POC reviewed and approved on 8/10/05 @ 1600 with Tim Kennedy CEO Anita Cox-Mills RN

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

PRINTED: 07/22/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING _____ B. WING _____	C 07/08/2005

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 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced	F 272	This plan of correction constitutes our allegation of compliance. RECEIVED AUG 10 2005 WYOMING DEPT OF HEALTH HEALTH FACILITIES	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8/1/05

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.

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F 272	Continued From page 1 by: Based on observation, medical record review, and staff interview, the facility failed to provide a comprehensive assessment related to pressure sores for one (#8) of two sample residents with pressure sores. The findings were: Observation of resident #8 with the treatment nurse on 7/8/05 at 10:25 AM showed a 2 centimeter (cm) by 1.5 cm open wound covered with eschar on the ball of the resident's left foot. Interview with the treatment nurse on 7/8/05 at 12:30 PM revealed the wound was originally a blister which the nurse thought opened in June 2005. Review of the nurses' notes and wound documentation with the treatment nurse showed staff failed to document when the blister actually opened. Review of the 5/6/05 quarterly Minimum Data Set (MDS) assessment showed resident #8 had a stage 3 pressure sore which would require comprehensive assessment. However, review of the nursing notes, the Resident Assessment Protocol (RAP) information, and the hospice documentation failed to reveal a comprehensive assessment which identified the causative and contributing factors related to development of the pressure sore. Interview with the social services director (who researched the facility's paperwork) on 7/8/05 at 2:10 PM confirmed the facility failed to complete an assessment.	F 272	F 272 Comprehensive Assessments For resident #8 a significant change of status MDS was completed on 7/28/05, to address wounds, Hospice care, and the unavoidable decline in health status. A skin /wound care team consisting of Director of nursing, MDS coordinator, Treatment nurse, Registered Dietician, and Bath aide (interdisciplinary team or IDT) was developed 7/6/05. Weekly rounds for the team will begin the week of 8/1/05. Any resident with stage II or greater will be assessed by the IDT for significant change of status, this assessment will identify causes and contributing factors. These causative and contributing factors will be used to create a care plan for each resident who is at risk or has developed a skin ulcer. The attached policy of physician notification for significant change was implemented on 7/28/05. The Administrator and DON along with the IDT will evaluate if the change of condition requires a significant change of status MDS. The continuous quality improvement coordinator or designee will audit 3 random charts, MAR's, and treatment sheets per month to assure we are following physician's orders and documentation, and will report findings to the QA committee on a quarterly basis.	9/1/05
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.	F 281		

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F 281	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record review and family and staff interviews, the facility failed to assure staff followed physician orders for three of three sample residents (#8. #16, #35). The findings were: 1. Review of the 6/21/05 physician referral form for resident #35 showed the following order: "Re-wrap ace bandages q (every) AM. (Have ... wear ace bandages X 7d [days]). Review of the June 2005 treatment record showed the resident refused to have the ace bandages re-wrapped for the first three days (June 22nd - June 24th), but the last four days on the treatment record were blank (June 25th - June 28th). Review of the nursing notes from 6/22/05 through 6/24/05 failed to show any documentation staff offered to re-wrap the ace bandages at a different time after the resident's initial refusals. In addition, there was no documentation from June 25th through June 28th that staff ever offered to re-wrap the bandages. Interview with a family member on 7/8/05 at 11:25 AM revealed s/he was the only person to re-wrapped the bandages and s/he did so on 6/28/05. Staff interviews on 7/8/05 confirmed the ace bandages were not re-wrapped as ordered by the physician. The facility was unable to provide any other evidence staff re-wrapped the ace bandages daily as ordered. 2. Observation of resident #8 with the treatment nurse on 7/8/05 at 10:25 AM showed a 2 centimeter (cm) by 1.5 cm open wound covered with eschar on the ball of the resident's left foot. Review of a physician's order dated 7/3/05 showed staff were to apply Acticoat to the wound	F 281	F 281 Comprehensive care Plans Nurse treatment sheets for residents #8, # 16, #35, were reviewed to ensure accuracy. A nursing in-service on following Physician orders and accurate documentation was completed on 7/28/05. (see attached notes of in-service). Treatments have been added to the careplan to include: interventions that address risk factors, and prevention. All residents with active treatments will be reviewed on a weekly basis for following physician orders, and documentation by director of nursing or designee. All active treatments will be flagged for identification by the licensed nurse taking the order.	8/27/05

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F 281	Continued From page 3 daily and as needed, then cover it with coversite. Review of the July 2005 treatment sheet showed the treatment was not completed on 7/4/05 and 7/7/05. During an interview on 7/8/05 at 12:30 PM, the treatment nurse stated she was off on those two dates, and she did not know if the treatment was provided. On 7/8/05 at 2 PM, interview with the nurse who worked on those dates confirmed he did not change the dressing. During an interview on 7/8/05 at 8:30 PM, the night nurse stated she did not do any dressing changes in July 2005 for the resident. 3. Review of nursing notes and the readmission assessment dated 7/1/05 showed resident #16 was readmitted to the facility with a dressing on the right heel. a gel pad, and a walking boot. According to the 7/1/05 readmission orders, staff were to apply Bactroban ointment (an antibiotic) to the blister on the resident's right heel and cover it with a Telfa dressing every day. Review of the July 2005 treatment sheet and pressure ulcer record showed the treatment was not completed on 7/4/05 and 7/7/05. During an interview on 7/8/05 at 12:30 PM, the treatment nurse stated she was off on those two dates and did not know if the treatment was provided. On 7/8/05 at 2 PM, interview with the nurse who worked on those dates revealed he did not change the dressing. During an interview on 7/8/05 at 8:30 PM, the night nurse stated she did not do any dressing changes for the resident. 4. Interview with the treatment nurse on 7/8/05 at 8:20 AM revealed staff did not always document that treatments were completed as ordered. The nurse further stated that treatments might not be done when she was not working or not working as the treatment nurse. During an interview on	F 281		

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F 281	Continued From page 4 7/8/05 at 1:10 PM, the director of nursing confirmed that if something (treatment, medication) was not documented, it was not done. She stated, "That's nursing." According to the July 2001 Wyoming Nurse Practice Act, nurses shall provide care according to the direction of a licensed physician.	F 281	F 309 QUALITY OF CARE Resident # 35 and family were informed about resident's rights and the consequences of refusing treatments, and medications as well as non compliance of diet, on 7/14/05. Nursing staff will be in-serviced on behavioral symptoms management plans (BSMP). This will include re-approaching at a later time and checking with residents or family to determine best time to attempt cares. Reporting refusals to, one of the following: administrator, DON, or Social Services designee. Consistent or frequent refusals will be reviewed by the interdisciplinary team. BSMP will be developed. The Continuous Quality Improvement Coordinator will audit 3 charts per month to monitor and identify possible deterioration of condition, reporting and documentation, and will report findings to the QA committee on a quarterly basis.	8/2/05
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.	F 309		
	This REQUIREMENT is not met as evidenced by: Based on medical record review and family and staff interviews, the facility failed to assure staff provided care and treatment as ordered for one (#35) of one sample residents. In addition, staff failed to monitor or identify the deteriorating condition of the resident. The findings were: Review of the 6/24/05 admission Minimum Data Set assessment showed resident #35 had no cognitive deficits. In addition, the nursing documentation from admission on 6/16/05 through 6/28/05 showed the resident had severe edema (swelling) in both feet and legs which did not abate, but increased throughout the resident's stay. On 6/20/05 at 3:55 PM, staff documented the resident had small fluid filled blisters on both lower legs. Review of the 6/21/05 physician			

POC reviewed and approved on 8/1/05 w/16 with Tim Kennedy CEO Anita Cornwell

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F 309	Continued From page 5 referral form for resident #35 showed the following orders: "1. Give 240 mg [milligrams] furosemide [a diuretic] now po [orally] (6/21/05) 2. Furosemide 240 mg po q [every] AM. 3. Re-wrap ace bandages q AM. (Have ... wear ace bandages X 7d [days])." Review of the June 2005 treatment record showed the resident refused to have the ace bandages re-wrapped for the first three days (June 22nd - June 24th), and the last four days on the treatment record were blank (June 25th - June 28th). The following concerns with the treatment were identified: a. Review of nursing notes from 6/22/05 through 6/24/05 failed to show any documentation staff offered to re-wrap the ace bandages at a different time after the resident's initial refusals. In addition, there was no documentation from June 25th through June 28th related to the resident's bandages. b. According to the 6/24/05 nursing notes written at 10:30 PM, the resident had extremely edematous legs with a large blister on the left foot. c. Review of the nursing notes also failed to show any documentation that staff educated the resident about the consequences of not wearing the ace wraps, presented alternative measures which could be implemented, or attempted alternative approaches to counteract the resident's documented refusals. d. Interview with the director of nursing on 7/8/05 at 8 AM revealed the resident was hospitalized on 7/5/05 for cellulitis (infection) in the legs. Interviews with staff on 7/8/05 confirmed they did not re-wrap the ace bandages. Interview with a family member on 7/8/05 at 11:25 AM revealed s/he personally re-wrapped the	F 309		

POC reviewed and approved on 8/1/05 at 1100 with Tim Ken. by CEO
[signature] RN

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F 309	Continued From page 6 bandages on 6/28/05 and 7/5/05. The family member also verified the resident's hospitalization on 7/5/05 due to infection in both legs. Furthermore, the family member stated the infection was due to lack of care while the resident was in the nursing home. e. Review of the nursing notes showed documentation ended on 6/30/05 at 6:30 AM. Staff failed to document the resident's condition from 6/30/05 until his/her hospitalization on 7/5/05.	F 309		