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

PRINTED: 02/02/2012
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 |
|---|---|---|---|
| | 53A002 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 01/18/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AMIE HOLT CARE CENTER | 497 W LOTT<br>BUFFALO, WY 82834 |

| (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 |
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| K 000 | INITIAL COMMENTS<br><br>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).<br><br>The facility was a fully sprinkled single story building of Type V (111) construction with plan approval in 1964, 1986, and 1996. The building was equipped with a supervised automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 50 certified Medicaid beds with a census of 42 residents. | K 000 | | |
| K 014 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure wall coverings had appropriate flame spread rating in 1 of 4 smoke compartments. The findings were:<br><br>Observation of the medication room on 1/17/12 at 6:01 PM showed carpet had been attached to the wall extending up to 4 feet above the floor. Further observation showed carpet had been added to the bottom 4 feet of the small dining room walls. On 1/18/12 at 8:10 AM the | K 014 | Amie Holt Care Center will ensure wall coverings have appropriate flame spread rating in smoke compartments by:<br><br>A) Removing carpet attached to the wall in the medication room and the small dining room.<br>B) Educate administration and maintenance on the need to ensure wall covering have appropriate Class A or B flame spread rating. This was done by the Life Safety Inspector at the time of the inspection.<br>C) The Maintenance Manager will be responsible for the aforementioned actions.<br>D) The Safety Chairperson will monitor for compliance during the quarterly safety inspections. | 2/10/2012 |

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

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.

FEB 15 2012

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZLHT21 Facility ID: WY0001 If continuation sheet Page 1 of 10

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| | 53A002 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 01/18/2012 |

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| K 014 | Continued From page 1<br>maintenance supervisor reported he was unaware that wall covering required a Class A or B flame spread rating. He confirmed he did not have flame spread rating for the aforementioned carpet. He also reported the carpet had been installed six months earlier. | K 014 | | |
| K 038 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure exit doors and gates were unobstructed and failed to ensure corridors had adequate headroom in 3 of 4 smoke compartments. The findings were:<br><br>1. Observation of the north courtyard on 1/17/12 at 4:40 PM showed the gate was locked with a combination pad lock. At 4:44 PM certified nurses assistant (CNA) #1 reported she did not have the combination pad lock and was unaware she was required to have the combination. At 4:50 PM registered nurse (RN) #1 reported the courtyard pad lock and special care unit (SCU) key pad locks had the same combination. On 1/18/12 at 8:50 AM the maintenance supervisor reported the combination was posted on the side of the gate/fence pipe in case staff members forgot the combination. He could not explain why CNA #1 did not know the combination, as it was reviewed during annual safety meetings. | K 038 | Amie Holt Care Center will ensure exit access is readily accessible at all times by:<br><br>A) Educating all staff on the combination to the courtyard and the gate and that it is posted on the courtyard door and the side of the gate/fence pipe in case staff members forget the combination. The Director of Nursing or Designee will be responsible for educating staff on the aforementioned actions.<br>B) The door electro-magnetic lock will be disconnected to the door leading into the former SCU area and the north former SCU area exit door, allowing the doors to open immediately when someone pushes on it. The Maintenance Manager will be responsible for the aforementioned action.<br>C) The courtyard door will have a sign placed on the door stating, "No Exit". The Maintenance Manager will be responsible for the aforementioned action.<br>D) The exit sign, near the medication room was moved and is now allows at least 6 feet 8 inches headroom. The Maintenance Manager will be responsible for the aforementioned action.<br>E) A quality improvement monitoring tool will be implemented by administration to ensure all staff are education on the combination to the the courtyard in case staff members forget the combination. This monitor will be completed quarterly by the | 3/6/2012 |

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| AMIE HOLT CARE CENTER | 497 W LOTT<br>BUFFALO, WY 82834 |

2/22/12

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| K 038 | Continued From page 2<br><br>2. Observation of the north SCU exit door on 1/17/12 at 4:50 PM showed the door was equipped with an electro-magnetic lock and key pad. When pressure was applied to the door for 30 seconds the magnetic lock did not release and allow the door to open. At the time of the observation the administrator reported the door was locked for the clinical needs of the patients. He then reported the SCU was no longer an alzheimer's wing and general residents were using this wing. He could not explain why electro-magnet lock had not been deactivated while the unit was used by general residents. At the same time as the observation CNA #1 did not have the combination to the key pad, but RN #1 and the director of nurses (DON) did have the combination. The DON could not explain why CNA #1 did know the combination.<br><br>3. Observation of the small dining room on 1/17/12 at 5:35 PM showed the bottom of the exit sign, near the medication room, was only 6 feet 5 inches above the floor. On 1/18/12 at 9 AM the maintenance supervisor reported he was aware the headroom requirement was 6 foot 8 inches above the floor. He could not explain why this exit sign had not been identified and moved during the quarterly inspections.<br><br>Reference, NFPA 101, 2000 Edition;<br>19.2.2.2.2 Locks shall not be permitted on patient sleeping room doors.<br>Exception No. 2: Door-locking arrangements shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that | K 038 | Director of Nurses or designee and any problems reported at the quarterly Performance Improvement meeting.<br>F) The Safety Chairperson will monitor for compliance during the quarterly safety inspections. | |

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| K 038 | Continued From page 3<br>Keys are carried by staff at all times.<br>19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.<br>Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.)<br>19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7.<br>7.1.5* Headroom. Means of egress shall be designed and maintained to provide headroom as provided in other sections of this Code and shall be not less than 7 ft 6 in. (2.3 m) with projections from the ceiling not less than 6 ft 8 in. (2 m) nominal height above the finished floor. The minimum ceiling height shall be maintained for not less than two-thirds of the ceiling area of any room or space, provided the ceiling height of remaining ceiling area is not less than 6 ft 8 in. (2 m). Headroom on stairs shall be not less than 6 ft 8 in. (2 m) and shall be measured vertically above a plane parallel to and tangent with the most forward projection of the stair tread. | K 038 | | |
| K 047 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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 | K 047 | Amie Holt Care Center will ensure that doors are no exit doors are properly identified by:<br><br>A) Putting a "NO EXIT" sign on the door on the former SCU dining exterior door to alert everyone this is not an exit. | 2/10/2012 |

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| K 047 | Continued From page 4<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure doors that may be mistaken as exit doors are signed with No Exit signs in 1 of 4 smoke compartments. The findings were:<br><br>Observation of the special care unit (SCU) dining room exterior door on 1/17/12 at 4:40 PM showed it lead into the courtyard. Further observation showed when the adjacent restroom corridor door was fully opened the door was obstructed and only had 22 inches of clear opening. The exterior door could have been confused as an exit door and was not signed with a No Exit sign. On 1/18/12 at 11:10 AM the blue prints showed the SCU dining room exterior door was not a required exit. At this same time the maintenance supervisor reported he was aware of the No Exit sign requirement, but could not explain why the door had not been appropriately signed.<br><br>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:<br>NO<br>EXIT<br>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 | B) The Maintenance Manager will be responsible for the aforementioned action.<br>C) The Safety Chairperson will monitor for compliance during the quarterly safety inspections. | |
| K 050<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD | K 050 | | |

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| K 050 | Continued From page 5<br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to ensure fire drills were held at unexpected times during 3 of 3 shifts. The findings were:<br><br>Review of the fire drill records showed the shifts occurred 6 AM to 2 PM, 2 PM to 10 PM and 10 PM to 6 AM. Further review showed three of the four drills conducted on the first shift in 2011 occurred between 1:25 PM and 1:41 PM. All four drills conducted on the second shift in 2011 occurred between 2:35 PM and 3:14 PM. All four drills conducted on the third shift in 2011 occurred between 6 AM and 6:45 AM. On 1/18/12 at 11:22 AM the fire drill coordinator reported she was unaware the drills were required to be at unexpected times throughout the shifts. | K 050 | Amie Holt Care Center will ensure that fire drills are held at unexpected times under various conditions, at least quarterly on each shift by:<br><br>A) Changing the shift times of the fire drills to 6 AM to 2 PM, 2 PM to 10 PM and 10 PM to 6 AM.<br>B) Varying the times of the fire drills on each shift to unexpected times.<br>C) Educate the Fire Drill Coordinator on the need to change the shift times of the fire drills and to vary the times of the fire drills to unexpected times. This was done the state Life Safety Code Inspector at the time of the inspection.<br>D) The Fire Drill Coordinator will be responsible for the aforementioned action.<br>E) The Safety Chairperson will monitor for compliance during the quarterly safety inspections. | 2/10/2012 |
| K 062<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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 | K 062 | Amie Holt Care Center will ensure that automatic sprinkler systems are inspected and tested on a quarterly basis by:<br><br>A) Inspecting and testing the all of the automatic sprinkler systems on a quarterly basis. | 2/10/2012 |

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| K 062 | Continued From page 6<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to test 2 of 4 sprinkler system components on a quarterly basis. The findings were:<br><br>Review of the sprinkler system testing records showed the waterflow alarm device and the supervisory signal devices had not been tested during the fourth quarter of 2011. On 1/18/12 at 11:15 AM the maintenance supervisor reported the devices were not tested because he thought they only needed to be tested on an annual basis.<br><br>Reference, NFPA 101, 2000 Edition, 19.3.5.1, 9.7.6, NFPA 25, 1998 Edition;<br>9-2.7 Waterflow alarm. All waterflow alarms shall be tested quarterly in accordance with manufacture's instructions.<br><br>Reference, NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.7, NFPA 72, 1999 Edition;<br>Table 7-3.2 Testing Frequencies.<br>15. Initiating Devices<br>j. Supervisory Signal Devices,.....quarterly | K 062 | B) Educate maintenance on the need to test the sprinkler system quarterly. This was done by the Life Safety Inspector at the time of the inspection.<br>C) The Maintenance Manager will be responsible for the aforementioned actions.<br>D) The Safety Chairperson will monitor for compliance during the quarterly safety inspections. | |
| K 075<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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 | K 075 | Amie Holt Care Center will ensure that soiled linen receptacles have adequate separation by:<br><br>A) Educating the staff on the need to separate the soiled linen receptacles by 8 square feet. This will be done by the Director of Nursing or designee.<br>B) A quality improvement monitoring tool | 3/5/2012 |

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| K 075 | Continued From page 7<br>greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure soiled linen receptacles had adequate separation in 1 of 4 smoke compartments. The findings were:<br><br>Observation of the special care unit tub room on 1/17/12 at 4:42 PM showed three soiled linen carts were stored within 8 feet of each other. At the time of the observation the administrator reported he was aware soiled linen carts must be separated by 8 square feet. He could not explain why the carts did not have adequate separation as the nursing staff had routine instruction on this issue. | K 075 | will be implemented to ensure all staff are separating the soiled linen receptacles by 8 square feet. This monitor will be completed quarterly. Individual education will be provided on an as needed basis.<br>C) The Director of Nursing or designee will be responsible for the aforementioned actions.<br>D) The Safety Chairperson will monitor for compliance during the quarterly safety inspections. | |
| K 141<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, facility policy and staff interview, the facility failed to sign areas were oxygen was used with No Smoking signs in 1 of 4 smoke compartments. The findings were: | K 141 | Amie Holt Care Center will ensure that No Smoking signs are posted in areas where oxygen is being used by:<br><br>A) Posting "No Smoking" signs on resident doors where oxygen is being used.<br>B) Educate nursing staff on the need to post "No Smoking signs on resident doors where oxygen is being used.<br>C) The Director of Nursing or designee will be responsible for the aforementioned actions.<br>D) The Safety Chairperson will monitor for compliance during the quarterly safety inspections. | 3/5/2012 |

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| K 141 | Continued From page 8<br>Observation of resident room #302 on 1/17/12 at 5:12 PM showed an oxygen concentrator was in use. Further observation showed the corridor door was not posted with a No Smoking sign. Observation of resident room corridor doors showed the facility practice was to posted oxygen use areas with No Smoking signs. At the time of the observation the administrator could not explain why the No Smoking sign was not posted. Review of the facility's smoking policy on 1/17/12 at 4:05 PM showed it did not address the signing of oxygen use areas. | K 141 | | |
| K 147 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure temporary electrical adapters did not replace permanent fixed wiring in 1 of 4 smoke compartments. The findings were:<br><br>Observation of resident room #302 of 1/17/12 at 5:11 PM showed the electrical cord to the power recliner was plugged into a 3-way electrical adapter. At the time of the observation the administrator could not explain why the adapter had not been noticed and removed during the quarterly safety inspections.<br><br>Reference, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: | K 147 | Amie Holt Care Center will ensure that temporary electrical adapters do not replace permanent fixed wiring by:<br><br>A) Removing the 3-way electrical adapter on the recliner chair. Maintenance will be responsible for removing the 3-way adapter.<br>B) Educate staff on not using electrical adapters and to notify the Director of nursing or supervisor of any electrical adapters. The Director of Nursing or designee will be responsible for educating staff.<br>C) The Maintenance Manager will be responsible for the aforementioned actions.<br>D) The Safety Chairperson will monitor for compliance during the quarterly safety inspections. | 3/6/2012 |

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|---|---|
| AMIE HOLT CARE CENTER | 497 W LOTT<br>BUFFALO, WY 82834 |

| (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 147 | Continued From page 9<br>(1) As a substitute for the fixed wiring of a structure<br>(2) Where run through holes in walls ...<br>(3) Where run through doorways, windows, or similar openings<br>(4) Where attached to building surfaces | K 147 | | |