STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING _____ B. WING _____	C 11/15/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 11/15/16. The survey was prompted by complaint intake WY00002311.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	12/16/16 Resident # 1 is no longer a resident of the facility. The facility will identify other residents having the potential to be affected by having the IDT audit incident reports weekly to ensure the "physician notification" and "family member / resident representative" sections have been completed. All nurses will be re-educated about the completion of incident reports ~~(see Tag F 225~~ delete Results from the weekly IDT meetings will be reported quarterly at the QI meeting. Charge nurse will notify Rep of any significant change of condition. With any change of condition, charge nurse will contact physician and family member if change of treatment is withheld.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tamara A. Reed — TITLE: Administrator — (X6) DATE: 12/1/16

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. Dept of Health

Changes made per phone on 12/22/16 @ 7:50 — with Tammy Reed, WHA

POC accepted.

Healthcare Licensing

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the physician and the resident's emergency contact were immediately informed of a significant change for 1 of 5 sample residents (#1) with a significant change in status or accident. The findings were: 1. Review of the medical record showed on 10/15/16 resident #1 fell while away from the facility, which required a visit to the emergency room. The resident was diagnosed with a right humerus fracture. The resident had a follow-up visit with the physician on 10/18/16. The physician wrote orders for the resident to wear a sling on the right arm and to have another appointment in 3 weeks. The following concerns were identified: a. Review of nursing notes showed on 11/7/16 nursing staff documented "bone protruding in shoulder area (R [right] shoulder area), concerned that it can possibly break through skin. Not sure if it is the humerus or collar bone..." The note also indicated the resident had a follow-up appointment for the following day (11/8/16) already scheduled. Review of hospice certified nurse aide (CNA) and nursing notes dated 11/7/16 also documented the bone protrusion at the right shoulder. b. Further review of the medical record showed no evidence the physician was notified immediately on 11/7/16 when nursing staff observed the bone protrusion at the right shoulder. In addition, there lacked evidence the resident's emergency contact was notified of the bone protrusion. c. On 11/15/16 at 3:05 PM registered nurse (RN) #1 reviewed the medical record. He stated	F 157		

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F 157	Continued From page 2 he was unable to find evidence that the physician or the emergency contact were notified on 11/7/16 of the bone protrusion.	F 157		