POC accepted
5/16/11
jc

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

PRINTED: 04/18/2011
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 04/14/2011

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=F	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 review of documents, the facility failed to ensure the administrator was licensed by the Wyoming Board of Nursing Home Administrators (NHA). The findings were: During the entrance conference on 4/13/11 at 1:20 PM, the administrator stated she did not have a license with the Wyoming Board of NHA. Review of documents presented by the facility showed she submitted paperwork to the Wyoming Board of NHA for a temporary license on 4/5/11.	F 493	WY Board of Nursing Home Administrators approved the application of Barbara Pelzek, for a temporary license, as Nursing Home Administrator. Date of issue was April 19, 2011. The expiration date is September 19, 2011. An Administrator, with an active, regular license, will be hired prior to the expiration date of Ms. Pelzek's temporary License. Continued compliance will be monitored by the facility's QA program. jc	4/19/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara A Pelzek — TITLE: Interim Administrator — (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. Change's made per Barbara Pelzek / Adv

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZCQS11 Facility ID: WY0017 If continuation sheet Page 1 of 1

during a phone call on 5/16/11 @ 1pm
Janice Cook 10/7/11

RECEIVED
Wyoming Dept of Health
APR 26 2011
Office of Healthcare Licensing and Surveys