STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING _____ B. WING _____	C 11/05/2024

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 complaint survey was conducted by Healthcare Licensing and Surveys on 10/23/24 through 11/5/24. The survey was prompted by complaint intakes WY000003986, WY000003987, WY000004010 and WY000004011. The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide RN: Registered Nurse DON: Director of Nursing MDS: Minimum Data Set SS: Social Services Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered;	F 622		11/22/24

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

Electronically Signed | 11/21/2024

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(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this

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F 622	Continued From page 2 section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident representative and staff interview, the facility failed to ensure resident's transferred to the hospital were allowed to return to the the facility for 1 of 3 sample residents (#1) reviewed for hospital transfers. The findings were: 1. Review of a discharge MDS assessment dated 9/21/24 showed resident #1 admitted to the facility on 7/16/24 and had a planned short-term	F 622	Corrective Action: All residents who are sent emergent or non-emergent to an acute care setting will be permitted to return to our facility, unless evidence of a change in status occurs, and the resident status does not fall within the perameters of our abilities to care for them, as outlined in our facility assessment; in which the rules of appeal for facility initiated discharge may apply.	

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F 622	Continued From page 3 general hospital discharge return not anticipated on 9/21/24. The following concerns were identified: a. Review of a progress note dated 9/21/24 and timed 11:55 AM showed "Resident sent to ER due to being violent towards staff and other residents. Staff had to intervene when [s/he] was going towards another resident when in a foul mood, and it look [sic] as though [s/he] was going to hit [him/her]. This RN discussed the situation with the nurse manager and decided it was safest for the residents if [s/he] were sent to the ER. The Non emergent ambulance was contacted, and they involved law enforcement due to [her/him] being violent- They were notified that resident was an 84-year-old [woman/man], small in stature. One officer arrived from law enforcement around twenty minutes after being contacted. The officer asked questions about the resident and witnessed [him/her] trying to hit others and yell at them. Another officer showed up and resident was very agitated, swinging and or yelling at residents and staff passing by [her/him]. [S/He] was still highly agitated when EMS came in. The nurse manager was trying to calm resident down and [s/he] grabbed her hand and started twisting it, [s/he] would not let go and she had to be helped by law enforcement. EMS tried to put resident onto the gurney, and [s/he] was trying to spit in their faces as well as hit them. At one point, resident tried to put one of the EMS men in a headlock and he slipped out of it. Resident was then sent to the ER." b. Review of a progress note dated 9/21/24 and timed 1:53 PM showed the facility received a call from the resident's family to notify them the hospital was ready for the resident to return to the facility. c. Review of a progress note dated 9/21/24	F 622	Identifying others: All resident referrals will be screened in accordance with our facility assessments resident needs and capabilities to provide care. In the event resident issues arise after admission, and our facility can not meet the needs of the resident, a discharge notice will be issued, and our facility will assist the resident and/or resident representative in finding appropriate placement prior to discharge. Our facility will maintain appropriate documentation, as well as documented communication from an appropriate physician regarding the transfer and/or discharge to another facility. Systemic Changes: Tansfer and discharge rights and processes will be added to the facility admit packet for resident and/or resident representative review. A sample transfer/discharge form will be reviewed at admit to inform the resident/representative of the policy/procedure in the event of a transfer to an acute care facility. Monitoring: A real time QAPI huddle will be performed and documented to discuss status change of any resident being transferred to an acute care setting. A review of the transfer and discharge rights will be reviewed with residents/representatives at the quarterly care conference. Tracking of transfer/discharge rights review and occurance will occur monthly x3 months, then quartlerly at QAPI there-after for review and outcomes compliance.	

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and timed 2:02 PM showed "Spoke to [name] RN from [hospital name], he stated elder has not been aggressive at the ER and behaviors are not present . This nurse stated that the elder was witnessed by [law enforcement] and staff when [s/he] was spitting and hitting at EMS staff, and that two employees reported elder attempts to hit two elders and that elders were safe due to the prompt response of the staff. Elder was also physically abused [sic] towards staff. Per the administrator's order [facility] is implementing an emergency discharge due to concerns for the safety of the elders and the and the staff, and for [facility] clinical department unable to provide cares to meet elder's needs at this time for correct placement. [name] stated that Dr. [name] was notified of elder transfer to ER. This nurse relayed information from administrator who contacted [service's name] to refer this case and request additional support for adequate placement for Elder [initials], [Service's name] stated that they would send the on call provider to [hospital] as soon as ER department contacted [service's name]. This nurse recommended contact [service's name] to have the on call provider assess and assist elder and family. [Name] stated that Elder's daughter is at the ER at this time and aware of situation. This nurse referred [name] RN to DON per his request."

d. Review of a progress note dated 9/21/24 and timed 3:05 PM showed "[Name] and elder's son here at the facility to discuss emergent discharge. This nurse used therapeutic communication to explain that due to incidents of near incidents of physical aggression and reports received by elders related to experiencing unwell-been due to [initials] elder violent displays. Per [facility] administrator indication; an emergency discharge was decided due to

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concerns for the safety of the elders and staff, the elder needs related to vascular dementia and proper placement can not be met by the facility at this time. This nurse indicated to [name] that information regarding [service's name] was recommended during the conversation with [name] RN from[hospital]. [Name] stated that she had been in contact. Dr. [name] after she was notified of emergency discharge and that would [sic] like to address this decision with DON and the administrative representative. This nurse used therapeutic communication to address family concerns and indicated to [name] and brother that DON and administration were informed about her request. Inventory of items was performed by CNA, SS was contacted to follow up with family regarding pick up arrangements of inventoried items."

e. Review of a "Transfer/Discharge Notice" dated 9/21/24 showed the reason for transfer/discharge was 'Unable to redirect elder at this time after two counts of physical aggression. Per Dr. [name] order send elder to ER [emergency room]." Further review showed "Is resident expected to return" was marked "yes", the resident's representative gave "telephone consent," and the charge nurse was the nurse manager.

f. Interview with the resident's son on 10/23/24 at 5:29 PM revealed the facility notified family the resident was being transferred to the emergency room by ambulance due aggressive episodes. He revealed while at the hospital, the physician felt the resident was ready to return to the facility; however, they were unable to get in touch with anyone at the facility. Family contacted the facility and let them know the resident was ready to return and were told the facility would go get the resident. The hospital notified family the

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facility would not accept the resident back to the facility. Further interview revealed the facility did not issue a discharge notice until family went to the facility to get the resident's belongings, after they were told the facility refused to allow the resident to return.

g. Interview with RN #1 on 10/24/24 at 1:22 PM revealed the resident had a lot of pain and would get aggressive at times. The RN revealed the resident had hallucinations a lot and was resistive to care. She confirmed she was at the facility the day the resident discharged and revealed the resident had been aggressive with staff and other residents. She revealed she and the nurse manager collaborated and called for non-emergent ambulance for transport to the hospital. She revealed she spoke with the administrator and was told not to accept the resident back, which she communicated to the hospital; however, she was unsure why the resident was not allowed to return. She revealed family was notified the resident would not be allowed to return when they came to the facility, after the hospital transfer.

h. Interview with the nurse manager on 10/24/24 at 1:48 PM revealed the resident admitted to the facility for short-term physical therapy and confirmed the resident had pain. The nurse manager revealed the behaviors, which family did not share, had started to emerge after the resident's admission. The nurse manager stated on the day of discharge, the resident had been yelling and screaming and some other residents voiced fears; however, the resident never physically harmed other residents and an investigation was not completed. The nurse manager revealed the resident had bitten a staff member the day prior to the incident and DON told staff the next time the resident was

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F 622	Continued From page 7 combative, s/he should go to the emergency room. The unit manager revealed after the resident was sent to the hospital emergency room, she "received orders" from the administrator to not accept the resident back as she was exercising her right to not readmit the resident. i. Interview with the social services director on 10/24/24 at 2:48 PM revealed the resident admitted on 7/16/24 for 20 days of rehabilitation and she confirmed the resident was in "bad pain" at that time. She revealed the facility met with the resident's son and daughter and let them know the resident needed more care. She revealed the administrator and DON met with the family and the family agreed to pay the resident's copay and stay at the facility longer than originally planned. Further interview confirmed the hospital said the resident was not having behaviors while in the emergency room. j. Interview with the resident's son and daughter on 10/24/24 at 9:31 AM confirmed the resident was not allowed to return to the facility following the hospital transfer. They revealed the resident discharged to another skilled nursing facility and passed away on 10/16/24. k. Interview with the administrator and DON on 10/24/24 at 3:20 PM confirmed they did not allow the resident to return to the facility following the hospital transfer as the resident was trying to hit other residents and staff. Further interview revealed the facility did not assist in finding alternate placement after the resident was transferred to the hospital.	F 622		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide	F 745		11/22/24

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F 745	Continued From page 8 medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident representative and staff interview, and Medicaid e-mail review, the facility failed to ensure medically-related social services assisted with financial matters for 1 of 3 sample residents (#1). The findings were: 1. Review of a discharge MDS assessment dated 9/21/24 showed resident #1 admitted to the facility on 7/16/24 and had a planned short-term general hospital discharge return not anticipated on 9/21/24. The following concerns were identified: a. Interview with the resident's son on 10/24/24 at 2:28 PM revealed he was notified the facility did not complete an LT101 for Medicaid and since the resident was deceased, it could not be performed. Further interview revealed he contacted the facility and they confirmed the LT101 had not been completed. b. Communication with Medicaid on 10/25/24 showed a client did not need their financial eligibility application approved in order to have a LT101. A client did have to be applying for Medicaid and when a facility puts in a request for a LT101, the specialist at the state will go into our eligibility system to see if an application had been received. If an application had been received, the LT101 was referred on to the appropriate individual for completion. Further, it was revealed an application for the resident was received on 8/19/24; however, a request for the LT101 completion was not made by the facility. c. Interview with the social services director	F 745	Corrective actions: Morning Star Care Center Social Services Manager will provide medically related social services under the regular consultation from a licenced Social Worker. Education of the new LT101 process has been provided to the Social Services manager, as well as the leadership team. Upon admission of a resident, the Social Services manager will interview the resident and/or representative, if the resident is on any other payor source besides being on Medicaid, the Social Services manageer will document the residents/respresentatives intentions of applying for Medicaid at any time. The Social Services manager will get concent, and request an LT101. The Social Services manager will email Wyo Medicaid to inform of situation, find out the status and the Medicaid application, and communicate to resident/representative the status of the application. A Resident/Family intentions checklist will be added to the admit packet for reivew at every admission. Identifying others: The Social Services manager conducted on audit of all residents residing at Morning Star Care Center to ensure an LT101 was in place. All residents have the right to have their level of nursing care identified to ensure	

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F 745	Continued From page 9 on 10/24/24 at 2:48 PM revealed an LT101 was not submitted for the resident because s/he was not on Medicaid. Further interview revealed the resident's son and daughter agreed to pay the resident's copay and the resident's daughter notified the facility a Medicaid application was submitted for the resident in August. d. Review of an email with Medicaid provided by the facility dated 9/5/24 showed the facility confirmed an application for Medicaid had been received for the resident.	F 745	proper placement and that their needs can be met. Others would be affected if Morning Star Care Center did not submit a request for an LT101, as the residents care could be in jeopardy if there was no LT101, and it affected their financial well being for long term placement when it was needed. Systemic Changes: An admission checklist will be added to the admit packet to include: interview with resident/representative regarding intentions for applying for Medicaid, requesting LT101, email to Wyo Medicaid to communication situation, and communication to resident/representative for status of application. the checklist will be uploaded to the resident electronic health record. Checklist review will be added to the care conference audit for review during quarterly care conference. Monitoring: Monthly audit x3 months of checklist completion, then quarterly thereafter. All audits will be reviewed quarterly a QAPI meeting and added to agenda.	