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

PRINTED: 01/04/2010
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
	535027	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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 Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in this section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association (NFPA). The facility was a fully sprinkled two story building with a basement of Type II (111) construction built in 1982 and 1992. The building was equipped with a supervised automatic wet sprinkler system with an addressable fire alarm system. The facility had a capacity of 128 certified Medicare and Medicaid beds.		Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations manual.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use ares in 1 of 12 smoke compartments. The findings were: Observation on 12/21/09 at 3:57 PM showed the	K 029	1. The facility will continue to ensure that hazardous areas are separated from use areas in smoke compartments. 2. The unsealed penetration in the East storeroom was sealed on 1/7/10. Work Order # 37743. 3. The facility will continue to monitor areas under construction for new penetrations in any smoke compartments, and do quarterly checks on existing areas. The Director of Plant Operations will ensure compliance.	01/07/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: JoAnne Kaiser, NHA | TITLE: Administrator | (X6) DATE: 01/14/10

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.

POC ACCEPTED W/ JOANNE KAISER, NHA, ON 1/19/10.

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K 029	Continued From page 1 east storeroom had two unsealed cable penetrations above the double doors. The largest gap was 1 inch wide. At the time of observation the maintenance director reported all hazardous areas were inspected quarterly to ensure smoke resistant separation. He further reported a new cable system had been installed one month earlier.	K 029 (cont'd)	4. Completion will be reported at least quarterly through the Environment of Care Committee, with oversight by the Quality Improvement (QI) committee, and monitored by the Director of Plant Operations.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and observation the facility failed to ensure fire drills were conducted quarterly on 2 of 3 shifts and failed to ensure staff members were familiar with emergency response procedures on 1 of 3 shifts. The findings were: 1. Review of the fire drill records showed the second shift occurred between 3 PM and 11 PM and the third shift was from 11 PM and 7 AM. Further review documented a drill had not been conducted on the second shift during the second and third quarters of 2009. Documentation also showed a drill had not been conducted on the third shift during the first, second and third shift of 2009. At 10:30 AM on 12/22/09 the member of	K 050	1. The facility will continue to ensure that fire drills are conducted quarterly on all shifts, and that staff members are familiar with emergency response procedures. 2. Training was provided by the Director of Plant Operations to the person conducting drills to ensure proper times and procedures are conducted. 3. A staff inservice will be conducted on 1/13/10 to ensure nursing staff members are educated regarding the emergency response plan. 4. Director of Plant Operations will ensure drills are conducted monthly and meet all requirements for each shift and area and documented correctly. 5. Completion will be reported at least quarterly through the Environment of Care Committee, with oversight by the QI committee, and monitored by the Director of Plant Operations.	01/13/10

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K 050	Continued From page 2 maintenance staff responsible for fire drills reported he was not aware a drill had to be conducted on each shift during each quarter. He also reported two recorded fire drills were desk top reviews and the staff did not activate the alarm or go through the needed actions in the event of a fire. The maintenance director confirmed the aforementioned shifts had not conducted drills during the noted quarters. 2. Observation of a fire drill on 12/22/09 at 11:01 AM showed a "fire" light was placed in resident room #11 and the nurse call light was activated. A Certified Nurses Aide (CNA) was the first responder to the "fire" room. She entered the room and then exited. The CNA did not appear to know what the red flashing light indicated. The second responder was also a CNA. She also exited the room because she was unsure what the light indicated. A nurse then entered the room, recognized the light, and instructed the first responder to activate the fire alarm pull station. Staff then reacted appropriately. After the drill the first responder reported she had worked at the the facility for six months and had never been involved in a fire drill. She further reported that she usually worked the first shift.	K 050		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the	K 062	1. The facility will continue to ensure that required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 2. All sprinklers checked and lowered if necessary by Western States Sprinkler contractor.	01/18/10

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K 062	Continued From page 3 facility failed to ensure sprinklers were not obstructed and free of corrosion in 3 of 12 smoke compartments. The findings were: 1. Observation on 12/21/09 between 3 PM and 4 PM showed one sprinkler head in the physical therapy (PT) gym and one in the PT office area were not located more than 1 inch from the ceiling. One of the sprinklers was observed to be flush with the ceiling. At 3:10 PM the maintenance director reported all sprinkler heads were inspected annually. He also reported that each year the contractor finds more sprinkler heads with less than 1 inch spacing. The contractor stated the sprinkler pipes moved with the heating and cooling of the building and this was anticipated to be a continual problem given the current spacing of sprinkler heads. 2. Observation on 12/21/09 at 3:23 PM showed the sprinkler in the PT office pediatric play area was obstructed by a ceiling-mounted light. The sprinkler was 6 inches from the light, and the bottom of the light was 2 inches below the sprinkler deflector. At the time of observation the maintenance director reported he was aware sprinklers were to be at or below any obstruction. He further reported the light was recently replaced in this particular location. 3. Observation on 12/21/09 at 4:20 PM showed the sprinkler in shower room #6-S was corroded. This condition of this sprinkler was confirmed with the maintenance director at the time of observation.	K 062 (cont'd)	3. Light obstructing sprinkler head will be relocated by 1/18/10. Work Order # 37853. 4. Sprinkler head to be replaced on 1/8/10 by Western States Sprinkler. 5. The Director of Plant Operations will ensure compliance through quarterly inspections of all sprinklers. 6. Completion will be reported at least quarterly through the Environment of Care Committee, with oversight by the QI committee, and monitored by the Director of Plant Operations.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069	1. The facility will continue to ensure that the kitchen hood fire suppression systems are maintained as required.	01/08/10

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K 069	Continued From page 4 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure 2 of 2 kitchen hood fire suppression systems were maintained as required. The findings were: Review of the kitchen hood fire suppression system testing records documented that the sprinkler heads had not been replaced within the last year. The facility was not able to provide documentation as to when the heads were last changed. On 12/22/09 at 10:30 AM the maintenance director confirmed the heads had not been changed in the last 18 months.	K 069 (cont'd)	2. The sprinkler heads were replaced on the kitchen hood on 1/8/10 by Western States Sprinkler contractor. 3. Preventative Maintenance schedule set up to print annually to replace heads. PE#483 4. The Director of Plant Operations will monitor and ensure compliance annually. 5. Completion will be reported annually through the Environment of Care Committee, with oversight by the QI committee.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation and staff interview the facility failed to ensure the stand-by emergency generator was properly maintained. The findings were: Review of the emergency generator testing records documented that a full oil change and service had not been done in at least 18 months.	K 144	1. The facility will continue to ensure that the stand-by emergency generator is properly maintained and tested. 2. New generators are being installed with new service agreement with Cat Tractor and Equipment. 3. Planned Event (PE) created to print annually to schedule service. PE #484 4. The Director of Plant Operations will monitor and ensure compliance annually.	01/07/10

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K 144	Continued From page 5 The facility was unable to provide documentation as to when the last full service was done. On 12/22/09 at 10:30 AM the maintenance director confirmed the generator had not been serviced in the past 18 months.	K 144 (cont'd)	5. Completion will be reported annually through the Environment of Care Committee, with oversight by the QI committee.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure receptacles in wet locations were protected with GFCI (ground fault circuit interrupter) receptacles and failed to ensure permanent wiring was not replaced with temporary wiring in 2 of 12 smoke compartments. The findings were: 1. Observation on 12/21/09 between 3 PM and 6 PM showed the electrical receptacle in the men's restroom in the basement and the receptacle in the first floor medication room were located within 6 feet of sinks. The receptacles were not protected with GFCI receptacles. One sink was only 24 inches from the receptacle. At 3:40 PM the maintenance director reported he was aware electrical receptacles within 6 feet of water sources were required to be GFCI protected. He also confirmed the receptacles were unprotected. 2. Observation on 12/21/09 at 5:10 PM showed a surge protector was attached to the wall in the first floor east tub room. At the time of observation the maintenance director reported he was aware surge protectors were prohibited from being attached to building surfaces. He further	K.147	1. Receptacles in the basement men's restroom and in the first floor medication room will be replaced with GFCI's. Work Order # 37849. 2. The surge protector will be removed and outlets (GFCI's) installed by 1/22/10 in the first floor east tub room. Work Order # 37744 3. Semi annual Planned Events will occur to ensure compliance. PE #486 4. This will be monitored by staff Electrical Technician, with the Director of Plant Operations being overall responsible for compliance. 5. Completion will be reported through the Environment of Care Committee, with oversight by the QI committee.	01/22/10

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K 147	Continued From page 6 reported the electrical system was inspected quarterly to ensure permanent electrical wiring was not replaced with temporary wiring.	K 147		
K 211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure ABHR (alcohol based hand rub) dispensers were not installed over ignition sources in 3 of 12 smoke compartments. The findings were: 1. Observation on 12/21/09 between 4:30 PM and 5 PM showed the ABHR dispenser in resident room #28 and the one installed in the SCU (special care unit) were installed over electrical receptacles. At the time of observation the maintenance director reported he was aware they were prohibited from being installed over ignitions	K 211	1. The facility will continue to ensure that alcohol based hand rub dispensers are not installed over ignition sources. 2. The dispensers in resident room #28 and in the special care unit were moved. Work Order #37745 3. All dispensers on the second floor were moved if they were over or adjacent to an ignition source. Work Order # 37745. 4. Director of Plant Operations will monitor to ensure compliance with quarterly checks. 5. A quarterly Planned Event (#487) has been set to occur to ensure compliance. 6. Completion will be reported at least quarterly through the Environment of Care Committee, with oversight by the QI committee.	01/04/10

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K 211	Continued From page 7 sources. He reported they were installed by the manufacturer of the dispensers. He also reported all rooms were inspected quarterly, but he could not explain why the dispensers were not noted during the last inspection. 2. Observation on 12/22/09 between 8 AM and 9 AM showed ABHR dispensers were installed over ignition sources in 16 of 20 resident room on the second floor. At 8:27 AM the maintenance director reported the dispensers had been installed for nearly a year.	K 211		

West Park Hospital
CODY, WYOMING

FAX TRANSMISSION

DATE: 1/14/10
TO: Jean McLean RD
Manager – OHLS

FAX NO. (307) 777-7127
PHONE: (307) 777-7123

REGARDING: Plans of correction for deficiencies noted in the Life Safety Code survey conducted on December 22, 2009

SENT BY: Jeanne Kaiser LTCC Administrator (307) 578-2434

COMMENTS:
Please find enclosed the plans of correction for deficiencies noted in the Life Safety Code survey conducted on December 22, 2009. Should you have any questions, please do not hesitate to contact me.

You are being faxed a total of 9 pages including the cover sheet. If you do not receive the entire number of pages or if there are problems with the quality or legibility, please contact the above person at the department/phone number listed above.

Originals will be mailed via certified mail on 1/14/10