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

PRINTED: 02/16/2012
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
	535027	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

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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 two story building with a basement of Type II (111) construction with plan approval in 1982 and 1992. The building was equipped with a supervised automatic wet sprinkler system and with an addressable fire alarm system. The facility had a capacity of 128 certified Medicare and Medicaid beds with a census of 74 residents.	K 000	Preparation and execution of this response and plan of correction does not constitute an 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. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations manual.	
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 observation and staff interview, the facility failed to ensure hazardous areas were separated form use areas in 1 of 10 smoke compartments. The findings were:	K 029	1. The facility will continue to ensure that hazardous areas are separated from use areas in all smoke compartments. 2. The rubber wedge was removed from the east basement storeroom on 02/01/2012. 3. A sheetrock contractor was hired to complete the wall above the ceiling to the deck in the storeroom corridor and fire caulk any gaps. This was completed 02/10/12. 4 The project manager of the remodel project was advised to notify all contractors that doors to hazardous areas cannot be impeded from closing, and that any gaps created in the walls above the ceiling must be covered to provide a continuous smoke barrier. 5. The Director of Plant Operations will conduct environmental rounds on a quarterly basis to ensure compliance.	2/29/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joanne Kaiser, NHA | TITLE: Administrator | (X6) DATE: 02/21/2012

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.

RECEIVED
WY Dept of Health
FEB 22 2012
Healthcare Licensing and Surveys

POC ACCEPTED w/ JOANNE KAISER, NHA DO 3/01/12

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6L8U21 Facility ID: WY0033 If continuation sheet Page 1 of 6

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K 029	Continued From page 1 Observation of the east basement storeroom on 1/31/12 at 2:52 PM showed one of the double doors were impeded from closing by a rubber wedge. At the time of the observation the director of plant operations reported he was aware storeroom corridor doors were prohibited from being propped open. He also stated the construction company completing the remodel to the building had propped the door open for easy access to the area. At 4:55 PM observation showed the storeroom corridor wall terminated above the ceiling tile and did not extended to the roof above. The observed incomplete portion of the wall measured 30 inches by 34 feet.	K 029	6. A Quality Improvement/Performance Improvement (QI/PI) indicator will be developed to monitor compliance of all hazardous areas, and the results will be reported to the Environment of Care Committee on a quarterly basis, with oversight by the organization-wide QI/PI Committee. 7. The Director of Plant Operations will monitor to assure compliance.	
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 and staff interview, the facility failed to ensure 1 of 2 emergency battery light tests were performed in a timely manner. The findings were: Review of the emergency battery light testing records showed the annual 90 minute test was last completed on 12/2/11. Review of the previous year testing documentation showed the test was performed on 10/11/10, more than one year earlier. On 1/31/12 at 1:30 PM the director of plant operations reported he was aware the tests were required to be performed on or before the same date the year before.	K 046	1. The facility will continue to ensure that all emergency battery light tests are conducted in a timely manner and no more than one year from the previous test. 2. A planned event was entered into the Total Maintenance System (TMS) on 02/08/12 to automatically generate a work order for one year from the date of the previous test of the emergency battery lights. 3. A QI/PI indicator will be developed to monitor compliance with all required testing of emergency lighting equipment, and the results will be reported to the Environment of Care Committee on a quarterly basis, with oversight by the organization-wide QI/PI Committee. 4. The Director of Plant Operations will monitor to assure compliance.	2/29/2012

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K 046	Continued From page 2 Reference, NFPA 101, 2000 Edition, 19.2.9.1; 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046		
K 047 SS=E	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 observation and staff interview, the facility failed to ensure exterior doors that could be confused as an exit are properly marked in 1 of 10 smoke compartments. The findings were: Observation of the dining room on 1/31/12 at 10:51 AM showed two glass patio doors were added to the north side of the dining room. Further observation showed the patio did not have an exit discharge pathway. The double doors could be confused as exit doors and were not posted with a No Exit sign. At the time of the observation the director of plant operations could not explain why the doors were not properly marked.	K 047	1 The facility will continue to ensure that exterior doors that could be confused as an exit are properly marked. 2. A "No Exit" sign was placed on the glass patio doors on the north side of the dining room on 02/14/12. 3. All exterior doors will be checked for propor signage during environmental rounds conducted by the Director of Plant Operations on a quarterly basis. 4 A QI/PI indicator will be developed to monitor compliance with proper exit signage, and the results will be reported to the Environment of Care Committee on a quarterly basis, with oversight by the organization-wide QI/PI Committee. 5. The Director of Plant Operations will monitor to assure compliance.	2/29/2012

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K 047	Continued From page 3 Reference, NFPA 101, 2000 Edition, 19.2.10.1; 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.	K 047		
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 observation and staff interview, the facility failed to ensure storage canopies were fully sprinkled in 1 of 10 smoke compartments. The findings were:	K 056	1. The facility will continue to ensure that sprinklers shall be installed under roofs or canopies over areas where combustibles are stored and handled 2. The propane tanks were removed on 02/03/12 from the two barbeque grills on the northwest exit patio. 3. Staff who use the barbeque grills were instructed on 02/03/12 that the grills cannot be stored under any roof or canopies without sprinkler coverage. The grills will be relocated to an appropriate outdoor area before the propane tanks are replaced and the grills are used. 4. The Director of Plant Operations will conduct environmental rounds on a quarterly basis to ensure no combustibles are stored or handled in any area without sprinkler coverage.	2/29/2012

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K 056	Continued From page 4 Observation of the northwest exit patio on 1/31/12 at 10:48 AM showed two barbeque grills and two, 5 gallon, propane tanks were stored under the canopy. Observation of the canopy showed it was constructed of steel structural members, it measured 8 feet by 14 feet, and did not have sprinkler coverage. At the time of the observation the director of plant operations reported he was unaware canopies were required to have complete sprinkler coverage if combustible items were stored under them. Reference, NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 5-13.8.2 Sprinklers shall be installed under roofs or canopies over areas where combustibles are stored and handled.	K 056	5. A QI/PI indicator will be developed to monitor compliance of all hazardous areas, and the results will be reported to the Environment of Care Committee on a quarterly basis, with oversight by the organization-wide QI/PI Committee. 6. The Director of Plant Operations will monitor.	
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211	1. The facility will continue to ensure that alcohol based hand rub dispensers are only installed in safe locations, and not over or adjacent to an ignition source. 2. The alcohol based hand rub dispenser in the main dining room was moved away from the outlet on 02/01/12 3. The location of all alcohol based hand rub dispensers will be inspected during quarterly environmental rounds conducted by the Director of Plant Operations. 4. A QI/PI indicator will be developed to monitor proper placement of all alcohol based hand rub dispensers, and the results will be reported to the Environment of Care Committee on a quarterly basis, with oversight by the organization-wide QI/PI Committee. 5. The Director of Plant Operations will monitor to assure compliance.	2/29/2012

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K 211	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure alcohol based hand rub dispenser were installed in safe locations in 1 of 10 smoke compartments. The findings were: Observation of the main dining room on 1/31/12 at 4:34 PM showed an alcohol based hand rub dispensed was installed directly over an electrical outlet, near the west exit. At the time of the observation the director of plant operations could not explain why the dispenser had been installed in that location and why it had not been noticed and removed during the quarterly inspections.	K 211		