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 _____	10/03/2019

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 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 9/30/19 through 10/3/19. The following common abbreviations are used throughout this document. ADON: Assistant Director of Nursing CMS: Centers for Medicare and Medicaid Services DON: Director of Nursing MDS: Minimum Data Set mg: milligrams PTA: Physical Therapist Assistant RAI: Resident Assessment Instrument Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this	F 582		11/8/19

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

Electronically Signed | 10/24/2019

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F 582	Continued From page 1 section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the	F 582	1. Corrective Action: A policy/procedure has been implemented which assigns	

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F 582	Continued From page 2 appropriate Notice of Medicare Provider Non-Coverage (NOMNC) form was issued correctly for 1 of 3 sample residents (#132). The findings were: Review of a "Skilled Nursing Facility Beneficiary Protection Notification Review" form completed by the facility showed resident #132 had a Medicare Part A stay that used fewer than the maximum 100 days covered by Medicare Part A. Further review showed the NOMNC (Notice of Medicare Non-Coverage) was not issued due to the resident initiating discharge. The following concerns were identified: a. Review of an occupational therapy note dated 9/5/19 showed the resident had met therapy goals and was safe to return home upon discharge from the facility. b. Review of a physical therapy note dated 9/6/19 showed the resident met with physical therapy and social services to plan for a discharge on 9/11/19. c. Review of the medical record showed a discharge order request was sent to the physician on 9/6/19. The request was signed by the physician on 9/9/19. Interview on 10/2/19 at 9:40 AM with the DON, social worker, PTA, and a business office representative revealed the facility was unaware of the NOMNC form or its purpose. The PTA confirmed the home safety assessment had been completed and the discharge was planned.	F 582	Social Services to present a NOMNOC/ ABN to Elder at least 72 hours prior to last covered day. 2. Identification of Others: All current and new Medicare residents will be placed on the Medicare Audit for NOMNOC/ABN and will be monitored daily during Alert Charting Meeting. The audit includes days used, days remaining, last covered day, and which form is indicated. 3. System Measures: Corrective action taken to prevent other residents from being affected includes: education to Social Services, Administrator, ADON, DON, QA, and RN staff. All current and new Medicare residents will be placed on the Medicare Audit for NOMNOC/ABN and will be monitored daily during Alert Charting Meeting. 4. Monitoring: All new Medicare residents will be placed on the Medicare Audit for NOMNOC/ABN and will be monitored daily during Alert Charting Meeting. Will be monitor daily for length of utilization of Medicare benefits. 5. Quality Assurance: Measurements of sustainable changes to prevent reoccurrence: weekly audit will take place during clinical meeting on all Medicare Part A stays to determine plan of discharge and/ or remaining days. Weekly audit has been implemented and	

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F 582	Continued From page 3	F 582	will be conducted by DON. A monthly audit will be conducted by QA for twelve months to ensure sustainability. All findings will be reported to quarterly QAPI meeting.	
F 641 SS=D	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, review of the CMS RAI version 3.0 manual, and staff interview, the facility failed to ensure assessments were accurate for 2 of 16 sample residents (#13, #19). The findings were: 1. Review of the 2/11/19 annual MDS assessment, the 5/12/19 quarterly MDS assessment, and the 8/5/19 quarterly MDS assessment for resident #13 showed the resident was coded as having received the influenza vaccine on 10/4/18. The following concerns were identified: a. Review of an "Exemption of Refusal of Flu Vaccination Form" showed the resident had refused the vaccination on 10/4/18. b. Interview on 10/3/19 at 11:26 AM with the DON/MDS coordinator confirmed the MDS assessment was not accurate. 2. Review of the 2/4/19 annual MDS assessment, the 5/16/19 quarterly MDS assessment, and the 7/29/19 quarterly MDS assessment for resident #19 showed the resident received an antidepressant 7 days of the 7-day look-back	F 641	1. Corrective action for residents #13 and #19 MDS errors have been corrected individually to reflect their accurate influenza and #19 to reflect corrected current diagnosis. Corrective action a. All new and current residents vaccination records will be reviewed to ensure influenza vaccination administration date is noted and input into the residents MDS. b. All new and current residents diagnosis will be reviewed to ensure correct diagnosis is input into the MDS. 2. Identification of others a. All new and current influenza vaccination administration dates will be monitored quarterly by the IDT team during alert charting meeting as well as during monthly ADON MDS audit. Vaccinations will be appropriately input into Preventive Health. b. All new and current resident diagnosis codes will be reviewed and monitored by the IDT team during daily alert charting	11/8/19

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F 641	Continued From page 4 period; however, review of section I showed the resident did not have an active diagnosis of depression. The following concerns were identified: a. Review of the most current physician orders showed the resident was prescribed sertraline (antidepressant) 50 mg daily with a start date of 7/13/18. b. Review of the resident's face sheet showed it was updated to include the diagnosis of major depressive disorder, recurrent, moderate (F33.1) on 1/4/19. c. Interview on 10/3/19 at 9:37 AM with the DON/MDS coordinator confirmed the MDS assessment was not accurate. 3. Review of the "CMS RAI version 3.0 manual, October 2017" showed under section I "...Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period..."	F 641	meeting as well as during the monthly ADON MDS audit. Corrective action taken to prevent other residents from being affected: ADON will audit MDS prior to submission for Influenza and diagnosis accuracy for monthly x three months. 3. System measures DON educated nursing staff on manual data input of influenza vaccine date into Matrix from 10/7/2019-10/14/2019. DON educated nursing staff that any changes to diagnosis codes needs to be monitored by Director of Nursing to ensure accuracy of MDS diagnosis codes. 4. Monitoring Maintain sustainability: ADON will audit MDS prior to submission for Influenza and diagnosis accuracy monthly for a period of 3 month and periodically thereafter to ensure continued compliance with Quarterly/Annual Review Audit Tool. 5. All resident vaccination record and diagnosis code audits will be reported to quarterly QAPI meeting.	
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 §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	F 656		11/8/19

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F 656	Continued From page 5 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 comprehensive person-centered care plan for 1 of 16 sample residents (#19). The findings were: 1. Review of the 2/4/19 annual MDS assessment showed resident #19 was admitted to the facility	F 656	Corrective action for resident #19 A. Resident care plan has been updated to reflect the residents mental health needs. Behavior monitor has since been implemented once a shift that includes to assess for the following behaviors: alternating appearance, self-isolation,	

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F 656	Continued From page 6 on 2/8/18. Review of the most current physician orders showed the resident was prescribed sertraline (antidepressant) 50 mg daily for major depressive disorder with a start date of 7/13/18. In addition, an order dated 5/23/18 showed the facility was to "Watch [the resident's] mood closely if [s/he] seem (sic) to be getting depressed or if [s/he] mentioned other things [the resident] needs to see [name of psychiatrist]. Review of the "Psychotropic Medication Management Tool" dated and signed by the physician on 1/24/19 showed a gradual dose reduction was not clinically indicated due to the resident having major depression with occasional suicidal ideation. Review of a social service note dated 10/2018 showed "over the last few months" the resident had shown a significant change with behaviors which included: withdrawal from interaction with staff and the community; sexual behaviors; suicidal ideations; and urinating in his/her drinking glasses. Further review of the medical record showed the resident was seen by a mental health consultant on 6/13/19 and at that time agreed to be seen regularly. The following concerns were identified: a. Review of the entire care plan showed no individualized plan had been developed to address the resident's mental health needs. b. Interview on 10/3/19 at 9:35 AM with the DON and the social worker confirmed the care plan had not been developed because depression had not been identified on the comprehensive MDS assessment.	F 656	suicidal ideation, and fixates on new signs and symptoms of illness. B. DON educated nursing staff that any changes to diagnosis codes needs to be monitored by director of nursing to ensure accuracy of MDS diagnosis codes. Corrective action 1. All new and current resident mental health needs will be identified by implementation of the BIMS, MOOD, and Spiritual care Assessments upon admission, and quarterly, with the exception of the Spiritual Care assessment, which is completed upon admission and annually. 2. All new and current resident mental health assessments will be input into the MDS upon completion. 3. Behavior monitoring sheets have been implemented upon identifying negative behaviors and reviewed daily during alert charting meeting. 4. All care plans are reviewed upon admission and quarterly to reflect resident mental health needs as well as spiritual care. Any behavioral support is outlined in each residents care plan to reflect their individual needs. Identification of others Correction action taken to prevent other residents from being affected: The clinical care team (DON, ADON, Infection Preventionist, QA, and Social Services will audit Quarterly and Annual Reviews to ensure accuracy of care plan during MDS Audit Meeting Monday, Wednesday, Thursday, and Fridays. Education provide to nursing staff on behavior monitoring sheets between the dates of	

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F 656	Continued From page 7	F 656	10/7/2019-10/14/2019. All residents have been reviewed to ensure no mental health diagnosis has been missed. System Measures Measurement of sustainable changes to prevent reoccurrence: The clinical care team will review care plans quarterly with the Quarterly/Annual Review audit to ensure all areas are addressed to encompass the resident's needs. ADON will audit MDS prior to submission for diagnosis accuracy monthly for a period of 3 months and periodically thereafter to ensure continued compliance with Quarterly/Annual Review Audit Tool. QA All monthly Quarterly / Annual Review Audits, as well as behavior monitoring will be reported to QAPI on a quarterly basis.	
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 700		11/8/19

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F 700	Continued From page 8 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure safety assessments were performed for 7 of 9 sample residents (#2, #3, #7, #12, #14, #21, #131) with positioning devices. The findings were: 1. Observation on 10/1/19 at 1:16 PM showed resident #2 had assist rails on the right side of the upper half of his/her bed. The assist bars were designed with an upper section which had openings measuring 3.75 inches by 4 inches and 3.25 inches by 4.25 inches and separated by a 0.25-inch metal bar. The lower section had spaces measuring 2 inches by 6 inches and were separated by a 0.25-inch metal bar. On the right side of the bed was a "transfer bar" of 1.25-inch diameter tubing with hand holds incorporated into the tubing structure. The bar extended from ceiling to floor and was immobile. The bar-to-bed placement had an 8-inch gap between the bed and the rail creating an entrapment risk. Review of the medical record showed no evidence the facility had completed a safety assessment which included the risk for entrapment. 2. Observation on 10/1/19 at 12:59 PM showed resident #3 had assist rails on both sides of the upper half of his/her bed and the right side of the bed was against the wall. The assist bars were designed with an upper section which had 2 holes that measured 3.75 inches by 4 inches and 3.25	F 700	1. Corrective action for resident # 2 includes a safety assessment completed on 10/07/2019 to reflect risk of entrapment. Consent for the use of a transfer pole was completed on 10/04/2019. 2. Corrective action for resident # 3 includes a safety assessment completed on 10/07/2019 to reflect risk of entrapment. Consent for the use of a buddy bar was completed on 10/04/2019. 3. Corrective action for resident # 7 includes a safety assessment completed on 10/07/2019 to reflect risk of entrapment. Consent for the use of a buddy bar was completed on 10/03/2019. 4. Corrective action for resident # 12 includes a safety assessment completed on 10/07/2019 to reflect risk of entrapment. Consent for the use of a buddy bar was completed on 10/07/2019. 5. Corrective action for resident # 14 includes a safety assessment completed on 10/07/2019 to reflect risk of entrapment. Consent for the use of a transfer pole and buddy bar was completed on 10/07/2019. 6. Corrective action for resident # 21 includes a safety assessment completed on 10/07/2019 to reflect risk of entrapment. Consent for the use of a	

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F 700	Continued From page 9 inches by 4.25 inches and were separated by a 0.25-inch metal bar. The lower section had 2 holes that measured 2 inches by 6 inches and were separated by a 0.25-inch metal bar. Review of the medical record showed no evidence the facility had completed a safety assessment which included the risk for entrapment. 3. Observation on 10/1/19 at 9:05 AM showed resident #7's bed was placed against the wall on the right side of the bed and had an assist rail on the left side of the upper half of the bed. The assist bars were designed with an upper section which had openings measuring 3.75 inches by 4 inches and 3.25 inches by 4.25 inches separated by a 0.25-inch metal bar. The lower section had spaces measuring 2 inches by 6 inches and were separated by a 0.25-inch metal bar. Review of the medical record showed no evidence the facility had completed a safety assessment which included the risk for entrapment. 4. Observation on 10/1/19 at 1:03 PM showed resident #12 had an assist rail on the upper right hand side of his/her bed. The bed was not pushed up against the wall. The assist bar was designed with an upper section which had 2 holes that measured 3.75 inches by 4 inches and 3.25 inches by 4.25 inches and was separated by a 0.25-inch metal bar. The lower section had 2 holes that measured 2 inches by 6 inches and were separated by a 0.25-inch metal bar. Review of the medical record showed no evidence the facility had completed a safety assessment which included the risk for entrapment. 5. Observation on 10/1/19 at 9:30 AM showed resident #14's bed was not against the wall. On the right side of the bed was a "transfer bar" of	F 700	transfer pole was completed on 10/07/2019. 7. Corrective action for resident # 131 includes a safety assessment completed on 10/07/2019 to reflect risk of entrapment. Consent for the use of a buddy bar was completed on 10/04/2019. Corrective action taken to prevent other residents from being affected: All residents in the building that have a transfer pole, bed buddy bar, and/or bed rails had a safety assessment completed on 10/07/2019, and will be reviewed on each individual MDS schedule with the Quarter/Annual Review Audit Tool. New admissions will be assessed for risk of entrapment if a transfer device is used. Education was provided to Registered Nurses between the dates of 10/7/2019-10/14/2019 regarding transfer pole length, and risk for entrapment with transferring devices. On 10/07/2019 Maintenance removed all transfer devices on unoccupied beds in the facility. A monthly audit will be completed by the maintenance department to ensure proper maintenance of transfer devices in the facility. Any concerns will be addressed at the monthly safety meeting. Measurement of sustainable changes to prevent reoccurrence: The clinical care team (Director of Nursing, Assistance Director of Nursing, Infection Preventionist, Quality Assurance, and Social Services) will review safety risk assessments quarterly with the Quarter/Annual Review Audit Tool to ensure all areas are addressed, to encompass the resident's individual	

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F 700	Continued From page 10 1.25-inch diameter tubing with hand holds incorporated into the tubing structure. The bar extended from ceiling to floor and was immobile. The bar-to-bed placement had a 4-inch gap between the bed and the rail creating an entrapment risk. Review of the medical record showed no evidence the facility had completed a safety assessment which included the risk for entrapment. 6. Observation on 10/1/19 at 1:28 PM showed resident #21's bed was placed against the wall on the left side of the bed. The resident had an assist rail on the right side of the upper half of the bed. The assist bars were designed with an upper section which had openings measuring 3.75 inches by 4 inches and 3.25 inches by 4.25 inches separated by a 0.25-inch metal bar. The lower section had spaces measuring 2 inches by 6 inches and were separated by a 0.25-inch metal bar. On the right side of the bed was a "transfer bar" of 1.25-inch diameter tubing with hand holds incorporated into the tubing structure. The bar extended from ceiling to floor and was immobile. The bar-to-bed placement had a 6-inch gap between the bed and the rail creating an entrapment risk. Review of the medical record showed no evidence the facility had completed a safety assessment which included the risk for entrapment. 7. Observation on 10/1/19 at 1:05 PM showed resident #131 had an assist bar located on the upper right hand side of his/her bed. The right hand side of the bed was against the wall. The assist bar was designed with an upper section which had 2 holes that measured 3.75 inches by 4 inches and 3.25 inches by 4.25 inches and was separated by a 0.25-inch metal bar. The lower	F 700	needs. Quality Assurance will audit the completion of Quarter/Annual Review Audit Tool monthly to ensure sustainability for twelve months.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 700	Continued From page 11 section had 2 holes that measured 2 inches by 6 inches and were separated by a 0.25-inch metal bar. Review of the medical record showed no evidence the facility had completed a safety assessment which included the risk for entrapment. 8. Interview with the quality assurance coordinator/PTA on 10/2/19 at 9:10 AM revealed the assist bars and transfer poles were used for transfer assistance and not for restraints. She was unaware the devices should be evaluated for safety. 9. Interview with the DON and the ADON on 10/2/19 at 2:50 PM revealed they were unaware the bed and the transfer pole could be moved to varying distances from each other. In addition the transfer poles were only used to assist the resident in getting out of bed, and the facility had not considered the gap between the bed and the transfer pole might become a place of entrapment.	F 700		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		11/8/19

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F 757	Continued From page 12 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 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 medications for 2 of 7 (#15, #21) sample residents reviewed for medications. The findings were: 1. Review of the most recent physician orders for resident #15 showed the resident was prescribed trimethoprim (antibiotic) 100 mg daily on 2/11/19 with no end date. Review of the care plan, last revised 8/14/19, showed the resident was on "Long term antibiotic use due to indwelling catheter." Further review of the medical record showed no evidence the resident's physician had provided justification for the indefinite use of the antibiotic. 2. Review of the most recent physician orders for resident #21 showed the resident was prescribed nitrofurantoin (antibiotic) 50 mg daily on 4/2/19 with no end date for an indwelling catheter. Further review of the medical record showed no evidence the resident's physician had provided justification for the indefinite use of the antibiotic. 3. Interview with the infection preventionist on 10/3/19 at 10:40 AM confirmed resident #15 and	F 757	1. Corrective action a. Corrective action for resident #5 includes a letter written to MD on 10/18/2019 requesting lorazepam 1 mg po bid prn be discontinued. b. Corrective action for resident #5 includes a letter written to MD on 10/18/2019 requesting mirtazapine (antidepressant) 30mg daily be decreased with a gradual dose reduction or risk/benefit statement. c. Corrective action for resident #5 includes behavior monitoring flowsheets that include behaviors: verbal aggression, refusals, isolation have been developed and were implemented on 10/9/2019 with intervention codes on flow sheets. 2. Identification of others a. All ordered psychotropic medication including PRN psychotropic medications will be reviewed daily for current and new residents during the alert charting meeting, as well as, during the weekly GDR meetings held Wednesdays. Nursing staff have been educated to copy any new psychotropic medication orders and submit them to the Assistant Director	

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F 757	Continued From page 13 #21 were on an antibiotic without a stop date. She further confirmed the facility failed to ensure the physician documented a risk-benefit statement.	F 757	of Nursing. b. Corrective action to prevent this from happening to other residents includes behavior monitor flow sheets implemented on 10/9/2019 for all elders with psychotropic medication orders. Behavior monitoring flow sheets are monitored daily during alert charting meeting. For any new psychotropic medication a behavior monitoring flow sheet will be implement as well as an audit to include a clinical psychotropic rational from the physician 3. System Measures Education provided to nursing staff regarding psychotropic rational, 14 day PRN psychotropic medication stop dates, and behavior monitoring flow sheets between the dates of 10/7/2019-10/14/2019.Unit Coordinator was educated on 10/9/2019 regarding 14 day face to face follow up appointments. ADON will monitor timeliness of GDR during weekly GDR meeting and monthly pharmacist review. IDT Team will monitor new psychotropic medications during daily alert charting meeting. 4. Monitoring Measurement of sustainable changes to prevent reoccurrence: The clinical IDT team (DON, ADON, Infection Preventionist, Social Services, and QA) will monitor completion of psychotropic medication use, behavior flowsheets, rational of use, and accuracy of nursing communication in regards to new psychotropic medication orders, from nursing staff and any adverse behaviors during Alert Meeting that is scheduled Monday through Friday. ADON will	

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F 757	Continued From page 14	F 757	monitor timeliness of GDR during weekly GDR meeting and monthly pharmacist review. 5. All audits will be presented to quarterly QAPI meetings for two quarters.	
F 758 SS=D	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 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	F 758		11/8/19

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F 758	Continued From page 15 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 medications for 1 of 5 residents (#5) reviewed for psychoactive medications. The findings were: Review of the 7/2/19 significant change assessment showed resident #5 was admitted to the facility on 3/7/18 and had diagnoses which included cancer, diabetes mellitus, and depression. Further review showed the resident received an antianxiety medication 4 days of the 7-day look-back period and an antidepressant 5 days of the 7-day look-back period. Review of the care plan showed the facility was to "observe for signs and symptoms of depression (tearfulness, hopelessness, loss of appetite, etc.)" The following concerns were identified: a. Review of the current physician orders showed the resident was prescribed lorazepam (anti-anxiety) 1 mg twice daily as needed for	F 758	1. Corrective action a. Corrective action for resident #5 includes a letter written to MD on 10/18/2019 requesting lorazepam 1 mg po bid prn be discontinued. b. Corrective action for resident #5 includes a letter written to MD on 10/18/2019 requesting mirtazapine (antidepressant) 30mg daily be decreased with a gradual dose reduction or risk/benefit statement. c. Corrective action for resident #5 includes behavior monitoring flowsheets that include behaviors: verbal aggression, refusals, isolation have been developed and were implemented on 10/9/2019 with intervention codes on flow sheets. 2. Identification of others a. All ordered psychotropic medication including PRN psychotropic medications will be reviewed daily for current and new	

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F 758	Continued From page 16 anxiety on 3/27/19. Further review of the orders showed a stop date had not been included in the order or a rationale for extending the use beyond 14 days. Review of the August and September 2019 MAR (medication administration record) showed the resident received the medication 3 times in August and zero times in September. b. Review of the current physician orders showed the resident was prescribed mirtazapine (antidepressant) 30 mg daily for depression on 3/7/18. Review of the "Psychotropic Medication Management Tool" showed it was submitted to the physician on 12/8/18 with a request for either an order for a gradual dose reduction or a risk/benefit statement. The undated response from the physician showed both options were unchecked and a statement of "currently on 2 sleep meds". c. Review of the medical record showed no evidence a behavior monitoring flowsheet had been developed to include specific target behaviors, triggers, or interventions. Interview on 10/2/19 at 3:51 PM with the ADON revealed the facility was in the process of changing the system for monitoring psychoactive medications. A new pharmacist had been hired to assist with gradual dose reductions and medication monitoring; and behavior monitoring flowsheets were in the process of being created. In addition, the ADON confirmed the resident had a PRN medication without a stop date and acknowledged the need for a clinical rationale from the physician for the continued use of the medication. Further, she stated she was unable to comment on the gradual dose reduction form received from the physician for the resident because she had only been at the facility for two months; however she recognized the form was	F 758	residents during the alert charting meeting, as well as, during the weekly GDR meetings held Wednesdays. Nursing staff have been educated to copy any new psychotropic medication orders and submit them to the Assistant Director of Nursing. b. Corrective action to prevent this from happening to other residents includes behavior monitor flow sheets implemented on 10/9/2019 for all elders with psychotropic medication orders. Behavior monitoring flow sheets are monitored daily during alert charting meeting. For any new psychotropic medication a behavior monitoring flow sheet will be implement as well as an audit to include a clinical psychotropic rational from the physician 3. System Measures Education provided to nursing staff regarding psychotropic rational, 14 day PRN psychotropic medication stop dates, and behavior monitoring flow sheets between the dates of 10/7/2019-10/14/2019.Unit Coordinator was educated on 10/9/2019 regarding 14 day face to face follow up appointments. ADON will monitor timeliness of GDR during weekly GDR meeting and monthly pharmacist review. IDT Team will monitor new psychotropic medications during daily alert charting meeting. 4. Monitoring Measurement of sustainable changes to prevent reoccurrence: The clinical IDT team (DON, ADON, Infection Preventionist, Social Services, and QA) will monitor completion of psychotropic medication use, behavior flowsheets,	

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F 758	Continued From page 17 incomplete.	F 758	rational of use, and accuracy of nursing communication in regards to new psychotropic medication orders, from nursing staff and any adverse behaviors during Alert Meeting that is scheduled Monday through Friday. ADON will monitor timeliness of GDR during weekly GDR meeting and monthly pharmacist review. 5. All audits will be presented to quarterly QAPI meetings for two quarters.	
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	F 761		11/8/19

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F 761	Continued From page 18 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications were not expired in 1 of 1 medication storage area. The findings were: Observation on 10/2/19 at 9:16 AM showed an open bottle of pharmaceutical mineral oil which was stocked on 6/21/17 and had a manufacturer's expiration date of 6/2018. Interview with the ADON on 10/2/19 at 2:30 PM revealed it was the facility's expectation medications stored and used in the facility would not be expired.	F 761	Corrective action included immediately removing out dated mineral oil. 1. Corrective Action a. An outdated medication audit tool was established and implemented to ensure no outdated medications are present on East or West medication cart. b. An outdated medication audit tool was established and implemented to ensure no outdated medications are present in the medication room. 2. Identification of others a. Any resident could potentially be harmed if outdated medications were dispersed. b. Corrective action to prevent this from happening in the future includes: a weekly audit during night shift by night registered nurse. Both medication carts will be audited Tuesday night and the med room will be audited Thursday night. Nursing staff were educated on removing expired medication from 10/7/2019-10/14/2019. 3. System Measures Measurement of sustainable changes to prevent reoccurrence includes: a weekly audit during night shift by night registered nurse. Both medication carts will be audited Tuesday night and the med room will be audited Thursday night. 4. Frequency Audit for medication room as well as the medication carts will be performed once a week for a period of 6 months. 5. All audits will be reported to QAPI quarterly	

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of food temperature logs, and review of the U.S. Public Health Service Food Code, the facility failed to ensure temperatures of mechanically-altered food were taken prior to food service. There were four residents who received mechanically-altered diets. Further, the facility failed to ensure food was properly stored in 1 of 1 kitchen. The findings were: Related to food temperatures: 1. Observation on 10/2/19 at 10:43 AM showed dietary aide #1 prepared pureed turkey with gravy for residents that required a mechanically-altered diet. The dietary aide failed to take the temperature of the food upon placing it on the	F 812	Corrective action for food temperatures include: A policy/procedure has been implemented. All food will be monitored for appropriate temperature prior to serving. Corrective action taken for single use articles included: All single use containers will be discarded from dietary after single use is completed. Corrective Action / single use containers 1. Dietary department will ensure proper quantity of non-single use containers are present in the kitchen. 2. A weekly audit log for single-use container use has been created, implemented and will be monitored by the	11/8/19

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F 812	Continued From page 20 steam table prior to service. Interview with the dietary aide at 11 AM revealed he "usually" took the temperature of the food, however he had forgotten. 2. Observation on 10/2/19 at 11 AM showed dietary aide #2 prepared pureed green beans for residents that required a mechanically-altered diet. The dietary aide failed to take the temperature of the food upon placing it on the steam table prior to service. Interview with dietary aide at that time revealed she usually took the temperature of the pureed food, however she was "busy" and did not do it. In addition, she stated the facility had recently changed the food temperature log sheets and the new forms did not have a place to log the temperature of the mechanically-altered food. 3. Review of the September 2019 food temperature log sheets showed no evidence the temperature of mechanically-altered foods had been taken prior to service on any of the 30 days reviewed. 4. Interview with the Certified Dietary Manager (CDM) on 10/3/19 at 8:28 AM revealed she had changed the temperature log sheets to make them easier to use; however she had forgotten to include a section for the mechanically-altered foods. 5. According to Food Code 2017, U.S. Public Health Service: 3-501.16 "(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY	F 812	dietary manager or designee. Any single-use container will be discarded after its original contents are finished. Corrective Action / Temping Modified Prepared Foods 1. Dietary staff will ensure food temps are taken during meals on modified prepared foods. 2. Dietary staff will ensure food temp logs are filled out daily. 3. Dietary manager developed and implemented a weekly audit log for all modified prepared foods to ensure all foods are being temped daily. Identification of Others Corrective action to prevent this from happening in the future includes: Education was provided between the dates of 10/04/2019-10/24/2019 to Dietary staff in regards to temperature log that now includes mechanically altered foods. Education was provided between the dates of 10/04/2019-10/24/2019 that all food transferred from its original container needs to be stored in a non-single use container. System measurement Measurements for sustainable changes to prevent reoccurrence includes: A weekly audit will take place by the Dietary Manager and/or the Assistant Dietary Manager. All single –use items will be discarded from dietary after single use is completed. Quality Assurance will audit the completion of dietary audits once a month for twelve months. All dietary audits for temping Modified prepared foods, as well as audit for single-use containers will be reported to	

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F 812	Continued From page 21 FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5ºC (41ºF) or less. Related to food storage: 1. Observation on 9/30/19 at 4:52 PM of the walk-in refrigerator showed a carton of "whipped topping"; however the label on the container stated it contained pineapple chunks with a preparation date of 9/29/19 and a use by date of 10/9/19. 2. Observation on 10/2/19 at 9:55 AM of the walk-in refrigerator showed the same storage container of pineapple chunks. Interview with the CDM at that time revealed she was aware of the container of pineapple chunks in the refrigerator. She stated she did not normally use "one time use" containers to store leftover food; however she had run out of the appropriate storage containers and had to order more. At that time, the CDM put the pineapple chunks into a multiuse container and went to the clean dish storage rack and discarded additional "whipped topping" containers. 3. According to Food Code 2017, U.S. Public Health Service: Definitions 1-201.10 Single-Use Articles. (1) "Single-use articles" means UTENSILS and bulk FOOD containers designed and constructed to be used once and discarded. (2) "Single-use articles" includes items such as wax paper, butcher paper, plastic wrap, formed aluminum FOOD containers, jars, plastic tubs or	F 812	quarterly QAPI meeting.	

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	535050	A. BUILDING _____ B. WING _____	10/03/2019

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 812	Continued From page 22 buckets, bread wrappers, pickle barrels, ketchup bottles, and number 10 cans which do not meet the materials, durability, strength, and cleanability specifications under §§ 4-101.11, 4-201.11, and 4-202.11 for multiuse UTENSILS.	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-	F 883		11/8/19

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F 883	Continued From page 23 (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy and procedure review, and staff interview, the facility failed to implement a system for ensuring pneumococcal vaccinations were offered for 2 of 5 sample residents (#7, #11) reviewed for vaccinations. The findings were: 1. Review of the 7/8/19 quarterly MDS assessment for resident #7 showed the resident was admitted to the facility on 4/12/18. Further review showed the question under section O, "Is the resident's Pneumoccal vaccination up to date?" was coded with a dash. The reason for the vaccination not being given was also coded with a dash.	F 883	Corrective Action for resident #7 included a Prevnar 13 was given on 10/22/2019. Corrective Action for resident #11 includes the vaccination will be administered per daughters approval once resident‘s acute illness is resolved. Corrective Action 1. Prior to or upon admission, residents will be assessed for eligibility to receive the Prevnar vaccination, and when indicated, will be offered the vaccination within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. 2. Prevnar vaccination date will be	

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F 883	Continued From page 24 2. Review of the 7/29/19 quarterly MDS assessment for resident #11 showed the resident was admitted to the facility on 4/22/19. Further review showed the pneumococcal vaccine was coded as not up to date and the reason was coded with a dash. 3. Interview with the infection preventionist on 10/3/19 at 10:40 AM revealed the facility did not provide pneumococcal vaccinations to the residents. Further, she stated it was the responsibility of the resident's physician to provide the vaccination. 4. Review of the "Pneumococcal Vaccine Policy" dated 6/21/12 showed. "Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumovax, and when indicated, will be offered the vaccination within thirty {30} days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessments of pneumococcal vaccination status will be conducted within five {5} working days of the resident's admission if not conducted prior to admission. Before receiving the Pneumovax, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Consent for vaccine will be obtained and placed in resident's chart. Provision of such education shall be documented in the resident's medical chart... Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. For residents who receive the vaccine, the date of	F 883	noted and input into MDS. 3. Preventive Health will be updated upon admission, quarterly and when indicated for completion of Prevnar, and /or contraindications of receiving Prevnar vaccination. Identification of others 1. All resident vaccination records will be reviewed quarterly with open MDS during the alert charting meeting, as well as during the monthly ADON MDS audit. 2. Corrective action to prevent this from happening to other residents includes education provided to registered nurses between the dates of 10/7/2019-10-14-2019 that prevnar 13 and pneumonvax will be offered to any new admissions. Infection Preventionist successfully completed Pneumonia Clinical Guidelines and Prevention webinar on 10/09/2019. Immunization records requested and medical chart review to determined immunization status. Immunization audit has been completed. All residents are up to date with pneumococcal vaccinations at this time with exception of resident #11 due to acute illness at this time. System Measures Measurement of sustainable changes to prevent reoccurrence includes access to the Wyoming Immunization Program and resident vaccination administrations reviewed on the Quarterly/Annual Review Audit Tool. Monitoring Maintain sustainability: Monthly ADON MDS audit one time a month x6 months for current vaccination record of Pneumovax to ensure continued	

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F 883	Continued From page 25 vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record. Administration of the pneumoccal vaccination or revaccinations will be made in accordance with current Centers for Disease Control and Prevention recommendations at the time of the vaccination."	F 883	compliance with Quarterly/Annual Review Audit Tool. All resident vaccination record audits will be reported to quarterly QAPI meeting.	