STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/15/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WY HEALTHCARE &	542 16TH STREET RAWLINS, WY 82301

12-15/06

(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 complete wet supervised automatic wet sprinkler system with a dry branch and fire alarm system. The main floor houses the nursing unit and business offices, the basement houses the laundry, maintenance shop and medical records storage. K6: Date of Plan Approval: 1965 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=90;SNF/NF=90 K9: The facility meets the Life Safety Code standards based on an acceptance of a Plan of Correction. "NFPA" National Fire Protection Association	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.* ACCEPTANCE OF THIS POC W/ CHRIS TANNER, NHA, DO 12/13/06 @ 3:15 PM.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observations the facility failed to maintain the construction integrity of smoke compartment barriers in accordance with NFPA 101 Section 19.1.6.4 and 3.3.185. The finding was: 1. Observation on 11/14/06 at 1:50 PM revealed	K 012	K12 1. The sprinkler pipe in the wall near the basement exit door will be sealed by joint compound. 2. The building will be inspected to ensure all protruding pipes are sealed properly. Any new construction or remodeling will also be inspected to make sure that pipes etc. are sealed properly. 3. The Maintenance Director will inspect the building monthly for the first quarter and quarterly there after for a year. Inspection logs will be presented quarterly to the facilities PI team.	Dec 19 2006

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

EXECUTIVE DIRECTOR 12/07/06

RECEIVED
DEC 08 2006
WYOMING DEPT OF HEALTH

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 012	Continued From page 1 an unsealed sprinkler pipe in the wall near the basement exit door.	K 012	*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 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 4.6.12.2. The findings were: 1. Observation on 11/14/06 between 2:30 PM and 3 PM revealed corridor doors to the following rooms did not fit tight into their frames in order to resist the passage of smoke: a. Resident room #41.	K 018	K18 1. It is the practice of this center to assure that all corridor doors resist the passage of smoke maintaining compliance at all times to include: 2. The doors at Room #41 and the front office will have weather stripping installed to ensure that there is a tight fit in the frames. Also the staffs lounge corridor door self-closing device will be adjusted to where it will fully pull the door closed and latch properly. 3. All doors shall be inspected monthly per our Preventative Maintenance Program to insure functionality and code compliance. Inspections will be documented and brought to PI meeting.	Dec 19 2006

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K 018	Continued From page 2 b. The front office. 2. Observation on 11/14/06 at 2:25 PM revealed the staff lounge corridor door was equipped with a self-closing device which was not able to fully latch the door into its frame.	K 018	*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 observations the facility failed to provide a 1-hour fire resistant rating for vertical openings in accordance with NFPA 101 Section 19.3.1.1. The finding was: 1. Observation on 11/14/06 at 4:10 PM revealed the self-closing device attached to main floor dumbwaiter door did not fully latch the door into its frame.	K 020	K20 The self-closing device and hinges will be adjusted on the dumbwaiter door so that it latches and closes properly. All like barriers will be inspected, corrected and Documented. Barriers will be inspected, corrected and documented Quarterly for one year and annually thereafter. The results will be presented in PI meeting.	Dec 19 2006

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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 observations the facility failed to separate 4 of 16 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 11/14/06 between 1 PM and 3 PM revealed each of the following locations lacked a complete 1-hour fire separation and was used to store large quantities of combustibles: a. The acitivities department had several bags of clothing stored in a basement closet. The closet door was not equipped with a self-closing device. b. A basement storeroom was being used to store numerous cardboard file boxes full of medical records. The door was not equipped a self-closing device. c. A closet near resident room #26 was being used to store 10 cardboard filing boxes full of records. The corridor door was not a 1-hour fire rated door and was not equipped with a self-closing device. 2. Observation on 11/14/06 at 1:41 PM revealed	K 029	*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.* K29 1. It is the practice of this center to assure that all hazardous locations are within compliance at all times to include: A. Basement closet will be cleaned out and a self-closing device will be equipped to ensure proper closer. B. Basement storeroom door will be equipped with a self-closing device to ensure proper closer. C. The closet near room #26 will be removed of all combustibles. D. The corridor door to the maintenance workshop will have a self-closure placed on door to ensure proper closer and to make sure it fully latches. 2. All doors will be inspected monthly during routine Preventive Maintenance Room checks. 3. These room checks will be documented in the centers Preventive Maintenance Log. Results will be brought to the PI meeting.	Dec 19 2006

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.K 029	Continued From page 4 the corridor door to the maintenance workshop was equipped with a self-closing device that did not fully latch the door into its frame.	K 029	*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 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 observations the facility failed to maintain an egress corridor system that was unobstructed and accessible at all times in accordance with NFPA 101 Section 7.2.1.6.1. The finding was: 1. Observation on 11/14/06 at 2:20 PM revealed the exit near resident room #39 was equipped with a delayed egress lock. The lock did not release with constant pressure applied to the releasing latch. The lock did release with the key pad and the activation of the fire alarm system.	K 038	K38 1. A Code Alert Technician will work on and adjust the exit door by room 39 so that with constant pressure it will release. All exits will be inspected to ensure compliance. 2. Maintenance Director will inspect exit access weekly and document in centers Preventive Maintenance Log. Preventive Maintenance Log will be reviewed by the PI to ensure continued compliance for one year following the noted issue.	Dec 19 2006
K 046 SS=F	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	K 046	K46 1. The facilities emergency battery light system will be tested for the annual 90-minute emergency battery light test and also the monthly 30-second emergency battery light tests. 2. An audit and inspection will be completed monthly to ensure tests are being completed on a monthly basis.	Dec 19 2006

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K 046	Continued From page 5 the emergency battery light system in accordance with NFPA 101 Section 7.9.3 and 7.9.1.2. respectively. The findings were: 1. Review of the emergency battery light records revealed neither the annual 90 minute emergency battery light tests, nor the monthly 30 second emergency battery light tests had been performed in the last 12 months.	K 046	*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 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 the facility failed to test the installed sprinkler system in accordance with NFPA 25 Section 9-2.6 and 9-2.7. The findings were: 1. Review of the sprinkler testing records revealed the quarterly main drain test and quarterly water flow alarm test had not been conducted during the third quarter of 2006.	K 062	3. Audits and inspections will be logged in center Preventive Maintenance program and presented in PI meeting. K62 1. The Automatic Sprinkler System was inspected by the Maintenance Director on Nov 16 2006' to ensure compliance with NFPA 13 and 25. 2. Maintenance Director and Licensed Contractor will inspect sprinkler system quarterly to ensure future compliance. 3. PI committee will inspect Automatic Sprinkler System inspection documentation quarterly for one year following the noted issue.	Dec 19 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 inspect 1 of 12 portable fire extinguisher in accordance with NFPA 10 Section 4-3.4.2. The findings were: 1. Observation on 11/14/06 at 2:11 PM revealed the K-type portable fire extinguisher in the kitchen had not received a monthly inspection for the months of August, September and October 2006.	K 064	*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.* K64 1. The type K portable fire extinguisher in the kitchen received its monthly inspection on Nov 15 2006. 2. The Maintenance Director will inspect Fire Extinguishers monthly. Monthly inspections will be documented in Preventive Maintenance Logs 3. Preventive Maintenance Logs will be reviewed by the Safety Committee quarterly to ensure continued compliance for one year following the noted issue.	Dec 19 2006
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation the facility failed to protect	K 076	K76 1. The E sized oxygen storage tank in the central supply closet was removed and placed in the proper storage closet. All closets will be checked to make sure all tanks are secured properly and are in compliance with NFPA 99. 2. An inservice is scheduled to educate staff on how to properly store and secure oxygen. 3. The Maintenance Director will inspect all oxygen storage areas weekly for one month and then monthly thereafter to assure compliance. Oxygen Room Inspections will be documented in the centers Preventive	Dec 19 2006

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K 076	Continued From page 7 portable oxygen cylinders in accordance with NFPA 99 Section 4-3.1.1.1 and 8.3.1.11.2. The findings were: 1. Observation on 11/14/06 at 2:42 PM revealed central supply was storing one "E" sized oxygen storage tank. The tank was not secured to prevent falling. In addition, the tank was not stored at least 5 feet from combustibles.	K 076	*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.* Maintenance Logs.	
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 observations and staff interview the facility failed to test the installed emergency generator in accordance with NFPA 110 Section 6-4.2. The findings were: 1. The facility's diesel powered emergency electrical generator was being tested on a monthly basis at less than the required 30 percent of the name plate rating and the generator had not been tested annually by a load bank test. a. Review of the generator testing records revealed the generator was rated at 130 kilowatts, which is 21 percent of the name plate rating. b. Record review revealed the last load bank test	K 144	Oxygen Room Inspection Logs will be reviewed by the centers Safety Committee quarterly to ensure continued compliance for one year following the noted issue. K144 1. The facility's diesel powered emergency electrical generator was tested and serviced by a licensed contractor on Nov 27 2006 for the load bank test. 2. The Maintenance Director will be inserviced on the proper testing for the generator. 3. The generator will be inspected weekly, ~~and tested to ensure that it is being run at 30% of the nameplate rating~~. The licensed contractor was instructed on the need for the annual load bank test. The test will be performed annually. Preventive Maintenance Logs will be reviewed by the Safety committee quarterly to ensure continued compliance for one year ~~following the noted issue.~~	Dec 19 2006

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K 144	Continued From page 8 was performed on July 12, 2005, more than a year ago. c. Interview on 11/15/06 at 8:05 AM with the maintenance director revealed he was unaware the load bank test was to be performed on an annual basis.	K 144	*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.*	