STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535053	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY MEMORIAL NURSING HOME	204 15TH STREET WHEATLAND, WY 82201

(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 V (111) construction built in 1965 and a single story east wing of Type II (111) construction built in 1978. 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 43 certified Medicare and Medicaid beds with a census of 38.	K 000	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied.	
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 observation and staff interview, the facility failed to ensure rooms open to the corridor had proper protection in 1 of 3 smoke compartments. The findings were: Observation of the resident lounge on 11/15/12 at 9:27 AM showed the corridor door was removed from the door frame. Further observation showed the room was not provided with a smoke detector. At the time of the observation the	K 038		

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

Administrator 12/7/12

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/ SHANE FILIPI, NHA, DN 12/14/12

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	535053	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY MEMORIAL NURSING HOME	204 15TH STREET WHEATLAND, WY 82201

12/14/12

(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 038	Continued From page 1 maintenance assistant reported he was unaware rooms open to the corridor required a smoke detector. He also reported the corridor door was removed three weeks earlier. Reference NFPA 101, 2000 Edition; 18.3.6.1 Corridors shall be separated from all other areas by partitions complying with 18.3.6.2 through 18.3.6.5. (See also 18.2.5.9.) Exception No. 1: Spaces shall be permitted to be unlimited in area and open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses ' station or similar space. (d) The space does not obstruct access to required exits.	K 038	K038 – On 12/5/12 the door was re-hung on the door frame. The facility will conduct an audit to ensure all smoke compartments have the proper safety protection by 12/30/12. Maintenance will report results to administrator to ensure compliance. Proper safety protection on smoke compartments will be monitored quarterly to ensure safety with results taken to QA&A for further analysis.	12/30/12
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	K 050		

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K 050	Continued From page 2 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 record review and staff interview, the facility failed to conduct alarmed fire drills between 6 AM and 10 PM on 1 of 3 shifts. The findings were: Review of the fire drill testing records showed the fire drill conducted on 5/21/12 at 9:25 PM was a silent fire drill. On 11/14/12 at 3:30 PM the maintenance assistant reported he was aware fire drill held between 6 AM and 10 PM were required to have the fire alarm system activated. He could not explain the fire alarm system was not activated for the aforementioned drill.	K 050	K050 - The facility does and will complete quarterly fire drills for all shifts during different times and under varied conditions. The facility will conduct one fire drill a month alternating shifts for the quarter with varied times and different conditions to ensure that all shifts receive a fire drill during the quarter. All fire drills performed between 10 pm and 6 am that are a silent drill will have an audible test of the system within 24 hours of the drill. Maintenance will complete monthly fire drills. They will report result monthly x 3 months and quarterly thereafter to the administrator to ensure compliance with fire drill regulations. The Safety Committee will review the policy annually to ensure validity of the procedure. Results will be taken to QA&A for further review and analysis.	12/30/12