STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A002	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/27/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 Surveyor #: 18185 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K3: Building: Type V (111) single story building with a supervised automatic wet sprinkler system and anti-freeze branch. The basement houses the kitchen, boiler room, laundry, and maintenance department. The nursing home is separated from the hospital by a 2-hour fire rated barrier. The three doors in the 2-hour fire rated barrier are 1 1/2 hour rated doors. K6: Date of Plan Approval: 1964 and 1996 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=50;NF=50 K9: The facility meets the Life Safety Code standards based on acceptance of a plan of corrections "NFPA" National Fire Protection Association	K 000		
K 014 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide flame retardant interior decorations in accordance with NFPA 101	K 014	The facility will ensure that interior decorations have proper flame retardant specifications. The Activities Director will acquire only decorations that meet acceptable standards. The Activities Director will ensure that proper documentation for such decorations is maintained and available for inspections.	

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.

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K 014	Continued From page 1 Section 19.3.3.1 and 10.3.1. The findings were: 1. Review of flame retardant documentation on 06/27/06 at 10:10 AM revealed the loose hanging banners and streamers in the main dining room did not have any flame retardant documentation. The activities coordinated reported there were no other records to review.	K 014	The Maintenance Managerwwill conduct periodic inspections to ensure compliance. Compliance will be monitored through a performance improvement monitor.	07/20/06
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. This STANDARD is not met as evidenced by: Based on observations the facility failed to protect the corridor system in accordance with NFPA 101 Section 19.3.6.3 and 7.2.1.5.4. The findings	K 018	The facility will protect the corridor system in accordance with applicable life safety standards. The door knob in question will be relocated to a height not to exceed 48 inches. The corridor door will be readjusted so that there is not a gap in excess of 1/8th of an inch.	

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K 018	Continued From page 2 were: 1. Observation on 06/27/06 at 9:18 AM revealed the door knob on the corridor to the 300 hall soiled utility room was more than the allowed 48 inches above the floor. The door knob was 60 inches above the floor. 2. Observation on 06/27/06 at 9:27 AM revealed the corridor door to the exercise room had a gap greater than the allowed 1/8th of an inch.	K 018	Maintenance personnel will be responsible for making these modifications. The Maintenance Manager will be responsible for monitoring to ensure future compliance. Compliance will be monitored through a performance improvement monitor.	08/01/06
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations the facility failed to seal penetrations in three of six barriers in accordance with NFPA 101 Section 19.3.7.3. The findings were: 1. Observation on 06/27/06 between 11 AM and 12 PM revealed the following vertical barrier walls had unsealed conduit penetrations above the ceiling tile: a. The fire barrier wall separating the care center	K 025	The facility will seal penetrations in smoke barriers. Maintenance personnel will seal all penetrations noted. The Maintenance Manager will be responsible for monitoring and surveying to ensure compliance. Compliance will be monitored through a performance improvement monitor.	07/28/06

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K 025	Continued From page 3 from the hospital above the east connecting wing double doors. b. The smoke barrier wall near resident room #114 above the double doors. c. The smoke barrier wall near the beauty shop above the double doors.	K 025		
K 029 SS=D	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 observations the facility failed to separate 2 of 9 hazardous areas from other spaces by smoke-resistant assemblies in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. Observation on 06/27/06 at 8:30 AM revealed the self-closing device attached to the corridor door of the soiled utility room near resident room #209 did not fully latch the door into the frame with each closing action. 2. Observation on 06/27/06 at 10:34 AM revealed the elevator control room was storing 5 trash	K 029	The facility will separate hazardous areas from other spaces by smoke resistant assemblies in accordance with applicable requirements. Maintenance personnel will adjust the self closing device to ensure the door closes properly. Maintenance personnel will install a self closing device on the door to the elevator control room. The Maintenance Manager is responsible for ensuring future compliance. Compliance will be monitored through a performance improvement monitor.	07/28/06

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K 029	Continued From page 4 receptacles and the corridor door was not equipped with a self-closing device as required by the Code.	K 029		
K 038 SS=D	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 observations and staff interview, the facility failed to provide egress access doors with a single releasing action in accordance with NFPA 101 Section 19.2.1 and 7.2.1.5.4. The findings were: 1. Observation on 06/27/06 at 10:17 AM revealed the dining rooms east exit access doors was equipped with hardware requiring more than one releasing operation. The north door was equipped with a dead bolt lock. The south door was equipped with a magnetic latching device which released with the either the numeric combination or the activation of the fire alarm system. Maintenance staff were not aware egress doors required a single action to release them.	K 038	The facility will provide egress access doors with a single releasing action in accordance with applicable requirements. Maintemance personnel will remove the dead bolt lock and magnetic latching device from the door in question. The Maintenance Manager is responsible for monitoring to ensure future compliance. Compliance will be monitored through a performance improvement monitor.	08/11/06

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K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review the facility failed to test the installed fire alarm system in accordance with NFPA 72 Table 7-3.2. The finding was: 1. Review of the fire alarm system testing records on 06/26/06 at 3:10 PM revealed the batteries in the annunciator panel had not received a load voltage test in the past six months as required by the Code.	K 052	The facility will test the installed fire alarm system in accordance with applicable requirements. Maintenance personnel will conduct a load voltage test on the batteries in the annunciator panel. OU ANNUAL BASIS. JA The Maintenance Manager will ensure future compliance. Compliance will be monitored through a performance improvement monitor.	07/31/06

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

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FORM APPROVED
OMB NO. 0938-0391

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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 This STANDARD is not met as evidenced by: Based on observations the facility was not fully sprinkled as required by NFPA 13 Section 5-1.1, 5-13.8.1, 5-6.5.1.2 and 5-6.3.2 respectively. The findings were: 1. Observation on 06/27/06 between 9 AM and 10:30 AM revealed the following areas did not have sprinkler coverage: a. The 300 hall resident room built in closets. b. The anti-freeze sprinkler closet. c. The base of the hydraulic sprinkler shaft. 2. Observation on 06/27/06 at 9 AM revealed the breaker panel room did not have complete sprinkler coverage. The three foot square area by the door did not have sprinkler coverage due to the ventilation system duct work was obstructing the spray pattern. 3. Observation on 06/27/06 at 10:24 AM revealed the canopy over the south east exit was wider than four feet, not constructed on non-combustible or limited combustible material	K 056	The facility will be fully sprinkled as required by the appropriate codes. A sprinkler will be installed in the anti-freeze sprinkler closet. A sprinkler will be installed in the base of the hydraulic sprinkle shaft. Sprinklers will be installed in th breaker panel room. Sprinklers will be installed under the canopy over the southeast exit. The sprinkler head in the clean utility room will be relocated to the proper distance from the light fixture. Extended coverage sprinklers will be installed in the Activities room. A waiver requesting an extension o time until February 11, 2007 will be requested in order to accomplis this project. The Administrator will coordinate this project. The Maintenance Mgr is responsible for ensuring com-pliance. A PI monitor will be established to ensure compliance. Date of completion 07/27/06 CONSTRUCTION PLANS WILL BE SUBMITTED & APPROVED BY THE WYOMING DEPT. OF HEALTH & FINAL INSPECTION REQUIRED.	

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K 056	Continued From page 7 and was not protected by a sprinkler head under the canopy. Observation revealed the canopy was constructed on two by six pine rafters and plywood sheeting. 4. Observation on 06/27/06 at 8:37 AM revealed the sprinkler head in the clean utility room near resident room #209 was located closer than the allowed six inches from the ceiling mounted florescent light. The sprinkler was located one inch from the light fixture. 5. Observation on 06/27/06 at 10:05 AM revealed the activities room sprinkler heads were located more than the allowed 7 ½ feet from the east wall. The sprinklers were 15 feet from the east wall.	K 056		
K 064 SS=D	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 observations the facility failed to maintain and test 1 of 18 portable fire extinguisher in accordance with NFPA 10 Table 5-2. The finding was. 1. Observation on 06/27/06 at 10:42 AM revealed the K-type portable fire extinguisher in the kitchen was manufactured in 1999 and had not received a 5-year hydrostatic test as required by the Code.	K 064	The facility will test and maintain all portable fire extinguishers in accordance with applicable requirements. Maintenance personnel will ensure that the K type portable fire extinguisher in the kitchen will receive a 5 year hydrostatic test. The Maintenance Manager is responsible for ensuring all extinguishers are test properly. Compliance will be monitored via a performance improvement monitor.	07/19/06

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K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observations the facility failed to limit the amount of soiled linen and trash collection receptacles in non-hazardous areas in accordance with NFPA 101 Section 19.7.5.5. The findings were: 1. Observation on 06/27/06 at 9:31 AM revealed the following locations were storing a 32 gallon soiled linen receptacle and a 32 gallon trash receptacle closer than the allowed eight feet apart: a. The pantry off the small dining room. b. The main dining room.	K 075	The facility will limit the amount fo soiled linen and trash collection receptacles in non-hazardous areas in accordance with applicable requirements. Maintenance personnel will relocate and remove receptacles in the noted areas. The Maintenance Manager is responsible for ensuring future compliance. Compliance will be monitored via a performance improvement monitor.	07/19/06

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K 147 SS=D	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 observations the facility failed to provide an electrical system installed in accordance with NFPA 70 Section 370-25 and 400-8 respectively. The findings were: 1. Observation on 06/27/06 at 9:45 AM revealed the atrium had a junction box without a cover plate. 2. Observation on 06/27/06 at 10 AM revealed the activities office had a 3-way adapter supplying power to a fan.	K 147	The facility will provide an electrical system in accordance with applicable requirements. Maintenance personnel will install a cover plate on the junction box. Maintenance personnel will remove the noted 3 way adapter. The Maintenance Manager is responsibl for ensuring future compliance. 07/19/06 Compliance will be monitored via a performance improvement monitor.	