DEPARTMENT OF HEALTH AND HUM. SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/22/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 333 N BRIDGER AVE PINEDALE, WY 82941

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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 builidng with a complete automatic supervised wet sprinkler system and fire alarm system. K6: Date of Plan Approval: 1978, 1983 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=54;SNF/NF=6; NF 54 K9: The facility meets the Life Safety Code standards based on an acceptance of a plan of corrections "NFPA" National Fire Protection Association	K 000	PoC ACCEPTED WITH DIRECTION WOOD, NHA, ON 4/20/06 @ 1:30 PM VIA TELECONFERENCE.	

CERTIFIED MAIL™

7005 1820 0005 7009 3737

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah J. Wood — TITLE: Administrator — (X6) DATE: 4/14/06

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.

APR 17 2006

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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 03/22/06 between 8:06 AM and 9:42 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. Resident room #108. b. Resident room #201. c. Resident room #8. d. Resident room #10. e. Resident room #13. f. Resident room #11.	K 018	A) Maintenance will install fire rated smoke seal on doors for room 108, 201, 8, 10, 13, 11, 9, 5, 1, the dining room corridor door, and the linen closet corridor door near the nurse's station. This will impede the passage of smoke from rooms into the corridors, but not effect the closing of the doors. B) Maintenance will monitor all doors through quarterly inspection to ensure gaps are sealed. Maintenance will report all findings to the Administrator. C) During attendance at the quarterly Quality Assurance meeting the Maintenance Director will review all finding for the quarter.	5/5/06

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K 018	Continued From page 2 g. Resident room #9. h. Resident room #5. i. Resident room #1. j. The dining room corridor door. k. The linen closet corridor door near the nurses station.	K 018		
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 maintain 2 of 10 smoke barrier doors in accordance with NFPA 101 Section 19.3.7.3, 8.3.4.1, and 4.6.12.2. The findings were: 1. Observation on 03/22/06 at 12:42 PM revealed the double smoke barrier doors leading to the west wing were equipped with latching devices. However, these latching devices were not maintained to ensure the doors would latch into the frame.	K 027	A) Maintenance will repair smoke barrier door latches on the west wing to ensure that they latch into the frame properly. B) Maintenance will inspect doors each quarter to monitor their function and ensure that the latches are in proper working order. Latches that are found not functioning properly will be reported to the Administrator. C) The Maintenance Director will review the inspection in the quarterly Quality Assurance meeting.	3/24/06

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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 1 of 8 hazardous areas from other spaces in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. Observation on 03/22/06 at 9:21 AM revealed the medical records corridor door was not equipped with a self-closing device as required by the Code.	K 029	A) Maintenance will install a self-closing device on the medical records corridor door. B) Maintenance will inspect all corridor doors each quarter to ensure that all self-closing devices are attached and functional. Findings from the inspection will be reported to the Administrator. C) The Maintenance Director will report findings from quarterly inspections at the quarterly Quality Assurance meetings.	5/5/06
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:	K 038	A) 1. Ice and snow were removed from the exit pathway to the public way. 2. A new latch system will be installed by Maintenance to ensure access from the inside and outside of the fence on the pathway to the public way outside of the dining room.	5/5/06

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K 038	Continued From page 4 Based on observations, the facility failed to maintain an egress exit system unobstructed and accessible at all times in accordance with NFPA 101 Section 7.1.10.1. The findings were: 1. Observation on 03/22/06 at 8:27 AM revealed the north egress exit pathway to the public way was obstructed by ice and snow. 2. Observation on 03/22/06 at 9:11 AM revealed the dining room egress exit pathway to the public way was obstructed by a white vinyl fence. The double door in the fence was locked from the outside and the lock was not accessible from the egress side of the fence.	K 038	B) Maintenance will conduct weekly inspections of exterior pathways to the public way to ensure all exits remains clear and accessible. All findings from inspection will be corrected and reported to the Administrator. C) The Maintenance Director will report findings from inspection at the quarterly Quality Assurance meeting.	
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. The findings were: 1. Review of emergency battery light testing records revealed emergency battery lights had been installed in each corridor during January, 2006. A 90 minute acceptance test had not been performed on these lights. 2. Review of emergency battery light testing records revealed the monthly 30 second tests had not been performed on the emergency battery lights during February, 2006.	K 046	A) Maintenance will be perform testing on a monthly basis for 30 seconds and on a ~~quarterly~~ ANNUAL basis for 90 minutes to ensure the emergency lighting is maintained and functional. B) Maintenance will establish documentation procedures for required testing of emergency lighting. Testing discrepancies and failures will be reported to the Administrator. C) The Maintenance Director will report all emergency lighting failures to the Quality Assurance Committee at the quarterly meeting.	4/12/06

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K 050 SS=D	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, the facility staff were not familiar with the emergency actions required under varied fire conditions in accordance with NFPA 101 Section 19.7.1.2 and 19.7.2.1 respectively. The findings were: 1. Observation on 03/22/06 at 1:35 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. Other staff members returned to the fire room and had to tell the first responder the red flag was a simulated fire. The first responder did not call out a code phrase to indicate a fire had been found. The first responder had worked at the facility for over a year. 2. On 03/22/06 at 1:42 PM, review of the facility's fire and safety manual revealed the policy did not mention the need to use a code phrase as required by the Code.	K 050	A) 1. A strobe light will be purchased to replace the flag that was previously used to identify fire during a drill. All staff will have the strobe light demonstrated during a general staff meeting, a videotape will be available for those who can not attend. 2. The fire response policy will be revised and reviewed with all staff at the videotaped meeting. B) The Housekeeping Director will perform one fire drill on each shift each month until June 30, 2006 to provide for resident safety in the event of a fire. Coded announcements will be used between 9 PM and 6 AM. The Housekeeping Director will report the results of these drills to the Administrator. C) The Housekeeping Director will review and distribute the Fire Response policy to all new employees. The Fire Response plan will be reviewed twice annually with all staff. The Fire Policy will be reviewed annually by the Housekeeping Director will resulting changes reviewed in the quarterly Quality Assurance meeting.	4/5/06

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K 062 SS=D	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. The findings were: 1. Observation on 03/22/06 at 10:30 AM revealed the sprinkler head in the janitors' closet near resident room #106 was not installed under a smooth continuous ceiling as required by the Code. The attic access door was left open. Interview tihe a member of the maintenance staff at the time of the observation revealed an outside contractor had been working the attic the week before.	K 062	A) Maintenance closed the attic access door. B) Maintenance will check all attic access doors following use by any contractor. Maintenance will check all attic access doors on weekly facility walk thrus. Housekeeping staff has been instructed to monitor the ceilings of closets to be sure that all attic accesses remain closed when not in use. Maintenance will report instances of open attic accesses to the Administrator. C) The Maintenance Director will address patterns of open attic accesses at the quarterly Quality Assurance meeting and will construct remedies for those patterns.	3/22/06

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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 receptacles in non-hazardous areas in accordance with NFPA 101 Section 19.7.5.5. The findings were: 1. Observation on 03/22/06 at 9:05 AM revealed the north hall bathroom had four, 32 gallon soiled linen receptacles stored side by side. The receptacles were not separated by 64 square feet as required by the Code.	K 075	A) Housekeeping will remove one receptacle from the North bath, leaving three receptacles ensuring that a 64 square foot area does not have a receptacle that exceeds a 32 gallon capacity. B) Housekeeping/Laundry will rotate full barrels out of the bathing rooms, replacing them with empty barrels to ensure a soiled linen barrel is available at all times. C) The Housekeeping Director will monitor the barrel placement on daily inspections and report findings to the Administrator and include findings in a report to the Quality Assurance Committee at the quarterly meeting. Barrel placement will be reviewed with all staff at a videotaped general staff meeting. The Housekeeping Director will train all current and new laundry staff on monitoring the placement of barrels.	4/5/06

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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, the facility failed to maintain the installed emergency generator in accordance with NFPA 101 Section 7.9.1.2. The findings were: 1. Observation on 03/22/06 at 1:27 PM revealed the emergency generator supplied power to the emergency corridor lights. To initiate a full electrical load transfer of the emergency generator the main electrical circuit to the building was turned off. The emergency generator did not start. Maintenance staff then manually started the generator and then attempted to re-start the generator by turning off the building's main electrical circuit. The generator started the second time, but not within the required 10 seconds. The generator picked up the full electrical load of the building in 12 seconds.	K 144	A) Maintenance determined the generator issues were linked to a short on the control panel. The control panel will be replaced to ensure the generator will start within the 10second power failure requirement. B) Maintenance will continue to perform weekly generator tests to ensure the emergency system in maintained and to identify any possible problems. Testing will be documented as per NFPA 99-3.4.4.1. Generator failure to comply with requirements will be reported to the Administrator. C) The Maintenance Director will address issues with the generator at the quarterly Quality Assurance meeting.	5/5/06

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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 400-8 and 370-28 respectively. The findings were: 1. Observation on 03/22/06 at 8:40 AM revealed the electrical receptacle near the television set in resident room #7 had a 3-way adapter supplying power to the set. 2. Observation on 03/22/06 at 9:26 AM revealed the medical records office had one surge protector plugged into another surge protector. The first surge protector had four open receptacles and only three appliances were plugged into the second surge protector. 3. Observation on 03/22/06 at 10:41 AM revealed there was no cover on the junction box in the attic above the janitors' closet near the nurses' station.	K 147	A) 1. Maintenance removed the 3-way adapter from room #7. 2. Medical records removed one surge protector. 3. Maintenance placed a cover on the junction box in the attic above the janitor's closet near the nurse's station. B) All staff will be trained regarding appropriate use of surge protectors and 3-way adapters in a videotaped general staff meeting. Maintenance will perform quarterly inspections of electrical devices to monitor and ensure that they are being used within accordance with NFPA 70, National Electrical Code 9.1.2. C) The Maintenance Director will report all findings to the Administrator and review the inspection with the Quality Assurance Committee.	4/12/06