

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

PRINTED: 06/12/2013
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 03/01/2006
NAME OF PROVIDER OR SUPPLIER MORNING STAR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 STATE STANDARD Rules and Regulations for Program Administration of Nursing Care Facilities (Chapter 11) 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. This STANDARD was not met as evidenced by: Based on staff interview and review of the Wyoming Board of Nursing Home Administrator's database, the governing body failed to appoint an administrator who was licensed in the state of Wyoming. The findings were: Upon entering the facility on 3/1/06 at 12 noon, employee #1 introduced himself as the administrator of the facility. During interviews on 3/1/06 at 12:02 PM and 1:50 PM, the administrator stated he did not have a Wyoming nursing home administrator license. He stated the previous administrator's last day was 2/28/06, and further stated he was the only person fulfilling the duties of the administrator.	F 000			

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

TITLE

(X6) 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.

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

PRINTED: 06/12/2013
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 03/01/2006
NAME OF PROVIDER OR SUPPLIER MORNING STAR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	Continued From page 1 Review of the Internet database for the Wyoming Board of Nursing Home Administrators on 3/1/06 revealed the administrator was not licensed.	F 000			