8/19/11

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

PRINTED: 08/08/2011
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 08/05/2011

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 493 SS=D	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on staff interview and licensure board staff interview, the facility failed to ensure the administrator was licensed by the Wyoming Board of Nursing Home Administrators (NHA). The findings were: During a telephone conversation on 8/5/11 at 10 AM, the administrator stated she did not have a license with the Wyoming Board of NHA. During a telephone conversation on 8/5/11 at 10:15 AM, a staff member at the Wyoming Board of NHA confirmed the facility administrator was not licensed. She also said the process for licensure application was not complete, and the outcome of that process was uncertain.	F 493	The Eastern Shoshone Business Council (Gov Board) hired Marla Martin on 8/1/11 as Administrator of the MSCC on the condition Marla obtain her Temporary Administrators license in the 2-week period of licensure accreditation. License date of issue: 8/18/2011 Expiration date: 2/18/2012 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** A resident meeting was held on 8/4/11 with the residents to voice their concerns regarding past Administrators and future organizational structure at MSCC. **How you will identify other residents having the potential to be affected by the same deficient practice(s) and what corrective action(s) will be taken.** There is a scheduled weekly residents one on one meeting with the Administrator pertaining to facility concerns and of all changes that are occurring and assurance their concerns are being addressed.	8/4/11 N/A per observation 2/1/12

Accepted w/ Changes. Changes made per phone conversation w/ NHA - Marla Martin

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

DOC - 8/18/11 — 8/19/11

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 5IJU11 Facility ID: WY0017 If continuation sheet Page 1 of 1

RECEIVED
Wyoming Dept of Health
AUG 18 2011
Office of Healthcare Licensing and Surveys

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Reviewed Wyoming Department of Health

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