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 _____	10/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 10/23/17 through 10/26/17. The following common abbreviations are used throughout this document: ADON- Assistant Director of Nursing MAR- Medication Administration Record MDS- Minimum Data Set mg- milligrams PRN- from the Latin "pro re nata," meaning as needed Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 253 SS=E	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 4 of 5 areas (east hallway, west hallway, front hallway, dining room) were clean and in good repair. The findings were: 1. Observation on 10/25/17 from 4:50 PM until 5:15 PM of the front hallway, dining room, and east hallway revealed the following issues: a. The front hallway showed 2 light fixtures in the front hallway by the main door were not flush with the ceiling which created an area that collected dust and could not be cleaned	F 253	A1a)The 2 light fixtures in the front hallway by door will be fixed or replaced so as that they are flush with the ceiling. 1b)The scale (to weigh residents in wheelchairs) will be striped of the non skid backing, cleaned then painted with a non skid paint. 1c)The floor tiles in the dining room by door will be replaced.We are waiting for LSC to aprove the new flooring for all of the dining room. 1d)The floor under the clock in the dining	12/22/17

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

Electronically Signed | 11/15/2017

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F 253	Continued From page 1 effectively. b. A scale (to weigh residents in wheelchairs) contained a 27 by 5 inches and a 27 by 7 inches strip where the non-skid adhesive backing had come off and created a surface that could not be cleaned effectively. c. The floor in the dining room by the door had two 12 by 7 inches tiles that were cracked and chipped which created a surface that could not be cleaned effectively. d. The floor under the clock in the dining room had a 12 by 12 inches tile that was chipped which created a surface that could not be cleaned effectively. e. An east window in the dining room by a resident table had a 14 inches by 5 1/2 inches crack which created a surface that could crack and shatter. f. The corner guard by the closet of resident room #109 was loose from the wall and created a surface that could not be cleaned effectively. g. The wall trim by the closet of resident room #111 had a 26 inch area of chipped paint that created an area that could not be cleaned effectively. 2. Observation on 10/26/17 from 8:45 AM until 8:26 AM of the west hallway revealed the following issues: a. The bathroom door of resident room #201 had a metal plate 25 1/2 inches by 12 1/2 inches in size with chipped paint exposing the underlying material, which created a surface that could not be cleaned effectively. b. The bathroom wall of resident room #203 had a 4 by 2 1/4 inches gouged area that created a surface that could not be cleaned effectively. c. The floor of the dirty utility room had a 12 by 12 inch tile that was cracked and created a	F 253	room will be replaced until new flooring is aproved. 1e)The east window in the dining room will be replaced with new window. 1f)The corner guard by closet of room 109 will be reglued so as to creat a surface that can be cleaned effectively. 1g)The wall trim by closet in room 111 will be cleaned, patched, sanded, primed and repainted. 2a)The bathroom door kick plate in room 201 will be primed and repainted. 2b)The bathroom wall in room 203 will be patched primed and painted. 2c)The floor tile in the dirty utility room will be replaced. The air vent in that room will be cleaned and repainted. The light fixture in that room will be replaced. 2d)The corner guard by the closet will be reglued or replaced. B)All residents and staff could be affected if a sanitary, orderly, and comfortable interior isn't maintained, there could be infection control issues that could injury or cause a death of a resident. Maintenance and housekeeping departments will observe and audit the facility once a month to maintain a sanitary, orderly, and comfortable interior. C)The Environmental Services Manager will in-service maintenance and housekeeping staff on services necessary to maintain a sanitary, orderly and comfortable interior. D)Environmental Services Manager will report all observations and audits to the	

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F 253	Continued From page 2 surface that could not be cleaned effectively. The air vent contained visible dust, and brown stains were observed by the air vent. The light fixture was cracked and contained dead bugs. d. The corner guard by the closet of resident room #200 was loose from the wall and created a surface that could not be cleaned effectively. 3. Interview with the maintenance director on 10/26/17 at 9:06 AM revealed the department performed 30 audits per month and kept records of weekly and monthly rounds. He stated he was behind on checking for bugs and the light fixtures crack easily. He also revealed the dirty vents and stains on the ceiling were housekeeping's job. He stated he fixed cracked tiles by grouting them. He was not aware of the cracked glass of the window in the dining room. He also revealed he had to budget for new flooring.	F 253	Quality Assurance Committee at the QAPI meetings.	
F 279 SS=E	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that	F 279		12/22/17

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F 279	Continued From page 3 includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 279		

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F 279	Continued From page 4 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to develop comprehensive care plans based on resident needs for 3 of 10 sample residents (#10, #22, #28). The findings were: 1. Review of the 4/28/17 significant change MDS assessment showed resident #22 had diagnoses that included dementia. Further review showed the resident was able to make him or herself understood, and sometimes understood others. Additionally, the resident required extensive assistance for toilet use and had frequent bladder incontinence. Review of the CAA Analysis Report showed areas requiring care planning included communication and urinary incontinence. However, review of the care plan last reviewed/revised on 10/13/17 revealed no comprehensive care planning for these areas. Interview with the ADON on 10/26/17 at 9:10 AM confirmed the care plans for these areas were not developed. 2. Review of the 4/28/17 admission MDS assessment showed resident #28 required a mechanically altered diet and was at risk for pressure ulcers. Review of the CAA Analysis Report showed areas requiring care planning included psychosocial well-being, nutritional status, and pressure ulcers. However, review of the care plan last reviewed/revised 6/23/17 revealed no comprehensive care planning for these areas. Interview with the ADON on 10/26/17 at 9:10 AM confirmed the care plans for	F 279	The facility will recognize each resident has a fundamental right to receive necessary care and services to attain the highest practicable physical, mental, and psychosocial well being consistent with the residents comprehensive care plan. Resident #22 care plan will be updated, and will address and identify communication and urinary incontinence issues. Resident # 28 care plan will be updated and will include the need for mechanical altered diet, risk for pressure ulcer, and support of psychosocial well-being as indicated on the CAA Analysis Report. Resident #10 care plan will be revised and updated to state resident receives dialysis, as well as state the interventions of checking the site, monitoring fluids, and regular blood pressures. An interdisciplinary care conference team will review all previous and current care plans, as well as any newly completed CAA's, to ensure comprehensive care plans for all residents are individualized and updated. A new MDS Coordinator recently completed the AANAC MDS training. New coordinator will review facility resource book "Care Area Assessments" for more information/training on completing comprehensive and accurate resident assessments. Quality Assurance Officer will do a	

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F 279	Continued From page 5 these areas were not developed. 3. Review of the 6/16/17 admission and 9/16/17 quarterly MDS assessments revealed resident #10 received dialysis. However, review of the current care plan (reviewed/revised 10/12/17) showed dialysis was not addressed. During an interview on 10/25/17 at 5:19 PM the ADON confirmed the care plan lacked interventions for dialysis. She stated a care plan should have been in place which would have addressed things like checking the site, monitoring fluids, and regular blood pressures.	F 279	monthly audit of care plans to verify that they are up to date. The results of the care plans reviews process will be reported quarterly at the QI meeting.	
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:	F 309		12/22/17

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F 309	Continued From page 6 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review and incident log review, the facility failed to provide necessary care and services to 1 of 1 sample resident (#17) with a brain injury with associated behaviors. The findings were: 1. Medical record review showed resident #17 was admitted with diagnoses that included anoxic brain damage, had a BIMS score of 7 (which indicated severe cognitive impact), a total mood severity of 8 which indicated mild depression, and 1-3 days of physical and verbal behaviors that affected other residents. Observation on 10/24/17 at 10:15 AM showed the resident was in his/her wheelchair in the hallway. The resident pushed another resident (#7) who was propelling in a wheelchair. Review of the Healthcare Licensing and Surveys (HLS) incident log from 12/6/16 through 7/28/17 showed the resident was the aggressor in 8 resident-to-resident altercations. Review of nursing notes dated 9/24/17, 10/1/17, 10/9/17 (two notes), 10/10/17, 10/12/17 and 10/23/17 showed the resident was verbally abusive to staff and/residents, or was physically	F 309	Morning Star Care Center recognizes each resident has a fundamental right to receive necessary care and services to attain the highest practicable physical, mental, psychosocial well being consistent with the residents comprehensive care plan. Resident #17 behavior plan will be reviewed, revised and updated to reflect the new team members responsible for building safe relationships, recognize #17 now attends counseling 1time a month, to also include engaging #17 in an activity when possible. The plan will also reflect specific discreet redirections in front of others, and to validate #17 feelings. Morning Star will identify and protect other residents from similar situations by reviewing all incident reports for the past 6 months of residents displaying aggressive behavior to identify the need for a behavioral plan intervention for any resident with a history of aggressive behavior towards others. If there are	

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F 309	Continued From page 7 abusive to residents. The following concerns were identified: a. Review of the medical record showed the resident had a behavior support plan that was developed in February 2017. There lacked evidence the plan had ever been updated. b. During an interview on 10/25/17 at 2:15 PM the social worker and ADON confirmed the resident's aggressive behaviors and stated luckily other residents had not been harmed by the resident. The social worker stated the behavior support plan had been developed with the assistance of the mental health ombudsman in February 2017 (8 months ago). She stated the plan had not been updated since it was developed in February nor had the facility reached out to the ombudsman program since then. She further stated the plan did need to be revised and staff did not consistently follow the current plan. When asked about the resident's behaviors, the social worker stated the behaviors were worse and the resident was harder to re-direct.	F 309	residents identified that require interventions, a plan will be developed and monitored on a quarterly basis. The behavior plan for resident #17 will be reviewed quarterly and updated as needed to ensure its appropriateness. Quality Assurance officer will do a monthly audit of care plans to verify that they are up to date. An in service will be completed by Dec. 31, 2017 for all nurses on care plan review and updates, with a focus on behavioral care plans. Additional care plan education will be added to nurse observation to ensure new nurses understand care plan updates. All audits and reviews to be reported to QI quarterly.	
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		12/22/17

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F 329	Continued From page 8 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary drugs for 1 of 10 sample residents (#5). The findings were: 1. Review of physician orders for resident #5 showed an order for Trazadone (antidepressant) 12.5 mg QID [four times per day] PRN for agitation dated 7/28/17, which was then discontinued on 8/17/17. Review of the August 2017 MAR showed the resident received the PRN	F 329	Morning Star Care Center nursing contacted #5 Dr. to confirm his order for the Trazadone. The discrepancy was noted and clarified to state resident may have the medication PRN up to 4 times a day. The consultant pharmacist will review each residents drug regimen to ensure the are no unnecessary medications. The pharmacist will report to QI immediately if findings are identified. The DON/ ADON	

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F 329	Continued From page 9 Trazadone on the following dates: 8/1 (twice), 8/4, 8/5, 8/8, 8/9, 8/12, 8/13 (twice), and 8/15. The following concerns were identified: a. Review of a "referral form" for an 8/18/17 physician visit showed the nurse's note read "Trazadone was d/c'd [discontinued] by [physician name] yesterday. Please see attached MAR for admin and effectiveness. Trazadone is helping when needed PRN, family is supportive of the PRN med. [Resident]'s behaviors worsen during the early afternoon to early evening, becoming angry and verbally violent." The physician wrote a note which read "Restart Trazadone 12.5 mg QID PRN for agitation..." b. Although the physician documented in his note on 8/18/17 that the Trazadone was to be PRN, review of the prescription dated 8/18/17 showed "Trazadone 50 mg 1/4 tab QID." c. Review of the MAR for September and October 2017 showed the resident was receiving Trazadone 12.5 mg four times per day. d. Review of the medical record showed no indication why the resident would require the Trazadone to be scheduled routinely four times per day. e. During an interview on 10/26/17 at 9:40 AM the ADON stated that going from a PRN Trazadone to scheduled four times a day "seemed like a lot." She stated nursing staff should have clarified the order with the physician because there was a discrepancy between his note and his order.	F 329	or designee will compare all current pharmacy orders with current medications already existing to the facility EMAR to ensure all medication orders match. In addition the newly created 24 hour chart check box will be utilized. The box was implemented in the nurses report room 9/21/17, in which any nurse receiving an order from a physician will input the order into the electronic record system. A review of the orders is conducted by the night nurse to ensure correct and valid order posting. Nurse education was provided by the Assistant Director of Nursing 9/21/17 on the procedure of checking orders with all nurses. Chart check box will be audited quarterly by DON/ADON/designee. A new Medication Management Quality Reviews report will also be utilized and reviewed monthly by the pharmacist to ensure all medication orders are entered into the electronic record correctly for all residents. Quality Assurance Officer will audit the Medication Management Quality Reviews report monthly. Results will be reported quarterly to QI team.	
F 356 SS=B	POSTED NURSE STAFFING INFORMATION CFR(s): 483.35(g)(1)-(4) 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post	F 356		12/22/17

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F 356	Continued From page 10 the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		

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F 356	Continued From page 11 (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of staffing documentation and staff interview, the facility failed to ensure the posted 24 hour nursing staff information was maintained and updated to reflect the correct number of staff and actual hours worked for 8 of 8 days reviewed (10/16/17 through 10/23/17). The following concerns were identified: 1. Review of the posted daily nursing staff information and review of the daily staffing sheet dated 10/16/17 through 10/23/17 revealed the facility failed to update the posting to reflect the actual number of nursing staff that were on duty. 2. Interview with the ADON on 10/25/17 at 1:55 PM confirmed the posted daily staffing schedule was not updated. She stated, "The daily posting is not reflective of true hours worked. There's a separate notebook for staff who call in. The daily staffing information is posted at midnight."	F 356	The facility ward clerk corrected the deficiency by updating the staffing ratios to reflect the correct number of staff actual hours worked for days 10/16/17-10/23/17. The posted nurse staffing information will be audited daily at 8am by the nurse ward clerk to ensure the 24 hour nurse staffing information reflects the current number of staff and hours worked. Ward clerk identifies call offs, staff present and updates staffing information throughout the day if staff ratios change. Nursing staff to be educated on process in the event ward clerk is absent to ensure continuity of documentation. A monthly audit will be performed by DON or designee to ensure staffing information is current and correct. The audit will identify discrepancies in documented staff ratios and correction of hours worked. Results to be reported quarterly to QI team.	
F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371		12/22/17

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	535050	A. BUILDING _____ B. WING _____	10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 12 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain equipment and the environment in a sanitary manner in 1 of 1 kitchens. In addition, the facility failed to separate raw animal products while thawing in 1 of 1 walk-in refrigerators. The findings were: 1. Observation during the initial tour of the kitchen on 10/23/17 at 3:23 PM and again on 10/25/17 at 2:46 PM revealed the following concerns: a. The inside of the microwave had splatters and dried food residue. b. The ceiling vent in the dry storage room was visibly dirty/dusty. c. The heater unit located above the clean side of the dish machine was visibly dirty/dusty. d. The front and sides of the stove/double	F 371	A1a)The microwave has been cleaned and sanitized inside and outside. 1b)The ceiling vent in the dry storage room will be cleaned and repainted. 1c)The heater unit locatedabove the clean side of the dish machine will be cleaned. 1d)The stove/double oven will be cleaned outsde and inside. 1e)The walls and cupboard doors near the commercial food processor will be cleaned and sanitized. 2a)All raw animal products will be kept in separate containers to prevent cross contamination.	

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F 371	Continued From page 13 oven unit had splatters and drips. e. The wall and cupboard doors near the commercial food processor had splatters and drips. During an interview on 10/26/17 at 10:23 AM the dietary manager confirmed the microwave, stove/oven, wall, heater unit and ceiling vent were in need of cleaning. She stated the kitchen had been short-staffed recently. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 2. Observation in the walk-in refrigerator on 10/23/17 at 3:23 PM revealed a tray on the bottom shelf of the rack which contained 2 thawed pork loins and 2 packages of thawed ground beef. The packages were touching each other on the tray. During an interview on 10/26/17 at 10:23 AM the dietary manager stated she had not thought about separating raw animal products when thawing or storing. According to Food Code 2013, U.S. Public Health Service: 3-302.11 (A) FOOD shall be protected from cross contamination by: "...(2) Except when combined as ingredients, separating types of raw animal FOODS from each other such as beef, FISH, lamb, pork, and POULTRY during storage, preparation, holding, and display by: (a) Using separate EQUIPMENT for each type, or (b)	F 371	B)All residents and staff could have been at risk of food poison if food was contamined. Dietary manager will observe and audit daily for one month and there after once a week. C)Dietary Manager will in-service all dietary staff on how to store, prepare, distribute and serve food under sanitary conditions. D) Dietary Manager will reporrt observations and audits to the Quality Assurance Committee at the QAPI meetings	

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F 371	Continued From page 14 Arranging each type of FOOD in EQUIPMENT so that cross contamination of one type with another is prevented."	F 371		
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F 514		12/22/17

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F 514	Continued From page 15 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medical record was complete and all documentation was readily accessible for 9 of 9 sample residents (#5, #6, #7, #10, #14, #17, #22, #26, #28). The findings were: Medical record review for sample residents #5, #6, #7, #10, #14, #17, #22, #26 and #28 revealed no evidence of the monthly drug regimen reviews by the pharmacist. Evidence of the monthly pharmacist reviews was requested from facility staff on 10/24/17 and 10/25/17. On 10/26/17 at 9:55 AM the administrator provided some pharmacist reviews that were emailed to the facility from the pharmacist. The administrator stated the facility did not have documentation of the pharmacy reviews so she asked the pharmacist to email them the information. The facility faxed additional pharmacy review information to the survey agency on 10/30/17. Interview on 10/26/17 at 9:00 AM with the pharmacist revealed he had problems with the facility's computer system and was unable to get monthly reviews into charts. He stated he wrote his monthly reviews and emailed them to the administrator and DON. The DON read the reports and faxed the recommendations to the physician.	F 514	All residents at the facility are at risk for potential harm from adverse drug interactions, inappropriate pharmaceutical use for current ICD 10 diagnosis, and order entry error if we do not have monthly pharmacist drug regimen review. Morning Star Care Center will provide a written list of job responsibilities to the contract pharmacist to include review all resident prescription orders, review all psychotropic drug use to include gradual dose reductions, use of appropriate medication for current diagnosis, review of medication errors, documentation of all reviews in MatrixCare (electronic record keeping) and provide Morning Star Care Center with a monthly Medication Management Quality Review report. This report will also be attached in every residents medical record under "Resident Documents". The pharmacist will perform a monthly drug regimen review. The pharmacist will have remote access as well as in -house access to the electronic medical record. DON/ADON or designee will audit monthly, times 4 months, to ensure pharmacist has computer access to electronic medical record, and is documenting on a monthly basis. Following 4 months time frame, Quality Assurance officer will do a quarterly audit to verify that pharmacy review has been uploaded to residents documents.	

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F 514	Continued From page 16	F 514	Results will be reported to quarterly QI meeting.	