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 _____	**10/02/2019**

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 10/02/2019. Requirements for Long Term Nursing Homes 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(000) 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 32. .	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		11/8/19

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

Electronically Signed | 10/24/2019

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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K 321	Continued From page 1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to protect hazardous areas could result in injury or death in the event of a fire. The deficiency affected one (1) of four (4) smoke compartments. The findings were: Observation on 10/02/19 at 12:45 PM revealed the medical storage room contained combustible material, and had an automatic door closer on it that had been disabled. Hazardous areas must be protected by an automatic-closing door. Interview with the maintenance manager 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.	K 321	1) The arm that was removed from the door closure device will be reinstalled by Oct 15 2019. Also it will be adjusted to close and latch under the operation of the closure device. In the future any time a door is moved or changed the maintenance manager will contact the code enforcement committee for requirements. 2) All the elders in our community and the employees would be affected if the door did not close correctly and a fire was allowed to spread. The maintenance staff will observe the closure devices to ensure they are in place where needed as required by NFPA 101. 3) The maintenance manager will in-service the maintenance crew on NFPA 101 8.7.1 and 19.3.5.9 to make observations of door closure devices on all rooms including storage rooms. This closure device will be audited during the closure device scheduled audits, and is already included on the closure device	

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K 321	Continued From page 2 Reference: 2012 NFPA 101 19.3.2.1.3 .	K 321	audits form. 4) The maintenance manager will report any observation of the door closure devices to the quality assurance committee	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiencies affected one (1) of one (1) fire alarm systems. The findings were: Document review on 10/02/19 at 1:45 PM revealed that the facility had not conducted the annual and semi-annual tests of the fire alarm system. Annual tests of the annunciation panels, alarm notification appliances, manual fire alarm boxes, heat detectors, and smoke detectors are required to be conducted. Semi-annual tests of the fire alarm batteries shall be conducted.	K 345	1)The yearly fire alarm system test will be conducted on Oct. 29 2019. At that time the previous year□s documentation will be supplied to the facility and added to our records. 2) All the elders within the facility and employees could be affected if the fire alarm system failed to notify them or the first responding agencies. 3) The maintenance manager will add a section within the audits book for the facility that encases the previous fire alarm system inspections and tests, a monthly fire alarm system audit is conducted. The maintenance staff will be made aware of all the documentation and its location. All the maintenance employees will also be updated on the requirement in NFPA 72, NFPA 70, 9.6.1,3	11/8/19

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K 345	Continued From page 3 Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 72 Table 14.4.5(1), Table 14.3.1(3), Table 14.4.5(20), Table 14.4.5(15)(f), Table 14.4.5(15(e), Table 14.4.5(15)(h) Document review on 10/02/19 at 1:45 PM revealed that the facility had activated the fire alarm system six (6) of the last twelve (12) months. The fire alarm system is required to be tested by activation every month. Interview with the maintenance manager 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 Table 14.4.5(24) .	K 345	and 9.6.1.5. 4) The maintenance employees will report any changes to function and/or problems with the alarm system to the quality assurance committee.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar	K 712		11/8/19

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K 712	Continued From page 4 with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly conduct fire drills could result in injury or death in the event of a fire. The deficiency affected all residents and staff. The findings were: Document review on 10/02/19 at 1:45 PM revealed that the facility had conducted fire drills on both shifts for two (2) of the last four (4) quarters. Fire drills shall be conducted quarterly on each shift. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.7.1.6 .	K 712	1)Moving forward starting Nov 1 2019 quarterly fire drills will be performed for all shifts to help familiarize all elders and employees with the practices of our fire evacuation policy, and give real feedback as to what skills will need improvement and which we do well. Maintenance staff in conjunction with nursing will administer the drills and critique all employees that participate. There is already a roster system in place to keep track of attendance. 2) All elders and employees could be affected by this deficiency due to a possibility of unknown procedure in a fire event. 3) The maintenance manager will in-service all employees that are new hire on fire drill procedures and policies. The maintenance manager will also in-service meetings periodically through the year outlining the policies in NFPA 101 19.7.1.4 through 19.7.1.7 4) The quality assurance committee will be made aware any time a fire drill is failed or if something needs to be updated.	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		11/8/19

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K 918	Continued From page 5 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the	K 918	1) In the following week to survey Oct 9 the maintenance manager found the previous audits done by the maintenance	

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K 918	Continued From page 6 2012 NFPA 99, Health Care Facilities Code. Failure to test and maintain the emergency generator could result in injury or death in the event of an emergency. The deficiency affected four (4) of four (4) smoke compartments. The findings were: Document review on 10/02/19 at 1:45 PM revealed that the facility had conducted the emergency generator 30 minute load test once a quarter for the last year. The 30 minute load test is required to be conducted monthly. Interview with the maintenance manager 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 99 6.4.4.1.1.4 (A); 2010 NFPA 110 8.4.2.4	K 918	crew. These forms were added to the audit book for the maintenance team. In the future the maintenance employees will audit the generator one time weekly with a load test one time monthly. 2) Loss of generated power can affect the entire staff and all the elders within the community. In an emergency situation the generated power will be needed for life safety. 3) Maintenance employees will be in-serviced on what requirements will be needed to comply with 6.4.4, 6.5.4, 6.6.4 (NFPA 99) NFPA 110, NFPA 111, and NFPA 70 700.10. 4) Any problems or concerns with the generated power will be brought to the quality assurance committee and will be first priority if there is a change.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident	K 920		11/8/19

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K 920	Continued From page 7 rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly use power strips in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly use power strips could result in injury or death. The deficiency affected one (1) of four (4) smoke compartments. The findings were: Observation on 10/02/19 at 12:10 PM revealed that resident room 206 had a power strip located within the patient care vicinity. The resident room contained patient care related electrical equipment. Power strips can not be located within the patient care vicinity in resident rooms that use patient care related electrical equipment. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement.	K 920	1) All extension cords and power strips have been removed from the patient care area. Pictures of the deficiency in room 206 are included. 2) This deficiency could affect all elders and staff as cords and power strips are trip hazards and fire hazards. Also the elder could be affected if the power strip had life safety equipment plugged into it and it failed. 3) The maintenance manager will in-service all maintenance employees as to the requirement in NFPA 101 10.2.3.6. Also during the monthly electrical inspection already in place the maintenance team will audit the rooms for power strips and/or cords being used incorrectly or in the patient care areas. 4) The quality assurance team will be updated periodically to maintain a safe patient area in each room that is occupied by a resident/elder of the community.	

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K 920	Continued From page 8 Interview with the administrator at the time of exit acknowledged the deficiency.	K 920		

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 10/03/2019. .	E 000		
E 018 SS=F	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(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:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):]	E 018		11/8/19

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E 018	Continued From page 1 Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Document review and staff interview revealed	E 018	1. Policy and procedures have been	

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E 018	Continued From page 2 that the facility failed to develop procedures that address the tracking of staff and patients. The findings were: Document review of the Emergency Preparedness Plan on 10/02/19 at 2:30 PM revealed that no procedure was available that addressed tracking of staff and patients if relocated during an emergency. Interview with the facility administrator acknowledged the deficiency. .	E 018	implemented to track the location of on duty staff and sheltered elders in the facility□s care, in the event that on duty staff and sheltered elders are relocated during an emergency. A roster has been developed for all in house elders, including hospice and dialysis, as well as all on duty staff to track the specific name and location of the receiving facility or other location in which they are relocated. 2. All elders and staff are at risk if the facility is unable to track them whereabouts in the event they have to be relocated in an emergency. 3. The Quality Assurance team will review our policies that involved tracking all on duty staff and sheltered elders, and ensure all phone numbers, names, and locations are current and updated quarterly or as changes occur. In addition all staff will be in serviced on the policy and procedure for tracking on duty staff and sheltered elders.	
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(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:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the	E 026		11/8/19

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 _____	10/02/2019

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
E 026	Continued From page 3 [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Document review and staff interview revealed that the facility failed to develop a policy that addressed the role of the facility under a waiver. The findings were: Document review of the Emergency Preparedness Plan on 10/02/19 at 2:30 PM revealed that no policy was available that addressed the role of facility under a waiver. Interview with the facility administrator acknowledged the deficiency.	E 026	1.A policy/procedure for the role of the facility under a waiver as declared by the secretary has been established. 2.Staff education has been initiated and will be ongoing for newly employed staff. 3.The Quality Assurance team will review the Role of the Facility under a waiver policy at least yearly and as necessary prior to.	
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:	E 031		11/8/19

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 _____	10/02/2019

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
E 031	Continued From page 4 (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Document review and staff interview revealed that the facility failed to develop a communications plan that included emergency officials contact information. The findings were: Document review of the Emergency Preparedness Plan on 10/02/19 at 2:30 PM revealed that required contact information for emergency officials was not included in the Communications plan. Interview with the facility administrator acknowledged the deficiency.	E 031	1. An all-inclusive Emergency Preparedness Contact list has been updated to include the federal, state, tribal, reginal, and local Emergency Preparedness staff members. 2. Staff education on the updated emergency staff numbers has been initiated and will be ongoing. 3. The Quality Assurance team will review the Emergency officials contact information yearly and prior too as necessary.	