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

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535050 | A. BUILDING _____ B. WING _____ | C 04/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MORNING STAR CARE CENTER | 4 NORTH FORK ROAD FORT WASHAKIE, WY 82514 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 280 SS=E | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation and staff interview, the facility failed to ensure staff reviewed and revised the care plan for 5 of 5 sample residents (#26, #30, #40, #41, #42) reviewed with a history of falls. In addition, the facility failed to revise the care plan for 1 of 1 sample resident (#31) who exhibited behaviors. The findings were:<br><br>1. Review of the medical record for resident #26 showed s/he had diagnoses to include osteoarthritis and paralysis agitans (Parkinson's | F 280 | F 280<br>1. Resident #26 was provided the physical interventions to assist with preventative measures however the Care Plan had not been updated to reflect these preventative measures. A policy is in place to update the care plans the week the fall occurs (within 72 hours) and is reviewed that same week at Risk Management meeting to ensure that any new changes to the care plan are in place and communicated to all interdisciplinary staff. Risk Management meeting is every Thursday consisting of the team members: Administrator, Medical Director, Director of Nursing, Social Services and Assistant Director of Nursing. The resident, resident family members or representatives are included in the care plan meetings and are providing signatures on the Care Plan hardcopy. Audit tool for falls and fall follow-up, risk and CQI will be done weekly related to every fall, times 3 months and then PRN by ADON and DON. Results of quality monitoring tool will be reported at weekly Risk meetings. ADON will provide education to all nursing staff related to fall documentation. | 5/6/12 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marla Martin — TITLE: Administrator — (X6) DATE: 5/22/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



POC was accepted & corrections reviewed with both the DON and Administrator on 5/23/12 via phone
Kathryn Rooney
State Surveyor

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

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535050 | A. BUILDING _____ B. WING _____ | C 04/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MORNING STAR CARE CENTER | 4 NORTH FORK ROAD FORT WASHAKIE, WY 82514 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 280 | Continued From page 1<br>Disease). Review of the incident reports and nurse's notes, showed the resident fell four times between 3/14/12 and 4/4/12. Observation on 4/4/12 at 3:45 PM showed the resident had a fall mat at his/her bedside. Review of the resident's care plan for falls last reviewed on 2/6/12 showed s/he was to be assessed for the need of fall interventions but did not indicate what interventions were currently in place. Interview with the DON (Director of Nursing) on 4/5/12 at 1 PM stated the resident's care plan needed to be revised to show the resident's current needs related to falls.<br><br>2. Review of the nurse's notes timed at 2:08 PM for resident #30 showed s/he fell while attempting to self transfer from the wheelchair. The resident was later diagnosed with a hip fracture. Review of the physical therapy and occupational therapy notes dated 3/8/12 showed the resident used a wheelchair and front wheeled walker. In addition s/he was to toe touch weight bear with ambulation and transfers. Review of the care plan for falls last reviewed on 2/21/12 did not show the resident had a recent hip fracture and the precautions to be taken during transfers and ambulation. However, an interview with the DON on 4/5/12 at 2:15 PM verified the care plan need to be revised to show the resident's current needs related to falls.<br><br>3. Review of the medical record for resident #40 showed s/he had diagnoses to include rheumatoid arthritis and blindness. Review of the 2/25/12 nurses' notes at 2:54 AM showed the resident fell hitting his/her head. Further, the nurse's note showed the resident slipped on liquids s/he had spilled while ambulating. Review | F 280 | 2. Resident #30. A policy is in place to update the Care Plans if a fall occurs and is reviewed that same week at Risk Management meeting. New policy states fall procedures and neurological assessment steps until resident medical provider orders to stop (d/c) or for 72 hours straight without d/c orders. The resident, resident family members or representatives are included in the Care Plan meetings, signatures are provided on hard copy Care Plan documents. Audit tool for falls and fall follow-up, risk and CQI will be done weekly related to every fall, times 3 months and then PRN by ADON and DON. Results of quality monitoring tool will be reported at weekly Risk meetings. ADON will provide education to all nursing staff related to fall documentation. and care plans as necessary 4/27/12<br><br>3. Resident #40 care plan had not been updated to reflect the need for precautions related to resident condition, resident ambulation and transfer conditions. A policy has been established for the nursing staff regarding Unwitnessed Falls and Neurological Assessment procedures. | |

and monitoring care plans for updates action corrective will be taken as necessary

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535050 | A. BUILDING _____ B. WING _____ | C 04/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MORNING STAR CARE CENTER | 4 NORTH FORK ROAD FORT WASHAKIE, WY 82514 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 280 | Continued From page 2<br>of the physical therapy notes dated from 2/23/12-2/29/12 showed the resident used a wheelchair for mobility. Interview with the DON on 4/5/12 at 2:15 PM revealed the resident often spilled his/her drinks due to his/her blindness. Review of the resident's entire care plan last reviewed on 1/31/12, showed it did not include the need for precautions related to the resident spilling his/her fluids or the use of a wheel chair. However, Interview with the DON on 4/5/12 at 2:15 PM verified the care plan should have been revised to reflect the resident's current condition and needs.<br><br>4. Review of the medical record for resident #41 showed s/he had diagnoses to include dementia and osteoarthritis. Review of the nurse's note showed the resident fell on 3/6/12 at 12:01 AM and on 3/13/12. Review of the nurse's note dated on 3/10/12 at 5:50 AM showed the resident had an alarm pad in his/her chair that was also used while s/he was in bed. In addition the resident had a floor pad in place. Review of the resident's care plan for falls last reviewed on 3/13/12 failed to show the resident used an alarm pad in his/her chair and bed or a floor pad. Interview with the DON on 4/5/12 at 1 PM verified the care plan should have been revised to reflect the resident's current condition and needs.<br><br>5. Review of the nurse's notes and incident reports for resident #42 showed s/he fell four times between 2/2/12 and 2/11/12. A nurse's note written on 2/2/12 showed the resident was unsteady and needed assistance with transfers. A nurse's note written on 2/3/12 at 5:53 AM showed the resident was confused and attempted to self transfer. Sit/stand alarms were placed in his | F 280 | The resident, resident family members or representatives are included in the Care Plan meetings. Audit tool for falls and fall follow-up, risk and CQI will be done weekly related to every fall, times 3 months and then PRN by ADON and DON. Results of quality monitoring tool will be reported at weekly Risk meetings. ADON will provide education to all nursing staff related to fall documentation. and care plans KR<br><br>4. Resident #41 needs were addressed in risk management but not updated on the resident's Care Plan. A policy has been established to update each Care Plan after identification of each resident's needs according to condition. Audit tool for falls and fall follow-up, risk and CQI will be done weekly related to every fall, times 3 months and then PRN by ADON and DON. Results of quality monitoring tool will be reported at weekly Risk meetings. ADON will provide education to all nursing staff related to fall documentation. and care plans KR<br><br>5. Resident #42 conditions were met physically by the assistive devices placed on the resident's bed and chair and the use of a gait belt. A policy has been | 4/27/12<br><br>4/27/12 |

monitoring for care plans updates corrective action will be taken as necessary KR

monitoring for care plans updates corrective action will be taken as necessary KR

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

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535050 | A. BUILDING _____ B. WING _____ | C 04/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MORNING STAR CARE CENTER | 4 NORTH FORK ROAD FORT WASHAKIE, WY 82514 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 280 | Continued From page 3<br>wheel chair and bed. In addition the resident was assisted to ambulate with a gait belt. Review of the care plan for falls, last reviewed on 2/17/12 did not indicate the use of alarms placed on the resident's bed and chair or that the resident ambulated with the use of a gait belt. An interview with the DON on 4/5/12 at 1:50 PM verified the care plan should have been revised to reflect the resident's current needs.<br><br>6. Review of the medical record for resident #31 showed s/he had diagnoses to include anxiety and depression. Review of the social services notes dated 1/9/12 showed the resident was refusing care and did not get along with some of the facility staff. Interview with the DON on 4/5/12 at 1 PM confirmed there had been complaints from the resident concerning staff. Further, the DON stated she had meetings with facility staff to include social services related to the complaints. Review of the entire care plan showed a plan of care had not been developed to address the resident's behaviors. The DON acknowledged at that time a care plan needed to be developed. | F 280 | established to update the Care Plan (within 72 hours) after incident and after weekly risk management or care plan meetings that would identify any new changes like these assistive devices. The resident, resident family members or representatives are included in the care plan meetings. The Neurological Assessment policy includes the guidelines for neurological assessments to be conducted for 72 hours straight unless d/c'd by resident medical provider. The neurological assessments will be documented and charted in the MedRight software program. Audit tool for falls and fall follow-up, risk and CQI will be done weekly related to every fall, times 3 months and then PRN by ADON and DON. Results of quality monitoring tool will be reported at weekly Risk meetings. ADON will provide education to all nursing staff related to fall documentation. and updating the care plan PRN<br><br>6. Resident #31 care plan has been updated to reflect residents anxiety and depression behaviors 4/6/12. A policy has been established to update the care plan immediately after weekly risk management or care plan meetings that would identify any new conditions or | 4/27/12 |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by: | F 323 | | |

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

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535050 | A. BUILDING _____ B. WING _____ | C 04/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MORNING STAR CARE CENTER | 4 NORTH FORK ROAD FORT WASHAKIE, WY 82514 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 4<br>Based on medical record review, staff interview and review of incident reports, the facility failed to perform a thorough evaluation of falls, revise the care plans related to falls and monitor the effectiveness of interventions to prevent further falls for 5 of 5 sample residents (#26, #30, #40, #41, #42). The findings were:<br><br>1. Review of the incident reports for resident #26 showed s/he fell four times between 3/19/12 and 4/4/12. Review of the incident reports, nurses' notes and the resident's care plan with the DON (Director of Nursing) on 4/5/12 at 1 PM acknowledged a thorough investigation was not conducted after each fall and appropriate interventions were not put in place. In addition, the care plan was not updated to reflect interventions related to the falls.<br><br>2. Review of the nurse's note dated 2/2/12 for resident #30 showed he/she fell in the bathroom. Further review showed the resident was later diagnosed with a hip fracture. Review of the incident report, nurses' notes and care plan with the DON on 4/5/12 at 1 PM acknowledged a thorough evaluation of the fall was not conducted and appropriate interventions were not put in place to reduce the risk of future falls.<br><br>3. Review of the medical record for resident #40 showed the resident had diagnoses to include blindness and rheumatoid arthritis. Review of the incident report with the DON on 4/5/12 at 2:15 PM revealed the resident fell on 2/25/12 after slipping in liquids that s/he had spilled. In addition, review of the nurse's note dated 2/26/12 at 2:10 AM showed the resident fell again. However, there was no evidence the falls were thoroughly | F 323 | changes. Any new behaviors will be updated in the MDS by the social services director or designated staff member. Additionally any behavior changes noted or reported a behavior assessment sheet will need to be completed within 72 hours and changes to care plan will be updated by the MDS coordinator. Audit tool for falls and fall follow-up, risk and CQI will be done weekly related to every fall, times 3 months and then PRN by ADON and DON. Results of quality monitoring tool will be reported at weekly Risk meetings. ADON will provide education to all nursing staff related to fall documentation. and any behaviors KR<br><br>updating the care plan to reflect the residents current needs and status KR | 4/27/12 |

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535050 | A. BUILDING _____ B. WING _____ | C 04/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MORNING STAR CARE CENTER | 4 NORTH FORK ROAD FORT WASHAKIE, WY 82514 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 5<br>evaluated. Review of the care plan for falls last reviewed on 1/31/12 showed there were no interventions put in place after the documented falls on 2/25/12 and 2/26/12 to reduce the risk of further falls. Interview with the DON at that time revealed a thorough evaluation needed to be done after each fall to determine the cause and to address preventive measures. In addition, the care plan needed to show specific preventive measures for the falls.<br><br>4. Review of the medical record for resident #41 showed s/he had diagnoses to include urine retention, dementia and osteoarthritis. Review of the 3/6/12 nurse's note timed at 4:53 AM showed the resident was found lying on the floor in his/her room with the catheter tubing wrapped around his/her foot. A 3/13/12 nurse's note timed at 7:30 PM showed the resident again fell. Review of the incident reports, nurses' notes and the resident's care plan with the DON on 4/5/12 at 1 PM acknowledged a thorough evaluation was not conducted after each fall and appropriate interventions were not put in place. In addition, the care plan was not updated to reflect interventions related to falls.<br><br>5. Review of the incident reports for resident #42 showed the resident fell four times between 2/2/12 and 2/11/12. Documentation showed during each incident, the resident had fallen from his/her wheelchair. Review of the incident reports, nurses' notes and the resident's care plan with the DON on 4/5/12 at 1:50 PM acknowledged a thorough investigation was not conducted to determine the cause of each fall and appropriate interventions were not developed. In addition, the care plan was not updated to reflect interventions | F 323 | F 323<br><br>1. A Falls Policy has been established on 4/22/12 outlining head to toe assessments, vital signs and the procedures to rule out significant injury. Neurological Assessments will begin if fall is unwitnessed. Nurses will notify resident medical provider with the results of the assessment and notify residents' family members. Training is being provided to all interdisciplinary staff. Training is being provided to include: review of Falls Policy and Neurological Assessment tlr<br><br>2. Residents #26, #40, #41, #42 and #30 Care Plan has been updated. The team has developed a more thorough requirement from the nursing staff when documenting falls on the incident report. The team is looking for staff to document environment and the witnesses will be identified by full name not initials. Additionally each resident will be tracked on a resident fall tracking log form and kept in a Fall/Injury binder. All falls and incident reports will be reviewed weekly at risk meetings and quarterly at CQI meetings. This will be monitored by DON, Staff coordinator and Medical Director reviewed by CQI members. | 5/25/12 |

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

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535050 | A. BUILDING _____ B. WING _____ | C 04/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MORNING STAR CARE CENTER | 4 NORTH FORK ROAD FORT WASHAKIE, WY 82514 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 6 related to falls. | F 323 | Audit tool for falls and fall follow-up, risk and CQI will be done weekly related to every fall, times 3 months and then PRN by ADON and DON. Results of quality monitoring tool will be reported at weekly Risk meetings. ADON will provide education to all nursing staff related to fall documentation. and assessment etc<br><br>3. This fall incident required us to look closely at the procedures the staff took and provide informational meetings with the staff to address the breakdown with documentation. Training is being provided to interdisciplinary staff and all staff will provide signatures of the in-service. Audit tool for falls and fall follow-up, risk and CQI will be done weekly related to every fall, times 3 months and then PRN by ADON and DON. Results of quality monitoring tool will be reported at weekly Risk meetings. ADON will provide education to all nursing staff related to fall documentation.<br><br>4. A Fall Policy has been established on 4/22/12 outlining head to toe assessments, vital signs and the procedures to rule out significant injury. Neurological | 5/25/12<br><br>5/25/12 |

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

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535050 | A. BUILDING _____ B. WING _____ | C 04/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MORNING STAR CARE CENTER | 4 NORTH FORK ROAD FORT WASHAKIE, WY 82514 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 6 related to falls. | F 323 | assessments will begin if fall is unwitnessed. Nurses will notify resident medical provider with the results of the assessment and notify residents' family members. Training is being provided to interdisciplinary staff and all staff will provide signatures of the in-service. Audit tool for falls and fall follow-up, risk and CQI will be done weekly related to every fall, times 3 months and then PRN by ADON and DON. Results of quality monitoring tool will be reported at weekly Risk meetings. ADON will provide education to all nursing staff related to fall documentation. and assessment tlr<br><br>5. This incident required our team to troubleshoot and thoroughly investigate the breakdown. A Falls Policy and Neurological Policy has been established and reviewed on 4/22/12 by Administration, Medical Director, DON and Staff Coordinator. Training is being provided to interdisciplinary staff and all staff will provide signatures of the in-service. Audit tool for falls and fall follow-up, risk and CQI will be done weekly related to every fall, times 3 months and then PRN by ADON and DON. Results of quality monitoring tool will be reported at weekly Risk meetings. ADON will provide education to all nursing staff related to fall documentation. and assessment tlr | 5/25/12<br><br>5/25/12 |