STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPL ER/CLIA IDENTIFICATION N MBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53503	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC IS (EACH DEFICIENCY MUST BE PRECEDED F FULL REGULATORY OR LSC IDENTIFYING INFORI ATION)	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 Requirements for Long Term Care Fac ilities Section 42 CFR 483.70 (a) except as o herwise provided in this section, the facility mu t meet the applicable provisions of the 2000 editi n of the Life Safety Code, Existing Health Care of the National Fire Protection Association (N FPA). The facility was a fully sprinkled single story building of Type V (111) construction b ilt in 1985. The building was equipped with supervised automatic wet sprinkler sys em and with an addressable fire alarm system. The facility had a capacity of 60 certified M dicare and Medicaid beds with a census of 36.	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STAN DARD One hour fire rated construction (with ; hour fire-rated doors) or an approved autom tic fire extinguishing system in accordance wi n 8.4.1 and/or 19.3.5.4 protects hazardous are as. When the approved automatic fire extinguishi g system option is used, the areas are separate from other spaces by smoke resisting partiti ns and doors. Doors are self-closing and non rated or field-applied protective plates that do n t exceed 48 inches from the bottom of the door a re permitted. 19.3.2.1 This STANDARD is not met as eviden ed by: Based on observation and staff intervie v the facility failed to ensure hazardous area were separated from use areas in 1 of 5 smo ke compartments. The findings were: Observation of resident room #311 on /21/10 at	K 029	K 029 The storage room will be converted back to a resident room on or before 10/15/2010. The locking door knob will be replaced with standard room door knob and materials stored in that location will be moved to storage garage behind building. The maintenance director will ensure rooms are not being used for unapproved storage and will report any concerns to the Quality Assurance Committee at least quarterly.	10/15/10

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

ADMINISTRATOR 10/4/2010

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. (ee 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 s provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available t the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
WyomingDeptofHealth

PC Mailed & accepted w/ Nancy Enyot, NHA

ON 10/13/10.

OCT 04 2010

Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPP IER/CLIA IDENTIFICATION UMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5350: 3	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS; CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

10/13/10

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN ES (EACH DEFICIENCY MUST BE PRECEDED Y FULL REGULATORY OR LSC IDENTIFYING INFOR IATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1 8:35 AM showed 9 mattresses where eing stored in the room. Further review sho ved the corridor door was not equipped with a elf-closing device. At the time of observation the maintenance director reported he was not aware that rooms storing excessive combust le must have fire separation.	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STAI DARD Exit access is arranged so that exits a e readily accessible at all times in accordance v th section 7.1. 19.2.1 This STANDARD is not met as eviden ed by: Based on observation and staff intervie v the facility failed to ensure egress doors ha f proper headroom in 1 of 5 smoke compartme s. The findings were: Observation of the egress system on 9 21/10 at 9:10 AM showed the double egress do s leading to the secure unit were equipped with r agnetic locks. Further review showed the botto of the egress locks were not the required 6 fo t 8 inches above the floor. The maintenance direc or measured the bottom of the locks at 6 1 et 5 inches. He was not aware of the 6 foot inch requirement.	K 038	K 038 The magnetic closure on the Secure Unit doorway will be relocated using Z brackets to ensure proper head clearance of 6 feet 8 inches. This will be completed on or before 10/31/2010. FACILITY DOOR WILL BE INSPECTED ANNUALLY TO ENSURE PROPER HEAD ROOM & DURING WEEKLY ROUNDS ALL FINDINGS WILL BE ADDRESSED @ THE NEXT Q.A. MEETING.	10/31/10