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 _____	R 12/18/2007

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 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 329} SS=D	483.25(l) 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. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and 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 medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary medications for 2 (#8, #17) of 7 sample residents. The findings were: a. Review of the medical record for resident #17 showed a physician's order dated 5/29/07 for Ambien (a hypnotic medication) 5 mg to be given every evening. According to the November and	{F 329}	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. F329 The DON will complete evaluations for the observed medications for Resident #17 and Resident #8 (Ambien). Physician will be given the evaluations and request form to either continue current doses, decrease doses, change frequency and/or discontinue medications and reason for decisions for Resident #17 and Resident #8. The DON will complete an evaluation of Residents' medications will be completed and results given	12-19-07 12-19-07

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

[signature] | NHA | 1-7-08

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.

JAN 14

Wyoming Dept of Health
Hospital and Survey

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 _____	R 12/18/2007

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 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 329}	Continued From page 1 December 2007 medication administration records (MARs) the medication was given as ordered. Further review showed there was no evidence in the medical record that a dose reduction was attempted since being started on the medication. In addition, there was no contraindication for a dose reduction, or an evaluation to show why the medication was needed. b. Review of the medical record for resident # 8 showed a Physician's order dated 2/21/07 for Ambien 10 mg to be given nightly. Review of the November and December 2007 MARs revealed the resident received the medication as ordered. Further record review showed there was no evidence of any attempt to reduce the dose of the medication in the 8 months s/he was receiving it. In addition, there was no contraindication for a dose reduction, or an evaluation to show why the medication was needed. c. Interview on 12/18/07 at 11:15 AM with the director of nursing, the nursing home administrator, the social worker and the nurse consultant revealed they were unaware of any attempts to reduce the dose of the hypnotics for these residents.	{F 329}		

Department of Health and Human Servic
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535050	A. Building B. Wing	12/18/2007

Name of Facility	Street Address, City, State, Zip Code
MORNING STAR CARE CENTER	P O BOX 859 FORT WASHAKIE, WY 82514

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0170 Reg. # 483.10(l)(1) LSC	Correction Completed 12/01/2007	ID Prefix F0176 Reg. # 483.10(n) LSC	Correction Completed 12/10/2007	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 12/01/2007
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 12/01/2007	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	Correction Completed 12/01/2007	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 12/01/2007
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 12/01/2007	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 12/01/2007	ID Prefix F0283 Reg. # 483.20(l)(1)&(2) LSC	Correction Completed 12/01/2007
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 12/01/2007	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 12/01/2007	ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 12/01/2007
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 12/01/2007	ID Prefix F0364 Reg. # 483.35(d)(1)-(2) LSC	Correction Completed 12/01/2007	ID Prefix F0368 Reg. # 483.35(f) LSC	Correction Completed 12/01/2007

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date: 12/20/07

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535050	A. Building B. Wing	12/18/2007

Name of Facility	Street Address, City, State, Zip Code
MORNING STAR CARE CENTER	P O BOX 859 FORT WASHAKIE, WY 82514

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0371 Reg. # 483.35(i)(2) LSC	Correction Completed 12/01/2007	ID Prefix F0425 Reg. # 483.60(a),(b) LSC	Correction Completed 12/01/2007	ID Prefix F0444 Reg. # 483.65(b)(3) LSC	Correction Completed 12/01/2007
ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 12/01/2007	ID Prefix F0502 Reg. # 483.75(i)(1) LSC	Correction Completed 12/01/2007		

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date: 12/20/07
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/18/2007

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO