PRINTED: 07/13/2005
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 01 - MAIN BUILDING 01 B. WING _____	06/28/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	P O BOX 859 FORT WASHAKIE, WY 82514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
K 000	INITIAL COMMENTS Surveyor #: 18185 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K3: Building: Type V (111) single story building without a basement with a dry sprinkler system. K6: Date of Plan Approval: 1983 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=45;SNF/NF=45 K9: The facility meets the Life Safety Code standards based on acceptance of a plan of corrections "NFPA" National Fire Protection Association	K 000	K 027 NFPA Life Safety Code Standard The hardware of the door into the East Wing was adjusted to ensure that the door would come to a positive latch when closed on 6/29/05. The Director of maintenance will check the smoke barrier doors on a weekly basis for one month and if no problems are found the doors will be checked on a monthly basis along with all other doors in the facility as part of the routine maintenance checklist. The director of maintenance will report findings from these monthly checks to the QA committee. As part of the quarterly QA report.	8/12/05
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and staff interview on	K 027		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/22/05

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.

ACCEPTANCE OF PAC WITH TIM KOWALD, NHA, ON 7/22/05 @ 245 PM NA RECOMMENDED.

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

PRINTED: 07/13/2005
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 01 - MAIN BUILDING 01 B. WING _____	06/28/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	P O BOX 859 FORT WASHAKIE, WY 82514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
K 027	Continued From page 1 6/28/05 between 12 PM and 1230 PM, the facility failed to protect 1 of 3 smoke barrier doors in accordance with NFPA 101 Section 19.3.7.3 and 8.3.2. The findings were: 1. The two east wing corridor smoke barrier doors were not able to fully close once released from the magnetic hold open devices. At the time of survey the maintenance director was not able to determine if the self-closing device on the door closest to room #202 was adjusted properly or if the ventilation system in the east wing had a negative pressure.	K 027	K 029 NFPA Life Safety Code Standard The doors into the soiled linen room near room #105 ,d the soiled linen room near room # 205, the clean linen room near room #111 and the door to the laundry soiled linen room were adjusted to ensure that the door would come to a positive latch when closed on 6/29/05. The Director of maintenance will check the doors on a weekly basis for one month and if no problems are found the doors will be checked on a monthly basis along with all other doors in the facility as part of the routine maintenance checklist. The director of maintenance will report findings from these monthly checks to the QA committee. As part of the quarterly QA report.	8/12/05
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview on 6/28/05 between 11 AM and 1 PM, the facility failed to provide 4 of 6 hazardous areas with proper separation in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. The soiled linen room near room #105, the soiled linen room near room #205, the clean linen	K 029		

PRINTED: 07/13/2005
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 01 - MAIN BUILDING 01 B. WING _____	06/28/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	P O BOX 859 FORT WASHAKIE, WY 82514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
K 029	Continued From page 2 room near room #111, and the laundry soiled linen room corridor doors did not latch in their frames with each self-closing operation. Maintenance staff verified the finding.	K 029	K 045 NFPA Life Safety Code Standard The bulbs in the East and West exits were changed on 6/28/05. The exit lighting on all five of the exits will be checked weekly by the night charge nurse for a period of one month, if no problems are found the lighting will be checked on a monthly basis by the night charge nurse. The director of Maintenance will report findings from these checks to the QA committee as part of the quarterly QA report.	8/12/05
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observations on 6/27/05 between 9 PM and 930 PM, the facility failed to provide continuous exit discharge lighting for 2 of 5 fixtures in accordance with NFPA 101 Section 19.2.8. The findings were: 1. The west and east wing exit discharge lighting fixtures were not illuminated as required by the Code. At the time of survey the other exit lighting fixtures were illuminated.	K 045		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by:	K 047	K 047 NFPA Life Safety Code Standard The director of Maintenance replaced the missing bulb in the West wing exit sign on 6/28/05 The Director of maintenance will check all exit signs on a weekly basis for one month and if no problems are found the signs will be checked on a monthly basis as part of the routine maintenance checklist. The director of maintenance will report findings from these monthly checks to the QA committee. As part of the quarterly QA report.	8/12/05

PRINTED: 07/13/2005
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 01 - MAIN BUILDING 01 B. WING _____	06/28/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	P O BOX 859 FORT WASHAKIE, WY 82514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
K 047	Continued From page 3 Based on observations and staff interview on 6/28/05 between 11 AM and 1130 AM, the facility failed to provide 1 of 8 exits signs with continuous illumination in accordance with NFPA 101 Section 7-10.5.2. The findings were: 1. The west wing exit sign was missing one of two light bulbs. Maintenance staff verified the finding.	K 047	K 056 NFPA Life Safety Code Standard The completion of sprinklers in the walk-in refrigerator and the roof over the front entrance will be completed by January 15, 2006 Waiver request attached with timetables and completion dates.	1/15/06
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview on 6/28/05 between 11 AM and 12 PM, the facility was not fully sprinkled as required by NFPA 13 Section 5-1.1 and 5-13.8.1. The findings were: 1. The two walk-in refrigerator units in the kitchen did not have sprinkler coverage as required by the Code. 2. The exterior roof above the front entrance was wider than 4 feet and did not have sprinkler	K 056		

PRINTED: 07/13/2005
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 01 - MAIN BUILDING 01 B. WING _____	06/28/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	P O BOX 859 FORT WASHAKIE, WY 82514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
K 056	Continued From page 4 coverage as required by the Code. 3. Maintenance staff verified the findings.	K 056	K 064 NFPA Life Safety Code Standard	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observations and staff interview on 6/28/05 between 11 AM and 12 PM, the facility failed to maintain and test 1 of 10 portable fire extinguishers in accordance with NFPA 10 Section 4-4.3 and Table 5-2. The findings were. 1. The dry chemical portable fire extinguisher in the laundry had a six year maintenance performed in 1998. The extinguisher did not have a hydrostatic test performed six years after the last maintenance as required by the Code. Maintenance staff verified the finding.	K 064	The dry chemical portable fire extinguisher located in the laundry area , was hydrostatically tested on 7/20/05. All fire extinguishers are scheduled to be tested in November of 2005. The director of maintenance will keep a log of fire extinguishers and the date of it's last test and when the extinguisher is to be retested. For any new extinguishers put into service the Director of Maintenance will add it to the with dates recorded for testing.	7/20/05