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

PRINTED: 02/25/2011
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 _____	02/09/2011

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 with plan approval in 1982 and 1992. The building was equipped with a supervised automatic wet sprinkler system and with an addressable fire alarm system. The facility had a capacity of 128 certified Medicare and Medicaid beds with a census of 73 residents.	K 000	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 facts ~~alleged~~ or conclusions set forth in 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 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	1. The facility will continue to ensure that corridor doors are smoke resistant. 2. The door latch to resident room #21 was adjusted on 02/11/2011 to properly close. 3. All doors will be checked on a quarterly basis by Plant Operations Department personnel to ensure proper closing to maintain smoke compartments. A planned event reminder prints quarterly to the Plant Operations Department to initiate the checking of all fire and smoke doors on a timely basis. 4. The completion of regular door checks will be reported by the Director of Plant Operations on a quarterly basis to the Environment of Care Committee, with oversight by the organization-wide Quality Improvement/Performance Improvement (QI/PI) Committee. 5. The Director of Plant Operations will monitor.	02/02/2011

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

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3SNR21 Facility ID: WY0039 If continuation sheet Page 1 of 6

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Wyoming Dept of Health
MAR 03 2011
Office of Healthcare Licensing and Surveys

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure corridor doors were smoke resistant in 1 of 12 smoke compartments. The findings were: Observation of the corridor door for resident room #21 on 2/09/11 at 10:52 AM showed it would not latch into the door frame, with three attempts. At the time of observation the maintenance director reported all corridor doors were inspected on a quarterly basis. He stated he did not know why this particular door failed to latch.	K 018		
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 areas in 1 of 12 smoke compartments. The findings were: Observation of the therapy pool mechanical room	K 029	1. The facility will continue to ensure that hazardous areas are separated from use areas in all smoke compartments. 2. The five unsealed pipe penetrations in the therapy pool mechanical room were repaired and sealed on 03/01/2011. 3. All areas of the facility where construction has occurred that may cause penetration in a smoke compartment will be inspected by Plant Operations Department personnel on at least a quarterly basis to insure any penetrations are sealed. 4. Results of these regular inspections will be reported by the Director of Plant Operations on a quarterly basis to the Environment of Care committee, with oversight by the organization-wide QI/PI Committee. 5. The Director of Plant Operations will monitor.	03/01/2011

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K 029	Continued From page 2 on 2/09/11 at 1:49 PM showed five unsealed pipe penetrations. The largest gap was 1/2 inch between the wall and pipe. At the time of observation the maintenance director reported the room was inspected on a quarterly basis. He could not explain why the holes had not been noticed and repaired.	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure exit discharge pathways were unobstructed at all times for 2 of 12 smoke compartments. The findings were: Observation of the north stair tower on 2/09/11 at 10:45 AM showed the north smoke compartment on the first and second floor designated this stair tower as an emergency exit route. Further review showed the exit discharge sidewalk was obstructed by a large ice mound formed from dripping water off the roof. The mound was solid ice and was 6 inches high and 24 inches wide with additional ice, resulting in a diameter of 48 inches from the mound. At the time of observation the maintenance director reported the sidewalks were inspected after each snow storm. He confirmed the less used exit pathways were not inspected on a routine basis.	K 038	1. The facility will continue to ensure that exit discharge pathways are unobstructed at all times. 2. The ice mound outside the north stair tower was removed on 02/09/2011. 3. Training and discussion was held with all grounds personnel regarding daily checks of all exits on their regular rounds. 4. The results of regular inspections of all exits will be reported by the Director of Plant Operations on a quarterly basis to the Environment of Care Committee with oversight by the organization-wide QI/PI Committee. 5. The Director of Plant Operations will monitor.	02/09/2011
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 047		

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K 047	Continued From page 3 Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 10.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure exit signs were illuminated in 1 of 12 smoke compartments. The findings were: Observation of the north stair tower on 2/09/11 at 10:42 AM showed the exit sign above the ground floor exit door did not have either light bulb illuminated. At the time of observation the maintenance director reported each sign was inspected on a quarterly basis. He stated he did not know why these lights had not been noticed and replaced.	K 047	1. The facility will continue to ensure that all exit and directional signs are displayed with continuous illumination. 2. The light bulbs in the exit sign above the ground floor exit door in the north stair tower were replaced on 02/16/11. 3. A new preventative maintenance planned event reminder has been set to generate on a bi-monthly basis to specifically check the exit sign at the north stair tower. All other exit signs will be checked quarterly by Plant Operations Department personnel on regular rounds. 4. The results of regular rounds to check all exit signs will be reported by the Director of Plant Operations on a quarterly basis to the Environment of Care Committee with oversight by the organization-wide QI/PI Committee. 5. The Director of Plant Operations will monitor.	02/16/2011
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	1. The facility will continue to ensure that complete sprinkler coverage is provided in all smoke compartments. 2. The sprinkler head in the back closet of the basement therapy gym was located above the door and was present but not noticed at the time of survey. 3. Quarterly environmental inspections will be conducted by Plant Operations Department personnel to ensure that all smoke compartments contain required sprinkler coverage. 4. The results of environmental rounds will be reported by the Director of Plant Operations on a quarterly basis to the Environment of Care Committee with oversight by the organization-wide QI/PI Committee.	02/09/2011

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K 056	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure complete sprinkler coverage in 1 of 12 smoke compartments. The findings were: Observation of the basement therapy gym on 2/09/11 at 1:41 PM showed therapy equipment was stored in the back closet. Further review showed the closet was 12 feet by 3 feet but had no interior sprinkler. At the time of observation the maintenance director reported he was aware complete sprinkler coverage was required. Furthermore, he reported the sprinkler system was inspected on an annual basis by an outside contractor. He confirmed the missing sprinkler head had not been identified by the outside contractor.	K 056	5. The Director of Plant Operations will monitor.	
K 062 SS=F	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 facility failed to ensure sprinklers were unobstructed in 2 of 12 smoke compartments. The findings were: Observation on 2/09/11 between 10 AM and 1:30 PM showed the sprinklers at the top of the main stair tower and in the basement men's staff	K 062	1. The facility will continue to ensure that sprinklers are unobstructed in all smoke compartments. 2. The light at the top of the main stair tower was moved on 02/11/2011. 3. The light in the basement men's staff restroom will be moved by 03/04/2011. 4. All sprinklers will be checked by the contracted provider on an annual basis. 5. The results of the regular sprinkler checks will be reported by the Director of Plant Operations on a quarterly basis to the Environment of Care Committee with oversight by the organization-wide QI/PI Committee. 6. The Director of Plant Operations will monitor.	03/04/2011

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K 062	Continued From page 5 restroom were obstructed. The sprinklers were installed within 12 inches of ceiling mounted lights and the bottom of the lights were below the bottom of the sprinkler deflectors. At 10:18 AM the maintenance director reported he was aware of the spacing requirement. He further reported that the system was inspected annually by an outside contractor, but they had not noted any obstructed sprinklers on their last report.	K 062		
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure portable fire extinguishers were inspected on a monthly basis in 1 of 12 smoke compartments. The findings were: Observation of the new generator room on 2/09/11 at 11:22 AM showed the three portable fire extinguishers were last serviced in August 2010. Further review showed they had not received a monthly inspection since they were installed. At the time of observation the maintenance director reported the extinguishers were added when the new generator room was completed. He stated the extinguishers must not have been added to the monthly inspection schedule.	K 064	1. The facility will continue to ensure that all portable fire extinguishers will be inspected on a monthly basis. 2. The three portable fire extinguishers in the new generator room were inspected on 02/11/2011, and added to the monthly check list. 3. All portable fire extinguishers will be inspected by Plant Operations personnel on a monthly basis. 4. The completion of monthly inspections of portable fire extinguishers will be reported by the Director of Plant Operations on a quarterly basis to the Environment of Care Committee with oversight by the organization-wide QI/PI Committee. 5. The Director of Plant Operations will monitor.	02/11/2011