RECEIVED
JAN 10 2017
Healthcare Licensing and Surveys

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

PRINTED: 12/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING _____ B. WING _____	C 12/12/2016

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 12/12/16. The survey was prompted by complaint intake WY00002326.	F 000	The facility will ensure implementation of policies related to protection of residents during abuse investigations. Administrator, DON, and ADON will review facility policy on "Abuse and Neglect Prevention" to ensure the following: All residents will be protected from harm during the investigation Staff suspected of abuse will be suspended until the results of the investigation are complete A written report of all internal investigation results will be submitted to the state within 5 working days All reports of abuse and/or neglect will be audited by the Administrator, DON, and ADON to ensure accuracy and timeliness. Results will be reported quarterly at the QI meeting.	01/15/17
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tamara A. Reed — TITLE: Administrator — (X6) DATE: 12/30/16

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. POC accepted. Spoke with Carolyn Clawson, DON on 1/11/17 @ 10:37a - [signature]

PRINTED: 12/27/2016
FORM APPROVED
OMB NO. 0938-0391

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 _____	C 12/12/2016

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 226	Continued From page 1 prevention. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, staff interview, and policy review, the facility failed to implement policies related to protection of residents during an investigation and reporting the results of an investigation for 1 of 1 allegations of abuse. The findings were: Review of an incident report dated 11/22/16 showed an allegation of physical abuse on 11/21/16 by certified nurse aide (CNA) #1 and CNA #2, involving resident #1. The following concerns were identified: a. Review of the facility's policy "Abuse and Neglect Prevention" (undated) showed "...Residents will be protected from harm during an investigation...Staff suspected of abuse will be suspended until the results of the investigation are complete." Review of facility investigation documentation showed no evidence the accused CNAs were suspended during the investigation. During an interview on 12/12/16 at 2:10 PM the interim administrator stated the CNAs were not placed on suspension pending the results of the investigation. b. Review of the facility's policy "Abuse and Neglect Prevention" (undated) revealed "...After conducting an internal investigation, a written report of all investigation results must be submitted to the state within 5 working days." Review of facility investigation documentation showed the facility submitted follow-up reports to the survey and certification agency on 11/25/16 and 11/30/16. However, review of the reports showed no final determination of the allegation. The report dated 11/30/16 showed the resident decided s/he did not want to press charges, and	F 226		

PRINTED: 12/27/2016
FORM APPROVED
OMB NO. 0938-0391

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 _____	C 12/12/2016

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 226	Continued From page 2 therefore the police did not pursue any action. However, the facility did not document and report the findings of their internal investigation. During an interview on 12/12/16 at 2:10 PM, the interim administrator confirmed the facility did not specify in writing the results of the investigation. She stated the allegation was unsubstantiated based on the investigation, but acknowledged that was not reported to the survey and certification agency.	F 226		
F 498 SS=E	483.35(c); 483.95(g)(1)(2)(4) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS 483.35 (c) Proficiency of Nurse Aides The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. 483.95 (g) Required In-service training for nurse aides. In-service training must- (g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. (g)(2) Include dementia management training and resident abuse prevention training. (g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 498		

PRINTED: 12/27/2016
FORM APPROVED
OMB NO. 0938-0391

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 _____	C 12/12/2016

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 498	Continued From page 3 Based on observation, review of inservice education and staffing, and staff interview, the facility failed to ensure certified nurse aides (CNAs) were competent for skills and techniques for 5 of 5 CNAs (CNA #1, #2, #3, #4, #5) observed. The findings were: Review of the staffing schedule showed CNAs #1, #2, #3, #4, and #5 were scheduled to work on 12/12/16 during the day shift. Observations on 12/12/16 from 12:35 PM until 12:44 PM showed all five CNAs provided care to residents (residents #2, #3, and #4) including transfers. The facility was requested to provide information to show the CNAs were competent to perform nurse aide tasks. The rehab manager provided evidence of inservice education on mechanical lift transfers for the CNAs. However, during an interview on 12/12/16 at 1:30 PM the rehab manager stated she did not have evidence that CNAs were competent for non-mechanical lift transfers, such as stand-pivot transfers. On 12/12/16 at 2:30 PM the director of nursing (DON) and interim administrator stated they had no competency evaluations for any of the CNAs. The DON stated she worked with new CNAs during the first three days of orientation, but did not keep any documentation. The DON and Administrator stated they had no documentation to provide to show CNAs were competent for the tasks they provided in the facility to residents.	F 498	The facility will ensure nurse aides are able to demonstrate competency in skills and techniques necessary to care for resident's needs, as identified through resident assessments, and described in the plan of care All nurse aides will be reviewed and checked off for competency of skills and techniques before finishing their "orientation" period and at a minimum of yearly thereafter. DON will audit all nurse aides to ensure they have a competency and skill checklist completed as required. Results will be reported quarterly at the QI meeting.	01/15/17