STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING **01** B. WING _____	**04/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	**4 NORTH FORK ROAD** **FORT WASHAKIE, WY 82514**

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 04/10/2025. Based on the findings of the survey team, it was determined that the facility was in compliance with all requirements in accordance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 04/10/2025. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in this 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, single story building of Type V(III) 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 Medicare and Medicaid beds with a census of 29 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
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	K 345		5/30/25

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

Electronically Signed | 05/02/2025

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K 345	Continued From page 1 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 properly test and maintain the fire alarm system could result in a malfunction or failure of the system resulting in injury or death in the event of a fire. The deficiency affected the fire alarm system, and could potentially affect all residents, staff, and visitors. The findings were: Document review on 04/10/25 starting at 2:05 PM revealed that the facility failed to perform all required testing of the fire alarm system. No documentation was available to demonstrate that the required 2-year smoke detector sensitivity test of the fire alarm system had been conducted in the last twenty four (24) months. Documentation was available to demonstrate that the fire alarm notification devices had been tested as part of the annual test of the fire alarm system in February of 2025. The provided documentation did not include a list of all notification devices with a location and test results for the testing of the device. Interview with maintenance manager at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency.	K 345	Corrective Action: The fire alarm contractor, who is a licensed smoke detector sensitivity testing company, has been scheduled 5/6/25 to complete a smoke detector sensitivity test. A fire alarm system audit, to include sensitivity testing of smoke detectors, has been implemented. Identifying others: Fire alarm systems use a test for smoke to ensure an alarm will sound to alert of tfires or smoke in an area of the facility. Each device that test this needs to function correctly to ensure an early alert of danger and thus will need tested periodically so the parts can be assured to work. This test must be done on a schedule of no less than 2 years to ensure the health and safety of all residents, employees and visitors. Systemic Changes: Maintenance review of fire system testing policy and procedures with administrator and all staff scheduled in-service 5/22/25. Smoke detection sensitivity test audit implemented and added to quarterly QAPI agenda to ensure every two year testing compliance date is followed. Monitoring: A quarterly audit implemented x1 year then yearly to ensure every two year completion and audits review to be completed quarterly at quarterly QAPI meeting.	

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K 345	Continued From page 2 Ref: 2010 NFPA 72 Table 14.4.5(15)(i), Table 14.4.5(20), Figure 14.6.2.4	K 345		
K 353 SS=F	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 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 properly test and maintain the fire sprinkler system could result in a malfunction or failure of the system resulting in injury or death in the event of a fire. The deficiency affected the fire sprinkler system, and could potentially affect all residents, staff, and visitors.	K 353	Corrective Action: The annual inspection contractor provided documents that show the correct number of inspections for the year, after the Life Safety inspection. The issue of documentation collection at the time of inspection will be remedied with maintenance follow-up and auditing timeline for which documentation is recieved related to testing of the sprinkler system. Systemic changes: Review of the	5/30/25

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K 353	Continued From page 3 The findings were: Document review on 04/10/25 starting at 2:05 PM revealed that the facility failed to conduct all required quarterly and annual inspections and tests of the fire sprinkler system. Documentation was available to demonstrate that the facility had conducted quarterly inspections and tests of the dry system priming water and dry system low air alarm for three (3) of the four (4) quarters of the last twelve (12) months. Documentation was available to demonstrate that the facility had conducted quarterly inspections and tests of the water flow alarm and supervisory signal for two (2) of the four (4) quarters of the last twelve (12) months No additional documentation was available to demonstrate inspection and testing of the fire sprinkler system was conducted for the other quarters of the previous twelve (12) months. No documentation was available at the time of the survey to demonstrate that the annual test of the backflow preventer had been conducted in the last twelve (12) months. Interview with maintenance manager at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2011 NFPA 25 Table 5.1.1.2, 5.3.2, Table 13.4.4.2.1, 13.4.4.2.6, 13.6.2.1	K 353	sprinkler system testing and maintenance policy and procedures completed by maintenance with the Administrator, and an all-staff in-service review is scheduled 5/8/25 to review compliance requirements. Monitoring: A sprinkler testing timeliness audit will be conducted monthly x3 months, then quarterly thereafter to ensure compliance for quarterly and yearly testing intervals. Audits will be reviewd at quarterly QAPI meeting and added to the QAPI agenda.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712		5/30/25

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K 712	Continued From page 4 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 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 an improper response by staff to an emergency, resulting in injury or death. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 04/10/25 starting at 2:05 PM revealed that the facility failed to conduct all required fire drills. Documentation was available at the time of the survey to demonstrate that the facility had conducted monthly fire drills for the last twelve (12) months. Documentation revealed that of the twelve (12) drills conducted only two (2) were conducted with the night shift. Drills shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required. Interview with maintenance manager at the time of the observation acknowledge the deficiency,	K 712	Corrective Action: Fire drills are conducted by maintenance and include all staff at the facility during the drill, each staff member will sign a ledger for attendance. To ensure each quarterly drill is done with the different shifts, there will be an addition to the scheduling calendar to include night shift, as well as day shift. The night shift fire drill will take place on or before 5/23/25 and then quarterly thereafter. Identifying others: Performing fire drill on a required rotation improves everone in our facilty's knowledge of procedures and practices in the event of a fire. If the staff does not train and a fire were to happen, there could be the potential of higher risk for injury or death. This can cause safety problems for any resident, employee, or visitor in the facility in the event of a fire. Systemic changes: The fire drills policy and procedures reviewed by maintenance with the administrator. The all-staff review is scheduled for 5/22/25 with acknowledgement of policy/procedure	

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K 712	Continued From page 5 and indicated that they were unaware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2012 NFPA 101 19.7.1.6	K 712	through in-service sign in sheet. Monitoring: Day and night shift fire drill completion audit will be completed by maintenance dept monthly x3 months, then quarterly thereafter. Audits will be reviewed at quarterly QAPI meeting and added to the agenda for ensured compliance.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to inspect and test fire door assemblies in accordance with the 2012 NFPA 101, Life Safety Code, and 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Failure to properly inspect and test fire door assemblies could result in the spread of smoke and fire, resulting in injury or death in the event of a fire. The deficiency affected all fire door assemblies, and has the potential to affect	K 761	corrective action Fire door inspection: MSCC maintenance manager is certified for door testing through NFPA. A testing system audit has been modified to include what testing is being done in detail, and how often. Corrective action vertical rolling fire door located in kitchen: Maintenance has inspected and tested the vertical rolling fire door located in the kitchen to ensure	5/30/25

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K 761	Continued From page 6 all residents, staff, and visitors. The findings were: Document review on 04/10/25 starting at 2:05 PM revealed that the facility failed to inspect and test fire door assemblies as required. No documentation was available to demonstrate that the fire door assemblies in the facility had been inspected and tested in the last twelve (12) months. Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be kept. Interview with maintenance manager at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2010 NFPA 80 5.2.1, 5.2.3 Document review on 04/10/25 starting at 2:05 PM revealed that the facility failed to inspect and test rolling fire doors as required. No documentation was available to demonstrate the the vertical rolling fire door located in the kitchen had been inspected and tested in the last twelve (12) months. Rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Interview with maintenance manager at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement.	K 761	proper functionality 4/24/25. An audit will be completed for vertical rolling door and all fire doors at every fire drill monthly, and as needed, and documented at that time by maintenance dept. Identifying others: Inspection and testing of all doors including fire-rated doors must be done to ensure correct functionality in case of an emergency and to ensure proper function in simple day-to-day use. Doors should be looked at for mechanical problems with latches, locks or hinges and be looked at for physical damage to the door and gaps or worn frames. These inspections are done by a certified person and are done on annual basis. Failure to do this could cause safety issues for the members of the care facility and any person visiting the facility for any reason. Systemic changes: The policy/procedure for maintenance, inspection and testing of doors reviewed by maintenance with adminstrator, and will be reviewed with all-staff at in-service scheduled 5/22/25. Monitoring: Audits will be conducted monthly x3 months, then quarterly thereafter. All audits will be reviewed at quarterly QAPI meeting to ensure compliance.	

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K 761	Continued From page 7 Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2010 NFPA 80 5.2.14.3	K 761		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full	K 923		5/30/25

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K 923	Continued From page 8 cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly store oxygen cylinders in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly store oxygen cylinders could result in damage to the cylinders and a release of oxygen gas, which could propagate the spread of smoke and fire, resulting in injury or death in the event of a fire. The deficiency affected one (1) exterior oxygen storage area, and has the potential to affect all residents, staff, and visitors in the area. The findings were: Observation on 04/10/25 at 1:49 PM revealed an exterior oxygen storage area with oxygen cylinders that were improperly stored. Observation of the oxygen storage area revealed approximately 90 E size oxygen cylinders being stored. Observation revealed nine (9) of the cylinders were placed laying down on top of the other oxygen cylinders that were being stored upright in carts. The nine cylinders were not secured in anyway, and had the potential to roll off the other cylinders and get damaged. Oxygen cylinders shall be protected from damage by being properly chained or supported in a stand or cart. Interview with maintenance manager at the time of the observation acknowledge the deficiency,	K 923	Corrective Action: MSCC staff has contacted the distributor who supplies the oxygen tanks and asked for an empty overflow cart that can be filled with excess bottles and returned. Staff will be trained as to how to carry, store and account for each bottle, ensuring that there will not be an overabundance in the future. MSCC staff will also do a visual inspection of the storage area and report any improper storage of oxygen tanks. The members of the QAA team will be assigned visual compliance checks and bring non-compliance issues to daily stand up huddles. The distributor has also been educated for proper storage policies for MSCC, and has agreed to assist with compliance for safety. Identifying others: Oxygen cylinders under pressure, incorrectly stored, can cause multiple dangers. Damage to any oxygen tank could be harmful to staff, residents, and visitors at MSCC, and all tanks should be stored in a safe and restrained manner. Systemic changes: The Oxygen policy and procedure reviewed by maintenance with administrator, and will be reviewed with all-staff at in-service 5/22/25. Monitoring: Proper storage and oxygen tank safety audit to be conducted weekly	

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K 923	Continued From page 9 and indicated that they were aware of the requirement. Interview with the administrator at the time of the exit confirmed the deficiency. Ref: 2012 NFPA 99 11.6.2.3	K 923	x4 weeks, then monthy x12 months by maintenance dept. All audits will be added to quarterly QAPI agenda, and reviewed for compliance.	