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 _____ AUG 29 2005 WYOMING DEPT OF HEALTH	08/03/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	P O BOX 859 FORT WASHAKIE, WY 82514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 241 SS=D	483.15(a) DIGNITY 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 interview, the facility failed to ensure dignity was provided for five residents (#12 #16 #11, #4 and #34) in the areas of: toileting, personal care/hygiene and catheter care. The facility census was 35. The findings were: According to the 7/8/05 quarterly Minimum Data Set (MDS) assessment, resident #12 was able to make his/her needs known, and was able to use the toilet with staff assistance. Observation on 8/1/05 at 9:55 AM revealed the resident sustained a large amount of loose stool in his/her pants. The resident informed the certified nurse aides (CNAs) #2 and #3 that he/she was given a suppository that morning. However, the CNAs stated they were unaware of this. Review of the medication administration record and confirmation by registered nurse (RN) #1 on 8/1/05 at 10:10 AM, revealed the resident was given a rectal suppository at 6 AM. The RN further stated that had the CNAs been notified of this, the resident could have been toileted timely, without the indignity of having to sustain bowel incontinence. On 7/31/05 at 7:45 PM, CNA #1 provided colostomy care for resident #16. Throughout the	F 241	F 241 Dignity Residents # 12, 16, 11, 4, 34 were assessed for bowel and bladder retraining. Care plans will be updated to include toileting plans for these residents by Sep. 9th, 2005. A list of residents receiving suppositories (including res #12, will be provided to the Certified Nurse's Aides at the beginning of the shift. All resident will have bowel and bladder retraining assessment completed by Sep 16th, 2005. The toileting schedule will be added to the group assignment sheet provided to Certified Nurses Aides at the beginning of each shift .Resident will be reassessed quarterly, annually and with significant change of status assessments for toileting. The Director of Nursing or her designee will provide education to the staff. Staff will be in-serviced on Bowel and Bladder programs of residents. Staff will be in-serviced regarding residents right to dignity and the importance of providing privacy. (Res #16 will be covered appropriately during all baths.) A random audit of 3 charts monthly will be conducted by the Director of Nursing or their designee to determine if bowel and bladder programs are in place and being	(16 2005

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

Administrator 8/26/05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

POC accepted 9/2/05 at 1245 & all changes & corrections per phone conversations & Jim Kennedy, CEO, & Betty Nelson, RN, Health Surveyor

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F 241	Continued From page 1 observation from 7:45 PM until 7:53 PM (8 minutes), the resident lay on his/her back in bed uncovered from the upper chest to the feet, with genitals exposed. During an interview on 8/1/05 at 4:30 PM, the resident stated it would have been reasonable for his/her genital area be covered during colostomy care for reasons related to dignity. On 8/2/05 at 10:15 AM resident #11 was observed to have dried food residue on his/her face and chin area. At 10:30 AM, CNA #2 assisted the resident to bed without offering or providing the resident an opportunity to wash his/her face. When the CNA transferred the resident to bed, there were pieces of residual pancake on the seat of the wheelchair. At 12 PM, when the resident was again transferred to his/her wheelchair for lunch, he/she was positioned back on the pancake crumbs, and the dried food substance remained on his/her face and chin. On 8/2/05 at 8:55 AM resident #4 was seated in a wheelchair in the television lounge. The resident's urinary drainage bag was uncovered with contents visible to any passerby. Observation on 8/1/05 at 10:16 AM and 8/2/05 at 10:20 AM revealed the urinary drainage bag for resident #34 was uncovered with contents visible to any passerby.	F 241	followed. The findings of these audits will be reported at the quarterly quality improvement committee. All nursing staff will be in-serviced regarding covering of catheter bags. The charge nurse will monitor daily that these bags are covered. An in-service will be provided for staff **"Be aware of resident's appearance"**. This in-service will stress the importance of reacting promptly if a resident is incontinent, has spilled food on his or her clothing or has food on his or her face and hands. The charge nurse will monitor residents leaving the dining room and through out the day for grooming and cleanliness. The resident's assistive devices will be monitored as well. Included in orientation for new employee will be the in-service, **"Be aware of resident's appearance"**. The charge nurse's will report to the Director of Nursing and Staff Education coordinator the appearance of the residents. These finding will be presented at the quarterly quality improvement committee meetings.	9/16/05
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		

res #11, #25, #34, and others c catheters.

res #11 and other

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F 282	Continued From page 2 care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure that care was provided according to the written plan of care for three of nine sample residents. Toileting and skin care was not provided for resident #11, toileting was not provided for resident #12 and fall interventions were not implemented for resident #33. The findings were: Review of the 6/7/05 annual Minimum Data Set (MDS) assessment for resident #11 revealed he/she was able to use the toilet with staff assistance. In addition, the care plan showed the resident was to be toileted every two hours, and a barrier cream applied to the skin after episodes of incontinence. However, on 7/31/05 at 8 PM, certified nurse aide (CNA) #1 was observed providing evening care for the resident. Without offering the resident the opportunity to toilet, the CNA transferred the resident to bed. When the resident was laid in bed, he/she began to urinate. The resident then requested to use the toilet. Furthermore, after the resident's skin was cleansed of urine, barrier cream was not applied. Review of the 7/8/05 quarterly MDS assessment for resident #12 revealed he/she was occasionally incontinent of bowel and was able to use the toilet with staff assistance. However, on 8/1/05 at 9:55 AM, CNA #2 and #3 assisted the resident after he/she had sustained an episode of bowel incontinence. The CNAs failed to offer or provide the resident the opportunity to toilet prior to	F 282	F 282 Comprehensive Care Plans Care plans for residents # 11, 12, 33 were reviewed with staff. Staff will be in-serviced regarding understanding and using care plans. The objectives of this training are: 1. Staff can describe care, services, and expected outcomes of the care they provide 2. Have a general knowledge of the care and services being provided by other specialists 3. Understand the expected outcomes of the care provided 4. Understand the relationship of the expected outcomes to the care they provide. Any changes to the plan of care involving direct resident care will be reported to the direct Care Staff by the Staff Education Coordinator or their designee. Changes involving ancillary staff will be reported to the staff by the appropriate Department Manager. The Director of Nursing will complete an audit of cares provided to resident #11, 12, and 33.	

care will be provided as planned.

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F 282	Continued From page 3 transferring him/her to bed. Review of the medical record revealed resident #33 was legally blind, and had fallen in his/her room on 2/7/05, 3/14/05, 5/2/05, 5/24/05, and 5/30/05. According to the 6/30/05 care plan with a target date of 7/14/05, a licensed nurse (LN) was to "assess need for fall interventions such as: Low bed, bed or chair alarms, non-skid strips on floor, gripper socks, raised toilet seat, padded floor next to bed, wedge in chair". The following concerns were noted: a. Observation of the resident's room on 7/31/05 at 7:50 PM, revealed a mechanical rising recliner chair, no alarm on the chair or bed, no non-skid strips on the floor, no padded floor, and no wedge in the chair. b. Interview with the social worker on 8/2/05 at 5:45 PM revealed she did not know of any assessment documentation for fall interventions as indicated by the care plan.	F 282	A random audit of 5 care plans and cares provided per month will be conducted by the Director of Nursing or their Designee. The finding of this audit will be presented at the quarterly Quality Improvement Committee. F 312 Activities of Daily Living	9/16/05
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING 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 record review, observation, and resident interview, the facility failed to ensure staff provided personal care for dependent residents. Resident #11 did not receive proper perineal care. Resident #11, #16 and #24 did not receive oral care. The facility census was 35. The findings	F 312	Certified Nursing Assistance assignment sheets for residents #11, 16, 24 have been updated to reflect the appropriate level of care required and the type of care needed will be provided. The assignment sheets will be updated for all residents by ~~Sept. 17, 2005~~ 9/16/05. The assignment sheets will assure that residents who need extensive or total assistance with Activities of Daily Living (maintenance of nutrition, dressing, grooming, personal hygiene, oral hygiene,	

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F 312	Continued From page 4 were: According to the 6/7/05 annual Minimum Data Set (MDS) assessment for resident #11, he/she was frequently incontinent of bladder and required total assistance of staff for personal hygiene. However, on 7/31/05 at 8 PM, certified nurse aide (CNA) #1 was observed providing bed time care for the resident. Without offering or providing any oral care for the resident, the CNA transferred him/her to bed. In addition, the resident sustained an episode of urinary incontinence saturating his/her incontinence brief. During perineal care the CNA failed to cleanse the resident's anterior perineal area which was in contact with urine. On 7/31/05 at 7:53 PM, CNA #1 was observed providing evening care for dependent resident #16. The CNA did not offer or provide oral care for the resident. Interview with the resident on 7/31/05 at 8 PM revealed staff had not provided oral care for him/her in at least two weeks. Interview with resident #24 on 8/1/05 at 2 PM revealed staff did not provide him/her with daily oral care.	F 312	toileting and bathing) will receive the appropriate level of care. Nursing staff will be in-serviced regarding level of care provided for residents requiring supervision, limited assistance, extensive assistance and total dependence. Staff will be educated to report any changes in care requirements to the Charge Nurse. The Charge Nurse will report to the Director of Nursing and MDS Coordinator. For each resident the MDS coordinator will assess the level of care required for Activities of Daily Living with each quarterly, annual, and significant change assessments. The MDS coordinator will revise the group assignment sheets to keep level of care accurate. The Director of Nursing will audit two Minimum Data Set assessments per month for accuracy of ADL coding. The Staff Education Coordinator/ Director of Nursing or their designee will do a random observation of cares provided to two residents per week. Staff will be in-serviced on any problematic areas that are identified. The results of these audits will be reported to the quarterly Quality Improvement Committee.	9/16/05
F 315 SS=E	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		

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F 315	Continued From page 5 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure two (#12 and #28) of four sample residents with urinary catheters had a diagnosis to support the use of such devices. In addition, one (#12) of the four sample residents did not receive catheter care to prevent infection. One (#11) of three incontinent residents in the sample did not receive services to maintain as much normal bladder function as possible. The findings were: Observation of resident #12 on 8/1/05 at 9:55 AM, revealed the resident had a urinary catheter in place. Review of nursing notes showed the resident had the urinary catheter on 7/29/05 at 2:15 PM. However, review of the July 2005 and August 2005 physician's orders showed no order for the catheter or clinical condition to support the use of the catheter. Furthermore, observation on 8/1/05 at 9:55 PM revealed the resident had sustained an episode of loose bowel incontinence. Although feces was on the urinary catheter tubing, Certified nurse aides (CNAs) #2 and #3 did not cleanse the resident's genitalia or catheter tubing that was in contact with feces. Review of a 5/31/05 physician's order revealed	F 315	F 315 Urinary Incontinence Residents # 12 and 28 have been assessed and have diagnosis from physician supporting the use of indwelling urinary catheter. Resident # 12 improved medically and the indwelling urinary catheter has been removed. Resident #12 & 28 was evaluated by physician and it was determined that the urinary catheter was medically necessary. The order was obtained with supporting diagnosis. Licensed Nurses will be in-serviced regarding the appropriate use of indwelling catheter. All staff will be trained and in-serviced regarding catheter care and prevention of infections associated with the use of urinary catheter. All res. ~~w~~ catheters, A bowel and bladder nurse has been ~~assigned~~ will receive assigned to assess and monitor proper cath care, residents for bowel and bladder retraining. All residents that require the insertion of a indwelling catheter will be evaluated by physician for use of catheter. The documentation on the physician's order for catheter use will have supporting diagnosis. All orders for insertion of urinary catheter will be reviewed by the Director of Nursing and the Bowel and Bladder Nurse. The Director of	

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F 316	Continued From page 6 resident #28 was to have his/her urinary catheter discontinued. Observation of the resident on 8/1/05 revealed she/he had a catheter. Interview with licensed practical nurse (LPN) #1 on 8/3/05 at 11 AM revealed he/she had replaced the resident's urinary catheter. The LPN further stated he/she had not obtained a physician's order, nor did he/she document in the nursing notes why he/she had felt reinsertion of the urinary catheter was warranted. In addition, he/she stated the physician was "not happy" the catheter had been reinserted. Review of the 6/7/05 annual Minimum Data Set (MDS) assessment for resident #11 revealed he/she was able to use the toilet with staff assistance, and continued to have some bladder control present. In addition, the care plan showed the resident was to be tolleted every two hours. However, on 7/31/05 at 8 PM, CNA #1 was observed providing evening care for the resident. Without providing the resident the opportunity to use the toilet, the CNA transferred the resident to bed. When the resident was laid in bed, he/she began to urinate. The CNA did not offer or provide the resident the opportunity to use the bathroom. Instead, the resident had to ask the CNA to take him/her to the toilet.	F 315	Nursing/Bowel & Bladder Nurse or their designee will monitor randomly three Certified Nursing Assistants providing catheter care. A report will be provided to the Quality Improvement Committee. 9/16/05 Res. #11 will be toileted q 2-3 hrs. All other residents will be toileted as care planned.	
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by:	F 323		

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F 323	Continued From page 7 Based on observation, record review and staff interview, the facility failed to ensure the environment was free of accident hazards. A treatment cart was left unlocked, doors to the clean utility room and mechanical room were unlocked, a sharps container without a cover was placed in a resident's room, and a licensed practical nurse (LPN) did not use safety measures when handling a used needle/syringe. The findings were: Observation on 7/31/05 at 6:45 PM and again at 8:20 PM revealed a treatment cart containing antiseptic (a substance that kills or prevents growth of microorganisms) creams including: zinc oxide, Carrasyn, and Lantiseptic was left unlocked and unattended. Observation on 7/31/05 at 6:50 PM revealed a clean utility room with a key in the door. In the unlocked room, a gallon bottle of Total Plus Disinfectant was on the counter. Review of the material safety data sheet for Total Plus Disinfectant identified the chemical as a health hazard, which "may cause eye and skin irritation...can be harmful if swallowed or if spray mist is inhaled." Observation on 7/31/05 at 6:55 PM revealed the mechanical room was unlocked. The mechanical room contained the boiler and hot water heaters. A pipe coming from the kitchen boiler pump, approximately two feet off the floor was hot to the touch. Observation on 7/31/05 at 7 PM revealed an uncovered sharps container in the room of resident #2. Observation on 7/31/05 at 6:45 PM revealed licensed practical nurse (LPN) #2 administering	F 323	F 323 Accidents The Passage lock to the room housing the treatment cart will changed by Sept. 9th, 2005, to a keypad lock, Locking the treatment cart behind a locked door when unattended. Staff will be in-serviced on the locking of the treatment cart when unattended, by the Director of Nursing the week of Aug 29th, 2005. The passage locks on the clean utility room door, and the mechanical room were changed to a keypad entry lock thus removing the potential of a key being left in the lock. The sharps container was removed from the room of Resident #2 on Aug 3, 2005. An in-service for all nursing will be conducted Sept. 2, 2005 on the proper disposal of used needles and sharps. The Director of nursing or designee will do a random monthly audit of the med cart and treatment cart to ensure it is either locked or stored behind the locked door when unattended, and will audit the nurses randomly to ensure proper procedures are followed for sharps and their disposal. Any findings not complying with industry standards will be reported to the QA committee on a quarterly basis.	9/9/05

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F 323	Continued From page 8 an injection to resident #24. In order to dispose of the used needle, the LPN had the uncapped, exposed needle/syringe pointed outward in her hand, as he/she walked approximately 20 to 30 feet down the east hallway to the medication cart. Interview with the administrator on 8/2/05 at 10 AM, confirmed the treatment cart and the mechanical room should have been locked. In addition, due to the Total Plus Disinfectant being placed on the counter, the clean utility room should have been locked.	F 323	F 329 Unnecessary Drugs Residents #11 and #21 were evaluated for depression and are subsequently being administered an antidepressant. Nursing staff have been in-serviced on unnecessary drug use, behavior monitoring and the federal regulations regarding use of psychotropic medications. The Director of Nursing or her designee will monitor documentation of behaviors monthly on all residents. Residents receiving psychotropic medications will be monitored for effectiveness and adverse side effects from use of psychotropic medications. The structured behavioral symptoms management plan will be review for these residents at that time as well. A ~~psychotropic medication and~~ behavior management team has been established and will meet weekly. All orders for psychotropic medications will be reviewed by the Director of Nursing for appropriateness and she will report changes to the psychotropic/behavior management team. Residents that have indicators of depressive symptoms and not on antidepressant will be review with emergence of	
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure two of nine sample residents did not receive an unnecessary drug. Resident #11 and #21 each received an antipsychotic medication without adequate monitoring or without adequate indications for its use. The findings were:			

See Copied Changes from facility

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F 329	Continued From page 9 1. Review of July 2005 physician's orders showed that on 4/6/05 resident #11 was started on Risperdal (antipsychotic) 0.5 milligrams by mouth twice a day. Further review of these orders showed that on 6/1/05 the resident's dosage was increased to three times daily. The following concerns were noted: a. Review of the April 2005 behavior monitoring sheet revealed no evidence to support the initiation of the Risperdal on 4/6/05. b. Review of the May 2005 behavior monitoring sheet revealed no evidence to support the increase in the dosage on 6/1/05. c. According to the June 2005 monitoring sheets the resident exhibited hitting at staff twice on 6/1/05, and four times on 6/5/05. In addition, the resident was noted to have cursed at staff twice on 6/1/05. d. Review of the 6/17/05 annual Minimum Data Set (MDS) assessment showed the resident exhibited the following depressive indicators that were not easily altered: persistent anger, repetitive anxious complaints, crying and tearfulness. Interview with the social services director on 8/3/05 at 9 AM revealed the resident was not evaluated for depression, but was instead kept on the Risperdal. According to the July 2005 physician orders, resident #21 was receiving Risperdal (antipsychotic) 0.5 milligrams by mouth everyday since 12/27/04. Review of the resident's 4/29/05 quarterly assessment and the 7/20/05 annual MDS assessment showed the resident exhibited the following depressive indicators that were not easily altered: persistent anger, sad, pained, and	F 329	new symptoms, quarterly, annually and with significant change of status. The Director of Nursing will be notified by Social Services Director of the occurrence of depressive symptom without use of antidepressant. The interdisciplinary care plan team will report to the Director of Nursing the findings of their evaluation. The Director of Nursing or her designee will contact the physician and report findings and request antidepressant when indicated. The structured behavioral symptoms plan will be developed by the Social Services Director. The Social Services Director and Director of Nursing will review the approaches and intervention to determine if approaches are care planed and being followed. The pharmacy consultant will report concerns regarding psychotropic antipsychotic medication to the Director of Nursing. The Director of Nursing or her designee will contact the primary care physician for required or recommended changes. The Medical Director will be consulted regarding psychotropic antipsychotic medications that are used out of the guidelines or inappropriately. The psychotropic medication/behavior team will report	

F 329 Unnecessary Drugs

Residents #11 and #21 were re-evaluated and are subsequently being administered an antipsychotic Nursing staff have been in-serviced on unnecessary drug use, behavior monitoring and the federal regulations regarding use of such medications. The Director of Nursing or her designee will monitor documentation of behaviors monthly on all residents. Residents receiving antipsychotic medications including residents #11 and 21 will be monitored for effectiveness and adverse side effects from use of antipsychotic medications. The structured behavioral symptoms management plan will be reviewed for these residents at that time as well. A behavior management team has been established and will meet weekly. All orders for antipsychotic medications will be reviewed by the Director of Nursing for appropriateness and she will report changes to the behavior management team. The structured behavioral symptoms plan will be developed by the Social Services Director. The Social Services Director and Director of Nursing will review the

approaches and intervention to determine if approaches are care planned and being followed. The pharmacy consultant will report concerns regarding antipsychotic medications to the Director of Nursing. The Director of Nursing or her designee will contact the primary care physician for required or recommended changes. The Medical Director will be consulted regarding antipsychotic medications that are used out of the guidelines or inappropriately. The behavior team will report their finding monthly to the administrator and quarterly to the Quality Improvement Committee.

9/16/05

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F 329	Continued From page 10 worried expression. Medical record review with confirmation by the social services director on 8/3/05 at 9 AM revealed the staff had failed to track behaviors, or to evaluate the resident for depression.	F 329	their finding monthly to the administrator and quarterly to the Quality Improvement Committee.	9/16/05
F 331 SS=D	483.25(l)(2)(ii) ANTIPSYCHOTIC DRUGS Based on a comprehensive assessment of a resident, the facility must ensure that residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure one (#21) of five residents receiving antipsychotic medications received gradual dose reductions, unless contraindicated. The findings were: According to the July 2005 physician orders, resident #21 had been receiving Risperdal (antipsychotic) 0.5 milligrams by mouth everyday since 12/27/04. Medical record review, with confirmation by the social services director on 8/3/05 at 9 AM, revealed an attempt at a gradual dose reduction of the drug was not done. Refer to F329 regarding the failure to monitor this medication for side effects or effectiveness.	F 331	F 331 Antipsychotic Drugs Resident #21 is receiving a trial reduction in the dose of antipsychotic. If successful this medication will be discontinued. The Director of Nursing or her designee will monitor antipsychotic documentation. Residents that receive antipsychotic drugs will be reviewed, quarterly, annually and with significant change of status for possible dose reduction. Residents receiving psychotropic medications will be monitored for effectiveness and adverse side effects from use of psychotropic medications. The Director of Nursing or her designee will contact the physician and request dose reductions for antipsychotic medications. Residents with diagnosis that prevent reduction of antipsychotic will have documentation in their medical record substantiating that dose reduction should not be attempted.	
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF	F 353		

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F 353	Continued From page 11 The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident and family interviews, review of the resident status report, and medical record review, the facility failed to provide sufficient staff to provide care and services to ensure resident dignity, meet resident activity of daily living needs, ensure appropriate documentation in medical records, and that chemical restraints were not used unnecessarily. The facility census was 35. The findings were: The following are concerns related to inadequate	F 353	The pharmacy consultant will report concerns regarding antipsychotic medications to the Director of Nursing. The Director of Nursing or her designee will contact the primary care physician for required or recommended changes. The Medical Director will be consulted regarding antipsychotic medications that are used out of the guidelines or inappropriately. The psychotropic medication/behavior team will report their finding monthly to the administrator and quarterly to the Quality Improvement Committee regarding use of antipsychotic drugs.	9/16/05

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F 353	Continued From page 12 staff to ensure dignity and activities of daily living 1. Review of the 7/8/05 quarterly Minimum Data Set (MDS) assessment for resident #12, revealed he/she was able to make his/her needs known, and was able to use the toilet with staff assistance. Observation on 8/1/05 at 9:55 AM revealed the resident was grossly incontinent of loose stool in his/her pants. The resident told certified nurse aide (CNA) #2 and #3 that he/she was given a suppository that morning. However, the CNAs stated they were unaware of this. Review of the medication administration record (MAR) on 8/1/05 10:10 AM with confirmation by registered nurse (RN) #1, revealed the resident was given a rectal suppository at 6 AM. The RN further stated that had the CNAs been notified of this, the resident could have been toileted timely, without the indignity of having to sustain a bowel movement in his/her pants. On 8/2/05 at 10:15 AM resident #11 was observed to have dried food residue on his/her face and chin area. At 10:30 AM, CNA #2 assisted the resident to bed without offering or providing the resident an opportunity to wash his/her face. When the CNA transferred the resident to bed, there were pieces of residual pancake on the seat of the wheelchair. At 12 PM when the resident was again transferred to his/her wheelchair for lunch, he/she was sat back on the residual pancake pieces, and the dried food substance remained on his/her face and chin. 2. Review of the medical record revealed resident #33 was legally blind, and had fallen in his/her room on 2/7/05, 3/14/05, 5/2/05, 5/24/05, and 5/30/05. According to the 6/30/05 care plan with a	F 353	F 353 Staffing The Charge Nurses have been in-serviced regarding staffing. The Charge Nurse will assure that sufficient qualified nursing staff are available on a daily basis to meet residents' needs for nursing care in a manner and in an environment which promotes each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life. The Charge Nurse will determine at the beginning of the shift if there is sufficient staff. If there is not sufficient staff to provide care to the residents, staff from the previous shift will be required to stay until other staff can be called and arrive at work. Staff will rotate staying late until staff can be called and arrive at work. The Nurses and Certified Nursing Assistants have been in-serviced regarding the facility policy that staff will report to the Charge Nurse before leaving the building and may be required to stay if the staffing is not sufficient. The facility will use agency Nurses RN/LPN and Certified Nurses Aides (temporary staff provided through a staffing agency) for planned shortages. The Charge Nurse will	

See 2 pages of computer copy for inservice held and sign in sheet from facility

F 353 Staffing

The Charge Nurses have been in-serviced regarding staffing. The Charge Nurse will assure that sufficient qualified nursing staff are available on a daily basis to meet residents' needs for nursing care in a manner and in an environment which promotes each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life. The Charge Nurse will determine at the beginning of the shift if there is sufficient staff. If there is not sufficient staff to provide care to the residents, staff from the previous shift will be required to stay until other staff can be called and arrive at work. Staff will rotate staying late until staff can be called and arrive at work. ***Advertisements for Rn's, LPN's, and C.N.A.'s are currently in local papers. A C.N.A. training course is being organized and anticipated to begin by Jan 5,2006 pending approval by regulators The current befit package offered to employees is being evaluated and changes are anticipated to begin by Nov 1,***

2005, offering a more competitive package to prospective employees. The Nurses and Certified Nursing Assistants have been in-serviced regarding the facility policy that staff will report to the Charge Nurse before leaving the building and may be required to stay if the staffing is not sufficient. The facility will use agency Nurses RN/LPN and Certified Nurses Aides (temporary staff provided through a staffing agency) for planned shortages. The Charge Nurse will contact the Director of Nursing or MDS Coordinator if they feel they are not able to complete assigned duties. The Director of Nursing or MDS Coordinator will assist the Charge Nurse to assure they have time for medication pass, treatments and documentation. The Director of Nursing will monitor staffing sheets and track staffing levels. A call list will be established and staff may sign up for preferred days to work if there is an absence that leaves the facility short staffed. The Director of Nursing will do four random chart audits per month to assure that documentation is completed. The Director of Nursing will also audit

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F 353	Continued From page 13 target date of 7/14/05 a licensed nurse (LN) would "assess need for fall interventions such as: Low bed, bed or chair alarms, non-skid strips on floor, gripper socks, raised toilet seat, padded floor next to bed, wedge in chair". The following concerns were noted: a. Observation of the resident's room on 7/31/05 at 7:50 PM, revealed a mechanical rising recliner chair, no alarm on the chair or bed, no non-skid strips on the floor, no padded floor, and no wedge in the chair. b. Interview with the social worker on 8/2/05 at 5:45 PM revealed she did not know of any documentation to show that fall interventions were assessed as indicated by the care plan. 3. Review of the 6/7/05 annual MDS assessment for resident #11 revealed he/she was able to use the toilet with staff assistance. In addition, the care plan showed the resident was to be toileted every two hours, and a barrier cream applied to the skin after incontinence episodes. However, on 7/31/05 at 8 PM CNA #1 was observed providing evening care for the resident. Without offering the resident the opportunity to use the toilet, the CNA transferred the resident to bed. When the resident was laid in bed, he/she began to urinate. The resident then requested to use the toilet. Furthermore, after the resident's skin was cleansed of urine, barrier cream was not applied. 4. Review of the 7/8/05 quarterly MDS assessment for resident #12 revealed he/she was occasionally incontinent of bowel and was able to use the toilet with staff assistance. However, on 8/1/05 at 9:55 AM, CNA #2 and #3 assisted the resident after he/she had sustained an episode of bowel incontinence. The CNAs failed to offer or provide the resident the opportunity to toilet prior	F 353	contact the Director of Nursing or MDS Coordinator if they feel they are not able to complete assigned duties. The Director of Nursing or MDS Coordinator will assist the Charge Nurse to assure they have time for medication pass, treatments and documentation. The Director of Nursing will monitor staffing sheets and track staffing levels. A call list will be established and staff may sign up for preferred days to work if there is an absence that leaves the facility short staffed. The Director of Nursing will do four random chart audits per month to assure that documentation is completed. The Director of Nursing will also audit four sets of Medication Administration Records and five sets of Treatment Administration Records per month for completeness. During nursing shift report treatments will be reported to the next shift. #1 Refer to Plan of Correction for F241 #2 Refer to Plan of Correction for F323 #3 Refer to Plan of Correction for F241, F315, F312 #4 Refer to Plan of Correction for F315, F282	

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F 353	Continued From page 14 to transferring him/her to bed. 5. Interview with resident #24 on 8/1/05 at 2 PM revealed staff did not provide him/her with daily oral care. 6. Review of the 6/7/05 annual MDS assessment for resident #11 revealed he/she was frequently incontinent of bladder and required total assistance by staff for personal hygiene. However, on 7/31/05 at 8 PM, CNA #1 was observed providing evening care for the resident. Without offering or providing oral care for the resident, the CNA transferred him/her to bed. In addition, the resident sustained an episode of urinary incontinence saturating his/her incontinence brief. During perineal care the CNA failed to cleanse the resident's anterior perineal area that was in contact with urine. 7. On 7/31/05 at 7:53 PM, CNA #1 was observed providing evening care for dependent resident #16. The CNA did not offer or provide oral care for the resident. During an interview with the resident on 7/31/05 at 8 PM, he/she stated staff had not offered or provided oral care for him/her for at least two weeks. 8. During observation on 8/1/05 at 9:55 PM, resident #12 sustained an episode of loose bowel incontinence with feces observed on the urinary catheter tubing. CNAs #2 and #3 did not provide any cleansing of the resident's genitals or catheter tubing. 9. Review of the 6/7/05 annual MDS assessment for resident #11 revealed he/she was able to use the toilet with staff assistance, and continued to have some bladder control present. In addition,	F 353	#5 & #7 Residents #24 & #16 were assessed for level of assistance needed for oral care ~~-~~ appropriate level of assistance will be provided The assignment sheet has been updated to reflect the level of assistance needed for all residents to obtain oral care. All Certified Nursing Assistance assignment sheets will include oral care, and appropriate level of assistance. Nursing staff will be in-serviced regarding oral cares. The Director of Nursing or Designee will monitor care provided. This will be a random check of three Certified Nurses Aides per week for 3 months if compliance has been achieved the audits will be done monthly on 3 random CNAs. All new CNAs will be required to show compliance during their orientation period. The findings of the audit will be reported to the Quality Improvement Committee quarterly. #6 Resident #11 was assessed for level of assistance need for peri care and oral care + appropriate level of assistance will be provided. The assignment sheet has been updated to reflect the level of assistance needed for this resident to obtain peri care. All Certified	

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F 353	Continued From page 15 the care plan showed the resident was to be toileted every two hours. However, on 7/31/05 at 8 PM, CNA #1 was observed providing evening care for the resident. Without providing the resident the opportunity to use the toilet, the CNA transferred the resident to bed. When the resident was laid in bed, he/she began to urinate. The CNA did not offer or provide the resident the opportunity to use the bathroom. Instead, the resident had to ask the CNA to take him/her to the toilet. The following are concerns related to inadequate staff to ensure appropriate medical record documentation: 1. Review of the July 2005 physicians orders for resident #19 revealed an order prescribed on 6/22/04 for the medication Depo-Provera Contra 150 mg IM (intramuscular) every three months. Review of the MAR for June 2005 revealed this medication was to be administered on 6/22/05, however there was no documentation on the MAR to indicate the medication was given. 2. Further review of the July 2005 physician orders for resident #19 revealed an order dated 3/1/05 to have his/her right palm checked daily for pressure ulceration. Review of the May 2005 treatment records showed no documentation that the palm was checked any day of the month, and the June 2005 treatment record was blank on 17 days (6/7, 6/8, 6/9, 6/10, 6/13, 6/17, 6/18, 6/19, 6/21, 6/22, 6/23, 6/24, 6/26, 6/27, 6/28, 6/29, and 6/30) with no documentation that the check was done. 3. Observation of resident #12 on 8/1/05 at 9:55 AM, revealed he had a urinary catheter in place.	F 353	Nursing Assistance assignment sheets will include peri care for residents who have episodes of bowel or bladder incontinence. Nursing staff will be in-serviced regarding peri care. The staff will be in-serviced regarding cares that need to be provided in the mornings and evenings as well. The Director of Nursing or Designee will monitor care provided. This will be a random check of three Certified Nurses Aides per week for 3 months. If compliance has been achieved the audits will be done monthly on 3 random CNAs. All new CNAs will be required to show compliance during their orientation period. The findings of the audit will be reported to the Quality Improvement Committee quarterly #8 Residents #12 catheter has been discontinued. All Certified Nursing Assistance assignment sheets for residents will include residents requiring catheter care and any specialized instructions. Nursing staff will be in-serviced regarding catheter care. The Director of Nursing or Designee will monitor catheter care provided. This will be	

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F 353	Continued From page 16 Review of nursing notes showed the resident had the urinary catheter on 7/29/05 at 2:15 PM. However, review of the July 2005 and August 2005 physician orders showed no order for the catheter. 4. Review of a physician order dated 5/31/05 revealed resident #28 was to have his/her urinary catheter discontinued. However, observation of the resident on 8/1/05 revealed she/he still had the catheter. Interview with licensed practical nurse #1 on 8/2/05 at 1600 revealed he/she had replaced the resident's urinary catheter. The LPN further stated he/she had not obtained a physician's order, nor did he/she document in the nursing notes why he/she had felt reinsertion of the urinary catheter was warranted. In addition, he/she stated the physician was "not happy" the catheter had been reinserted. The following are concerns related to inadequate staff to ensure that chemical restraints were not used unnecessarily: 1. Review of July 2005 physician orders showed that on 4/6/05 resident #11 was started on Risperdal (antipsychotic) 0.5 milligrams by mouth twice a day. Further review of these orders showed that on 6/1/05 the resident's dosage was increased to three times daily. The following concerns were noted: a. Review of the April 2005 behavior monitoring sheet revealed no evidence to support the initiation of the Risperdal on 4/6/05. b. Review of the May 2005 behavior monitoring sheet revealed no evidence to support the increase in the dosage on 6/1/05. c. According to the June 2005 monitoring sheets the resident exhibited hitting at staff twice	F 353	a random check of three Certified Nurses Aides per month. The findings of the audit will be reported to the Quality Improvement Committee quarterly. #9 Refer to Plan of Correction For F315 Concerns related to inadequate staff to ensure appropriate medical record documentation. #1 Resident # 19 has received the ordered injections/ appropriate doc. is completed #2 The Director of Nursing review the treatment sheets for Resident #19 with the nursing staff. #3 Resident # 12 had catheter removed/ appropriate doc. is completed. #4 For resident #28 an order for catheter was obtained from physician. The reason for catheter is documented in the Medical Record. See monitoring of documentation from above. Concern related to inadequate staff to ensure that chemical restraints were not used unnecessarily. #1 Refer to Plan of Correction for F329, F331	9/16/05

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F 353	Continued From page 17 on 6/1/05, and four times on 6/5/05. In addition, the resident was noted to have cursed at staff twice on 6/1/05. d. Review of the 6/17/05 annual Minimum Data Set (MDS) assessment showed the resident exhibited the following depressive indicators that were not easily altered: persistent anger, repetitive anxious complaints, crying and tearfulness. Interview with the social services director on 8/3/05 at 9 AM revealed the resident was not evaluated for depression, but was instead kept on the Risperdal. According to the July 2005 physician orders, resident #21 was receiving Risperdal (antipsychotic) 0.5 milligrams by mouth everyday since 12/27/04. Review of the resident's 4/29/05 quarterly assessment and the 7/20/05 annual MDS assessment showed the resident exhibited the following depressive indicators that were not easily altered: persistent anger, sad, pained, and worried expression. Medical record review with confirmation by the social services director on 8/3/05 at 9 AM revealed the staff had failed to track behaviors, or to evaluate the resident for depression. During an interview with resident #32 on 8/1/08 at 11:30 AM, he/she stated that due to lack of permanent staff, the facility was having to utilize temporary staff. During a family interview on 8/1/05 at 4:45 PM, he/she stated that due to staff turnover and the use of temporary staff, he/she felt resident care suffered as staff didn't know the residents or their	F 353		

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F 363	Continued From page 18 personal traits. Interview with the facility administrator throughout the survey confirmed that staffing to ensure resident needs were met was a current concern.	F 353		
F 363 SS=D	483.35(c) MENUS AND NUTRITIONAL ADEQUACY 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, staff interview and review of the planned menu, the facility failed to follow the planned menu during one meal service observation for residents who were to receive pureed diets. Review of diet cards and interview with the cook revealed five residents received pureed diets. The resident census was 35. The findings were: Review of the evening menu on 8/1/05 showed residents with pureed diets were to receive pureed soup, a slurry (a mixture of powdered thickener and water) of crackers, a pureed ham and cheese sandwich, pureed lettuce and tomatoes, and pureed pineapple tidbits with cherries. Observation of the evening meal preparation and service on 8/1/05 between 4:45 PM and 6:50	F 363	F 363 Menus and Nutritional Adequacy A mandatory in-service for all Dietary staff covering pureed diets and menu substitution, will be conducted by the contract RD, the week of Aug 29th, 2005. The Dietary manager or designee will do a random audit to ensure the menus are being followed as written. Audits will be conducted weekly for the first month and if no problems found, audits will be conducted once per month thereafter. Findings from the audit will be reported to the QA committee on a quarterly basis. and person pureed diets are receiving their diet as planned 9/9/05	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535060	A. BUILDING _____ B. WING _____	08/03/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	P O BOX 859 FORT WASHAKIE, WY 82514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 363	Continued From page 19 PM revealed crackers were not pureed with the soup, and no slurry of crackers was prepared. Lettuce and tomato were not pureed and served. Interview with the dietary manager on 8/2/05 at 9 AM revealed that the expectation was for the cooks to follow the menu for all diets including pureed. She also confirmed the menu was approved by the registered dietitian, and the observed meal should have been followed as written.	F 363	F 454 Physical Environment The carpet in the resident television lounge will be replaced by ~~Sept. 30th~~ Sept. 19, 2005. The vent in the East tub room was cleaned on Aug 4, 2005. The floor around the edge of the wall and the water pipes below the three compartment sinks were cleaned on Aug. 9th, 2005. The drain on the bottom of the reach in cooler was modified allowing it to drain directly into the drain rather than dripping on the floor. The air vents in the kitchen were all cleaned on Aug. 10th, 2005. The window located above the three compartment sink was cleaned on Aug 3rd, 2005, and the blinds were permanently removed from the window on Aug 4th 2005. The air vents have been added to the monthly cleaning schedule for maintenance. The floor around the water pipes will be covered by the director of maintenance by Sept 16th,2005 Encasing the pipes and making it a more readily cleanable surface. The Dietary Manager or designee will do a random audit quarterly of the windows, kitchen vents, and kitchen floors, and report findings to the QA committee on a quarterly basis. The	
F 454 SS=D	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the television lounge, east tub room, and kitchen were maintained in a clean manner. The finding were: Observation of the resident television lounge on 7/31/05 at 7:15 PM revealed the carpet in the middle of the room and around the furnishings was stained and discolored. Observation on 8/2/05 at 9:45 AM of the east tub room revealed a dust build up on the air vent above the toilet, an orange colored stain on the chair lift platform, and orange stains on the floor at the base of the platform. Observation on 8/1/05 at 4:50 PM revealed the following problems with cleanliness in the kitchen:	F 454		

The stains listed in the deficiency are being repaired by 9/16/05

assuring cleaning schedules are followed.

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 _____	08/03/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	P O BOX 859 FORT WASHAKIE, WY 82514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 454	Continued From page 20 a. The kitchen floor had dirt build up around the edge of the wall and on the water pipes below the handwashing sink and the three compartment sink. b. A drain on the bottom of a reach-in refrigerator was not positioned over the floor drain. Thus, water was pooling on the floor underneath and behind the reach-in refrigerator. c. Ten air vents on the ceiling of the kitchen had a build up of dust on and around them. d. A window located above the three compartment sink had dried food and a build up of dirt around the frame. Between the screen and the glass was dead insects and an accumulation of dirt. The metal blinds attached to this window had rust spots and dust across the top. Interview with the administrator on 8/2/05 at 10 AM revealed that he was aware of the carpet stains in the TV lounge.He further stated he was aware that the floor, ceiling and window in the kitchen needed cleaning. The administrator verified that the drain on the reach-in refrigerator should not drip onto the floor, and the blinds should be "thrown out."	F 454	Director of Maintenance will audit the cleanliness of all vents and fan covers on a monthly basis and report findings to the QA committee on a quarterly basis.	~~9/15/05~~ 9/16/05
F 469 SS=B	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, review of a pest control invoice, and staff interview, the facility failed to assure the pest control program was effective, and the facility was free of insects. The findings	F 469	F 469 Physical Environment- Pest Control The facility was re-sprayed by the Pest control contractor on 08/03/05. The contract with the current pest control Company was revised, to include free call-backs within 24 hours of notification. The facility dept heads will be responsible to look for insects during the facility walkthrough completed on a weekly basis and reported weekly at the facility managers meeting.	8/26/05

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F 469	Continued From page 21 were: Observation on 8/1/05 at 1:12 PM, 8/2/05 at 10:35 AM, and 8/3/05 at 9:35 AM revealed live and dead flying ants on window ledges, heater ledges, and the floor of the education/conference room. Observation on 8/2/05 at 10 AM also revealed ants in the mechanical room on the floor near an enclosed mouse trap by the back door. Review of a Terminix (a pest control company) invoice revealed the building was sprayed for pests on 7/6/05, and on 7/18/05. Interview with the administrator on 8/3/05 at 12:45 PM revealed more should be done to eliminate the insects.	F 469		