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

PRINTED: 08/22/2012
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
	53A051	A. BUILDING _____ B. MAIN BUILDING 01 B. WING _____	08/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the 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. The facility was a fully sprinkled single story building of Type II (111) construction built in 1998.The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze loop and an addressable fire alarm system. The facility had a capacity of 24 certified Medicare and Medicaid beds with a census of 20.	K 000		
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 observation and staff interview, the facility failed to ensure walls were smoke resistant in 2 of 3 smoke compartments. The findings were: 1. Observation of the boardroom on 8/14/12 at 9:01 AM showed two unsealed ½ inch circular penetrations. At the time of the observation maintenance technician #1 reported a television bracket was relocated more than 3 months ago. He could not explain why the holes had not been filled after the project was completed.	K 012	1)The two unsealed 1/2 inch circular penetrations have been sealed. All areas will be inspected quarterly. 2) The director of plant operations will develop a quality monitoring tool to ensure future compliance. 3. The results of the monitoring tool will be reported at the monthly QA/QI meeting.	8/27/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 9/11/12

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.

POC ACCEPTED W/ERAL FOLEY, CEO, ON 9/20/12

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K 012	Continued From page 1 2. Observation of the kitchen on 8/14/12 at 10:05 AM showed a 6 inch by 48 inch ceiling tile was missing. At the time of the observation maintenance technician #1 reported the kitchen was not routinely inspected for wall and ceiling penetrations. Reference NFPA 101, 2000 Edition; 19.3.6.2.1* Corridor walls shall be continuous from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces, and they shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1*: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, a corridor shall be permitted to be separated from all other areas by non-fire-rated partitions and shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke.	K 012	1) The 6"X48" ceiling tile has been replaced. 2) The kitchen area will be routinley inspected for wall and cieling penetrations and repaired as needed. 3) The director of plant operations will develop a quality monitoring tool to ensure future compliance. All areas will be inspected quarterly. 4. The results of the monitoring tool will be reported in the monthly QA/QI meeting.	8/27/12
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.)	K 017		

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K 017	Continued From page 2 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor walls were smoke resistant in 1 of 3 smoke compartments. The findings were: Observation on 8/14/12 at 9:14 AM showed a ½ inch circular penetration in the corridor ceiling near resident room #102. At the time of the observation maintenance technician #1 could not explain why the hole had not been noticed and repaired during the monthly inspections.	K 017	1) The 1/2 inch circular penetration in the corridor ceiling near resident room #102 has been sealed. 2) The director of plant operations will develop a quality monitoring tool to ensure furture compliance. All areas will be inspected quarterly. 4. The results of the monitoring tool will be reported in the monthly QA/QI meeting.	8/27/12
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.	K 018		

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K 018	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor doors were smoke resistant in 1 of 3 smoke compartments. The findings were: Observation of resident room #106 on 8/14/12 at 9:21 AM showed the latch bolt was not able to insert into the strike plate with three attempts. At the time of the observation maintenance technician #1 could not explain why the latch had not been noticed and repaired during the monthly inspections.	K 018	1) The door latch bolt and strike plate have been repaired so that the bolt will insert into the strike plate to securley hold 2)The director of plant operations will develop a quality monitoring tool to ensure furture compliance. All areas will be inspected quarterly. 3. The results of the qualityly monitoring tool will be reported in the monthly QA/QI meeting.	8/27/12
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:	K 025		

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K 025	Continued From page 4 Based on observation and staff interview, the facility failed to ensure the smoke barrier wall was smoke resistant. The findings were: 1. Observation on 8/14/12 at 10:11 AM showed a 1 inch by 8 inch gap between the sheetrock wall and cinder block wall above the east double doors. The gap was formed after sheetrock texture had fallen away. At the time of the observation maintenance technician #1 reported the texture must have fallen away since the last annual inspection. 2. Observation of the smoke barrier wall in the boardroom on 8/14/12 at 10:12 AM showed a 2 inch by 8 inch gap along a corner seem. The gap was formed after sheetrock texture had fallen away. At the time of the observation maintenance technician #1 could not explain why the gap had not been noticed and repaired during the annual inspection.	K 025	1) The 1 inch by 8 inch gap between the sheetrock wall and cinder block wall has been sealed. 2) The director of plant operations will develop a quality monitoring tool to ensure furture compliance. All areas will be inspected quarterly. 3. The results of the quality monitoring tool will be reported in the monthly QA/QI meeting. 1) The 2 inch by 8 inch gap along a corner seam has been sealed. 2) The director of plant operations will develop a quality monitoring tool to ensure future compliance.	8/27/12 8/27/12
K 052 SS=F	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	K 052		

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K 052	Continued From page 5 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 of 8 fire alarm system tests was completed. The findings were: Review of the fire alarm system testing records showed the smoke detector sensitivity bi-annual test was last performed on 1/12/10, more than two years ago. On 8/13/12 at 5 PM the plant operations superintendent confirmed the test was last completed on 1/12/10. He could not explain why the test had not performed on a bi-annual basis. Reference, NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; Table 7-3.2 Testing Frequencies. 15. Initiating Devices i. Smoke Detectors- Sensitivity, ...bi-annually	K 052	1) The sensitivity testing for smoke detectors has been completed. 2) The plant of operations director will ensure that sensitivity tests will be done within a two year period. 3) The plant operations director will develop a quality monitoring tool to ensure future compliance.	9/04/12
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 observation and staff interview, the facility failed to ensure monthly inspections were conducted on portable fire extinguishers in 2 of 3 smoke compartments. The findings were: Observation on 8/14/12 between 10:30 AM and 11 AM showed a monthly safety inspection had	K 064	1) All fire extingushers will be inspected at least monthly. 2) The plant operations manager will develop a quality directoring tool to ensure future compliance. All areas will be inspected quarterly. 3. The results of the quality monitoring tool will be reported in the monthly QA/QI meeting.	8/27/12

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K 064	Continued From page 6 not been conducted on the portable fire extinguishers in the kitchen dish room and home oxygen office during July 2012. At 10:36 AM the plant operations superintendent could not explain how these extinguisher had been missed. Reference, NFPA 101, 2000 Edition, 19.3.5.6, 9.7.4.1, NFPA 10, 1998 Edition; 4-3 Inspection. 4-3.1 Frequency. Extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals	K 064	See page 6	
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by:	K 074		

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K 074	Continued From page 7 Based on observation and staff interview, the facility failed to ensure curtains were flame retardant in 1 of 3 smoke compartments. The findings were: Observation of the television area on 8/14/12 at 9:43 AM showed none of the twelve window curtains had flame retardant documentation attached to them. On 8/14/12 at 11:15 AM the maintenance director confirmed he did not have documentation showing the curtains had been treated with flame retardant solution after they were last laundered.	K 074	1) All of the window curtains have flame retardant treatment applied and have documentation attached. 2) The plant operations director will develop a quality monitoring tool to ensure future compliance. All of the areas will be inspected quarterly. 3. The results of the quality monitoring tool will be reported in te monthly QA/QI meeting.	8/27/12