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

PRINTED: 04/05/20
FORM APPROV
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/21/2006

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 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) COMPLETIO 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 two complete automatic supervised dry sprinkler systems and fire alarm system. K6: Date of Plan Approval: 1985 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=60;SNF/NF=60 K9: The facility meets the Life Safety Code standards based on an acceptance of a plan of corrections "NFPA" National Fire Protection Association "SCU" Special Care Unit	K 000	ADMISSIONS & ACCEPTANCE OF THIS POC WITH RANDY PARK, GM, ON 4/24/06 @ 2PM VIA TELECONFERENCE.	

(BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane K. Coolley, NHA #537 | TITLE: Administrator | (X6) DATE: 4/14/06

ly deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

RM CMS-2567(02-99) Previous Versions Obsolete Event ID: FOPY21 Facility ID: WY0025 If continuation sheet Page 1 of 15

APR 14 2006
WYOMING DEPT. OF HEALTH
HEALTH FACILITIES

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K 018 SS=E	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. The findings were: 1. Observation on 03/21/06 between 8:53 AM and 10:57 AM revealed the following corridor doors had gaps between the top edge of the doors and the door frames which were greater than 1/8 inch: a. The conference room. b. The social services office. c. The mechanical room on the 300 hall. d. Resident room #301. e. Resident room #307.	K 018	K018 The facility will ensure this standard is accomplished by: 1. All corridors will be fixed by completing the following: A. Replacing fire rated seal around the doors to maintain the smoke barrier. B. Replacing fire rated seal around the door to maintain the smoke barrier. C. Placing metal strips on both inside door and outside door to maintain the smoke barrier. D. Replacing fire rated seal round door to ensure smoke barrier. E. Replace firerated seal around door to maintain the smoke barrier and add proper sized wood to top of door. F. Replace fire rated seal around door to ensure smoke barrier. Also add proper sized wood piece. G. Replace Fire rated seal around door to ensure smoke barrier and add proper sized wood piece on top of door. H. Replace Fire rated seal around door to ensure smoke barrier and add proper sized wood piece on top of door. I. Replace Fire rated seal around door to ensure smoke barrier and add proper sized wood piece on top of door.	

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K 018	Continued From page 2 f. Resident room #308. g. Resident room #203. h. Resident room #100. i. Resident room #105. 2. Observation on 03/21/06 at 11:02 AM revealed the corridor door to resident room #103 had a latch bolt which would not insert into the strike plate of the door frame, thereby preventing the door from latching. 3. On 03/21/06 at 9:16 AM, the physical therapy corridor door was impeded by a set of parallel bars.	K 018	2. Replace door strike plate to ensure the door will latch properly. 3. The parallel bars will be moved over 7". This will allow the door to open and close properly. 4. This will be monitored by QA quarterly. 5. ALL CORRIDORS DOORS WILL BE INSPECTED & AMAWISVANCE LOG PUT IN PLACE ON A MONTHLY BASIS THIRD AFTER.	04/28/06
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 two of four smoke barriers in accordance with NFPA 101 Section 19.3.7.3. The findings were: 1. Observation on 03/21/06 at 11:29 AM revealed the vertical smoke barrier wall above the double	K 025	K025 The facility will ensure this standard is accomplished by: 1. Holes will be plugged with texture, then taped over with perfa-tape and finished off properly. 2. This will be monitored by QA Quarterly. 3. ALL SMOKE BARRIERS WILL BE INSPECTED FOR COMPLIANCE.	04/28/06

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K 025	Continued From page 3 doors near the activities office had unsealed conduit penetrations above the ceiling tile. 2. On 03/21/06 at 11:30 AM, the 200 hall vertical smoke barrier wall had two unsealed conduit penetrations in the attic.	K 025		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations, the facility failed to protect 2 of 8 smoke barrier corridor doors in accordance with NFPA 101 Section 19.3.7.3 and 8.3.4.1. The findings were: 1. Observation on 03/21/06 at 12:42 PM, revealed the 300 hall double smoke barrier doors had a gap greater than 1/8 inch between the leading edges of the two doors.	K 027	K027 The facility will ensure this standard is accomplished by: 1. Fire rated seal will be applied to the leading edges of the two doors on the 300 hall double smoke barrier doors. 2. This will be monitored by maintenance director monthly and by QA Quarterly. 3. ALL SMOKE BARRIER DOORS WILL BE INSPECTED FOR COMPLIANCE	04/28/06

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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 3 of 11 hazardous areas from other spaces in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. Observation on 03/21/06 between 8:35 AM and 8:47 AM revealed the following doors were equipped with self-closing devices that had the arms removed: a. The corridor door to the clean linen side of the laundry. b. The door to the soiled linen room in the laundry. 2. Observation on 03/21/06 at 9:36 AM revealed the corridor door to the 300 hall soiled linen room was equipped with a self-closing device which did not latch the door into its frame.	K 029	K029 The facility will ensure this standard is accomplished by: 1. All self closing devices will be checked monthly to ensure they are in proper working order. A. New self closers have been ordered and will be replaced. B. New self closers have been ordered and will be replaced. 2. The striker plate will be replaced with a new one. This will allow the door latch to close properly. 3. This will be monitored by QA quarterly.	04/25/06

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K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review, the facility failed to test the emergency battery light system in accordance with NFPA 101 Section 7.9.3 and 7.9.2.1 respectively. The findings were: 1. Review of emergency battery light testing records revealed the annual 90 minute emergency battery light tests had not been performed in the last 12 months. 2. Review of emergency battery light testing records revealed the monthly 30 second emergency battery light tests had not been performed since June, 2005. 3. Review of generator powered emergency lighting testing records revealed the emergency generator transfer times had not been collected since June, 2005.	K 046	K046 The facility will ensure this standard is accomplished by: 1. A clip board will be place by the light with the sign in sheet to record when testing is completed yearly. Then it will be filed in the maintenance director's office for inspection. 2. The emergency battery light testing for the monthly 30 second tests will be on the same sheet as #1 and will be filed in the same process. 3. A form will be made and posted to collect the generator transfer times. The form will be placed by the generator and will be signed off each time the test is run. At the end of the year (or a completed form) it will be filed in the maintenance director's office. 4. This will be monitored by the Administrator and quarterly by QA.	04/25/06
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain 4 of 14 exits signs in accordance with NFPA 101 Section 7.10.5.2. The findings were:	K 047	K047 The facility will ensure this standard is accomplished by: 1. The Maintenance Director will do weekly checks of all exit signs to ensure they are working properly.	

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K 047	Continued From page 6 1. Observation on 03/21/06 between 8:59 AM and 10:33 AM revealed the following exit signs were not maintained with both light bulbs continuously illuminated: a. The directional sign to the front entrance. b. The dining room sign to the patio. c. The sign leading to the secure unit's smoke barrier. d. The secure unit's sign above the exit.	K 047	2. The sign in the front office will be repaired with new bulbs. 3. Dining room & patio signs will be repaired with new bulbs. 4. Secure unit smoke barrier area sign will be repaired with a new bulb. 5. The Secure Unit sign will be repaired with a new bulb. 6. This will be monitored by QA & the Administrator.	04/28/06
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 observations, record review, and staff interview, facility staff were not familiar with the emergency actions required under varied fire conditions and fire drills were not held on each shift per quarter in accordance with NFPA 101 Section 19.7.1.2. The findings were: 1. Observation on 03/21/06 at 2:30 PM revealed that during the fire drill the first responder to the fire room did not recognize the "fire flag," and left the room without taking any emergency actions. The first responder was directed to go back to the	K 050	K050 The facility will ensure this requirement is accomplished by: 1. A strobe light has been purchased will a red lens, this will replace the fire flag. All staff will be trained on fire drills and all steps. 1. Call out code red while removing all occupants in dander. 2. Activate nearest manual pull station to alert all occupants & staff. 3. Call fire department. 4. Close all doors to isolate fire. 5. Evacuate if necessary. 6. Extinguish if possible. 2. All fire drills will be recorded and kept in a file for review upon request. 3. This will be monitored by the Administrator and QA quarterly.	04/28/06

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K 050	Continued From page 7 room and look for the "fire flag." When the first responder returned to the room and found the "fire flag" she left the room to activate the alarm system without calling out "Code Red" or the location of the fire, as indicated in the facility's "Procedure For Fire." Other staff members delayed emergency actions because "Code Red" was not called out. Other staff members were not sure if the alarms were an actual firedrill or a malfunction because the alarm system had sounded so often in the past few weeks, as reported by maintenance staff at the time of the drill. 2. Review of the fire drill records revealed the second shift had not conducted a fire drill during the fourth quarter of 2005.	K 050		

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K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on record review, staff interview and observations, the facility failed to maintain and test the installed fire alarm system in accordance with NFPA 72 Table 7-3.2 and Section 5-2.2.3.1.1 respectively. The findings were: 1. Review of the fire alarm system testing records revealed the annunciator panel, alarm notification appliances, manual fire alarm boxes, heat detectors, smoke dampers, and smoke detectors had not been tested in the past year as	K 051	K051 The facility will ensure that standards are met by testing the fire alarm. 1. The fire alarm system will be checked by an outside contractor to ensure the annunciation panel, alarm notification appliances, manual fire alarm booties, heat detector, smoke dampers and smoke detectors are ~~inspected quarterly~~. To test Annually. 2. All documentation will be signed off by the Maintenance Director and stored in the maintenance files. 3. The Maintenance Director will do all checks in a timely manner. 4. The place card is in place it is a self adherent 3x5 size on the front of the panel with the contractors name and phone number. 5. A contractor has been contacted for certification he will change our service over to a certified station by 04/30/06 6. This will be monitored by QA & the Administrator.	04/28/06

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K 051	Continued From page 9 required by the Code. 2. On 03/21/06 at 2:59 PM, the required central station placard was not posted within 36 inches of the fire alarm panel. 3. Interview with a member of administative staff on 03/21/06 at 3:01 PM revealed the staff member did not know if the facility's central station was certified. When the administrative staff member called the central station to request verification of certification, he was told the central station was not certified.	K 051		
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 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's sprinkler system was not installed in accordance with NFPA 13 Section 5-6.4.1.1. The findings were: 1. Observation on 03/21/06 between 8:06 AM and 11:21 AM revealed the following locations had	K 056	K 056 The facility will ensure sprinkler system is in compliance with NFPA 13 & 25. This will be accomplished by: 1. Maintenance Director will check hanger in attic/crawl space for proper adjustments. If adjustments can't be made appropriately for compliance heads will be replaced. 2. Bolier room has been adjusted. 3. Dining room has been adjusted. 4. Restroom in resident room 301 has been adjusted. 5. Resident room #309 has been adjusted. 6. Resident room #311 has been adjusted.	

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K 056	Continued From page 10 sprinkler deflectors located within 1 inch of the ceiling: a. The boiler room. b. The dining room. c. The restroom in resident room #301. d. Resident room #309. e. Resident room #311. f. Resident room #200. g. The closet in resident room #202. h. Resident room #210. i. The restroom in resident room #211. j. The 100 hall west bathroom. k. The general storeroom.	K 056	7. Resident room #200 has been adjusted. 8. Closet in resident room #202 adjusted. 9. Resident room #210 adjusted. 10. Restroom in resident room #211 adjusted. 11. 100 hall west bathroom adjusted. 12. General store room adjusted. 13. Will replace any sprinkler heads will be checked quarterly by maintenance director to maintain compliance.	04/28/06
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 observations and staff interview, the facility failed to maintain the installed sprinkler system in accordance with NFPA 13 Section 1-4.6, 3-2.7.2, 5-1.1, 6-2.3.1, and NFPA 25 Section 2-2.1.1 respectively. The findings were: 1. Observation on 03/21/06 between 8:15 AM and 12:05 PM revealed the following locations had sprinkler heads that were not installed under a smooth continuous ceiling: a. The dish room had an unsealed attic access opening. b. The conference room had an unsealed attic	K 062	14. CONTRACT SYSTEM DRAWINGS TO ORIGINAL K062 PLAN SPECIFICATIONS NEW SPRINKLER HEADS FROM. The facility will ensure automatic sprinkler system is in proper operating condition by: 1. The locations will be corrected by: A. Replacing sheetrock and finishing the ceiling to a smooth surface to put in an attic access that will meet all fire code and state and federal regulations. B. Sheet rock will be replaced and smooth ceiling surface and will be obtained to proper compliance.	

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K 062	Continued From page 11 access opening. c. Boiler room #1 had an unsealed opening for attic access. 2. Between 8:01 AM and 9:31 AM on 3/21/06, observation revealed the following locations had sprinkler heads with escutcheon plates missing: a. The kitchen dry storage room. b. The walk-in freezer. c. The kiln room. d. The activities room. 3. Observation on 03/21/06 between 8:21 AM and 1:05 PM revealed the following locations had sprinkler heads damaged from freezing temperatures that were not replaced: a. One of 15 sprinkler heads in the dining room was replaced with a low point drain valve. b. Two of 2 sprinkler heads were not replaced under the canopy outside of the dining room. 4. A sprinkler branch line in the attic above the kitchen storeroom had a hanger which was broken and not replaced as required by the Code. 5. One of 4 sprinkler heads in the 100 wall west bathroom was corroded. 6. On 03/21/06 at 1:05 PM the maintenance director reported 7 sprinkler heads had been damaged by frozen water this winter and the dry pendent heads had been damaged by water that had collected in the branch lines over the pendent heads. The maintenance director could not provide assurance that other sprinkler heads were not currently blocked by ice in the branch lines. The maintenance director could not explain why water had remained in the branch lines, and further reported all low point drains were being checked weekly to remove condensation from the system. The sprinkler system had not been reviewed by an engineer to certify the system was maintained to national standards.	K 062	2. Boiler room #1 will be sealed up and placed in the proper original state. 3. The escutcheon plates will be replaced. 4. Escutcheon plates in kitchen dry storage room will be replaced. 5. The walk in freezer Escutcheon plate will be replaced 6. The kiln room Escutcheon plate will be replaced. 7. The Activities Room Escutcheon plate will be replaced. 8. Sprinkler heads have been ordered for complete replacement. 9. Sprinkler head will be replaced in dining room with a new head. 10. Both heads will be replaced under canopy outside the dining room. 11. Sprinkler branch line in attic above kitchen store room will have hanger replaced to meet code. 12. The corroded sprinkler head will be replaced with a new head. 13. A new valve has been put in the sprinkler system. Low point drains are bled off weekly with no water in the system at this time. Dry system & no freezing can or will occur. 14. We are contracting with an engineering company to have re-certification done on the sprinkler system. (SEE ATTACHMENT) 04/28/06 5/10/06 15. This will be monitored by the Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/21/2006

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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 provide maximum travel distance for 1 of 16 portable fire extinguisher in accordance with NFPA 10 Table 3-2.1. The findings were: 1. On 03/21/06 at 10:24 AM, the portable fire extinguisher in the SCU had been removed from the installed extinguisher cabinet. The closest fire extinguisher from the SCU exit was more than 75 feet.	K 064	K064 The facility will ensure fire extinguishers are provided in all areas of the building as state and federal regulations call for. 1. The fire extinguishers will be placed back in the proper location for fire safety compliance in the Secure Unit. 2. This will be monitored by the Administrator.	04/28/06
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 observations, the facility failed to provide an electrical system installed in accordance with NFPA 70 Section 400-8 and 370-28 respectively. The findings were: 1. Observation on 03/21/06 between 9:06 AM and 9:25 AM revealed the following locations had surge protectors attached to the wall because not	K 147	K147 The facility will ensure all surge protectors are removed. 1. The surge protectors will be discontinued and proper plug in procedures will be followed 2. The main corridor pop machine will be plugged in with the water fountain.	

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	535038	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/21/2006

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K 147	Continued From page 13 enough outlets were provided: a. The main corridor in the vicinity of the pop machine. b. The mechanical room near the telephone board. 2. The SCU dayroom was observed at 10:22 AM on 3/21/06 and noted to have an extension cord supplying power to the refrigerator. 3. Observation on 3/21/06 at 8:31 AM revealed the maintenance shop had a light which was being supplied with power from the originally installed light in the room. The electrical wires feeding the second light were not in conduit and had the spliced electrical wires and wire nuts exposed.	K 147	3. The mechanical room will have surge protectors removed and items will be plugged in to the proper wall outlets. 4. The light in the maintenance shop will be removed and electrical wires removed to restore to proper code.	04/29/06
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to follow their fire watch policy for the loss of water to the automatic sprinkler system for 4 hours in a 24 hour period in accordance with NFPA 101 Section 9.7.6.1. The findings were: 1. On 03/21/06 at 1:10 PM, maintenance staff	K 154	K154 The facility will ensure that the standard for proper coverage of fire watch is followed and implemented in 15 min. This will be accomplished by: 1. Anytime the sprinkler system goes down with in 15 min the maintenance director will initiate the fire watch. A clip board with a complete policy & tracking sheets will be given to the person on fire watch. 2. Anytime the alarm system goes down for 4 hours we will 1. Notify the fire department with in the first 15 min of the system going down or if maintenance is being	

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	535038	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/21/2006

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4/24/06

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K 154	Continued From page 14 reported a dry pipe sprinkler valve was replaced which took longer than 4 hours to replace and a fire watch was not initiated. The facility also had shut the sprinkler system down 7 times to replace frozen sprinkler heads and branch lines this winter. The facility did not notify the local fire department or the Wyoming department of health of these lapses in protection.	K 154	performed. 2. At 4 hours we will notify the owner of the building, fire department & Office of Healthcare Licensing & Surveys'. 3. All items will be monitored by Administrator and reported to QA Committee for their ideas of making things safer for all resident's and staff. 4. SEE ATTACHED FIRE WATCH POLICY #5	04/28/06

4. ATTACHMENT.
F. W.