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 _____	**10/17/2018**

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
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on October 17, 2018. Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association. The facility was a fully sprinklered, one-story building of Type V(111) construction built in 1983. The building was equipped with a supervised automatic dry sprinkler system with dry pendent heads and an addressable fire alarm system. The facility had a capacity of 45 certified beds with a census of 34.	K 000		
K 344 SS=E	Fire Alarm - Control Functions CFR(s): NFPA 101 Fire Alarm - Control Functions The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire alarm system in accordance with the 2010 NFPA 72 National Fire Alarm and Signaling Code. Failure to maintain the fire alarm system could result in injury or death in the event of an emergency. The deficiency affected four (4) of four (4) smoke compartments.	K 344	K344 1)A red label will be placed on the E.L. panel saying in red Fire Alarm Circuit. Inside the panel, breaker no. 6 will be marked red also that is the fire alarm breaker. 2)All residents, staff and visitors could be	12/2/18

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K 344	Continued From page 1 The findings were: Observation on 10/17/18 at 12:51 PM revealed that the electrical disconnect for the fire alarm system was located in a electrical panel located in the employee lounge, and was not provided with a label. The electrical disconnect for the fire alarm system must be identified with a red "FIRE ALARM CIRCUIT" label. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 72 10.5.5.2.2, 10.5.5.2.3	K 344	affected if circuit was tripped and there was a fire. Maintenance staff will observe when passing by that label is in place. 3)Maintenance Manager will in-service Maintenance staff on NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, 4)Maintenance Manager will report observations of the Fire Alarm Circuit to the Quality Assurance Committee.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		12/2/18

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K 353	Continued From page 2 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire sprinkler system in accordance with the 2011 NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to test and maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiencies affected four (4) of four (4) smoke compartments. The findings were: 1. Document review on 10/17/18 at 1:10 PM revealed that the backflow preventer for the fire sprinkler system was last tested in the spring of 2017. The backflow preventer for the fire sprinkler system is required to be tested once every 12 months. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2011 NFPA 25 13.6.2.1 2. Document review on 10/17/18 at 1:10 PM revealed that the full flow test of the dry fire sprinkler system was due to be tested this year, but had not been performed. The full flow test is	K 353	K353 1)The backflow preventer and the 3 year full flow test will be done ASAP. 2)All residents, staff and visitors could be affected if there were a problem with the fire sprinkler system and there was a fire. Maintenance will observe outside contractors when preforming the tests have completed tests. 3)Maintenance Manager will in-service maintenance staff on NFPA 101 9.75., 9.7.7, 9.7.8 and NFPA 25 4)Maintenance Manager will report observations of the Fire sprinkler inspections to the Quality Assurance Committee.	

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	535050	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/17/2018**

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K 353	Continued From page 3 required to conducted once every 3 years. Interview with the maintenance director at the time of the observation acknowledged the deficiency. He believed the test had been completed, but acknowledged the testing documentation stated it had not been completed. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2011 NFPA 25 13.4.4.2.2.2	K 353		
K 781 SS=E	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to keep portable space-heating devices out of prohibited areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to keep portable space-heating devices out of prohibited areas could result in injury or death by initiating a fire. The deficiencies affected two (2) of four (4) smoke compartments. The findings were: Observation on 10/17/18 at 11:52 AM and throughout the survey revealed several resident rooms with portable space-heating devices.	K 781	K781 1)All portable space heaters will be removed ASAP from smoke compartments where people will sleep. 2)All residents, staff and visitors could be affected if heater would start something on fire. Maintenance staff will observe and audit all sleeping smoke compartments for portable space heaters 3)Maintenance Manager will in-service maintenance staff on NFPA 101 18.7.8,	12/2/18

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K 781	Continued From page 4 Portable space-heating devices are prohibited in healthcare occupancies unless they are in non-sleeping staff and employee areas. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.7.8	K 781	19.7.8. 4)Maintenance Manager will report observations of the Portable space heaters to the Quality Assurance Committee.	

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 10/17/2018. .	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only.	E 015		12/2/18

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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.

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E 015	Continued From page 1 The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to develop policies and procedures that address all the subsistence needs for staff and patients. The findings were: Document review of the Emergency Preparedness Plan on 10/17/18 at 2:00 PM revealed that the policies for subsistence needs did not address food, medication, or pharmaceutical supplies. The policies also were missing vendor names and numbers, as well as the amount of supplies on hand. Interview with the facility administrator acknowledged the deficiency. .	E 015	EO15 1) D.O.N. and Dietary Manager will develop the policies for subsistence needs in food, medication, or pharmaceutical supplies, along with vender names, phone numbers and amount of supplies on hand. 2) All residents, staff and visitors are at risk related to the lack of our subsistence needs in our policies and procedures, therefore the D.O.N. and Dietary Manager will review our policies that involve food, medication, pharmaceutical supplies, and vender names, numbers along with the amount of supplies they have on hand. 3) Nursing, Dietary, Housekeeping and Maintenance departments will in-service their own staff departments on CFR(s): 483.73(b)(1), 418.113(b)(6)(iii) 4) Once a year. D.O.N., Dietary Manager	

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E 015	Continued From page 2	E 015	will review our policies that involve subsistence needs policies and report them to Quality Assurance Committee. 5) Completion date 12/2/18	
E 022 SS=F	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to develop policies and procedures for sheltering in place.	E 022	EO22 1)Maintenance Manager will develop a policy and procedure for sheltering in place for residents, staff and volunteers.	12/2/18

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E 022	Continued From page 3 The findings were: Document review of the Emergency Preparedness Plan on 10/17/18 at 2:00 PM revealed that no policy was available for sheltering in place for patients, staff and volunteers. Interview with the facility administrator acknowledged the deficiency. .	E 022	2)All residents, staff and volunteers are at risk with not having a policy and procedure for sheltering in place, related to where would they would sleep. Maintenance Manager will review our sheltering in place, policy and procedure once a year. 3)Nursing, Dietary, Housekeeping and Maintenance departments will in-service their own staff on CFR(s): 483.73(b)(4) and 418.113(b) 4)Once a year, nursing, dietary, housekeeping and maintenance departments will review our policy on sheltering in place and report them to Quality Assurance Committee. 5) Completion date 12/2/18	
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role	E 024		12/2/18

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E 024	Continued From page 4 for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to develop policies and procedures for use of volunteers in an emergency. The findings were: Document review of the Emergency Preparedness Plan on 10/17/18 at 2:00 PM revealed that no policy was available for the use of volunteers in an emergency, or other emergency staffing strategies. Interview with the facility administrator acknowledged the deficiency. .	E 024	EO24 1)Q.A.P.I. will develop a policy and procedure for volunteers in an emergency. 2)All residents, staff and visitors are at risk with not having a policy and procedure for volunteers in an energy we need to know who and how they can help. Nursing, Dietary, Housekeeping and Maintenance departments will review our volunteer policy and procedure once a year. 3)Human Resources will in-service employees on CFR(s): 483.73(b)(6) 4)Once a year Q.A.P.I. will review our policy on volunteers in an energy policy and report them to Quality Assurance	

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E 024	Continued From page 5	E 024	Committee. EO24	
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph	E 036		12/2/18

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E 036	Continued From page 6 (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to develop policies and procedures for Emergency Preparedness training and testing. The findings were: Document review of the Emergency Preparedness Plan on 10/17/18 at 2:00 PM revealed that no policy or procedure was available for the training and testing of the emergency preparedness program. Interview with the facility administrator acknowledged the deficiency.	E 036	EO36 1)Human Resources will write a policy and procedure for training and testing employees for emergency preparedness. 2)All residents, staff and visitors are at risk with not having a policy and procedure for emergency preparedness if an emergency happened no one would know what to do. Human Resources will review training and testing of employees for emergency preparedness policy and procedure once a year. 3)Training will give to new employees and once a year to all employees. 4)Human Resources will give a report of training in emergency preparedness to the Quality Assurance Committee. 5)Completion date 12/2/18	