident #28 – Care Plan has been corrected and updated and is in place. Negative stimulus and diversional activities have been individualized in care plan. Social Services/Activities manager has addressed and created an individualized care plan for this resident. Resident #16 - Care Plan is corrected, updated and individualized.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP 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.	F 279		

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	535050	A. BUILDING _____ B. WING _____	08/01/2013

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 279	Continued From page 10 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, staff and resident interviews, the facility failed to develop a comprehensive and individualized care plan to include measurable objectives to meet the residents' needs for 4 of 9 sample residents (#10, #15, #16, #28). The findings were: 1. Review of the medical record showed resident #10 had diagnoses that included Alzheimer's disease and hypertension (high blood pressure). Review of the weekly/monthly [nursing] summary dated 7/16/13 showed the resident was verbally abusive and made negative statements. The following concerns were identified: a. Review of the care plan for hypertension, last reviewed on 7/16/13, showed the resident was to maintain his/her blood pressure within "acceptable limits" but did not show what was acceptable. b. Review of the care plan for combative behaviors, last reviewed on 7/16/13, showed the resident was at risk for hitting other residents. Interventions included "intervene if signs of hostility or anger appear" and "assist avoiding situations that may incite outbursts." However, the care plan did not indicate what the signs of	F 279	• Newly developed Care Plan Team was implemented on 8/7/2013. The team will meet weekly to make sure all resident care plans are comprehensively detailed and individualized for each resident. All triggers will be care planned. • Each Team Member is required to give applicable input during the Care Plan Team Meeting. Care Plan will not be signed off by the MDS Coordinator until all team members have completed their sections. • Quarterly Mock Survey RN will review a sample selection of Care Plans to verify each one is meeting the purpose of the Care Plan Team Meeting. All resident's care plans will be reviewed during Care Plan Review Team Meetings as scheduled for their MDS. • The goal is to have all residents care plans updated correctly by November 1, 2013. 11/01/2013	

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F 279	Continued From page 11 hostility were, what situations might incite outbursts, or what actions should be taken in response. 2. Review of the medical record for resident #15 showed s/he had diagnoses that included a hip fracture, and depression. The following concerns were identified: a. Review of the care plan for falls, last reviewed on 5/21/13, showed the resident sustained a left hip fracture. The staff were to monitor for signs of increased agitation and monitor for fatigue and other risk factors that could lead to falls. The care plan did not indicate what the resident's signs of increased agitation were, or the resident's risk factors for falls. b. Review of the resident's care plan for psychotropic drug use, last reviewed on 5/21/13, showed s/he was on medications for depression. The staff was to monitor the resident's behavior patterns for possible behavior triggers, then "reduce/eliminate" those triggers. The care plan did not specify what behaviors staff were to monitor or what triggers they were to address for this resident. In addition, the staff was to involve the resident in "diversional activities" but it did not show what activities the resident would be receptive to. 3. Resident #28 was admitted to the facility on 5/22/12 with diagnoses that included heart failure, diabetes mellitus, depression and generalized pain. The following concerns were identified: a. Review of the resident's 7/2/12 admission MDS assessment revealed that the care area of activities was triggered. However, review of the CAAs revealed there was no analysis of the resident's activity-related needs. No care plan	F 279		

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F 279	Continued From page 12 was formulated for this resident's activity-related needs, and no rationale for the failure to care-plan activities was supplied. Interview with the resident on 7/30/13 at 4 PM revealed the resident was alert and oriented to person, place and time. The resident stated that s/he participated in exercise class every day that such activity was available, and s/he would like to be involved in card games. b. The resident's care plan for psychotropic drug use, last reviewed by the facility 7/24/13, included the interventions "Reduce negative stimulus as possible" (but did not indicate what might constitute a negative stimulus for this resident), and "Involve in diversional activities" (but did not indicate what sort of activities this resident might find diversional). c. During interview on 7/31/13 at 12:05 PM the facility social worker confirmed the resident's care plan was non-specific, and that activities should have been care-planned for the resident. 4. Review of the 2/11/13 annual MDS assessment for resident #16 showed s/he triggered for comprehensive review of communication, delirium, and activities of daily living (ADLs). Review of the CAAs for these triggered areas showed after further review, a care plan should be developed to address each area. However, review of the 5/21/13 care plan showed no care plan was developed or implemented for those areas. Interview with the MDS assessment coordinator at 8:40 AM on 8/1/13 verified these areas were not care-planned but they should have been. During an interview with the MDS coordinator and the DON on 8/1/13 at 8:45 AM, they acknowledged the care plans were not	F 279		

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F 279	Continued From page 13 individualized.	F 279	F280 • Resident # 15 – Care Plan has been corrected and updated to reflect current status. Resident #16 – Care Plan has been corrected and updated to reflect current status. • Newly developed Care Plan Team was implemented on 8/7/2013. The team will meet weekly to make sure all resident care plans are comprehensively detailed and individualized for each resident to reflect current status. • Each Team Member is required to give applicable input during the Care Plan Team Meeting. Care Plan will not be signed off by the MDS Coordinator until all team members have completed their sections. • Quarterly Mock Survey RN will review a sample selection of Care Plans to verify each one is meeting the purpose of the Care Plan Team Meeting. All resident's care plans will be reviewed during Care Plan Review Team Meetings as scheduled for their MDS.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and resident and staff interview, the facility failed to ensure staff reviewed and revised care plans to accurately reflect the current status of 2 of 9 sample residents (#15, #16). The findings were: 1. Observation on 7/30/13 at 9:15 AM showed resident #15 transferred him/herself from the wheelchair to the bed independently. In addition, an interview with the resident at that time	F 280		

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F 280	Continued From page 14 revealed s/he ambulated with the staff and used a gait belt. The belt was located in the resident's room. The resident also stated s/he walked with a wheelchair for support due to his/her oxygen tank. The care plan did not show the resident could transfer him/herself, or that s/he ambulated with assistance using a gait belt and/or a wheelchair. During an interview with the MDS coordinator on 8/1/13 at 8:45 AM, she acknowledged the care plans needed to reflect the resident's current status. 2. Review of the 5/21/13 care plan for resident #16 showed interventions included wearing a splint to the left forearm. Periodic observations from 7/29/13 through 8/1/13 showed the resident did not wear the splint at any time. Interview with the MDS coordinator on 8/1/13 at 8:40 AM revealed the resident had required the splint after a fall but no longer needed it. She verified the care plan had not been updated to discontinue the use of the splint.	F 280	• The goal is to have all residents care plans updated correctly by November 1, 2013. o 11/1/2013 F281 • Resident #16 – will be included in "Sliding Scale Insulin Audit" initiated on August 19, 2013. Sliding Scale Insulin Care Plan has been individualized and updated. Daily BM audit was initiated on resident #16 on August 26, 2013. Bowel protocol has been updated and implemented. Resident #28 – All physician orders have been clarified and are in place. • All residents with a Sliding Scale Insulin order will be placed on the "Sliding Scale Insulin Audit" and will be completed by the DON. • DON to post list of Sliding Scale Insulin residents and a policy for administering sliding scale insulin was developed. All Sliding Scale Insulin orders will be followed as ordered by the MD. Bowel Management Program –CNA Supervisor will follow the updated BM protocol as stated in the policy for all residents. CNA	
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 medication administration for 2 of 9 sample residents (#16, #28). In addition, the facility failed to follow physician orders regarding bowel elimination management for 1 of 9 sample residents (#16).	F 281		

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F 281	Continued From page 15 The findings were: In regard to medication management: 1. Review of the 5/31/13 physician's orders for resident #16 showed orders for sliding scale insulin management using Novolog insulin at 8 AM and noon daily. The following concerns regarding diabetic management were identified: a. Review of the MAR for June 2013 showed the resident had a finger stick blood sugar (FSBS) reading of 268 milligrams per deciliter (mg/dl) on 6/10/13 at noon. Further review showed the resident was not administered any insulin. However, review of the sliding scale insulin orders showed the resident should have received 4 units of Novolog insulin. Review of the FSBS reading obtained that evening prior to the meal showed it was 414 mg/dl. b. Review of the June 2013 MAR showed on 6/17/13 the resident's FSBS reading was 290 mg/dl at noon. According to the physician's sliding scale orders the resident should have been administered 4 units of Novolog insulin. However, review of the MAR showed the resident received no insulin. c. Review of the June 2013 MAR showed a FSBS reading of 241 mg/dl on 6/24/13 at noon. Review of the physician's sliding scale orders showed the resident required administration of 2 units of Novolog insulin. According to the MAR, the resident received no insulin. d. Review of the July 2013 MAR showed the resident had a FSBS of 89 mg/dl on the morning of 7/5/13 and the resident was administered 2 units of Novolog insulin. According to physician's orders the resident should not have received any insulin. e. Review of the July 2013 MAR showed the	F 281	Supervisor will audit all BM's daily. • Quarterly Mock Survey RN will be reviewing a sample selection of files to verify all audits are completed and that orders are being obtained in a timely manner. Any deficiencies will be reported to the DON immediately and followed by the Care Plan Team and Risk Management. • Sliding Scale Insulin Audit started on August 19, 2013. BM audit will start on August 26, 2013. Follow up Clarification of Physician Orders policy and procedure will be in effect on August 19, 2013. o 8/26/2013	

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F 281	Continued From page 16 resident's FSBS was 259 mg/dl on 7/8/13 at noon. Review of the MAR for this date and time showed the resident received no insulin but should have received 4 units. f. During an interview with the DON on 8/1/13 at 8:40 AM, she verified the above information was correct and stated the facility had been having a problem with accurate administration of sliding scale insulin. She further stated physician's orders should be followed. 2. Resident #28 was originally admitted on 5/22/12 with diagnoses that included heart failure, hypertension, diabetes mellitus and gastroesophageal reflux disease. Review of medical records revealed that upon the resident's most recent admission on 7/24/13, physician orders included an order for Protonix 40mg daily, and an order for Plavix 75mg daily.The following concerns were identified: a. According to a fax from the pharmacy dated 7/25/13, the pharmacy declined to provide Protonix pending clarification from the resident's physician due to a "major reaction" between the two medications. b. Review of the resident's MAR revealed the resident did not receive Protonix 40mg as ordered by the physician from the date of admission through 8/1/13 (8 days), nor was the order discontinued. Interview with the DON on 7/31/13 revealed the facility had not followed up with the physician to get the order clarified. In regard to bowel management: Review of the physician's orders for resident #16 showed orders dated 5/31/13 for Dulcolax 10 mg 1 suppository, fleet enema, milk of magnesia 30 cc, or natural fruit laxative as needed for bowel	F 281		

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F 281	Continued From page 17 elimination. The following concerns were identified: a. Review of the bowel flow sheet and the nursing notes showed the resident had no bowel movement from 6/17/13 through 6/21/13 (5 days). Review showed the resident again had no bowel movement from 7/4/13 through 7/10/13 (7 days). Further review showed the resident had no bowel movement from 7/16/13 through 7/22/13 (7 days). b. Review of the MAR for those dates showed no evidence the resident received any type of laxative or enema. Interview with the DON on 8/1/13 at 8:40 AM verified the resident received no laxatives or enema. She further said physician's orders should always be followed. 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	F309 • Resident #16 – will be included in "Sliding Scale Insulin Audit" initiated on August 19, 2013. Sliding Scale Insulin Care Plan has been individualized and updated. Pain Management flow sheet/audit for resident #16 was initiated on August 19, 2013. Pharmacy Consultant to assess resident #16 during monthly audit. • All residents with a Sliding Scale Insulin order will be placed on the "Sliding Scale Insulin Audit" and will be completed by the DON. • DON to post list of Sliding Scale Insulin residents and a policy for administering sliding scale insulin was developed. All Sliding Scale Insulin orders will be followed as ordered by the MD. Pain Management Flow Sheet will reflect any pain, effectiveness of pain management, location, and severity. This Flow Sheet will be used for PRN pain management treatments/medications.	
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 ensure correct doses of insulin were administered for 1 of 1 sample	F 309		

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F 309	Continued From page 18 resident (#16) on sliding scale insulin for diabetes mellitus. In addition, the facility lacked evidence nursing staff provided the necessary assessments and monitoring to ensure adequate pain management for 1 of 6 sample residents who had pain (#16). The findings were: In regard to sliding scale management of diabetes: Review of the 5/31/13 physician's orders for resident #16 showed orders for sliding scale insulin management using Novolog insulin at 8 AM and noon daily. The following concerns regarding diabetic management were identified: a. Review of the MAR for June 2013 showed the resident had a FSBS reading of 268 milligrams per deciliter (mg/dl) on 6/10/13 at noon. Further review showed the resident was not administered any insulin. However, review of the sliding scale insulin orders showed the resident should have received 4 units of Novolog insulin. Review of the FSBS reading obtained that evening prior to the meal showed it was 414 mg/dl. b. Review of the June 2013 MAR showed on 6/17/13 the resident's FSBS reading was 290 mg/dl at noon. According to the physician's sliding scale orders the resident should have been administered 4 units of Novolog insulin. However, review of the MAR showed the resident received no insulin. c. Review of the June 2013 MAR showed a FSBS reading of 241 mg/dl on 6/24/13 at noon. Review of the physician's sliding scale orders showed the resident required administration of 2 units of Novolog insulin. According to the MAR, the resident received no insulin. d. Review of the July 2013 MAR showed the	F 309	• Quarterly Mock Survey RN will be reviewing a sample selection of files to verify all audits are completed and that orders are being obtained in a timely manner. Any deficiencies will be reported to the DON immediately and followed by the Care Plan Team and Risk Management. Review of Pain Management Flow Sheet will be reviewed monthly by DON, MDS Coordinator, and Pharmacy Consultant. • Sliding Scale Insulin Audit started on August 19, 2013. Pain Management Flow Sheets were implemented on September 1, 2013. o 9/01/2013	

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F 309	Continued From page 19	F 309		

resident had a FSBS of 89 mg/dl on the morning of 7/5/13 and the resident was administered 2 units of Novolog insulin. According to physician's orders the resident should not have received any insulin.

e. Review of the July 2013 MAR showed the resident's FSBS was 259 mg/dl on 7/8/13 at noon. Review of the MAR for this date and time showed the resident received no insulin but should have received 4 units.

f. During an interview with the DON on 8/1/13 at 8:40 AM, she verified the above information was correct and stated the facility had been having a problem with accurate administration of sliding scale insulin.

In regard to pain management:

Review of the 5/8/13 MDS assessment for resident #16 showed s/he had occasional moderate pain. Review of the 5/31/13 physician's orders showed an order for Tylenol 325 mg 1 to 2 tablets as needed every 4 hours for pain. The following concerns were identified:

a. Review of the June 2013 MAR showed the resident received Tylenol on 6/10/13, 6/11/13, and 6/12/13 without evidence a pain assessment was performed. Review of the pain flowsheet showed no description, location, or severity of the pain. Review of the pain flow sheet also showed no evidence the Tylenol was administered for pain.

b. Continued review of the medical record showed no evidence the resident's pain was re-assessed to determine the effectiveness of the medication in relieving the resident's pain. In addition, there was no evidence in the medical record that non-pharmacological interventions were attempted.

c. Finally, review of the 6/4/13 care plan

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F 309	Continued From page 20 showed no evidence a care plan was developed or implemented to address the resident's pain. Interview with the DON and MDS assessment coordinator on 8/1/13 at 8:40 AM verified no assessment or re-assessment of the resident's pain was performed. They further verified no care plan addressing pain was developed or implemented.	F 309	F329 • Resident #32 – Medical chart complete with all current documentation of lab results. An INR flow sheet is in place for resident #32. Labs are drawn as ordered by MD for Resident #32. A five check point process has been initiated for all of Resident #32 labs. Resident #16 is being followed by Wyoming Counseling and a private psychiatric Physician's Assistant and in-house Social Services. Resident #16 anti-psychotic drug regimen is being monitored quarterly by physician. Resident #15 anti-psychotic drug regimen is being monitored quarterly by physician. • Labs will be reviewed by DON monthly/PRN. MAR will be reviewed monthly to verify no medication errors by Pharmacy Consultant. A new Psychotropic Medication Policy was issued to all attending physicians. • Behavior Sheets are now placed at the medication carts for the charge nurse to use and document behavior changes and	
F 329 SS=G	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. 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	F 329		

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F 329	Continued From page 21 by: Based on staff interview and medical record review and review of the laboratory tracking logs, the facility failed to appropriately monitor anti-coagulant therapy for 1 of 2 sample residents (#32) on anti-coagulant therapy. In addition the facility failed to ensure the drug regimen was free of unnecessary antipsychotic medications for 2 of 3 sample residents (#15, #16) who received an antipsychotic. The facility's failure to provide appropriate monitoring of laboratory testing for resident #32 resulted in his/her admission to the hospital intensive care unit due to a critical INR value. The findings were: 1. Resident #32 was admitted to the facility on 3/11/12 with diagnoses that included anemia, heart failure, atrial fibrillation and non-Alzheimer's dementia. The following concerns with anti-coagulation therapy were identified: a. Review of a physician's telephone order dated 4/5/13 revealed orders for "Coumadin [an anti-coagulant] 5 mg daily. Recheck INR in 1 month." No evidence of an INR being performed on or around 5/5/13 could be located in the medical record. Review of a physician's note dated 5/16/13 revealed the resident was "On Coumadin, no recent INR." b. Further review of the resident's medical records revealed the resident was sent to the emergency room on 5/19/13 due to a nosebleed the facility had been unable to stop for over two hours. At the hospital an INR test was performed and the result was 15.4. According to Pagana and Pagana, Mosby's Diagnostic and Laboratory Test Reference, 11th Edition, 2013 any INR value greater than 5.5 indicated a high risk of morbidity or mortality in the absence of rapid intervention to treat the abnormality or its underlying cause.	F 329	side effects of any psychotropic medications. Any resident on the medication (Coumadin or Anti-coagulant) will be monitored as ordered by their attending physician. Labs will be reviewed by DON monthly. Coumadin/INR flow sheet will be included with the MAR/medication cart. Social Worker to audit behavior sheets monthly. • The new psychotropic medication assessment paperwork will address any changes to include clinical rational. Any changes in behavior will be reported to outside providers to re-evaluate for any necessary changes to medication treatment. Quarterly Mock Survey RN will be activity looking at a sample selection of files to verify audits are being completed and policies are being followed. Results of findings will be reported to the Pharmacy and Risk Management Committees and followed up monthly. • New policies and procedures will be effective October 1, 2013. New Policy for Psychotropic	

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F 329	Continued From page 22 c. Review of the resident's hospital discharge summary dated 5/22/13 revealed the resident was admitted to the intensive care unit on 5/19/13, and required the administration of vitamin K and the transfusion of three units of packed red blood cells to stabilize his/her condition. d. Interview with the DON on 8/1/13 at 2 PM confirmed that the physician order to test the resident's INR on 5/5/13 was overlooked, and the test was not completed as ordered. The DON further confirmed the facility had performed no investigation into the cause of the resident's critical INR. May 2013 MARs were not available to determine whether or not the resident's medication regimen contributed to his/her unanticipated decline. Interview with the medical records director on 8/1/13 at 9:45 AM confirmed the facility was unable to locate May 2013 MARs for all residents residing in the facility. 2. Review of the July 2013 physician order sheet for resident #16 showed an order for Risperdal (an anti-psychotic) 1 milligram (mg) 0.25 mg for a diagnosis of dementia with behavioral disturbances. This order was dated 5/31/13. The following concerns with the utilization of an antipsychotic medication without clear indication of necessity were identified: a. Review of the monthly behavior monitoring flow sheets for June 2013 showed the resident had 1 abusive behavior in June 2013. Review of June 2013 nursing notes revealed no documented behaviors. Review of the monthly behavior monitoring flow sheets for July 2013 revealed the resident exhibited behaviors on 7/7/13, 7/10/13 and 7/25/13. Review of July 2013 nursing notes revealed on 7/7/13 s/he was tearful and wanting to go home but no behaviors were	F 329	Medications was sent with Physician Orders on 9/1/2013. o 10/1/2013	

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F 329	Continued From page 23 documented. Review of the nursing notes for 7/10/13 and 7/25/13 showed no documentation of behavioral episodes; there was no description of what the behaviors were or that anything happened. b. Review of the physician's progress notes written in June and July of 2013 showed the resident's mental status, mood, and behaviors were not addressed. c. Review of the physician progress notes in the medical record showed no evidence the physician identified or addressed the risks of the Risperdal or evaluated whether the resident's symptoms were severe and distressing enough to adversely affect the safety of the resident. d. Interview with the DON on 8/1/13 at 8:40 AM verified while the resident was depressed, there was no clear indication for the continued utilization for the antipsychotic medication. 3. Review of the medical record for resident #15 showed s/he had diagnoses to include depression. The following concerns were identified: a. Review of the request for psychopharmacological medication change dated 5/3/13 showed the resident received Zoloft (an anti-depressant) 50 mg daily for depression. The physician indicated he did not want to attempt to taper the dose of the medication. No clinical rational was given. b. Review of the psychotropic medication quarterly evaluation dated 5/3/13 showed the resident received the medication Zoloft for depression. Further review of the document did not indicate the behaviors warranting the use of the medication or any adverse reactions to Zoloft to include no reaction to the medication was	F 329		

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F 329	Continued From page 24 apparent. There also was no evaluation related to the effectiveness of the medication. c. Review of the physician orders dated 6/19/13 showed the medication Zoloft was increased from 50 mg to 100 mg daily and the medication buspirone (an anti-anxiety agent) 5 mg to be given twice daily was added. Further review of the physician orders and progress notes did not show any documentation to indicate the reason for the medication changes. d. An interview with the DON and the MDS coordinator on 8/1/13 at 10 AM confirmed there was no documentation to show the reason the physician had doubled the dose of Zoloft and added the buspirone for anxiety. In addition, they acknowledged an evaluation needed to be completed to show the rationale for the use of the psychotropic medications.	F 329	F425 • All expired medications have been removed from the Medication Cart and from the Medication Room. • Routinely all medications will be checked for expiration dates. All expired medication will be packaged up to be disposed of by the DON and Pharmacy Consultant. • Contract Pharmacy is ensuring the expiration date is predominately highlighted on the back on medication card. Weekly audit produced by Wednesday Night Charge Nurse. • Pharmacy Consultant will do a sample from one of 3 medication storage areas monthly to verify there are no medications that have expiration dates. Pharmacy Consultant and DON will dispense all expired medications monthly. • The start of the Audit will be October 1, 2013. o 10/1/2013	
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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy	F 425		

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F 425	Continued From page 25 services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications were removed or used prior to the expiration date in 1 of 2 medication carts and 1of 1 medication storage areas. The findings were: 1. An observation of the west medication cart with the DON on 7/31/13 showed the stock medication alavert D-12 was in the cart and available for use. The medication had an expiration date of 6/13. An interview with the DON at that time confirmed the medication was expired and needed to be removed from the cart. 2. An observation of the medication storage room on 7/31/13 at 3:20 PM with LPN #1 revealed the stock medication Citrucel, which was available for use, had an expiration date of 3/13. The LPN acknowledged at that time the medication needed to be discarded. According to Perry, Potter, Elkin. Nursing Interventions and Clinical Skills, 5th Edition 2012, "Implementation for Administering Oral Medications...g. Check medication date on all medications. Return all outdated drugs to pharmacy."	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

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F 431	Continued From page 26 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications available for use were visibly labeled with the expiration date in 2 of 2 medication carts and 1 of 1 medication	F 431	F431 • All over-the-counter medications were checked for expiration dates and dated upon opening of package. • Contract Pharmacy is aware of the issue and has corrected their label to include the expiration date. • Charge Nurse accepting any new medications from the pharmacy will verify if there isn't an expiration date listed. If there are any medications without expiration dates the charge nurse will contact Contract Pharmacy. Charge Nurse will report medication without expiration dates on audit to DON. • Pharmacy Consultant will do a sample from one of 3 medication storage areas monthly to verify there are no medications that have expiration dates. Pharmacy Consultant and DON will dispense all expired medications monthly. • The start of the Audit will be October 1, 2013. o 10/1/2013	

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F 431	Continued From page 27 storage areas. The findings were: 1. Observation on 7/30/13 at 8:35 AM showed RN #1 dispensed the medication Colace from the east medication cart. The expiration date was not found on the label. An interview with the nurse at that time confirmed the expiration date was not on the medication label. 2. Observation on 7/30/13 at 9 AM showed the DON dispensed the medication olanzapine from the east medication cart. The expiration date was not found on the label. An interview with the nurse at that time confirmed the expiration date was not on the medication label. 3. Observation of the west medication cart on 7/31/13 at 3:35 PM with the DON showed the medications calcivit with vitamin D and sucralfate were labeled with no expiration dates. The DON at that time verified the medications labels did not have an expiration date. 4. Observation of the medication storage room on 7/31/13 at 3:20 PM with LPN #1 showed the medication glucosamine/chondroitin was not labeled with an expiration date. 5. According to Smith, Duell and Martin. Clinical Nursing Skills Basic to Advanced Skills, seventh edition; 2008, "When you administer drugs, you must follow certain safety rules, also known as 'The Six Rights.' These rules are to be carried out each time you give a drug to a client. Right medication. Compare drug container label to the medication sheet (MAR) three times. Note expiration date..."	F 431		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=E	Continued From page 28 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; (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.	F 441	F441 • New Shower Room Policy was implemented on July 30, 2013 to allow for appropriate disinfecting of shower. • The Infection Control Nurse providing an in-service to housekeeping/CNA/Bath Aides on September 2, 2013 to ensure knowledge of proper disinfecting of shower facilities. • The Infection Control Nurse will be auditing 1 shower room per week (2 audits per week) to verify that the cleaning of the shower chair was done correctly. This audit will be ongoing with no stop date. • Any concerns from the Infection Control Nurse will be addressed by the Risk Management Team. • Audit starts on October 1, 2013 10/1/2013	

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F 441	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of infection control policies and procedures and manufacturer's instructions, the facility failed to ensure staff followed appropriate infection control practices during 1 of 1 observation of cleaning the shower room. The findings were: CNA #2 was observed cleaning the shower room after showering resident #16 on 7/30/13. Observation showed the CNA sprayed the shower chair and shower area with "hdqc2" disinfectant at 10:45 AM. She then rinsed off the disinfectant at 10:50 AM; leaving it on for 5 minutes. Review of the protocol posted on the wall in the shower room showed "Allow disinfectant to remain on surfaces for 15 minutes". Review of the facility's policy and procedure for cleaning the shower room, dated July 31, 2013 showed "Allow disinfectant to air dry for 10 minutes." Review of the manufacturer's instructions showed "Allow to remain wet for 10 minutes..." Interview with the CNA on 8/1/13 at 11:55 AM revealed she was aware of the 10 to 15 minute wait time and thought she had waited that long but had not checked her watch for exact times.	F 441	State F tag 2013 F465 • Maintenance will replace garbage disposal and floor tile under triple sink. • Maintenance will observe and audit garbage disposal monthly on grease trap audit. Dietary will observe garbage disposal if found leaking dietary will write a maintenance request and maintenance will fix or replace a.s.a.p. • Maintenance Manager will in service Dietary Manager and Maintenance staff on leaks and how to write up a maintenance request. • Maintenance Manager will report to Risk monthly and to Q.I. committee quarterly. • Garbage disposal was replaced on 8/7/2013, audits and in service will be completed by 9/6/2013. o 9/6/2013	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465		

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F 465	Continued From page 30 by: Based on observation and staff interview, the facility failed to ensure the garbage disposal located under the triple sink in the kitchen was maintained in a sanitary and safe working condition. The findings were: Observation on 7/30/13 at 3:45 PM showed there was a pool of brown-colored liquid under the garbage disposal. An interview with the dietary manager at that time revealed the garbage disposal leaked when it was turned on. She was not certain how long it had been broken. An observation on 7/31/13 at 9:45 AM showed when the water was turned on at the sink, liquid dripped from the bottom of the garbage disposal. In addition, when the garbage disposal was turned on, water squirted from its side. An interview with the maintenance assistant on 7/31/13 at 10 AM revealed the disposal had been broken for approximately 2 months. An interview with the maintenance director on 7/31/13 at 10:30 AM verified no work order had been completed and he acknowledged the garbage disposal needed to be fixed.	F 465	F502 • Resident #16 –results of physician ordered labs are current and included in the resident medical record. Resident #32 – Medical chart complete with all current documentation of lab results. An INR flow sheet is in place for resident #32. Labs are drawn as ordered by MD for Resident #32. A five check point process has been initiated for all of Resident #32 labs. • Labs will be reviewed by DON monthly/PRN. MAR will be reviewed monthly to verify no medication errors by Pharmacy Consultant. • Any resident on the medication (Coumadin or Anti-coagulant) will be monitored as ordered by their attending physician. Labs will be reviewed by DON monthly. Coumadin/INR flow sheet will be included with the MAR/medication cart. • Quarterly Mock Survey RN will be activity looking at a sample selection of files to verify audits are being completed and policies are being followed. Results of	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review, laboratory tracking log review and staff interview, the facility failed to ensure laboratory tests were completed	F 502		

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F 502	Continued From page 31 in accordance with physician's orders for 2 of 10 sample residents (#16, #32). The findings were: 1. Review of physician orders showed on 3/21/13 the physician ordered a BMP (basic metabolic panel) to be performed in 2 weeks (4/12/13) for resident #16. However, review of the medical record and the laboratory tracking log showed no evidence the laboratory test was performed. In addition, on 4/26/13 the physician wrote an order for a BMP every 2 weeks. Review of the medical record and the laboratory tracking log showed no evidence the laboratory test was performed on or around 5/24/13, 6/7/13, 6/21/13, or 7/19/13 as ordered. 2. Review of medical records for resident #32 revealed a physician's telephone order dated 4/5/13with orders for "Coumadin [an anti-coagulant] 5 mg daily. Recheck INR in 1 month." No evidence of an INR being performed on or around 5/5/13 could be located in the medical record or the laboratory tracking log. A physician's note dated 5/16/13 revealed the resident was "On Coumadin, no recent INR." Interview with the DON on 8/1/13 at 2 PM confirmed that the physician order to test the resident's INR on 5/5/13 was overlooked, and the test was not completed as ordered.	F 502	findings will be reported to the Pharmacy and Risk Management Committees and followed up monthly. • New procedures will be effective October 1, 2013. o 10/1/2013 F507 • Resident #16 – All labs have been received and are filed in the resident's record. Resident #8 – All labs have been received and are filed in the resident's medical record. • A monthly lab audit has been completed and implemented. • Audit will be monitored by DON. • Any labs not received and reviewed will be reported to Administrator and Medical Director. Mock Survey RN will review Lab Book to verify Labs are being completed as ordered. Quarterly Mock Survey RN will be activity looking at a sample selection of files to verify audits are being completed and policies are being followed and reported to the Risk Management Committee.	
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.	F 507		

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	535050	A. BUILDING _____ B. WING _____	08/01/2013

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 507	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and laboratory tracking log review, the facility failed to ensure laboratory test results were received and placed in the record for 2 of 10 sample residents (#16, #8) who had laboratory tests ordered. The findings were: 1. Review of the physician's orders for resident #16 showed an order dated 4/22/13 to re-check the TSH (thyroid stimulating hormone) levels in 2 months, approximately 6/22/13. Review of the laboratory log showed a TSH level was checked on 6/12/13, however, the results were not filed in the medical record. Additionally, medical record review showed the physician ordered a BMP (basic metabolic panel) to be drawn on 3/19/13. Review of the laboratory log showed the test was performed, however, review of the medical record showed no results were filed. Finally, review of the physician's orders showed a BMP was to be drawn on 5/11/13. Again, review of the laboratory log showed this test was performed but review of the medical record showed no results were filed in the medical record. Interview with the DON on 8/1/13 at 8:40 AM verified the facility had a problem with tracking laboratory testing and results. 2. Review of resident #8's medical record on 7/30/13 revealed an order dated 7/10/13 for laboratory tests to be done with the "next draw." The tests ordered were a CBC (complete blood count), CMP (comprehensive metabolic panel), lipid panel, urinalysis, and an HgA1c (a test for assessing long-term blood sugar control). Although the tests had been ordered 20 days	F 507	• New policies and procedures will be in effect October 1, 2013. Medical Records will initiate a log of labs ordered by October 1, 2013. o 10/1/2013	

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MORNING STAR CARE CENTER	4 NORTH FORK ROAD FORT WASHAKIE, WY 82514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 33 previously, no results had been filed in the medical record. Interview with the DON on 8/1/13 at 1:50 PM confirmed that these laboratory test results were not contained in the medical record, and the facility was unaware that the results had not been obtained. She further stated, regarding laboratory test tracking, that "we need to do something better because it's a mess."	F 507	F515 • MSCC has exhausted all possibilities of retrieving or locating the May 2013 MARs. • MAR will be secured in the Medical Records office in a locked file cabinet. A sign-in/sign-out log will be initiated to identify staff utilizing the MARs for audit purposes. At mid-night on the first of the month, the prior months MAR will be secured in a locked Med-room until retrieval by Medical Records. • The MAR will be secured in a locked filing cabinet with proper check out procedures put in place. • The Medical Record's Department Supervisor will have control over the check- out process. • The new process will be effective September 1, 2013 for control over prior months MARs. o 9/1/2013	
F 515 SS=F	483.75(l)(2) RETENTION OF RESIDENT CLINICAL RECORDS Clinical records must be retained for the period of time required by state law; or five years from the date of discharge when there is no requirement in State law; or, for a minor, three years after a resident reaches legal age under State law. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to maintain complete medical records for 9 of 9 sample residents (#4, #5, #8, #10, #12, #15, #16, #28, #32). The findings were: Review of medical records, and MARs revealed MARs from the month of May 2013 were not contained within the sample residents' medical records (#4, #5, #8, #10, #12, #15, #16, #28, #32). Interview with the medical records director on 8/1/13 at 9:45 AM revealed that all of the MARs for the month of May 2013 had last been seen ona previous employee's desk, that she had	F 515		

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F 515	Continued From page 34 "checked every nook and cranny" of the facility, and the records could not be found.	F 515		