POC accepted 10/1/08

HEALTHCARE LIC&SURV

SEP 27 2008

Wyoming Dept of Health

PRINTED: 09/24/2008
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	P O BOX 668 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 253 SS=E	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 and resident and staff interviews, the facility failed to maintain a clean, sanitary environment for residents. The facility census was forty-four residents. The findings were: During interview on 9/9/08 at 9:30 AM, six of six residents said the floor behind the door in each of their rooms was dirty. The residents also commented that areas along the wall and the corners were dusty. Observation with the maintenance director on 9/11/08 at 9:45 AM revealed the corners of the floor behind all the fire doors and resident room doors were gray with built up grime and dust. In addition, the doorway between the kitchen and dining room was discolored and grimy. Furthermore, despite the acute gastrointestinal outbreak experienced by the facility during the survey, observation showed additional cleaning of common environmental surfaces (such as handrails, chairs, and tables) was not provided. The maintenance director confirmed the lack of cleanliness during the observations.	F 253	This plan of correction is the facility's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of truth of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared because it is required by the provision of federal and state law. F253 The six observed floor areas in the Resident rooms will be cleaned by stripping the wax buildup, cleaning the floors and re-waxing the floors. The floors along the walls, behind doors and corners will be dusted and mopped. 10-4-08 The floors behind all fire doors and Resident room doors will be cleaned by stripping the wax buildup, cleaning the floors and re-waxing the floors. 10-4-08 The doorway between the kitchen and dining room will be cleaned to remove discoloration. 10-4-08	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	Cleaning of all common environmental surfaces observed will be completed. 9-30-08 All the above cleaning will be completed by housekeeping and/or maintenance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 9-27-08

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.

Changes made per phone call with Joann Cedrick, NHA on 10/1/08 @ 10:35. Janelle Cole, OTR/L

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Wyoming Dept of Health

OCT 1 6 2008

Office of Healthcare Licensing and Surveys

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

Wyoming Dept of Health

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	535060	A. BUILDING _____ B. WING _____	09/11/2008

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

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

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F 280	Continued From page 1 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and medical record review, the facility failed to revise the care plan to reflect the current status of 1 (#19) of 10 sample residents. The findings were: Observation on 9/8/08 at 4:55 PM showed resident #19 was in bed with a wound vacuum in place. The resident stated it was for a pressure sore that s/he had had for some time. During a conversation on 9/9/08 at 2 PM the resident stated s/he was "never free of pain." At this time the resident reported the pain medications just "took the edge off." She stated his/her pain level was a nine on a scale of one to ten (with ten being the most severe level of pain). The resident also stated the pain was constant and s/he was never pain free. Review of the 7/25/08 pain assessment showed the resident's pain was documented as a ten. The following concerns	F 280	F253 cont'd: All floor and common environmental surfaces will be monitored for cleanliness weekly by Infection Control Professional (ICP) and daily by Housekeeping Supervisor and/or designee. Any issues discovered in the monitoring will be corrected at the time of the observation by housekeeping. The Housekeeping Supervisor will implement a schedule of routine cleaning of floors and common environmental surfaces. A member of the Quality Assurance Committee will audit floors and common environmental surfaces within each quarter. All monitoring and audit documentation will be brought to the Quality Assurance meeting at least quarterly. DOC = 10/4/08 F280 a. Pain assessment for Resident #19 will be reviewed by the DON and/or RN designee to reassess the pain management program. 9-24-08 DON and/or RN designee will discuss pain management therapy with the Pharmacy Consultant. DON and/or RN designee will contact Primary Care Physician (PCP) to ascertain any new treatment orders. 9-24-08	

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	536059	A. BUILDING _____ B. WING _____	08/11/2008

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MORNING STAR CARE CENTER	P O BOX 659 FORT WASHAKIE, WY 82514

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F 280	Continued From page 2 with the resident's care plan were identified: a. Refer to F309 for detailed information regarding the failure of the facility to update this resident's plan of care related to pain. b. Review of the section of the care plan for wound care showed the resident was to receive daily dressing changes. However, the resident returned from the hospital on 7/25/08 with a wound vacuum in place, and the care plan was not revised to reflect this change in his/her condition.	F 280	F280 cont'd: If new treatment is ordered by PCP, Resident #19 will be reassessed regarding any new pain management effectiveness within the time the desired result of the treatment is obtained. DON and/or RN designee will review pain management assessments and results of treatments for all Residents.	9-30-08 10-4-08
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff maintained professional standards of practice for 2 (#19, #46) of 11 sample and 3 (#4, #6, #25) non-sample residents. These failures included failure to follow the standard of practice for licensed practical nurses as defined by the Wyoming State Board of Nursing, failure to follow physicians' orders, and failure to prepare and administer intravenous medication appropriately. The findings were: 1. Review of the "Nursing Practice Act July 2006 and Administrative Rules and Regulations November 2003" for the Wyoming State Board of Nursing revealed "(i.)The licensed practical nurse shall (A.) Contribute to the nursing assessment by: (I.) Collecting, reporting and recording objective and subjective data in an accurate and timely manner. Data collection includes: (1.)	F 281	Pain management assessments and results will reviewed by the DON and/or RN designee for all Residents on a quarterly basis at the time of the MDS. Documentation of reviews will be taken to the Quality Assurance meeting at least quarterly. b. The observed care plan for Resident #19 will be up-dated to reflect the change in condition upon return from the hospital relating to the use of the wound vac. All Residents returning from the hospital will be assessed for any change in condition. Any change in condition will be included in the care plan to reflect the current status of the Resident. All such care plans will be reviewed by the Director of Nursing (DON) to ascertain appropriate reflection of current status of each	9-24-08 9-24-08 10-4-08

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F 281	Continued From page 3 Observation about the condition or change in condition of the client; (2.) Signs and symptoms of deviation from normal health status." Failure to practice in accordance with this standard was identified as follows: a. Medical record review showed a significant change Minimum Data Set (MDS) assessment was completed for resident #19 on 6/18/08. The resident required comprehensive nursing assessments for ADL (activities of daily living) functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, pressures ulcers, and psychotropic drug use. Review of these assessments showed they were signed as completed by licensed practical nurse (LPN) #1. The section for falls was signed, but incomplete. The section for psychotropic medications was signed, but lacked a summarization of the collected data. The other assessments had been completed by the LPN. b. Review of the 8/21/08 admission Minimum Data Set (MDS) assessment for resident #46 revealed the Resident Assessment Protocols (RAPs) for the following areas were signed as completed by an LPN, and not a registered nurse (RN): delirium, vision, communication, activities of daily living, incontinence, mood, behaviors, falls, dehydration, dental, and pressure ulcers. On 9/11/08 at 11:10 AM the interim director of nursing (IDON) stated she signed the MDS at section AA8 with the understanding that meant she completed the assessments. She further stated the LPN did the assessments. The IDON stated she routinely reviewed the information, but did not make any changes or additions. She had no comment about the incomplete assessments for resident #19.	F 281	F280 con't'd: Resident within 7 days from return from hospital. Upon review, if necessary care plan up dates are not present, the DON will coordinate the nursing staff to ensure care plans are appropriate. 10-4-08 All monitoring documentation will be brought by the DON to the Quality Assurance Committee meeting at least quarterly. DOC - 10/4/08 F281 1. a. The MDS assessment for Resident #19 will be reviewed by the DON to ensure completeness, accuracy and inclusion of signatures of all observed comprehensive assessments. 9-30-08 b. The Resident Assessment Protocols (RAPS) for Resident #46 will be reviewed by the DON to ensure completeness, accuracy. The DON will make any necessary changes and sign the RAPS. 9-30-08 The DON and/or RN designee will review all MDS assessments and all RAPS for all Residents to ensure completeness and accuracy. Correct 10-4-08 The DON and/or RN designee will review all MDS assessments and all RAPS for each Resident at the time of the MDS assessments and RAPS are due for review. Complete	

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F 281	Continued From page 4 2. Observation on 9/8/08 at 6:12 PM showed LPN #4 prepared and administered medications, including Calcium 500 milligrams (mg) with Vitamin D 200 mg for resident #4. Reconciliation of the medications with the orders showed the physician wrote an order on 3/10/08 for Calcium with Vitamin D 500 mg. This order was transcribed on each medication administration record and the recapitulation of orders as the physician wrote it, but the specific amount of each medication was never clarified. On 9/9/08 at 9:40 AM the IDON stated she checked with the pharmacy and they always sent Calcium 500 mg with Vitamin D 200 mg when the physician did not specify a dose. The IDON further stated that nursing should have clarified the order. According to the sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, 2004, "If a written order is...questionable for any reason, the physician must be notified for clarification." 3. Observation on 9/9/08 at 3:40 PM revealed the IDON prepared an intravenous (IV) medication for administration to resident #19. During the preparation, the IDON used a 10 milliliter (ml) syringe to obtain bacteriostatic normal saline. Before withdrawing the saline, the IDON placed her hand and fingers on the plunger while drawing air into the syringe. This practice contaminated the syringe and, by injecting the air back into the vial, contaminated the saline. After drawing the contaminated saline into the syringe, the IDON replaced the vial in the cabinet for future use. The IDON then injected the contaminated saline into the resident's IV line. Interview with the IDON on 9/9/9/08 at 3:50 PM confirmed the plunger of a syringe is sterile and that the sterility should have	F 281	F281 cont'd: The review documentation will be taken to the Quality Assurance meeting by the DON at least quarterly. 2. The DON will clarify with the Physician as to the Calcium with Vitamin D 500 mg. DON will order the correct amount of this medication from the pharmacy. All physician orders relating to the observed issue will be reviewed by the DON and/or designee. All physician orders will be reviewed by the DON and/or designee daily to ensure clarification, if necessary, is obtained. The DON will inservice all Licensed staff relating to when clarification of an order is necessary and how to obtain any necessary clarification. The review documentation will be taken by the DON to the Quality Assurance Committee meeting at least quarterly. 3. All licensed nursing staff will be inserviced by the Staff Development Coordinator (SDC) relating to use of syringe in withdrawing liquid from vial to ensure sterility is maintained. Evidence of understanding will be shown by return demonstration. 4. a. Stool sample will be obtained for Resident #25	

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F 281	Continued From page 6 been, but was not, maintained. The IDON stated she was unaware she had touched the plunger of the syringe. Review of the 4th edition of "Nursing Interventions & Clinical Skills" by Elkin, Perry, and Potter, 2007, revealed one should "avoid touching" the plunger of the syringe. 4. According to the "Nursing Practice Act July 2006 and Administrative Rules and Regulations November 2003" for the Wyoming State Board of Nursing, nurses must practice under the direction of a physician or midlevel practitioner. Failure to practice within this standard was identified as follows: a. Review of a nursing note dated 9/5/08 showed resident #25 had been vomiting and had diarrhea for two days. Review of physician's orders showed on 9/4/08 the physician ordered staff to obtain a stool sample "to rule out bacteria or virus." Further medical record review revealed no evidence the stool sample had ever been obtained. b. Review of a nursing note dated 9/6/08 showed resident #6 had diarrhea. Review of physician's orders showed on 9/6/08, the physician ordered a stool specimen. Further medical record review showed no evidence the specimen was ever obtained. c. During an interview on 9/10/08 at 3:10 PM, the infection control nurse (ICN) confirmed the stool cultures for residents #25 and #6 were not obtained. She stated the residents had no further episodes of diarrhea, and the cultures were "missed."	F 281	F281 cont'd: b. Stool specimen will be obtained for Resident #6. 9-24-08 All orders for lab specimens will be reviewed by the DON and/or designee to ensure specimen is collected, taken to the lab, lab results are returned and any required treatments are followed. 9-26-08 SDC will inservice all licensed nurses relating to following physician orders regarding collecting specimens, sending to the lab, ensuring lab results are obtained and any required treatments followed. 9-30-08 All review documentation will be taken to the Quality Assurance meeting by the DON at least quarterly. DOC = 10/4/08 F282 1. The system for performing routine skin assessment, monitoring and assessing pressure sores and performing ongoing evaluation of the effectiveness of interventions for care of pressure sores will be reinstated by the DON. 10-1-08 2.a. Resident #33 will have appropriate dressing for the observed pressure sore at all times per treatment plan. 9-19-08 b. Resident #33 will have up-dated assessment completed. 9-19-08	DOC = 10/4/08
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		

Facility will assure the Care plan is followed for residents #3 & #33. Staff will be educated regarding following the care plans. Refer to F309 & F315 for additional details. Will be taken to QA meeting at least quarterly

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F 282	Continued From page 6 care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review,the facility failed to ensure staff followed the care plans as written for two (#33, #3) of ten sample residents. Interventions not implemented included those for pressure sore care, toileting, and incontinence care. The findings were: 1. Refer to F314 and F315 for detailed information regarding resident #33 related to the failure of the facility to provide toileting assistance and pressure ulcer care in accordance with the resident's plan of care. 2. Refer to F315 for detailed information regarding the failure to follow the toileting care plan for resident #3.	F 282	F282 cont'd: c. Resident #33 will have pressure sore reassessed for effectiveness of current treatment. PCP will be notified if treatment is not effective to consider alternative treatment. 3. a. Resident #41 will have pressure sore assessed for effectiveness of current treatment. PCP will be notified if treatment is not effective to consider alternative treatment. b. DON will reassess the observed pressure sores for Resident #41 and document in the record the actual measurements. c. DON will reassess the observed pressure sores for Resident #41 and document appearance and overall status of the wound.	10-1-08 10-1-08 10-1-08 10-1-08
F 309 SS=G	483.25 QUALITY OF CARE 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 observation, resident and staff interviews, and medical record review, the facility failed to provide the necessary care and services to relieve or minimize avoidable pain for one	F 309	d. Treatment of pressure sores for Resident #41 will be clarified by DON with PCP. Clarification will be documented in medical record. DON will observe dressing changes/wound care to ensure accuracy, consistency and all license nurses are knowledgeable of treatment. SDC will inservice all licensed nurses regarding the system for performing routine skin assessments, monitoring and assessing pressure sores and performing ongoing evaluation of the effectiveness of interventions for care of pressure sores. DON and/or RN designee will assess all pressure sores to ensure documentation is accurate.	10-1-08 10-4-08 10-4-08

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F 309	Continued From page 7 (#19) of six sample residents identified with pain. The findings were: During a conversation on 9/9/08 at 9:30 AM, resident #19 stated, "It's awful to have pain and you can't get relief." At 2 PM that day, the resident stated s/he was "never free of pain." At this time the resident reported the pain medications just "took the edge off." S/he stated his/her pain level was a nine on a scale of one to ten (with ten being the most sever level of pain). The resident also stated the pain was constant and that s/he was never pain free. Review of the 7/25/08 pain assessment showed the facility documented the resident's pain as a ten, the worst. Review of the care plan showed it had not been revised since 5/7/08. One of the goals was that the resident have periods of time throughout the day where s/he was free of pain. The approaches to achieve this goal included monthly visits to the chiropractor, diversionary activities, occupational therapy for upper extremity strengthening, and administration of Klonopin twice daily, Mobic once a day, Norflex twice daily, and Morphine Sulfate three times a day. Review of physician's orders showed the dosages of the medications were unchanged since they were ordered...Klonopin and Morphine Sulfate on 5/29/07, Mobic on 6/1/07, and Norflex on 2/25/08. The action plan developed by the facility on 6/24/08 was to continue with the same plan currently in place, even though the goal of freedom from pain was not met with the current plan. During an interview on 9/9/08 at 4 PM, the pharmacist stated he was not involved in pain management for any resident unless specifically requested by the facility. He further stated that he was not involved with this resident's pain	F 309	F282 cont'd: descriptive and treatments are effective. Any non-effective treatments will be reviewed by the PCP and any new treatment orders will be implemented. The Charge Nurses will complete weekly skin assessments for all Residents who are indicated to be at high risk for skin breakdown by the pressure risk assessment. Any indications of skin breakdown will be documented in medical record and referred to DON for accuracy of assessment, accuracy of documentation and referral to PCP for appropriate treatment. 10.4.08 Charge nurses will be inserviced by SDC regarding identifying, contacting PCP and following any PCP treatment orders. 10.4.08 C NA staff will be inserviced by SDC regarding identifying and reporting problematic skin areas to the Charge Nurse. 10.4.08 DON will implement tracking log for all skin breakdown; tracking assessments, measurements, documentation, treatments and results of treatments. The DON will follow-up on any necessary changes in the plan of care for any skin breakdown based on the review of the tracking logs. 9.30.08 DON and/or designee will audit the efficacy of the system for performing routine skin assessments, monitoring and assessing pressure 10.4.08	

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F 309	Continued From page 8 management. The pharmacist identified four specific types of medications which might be beneficial in reducing the resident's pain, but which had not been attempted. On 9/11/08 at 8:30 AM the IDON stated the facility had no further information related to pain management for this resident.	F 309	F282 cont'd: sores, and performing ongoing evaluation of the effectiveness of interventions for care of pressure sores.	
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review the facility failed to provide appropriate pressure sore treatment, monitoring, and assessment of care for two (#33, #41) of three sample residents with pressure sores. The lack of treatment, monitoring, and assessment resulted in deterioration and avoidable harm for both residents. The findings were: 1. Review of the skin care information provided by the facility during the survey revealed the facility did not have a system for performing routine skin assessments, monitoring and assessing pressure sores, and performing ongoing evaluation of the effectiveness of interventions for care of pressure sores. Interview with the IDON on 9/9/08 at 8:00	F 314	The DON will bring all documentation regarding skin issues (from above) to the Assurance Committee meeting at least quarterly. F309 Pain assessment for Resident #19 will be reviewed by the DON and/or RN designee to reassess the pain management program. DON and/or RN designee will discuss pain management therapy with the Pharmacy Consultant. DON and/or RN designee will contact Primary Care Physician (PCP) to ascertain any new treatment orders. If new treatment is ordered by PCP, Resident #19 will be reassessed regarding any new pain management effectiveness within the time the desired result of the treatment is obtained. DON and/or RN designee will review pain management assessments and results of treatments for all Residents. Pain management assessments and results will be reviewed by the DON and/or RN designees for all	9-22-08 9-24-08 9-30-08 10-4-08 10-4-08

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F 314	Continued From page 9 PM confirmed the facility's lack of a current system. The IDON said the previously used system had been discontinued six months before the survey, and information regarding the decline or improvement of existing pressure sores was currently limited to the inconsistent documentation in the nurse's notes. 2. Review of the 7/14/08 quarterly Minimum Data Set (MDS) assessment revealed resident #33 required total assistance with all activities of daily living and had a stage II pressure sore. Review of the resident's 7/14/08 updated care plan, revealed skin care interventions for providing treatment as ordered by the physician. Review of the September 2008 physician's order sheet revealed daily orders to clean the coccyx pressure sore with wound cleanser, apply a thin layer of calcium and cover with a Mepilex dressing. Review of the documented assessments of the resident's pressure sore revealed the most current assessment was a 7/3/08 nurse's notes that said the resident had two small approximately 1 centimeter (cm) open areas in between the buttocks. The following concerns were identified regarding the care of the resident's pressure sore: a. Observation on 9/9/08 from 1:15 PM until 5:30 PM (elapsed time: 4.25 hours) revealed the resident remained in bed throughout the time period and staff did not provide skin care or incontinence care. At 5:30 PM CNAs #1 and #2 removed the resident's urine-saturated brief and exposed an uncovered stage II pressure sore. The pressure sore that was 1 cm on 7/3/08 had deteriorated to an approximately 4 cm long moist pink area on the coccyx between the gluteal folds. The CNA's provided incontinence care, transferred the resident to his/ her wheelchair,	F 314	F309 cont'd: Residents on a quarterly basis at the time of the MDS. Documentation of reviews will be taken to the Quality Assurance meeting at least quarterly. F315 DON and/or designee will review care plans for Residents with toileting programs and those requiring assistance with toileting. F315 cont'd: SDC will inservice nursing service staff regarding following the care plan regarding toileting and assistance with toileting. DON and/or designee will audit weekly 10 % (different Residents each week) for those identified as needing toileting and toileting assistance to ensure nursing service staff are following the care plan for those Residents. DON will bring audits to the Quality Assurance meeting at least quarterly. F314 1. The system for performing routine skin assessment, monitoring and assessing pressure sores and performing ongoing evaluation of the effectiveness of interventions for care of pressure sores will be reinstated by the DON.	DOC = 10/4/08 10.4.08 10.4.08 10.4.08 10-4-08

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F 314	Continued From page 10 and propelled him/her to the dining room without a dressing covering his/ her pressure sore. Interview with CNA #1 on 9/9/08 at 5:30 PM and with LPN #2 at 6 PM revealed they knew the pressure sore should have a dressing, but they did not know why the dressing had not been applied. Further observation from 5:30 PM until 6:30 PM revealed the resident continued to sit in his/her wheelchair in the dining room without the dressing for his/her pressure sore. b. Interview with the IDON on 9/9/08 at 6:00 PM confirmed that the 7/3/08 documentation was the most current assessment of the resident's pressure sore. C. Interview with the IDON on 9/11/08 at 9:00 AM revealed no changes in the treatment or new interventions had been implemented in the past two months to address the resident's deteriorating pressure sores. 3. Review of the 7/9/08 admission MDS assessment revealed resident #41 was admitted to the facility with stage III pressure sores. Review of the resident's 7/9/08 care plan revealed approaches to observe and record signs of improvement or regression and provide treatment as ordered by the physician. The following concerns were identified regarding the care of the resident's pressure sore: a. Interview with LPN #2 on 9/10/08 at 11:25 AM revealed the resident's pressure sore had not improved and staff had not assessed the effectiveness of the current treatment or reported the lack of improvement to the physician. b. Review of the documented assessments of the resident's pressure sore revealed the most current assessment was an 8/9/08 nurse's notes that said the the pressure sores on each hip measured .5 by .5 cm and the	F 314	F314 cont'd: 2.a. Resident #33 will have appropriate dressing for the observed pressure sore at all times per treatment plan. 9-9-08 b. Resident #33 will have up-dated assessment completed. 9-9-08 c. Resident #33 will have pressure sore reassessed for effectiveness of current treatment. PCP will be notified if treatment is not effective to consider alternative treatment. 10-1-08 3. a. Resident #41 will have pressure sore assessed for effectiveness of current treatment. F314 cont'd: PCP will be notified if treatment is not effective to consider alterative treatment. 10-1-08 b. DON will reassess the observed pressure sores for Resident #41 and document in the record the actual measurements. 10-1-08 c. DON will reassess the observed pressure sores for Resident #41 and document appearance and overall status of the wound. 10-1-08 d. Treatment of pressure sores for Resident #41 will be clarified by DON with PCP. Clarification will be documented in medical record. DON will observe dressing changes/wound care to ensure accuracy, consistency and all license nurses are knowledgeable of treatment. 10-1-08 SDC will inservice all licensed nurses regarding the system for performing routine skin 10-1-08	

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F 314	Continued From page 11 one on the coccyx measured 3 cm by 3 cm with no depth. Observation of the resident's pressure sores while LPN #2 changed the dressing on 9/11/08 at 12:15 PM revealed the pressure sores had worsened since 8/9/08. Further observation revealed the stage II pressure sores on the bilateral hips were approximately 1 cm in circumference and 1 cm deep, and the stage III pressure sore on the coccyx was 4 cm in circumference with a 1.5 to 2.0 cm depth. C. Interview with LPN #2 on 9/11/08 at 12:15 PM revealed staff recently noted drainage from the pressure sore on the right hip that was not noted last week. d. Interview with the resident on 9/11/08 at 12:25 PM revealed "it hurt" when the resident sat on the coccyx pressure sore. The resident also said the pressure sore treatment implemented prior to admission to the facility "made the pressure sores start to heal," but the facility did not use the same treatment and the pressure sores had worsened.	F 314	F314 cont'd: assessments, monitoring and assessing pressure sores and performing ongoing evaluation of the effectiveness of interventions for care of pressure sores. DON and/or RN designee will assess all pressure sores to ensure documentation is accurate, descriptive and treatments are effective. Any non-effective treatments will be reviewed by the PCP and any new treatment orders will be implemented. The Charge Nurses will complete weekly skin assessments for all Residents who are indicated to be at high risk for skin breakdown by the pressure risk assessment. Any indications of skin breakdown will be documented in medical record and referred to DON for accuracy of assessment, accuracy of documentation and referral to PCP for appropriate treatment. Charge nurses will be inserviced by SDC regarding identifying, contacting PCP and following any PCP treatment orders. C NA staff will be inserviced by SDC regarding identifying and reporting problematic skin areas to the Charge Nurse. DON will implement tracking log for all skin breakdown; tracking assessments, measurements, documentation, treatments and results of treatments. The DON will follow up on	10.4.08 10.4.08 10.4.08 10.4.08 10.4.08 9.30.08
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 315		

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F 315	Continued From page 12 Interview, staff failed to provide toileting assistance for two (#3 , #33) of three sample residents who required assistance. The findings were: 1. Review of the 7/14/08 quarterly Minimum Data Set (MDS) assessment revealed resident #33 had multiple daily episodes of bladder incontinence and required total assistance with toileting and personal hygiene. Review of care plan, updated on 7/14/08, revealed approaches for incontinence care included " assist with incontinence and personal hygiene care" and "keep skin clean and dry." Observation of the resident on 9/9/08 from 1:15 PM until 5:30 PM (elapsed time: 4.25 hours) revealed the resident remained in bed throughout the time period and staff did not check or change the resident's brief or assist the resident to the bathroom. At 5:30 PM, CNA #1 and CNA #2 removed the resident's urine-saturated brief and exposed an uncovered stage II pressure sore. Interview with CNA #1 on 9/9/08 at 5:30 PM revealed the CNA did not check the resident for incontinence from 1:15 PM to 5:30 PM due to the lack of sufficient staff. 2. Review of the 6/23/08 annual MDS assessment revealed resident #3 had multiple daily episodes of bladder incontinence and required total assistance with toileting and personal hygiene. Review of the care plan, updated on 6/23/08, revealed approaches for incontinence care included "perform voiding diary and set up timed toilet schedule," "cue and assist to the bathroom," and "give resident approximately every two hour reminders to go to the bathroom."	F 315	F314 cont'd: any necessary changes in the plan of care for any skin breakdown based on the review of the tracking logs. DON and/or designee will audit the efficacy of the system for performing routine skin assessments, monitoring and assessing pressure sores, and performing ongoing evaluation of the effectiveness of interventions for care of pressure sores. The DON will bring all documentation regarding skin issues (from above) to the Assurance Committee meeting at least quarterly. DOC = 10/4/08 F315 1. Resident #33 will be assisted with incontinence and personal hygiene care and keep skin clean and dry by the C NA and/or licensed nursing staff. 9-19-08 2. Resident #3 will be assisted with toileting per the care plan by the C NA and/or licensed nursing staff. 9-19-08 DON and/or designee will review care plans for Residents with toileting programs and those requiring assistance with toileting. 9-30-08	

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F 315	Continued From page 13 Observation of the resident on 9/9/08 from 1:45 PM until 5:15 PM (elapsed time: 3.5 hours) revealed the resident remained in bed throughout the time period, and staff did not check or change the resident's brief or assist the resident to the bathroom. At 5:15 PM, CNA #1 removed the resident's urine-saturated brief, provided incontinence care, transferred the resident to his/her wheelchair, and propelled the resident to the hallway. Interview with CNA #1 on 9/9/08 at 5:15 PM revealed she knew the resident was to be toileted every two hours, but she had not provided toileting assistance, cues, or reminders on 9/9/08 as directed on the plan of care due to the lack of sufficient staff.	F 315	F315 cont'd: SDC will inservice nursing service staff regarding following the care plan regarding toileting and assistance with toileting. DON and/or designee will audit weekly 10 % (different Residents each week) for those identified as needing toileting and toileting assistance to ensure nursing service staff are following the care plan for those Residents. DON will bring audits to the Quality Assurance meeting at least quarterly.	
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure the environment was as free of hazards as possible for one (#33) of ten sample residents who required protection against hard surfaces of the wheelchair and twenty-three of forty-four residents who could potentially access the coffee machine without staff assistance. The findings were: 1. Observation in the dining room on 9/10/08 at	F 323	F323 1. The NHA and Dietary Manager will obtain coffee containers which will ensure safety of the Residents. 10.4.08 2. Resident #33 will be assessed for positioning in wheelchair by Occupational Therapy to ensure wheelchair has not hard surfaces which Residents leg can come in contact. 10-4-08 DM will audit coffee service to ensure safety of Residents daily for one week and randomly thereafter. 10-4-08 Occupational Therapy will review all wheelchairs to ensure wheelchairs do not have hard surfaces Residents legs can come in contact. 10-4-08	

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F 323	Continued From page 14 11:12 AM and again on 9/11/08 at 8:50 AM revealed two coffee machines located on the counter such that residents could freely access the coffee. The sides of the metal coffee machines and the spigots were hot to the touch. The temperature of the coffee ranged from 140 degrees Fahrenheit (F) to 142 degrees F. During an interview on 9/9/08 at 3:37 PM, the IDON stated resident #36 ended up with blisters on his/her legs from coffee that had spilled on his/her lap. During an interview on 9/11/08 at 1:10 PM the administrator was asked if the facility had evaluated the safety of the coffee machines. The administrator stated, "I don't believe the coffee has been looked at." 2. Review of the 1/7/08 nursing admission assessment revealed resident #33 had decreased sensation and limited ability to move his/her right arm and leg due to a stroke. Review of the 7/14/08 quarterly Minimum Data Set (MDS) assessment revealed the resident required total assistance with all activities of daily livings and the resident's skin was desensitized to pain and pressure. Observation on 9/08/08 from 4:45 PM until 7:00 PM revealed the resident sat in the wheelchair with his/her right leg and ankle against the hardware of the wheelchair footrest. The constant pressure against the resident's skin caused indented red areas on the resident's lower leg. Although staff were present in the dining room during this time, they did not reposition the resident's leg or provide a cushion to protect the resident from the hard surface of the wheelchair. Interview with the IDON on 9/11/08 at 1:15 PM revealed staff knew the resident needed to be reassessed for proper support devices to assist his/her positioning while in the wheelchair, but they were not aware that the poor positioning	F 323	F323 cont'd: SDC will inservice nursing service staff regarding identifying the need of Residents to be repositioned to avoid pressure against hard surfaces of wheelchair. DON and/or designee will audit Residents in wheelchairs to ascertain positioning as to avoid pressure against hard surfaces of wheelchair weekly for all those Residents in wheelchairs. DM will bring audit documentation relating to the coffee service to the Quality Assurance meeting at least quarterly. The DON will bring audit documentation regarding the hard surfaces of wheelchairs to the Quality Assurance committee meeting at least quarterly. DOC = 10/4/08 F332 1. Physician for Resident #4 will be notified of Metamucil given twice in one day. Any new orders and/or treatments will be implemented per PCP orders. 9-27-08 2. Physician for Resident #2 will be notified of multivitamin not given. Any new orders and/or treatments will be implemented per PCP orders. 9-27-08	

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F 323	Continued From page 15 caused the resident to maintain his/her leg against the wheelchair.	F 323		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain an error rate under five percent (%). Five errors occurred out of 46 opportunities for error, resulting in an error rate of 10.86 %. The findings were: 1. Observation on 9/8/08 at 6:12 PM showed LPN #4 prepared and administered medications for resident #4. The medications included a packet of Metamucil that the LPN mixed with water and gave to the resident to consume. Reconciliation of the medications with the orders showed the physician ordered Metamucil daily. Review of the medication administration record (MAR) showed the medication was scheduled for 8 AM. Further review showed the medication had already been given once that day. 2. On 9/9/08 at 7:45 AM LPN #2 was observed preparing medications for resident #16. During preparation, the LPN stated the facility was out of multivitamins and she would not be giving it. Reconciliation of the orders showed the resident was to receive a multivitamin once daily, and, according to the MAR, it was scheduled at 8 AM. The pharmacist delivered medications later that day, but review of the MAR at 6:30 PM that	F 332	F332 cont'd: 3. Physician for Resident #37 will be notified of missing doses of the three observed medications. Any new orders and/or treatments will be implemented per PCP orders. 9-29-08 All observed Residents will be monitored for adverse effects of missing medications. PCP will be notified of any signs/symptoms of adverse effects. Any new orders will be implemented at time of order. DON and/or designee will review medication supplies weekly to ensure supplies are available. If any medication is not in the supply, it will be ordered from contracted pharmacy at that time. If contracted pharmacy cannot deliver 10/10/08 medications timely, medications will be obtained from local contracted emergency pharmacy. SDC will inservice licensed nurses regarding ordering medications, completing medication error reports, and how to obtain medications from contracted emergency pharmacy. 10-10-08 All documentation regarding review of medication supplies, medication errors will be taken by the DON to the Quality Assurance committee meeting at least quarterly. DOC 10/10/08 F371 1. Dietary manager (DM) will train all dietary staff to accurately complete PPM test for dish 9/10/08	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 16 evening showed the medication was not documented as given. On 9/10/08 at 11:25 AM LPN #2 confirmed she did not give the medication. This was an error of omission. 3. On 9/11/08 at 8:30 AM registered nurse (RN) #1 was observed preparing medications for resident #37. During preparation, RN #1 stated s/he did not administer the resident's morning doses of lisinopril, spironolactone, and vitamin K because the medication packages were empty, and the pharmacy had not delivered the refills. The RN said the same medications were not available on the previous day for the same reason. Reconciliation of the orders showed the resident was to receive five milligrams of lisinopril, fifty milligrams of spironolactone and five milligrams of vitamin K every morning. Review of the September 2008 MAR showed the medications were scheduled to be given at 8:00 AM. Further review of the MAR revealed the three medications were documented as not given on 9/10/08 and on 9/11/08 at 8:00 AM. These were three errors of omission.	F 332		
F 371 SS=L	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		

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	535080	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	P O BOX 569 FORT WASHAKIE, WY 82514

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F 371	Continued From page 17 Based on observation, policy review, staff interview, and review of facility documentation, the facility failed to assure the dishmachine was sanitizing, which resulted in immediate jeopardy. In addition, the facility failed to maintain the hood above the range in a clean manner. The findings were: 1. The following concerns with the dishmachine sanitization were identified: a. On 9/8/08 at 5:20 PM, the administrator informed the surveyors of an outbreak of gastrointestinal (GI) illness which included nausea, vomiting, and diarrhea. Residents #2, #4, #32, and #45 were affected at the time of the interview. Observation in the kitchen on 9/8/08 at 5:50 PM revealed a note that those residents were to receive a clear liquid diet that evening due to illness. Review of documentation provided by the facility revealed the following nine residents had been ill the previous week with symptoms including nausea, vomiting, and diarrhea: #3, #8, #8, #19, #20, #26, #27, #28, and #42. b. Interview with the dietary manager on 9/9/08 at 4:35 PM revealed the dishmachine was a low temperature/chemical sanitizing (chlorine) machine. The dietary manager stated staff did not monitor the chlorine concentration of the dishmachine. She stated a company came once per month to check the machine and so she "assumed it was right." During an interview on 9/10/08 at 2:10 PM the dietary manager stated she had been the dietary manager in the facility since "about May." c. On 9/9/08 at 6 PM the surveyor requested the chlorine concentration level be tested for the next load of dishes. The dietary manager stated the facility did not have any chlorine test strips. When the load of dishes were removed from the machine, the surveyor used her test strips to	F 371	F371 cont'd: machine sanitizer and complete a return demonstration to ensure knowledge. Test strips will be used to quantify the sanitizer as the machine requires chemicals not water temperature to sanitize. Test results should be at 50 to 100 parts per million (PPM). 2. Dietary staff will test the PPM on the first rack of dishes after each meal to ensure sanitation for next meal. Dietary staff will record the test results for each test at least three times per day. 3. Dietary staff completing the test will notify DM and NHA after each test for 20 days. If DM and NHA are not in facility, staff will call and leave message with the results of the test. DM F371 cont'd: and NHA will document the results of the tests per these messages. 4. DM will complete random PPM tests 4 times per week in addition to the routine testing for the next 14 days. NHA will complete random PPM testing 1 time per week for the next 14 days. Random testing by DM and NHA will be completed 1 time per week over the next three months and randomly thereafter. 5. DM and NHA will call facility randomly 2 times per week when not in the facility to obtain test results for the next 20 days. 6. A copy of all recording logs for the PPM testing will be given to the NHA weekly.	9-10-08 9-10-08 9-10-08 9-10-08

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 18 determine the chlorine concentration at the dish surface. The chlorine concentration was 0 parts per million (ppm); it should have been 50 ppm per manufacturer's guidelines. At 5:20 PM another surveyor used her test strips to determine the chlorine concentration; again, it was 0 ppm. The dietary manager told the surveyors "maybe the chemicals were rinsed off" during the rinse cycle. At 5:25 PM the dietary manager stated the machine "was primed" and requested the surveyors check the concentration again. The test strip indicated 0 ppm of chlorine. At 5:30 PM the surveyor informed the administrator that the dishmachine was not sanitizing. The administrator stated she would call the company that was responsible for the monthly checks. At 5:45 PM, when the surveyor re-entered the kitchen, the dietary manager was testing the sanitization level of the dishmachine by using a quaternary ammonium "QT-10" test strip, rather than a strip for chlorine. The surveyor asked the dietary manager what her plan was, and she replied that she was waiting for a call back from the company. At 5:50 PM the staff started the trayline service. They used regular plates, utensils, and pots and pans, including an item that had been run through the dishmachine earlier (when the test strip indicated 0 ppm). After the trayline at 6:41 PM, the surveyor again asked the dietary manager about her plans for addressing the inadequate chlorine concentration. She replied she was still waiting for a call back from the dishmachine company. When questioned further, she said she would use disposable plates and utensils for the breakfast meal the next day if the machine was not fixed. d. On 9/10/08 at 7:42 AM observation revealed disposable plates, cups and utensils in the dining room for the resident meal. At that	F 371	F371 cont'd: 7. NHA will approve new lease with new company for dish machine to obtain better services. ProChem will install new machine on 9/15/08. ProChem will also install chemical system for the three compartment sink. 9/10/08 8. If results of any test are not at appropriate level of sanitizer, Dietary staff will immediately notify DM and NHA. Staff will use disposable kitchen ware for service of food to Residents. Dietary staff will use the three compartment sink for cooking ware/utensils if PPM levels cannot be found to be at acceptable levels prior to next meal. 9/10/08 9. Dietary staff will be trained on three compartment sink testing to ensure appropriate PPM levels for chemical sanitizer. 9/10/08 10. Dietary staff will systematically, on 9/10/08, wash all dishes, kitchen ware, cooking ware prior to using to ensure sanitizer is working. (A systematic approach will ensure all items have been re-washed.) 9/10/08 11. Registered Dietician (RD) will weekly check staff knowledge of testing for PPM of sanitizer in dish machine and three compartment sink over next month. 9/9/08 RD will inservice any new staff relating to testing of the PPM for the sanitizer for dish machine and 9/9/08	

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F 371	Continued From page 19 time, the dietary manager stated she had enough pots and pans in the kitchen to use for the preparation of the meal. When the surveyor asked how she knew those pots and pans had been correctly sanitized, she replied those items had probably been sanitized "a long time ago." When specifically asked, the dietary manager stated she did not know for sure that those items had been properly sanitized. The dietary manager then told the surveyor that they had the three compartment sink ready to use and "we think it's where it needs to be." She requested the surveyor check the chlorine concentration; it was between 10 ppm and 50 ppm. The dietary manager stated it needed to be at least 50 ppm. e. Review of reports given to the facility by the company who inspected the dishmachine monthly revealed that twice (5/21/08 and 8/14/08) in the past 5 months the report indicated the chlorine concentration was at 0 ppm when tested. During an interview on 9/11/08 at 1:10 PM, the administrator stated the reports were given to the dietary manager and herself. She stated the facility did not implement any monitoring of the dishmachine after the two reports showed inadequate chlorine concentration. f. On 9/11/08 at 9 AM, after looking through the policy manual in the kitchen, the dietary manager stated she could not find a policy on sanitization of the dishmachine. She stated the policy "was missing." g. Review of the dietary in-service education records for January through August 2008 revealed no education for staff regarding checking the sanitization of the dishmachine. During an interview on 9/10/08 at 2:10 PM the dietary manager stated the staff had not been educated. h. Review of the consultant registered	F 371	F371 cont'd: RD will weekly review sanitization logs and give written report to NHA. 9-19-08 DM will inservice all dietary staff relating to cleaning the stove hood area above stove in addition to the Maintenance Director cleaning monthly the hood itself. 9-29-08 DM will create a cleaning log that shows cleaning stove hood area will be completed weekly. 9-29-08 All documentation relating to logs, testing, cleaning will be taken to the Quality Assurance Committee meeting at least quarterly by the DM. DOC - 9/29/08 F425 DON and/or designee will initiate system of ensuring routine and emergency drugs and biological are ordered and received. 10-1-08 including Pol. nos #6, D 15, P 37 DON and/or designee will contact contracted pharmacy to clarify when to order to ensure medications are received timely. 10-1-08 DON and/or designee will incorporate needs of the contracted pharmacy into the above referenced system. 10-1-08 DON and/or designee will contact contracted pharmacy to clarify what action is required from the facility "after hours and/or emergency services" 10-1-08	

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F 371	Continued From page 20 dietitian (RD) visit notes from January through August 2008 showed no evidence the RD had monitored the dishmachine sanitization. During an interview on 9/11/08 at 9:05 AM, the RD stated she was not sure the last time dietary staff checked the chlorine concentration of the dishmachine. The RD further stated she did look at the dishmachine when she visited. She stated she would ask staff if they had any problems with the machine. She also stated she had tested the concentration level using test strips herself, but was unable to say when she had last done that. On 9/10/08 at 9:50 AM, the administrator was notified of the immediate jeopardy. On 9/10/08 at 2:15 PM, the immediate jeopardy was removed on-site by the following actions: the facility obtained chlorine test strips; the machine was sanitizing with a chlorine concentration of 50 ppm, staff were now monitoring the concentration level on the first load after each meal (three times per day); all dietary staff currently working had been educated; and all dishes used had been run through the dishmachine after the chlorine concentration was adequate. The facility submitted a written plan to assure all remaining dishes, pots, pans, and utensils would be re-sanitized and to assure all remaining dietary staff would be educated. 2. Observation on 9/8/08 at 3:45 PM and on 9/9/08 at 4:20 PM revealed the hood above the range had an accumulation of grease and dust. Strands of dust were hanging from the edge directly over the range. During an interview on 9/10/08 at 2:10 PM, the dietary manager stated the maintenance department was responsible for cleaning the hood. On 9/11/08 at 8:05 AM the maintenance supervisor stated the hood is cleaned monthly. On 9/11/08 at 9 AM the	F 371	F425 cont'd: DON and/or designee will incorporate needs of the contracted pharmacy concerning "after hours and/or emergency services" into the above referenced system. DON and/or designee will inservice licensed nursing staff relating to the system of ensuring medications are ordered and received. DON and/or designee will review results of initiated system weekly to ensure medications are ordered and received timely and create a log to document results of review. DON will take all documentation to the Quality Assurance Committee at least quarterly. F428 DON will clarify with PCP for Resident #19 the simultaneous use of Lexapro and Ambien and follow any changes the PCP orders. DON and/or designee will review medications for all Residents with the Pharmacy Consultant monthly to ensure all irregularities are identified. PCP will be notified of any such identifications and any changes in physician orders will be followed. DON will bring medication review documentation to the Quality Assurance committee meeting at least quarterly.	10.6.08 10.6.08 DOC = 10/6/08 9-29-08 10/6/08 DOC = 10/6/08

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F 371	Continued From page 21 surveyor asked the dietary manager what the policy was for cleaning the hood. After looking in the policy book, she stated "weekly".	F 371		
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES 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 services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interviews, the facility failed to establish an effective system for ordering and receiving medications in a timely fashion for 3 (#6, #16, #37) of 11 residents observed during medication passes. The findings were: Observation on 9/9/08 at 7:40 AM showed LPN #3 prepared medications for resident #6. During the procedure, the LPN circled Vitamin C,	F 425	F441 DON, ICP, NHA and Medical Director will review infection control policies and procedures to ensure they are based on current standards and practices. 9.22.08 Policy and procedures for surveillance of activities associated with infection control will be inserviced to all licensed nurses and C NA staff by ICP. 9.19.08 All facility department supervisors will be inserviced regarding activities associated with infection control and how each department is involved. 9.19.08 F441 cont'd: All departments will be informed of any infection control issue at the daily morning meetings and at other times of the day/week by the ICP to ensure appropriate requirements are implemented, i.e., laundry staff will know how to handle laundry issues. 9.19.08 Surveillance logs will be initiated by the ICP based on suspicion of having any signs/symptoms of an infection, any physician orders for antibiotics, results of any culture results from the lab. 9.19.08 ICP will inservice all staff relating to the signs/symptoms of infection, who to report to. 9.24.08	

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F 425	Continued From page 22 Megace, multivitamins, and Calcium Carbonate with Vitamin D. The LPN stated she could not give the medications as they had not been delivered from the pharmacy. Reconciliation of the medications showed they were all ordered daily. Observation on 9/9/08 at 7:46 AM showed LPN #2 circled the multivitamin for resident #16 and stated they were "out of" it. Review of the physician's orders showed the resident was to receive it daily. On 9/11/08 at 8:30 AM RN #1 was observed preparing medications for resident #37. During preparation, RN #1 stated s/he did not administer the resident's morning doses of lisinopril, spironolactone, and vitamin K because the medication packages were empty and the pharmacy had not delivered the refills. The RN said the same medications were not available on the previous day for the same reason. Review of the September 2008 MAR revealed the three medications were documented as not given on 9/10/08 and on 9/11/08 at 8:00 AM. During confidential interviews on 9/9/08 at 9:30 AM, five residents said they don't received their medications because the facility "runs out of medications" at least one time every month and one resident said, "its awful to have pain and you can't get relief." Interview with the IDON on 9 /10/08 at 11:45 AM confirmed that obtaining medications, particularly stock medications, in a timely fashion was a problem. The IDON stated the facility ordered stock medications last Friday, 9/5/08, and still had not received them all by 9/10/08. She further	F 425	F441 cont'd: ICP will inservice licensed nursing staff relating to following infection control policy and procedures if signs/symptoms, physician orders and/or results of any culture results from the lab occur on a weekend or any other time the ICP is out of the facility. 9-24-08 ICP will monitor logs to ensure documentation is accurate, timely and appropriate. 9-24-08 DON and/or designee will review physician orders daily to ensure treatments are implemented and cultures are obtained and taken to the lab. 9-29-08 ICP will audit facility environmental factors by mapping any infections for location, date of onset to ensure any "cluster" is identified. 9-11-08 ICP will communicate with local health agencies to determine if infections are in the community in order to determine if infections in the facility are community acquired. 9-11-08 ICP will inservice all staff relating to proper hand washing and evaluate competency by return demonstration. Licensed staff will complete competency of staff working nights and weekends. (after proving their competency to the ICP). 9-10-08 Other department supervisors will prove competency to the ICP in order to enable them to test their department staff for competency. 9-11-08	

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F 425	Continued From page 23 stated they had called the pharmacy several times, but they "get medications when they arrive."	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview with the pharmacist, the facility failed to ensure the pharmacist identified and reported irregularities when completing the monthly medication regimen review (MRR) for 1 (#19) of 11 sample residents. The findings were: Medical record review showed the physician ordered Lexapro (an antidepressant)10 milligrams (mg) nightly on 5/29/07 for resident #19. Further review showed Ambien (sleeping pill) 5 mg was changed from nightly to an "as needed" basis on 5/12/08. Review of the medication administration records since 5/29/07 showed the resident received the Lexapro as ordered, and s/he requested and received the Ambien almost nightly. Review of the MRRs since 10/4/07 showed the pharmacist documented the resident received the medications, but he did not identify or report them as irregularities. On 9/9/08	F 428	F441 cont'd: ICP will initiate a log of current status of TST and HBV immunizations of employees. Any new hires will have a negative TST prior to working with Residents. ICP will track all employees to ensure annual TST is completed. TST will be completed annually for all employees based on the hire date. Definition of "communicable infections" will be inserviced to all staff by the ICP. NHA will inservice all staff relating to not working if individuals have communicable infection and that their duties will be performed by other appropriate staffing. ICP will be in contact with staff who have a communicable infection to ensure they are not infected at the time they come back to their duties. ICP will define an outbreak as being 2 or more with same signs/symptoms of same infection per the Wyoming Department of Health Epidemiology Agency. ICP will track infections in the facility to ensure an outbreak is identified. ICP will implement outbreak control measures as appropriate for the type of infection i.e. isolation, PPE, hospitalization, visitor restrictions. ICP and/or designee will notify Epidemiology Agency of any outbreak. If message is left on their answering service, that office will be called	9.19.08 9.24.08 9.24.08 9.12.08 9.19.08 9.19.08 9.19.08

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F 428	Continued From page 24 at 4 PM the pharmacist confirmed he had not identified and reported the extensive use of the medications as irregularities.	F 428		
F 441 SS=L	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of internal information and nursing schedules, and staff interview, the facility failed to establish, implement, monitor, and maintain an effective infection control program based on current standards of practice. During an ongoing outbreak of gastrointestinal illness where, the facility failed to monitor sanitization of the dishmachine, report the outbreak to the Wyoming Department of Epidemiology or to public health, obtain ordered cultures, monitor staff for signs and symptoms of the illness, or developed criteria specifying when staff could either leave the facility or stay at home when ill. In addition, the facility failed to develop return to work criteria for staff, develop an effective method for communicating infections/illnesses to the infection control nurse, or monitor the immunization status of employees. Furthermore, observed practices related to	F 441	F441 cont'd: until a person answers. ICP and/or designee will notify Depart of Health Office of Licensing and Surveys, local public health agency of any outbreak. DON and/or designee will review physician orders daily to ensure of any specimen orders are obtained and taken to the lab. DON and/or designee will review lab results to ensure physician is notified. DON and/or designee will review any physician orders to ensure any treatment order is followed. DON and/or designee will initiate a log to track any such orders to ensure complete follow through. 9-19-08 All staff will be required to either have a work release notation from their physician or through the ICP have no reason to stay away from facility. 9-19-08 The ICP will use the "Guidelines for Work Restrictions and Management of Infectious Illness for Healthcare Workers" from the CDC to inservice all staff relating to communicable infections and return to work requirements. 9-24-08 All Department supervisors will be inserviced by ICP relating to definitions of communicable infections and return to work requirements. 9-24-08 ICP will initiate a log to track staff infections to ensure staff do not work while infected and return to work according to guidelines. 9-19-08	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 25 medication administration and general cleaning revealed staff did not follow professional standards of practice to minimize the risk of cross contamination. At the time of the survey, 13 residents or 29.54% of the total resident population, exhibited or had exhibited signs and symptoms of acute gastrointestinal illness (#2, #3, #6, #8, #19, #20, #24, #25, #27, #28, #32, #42, and #45). These findings resulted in an immediate jeopardy situation. The findings were: 1. On 9/8/08 at 5:20 PM the administrator informed the surveyors of an ongoing outbreak of gastrointestinal (GI) illness which included nausea, vomiting, and diarrhea. Residents #2, #24, #32, and #45 (9.09 % of the resident population) were identified as currently affected, and observation in the kitchen on 9/8/08 at 5:50 PM revealed a note that those residents were to receive a clear liquid diet that evening due to the illness. 2. On 9/10/08 the facility provided the survey team with a list of residents who had been sick the week before with symptoms including nausea, vomiting, and diarrhea. Further investigation revealed the GI outbreak began on 9/2/08. The list identified nine residents, #3, #6, # 8, #19, #20, #25, #27, #28, and #42 (20.45 % of the population), affected by the outbreak. Medical record review revealed the information: a. Nursing notes documented that on 9/2/08 at 1 PM resident #3 vomited a "large amount" in the hallway. According to the September 2008 medication administration record (MAR), the 5 PM medications were held on 9/2/08 due to vomiting. Further review of the MAR show Lactulose (laxative) was held at 8 AM and 5:30 PM on 9/5/08 and at 8 AM on 9/6/08 due to diarrhea.	F 441	F441 cont'd: ICP will report to Department Supervisors weekly regarding all employee illness. NHA will contact Epidemiology agency to request staff training relating to total infection control system. All licensed nursing staff will be inserviced by the Staff Development Coordinator (SDC) relating to use of syringe in withdrawing liquid from vial to ensure sterility is maintained. Evidence of understanding will be shown by return demonstration. All documentation of monitoring, audits, reviews, logs will be taken to the Quality Assurance Committee meeting at least quarterly by the DON and/or ICP. F502 Laboratory test for Resident #33 for a complete blood count wit differential and basic metabolic panel will be completed. DON and/or designee will review physician orders daily to ensure orders for lab tests are followed. SDC will inservice licensed nurses relating to identifying lab test orders.	9-19-08 9-22-08 9-30-08 POC = 9/30/08 9-25-08 9-25-08 9-30-08

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	535050	A. BUILDING _____ B. WING _____	09/11/2008

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 441	Continued From page 26 b. On 9/2/08 nursing staff documented resident #19 complained of nausea. On 9/3/08 at 0030 (12:30 AM) the resident had a temperature of 101.7 degrees Fahrenheit with vomiting and diarrhea. Nursing notes dated 9/3/08 at 1:45 PM showed the resident remained nauseated. c. Nursing notes revealed resident #27 vomited on 9/2/08. d. Nursing notes showed that on 9/3/08 at 0045 (12:45 AM) resident #28 vomited. e. On 9/5/08 nursing staff documented that resident #25 was vomiting and had had diarrhea for the past two days. Review of physician orders showed on 9/4/08 the physician ordered staff to obtain a stool sample "to rule out bacteria or virus." Further medical record review revealed no evidence the stool sample was obtained. f. Nursing notes revealed resident #5 had diarrhea on 9/5/08. Review of physician orders dated 9/5/08 showed the physician ordered a stool specimen. Further medical record review showed no evidence the stool sample was obtained. On 9/6/08 at 3:30 PM nursing documented the resident was complaining of "achiness" and refused to come out for meals. g. Nursing notes showed on 9/6/08 at 11 AM that resident #42 was nauseated and vomited. h. Review of nursing notes showed no documentation of illness for residents #20 and #8. Interview with the IDON on 9/11/08 at 8:45 AM revealed both residents had diarrhea. She stated she thought they became ill towards the beginning of the outbreak. 3. Refer to F371 for specific details regarding the failure of the facility to ensure all dishware, pots, glassware, and utensils were sanitized. 4. On 9/10/08 at 2:45 PM the IDON stated the	F 441	F502 cont'd: DON will implement log for physician ordered lab tests to track date of order and date taken to the lab and results of lab test. Any lab testing not completed will be completed at the time of identification by use of the log. DON will bring all documentation to the Quality Assurance committee meeting at least quarterly.	DOC: 9/30/08

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F 441	Continued From page 27 minimum data set coordinator, LPN #1 went home that day due to projectile vomiting. 5. Interview with LPN #3 on 9/10/08 at 3:10 PM revealed she was hired on 8/25/08 and assigned as the infection control nurse (ICN). She stated the "24 hour bug" started on 9/2/08 with one ill resident. This progressed to three or four residents who were sick at one time. Staff were also ill, and she identified five, including herself, who had nausea, vomiting, and/or diarrhea. The ICN stated she did not report the illness to the Wyoming Department of Epidemiology or to the public health department. The ICN further stated she became aware of infection control issues by reading the 24 hour report, working the floor, or from information passed by staff from shift to shift. In short, the facility relied on passive communication rather than implementing an active surveillance program. The following concerns were identified during the interview: a. The ICN confirmed the stool cultures ordered for residents #6 and #25 were not obtained as the residents had no further episodes of diarrhea; the cultures were just "missed." These cultures were ordered early in the outbreak and, according to the guidelines from the Centers for Disease Control and Prevention, would have provided information about the type of outbreak the facility was experiencing. b. There was no routine monitoring for staff compliance with infection control practices, including handwashing for all departments and sanitization in the kitchen. c. Monitoring for staff illnesses was not in place. The ICN stated she was unaware of the employee who left that day with projectile vomiting. d. Criteria for staff leaving the facility or staying home when ill were not developed. In	F 441		

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F 441	Continued From page 28	F 441		

addition, criteria specifying when staff could return to work and when a physician 's release was required was lacking. The ICN stated staff returned to work as soon as the symptoms ceased. Review of the nursing schedule and interview with LPN #2 on 9/10/08 at 11:26 AM confirmed staff returned to work the day after they were ill with nausea, vomiting, and/or diarrhea.

e. Policies and procedures specific to the facility's infection control program had not been adopted.

f. A consistent method of notifying the ICN of infections and illnesses had not been developed. Review of the 24 hour reports from 9/1/08 through 9/10/08 and the infection control logs showed no information related to the GI outbreak. In addition, the ICN was unable to identify the reason contact and drainage precaution signs were posted in the 200 hall from 9/8/08 through 9/10/08.

g. Criteria for nosocomial (healthcare acquired) versus community acquired infections was lacking.

h. Although medical record audits had been completed, an audit specific to infection control issues had not been conducted.

i. Even though the ICN was to track employee immunizations, there were no procedures for doing so.

6. Observation throughout the days of the survey showed visitors freely entered and left the facility and were not restricted in any way during the outbreak.

7. Observation throughout the days of the survey showed staff did not perform extra cleaning of environmental surfaces, such as handrails, tables, and chairs, touched by all residents. In addition, built up dirt and grime was observed

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 29 behind the resident room doors, the fire doors, and the kitchen door into the dining room. 8. On 9/11/08 at 10:50 AM the administrator stated she called and left a message with the Department of Epidemiology, but did not receive a call back. The administrator stated she did not place the call again so the facility did not confirm whether or not the Department of Epidemiology was aware of the outbreak. Contact with the Department of Epidemiology on 9/15/08 revealed they did not receive the message. Review of the guidelines for a suspected outbreak of viral gastroenteritis published by the Wyoming Department of Epidemiology showed the viruses are "highly contagious and very hardy, so stringent adherence is necessary. Preventive measures should be continued for at least 3 days after the outbreak appears over, since infected persons continue to shed the virus after they have recovered...Minimize the flow of staff between sick and well residents...Staff should be assigned to work with either well residents or sick residents, but should not care for both groups. Staff who go back and forth between ill and well residents play an important role in transmitting the virus from resident to resident...Ill staff should remain out of work for 3 days following cessation of diarrhea and/or vomiting...Use a disinfectant to frequently clean surfaces such as handrails, doorknobs, physical/occupational therapy equipment, etc. (Think of items that are touched regularly and make sure that they are cleaned frequently.)...It may be prudent to discontinue visitation to the nursing home until the outbreak is over. If visitation is allowed, visitors should go directly to the person they are visiting and not spend time with anyone else. They should wash their hands upon entering and leaving the room.	F 441		

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F 441	Continued From page 30 They should not visit if they are sick. PLEASE CONTACT THE WYOMING DEPARTMENT OF HEALTH-EPIDEMIOLOGY SECTION AT (307) 777-3503 OR 1-888-996-9104 FOR ASSISTANCE AS SOON AS AN OUTBREAK IS SUSPECTED." Due to the facility's failure to protect a vulnerable resident population at high risk for infection, immediate jeopardy was called at 5:15 PM on 9/10/08. 10. Observation on 9/9/08 at 3:40 PM revealed the interim director of nursing (IDON) prepared an intravenous (IV) medication for administration to resident #19. During the preparation, the IDON used a 10 milliliter (ml) syringe to obtain bacteriostatic normal saline. Before withdrawing the saline, the IDON placed her hand and fingers on the plunger while drawing air into the syringe. This practice contaminated the syringe and, by injecting the air back into the vial, contaminated the saline. After drawing the contaminated saline into the syringe, the IDON replaced the vial in the cabinet for future use. The IDON then injected the contaminated saline into the resident's IV line. Interview with the IDON on 9/9/9/08 at 3:50 PM confirmed the plunger of a syringe is sterile and that the sterility should be maintained. The IDON stated she was unaware she had touched the plunger of the syringe.	F 441		
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES 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	F 502		

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F 502	Continued From page 31 by: Based on staff interview and medical record review, the facility failed to ensure laboratory tests were conducted as ordered by the physician for one (#33) of ten sample residents. The findings were: Review of the physician's orders for resident #33 revealed an order dated 8/27/08 for complete blood count with differential and basic metabolic panel. Review of the entire medical record revealed no evidence the tests were done. Interview with the Interim DON (IDON) on 9/9/08 at 4:15 PM confirmed the tests were not done. The IDON said the facility's system for checking all orders to ensure they are completed consists of monthly chart audits conducted by the medical records staff, but this system did not identify physician's orders that had not been followed until several weeks after the orders were written.	F 502		