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 10/18/2018

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MORNING STAR CARE CENTER	4 NORTH FORK ROAD FORT WASHAKIE, WY 82514

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 10/15/18 through 10/18/18. Also reviewed in the course of the survey was complaint intake WY00002557. The following common abbreviations are used throughout this document. ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing EMR: Electronic Medical Record MDS: Minimum Data Set mg: Milligrams ml: Milliliters RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the	F 583		12/2/18

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

Electronically Signed | 11/07/2018

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F 583	Continued From page 1 right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and policy review the facility failed to ensure residents received mail on Saturday. The facility census was 34. The findings were: 1. Interview with a group of 11 residents on 10/16/18 at 1 PM revealed while they received mail on weekdays, they did not receive mail on Saturday. 2. Interview with the activities coordinator on 10/17/18 at 10:02 AM revealed the mail was supposed to be delivered Monday through Saturday. Housekeeping was to deliver mail on Saturday, however the activities coordinator did not know if mail was being delivered on Saturdays.	F 583	F583: Corrective Action: A policy/procedure has been implemented which assigns the weekend Activities staff to retrieve the mail every Saturday and it is to be dispersed immediately. Corrective action taken to prevent other residents from being affected: All Activities staff, QA officer, administrator and nursing staff have received traning on the process for retrieving the mail on Saturdays. Measurements of sustainable changes to prevent reoccurrence: A signature sign-off will be implemented by the activities department and signed off every Saturday to ensure the mail is picked up. The QA	

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F 583	Continued From page 2 3. Interview with housekeeper #1 on 10/18/18 at 8:10 AM revealed housekeepers "do not do the mail or pick up mail on the weekends or other days." 4. Review of the resident policy handbook revised August 2017 showed, "(i) Mail. The resident has the right to privacy in written communications, including the right to: (1) Send and promptly receive mail that is unopened..."	F 583	officer will audit this for 8 weeks and then monthly for 12 months and periodically thereafter to ensure compliance. Audit to be reviewed at quarterly QAPI meeting.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical	F 604		12/2/18

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F 604	Continued From page 3 symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assess devices for resident safety and to ensure they were the least restrictive alternative for 1 of 1 sample residents (#9) with a restraint. The findings were: 1. Review of the quarterly MDS assessment dated 7/27/18 showed resident #9 had a BIMS score of 2/15 (severe cognitive impairment) and diagnoses which included unspecified dementia without behavioral disturbance. Further review showed the resident was coded as having no restraints, used alarms for the bed and chair and wandered. The following concerns were identified: a. Review of a physician's orders dated 5/1/18 showed an order for a wheelchair safety belt. b. Interview with the DON on 10/17/18 at 2:58 PM revealed a safety assessment of the wheelchair seatbelt was not performed.	F 604	F604: Corrective Action for resident number 9: A discontinuation of the seatbelt from the resident□s physician as the use of tabs alarms is least restrictive. A fall risk assessment has been completed as well as a safety assessment. Corrective Action taken to prevent other residents from being affected: All residents with a wheelchair seatbelt have had a fall risk assessment, safety assessment, as well as a physical audit completed by the QA officer to see if they are able to release it themselves. All future residents with a wheelchair will have a fall risk assessment, safety assessment, as well as a physical release audit completed upon admission, and quarterly with their MDS thereafter. A care plan audit form has been implemented in order to audit that these assessments have been completed for all the residents and are reviewed on a quarterly basis. DON or designee will train all current and new nursing staff on completing above mentioned assessments. Measurement of sustainable changes to prevent reoccurrence:	

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F 604	Continued From page 4	F 604	All nursing staff have received training on the process for filling out the assessments for all residents on a quarterly basis. The QA officer will audit each resident□s chart for 8 weeks to ensure the assessments have been completed, and then quarterly for 12 months to ensure compliance. A care plan audit list has been implemented and the IDT team will also perform a care plan audit quarterly to ensure compliance.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		12/2/18

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F 623	Continued From page 5	F 623		

before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with

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F 623	Continued From page 6 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a transfer notice was issued and the ombudsman was notified for 4 of 4 sample residents with facility-initiated hospital transfers (#12, #22, #24, #83). The findings were: 1. Review of the medical record for resident #12	F 623	F623 Corrective action for residents number 12, 22, 24, and 83: Residents have been given a written transfer notice for all facility- initiated discharges on the dates indicated for CMS form 2567.	

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F 623	Continued From page 7 showed s/he was transferred to the emergency department on 5/1/18 for an evaluation after a fall. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 2. Review of the medical record for resident #22 showed s/he was transferred to the emergency department on 7/27/18 for an evaluation after a fall. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 3. Review of the medical record for resident #24 showed s/he was admitted to the hospital for an acute change of condition on 6/9/18 and was readmitted to the facility on 7/3/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 4. Review of the medical record for resident #83 showed s/he was transferred to the emergency department on 10/11/18 and again on 10/13/18 for an acute change of condition. The resident was admitted to the hospital on 10/13/18 and had not returned to the facility during the survey timeframe. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 5. Interview on 10/17/18 at 11:23 AM with the DON and the social worker confirmed the facility had not issued written notices of transfer with all the required information to the residents or the residents' representatives. In addition, they confirmed the ombudsman was not notified of the transfers.	F 623	Corrective action taken to prevent other residents from being affected: A written resident transfer/discharge form was developed 10/26/18 and implemented. Social Services will present the form at the next resident council meeting on 11/16/18 and inform the residents that the notice will be sent on all facility-initiated transfers. Measurement of sustainable changes to prevent reoccurrence: Social Services or designee will issue a written transfer/discharge notice for all residents who have a facility-initiated discharge or transfer, as soon as practicable. A copy of the notice will be sent to the Long Term Care Ombudsman and scanned into the residents electronic record. Social Services, administrator, Quality Assurance officer, and all nurses have received training on the new process. Monitoring for sustainability: The QA officer will audit all facility-initiated discharges/transfers weekly for 8 weeks, then monthly for 12 months, and periodically thereafter to ensure compliance. Audit to be reviewed at the quarterly QAPI meeting	

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F 625	Continued From page 8	F 625		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide written information on the bed-hold policy for 4 of 4 sample residents (#12, #22, #24, #83) reviewed for facility-initiated transfers. The findings were:	F 625	F625 Corrective action for residents number 12, 22, 24, and 83: Residents have been given a written bed hold and return policy notice for all	12/2/18

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F 625	Continued From page 9 1. Review of the medical record for resident #12 showed s/he was transferred to the emergency department on 5/1/18 for an evaluation after a fall. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 2. Review of the medical record for resident #22 showed s/he was transferred to the emergency department on 7/27/18 for an evaluation after a fall. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 3. Review of the medical record for resident #24 showed s/he was admitted to the hospital for an acute change of condition on 6/9/18 and was readmitted to the facility on 7/3/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 4. Review of the medical record for resident #83 showed s/he was transferred to the emergency department on 10/11/18 and again on 10/13/18 for an acute change of condition. The resident was admitted to the hospital on 10/13/18 and had not returned to the facility during the survey timeframe. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 5. Interview on 10/17/18 at 11:23 AM with the DON and the social worker confirmed the facility had not issued written notices of the bed-hold policy to the residents or the residents'	F 625	facility-initiated discharges on the dates indicated on form CMS 2567. Corrective Action taken to prevent other residents being affected: A written bed hold return policy notice was developed 11/5/18 and implemented. Social Services will present the notice at the next resident council meeting on 11/16/18 and inform the residents the notice will be issued at any facility-initiated transfer/discharge or leave from the facility. Measurement of sustainable changes to prevent reoccurrence: Social Services or designee will issue a written bed hold policy and return policy for all residents who have a facility-initiated transfer/discharge or leave as soon as practicable. A copy of the notice will be uploaded to the residents electronic medical record. Social Services, administrator, Quality Assurance officer, and all nurses have been received training on this process. Monitoring sustainability: The QA officer will audit all facility-initiated discharges/transfers or leaves and the issuance of the bed hold and return policy for 8 weeks, then monthly for 12 months, and periodically thereafter to ensure compliance. Audit to be reviewed by QAA quarterly.	

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F 625	Continued From page 10 representatives.	F 625		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure MDS assessments were accurately completed for 4 of 15 sample residents (#9, #24, #29, #30) reviewed. The findings were: 1. Review of the medical record for resident #9 showed s/he received the influenza vaccine on 10/22/17. Review of the 10/25/17 admission MDS assessment and the 1/25/18 quarterly MDS assessment showed the resident's influenza vaccination status was left blank. 2. Review of the medical record for resident #24 showed s/he received the influenza vaccine on 10/1/17 and had active diagnoses which included anoxic brain damage, partial intestinal obstruction, gastro-esophageal reflux disease, and hypokalemia. The following concerns were identified: a. Review of the 12/15/17 quarterly MDS assessment and the 3/16/18 annual MDS assessment showed the resident received the influenza vaccine on 10/21/16. b. Review of the 9/13/18 quarterly MDS assessment under section I showed no diagnoses were listed. 3. Review of the medical record for resident #29	F 641	641: Corrective action for residents #9, #24, #29, and #30 MDS errors have been corrected individually to reflect their accurate influenza date and #24 to reflect corrected current diagnosis. Corrective action taken to prevent other resident from being effected: Matrix MDS training concerning influenza data input and diagnosis data input completed with new MDS coordinator. DON will audit MDS prior to submission for Influenza and diagnosis accuracy for a period of 3 months. Don or designee will educate MDS coordinator and nursing staff on manual data input of influenza vaccine date into the MDS. Maintain sustainability: DON will audit MDS prior to submission for Influenza and diagnosis accuracy for a period of 3 months and periodically thereafter to insure continued compliance.	12/2/18

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F 641	Continued From page 11 showed s/he received the influenza vaccine on 10/12/17. Review of the 5/25/18 quarterly MDS assessment and the 8/24/18 annual assessment showed the resident received the influenza vaccine on 10/21/16. 4. Review of the medical record for resident #30 showed s/he received the influenza vaccine on 10/12/17. Review of the 8/23/18 annual MDS assessment showed the resident received the influenza vaccine on 10/21/16. 5. Interview on 10/16/18 at 5 PM with the MDS consultant revealed she was new to the facility and had thought the EMR system would automatically populate the diagnoses section of the MDS assessment with the correct codes. After researching the issue she discovered the diagnoses must be manually entered into the "additional active diagnoses" section of the MDS assessment and confirmed she had not completed it accurately. 6. Interview on 10/17/18 at 11:43 AM with the DON revealed the facility had thought vaccination dates would automatically transfer from the EMR to the MDS. After researching the issue she discovered the vaccination dates must be entered manually and confirmed the dates were inaccurately coded on the MDS assessments.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		12/2/18

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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 656	Continued From page 12 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a	F 656	F656	

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F 656	Continued From page 13 comprehensive care plan for 1 of 15 sample residents (#9). The findings were: 1. Review of the quarterly MDS assessment dated 7/27/18 showed resident #9 had a BIMS score of 2/15 (severe cognitive impairment) and diagnoses which included malignant neoplasm of prostate, hypertension, bilateral primary osteoarthritis of the knee, primary osteoarthritis, nocturia, and unspecified dementia without behavioral disturbance. Further review showed the resident was coded as having no restraints, daily use of alarms for the bed and chair, and wandering. The following concerns were identified: a. Review of a physician's order dated 5/1/18 showed the resident had an order for a wheelchair safety belt. b. Review of the "Smoking risk" dated 10/17/18 at 12:21 PM showed the resident smoked cigarettes a couple times per day, general awareness and orientation was not a problem, and had minimal problems following the facility safe smoking policy. Further review showed the resident's smoking risk score was 6.0 and determined a "safe smoker." c. Review of the resident's care plan last revised 10/9/18 showed the facility failed to address the resident's smoking and restraint. d. Interview with the DON on 10/17/18 at 2:58 PM revealed the facility had not developed a care plan that addressed the resident's smoking and restraint.	F 656	Corrective action for resident number 9: Resident care plan has been updated to reflect the resident□s use of tobacco and the discontinuation of the seatbelt order, as the resident was not utilizing a seatbelt. An updated smoking assessment has been completed as well. Corrective action taken to prevent other residents from being affected: The Don or designee will train all current and future nurses on how to do a smoking assessment, including frequency, for all current and future smoking residents. A care plan audit checklist has been developed and implemented and is reviewed with every residents□ care plan quarterly to ensure all assessments have been completed as well as all resident care areas have been addressed. Measurement of sustainable changes to prevent reoccurrence: The IDT team will review care plans every Wednesday as well as quarterly with the care plan audit form to ensure all areas are addressed to encompass the resident□s needs. QA officer will audit care plans quarterly and report to quarterly QAPI meeting.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		12/2/18

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F 657	Continued From page 14 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and medical record review, the facility failed to ensure care plans were updated for 2 of 15 sample residents (#12, #22). The findings were: 1. Review of the 7/27/18 quarterly MDS assessment showed resident #12 had a BIMS score of 14/15 (cognitively intact); required limited assistance of 1 staff member for bed mobility, transfers, and ambulation; and had diagnoses which included hypotension of hemodialysis,	F 657	F657 Corrective action for resident number 12: Resident care plan has been updated to reflect the resident□s use of the fall mat. Resident number 22□s care plan has been updated to reflect the use of a wander-guard. Corrective action taken to prevent other residents being affected:	

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F 657	Continued From page 15 seizures, atrial fibrillation, and muscle weakness. The following concerns were identified: a. Interview with the resident on 10/16/18 at 12:54 PM revealed s/he had fallen "6-8 months ago" and hit his/her head on the floor. Further s/he stated the fall mat was on the floor next to the bed as a result of that fall. Observation at that time showed the resident's bed was in a low position and the fall mat was in place. b. Review of a nurse's note dated 5/1/18 showed the resident had a fall which resulted in a hematoma, and the resident was sent to the emergency department. Review of a nurse's note dated 5/3/18 showed the resident was found in his/her room "face down." Further review of the note showed interventions of a fall mat and keeping the bed in a low position were initiated. c. Review of the care plan showed the use of the fall mat was not included. d. Interview with the DON on 10/16/18 at 5:56 PM confirmed the care plan had not been revised to include the use of the fall mat. 2. Review of the 8/17/18 quarterly MDS assessment showed resident #22 was admitted to the facility on 5/9/16; had a BIMS score of 0/15 (severe cognitive impairment); required the supervision of one staff member for transfers and ambulation; had diagnoses which included Alzheimer's disease; and wandered daily. The following concerns were identified: a. Observation during the survey timeframe showed the resident frequently wandered throughout the facility using a walker for ambulation. Observation on 10/17/18 at 2:15 PM showed a wanderguard was present on his/her left ankle. b. Review of a physician order dated 9/24/17 showed the wanderguard was to be checked	F 657	A care plan audit checklist has been developed and implemented and is reviewed with every resident□s care plan quarterly to ensure all assessments have been completed as well as all resident care areas have been addressed. Don or designee will train all current and future nurses on to alert MDS coordinator on new changes/or the need for changes to the care plan. Measurement of sustainable changes to prevent reoccurrence: The QA officers will audit care plans every Wednesday as well as quarterly with the care plan audit form to ensure all areas are addressed to encompass the resident□s needs. QA officer will audit care plans quarterly and report to quarterly QAPI meeting.	

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F 657	Continued From page 16 twice a day for "presence and operability." c. Review of the "Behavioral" care plan in regard to wandering showed it was last reviewed on 7/27/18; however it did not include the use of the wanderguard. d. Interview with the DON on 10/17/18 at 3:03 PM confirmed the wanderguard was not included in the care plan.	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident	F 660		12/2/18

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F 660	Continued From page 17	F 660		

representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the

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F 660	Continued From page 18 evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop and implement an effective discharge plan for 1 of 1 sample residents (#85) reviewed for discharge to the community. The findings were: Review of the medical record for resident #85 showed s/he was admitted to the facility on 6/13/18 for rehabilitation. The resident was discharged to the community on 7/14/18. Further review of the medical record showed no evidence an evaluation of the resident's needs or a discharge plan had been completed. During an interview on 10/18/18 at 12:05 PM the social worker and physical therapy assistant (PTA) described what had been done for the resident to prepare for discharge to the community and stated all of the information should have been scanned into the medical record. On 10/18/18 at 1:14 PM the PTA confirmed documentation of the discharge could not be found.	F 660	F660 Corrective action for resident number 85: A follow-up home assessment was completed 11/1/18 to address any further needs of the discharged resident. A progress note made in his electronic medical record to include the items and changes established at the first home assessment were still being utilized. Corrective action taken to prevent other residents from being affected: A home assessment checklist form has been developed and implemented for future discharging residents. The completed, signed, and dated form will be uploaded to the resident□s electronic medical record. A resident admission/discharge checklist-summary has been developed and implemented to address the resident□s discharge plans/expectations at the time of admission. This form will be uploaded to the resident□s electronic medical record. Measurement of sustainable changes to prevent reoccurrence: Social Services to follow up at discharge with the resident and complete the form. QA officers to audit residents discharging to ensure their discharge plan summary is	

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F 660	Continued From page 19	F 660	complete. QA officer will audit the process monthly for 12 months then periodically thereafter. Audit to be monitored and reported at the quarterly QAPI meeting.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 661	F661	12/2/18

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F 661	Continued From page 20 interview, the facility failed to complete a discharge summary which included a recapitulation of the resident's stay for 1 of 1 sample residents (#85) reviewed for discharge to the community. Review of the medical record for resident #85 showed s/he was admitted to the facility on 6/13/18 for rehabilitation. The resident was discharged to the community on 7/14/18. Further review showed no evidence a recapitulation of the resident's stay had been completed. During an interview on 10/18/18 at 12:05 PM the social worker revealed a recapitulation of stay was supposed to be completed and scanned into the medical record when a resident discharged; however, she was unable to locate the documentation.	F 661	Corrective action taken for resident number 85: A discharge recapitulation of stay cannot be run for this resident as he has been discharged to home. Corrective action taken to prevent other residents from being affected: Social Services will train current and future nursing staff on the correct process to complete all necessary discharge paperwork including the recapitulation of stay when a resident is to discharge from morning star. Upon future residents discharge, Social Services or designee will prompt nursing to complete the discharge summary with a recapitulation of stay. All nurses, DON, and QA officer will receive training on this process from social services. Measurements of sustainable changes to prevent reoccurrence: QA officer will audit to ensure the recapitulation of stay and discharge summary is completed for every resident discharging from the facility. QA officer will audit monthly for 12 months and periodically thereafter to ensure compliance. Will review at quarterly QAPI meeting.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		12/2/18

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F 689	Continued From page 21 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, medical record review, and staff interview, the facility failed to ensure the safety of residents for 2 of 2 sample residents (#9, #24) reviewed for safety during smoking. The findings were: 1. Review of the 9/13/18 quarterly MDS assessment showed resident #24 had a BIMS score of 13/15 (cognitively intact), and required limited assistance with locomotion using a wheelchair. Review of the resident's smoking care plan with a start date of 5/29/17 showed the resident was at risk for burns related to smoking and decreased fine motor skills. Interventions included: "[the resident] will wear a smoking apron while smoking whether it be out front and or in the smoke room." The following concerns were identified: a. Observation on 10/17/18 at 8:59 AM showed the resident was seated in his/her wheelchair in front of the facility smoking a cigarette. The resident was not wearing a protective apron and no staff were present. b. Review of the most recent "Smoking Safety Evaluation" completed showed it was dated 8/11/16 (over 2 years ago). c. Review of a "General Order" dated 5/29/17 showed "Note when resident is smoking in an unsafe manner without a smoking apron due to	F 689	F689 Corrective action taken for resident number 24: An updated smoking assessment has been completed 10/17/18. Smoking safety education has been shared with resident and the resident acknowledged the policy. The apron hook has been moved so she can reach the apron. Nursing will document in electronic medical record if unsafe smoking behavior occurs. Corrective action for resident number 9: Review of facility smoking policy completed with resident. An updated smoking assessment completed to support his comprehension of the policy. Corrective action taken to prevent other residents from being affected: Social Services will educate current and future residents on smoking safety. Don or designee will educate the current and future nurses on the smoking assessment and it□s timing to ensure that the	

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F 689	Continued From page 22 previous injury." Further review showed the behavior of smoking without a smoking apron was to be documented at the end of each shift. d. Review of the behavior tracking documentation from 10/4/18 through 10/16/18 showed 4 of 24 shifts were left blank. e. Interview with the DON on 10/17/18 at 3:15 PM revealed the resident carried his/her cigarettes and lighter with him/her at all times and went outside to smoke whenever s/he wanted to. In addition, the smoking apron was kept near the front door and the resident was supposed to grab it and take it outside; however, at times the resident would go outside just to sit and then decide to smoke without coming back in to retrieve the apron. 2. Review of the quarterly MDS assessment dated 7/27/18 showed resident #9 had a BIMS score of 2/15 (severe cognitive impairment) and diagnoses which included malignant neoplasm of prostate, hypertension, bilateral primary osteoarthritis of the knee, primary osteoarthritis, nocturia, and unspecified dementia without behavioral disturbance. Further review showed the resident was coded as having no restraints, daily use of alarms for the bed and chair, and wandering. The following concerns were identified: a. Review of the "Smoking risk" dated 10/17/18 at 12:21 PM showed the resident smoked cigarettes a couple times per day, general awareness and orientation was not a problem, and had minimal problems following the facility safe smoking policy. Further review showed the resident's smoking risk score was 6.0, and s/he was determined to be a "safe smoker." b. Interview with the DON on 10/17/18 at 2:58	F 689	residents are assessed on their smoking safety. Don or Designee will also educate the residents and nursing staff on the proper use of the smoking apron. IDT team will perform a care plan audit by utilizing the care plan audit checklist to ensure a current smoking assessment for safety is completed for all residents who smoke, as well as determine if an apron is indicated for safety. If the apron is indicated, it will be included on their care plan as well. All care plans are reviewed quarterly and as needed on Wednesdays at the IDT team meeting. A smoking safety policy will be reviewed with each resident who smokes. IDT team to complete the care plan audit checklist for all residents who smoke quarterly to ensure smoking assessment is up to date and appropriate. Measurements of sustainable changes to prevent reoccurrence: Nurse education provided for importance of documenting unsafe smoking behaviors. QA officer will audit nursing documentation for unsafe smoking behavior to ensure the smoking assessment is still accurate. IDT team will review the care plans quarterly and Wednesdays for issues that arise before the quarterly review. QA officer will audit quarterly for completion of smoking assessments. Audits reviewed quarterly at QAPI meeting.	

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F 689	Continued From page 23 PM revealed no assessment of the resident's ability to smoke safely was completed prior to 10/17/18. 3. Review of the "Resident Smoking Policy" showed "Residents who choose to smoke shall be evaluated by staff to determine their avidity to smoke safely...Staff shall re-evaluate residents on a periodic basis, or whenever changes in physical and/or mental status may indicate a need for reassessment."	F 689		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		12/2/18

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F 758	Continued From page 24 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were free from unnecessary psychotropic medications for 3 of 5 sample residents (#10, #26, #30) reviewed for medications. The findings were: 1. Review of the 7/26/18 annual MDS assessment showed resident #10 had diagnoses which included depression and dementia with behavioral disturbances. Further review showed the resident had a BIMS score of 3/15 (severe cognitive impairment) and had shown an improvement in behaviors from the prior assessment. Review of current physician's orders	F 758	758: Corrective actions for resident # 10 a)A request was sent to physician to update the PRN order for lorazepam to include a stop date. b)A request was sent to physician 1 to update the PRN order for IM lorazepam to include a stop date. c)GDR will be re-sent to MD for sertraline with a start date 9/16/17 on 11-9-18 by the High risk medication compliance coordinator. d)GDR will be re-sent to MD for quetiapine with a start date 6/19/17 on	

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F 758	Continued From page 25 showed the resident was prescribed lorazepam 0.5 mg orally with special instructions of "every 4-6 hours PRN (as needed) agitation. Use this second to trazodone" for a diagnosis of dementia with behavioral disturbance; lorazepam 2 mg/ml, 1 mg injection PRN for agitation every 6 hours for a diagnosis of dementia with behavioral disturbance; trazodone (sedative and antidepressant) 12.5 mg four times daily for a diagnosis of dementia with behavioral disturbance; sertraline 75 mg daily for a diagnosis of anxiety disorder; and quetiapine (antipsychotic) 25 mg four times daily for a diagnosis of restlessness and agitation. The following concerns were identified: a. Review of the order for the oral lorazepam showed a start date of 7/2/18 with no evidence a stop date was indicated. This medication was ordered by physician assistant #1. b. Review of the order for the IM (intramuscular) lorazepam showed a start date of 9/7/18 with no evidence a stop date was indicated. This medication was ordered by physician #1. c. Review of the order for sertraline showed a start date of 9/6/17 and a corresponding diagnosis of "generalized anxiety disorder." Further review showed no evidence a gradual dose reduction (GDR) had been attempted or the resident's physician provided justification for continued use in the last 12 months. This medication was ordered by physician #1. d. Review of the order for quetiapine showed a start date of 6/19/17 and a corresponding diagnosis of "restlessness and agitation." Further review showed no evidence a gradual dose reduction (GDR) had been attempted or the resident's physician provided justification for continued use in the last 12 months. This	F 758	11-9-18 by the High risk medication compliance coordinator. Corrective actions for resident # 26 a)An request was sent on 10/18/18 to physician for a stop date 14 days after start date for lorazepam b)GDR will be sent to MD for olanzapine with a start date of 12/16/16 on 11-9-18 c)GDR well be sent to MD for sertraline with a start date of 03/28/13 on 11-9-18 Corrective actions for resident #30 a)GDR will be sent to MD for aripiprzole with a start date of 9/13/17 on 11-9-18 by the High risk medication compliance coordinator. Corrective actions take to prevent other resident from being affected: 1)Update MSCC Policies and Procedures so that all PRN psychotropic medications will automatically have: 14 day limit and D/C date entered into EMAR when new order is entered into EMAR. Or If Provider documents clear clinical rational and documents a duration of PRN order. The new PRN Psychotropic medication will have a DC date that corresponds to the documented duration.	

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F 758	Continued From page 26 medication was ordered by physician assistant #1. e. Review of the order for trazodone showed a start date of 7/11/18 and a corresponding diagnosis of dementia with behavioral disturbance. This medication was ordered by physician assistant #1. f. Review of the "Psychotropic Medication Management Tool" showed it was sent to physician #2 on 8/22/18 with no response received. g. Interview with RN #1 on 10/17/18 at 4 PM revealed he had been in contact with the physicians to obtain the correct diagnoses to correspond to the medication prescribed. In addition he had difficulty with a few physicians not responding to requests for GDRs. 2. Review of the 9/13/18 quarterly MDS assessment showed resident #26 had diagnoses which included major depressive disorder, adjustment disorder with disturbance of conduct, and seizure disorder. Further review showed staff assessed the resident as being severely cognitively impaired, and the resident did not exhibit any behaviors during the 7-day look-back period. Review of current physician orders showed the resident was prescribed lorazepam (anti-anxiety) 0.5-2 mg by mouth/sublingual/rectal every hour as needed for anxiety or shortness of breath due to seizure disorder; olanzapine (antipsychotic) 5 mg daily for adjustment disorder with disturbance of conduct; and sertraline (antidepressant) 50 mg daily for major depressive disorder. The following concerns were identified: a. Review of the order for lorazepam showed the start date was 3/30/18 with no evidence a stop date was indicated. Review of the "Psychotropic Medication Management Tool"	F 758	2)Don or Designee will conduct training for clinical staff and pharmacists that all PRN psychotropic medication must either have a 14 day DC date at the time of entry into EMAR or a DC date that corresponds with documented duration from a qualified extended order. 3)Update MSCC Policies and Procedures so that: A) All residents with psychotropic medications will have a GDR attempted: 1)2 times, separated by at least a month, within the first two quarters of admission or start of a new Psychotropic medication 2)Annually after first year of admission or after the first year of starting a new psychotropic medication. B) After admission or after the start of a new psychotropic medication, residents will have non-pharmacological interventions identified during growth planning meeting. Non-pharmacological interventions identified will be entered into the patient EMAR by MSCC high risk medication compliance coordinator or other qualified clinical personal. C) All residents with psychotropic medication will have, Psychotropic Medication Management Tool completed during growth planning meeting D) Psychotropic Medication Management Tool will be sent to prescribing provider	

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F 758	Continued From page 27 submitted to the physician on 10/18/18 revealed the resident had not received the lorazepam since 4/2/18. b. Review of the order for olanzapine showed the start date was 12/16/16. Further review showed no evidence a GDR had been attempted or the resident's physician provided justification for continued use in the last 12 months. c. Review of the order for sertraline showed the start date was 3/28/13. Further review showed no evidence a GDR had been attempted or the resident's physician provided justification for continued use in the last 12 months. d. Interview on 10/18/18 at 11:45 AM with the unit clerk confirmed a GDR had not been attempted in the last 12 months for the identified medications. 3. Review of the 9/4/18 quarterly MDS assessment showed resident #30 had a BIMs score of 6/15 (severe cognitive impairment); had a mood score of 0/27 (no symptoms of depression); and exhibited no behaviors in the 7-day look-back period. Further review of the medical record showed the resident had a diagnosis of "other depressive episodes." Review of current physician orders showed the resident was prescribed aripiprazole (anti-psychotic) 2 mg daily at bedtime. The following concerns were identified: a. Review of the order for aripiprazole showed the start date was 9/13/17. b. Interview with RN #1 on 10/17/18 at 4 PM confirmed the risk-benefit statement received on 10/17/18 was the first one received since the start of the medication on 9/13/17. Interview with the quality assurance coordinator on 10/18/18 at 9:39 AM confirmed a GDR had not been attempted in the last 12 months.	F 758	during 60 day appointment. Transport personnel will be trained that the do not leave the prescribers office without prescriber completing and signing Psychotropic Medication Management tool. E) Care plan will be updated during growth planning to reflect use of psychotropic medications. Measurement of sustainable changes to prevent reoccurrence: MSCC High Risk Medication Compliance Coordinator will conduct weekly audits to identify patients that are prescribed psychotropic medications. Once identified patients will be entered into a scheduling algorithm by unit clerk. Audits will be reported and reviewed at quarterly QAPI meeting.	

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F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of Federal and State regulations, the facility failed to ensure medications available for use were not expired in 1 of 3 medication storage areas (east medication cart). The findings were: 1. Observation of the east medication cart on 10/17/18 at 9:47 AM showed resident #14 had a bottle of trazodone (sedative and antidepressant) 50 mg tablets and a bottle of chlorpromazine HCL	F 761	761: Corrective action for resident #14 a request was made to Arapaho clinic for a new medication bottle with an expiration to be included on it. Corrective action to prevent this from happening to other residents: All new medication will be audited as it is received to verify it to be in compliance to	12/2/18

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F 761	Continued From page 29 (antipsychotic) 25 mg which did not have an expiration date. 2. Interview with RN #1 on 10/17/18 at 9:47 AM confirmed the medications were for resident use and there were no expiration dates on the bottle. In addition the nurse confirmed the medications provided were by a federal entity. 3. Interview with the DON on 10/17/18 at 11:30 AM confirmed the medications were from a federal entity and did not have an expiration dates. 4. Review of Indian Health Services, Indian Health Manual Rules and Regulations for Program Operation (Labeling, Chapter 7, part 3(d) (ii) showed: "All containers must be properly labeled and must conform with Federal rules and regulations and to State laws, where applicable..." 5. Review of State of Wyoming Pharmacy Act Rules and Regulations (Pharmacy Responsibilities, Chapter 15, Section 6 (a), showed: "Dispensing drugs pursuant to a medication order for an individual resident, properly labeled for that resident, as addressed in Chapter 2 of these rules, including the manufacturer's expiration date. If prepackaged or repackaged by the pharmacy, the expiration date shall be the lesser of the manufacture's expiration date or twelve (12) months from the date of prepackaging or repackaging."	F 761	pharmacology regulations via the New Medication Intake Form completed by the nurse receiving the medication on a daily basis. Monitoring for sustainability: The quality assurance officer will perform a monthly audit on the New Medication Intake forms to confirm that they are being completed. Audit will be reported and reviewed at quarterly QAPI meeting.	