

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

PRINTED: 01/12/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/29/2005
NAME OF PROVIDER OR SUPPLIER MORNING STAR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE P O BOX 559 PORT 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 State Standards Rules and Regulations for Program Administration of Nursing Care Facilities Section 5. Organization and Administration. (a) Governing Body. The Nursing Care Facility shall have a governing body which has the legal authority and responsibility to operate the Nursing Care Facility. The governing body shall: (i) Appoint a full-time, on premise, administrator qualified by education, training and experience as established by the Wyoming Board of Nursing Home Administrators. (A) The administrator shall have a current license as a Wyoming Licensed Nursing home Administrator. (v) The administrator shall enforce the rules and regulations relative to the level of health care and safety of residents and for the protection of their personal and property rights. This Standard was not met as evidenced by: Based on phone conversation with the acting nursing home administrator, the facility failed to ensure there was a qualified full-time nursing home administrator (NHA) on the premises. The findings were: A phone conversation with staff member #1, on 12/29/05 at approximately 9:30 AM revealed he	F 000	The current acting administrator is licensed in the state of Montana and is in the process of achieving Wyoming licensure. The governing body will be informed of their responsibility to ensure that the facility administrator is licensed in the state of Wyoming. A monitor will be added to the Quality Assurance Committee agenda to assure that the facility administrator holds a current Wyoming NHA license	2/1/06 2/1/06 2/1/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____

TITLE

(X4) DATE

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.

1/27/02

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FORM CMS-2567(02-99) Previous Versions Obsolete