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 _____	01/25/2024

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 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 1/22/24 through 1/25/24. The following common abbreviations are used throughout this document: DON: Director of Nursing MDS: Minimum Data Set MAR: Medication Administration Record mg: milligrams PCV: Pneumococcal conjugate vaccine PRN: acronym for Latin term "pro re nata" which means "as needed" Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 578		3/1/24

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

Electronically Signed | 02/12/2024

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 _____	01/25/2024

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 578	Continued From page 1 medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interviews, and review of facility policies, the facility failed to ensure the resident's right to refuse treatment was protected for 1 of 10 sample residents (#24). The resident's refusals resulted in negative consequences implemented by the facility. The findings were: 1. Review of the 12/11/23 annual MDS assessment showed resident #24 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact, had diagnoses including cerebral palsy and depression, and wheeled a motorized wheelchair (w/c) 150 feet independently. Review of the care	F 578	1) Corrective Action for resident #24: a) A copy of Resident Rights has been reviewed with resident. b) The resident smoking policy was reviewed and amended to include the facility standards regarding smoking at Morning Star Care Center on 1/26/24. c) #24 care plan has been reviewed and additional interventions have been added 2/5/24 d) #24 behavior plan has been dissolved, care plan reviewed with care partners, and care partners education for approaches and interventions. 2) Corrective Action taken to prevent other	

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 _____	01/25/2024

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 578	Continued From page 2	F 578		

plan for behavioral symptoms, initiated 12/6/22, showed the resident rejected cares, including medications, skin checks, wound care, and activities of daily living (ADLs). The only approaches/interventions listed were to reapproach the resident in 15-20 minutes and offer again and to document rejection and attempts to reapproach. The following concerns were identified:

a. Review of the medical record showed a "Behavior Support Plan" signed by the facility and the resident dated 12/26/23. The behavior plan stated there was a 15 minute time limit to smoke a cigarette in the smoking room. It also listed the daily schedule the resident must follow which included being checked/changed and repositioned every two hours during waking hours and showering three times a week. The plan stated "...Delaying, Refusing, and not following the above daily schedule, shower schedule & staying longer than 15 minutes in the smoking room and mistreating your assigned Care Partners who assist/help you will result in the privilege of not being able to smoke cigarettes in the smoking room until elder, [resident name] follows [his/her] behavior support plan for two weeks..."

b. During an interview on 1/25/24 at 8:52 AM the resident stated s/he had a behavior contract "they made me sign." S/he stated they make rules for him/her, but not for others. S/he stated other residents were not limited to 15 minutes in the smoke room. The resident further stated if s/he refused care, s/he loses the smoke room for two weeks and "I don't think that's fair."

c. On 1/25/24 at 9:56 AM the social services director (SSD) stated the resident refused cares and remained in the smoke room for long periods of time. She stated they have a behavior plan in

residents from being affected:
a) smoking policy reviewed and signed by all smoking elders/residents.
3) Identification of Others:
a) social services will review and have all new admissions that smoke sign the smoking policy and have it uploaded to their electronic record.
b) Social Services reviewed resident rights with all residents that reside at Morning Star Care Center.
c) Behavior plan audit was performed for all current residents and no other plans exist.
d) An audit of all current resident care plans completed to ensure no violation of resident rights was present in their care plans.
4) Systems Measures:
a) The smoking policy will be reviewed annually to ensure safety measures in place are sustained.
b) A quarterly smoking assessment will be done for all smokers to ensure safe smoking habits.
5) Monitoring:
a) IDT to audit that all smoking elders have reviewed and signed the smoking policy and are following the smoking policy on a quarterly basis at their quarterly care conference, and at any time the policy is amended.
b) All current residents care plans and medical records will be reviewed during quarterly MDS and quarterly care conferences to identify resident rights are being protected.
c) If it is identified by IDT and resident that a behavior plan needs to be implemented

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 _____	01/25/2024

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 578	Continued From page 3 place to minimize behaviors and stay on schedule. She confirmed if the resident refused cares it would result in the resident losing the smoking room for two weeks. When asked if the behavior plan was violating the resident's right to refuse treatment, she stated "we hoped we weren't violating [his/her] rights." d. Review of the facility's smoking policy (undated) showed there was no limit of 15 minutes in the smoking room.	F 578	at any time, IDT will contact the State regional Ombudsman for guidance to ensure resident rights are protected and the residents needs are being met. d) All audits will be reported to QAPI Coordinator and reviewed at every quarterly QAPI meeting. e) QAPI team will review compliance of following smoking policy based on audits completed and review policy with smoking elders if necessary. f) these reviews will be added to the QAPI agenda.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to	F 661		3/1/24

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 _____	01/25/2024

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 661	Continued From page 4 adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a discharge summary which included a recapitulation of stay was completed for 1 or 1 sample resident (#29) who was discharged. The findings were: 1. Review of the 11/2/23 return not anticipated discharge MDS assessment showed resident #29 was discharged to home/community. Review of a progress note showed on 11/2/23 the resident was discharged. The following concerns were identified: a. Review of the 11/2/23 discharge instructions/plan of care in the medical record showed no discharge summary with a recapitulation (recap) of stay. Further review of the medical record showed no evidence of a discharge summary with a recap of stay. b. During an interview on 1/25/24 at 9:34 AM the DON stated confirmed there was no discharge summary with a recap of stay for this resident.	F 661	1) Corrective Action: a) DON updated d/c checklist and provided education to all nurses regarding residents with anticipated discharges. b) DON reviewed d/c policy with all nurses, and provided hands on training to ensure proper documentation implementation on MATRIXCARE c) Corrective action for resident #29: a discharge summary was created for residents discharge date of 11/2/23. 2) Identifying Others: a) upon admission of any resident, DON will audit admission checklist to ensure d/c planning process is initiated b) An audit was performed for all residents in the past year that discharged and discharge summaries completed. 3) Systemic Changes: a) the d/c planning process, d/c policy and checklist will be added to the nurses guide book, and all new hires will be trained on the implementation process. 4) Monitoring: a) DON to audit all current and new admissions with anticipated discharges d/c planning checklist and documentation weekly x12 weeks, then monthly there after to ensure sustainability. b) all audits will be brought to QAPI coordinator and reviewed at quarterly	

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 _____	01/25/2024

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 661	Continued From page 5	F 661	QAPI meeting, and added to the agenda going forward.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff and resident interviews, the facility failed to ensure pain management was provided to meet the needs of the resident for 1 of 1 sample resident (#2) reviewed for pain management. The findings were: 1. Review of the 1/9/24 quarterly MDS assessment showed resident #2 had frequent pain at a level of 7, on a scale of 0 to 10, and had diagnoses including stroke and hemiplegia. Review of the 1/13/24 "Pain-MDS Focused" assessment showed the resident received scheduled and PRN pain medication and had frequent pain. The resident stated pain frequently affected sleep and day-to-day activities. The resident described his/her pain as "moderate." Review of physician orders showed the resident was ordered the following pain medications: acetaminophen 325 mg, 2 tabs, every 6 hours PRN; Lidoderm adhesive patch, 5%, to coccyx topical 12 hours on, 12 hours off; oxycodone 5 mg, 2 tablets, at bedtime; and tramadol 50 mg, 1.5 tablets, twice per day. The following concerns were identified:	F 697	1) Corrective Actions: a) When medication is received a medication count will be done by the receiving nurse. a medication reconciliation with order, dose and packaging is double checked by shift change medication count b) an emergency medication lock box has been implemented in the case of unavailability of medication c) Corrective action for resident #2: An audit of all medications, including pain medications, was performed and all medications were available. d) An audit was performed for all residents medications and all medications were available. 2) Identifying Others: a) DON to audit emergency medication lock box to ensure various medications for pain management are in the facility. 3) Systemic Measures: a) DON to educate all nurses on emergency medication lock box and its contents.	3/1/24

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 _____	01/25/2024

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 697	Continued From page 6 a. During an interview on 1/23/24 at 9:44 AM the resident stated s/he had pain and thought pain control could be better. b. Review of the January 2024 MAR showed the tramadol 50 mg, 1.5 tablet, twice per day was documented as not administered for 3.5 days (on 1/19/24 at 2:05 PM, 1/20/24 at 9:09 AM and 2:39 PM, 1/21/24 at 8:28 AM and 3:09 PM, and on 1/22/24 at 9:30 AM and 3:42 PM.) The reason listed was "drug/item not available." c. On 1/25/24 at 8:47 AM the resident stated his/her pain was usually a "7." S/he stated there have been times when s/he did not get the tramadol because they didn't have it. The resident stated s/he can take Tylenol when that happens, but it doesn't help as much. d. During an interview on 1/25/24 at 11:24 AM the DON confirmed the resident did not get the tramadol on those days. The DON stated getting medications had been a problem and the facility was working on that issue. When asked if the physician was notified of the medication not being available she stated she thought the nurse called the on-call physician, who wasn't comfortable prescribing medication. However, review of the medical record showed no documentation the physician was notified.	F 697	b) An audit of all resident pain medication needs was performed and an emergency supply for each resident was included in the lock box. 4) Monitoring: a) DON to audit usage of emergency medication lock box 1x a week for x12 weeks then monthly thereafter. b) An audit of pain medication administration will be completed each shift to ensure pain management is being addressed and sustained. c) all audits will be brought to QAPI Coordinator and reviewed at quarterly QAPI meeting, and added to the agenda going forward.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		3/1/24

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 _____	01/25/2024

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 755	Continued From page 7 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and resident interviews, the facility failed to provide routine medications for 1 of 9 sample residents (#2) who were reviewed for medications. The findings were: 1. Review of physician orders showed resident #2 was ordered tramadol 50 mg, 1.5 tablets, twice per day. The following concerns were identified: a. Review of the January 2024 MAR showed the tramadol 50 mg, 1.5 tablet, twice per day was documented as not administered for 3.5 days (on 1/19/24 at 2:05 PM, 1/20/24 at 9:09 AM and 2:39 PM, 1/21/24 at 8:28 AM and 3:09 PM, and on	F 755	1) Corrective Actions: a) DON updated medication ordering system. At shift change, during the medication count, when there are 7 days remaining, prior to the medication being depleted, an order will be faxed to the pharmacy, a copy will be placed in the DON's box and the chart check box for night nurse to validate. b) education has been provided to all nurses on the system changes c) DON or nurse manager to follow-up with pharmacy within 2 days to ensure medication has been filled prior to	

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 _____	01/25/2024

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 755	Continued From page 8 1/22/24 at 9:30 AM and 3:42 PM.) The reason listed was "drug/item not available." b. On 1/25/24 at 8:47 AM the resident stated his/her pain was usually a "7." S/he stated there have been times when s/he did not get the tramadol because they didn't have it. The resident stated s/he can take Tylenol when that happens, but it doesn't help as much. c. During an interview on 1/25/24 at 11:24 AM the DON confirmed the resident did not get the tramadol on those days. The DON stated getting medications had been a problem but the facility was working on that issue.	F 755	medication being depleted. d) Corrective action for #2: an audit was performed to ensure all medications were available and in the facility. e) An audit was performed for all resident medications, and all were available and in the facility. 2) Identifying Others: a) at every shift change med count, all residents medications will be reviewed and both nurses to sign off on the count. 3) Systemic Changes: a) The updated medication ordering system process has been added to the new hire nurses guide book and training will be initiated at hire date. 4) Monitoring: a) DON or nurse manager will audit medication cart counts 1x a week x12 weeks, then 1x month thereafter. b) All resident medications will be audited by each shift daily to ensure availability. c) all audits will be reported to QAPI coordinator and reviewed at quarterly QAPI meeting to ensure timely medication ordering. These reviews will be included on the ongoing quarterly QAPI meeting agenda going forward.	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		3/1/24

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 _____	01/25/2024

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 756	Continued From page 9 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the pharmacist identified and reported irregularities to the physician during the monthly drug regimen review for 3 of 5 sample residents (#2, #19, #23) reviewed for unnecessary medications. The findings were:	F 756	1) Corrective Action: a) DON, nurse manager, and pharmacist created a spread sheet of who all are on psychotropic medications that monitors the administration of psychotropic medications, whether they are scheduled, PRN, if it is a needed medication based	

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 _____	01/25/2024

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 756	Continued From page 10 1. Review of the 1/9/24 quarterly MDS assessment showed resident #2 received an antianxiety medication and an antidepressant. The following concerns were identified: a. Review of physician orders for resident #2 showed the resident was ordered Trazadone (antidepressant) 50 mg at bedtime PRN on 11/14/23 and lorazepam (antianxiety) 0.5 mg daily PRN on 11/6/23. The PRN orders were not limited to 14 days. b. Review of the medical record showed no physician documentation on why the PRN orders should be longer than 14 days. c. Review of the January 2024 MAR (through 1/24/24) showed the resident received the PRN lorazepam 6 times and the PRN Trazadone 11 times. d. Review of the December 2023 drug regimen review (DRR) dated 1/6/24 and the November 2023 DRR dated 12/2/23 showed the PRN psychotropic medications were not identified as a potential irregularity. 2. Review of the 12/11/23 quarterly MDS assessment showed resident #23 received an antidepressant and an antipsychotic. The following concerns were identified: a. Review of physician orders showed the resident was ordered Trazadone (antidepressant) 50 mg 1.5 tabs at bedtime since 7/19/22 and quetiapine (antipsychotic) 25 mg daily PRN since 4/10/23. On 12/18/23 the physician ordered quetiapine 25 mg at bedtime routinely, but stated the resident could still receive one PRN dose daily. b. Review of the medical record showed no evidence the Trazadone had a gradual dose reduction (GDR) since it was ordered 7/19/22, nor	F 756	on history of administration, as well as monitors the 14 day compliance timeline and provider visits. b) Pharmacist to highlight PRN psychotropic medication section on the drug regimen review to alert of a PRN medication use irregularities, and contact the provider and report irregularities. c) PCP will be provided with a form that gives them the option to d/c the medication, schedule and appointment, or send a new order for either 14 days or a 14 day extension rational. d) Corrective action for resident #2: PRN order end date to be updated and PCP will review order at weekly rounds 2/15/24. Corrective action for resident # 19: PRN order switched to a scheduled mediation per PCP indication 2/9/24. Corrective action for resident #23: Resident scheduled for 14 day face to face for PRN 2/22/24 2) Identifying Others: a) DON to audit PRN orders are limited to 14 days and face to face visits with PCP are scheduled to ensure compliance. b) DON or nurse manager to communicate weekly with pharmacist to ensure irregularities are identified and communication with PCP has occurred. 3)Systemic Changes: a) PRN order 14 day limitation training provided to all nurses and added to the new hire nurses guide book and training will be initiated at hire date. 4) Monitoring: a) all psychotropic medications will have a quarterly review scheduled when order is received, whether at admission or as a	

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 _____	01/25/2024

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 756	Continued From page 11 was there documentation from the physician why a GDR would be contraindicated. c. Review of the January 2024 MAR (through 1/24/24) showed the resident received the PRN quetiapine 4 times. d. Further review of the physician orders and the MAR showed the PRN quetiapine order was not limited to 14 days. e. Review of the 1/7/24 drug regimen review (DRR) for December 2023 showed the PRN quetiapine was listed, but there lacked evidence the pharmacist identified it as an irregularity and reported it to the physician. The DRR stated the Trazadone was due for a GDR in June 2024. 3. Review of the of the care plan last revised 12/24/23 for resident #19 showed to administer lorazepam 0.5 mg three times a day as needed for behaviors. The following concerns were identified: a. Review of the prescription order dated 11/6/2023 showed a current order to give one tablet of lorazepam 0.5 mg; by mouth three times daily as needed for anxiety, muscle spasms, agitation and dementia. The PRN order did not have an end date. b. Review of the MAR showed lorazepam was given 24 days out of 31 in December 2023 and was given 22 days out of 25 days in January 2024. c. Review of the December 2023 drug regimen review showed no evidence the pharmacist identified the irregularity. 4. Interview with the DON on 1/25/24 at 11:24 AM revealed she was new to the DON position and the PRN psychotropics were not on her radar at that time. She revealed there had been turnover with pharmacists and the staff responsible for	F 756	new order. b) nurse manager to audit PRN medication orders weekly x12 weeks, then monthly there after, or when new order is received to ensure 14 day limitation or extension rational is indicated. c) Quarterly audit on all psychotropic medications, GDR will be done by nurse manager and documented in the psychotropic medication audit book. d) all audits will be brought to Quality Assurance Coordinator and reviewed at quarterly QAPI meeting. Quarterly review of psychotropic medications will be reviewed at resident care conference, as well as quarterly MDS/care plan review. These reviews will be included on the ongoing quarterly QAPI meeting agenda going forward.	

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 _____	01/25/2024

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 756	Continued From page 12 monitoring GDRs. 5. Interview with the consultant pharmacist on 1/25/24 at 12:05 PM revealed she documented on the monthly drug regimen review if the resident had PRN psychotropics, but had not been monitoring them for compliance with the regulations (14 day limit). She stated she would start identifying them as an irregularity and notify the physician. In addition, she stated she had sent a GDR request to the physician for resident #23 on 6/15/23, but had not received a response back. She stated they would get better about tracking GDRs to ensure they received a response back.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		3/1/24

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 _____	01/25/2024

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 758	Continued From page 13 §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 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 on psychotropic medications received gradual dose reductions (GDRs) and PRN orders for psychotropic medications were limited to 14 days for 3 of 5 sample residents (#2, #19, #23) reviewed for unnecessary medications. The findings were: 1. Review of the 1/9/24 quarterly MDS assessment showed resident #2 received an	F 758	1) Corrective Action: a) Nurse manager audited all resident psychotropic medication orders and ensured each have a GDR, PRN orders for psychotropic medications were limited to 14 days and if indicated by PCP, a rational was put in place if an extension was warranted. b) The psychotropic spreadsheet was updated to include GDR, PRN 14 day limitations, face to face visits and rational.	

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 _____	01/25/2024

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 758	Continued From page 14 antianxiety medication and an antidepressant medication. The following concerns were identified: a. Review of the physician orders for resident #2 showed the resident was ordered Trazadone (antidepressant) 50 mg at bedtime PRN on 11/14/23 and lorazepam (antianxiety) 0.5 mg daily PRN on 11/6/23. The PRN orders were not limited to 14 days. b. Review of the medical record showed no physician documentation on why the PRN orders should be longer than 14 days. c. Review of the January 2024 MAR (through 1/24/24) showed the resident received the PRN lorazepam 6 times and the PRN Trazadone 11 times. 2. Review of 12/11/23 quarterly MDS assessment showed resident #23 received an antidepressant and an antipsychotic. The following concerns were identified: a. Review of the physician orders showed the resident was ordered Trazadone (antidepressant) 50 mg 1.5 tabs at bedtime since 7/19/22 and quetiapine (antipsychotic) 25 mg daily PRN since 4/10/23. On 12/18/23 the physician ordered quetiapine 25 mg at bedtime routinely, but stated the resident could still receive one PRN dose daily. b. Review of the medical record showed no evidence the Trazadone had a gradual dose reduction (GDR) since it was ordered on 7/19/22, nor was there documentation from the physician why a GDR would be contraindicated. c. Review of the January 2024 MAR (through 1/24/24) showed the resident received the PRN quetiapine 4 times. d. Further review of the physician orders and the MAR showed the PRN quetiapine order was	F 758	c) Corrective action for resident # 2: a GDR and PRN 14 day limitation put in place. d) Corrective action for resident #19: A GDR was put in place and PRN was changed to scheduled per PCP indication. e) Corrective action for resident # 23: a GDR was put in place as well as PRN 14 day limitation 2) Identifying others: a) upon admission, as well as quarterly at MDS, and care conference, all new orders for psychotropic medications will have a GDR established, or renewed, as well as a 14 day limitation if indicated and ensure rational is in place if PCP indicates an extension of PRN. 3) Systemic Changes: a) nurse training for receipt of new psychotropic orders will be added to new hire nurses guide book. Nurse manager will be informed of new orders and nurse manager will communicate with pharmacist for drug regimen review. 4) Monitoring: a) nurse manager will audit resident electronic record weekly x12 weeks, then monthly for psychotropic medications, GDR, PRN 14 day limitations and rational when indicated by PCP. b) All audits will be brought to Quality Assurance coordinator and reviewed at quarterly QAPI meeting. Quarterly review of psychotropic medication will be reviewed at resident care conferences, as well as quarterly MDS/care plan review. These reviews will be included on the ongoing quarterly QAPI meeting agenda going forward.	

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 _____	01/25/2024

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 758	Continued From page 15	F 758		

not limited to 14 days.

3. Review of the of the care plan last revised 12/24/23 for resident #19 showed to administer lorazepam 0.5 mg three times a day as needed for behaviors. The following concerns were identified:

a. Review of the prescription order dated 11/6/2023 showed a current order to give one tablet of lorazepam 0.5 mg; by mouth three times daily as needed for anxiety, muscle spasms, agitation and dementia. The PRN order did not have an end date.

b. Review of the MAR showed lorazepam was given 24 days out of 31 in December 2023 and was given 22 days out of 25 days in January 2024.

4. Interview with the DON on 1/25/24 at 11:24 AM revealed she was new to the DON position and the PRN psychotropics were not on her radar so far. She revealed there had been turnover with pharmacists and the staff responsible for monitoring GDRs.

5. Interview with the consultant pharmacist on 1/25/24 at 12:05 PM revealed she documented on the drug regimen review (DRR) if the resident had PRN psychotropics, but had not been monitoring them for compliance with the regulations (14 day limit). She stated she would start identifying them as an irregularity and notify the physician. In addition, she stated she had sent a GDR request to the physician for resident #23 on 6/15/23, but had not received a response back. She stated they would get better about tracking GDRs to ensure they received a response back.

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 _____	01/25/2024

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 883	Continued From page 16	F 883		
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- (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;	F 883		3/1/24

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 _____	01/25/2024

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 883	Continued From page 17 (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, staff interview and review of facility policy and procedures, the facility failed to ensure residents were offered or received the pneumococcal immunization for 2 out of 5 sample residents (#15, #19) reviewed for immunizations. The findings were: 1. Review of the medical record on 1/25/24 at 1 PM for resident #15 showed the last pneumococcal (PCV-13) vaccine received was on 11/5/2019. Further review showed no evidence the resident was offered an updated vaccine. 2. Review of the medical record on 1/24/24 at 8:50 AM for resident #19 showed the last pneumococcal (PCV-13) vaccine received was on 6/11/2015. Further review showed no evidence the resident was offered an updated vaccine. 3. Interview on 1/25/24 at 11:44 AM with the DON	F 883	1) Corrective Action: a) The vaccination policy has been amended to include the initial visit at admission with PCP to review vaccination status. b) Infection Preventionist will review vaccination records upon admission to ensure residents are offered the pneumococcal, inluenza, and Covid-19 vaccinations and document accordingly. c) Corrective action for resident #15: An appointment for pneumococcal vaccination scheduled for 2/15/24. d) Corrective action for resident # 19: An appointment for pneumococcal vaccination scheduled for 2/15/24. 2) Identifying others: a) Infection Preventionist will audit all residents vaccination status at admission, quarterly at care conference/care plan	

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 _____	01/25/2024

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 883	Continued From page 18 revealed it was the facility's expectation that all residents be up to date with vaccines. 4. Review of the article from the CDC website found on 2/7/24 at 8:33 AM titled " Pneumococcal Vaccination: Summary of Who and When to Vaccinate" at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/who-when-to-vaccinate.html#adults-65-over showed for adults over 65 years old who "Only Received PCV13 For older adults who don't have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak: Give 1 dose of PCV20 or PPSV23 at least 1 year after PCV13. Regardless of vaccine used, their vaccines are then complete." Or "For older adults who have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak: Give 1 dose of PCV20 or PPSV23. Regardless of vaccine used, their vaccines are then complete. The PCV20 dose should be given at least 1 year after PCV13. The PPSV23 dose should be given at least 8 weeks after PCV13."	F 883	review, an quarterly MDS submission, and schedule vaccinations according to what is needed. b) An audit of all residents vaccination status was performed and a public health nurse is scheduled to come to Morning Star Care Center to offer and administer vaccinations as indicated for all residents. 3) Systemic changes: a) upon admission, Infection Preventionist will chick immunization registry and contact PCP for documentation of immunization history. If the resident does not have vaccination status documented, vaccines will be offered either in the facility or an appointment will be made for resident to visit PCP. 4) Monitoring: a) Infection Preventionist will audit all resident vaccinations at admission, quarterly for care conference/care plan review, and at the time quarterly MDS. All audits will be reported to Quality Assurance Coordinator and reviewed at the quarterly QAPI meeting. These reviews will be included on the ongoing quarterly QAPI meeting agenda going forward.	