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WY Dept of Health
OCT 06 2014
Healthcare Licensing and Surveys

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 ___	C 09/12/2014

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 The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	F225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 1.The investigations related to a resident to resident abuse allegation involving residents #10 and #21 will be completed and reported to the state survey and certification agency within 10 days of submission of this plan of correction. 2. All residents are at risk if alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are not reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 10/6/14

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.

POC accepted with changes per telephone call on 10/9/14 @ 1:38pm with Tim Marke, NHA.
[signature] 10/14/14

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of investigation and employee files, the facility failed to ensure 2 of 3 investigations reviewed met the required time frames for reporting and/or investigation. In addition, the facility failed to ensure 1 of 3 CNAs (CNA #1) was registered with no findings on the CNA abuse registry. The findings were: 1. Review of information related to a resident to resident abuse allegation (residents #10 and #21) showed it was reported to the state survey and certification agency on 8/12/14. Further review showed some safety interventions were in place for the residents; however, the investigation was incomplete and there was no further report of investigation findings made to the State survey and certification agency. Interview with the DON on 9/12/14 at 10 AM verified a completed investigation was lacking. 2. Review of an incident that occurred on 7/18/14	F 225	3. The Administrator/Designee will update the procedure for hiring employees to include the requirement that potential employees will have their licenses verified and checked against the state board of nursing license verification for evidence of disciplinary action, including abuse, at the time that application is submitted to facility. The printed results of the verification will be attached to the employment application and/or maintained in the employee's personal file. Abuse registry will be checked for all newly hired CNAs. The Administrator/Designee will complete an in-service with staff regarding requirements for reporting alleged violations involving mistreatment, neglect, or abuse. Personnel responsible for hiring and/or maintaining employee records will also be educated regarding requirements for verification of licensure with the State Board of Nursing and maintenance of such records. 4. The Administrator/Designee will complete weekly rounds for one month to ensure that any violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in	

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F 225	Continued From page 2 involving a CNA and resident #8 showed the investigation was complete, and the facility was aware of the incident on 7/18/14. However, the State survey and certification agency was not notified until 7/21/14 of the allegation. 3. Review of the employee file for CNA #1 revealed the CNA was hired on 7/2/14 and the abuse registry was checked on 7/1/14 to ensure the CNA had no abuse findings against her. The findings showed the CNA's name was unable to be found. Review of the State board of nursing license verification showed this person was a CNA since April of 2014. Interview with the nursing home administrator on 9/11/14 at 3:20 PM verified the CNA registry check for this person was incomplete due to paperwork not having been submitted upon hire on 7/2/14.	F 225	accordance with State law through established procedures (including to the State survey and certification agency), any discrepancies will be replaced a applicable. An audit of all nursing employee records for appropriate documentation of licensure verification will be completed by human resource personnel and any discrepancies reported to the Administrator/Designee. Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical director quarterly., Completion date is October 24, 2014	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to ensure 10 residents (#2, #3, #4, #5, #6, #12, #16, #17, #20, #33) who were interviewed were treated with respect in relation to notice of scheduled appointments. The facility census was 36. The findings were: Interview with 10 residents (#2, #3, #4, #5, #6, #12, #16, #17, #20, #33) on 9/11/14 at 1 PM	F 241	F241 DIGNITY AND RESPECT OF INDIVIDUALITY 1.The person(s) responsible for scheduling appointments has spoken to residents #2,3,4,5,6,12,16,17,20 and 33 about failure to notify them in a timely manner of scheduled appointments. 2. All residents are at risk if staff fail to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality.	

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F 241	Continued From page 3 revealed they were concerned regarding the facility's failure to inform them of appointments until just before time to leave the facility. Interview on 9/11/14 at 2:35 PM with the Physical Therapy Assistant who was newly assigned the task of scheduling appointments, verified last minute notification of appointments for residents was a problem. She stated the residents were upset and had complained about not always knowing they had to go until just before they left the building.	F 241	3. The Director of Nursing/Designee will update the procedure for scheduling appointments to include the requirement that the person responsible for appointments will notify each resident verbally of their scheduled appointment. In addition a written reminder of the appointment will be posted in the resident's room in a consistent location. A written schedule of appointments for the day will be posted at the nurses' station for reference by both staff and residents.	
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and review of monthly activity calendars, the facility failed to ensure meaningful activities were provided for residents on weekends. The census was 36. The findings were: Review of the monthly activity calendars for June, July, and August of 2014 showed a marked decrease in activity offerings to residents on weekends. For Saturdays, the calendars only listed "Movie and Popcorn." For Sundays, the calendars only listed "Bingo" each week, and a single church service every other week on the July and August calendars. Interview with 10 residents (#2, #3, #4, #5, #6, #12, #16, #17, #20, #33) on 9/11/14 at 1 PM revealed they would like	F 248	The Administrator/Designee will complete and in-service with staff regarding promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. 4. The Director of Nursing/Designee will complete weekly focus rounds for one month to ensure that residents are being provided verbal and written notification of scheduled appointments to maintain/enhance each resident's dignity and respect. Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical Director quarterly. Completion date is October 24, 2014	

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F 248	Continued From page 4 more activities on the weekends. Interview with the activity director on 9/11/14 at 2 PM confirmed there were less activity offerings on the weekend, and she was the only activity employee currently working at the facility.	F 248	F248 ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT 1.The activity director has spoken to residents #2,3,4,5,6,12,16,17,20 and 33 about the lack of meaningful weekend activities. The item has also been added to the agenda for the next Resident Council meeting. 2. All residents are at risk if the facility fails to provide an ongoing program of activities designed to meet the interests and the physical, mental and psychosocial well-being of each resident. 3. The Activity Director will update assessments for all residents to include current interests/requests for activities. 4. The Administrator/Designee will review the monthly activity calendar to assure that the programs offered meet the physical, mental and psychosocial needs of each residents as well as being offered at an appropriate frequency, including weekends. Staffing has been adjusted to allow for additional activity staff to offer/supervise activities on weekends. Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical Director quarterly. Completion date is October 24, 2014	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 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 staff interview, the facility failed to ensure a variety of items in 2 of 2 resident areas (100 hallway, 200 hallway) were clean and well maintained. The findings were: Observation on 9/12/14 from 8:15 AM through 9 AM revealed the following concerns: 1. The following issues with doors were identified: a. The inner bathroom door kickplate of room #109 was chipped on the inside from the floor to 5 inches in height and 1.5 inches across. b. The kick plate on one closet slide door of room #108 was chipped on the left side at 6 inches above the floor, 3 inches across and 2 inches wide. Also, the kick plate was chipped on the right side at 8 inches above the floor, 4 inches across and 1.5 inches wide. The inner bathroom door was scraped from the floor to 18 inches in height and 36 inches across. c. The kick plate on one closet slide door of room #212 was scraped across with paint missing from the floor to 32 inches in height and	F 253		

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F 253	Continued From page 5 32 inches across. d. The inside bathroom door kick plate of room #210 was scraped from the floor to 18 inches in height and 36 inches across. e. The inside bathroom door kick plate of room #204 was scraped at 18 inches in height and 18 inches across. f. The kick plate on one closet slide door of room #208 was scraped at 26 inches in height and 32 inches across. g. The kick plate on one closet slide door of room #201 was entirely scraped 32 inches across. 2. The following issues with floors was identified: a. The bathroom floor of room #110 had 1 chipped tile to the right of the toilet that measured 1 inch by 3 inches and was not a cleanable surface. b. The shower room across from room #108 had two chipped tiles outside of the shower stall that measured 1 inch by 1 inch, and 1.5 inches by 3.5 inches and was not a cleanable surface. c. The floor tiles in front of the closet of room #212 were damaged 3 tiles across that measured 4 inches by 3 inches and was not a cleanable surface. d. The shower room across from room #208 had a 1 foot by 1 foot tile area that did not meet other tiles at 0.26 inches wide and created a surface that was not cleanable. e. The bathroom floor tile of room #204 had 1 tile to the right with a chip out that measured 1 inch by 0.5 inches and was not a cleanable surface. f. The bathroom floor tile of room #206 had 1 tile behind the toilet that had a 1 foot by 4 inch area missing that created a surface that was not cleanable.	F 253	F253 HOUSEKEEPING AND MAINTENANCE SERVICES 1.The kick plates in rooms #108,#212,#204,#206,#201 have been replaced and/or repaired to correct scrapes and/or chips noted during the survey. The floors in rooms #110, #108, #212, #204, #206, #203, and shower room across from room #208 have been repaired to correct chips, damaged tiles, missing tiles, and cracks which were noted during the survey. The baseboard to the right of the closet of room #108 has been reattached to the wall. The scrape in the paint in the bathroom of room #210 has been repaired. The missing strip on the back wall heat vent in room #206 has been replaced. 2. All residents are at risk if the facility fails to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 3. The Administrator will complete an in-service with the Maintenance Director to ensure that housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior are being followed.	

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F 253	Continued From page 6 g. The bathroom floor tile under the sink of the bathroom in room #203 had a 1 foot by 1 inch crack that created a surface that was not cleanable. 3. The following miscellaneous issues in resident areas were identified: a. The baseboard to the right of the closet of room #108 was torn from the wall from the floor to 3 inches in height. b. The left wall in the bathroom of room #210 was scraped with paint missing 12 inches above the floor and 12 inches across. c. The back wall heat vent in room #206 had a strip missing in the middle that measured 3 inches by 16 inches. Interview with the maintenance director on 9/12/14 at 9:45 AM confirmed he knew about the issues with building maintenance. However, the facility failed to have a plan with a timeframe to address those issues.	F 253	4. The Maintenance Director/Designee will complete quarterly focus rounds of resident rooms and shower rooms to ensure they are maintained in a sanitary, orderly, and comfortable manner. Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical Director quarterly. Completion date is October 24, 2014.	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL 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:	F 314	F314 TREATMENTS/SVCS TO PREVENT/HEAL PRESSURE SORES 1.Resident #28 assessments, physicians orders, and care plans have been reviewed and updated as applicable. An off load wheel chair cushion was applied to the resident's wheel chair during survey. The care plan was updated to include float heels. JC 2. All residents are at risk if the facility fails to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless that individual's clinical condition demonstrates that they are unavoidable; and a resident having pressure sores receives necessary treatment and services	

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F 314	Continued From page 7 Based on observation, medical record review, and resident and staff interview, the facility failed to prevent the development of avoidable pressure ulcers for 1 of 1 sample resident (#28) with pressure ulcers. The failure to prevent the development of a stage IV pressure ulcer resulted in actual harm to the resident. The findings were: Medical record review showed resident #28 was admitted to the facility on 2/26/14 with diagnoses which included peripheral vascular disease, diabetes mellitus type II, end stage renal disease, and bilateral traumatic amputation of the legs. Review of the 3/7/14 admission MDS assessment showed the resident had no pressure ulcers. Review of the corresponding pressure ulcer CAA showed, "No skin issues at this time." Review of the 6/24/14 quarterly MDS assessment also showed the resident had no pressure ulcers. Review of the 6/6/14 Pressure Ulcer Risk Evaluation/Prevention Intervention Protocol confirmed the resident scored a 16 (high risk). Nursing note review revealed a 6/19/14 note written at 1405 [2:05 PM] that stated, "[Resident's physician] faxed regarding patients continued mild lethargy, open areas on coccyx, butt, and right hip..." Observation on 9/10/14 at 5:15 PM showed the resident had pressure ulcers on the sacrum, left ischial tuberosity, and right ischial tuberosity. Interview on 9/10/14 at 5:15 PM with RN #2 confirmed the resident's pressure ulcers on his sacrum and left ischial tuberosity could be a stage I or II. However, he confirmed the pressure ulcer on the right ischial tuberosity tunneled to the bone and was stage IV. The nurse also stated the resident was scheduled for surgical debridement of his/her pressure ulcers for 9/11/14. The following concerns were	F 314	to promote healing, prevent infection and prevent new sores from developing. 3. The Director of Nursing/Designee will complete an audit of resident's skin to ensure that residents having pressure sores receive necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. The Director of Nursing/Designee will complete and in-service with staff to ensure that residents having pressure ores receive necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 4. The Director of Nursing/Designee will complete weekly focus rounds to ensure that residents having pressure sores receive necessary treatment and services to promote healing prevent infection and prevent new sores from developing. Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical Director quarterly. Completion date is October 24, 2014.	

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F 314	Continued From page 8 identified: a. Observation on 9/10/14 from 8:45 AM through 10:30 AM (the resident left via wheelchair in the facility van for dialysis at that time) showed the resident in his/her wheelchair sitting on a folded blanket. The observation revealed facility staff failed to off-load or reposition the resident during the observation. b. Interview with the resident on 9/12/14 at 10:25 AM confirmed s/he routinely stayed up in a wheelchair from before breakfast at 8 AM through the lunch period that started at 12 noon. The resident further confirmed facility staff did not offer to offload or reposition him/her while up in the wheelchair. When uncomfortable, the resident stated s/he would make an attempt to reposition while in the wheelchair. However, the resident's care plan for ADLs reviewed on 7/10/14 revealed, "Maximum assist of 2 with transfers and repositioning. 1-2 with the full body lift or a 3 person manual lift until prosthesis are fixed. Use the full body lift if [the resident] is not in pain." The resident further confirmed s/he had no pressure ulcers until after admission on 2/26/14. c. Review of the resident's care plans showed each had problem dates of 11/2006 (the resident had prior admissions). However, for the 2/26/14 admission the facility failed to review the pressure ulcer care plan until 6/19/14, the date the pressure ulcers were identified (13 days after the resident was assessed at high risk for pressure ulcers). The care plan included wound measurements at that time. d. Review of the care plan showed the facility failed to address repositioning/offloading the resident while up in a wheelchair. e. Interview with the DON on 9/12/14 at 11:20 AM confirmed the resident had no prior pressure ulcers before those identified on 6/19/14. She	F 314		

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F 314	Continued From page 9 further confirmed the facility failed to care plan repositioning/offloading the resident when up in the wheelchair. She also acknowledged the facility failed to review/revise the resident care plan for pressure ulcers until after the development of pressure ulcers.	F 314	F356 POSTED NURSE STAFFING INFORMATION	
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. 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.	F 356	1.Nurse staffing data is now posted daily as required. 2. All residents are at risk if the facility fails to post required nurse staffing data on a daily basis at the beginning of each shift in a clear and readable format which is in a prominent place readily accessible to residents and visitors. 3. The Director of Nursing/Designee will complete an in-service with nursing staff regarding the form and the requirements for posting. Responsibility for posting nurse-staffing data each day has been assigned to a specific shift/individual. 4. The Director of Nursing/Designee will complete a quarterly audit to ensure that the required nurse staffing date is being posted and is accurate. Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical Director quarterly. Completion date is October 24, 2014.	

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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 366	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of the posted staffing, and staff interview, the facility failed to post all required information on their daily staff postings. The findings were: Periodic observations during the survey showed the facility posted a daily staffing and resident census list. Review of the staffing for the last 15 months revealed the facility failed to post actual numbers of employees in each category that worked, only listing category hours. Also, the facility failed to revise the posting when warranted. The facility also posted for 24 hours, and not per shift. Interview with the DON on 9/12/14 at 10 AM confirmed the facility posted staff hours only, and not staff numbers. She also confirmed the facility posted staffing for 24 hours and not per shift, and did not revise the posting for changes.	F 366		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of menus, recipes, and	F 363	F363 MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED 1.Serving sizes for the 22 residents cited in the survey were corrected at the time of the survey. The cook #1 was immediately educated regarding serving sizes as specified on the prepared menus.	

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F 363	Continued From page 11 resident diet/meal information, the facility failed to ensure the menu was followed related to portion sizes. During the survey there were 22 residents (#1, #2, #3, #4, #5, #6, #7, #8, #10, #11, #12, #15, #16, #18, #20, #22, #24, #25, #26, #28, #29, #36) with regular or double size portions. The findings were: Observation of the evening meal on 9/9/14 at 6:16 PM showed all residents in the dining room were served one-half of a grilled cheese sandwich and 1/2 cup of tomato soup (4 ounces). Review of the planned menu showed the serving size for the sandwich was 3 ounces of cheese and two slices of bread. The serving size for the soup was 3/4 cup (6 ounces). Interview with 10 residents (#2, #3, #4, #5, #6, #12, #16, #17, #20, #33) on 9/11/14 at 1 PM revealed they were served only half-sandwiches when sandwiches were served. In addition, all 10 residents stated the facility failed to provide enough food during meals, and often they could not receive any additional food when requested. All 10 residents stated they often supplemented their own diets with food from vending machines and outside sources. Interview with the dietary manager on 9/11/14 at 3:20 PM verified she was unsure what serving size was used when sandwiches such as the grilled cheese were on the menu. She further revealed her shift ended prior to the evening meal which was when most sandwiches were planned on the 6 week cycle menu and she did not monitor for what portions were served. Review of the 6 week cycle menu showed there were 8 planned meals that included sandwiches on sliced bread. The dietary manager also stated a	F 363	2. All residents are at risk if the facility fails to provide menus which meet the nutritional needs of residents in accordance with standard recommended dietary allowances, be prepared in advance, and be followed. 3. The Dietary Manager will complete and in-service with all kitchen staff to ensure that menus are understood and followed in regard to serving sizes. 4, The Dietary Manager will complete and audit of meals daily for one week, then weekly for one month to ensure that menus are followed in regard to serving sizes. Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical Director quarterly. Completion date is October 24, 2014.	

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F 363	Continued From page 12 sandwich was offered as an alternate meal routinely in the evenings. On 9/11/14 at 4:08 PM cook #1 was interviewed regarding her plan for the chicken salad sandwiches on that evening's planned alternate meal. The cook stated she was taught to make the sandwiches and cut them in half and served each resident one half of a sandwich. At that time she was preparing the chicken salad and this was her plan for the nights sandwich serving size. Review of the menu showed the serving size for a regular portion was a #12 scoop (equivalent to 2 1/2 - 3 ounces) of chicken filling and two slices of bread. Review of the diet orders and meal plan information as of 9/9/14 showed there were 20 residents (#1, #2, #3, #4, #5, #6, #7, #8, #10, #11, #15, #16, #18, #22, #24, #25, #26, #28, #29, #36) with orders for regular portions, and 2 (#12, #20) with instructions for double portions of meats.	F 363		
F 371 68=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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	F371 FOOD PROCURE,STORE/PREPARE/SERVE-SANITARY 1.The dietary aide has been educated regarding proper preparation and handling of food. The ice machine has been completely emptied and sanitized. The metal hood system has been cleaned of grease.	

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F 371	Continued From page 13 Based on observation, review of cleaning logs, and staff interview, the facility failed to ensure sanitary conditions in the kitchen. The findings were: 1. Observation on 9/11/14 from 11:05 to 11:49 AM showed multiple examples of the dietary aide failing to remove soiled gloves and/or performing hand hygiene. At 11:10 AM the dietary aide was wearing disposable gloves while cutting apple pie and placing pieces onto resident plates. While wearing the gloves, the aide opened the walk-in refrigerator door and returned to slicing pies without disposing the gloves and performing hand hygiene. At 11:20 AM, while wearing the disposable gloves, the aide took dishes to the dish room, used the dish machine sprayer, and without any hand hygiene handled a cart with clean dishes and returned to prepare resident beverages. At 11:33 AM the aide used the sprayer in the dish room, and removed the disposable gloves. There was no hand washing prior to handling the coffee pots and prior to donning new gloves. According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands..." 2. Observation on 9/9/14 at 3:20 PM showed the interior white part of the ice machine was soiled with a pink-colored substance. The ice bin was full and the ice was about one half of an inch away from contacting the soiled part of the ice	F 371	The cutting board attached to the steam table has/will be replaced or removed from service. 2. All residents are at risk if the facility fails to store, prepare, distribute and serve food under sanitary conditions. 3. The Dietary Manager will complete an in-service with all kitchen staff to review proper hand hygiene and use of gloves when preparing/serving food. The Dietary Manager/Maintenance Director will establish a procedure for cleaning the metal hood system on a scheduled basis and/or as needed. 4. The Administrator/Dietary Manager will complete an audit of the kitchen weekly for one month to ensure that sanitary conditions are present for food preparation. The Dietary Manager will complete an audit of meals two days per week for one month to ensure that proper food handling/preparation procedures are being followed. Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical Director quarterly. Completion date is October 24, 2014.	

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F 371	Continued From page 14 machine. Observation on 9/11/14 at 11:26 AM, and interview with the dietary manager at that time, revealed the soiled area had been cleaned. Review of the cleaning log showed the machine was last sanitized in June 2014 and was due every 3 months. The manager verified she had wiped down the soiled area with a cloth, and the machine was not emptied or sanitized at that time. 3. Observation on 9/9/14 at 3:20 PM, and on 9/11/14 at 11:05 AM, showed metal parts of the exhaust hood system were dripping with grease. Interview with the dietary manager on 9/11/14 at 11:23 AM revealed the vents of the hood system were last cleaned on 8/4/14. She acknowledged the dripping grease and stated it accumulated quickly. 4. Observation on 9/9/14 at 3:20 PM, and on 9/11/14 at 11:05 AM, showed the cutting board attached to the steam table was stained and scored. The cutting surface was plastic and unable to be effectively sanitized due to the damaged condition. 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."	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c)	F 386	F386 PHYSICIAN VISITS-REVIEW CARE/NOTES/ORDERS 1.The physicians for Resident #24 and Resident #20 have been contacted and	

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F 386	Continued From page 15 of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure physician progress notes were available in the medical record for 2 of 8 sample residents (#20, #24). The findings were: 1. Review of the medical record showed resident #24 was seen by the physician on 11/13/13, 3/10/14, and 7/18/14. The documentation available in the medical record included new orders and instructions signed by the physician; however, there were no physician progress notes for these visits. 2. Review of the medical record showed resident #20 was seen by the physician on 4/21/14, 5/14/14, 6/20/14, and 8/28/14. The documentation available in the medical record included new orders and instructions signed by the physician; however, there were no physician progress notes for these visits. 3. Interview with the DON on 9/11/14 at 10:30 AM verified she was unable to locate physician progress notes for these visits. She planned to contact the physicians' offices to obtain the notes.	F 386	copies obtained of the office progress notes for the most recent physician visits. Responsibility for physician visits has been reassigned to another individual. 2. All residents are at risk if the facility fails to ensure that physician progress notes are available in the medical record for each resident. 3. The Director of Nursing/Designee will revise the procedure for documenting physician visits to include a physician progress note to accompany each resident on their physician visit. The Director of Nursing/Designee will complete an in-service with all nursing staff regarding physician visits and proper documentation. 4. The Director of Nursing/Designee will complete a random audit of resident medical records monthly for 3 months to ensure that documentation of physician visits is complete. Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical Director quarterly. Completion date is October 24, 2014	
F 387 SS=E	483.40(a)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	F 387	F387 FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	

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F 387	Continued From page 16 The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure physician visits were completed in the required time frames for 5 of 8 sample residents (#6, #21, #24, #28, #36). The findings were: Interview with the DON on 9/11/14 at 10:30 AM verified the physician visits were not completed as required for many residents. The facility had been unaware of the regulatory requirements and most visits were scheduled for comprehensive reviews by the physicians every 90 days. Review of the medical record information showed the following sample residents with overdue physician visits: a. Resident #28 was admitted on 2/26/14. The resident was visited by a physician only once, on 7/24/14 (147 days after admission). b. Resident #36 was admitted on 8/24/12. The resident was not visited by a physician since December of 2013. c. Resident #21 was admitted on 4/1/14. The resident was not visited by a physician since admission. d. Resident #6 was admitted on 2/19/07. The last 3 visits were made by a physician's assistant	F 387	1.Residents #28,35,21,5 and 24 have been scheduled for physician visits. Responsibility for physician visits has been reassigned to another individual. 2. All residents are at risk if the facility fails to ensure physician visits were completed in the required time frames. 3. The Director of Nursing/Designee will revise the procedure for scheduling physician visits and a reminder system will be put into place. The Director of Nursing/Designee will complete an in-service for all nursing staff regarding regulations concerning physician visits, including frequency and timeliness. 4. The Director of Nursing/Designee will complete a random audit of resident medical records monthly for 3 months to ensure that physician visits are being scheduled in a timely manner according to current regulations. Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical Director quarterly. Completion date is October 24, 2014	

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F 387	Continued From page 17 on 12/4/13, 3/28/14, and 6/16/14. e. Resident #24 was admitted on 2/19/13. The last 3 physician visits were 11/13/13, 3/10/14, and 7/16/14.	F 387	F406 PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES	
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure a speech evaluation was conducted as ordered for 1 of 3 sample residents (#19) who required that evaluation. The findings were: Observation on 9/11/14 at 12:10 PM in the dining room showed resident #19 was eating mechanically ground food without difficulty. Medical record review showed the resident had a 7/4/14 physician order for "speech eval-swallow study." Further review showed no information related to a speech evaluation. Interview with the DON on 9/12/14 at 10 AM confirmed the facility failed to ensure a speech evaluation was completed for the resident as ordered.	F 406	1. The physician's order for Resident #19 for a speech eval-swallow study has been cancelled by the physician. 2. All residents are at risk if the facility fails to ensure that specialized rehabilitative services are provided if required in the resident's comprehensive plan of care. 3. The Director of Nursing/Designee will complete an in-service for all nursing staff regarding specialized rehabilitative services and procedures to be followed when such services are ordered by the physician. 4. The Director of Nursing/Designee will complete a random audit of resident medical records monthly for 3 months to ensure that orders for specialized rehabilitative services are being completed. Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical Director quarterly. Completion date is October 24, 2014.	
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		

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F 428 SS=E	Continued From page 18 IRREGULAR, ACT ON 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 staff interview, the facility failed to ensure a monthly medication review was completed by a licensed pharmacist as required for 6 of 8 sample residents (#5, #24, #25, #28, #35). The findings were: 1. Medical record review showed resident #35 was admitted to the facility on 8/24/12. Further review showed the consultant pharmacist failed to complete the required monthly medication regimen evaluation between 2/24/14 and 8/1/14 (65 days). 2. Medical record review showed resident #28 was admitted to the facility on 2/26/14. Further review showed the consultant pharmacist failed to complete the required monthly medication regimen evaluation until 4/28/14 (61 days after admission). 3. Review of the medical record showed the monthly medication review by the pharmacist was	F 428	F428 DRUG REGIMEN REVIEW, REPORT IRREGULAR ACTION 1.Medication reviews for Residents #5,24,25,28,35 were completed during the regular September pharmacist review. 2. All residents are at risk if the facility fails to ensure that the drug regimen of each resident in not reviewed at least once a month by a licensed pharmacist. 3. The Administrator/Designee will complete an in-service for the consulting pharmacist regarding current state regulations. The Director of Nursing/Designee will complete an in-service for all nursing staff regarding requirements for monthly drug regimen reviews. 4. The Director of Nursing/Designee will complete a random audit of resident medical records monthly for 3 months to ensure that the drug regimen of each resident is being reviewed at least monthly. Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical Director quarterly. Completion date is October 24, 2014.	

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F 428	Continued From page 19 missing for March and May 2014 for resident #5. 4. Review of the medical record showed the monthly medication review by the pharmacist was missing for March 2014 for resident #25. 5. Review of the medical record showed the monthly medication review by the pharmacist was missing for November 2013 for resident #24. 6. Interview with RN #2 on 9/12/14 at 10:46 AM verified some months the pharmacy reviews were not completed. He contributed the missing reviews to changes in the contractor providing the services.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431	F431 DRUG RECORDS,LABEL/STORE DRUGS & BIOLOGICALS 1.The insulin vials for Resident #12 and Resident #8 have been discarded. 2. All residents are at risk if the facility fails to ensure outdated medications are not available for use. 3. The Director of Nursing/Designee will complete an in-service for all nursing staff regarding regulations regarding outdated medications. 4. The Director of Nursing/Designee will complete a random audit of medication carts monthly for 3 months to ensure that the regulations regarding outdated medications is being followed.	

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F 431	Continued From page 20 have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure outdated medications were not available for use in 1 of 3 storage areas (200 Hallway Medication Cart). The findings were: Observation of the 200 Hallway Medication Cart on 9/12/14 at 10:50 AM revealed 1 vial of Novolog Insulin for resident #12. The vial had an open date of 7/5/14 (69 days). Continued observation revealed a vial of Novolin R Insulin for resident #8. The vial had an open date of 8/4/14 (39 days). The observation showed a note on the wall by the cart that stated insulin vials are good for 30 days after opening. Interview with RN #1 at that time confirmed the vials were available for use, but should have been discarded after 30 days.	F 431	Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical Director quarterly. Completion date is October 24, 2014.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	F441 INFECTION CONTROL,PREVENT SPREAD,LINENS	

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

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F 441	Continued From page 21 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the infection control program information, the	F 441	1. The infection control logs have been updated to include date of resolution, as appropriate, of infections for Residents #4,7,8,11,16,18,19,20,28 and 29. The MRSA infection for Resident #16 has been entered into the infection control log. 2. All residents are at risk if the facility fails to ensure that resident infection tracking information is up-to-date and completed. 3. The Director of Nursing/Designee will complete an in-service for all nursing staff regarding regulations for resident infection tracking information. The Director of Nursing/Designee will conduct a one-on-one in-service with the infection control nurse regarding regulations for resident infection tracking information. 4. The Director of Nursing/Designee will complete a random audit of the infection control logs monthly for 3 months to ensure that the regulations regarding tracking are being followed. Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical Director quarterly. Completion date is October 24, 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536060	A. BUILDING _____ B. WING _____	C 09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 22 facility failed to ensure the resident infection tracking information was up-to-date and completed. There were 10 residents (#4, #7, #8, #11, #16, #18, #19, #20, #28, #29) identified on the logs. The findings were: 1. Review of the infection control log for a reporting period of July 1, 2014 to September 30, 2014 showed there were 10 residents (#4, #7, #8, #11, #16, #18, #19, #20, #28, #29) identified who were receiving antibiotic treatment for various types of infections. The onset dates for these infections were all shown to be in the month of July 2014. The infection control log failed to include any information as to the date these infections were resolved. 2. Observation on 9/9/14 at 3:16 PM showed resident #16 had an isolation cart located outside his/her room which contained masks, gowns and gloves. Review of the 9/5/14 physician progress note showed the resident was being treated for draining abscesses on his/her back. The notes further showed the resident was positive for methicillin-resistant Staphylococcus aureus (MRSA). Interview with RN #1 on 9/12/14 at 11:20 AM verified the resident had special precautions in place related to direct contact with the abscesses and the dressing changes. However, the infection control log did not include the MRSA infection for this resident on the tracking logs.	F 441		
F 516 6S=E	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is	F 516	F516 RELEASE RES.INFO.SAFEUARD CLINICAL RECORDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535080	A. BUILDING _____ B. WING _____	C 09/12/2014

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F 616	Continued From page 23 resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safeguard the confidentiality of medical record information in 3 of 5 storage areas (patio storage building, network room, garage). The findings were: Observation with maintenance staff #1 on 9/11/14 at 3 PM revealed a locked room in a building adjacent to the main facility which contained an outside patio. The staff member was able to unlock the door, which revealed a storage of 10 shelves of medical records. Observation on 9/11/14 at 3:36 PM with the administrator and maintenance supervisor revealed a room adjacent to the facility board room (network room) which had a lateral file with 4 rows of shelves that contained multiple medical records. At that time the maintenance director confirmed he had a key to the network room. The administrator and maintenance director then took the surveyor to the garage, a stand alone building outside of the main facility, which the maintenance director then unlooked. The garage area stored 8 cardboard boxes of medical records. Interview with the administrator at that time acknowledged the 2 maintenance staff had access to the observed	F 616	1.The medical records in the stand alone building outside of the main facility have been moved to the locked room in the building adjacent to the main facility which contains an outside patio. The medical records in the network room adjacent to the facility board room have been moved to the locked room in the building adjacent to the main facility which contains an outside patio. The keys to the above described locked room have been removed from maintenance personnel. Access to the above described locked room is now limited to the Administrator, Medical Records Director, and Director of Nursing/Designee. 2. All residents are at risk if the facility fails to safeguard the confidentiality of medical record information. 3. The Medical Records Director will complete an in-service for all staff regarding regulations to safeguard the confidentiality of medical record information. The Medical Records Director will initiate a log to track entry into the above described locked room.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	- 536050	A. BUILDING _____ B. WING _____	C 09/12/2014

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F 516	Continued From page 24 medical records, and they did not have a need to know what was in those records.	F 516	4. The Medical Records Director will audit the entry log monthly for 3 months to ensure that regulations regarding medical record confidentiality are being followed. The Administrator/Medical Records Director will check keys monthly to ensure that no unauthorized persons have access to medical records. Identified trends will be reviewed/reported to the Quality Assurance Committee as reviewed by the Medical Directory quarterly. Completion date is October 24, 2014.	