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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING _____ B. WING _____	11/18/2010

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

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: DON- Director of Nursing CNA- Certified Nurse Aide LPN - Licensed Practical Nurse MDS - Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	This plan of correction is the facility's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of truth of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared because it is required by the provision of federal and state law.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of employee records and staff interview, the facility failed to ensure reference checks were conducted for 4 of 5 new employees (#1, #3, #5, #9) prior to hiring. The findings were: 1. Review of employee #5's record showed the employee was hired on 7/26/10 as a CNA. The record showed no evidence the facility contacted previous employers or employee listed references to ensure the employee's background was free of abuse and neglect to individuals. 2. Review of employee #1's record showed the employee was hired on 10/14/10 as a CNA. The record revealed no evidence that the facility ever contacted previous employers or references to ensure the employee's background was free of	F 226	The following common abbreviations are used throughout this document: DON – Director of Nursing CNA – Certified Nurse Aide LPN – Licensed Practical Nurse RN – Registered Nurse MDS – Minimum Data Set F 226: 1. Employee #5 employee file will contain documented evidence of contact with previous employers to ensure the background was free of abuse and neglect to individuals. 2. Employee #1 employee file will contain documented evidence of contact with previous employers to ensure the background was free of abuse and neglect to individuals.	

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

JoAnn Aldrich | NHA | 12-10-10

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.

RECEIVED
Wyoming Dept of Health

DEC 14 2010

Office of Healthcare Licensing and Surveys

12/21/10 Per telephone call with JoAnn Aldrich NHA POC accepted & corrections. Day of compliance 1/2/11 Karla Herbert

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F 226	Continued From page 1 abuse and neglect to individuals. 3. Review of employee #9's record showed the employee was hired on 9/1/10 as a housekeeper/laundry aide. The record lacked evidence the facility ever contacted references or previous employers to ensure the employee's background was free of abuse and neglect to individuals. 4. Review of employee #3's record showed the employee was hired on 9/8/10 as a dietary aide. The record revealed no evidence that the facility contacted previous employers or references to ensure the employee's background was free of abuse and neglect to individuals. 5. An interview with the facility administrator on 11/18/10 at 10:48 AM confirmed reference checks on the above listed individuals were either not conducted or not documented in the employees' files prior to employment.	F 226	F 266 continued; 3. Employee #9 employee file will contain documented evidence of contact with previous employers to ensure the background was free of abuse and neglect to individuals. 4. Employee #3 employee file will contain documented evidence of contact with previous employers to ensure the background was free of abuse and neglect to individuals. 5. All new employee files will be reviewed by the Administrator to ensure each contains documented evidence of contact with previous employers to ensure the background was free of abuse and neglect to individuals.	
F 241 SS=D	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 observation and resident and staff interviews, the facility failed to ensure dignity was maintained for 2 of 9 sample residents (#20, #24). The findings were: 1. At 5:20 PM on 11/15/10 resident #24 was	F 241	All new employee files will contain a checklist which includes reference checks with previous employers to ensure the background was free of abuse and neglect to individuals. The Business Office Manager will review checklists prior to completing the new hire process. The Checklists will be taken to the Quality Assurance Committee at F266 continued; least quarterly by the Business Office Manager.	12/28/10

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F 241	Continued From page 2 overheard to say to LPN #4 that s/he could wait to go to the bathroom until after eating. No one offered to take the resident to the bathroom at that time. At 5:58 PM that evening the resident called out to LPN #4, "I can't wait any longer." Without offering assistance or asking the resident what was needed, the LPN stated food was currently being served and walked off. Continued observation showed the resident received his/her dinner tray at 6:16 PM and again stated, "I need to go the bathroom or I'm going to pee my pants." At 6:18 PM, fifty eight minutes after the resident first mentioned the bathroom, CNA #6 assisted him/her to the bathroom. The resident returned to the dinner table at 6:29 PM. Observation showed the resident's meal tray had not been covered or kept warm during the 13-minute absence from the table. Staff did not offer to re-heat the meal. When interviewed at 7 PM that evening, the resident stated the food had been cold. The resident further stated s/he did not understand why everything took so long. 2. Observation of the name posted outside the door of the room for resident #20 showed his/her last name was misspelled. Interview with the resident on 11/18/10 at 10:30 AM revealed the resident did not like the fact that his/her name was not spelled correctly and would prefer to have it spelled right.	F 241	F 241: 1. Resident #24 will be taken to the bathroom at any time during the time he/she is in the dining room at the time he/she requests. If Resident #24 leaves the dining room while his/her meal is at the table, the meal will be reheated and/or replaced by dietary staff at the request of the nursing staff. 2. The name posted outside the door of the room for Resident #20 will be corrected to reflect correct spelling by the Activity Director. All Residents during the time they are in the dining room will be taken to the bathroom by the nursing staff at the time they request. If any meal is not at the preferred temperature, the nursing staff will request from the dietary that the meal will be reheated and/or replaced.	
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	F 272	The spelling of the names on the outside of Resident rooms will be reviewed by the Administrator and/or designee for accuracy. All spelling of the names on the outside of Resident rooms will be accurate at the time of admission and/or any room changes. DON and/or designee will audit the dining room at meals to ensure	

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F 272	Continued From page 3 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 by: Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed as required for 1 of 9 sample residents (#32). The findings were: According to Section V of the 8/2/10 annual MDS (Minimum Data Set) assessment, sample resident #32 required a comprehensive nutrition assessment. However, a current nutrition assessment was not found in the record. Further review of the record revealed the last nutrition	F 272	Residents are taken to the bathroom at the time of the request. DON and/or designee will audit the meals to ensure those who have left the dining room and returned, have meals at the preferred temperature. Audits will be completed one meal per day for one week, and randomly weekly thereafter for three months, and randomly thereafter. NHA and/or designee will audit the accuracy of the spelling of the names on the outside of the Resident rooms. Audit will be completed on any new admission and any room change. All results of audits will be taken to the Quality Assurance Committee at least quarterly. F 272 The comprehensive nutrition assessment for Resident #32 will be completed by the Registered Dietician. All comprehensive nutrition assessments for each Resident will be reviewed for timeliness by the MDS Coordinator. The MDS Coordinator will review each Resident Comprehensive Nutrition Assessment at each quarterly care plan date for completion.	~~1/5/11~~ 1/2/11

F 272 continued;

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F 272	Continued From page 4 assessment by a registered dietitian was conducted on 12/1/09. Since that time, the following concerns had occurred. a. The resident's diet texture had gone from a mechanical soft to a pureed. b. In addition, the resident had experienced a 5- pound weight gain. c. Four laboratory values (sodium, calcium, BUN and serum osmolality) were determined to be out of range on multiple occasions. Interview with the registered dietitian on 11/16/10 at 2:48 confirmed a comprehensive nutrition assessment should have been done for this resident.	F 272	Results of reviews will be taken to the Quality Assurance Committee at least quarterly by the MDS Coordinator.	~~1/5/11~~ 1/2/11 A
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F 280 Care plan for Resident #24 will be updated to include "to notify physician if Resident's systolic blood pressure reading is less than 110" by the DON. F 280 continued; All care plans will be reviewed by the DON and/or designee to ensure they are updated to include any orders related to the blood pressure parameters and physician notification. The nurse receiving such physician orders will include the blood pressure parameters and physician notification in the care plan. The DON and/or designee will audit orders/care plans for such accuracy. Results of audits will be taken to the Quality Assurance Committee at least quarterly by the DON and/or designee. F 281 1. a. Physician order for Resident #1 will be clarified with the physician as F281 continued;	~~1/7/11~~ 1/2/11 A (?)

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F 280	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review the facility failed to ensure the care plan accurately reflected the care required for 1 of 9 sample residents (#24). The findings were: Review of the 11/8/10 physician's orders for resident #24 showed an order to notify the physician if the resident's systolic blood pressure reading was less than 110. Review of the current care plan showed these parameters were not included. Interview with the DON on 11/18/10 at 9 AM revealed the care plan should have been updated to include the blood pressure parameters and physician notification.	F 280	F281 continued; to what product is to be added to the "sponge" used with the wound vacuum by LPN. The physician order for sliding scale insulin which is overlapping will be clarified with the physician by the LPN. All Resident orders will be reviewed by DON and/or designee for accuracy of clarification and clarified if not accurate.	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure staff followed professional standards of practice for 4 of 9 sample residents (#1, #8, #19, #24) related to clarification and/or implementation of physicians' orders. The findings were: 1. According to Smith, Duell, and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," 7th Edition; 2008, page 568: "If a written order is illegible or questionable for any reason, the physician must be notified for clarification." In addition, the Wyoming State Board of Nursing Administrative Rules and Regulations (7/2/10) instructs nurses to seek clarification of orders	F 281	All professional nursing staff will be inserviced by DON and/or designee relating to the clarification of orders. DON and/or designee will audit new orders daily for one week, and randomly each week thereafter. Results of audit will be taken to the Quality Assurance Committee at least quarterly by the DON and/or designee. b. Recapitulation of orders format for Resident #8 will be corrected to include the order for Hospice services by Medical Records. c. Recapitulation of orders format for Resident # 19 will be corrected to	

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F 281	Continued From page 6 when needed. Failure to follow these standards of practice was identified in the following instances: a. Medical record review revealed a physician's order dated 10/25/10 for an "impregnated silver membrane" to be added to the "sponge" used with the wound vacuum. Observation on 11/16/10 at 7:05 AM showed LPN #2 changed the wound vacuum on the pressure ulcer for the resident. However, she did not use a silver impregnated membrane with the sponge. At 10 AM that day the LPN stated she did not use the silver membrane because it "falls apart" and "comes out of the wound." The LPN further stated she had to get an order today (11/16/10) for a different sponge. A time period of three weeks had elapsed since the original order was received, but the physician had not yet been contacted. Review of the resident's 10/24/10 orders for sliding scale insulin showed an overlapping range of numbers (example: 150 to 200 = 2 units insulin, 200 to 250 = 4 units insulin, 250 to 300 = 6 units insulin). It was not clear whether the resident should receive the lesser or higher amount of insulin when the numbers were the same. Further review also showed an order for Lantus insulin 15 units at bedtime, but a new order, written on 11/8/10, instructed staff to administer 5 units of Lantus at bedtime. The previous order for 15 units was not discontinued, and it was unclear if the resident was to receive 5 units or 20 units of Lantus insulin. On 11/16/10 at 3:10 PM LPN #2 confirmed both orders had been written incorrectly and each should have been clarified. b. According to information in the medical record, resident #8 had received hospice services since 7/6/08. The original order was found, but these services were not included on the recapitulation of orders (Recap) prepared by the facility and signed by the	F 281	F 281 continued; include the order for Hospice services by Medical Records. All Resident recapitulation of orders format will be corrected to include the order for Hospice services by Medical Records. DON and/or designee will audit recapitulation of orders for all Residents monthly. Results of audit will be taken to the Quality Assurance Committee at least quarterly by the DON and/or designee. 2. Physician for Resident #24 will be notified of the Resident's systolic blood pressure reading being less than 110 millimeters of mercury on 11/10/10, 11/13/10 and 11/15/10. All Residents with an order physician notification relating to parameters will be reviewed by the DON and/or designee to ensure notification is taking place. All professional nurses will be inserviced relating to appropriate notification of physicians by DON and/or designee. DON and/or designee will complete audits relating to physician notification F 281 continued; relating to parameters weekly for one month and randomly thereafter.	

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F 281	Continued From page 7 physician every 60 days. Furthermore, the instructions on each Recap read, "Discontinue all previous orders." On 11/17/10 at 3:15 PM the DON confirmed the order was lacking. He further stated it would be lacking on every resident receiving hospice services as the orders had not been carried over. c. Review of the medical record for resident #19 showed s/he had hospice care ordered on 2/25/10. Interview with the DON on 1/18/10 at 9 AM revealed the resident remained on hospice care as of 11/18/10. However, review of the signed physician's Recap of orders through November 2010 showed no evidence hospice was to be continued. Furthermore, each Recap included a statement that all previous orders were discontinued. Interview with the DON on 11/18/10 revealed nursing staff should have transferred the hospice order for each monthly Recap. 2. Review of the 11/8/10 physician's orders for resident #24 showed an order to notify the physician if the resident's systolic blood pressure reading was less than 110 millimeters of mercury. Review of the blood pressure readings showed the resident's systolic blood pressure reading was 106 on 11/10/10, was 104 on 11/13/10, and was 108 on 11/15/10. Review of the medical record showed no evidence the physician was notified as ordered. Interview with the DON on 11/18/10 at 9:58 AM revealed he was unable to locate any evidence the physician was notified of the low systolic blood pressure readings on those dates. According to the Wyoming State Board of Nursing Administrative Rules and Regulations 7/2/10, a nurse "implement[s] treatment and therapy." as ordered.	F 281	F281 continued; Results from audits will be taken to the Quality Assurance Committee at least quarterly by the DON and/or designee. ~~1/10/11~~ 1/2/11 F312 All CNA staff will be inserviced relating to peri care for Resident #8 by the Staff Development Coordinator. All CNA staff will be inserviced relating to peri care for all Residents by the Staff Development Coordinator. Audits will be conducted by the DON and/or designee for appropriate peri care technique once per week for three weeks and randomly thereafter. Results of audits will be brought to the Quality Assurance Committee at least quarterly by the DON and/or designee. 12/28/10 F318 1. a &.b. Resident #20 will receive restorative care three to five times each week.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 8 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff provided appropriate perineal (incontinence) care for 1 of 5 residents (#8) who required staff assistance with personal hygiene. The findings were: Observation on 11/15/10 at 7:07 PM showed CNA #8 transferred resident #8 to bed, removed the disposable brief, and provided perineal care. The CNA cleansed the anterior groin correctly but twice wiped from the rectum towards the urethra (back to front) while cleansing the buttocks and anus. The wipe showed fecal stains both times. Interview with the CNA immediately after the observation revealed the CNA knew she had completed care incorrectly She stated she should have cleansed the resident from front to back.	F 312	F 318 continued; c. Resident #20 will be evaluated by Physical Therapy to determine if therapy is appropriate. d. An additional CNA will be trained as a Restorative Nurse Aide to ensure the restorative program is available at all times. 2. Resident #23 will receive restorative care three to five times each week. An additional CNA will be trained as a Restorative Nurse Aide to ensure the restorative program is available at all times. All Residents receiving restorative care will receive restorative care three to five times per week. Audits will be conducted by the DON and/or designee to ensure restorative care is being given three to five times per week weekly for one month and randomly thereafter. Results of audit will be brought to the Quality Assurance Meeting at least quarterly.	~~1/3/11~~ 1/2/11 A
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		

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F 318	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interviews, the facility failed to ensure 2 of 2 (#20, #23) sample residents in need of restorative services received those services as planned. The findings were: 1. Review of the 7/24/10 physician's orders for resident #20 showed an order for restorative nursing exercises. Review of the 7/23/10 restorative therapy plan of care showed the resident required restorative exercises three to five times per week for lower extremely strengthening and increased mobility in the wheelchair. Review of the 10/21/10 restorative therapy plan of care showed the plan should be continued. Review of the 11/4/10 restorative therapy plan of care showed the resident should receive upper extremity restorative exercises from three to five times per week to increase upper extremity mobility and range of motion. The following concerns were identified: a. Review of the restorative care flow record for September 2010 showed the resident received only one day of restorative exercises during the week of 9/26 through 10/2/10. b. Review of the November 2010 restorative care flow record showed the resident received only one day of restorative exercises during the week of 11/7 through 11/13/10. c. Interview with the resident on 11/16/10 at 7:30 PM revealed s/he had a desire to become more mobile and that s/he did not receive enough therapy. The resident said s/he really wanted to be able to go home at some time in the future and was working hard to become more mobile and independent. d. Interview with the restorative nurse aide	F 318	F332 1. Physician will be notified that Resident #3 received Metoprolol instead of it being held relating to the systolic blood pressure reading. LPN #2 will be inserviced relating to making sure the order for the medication is thoroughly read prior to giving any medication by DON and/or designee. 2. Physician will be notified that Resident #21 received two tablets of Tylenol instead of one. LPN #10 will be inserviced relating to making sure the order for the medication is thoroughly read prior to giving any medication by the DON and/or designee. All professional nurses will be inserviced relating to passing medications by the Don and/or designee. Audits will be completed by the DON and/or designee relating to medication pass one time weekly for one month then randomly thereafter. Results of audits will be taken to the Quality Assurance Committee at least quarterly by the DON and/or designee. 12/29/10	

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	535050	A. BUILDING _____ B. WING _____	11/18/2010

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 318	Continued From page 10 (RNA) on 11/18/10 at 9:40 AM revealed exercises were not provided during those two weeks because she was either off work or was asked to work on the unit as a CNA, and was, therefore, unable to perform her restorative services. Interview with the DON on 11/18/10 at the same time revealed he agreed with the RNA's explanation. He also said sometimes it was necessary to ask the RNA to work as a CNA instead of performing restorative services if there was a shortage of staff to work the unit, but that it was not often. 2. According to the 11/12/10 significant change MDS assessment, resident #23 exhibited limitations with movement in both the upper and lower extremities. Review of the restorative treatment plan showed restorative services were to be provided three times per week. However, review of the 2010 restorative care flow records showed the services were not provided from November 6th - 12th, September 16th - 20th, or July 7th - 10th and 14th - 22nd. On 11/18/10 at 10:48 AM the restorative CNA confirmed the resident did not receive the services during the aforementioned dates. She stated she was the only RNA, and was not aware of a backup plan during those occasions when she was re-assigned to work as a CNA or was absent. She further stated 11 to 13 residents received restorative services in July, September, and November of 2010, but none of them received services during the dates in question.	F 318	F 354 When Medicare MDS requirements cause increased hours for the DON, another MDS Certified RN will be pulled from Charge Nurse duties to complete the required MDS. Administrator will recruit an MDS Coordinator to be employed. Administrator will audit the hours the DON works on duties other than the DON duties on a weekly basis until hiring of new staff is accomplished. Results of audit will be taken to the Quality Assurance Committee at least quarterly by the Administrator. ~~1/3/11~~ 1/2/11 F 371 1. Observed dietary employee #7 will wear a hair restraint while assisting in the preparation and distribution of food. All Dietary employees will be inserviced by the Administrator relating to the requirement of wearing of hair restraints.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	Audits will be completed by the Dietary Manager and/or Administrator and/or designee relating the wearing of hair restraints.	

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F 332	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure a medication error rate of 5% or less. Two out of 40 opportunities for error occurred,, resulting in an error rate of 5%. The findings were: 1. Observation on 11/16/10 showed LPN #2 prepared and administered medications, including Metoprolol 25 milligrams (mg), for resident #3. At the time of administration, the LPN stated the resident's blood pressure (BP) was 105/69 millimeters of mercury. Reconciliation of the medications showed the physician's order was to hold the Metoprolol if the resident's systolic BP was below 110. At 8:25 AM that morning, the LPN confirmed the parameters and verified she administered the medication. She stated the parameters were listed on the computer, but she did not check before giving the medication. 2. On 11/17/10 at 12 PM LPN #10 was observed to administer medications, including two tablets of Tylenol 325 mg, for resident #21. Reconciliation of the medication pass revealed the physician's order was for only one tablet of Tylenol 325 mg. At 6:25 PM that day, the LPN confirmed she gave two tablets of Tylenol to the resident. She also confirmed that the instructions were on the computer, but she "missed it"	F 332	F 371 continued; Results of audits will be taken to the Quality Assurance Committee at least quarterly by the Dietary Manager. 2. The refrigerator and freezer will have a tight seal around the doors. Maintenance Director will evaluate to determine if he can ensure a tight seal or a contractor is necessary. Dietary employees will be inserviced by the Maintenance Director relating to maintaining the tight seal. Dietary Manager, or Administrator and/or designee will audit the refrigerator and freezer doors to ensure a tight seal is maintained weekly for one month and randomly thereafter. Results of the audit will be taken to the Quality Assurance Committee at least quarterly by the Dietary Manager or Administrator and/or designee. 3. A staff refrigerator will be placed in the staff break room to ensure staff have refrigerator available for personal items. Staff will be notified of placement of staff refrigerator by written notification by the Administrator.	
F 354 SS=C	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours	F 354		

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

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F 354	Continued From page 12 a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure there was a full-time nursing director. The census was 33. The findings were as follows: Periodic observations from 11/15 through 11/17/10 showed at times the DON performed duties other than those of a director. Interview with the DON on 11/17/10 at 5 PM revealed he worked an average of 25 to 30 hours per week completing Minimum Data Set (MDS) assessments for Medicare residents. Further interview revealed, that due to the responsibility of completing the MDS assessments, the DON did not have 32 hours per week available for oversight and direction of nursing services. The DON said the facility's definition of full-time employment was working 32 hours per week.	F 354	~~F 371 continued;~~ Refrigerator in dietary area will be audited by Dietary Manager weekly relating to staff personal items in refrigerator. Results of audit will be taken to the Quality Assurance Committee at least quarterly by the Dietary Manager.	~~1/5/11~~ 11/2/11
F 371 SS=E	483.35(l) 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	F 371		

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F 371	Continued From page 13 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to prevent resident food from exposure to possible contamination. The findings were: 1. Observation on 11/15/10 from 4 PM through 6 PM and again on 11/16/10 from 3:30 PM through 6:30 PM revealed a new dietary employee #7 did not wear a hair restraint while assisting in the preparation and distribution of food, Interview with the kitchen manager on 11/17/10 at 2:48 PM revealed she believed staff with short hair did not need to have a hair restraint. According to Food Code 2009 U.S. Public Health Service, Food and Drug Administration, 2-402.11, Effectiveness. a. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. b. (B) This section does not apply to FOOD EMPLOYEES such as counter staff who only serve BEVERAGES and wrapped or PACKAGED FOODS, hostesses, and wait staff if they present a minimal RISK of contaminating exposed FOOD;	F 371		

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F 371	Continued From page 14 clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. 2. Observation on 11/15/10 from 4 PM through 6 PM revealed the freezer door had approximately 2- inches of ice around the door seal, preventing the door from closing. In addition, observation on 11/15/10 from 4 PM through 6 PM, on 11/16/10 from 3:30 PM to 6:30 PM, and again on 11/17/10 from 9:48 AM through 11:30 AM revealed kitchen employees frequently entered and exited the walk-in refrigerator. The refrigerator door did have a self closure mechanism attached to it that allowed the door to partially close; however, without manually closing the door upon exiting, an approximate one inch gap remained. Interview with the kitchen manager on 11/17/10 at 2:48 PM revealed she was aware that the doors did not form a tight seal. According to the Food Code 2009 U.S. Public Health Service, Food and Drug Administration, Equipment 4-501.11(B) Equipment components such as doors, seal, hinges, fasteners, and kick plates shall be kept intact, tight and adjusted in accordance with manufacturer's specifications." 3. Observation on 11/15/10 from 4 PM through 6 PM and on 11/16/10 from 3:30 PM to 6:30 PM revealed two partially full water bottles in the walk-in refrigerator. Inscribed on the bottles was the word "Dani." Interview with the kitchen manager on 11/17/10 at 2:48 PM revealed the bottles belonged to a kitchen employee. The manager stated she was unaware employee food items could not be stored with resident food items. According to the Food Code 2009, U.S. Public Health Service, Food and Drug	F 371		

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F 371	Continued From page 15 Administration, 3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.	F 371		