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

PRINTED: 06/07/2010
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
	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEA B. WING _____	05/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE & REHABILITATION CENTER	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(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 three story building with a basement of Type II (222) construction built in 1972. The building was equipped with a supervised automatic wet sprinkler system with an addressable fire alarm system. The facility had a capacity of 143 certified Medicare and Medicaid beds.	K 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute 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.*	
K 020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure items were not stored in 1 of 3 stair towers. The findings were: Observation of the south stair tower on 5/18/10 at 9:50 AM showed five cardboard boxes were stored under the stairs in the basement landing. At the time of observation the maintenance director reported he was unaware storage could not be maintained in the stairwell.	K 020	K-020: NFPA 101 Life Safety Code Standard **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director or designee removed the boxes that were located under the south stair tower. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director or designee will conduct a facility-wide audit to confirm that boxes are not stored in stair tower areas.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

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

Executive Director 6-18-10

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 MODIFIED TO INCLUDE W/ AND STACKS, NHA, ON 6/25/10 Received Wyoming Dept of Health Head

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6OHZ2 Facility ID: WY0018 JUN 2 1 2010 If continuation sheet Page 1 of 6

6-18-10 Delivered

Office of Healthcare Licensing and Surveys

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K 020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure items were not stored in 1 of 3 stair towers. The findings were: Observation of the south stair tower on 5/18/10 at 9:50 AM showed five cardboard boxes were stored under the stairs in the basement landing. At the time of observation the maintenance director reported he was unaware storage could not be maintained in the stairwell.	K 020		
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K 029	Continued From page 1 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 basement elevator room on 5/18/10 at 10:24 AM showed the the room had three unsealed pipe penetrations. The largest gap was 1 inch between the pipe and the wall. At the time of observation the maintenance director reported the room was inspected quarterly to ensure it was smoke resistant. However, he could not explain why the penetrations had not been sealed.	K 029	K-029: NFPA 101 Life Safety Code Standard **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director or designee sealed the three (3) pipe penetrations located in the basement elevator room. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director or designee will conduct a facility-wide audit to confirm that pipe penetrations are sealed. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director or designee will incorporate into their routine rounds the inspection of pipes to confirm that they are sealed. **Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** Random audits will be performed monthly times 3 months by the Maintenance Director or designee to confirm that pipes are sealed.	
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	K 038		

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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	K 038		

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K 038	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 2 of 6 egress pathways were unobstructed. The findings were: 1. Observation on 5/18/10 at 10:45 AM showed the exterior gate to the courtyard was secured with two locks. At the time of observation the maintenance director reported he was not aware doors in the path of egress could only have one lock. 2. Observation on 5/18/10 at 10:52 AM showed the exit door near resident room #104 opened into the courtyard. The sidewalk between the exit door and the exterior gate was obstructed by a steel bench. The unobstructed portion of the pathway measured 32 inches wide. At the time of observation the maintenance director reported the egress pathways were inspected quarterly. He stated he was unsure why the bench had not been removed from the egress pathway. 3. Observation on 5/18/10 at 11:17 AM showed the west stair tower egress pathway was not 48 inches wide. The sidewalk was only 30 inches wide due to a portion of the walk being broken. At the time of observation the maintenance director reported the sidewalk was damaged during demolition of a building that had been recently removed. He further reported the building had been removed more than 6 months ago.	K 038	K-038: NFPA 101 Life Safety Code Standard **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director or designee removed one of the locks on the exterior gate in the courtyard. The Maintenance Director or designee removed the steel bench from an exit ~~door~~ PATHWAY near resident room #104. The Maintenance Director or designee will construct a sidewalk 48 inches wide near the west stair tower. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director or designee will conduct an audit to confirm that a second lock is not being used on the exterior gate in the courtyard. The Maintenance Director or designee will conduct an audit to confirm that benches, or anything else, is not obstructing exit doors.	
K 056 SS=F	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	K 056		

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K 056 SS=F	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	K 056		

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K 056	Continued From page 3 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 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the sprinkler system was electronically supervised and failed to ensure the building had complete sprinkler coverage in 2 of 12 smoke compartments. The findings were: 1. Observation of the basement elevator room on 5/18/10 at 10:39 AM showed the sprinkler shut-off valve to the elevator pit was not electronically supervised. At the time of observation the maintenance director reported he was not aware all sprinkler shut-off valves were required to be supervised. He further reported that the sprinkler system was inspected annually by an outside contractor and lack of supervision of the valve was not noted on the last inspection report. 2. Observation of the therapy pantry on 5/18/10 at 11:29 AM showed there was not sprinkler coverage beneath the air duct. Further review showed the duct was 40 inches wide and 57 inches long. At the time of observation the maintenance director reported he was not aware duct work wider than 48 inches required sprinkler coverage under them. He further reported that the	K 056	K-056: NFPA 101 Life Safety Code Standard **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director or designee will remove the valve from the basement elevator room. The Maintenance Director or designee will install a new sprinkler head beneath the air duct in the therapy pantry. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director or designee will conduct a facility-wide audit to confirm that sprinkler heads are located below any obstructing object **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director or designee will incorporate into their routine rounds the inspection of sprinkler heads to confirm that they are not obstructed.	

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K 056	Continued From page 4 sprinkler system was inspected annually by an outside contractor and the lack of sprinkler coverage was not noted on the last inspection report.	K 056		
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, record review and staff interview the facility failed to ensure sprinkler were unobstructed in 1 of 12 smoke compartments and failed to ensure 2 of 4 sprinkler system components were properly tested. The findings were: 1. Observation of the basement electrical room on 5/18/10 at 10:09 AM showed both lights were obstructed by the ceiling mounted fluorescent lights. The lights were installed 6 inches away and 2 inches below the sprinkler deflectors. At time of observation the maintenance director reported the sprinkler system was inspected annually by an outside contractor, and the obstructed sprinklers were not noted on the last inspection report. 2. Review of the sprinkler system testing reports showed the supervisory signal device #3-C did not report to the fire alarm panel during the 2/22/10 and 5/06/10 testing. On 5/18/10 at 3 PM the maintenance director reported he had not noticed the above noted issue.	K 062	K-062: NFPA 101 Life Safety Code Standard **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Maintenance Director or designee will lower the sprinkler head in the basement electrical room. The Maintenance Director or designee will repair the supervisory signal device #3-C to confirm that it will report to the fire alarm panel. The Maintenance Director or designee will repair waterflow devices #3-A and #1-B to confirm that they activate the fire alarm system within ninety (90) seconds. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Maintenance Director or designee will conduct a facility-wide audit to confirm that sprinkler heads are not obstructed by fluorescent lights. The Maintenance Director or designee will confirm that upon completion of the supervisory signal repair that the supervisory	

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	535013	A. BUILDING 01 - MOUNTAIN TOWERS HEA B. WING _____	05/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE & REHABILITATION CENTER	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(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 056	Continued From page 4 sprinkler system was inspected annually by an outside contractor and the lack of sprinkler coverage was not noted on the last inspection report.	K 056		
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, record review and staff interview the facility failed to ensure sprinkler were unobstructed in 1 of 12 smoke compartments and failed to ensure 2 of 4 sprinkler system components were properly tested. The findings were: 1. Observation of the basement electrical room on 5/18/10 at 10:09 AM showed both lights were obstructed by the ceiling mounted fluorescent lights. The lights were installed 6 inches away and 2 inches below the sprinkler deflectors. At time of observation the maintenance director reported the sprinkler system was inspected annually by an outside contractor, and the obstructed sprinklers were not noted on the last inspection report. 2. Review of the sprinkler system testing reports showed the supervisory signal device #3-C did not report to the fire alarm panel during the 2/22/10 and 5/06/10 testing. On 5/18/10 at 3 PM the maintenance director reported he had not noticed the above noted issue.	K 062	signal devices report to the fire alarm panel. The Maintenance Director or designee will confirm that upon completion of the waterflow device repair that the waterflow device activates the fire alarm system. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Maintenance Director or designee will incorporate into their routine rounds the inspection of sprinkler heads to confirm that they are not obstructed by fluorescent lights. The Maintenance Director or designee will confirm that upon the completion of quarterly inspections that the supervisory signal devices report to the fire alarm panel. The Maintenance Director or designee will confirm that upon the completion of the quarterly inspections that the waterflow devices activate the fire alarm system. **Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** Random audits will be performed monthly times 3 months by the Maintenance Director or designee to confirm that sprinkler heads	

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K 062	Continued From page 5 3. Review of the sprinkler system testing reports showed waterflow devices did not activate the fire alarm system within 90 seconds. Device #3-A did not activate the fire alarm panel on 5/06/10, on 2/22/10 the alarm sounded after 112 seconds and on 11/16/09 the alarm sounded after 115 seconds. Further review of device # 1-B showed the alarm sounded after 104 seconds on 2/22/10 and after 105 seconds on 11/16/09. On 5/18/10 at 3 PM the maintenance director reported he had not noticed the above noted issues on the testing report.	K 062	are not obstructed by fluorescent lights. During the next quarterly inspection, the Maintenance Director or designee will confirm that supervisory signal devices report to the fire alarm panel. During the next quarterly inspection, the Maintenance Director or designee will confirm that waterflow devices activate the fire alarm system. Results of the random audits will be presented to the Performance Improvement Committee monthly for 3 months. Date of compliance is July 5, 2010.	7/05/10