STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 Surveyor#: 18185 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K3: Building: Type II (222) three story building with a supervised automatic wet sprinkler system and fire alarm system. K6: Date of Plan Approval: 1972 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=170;SNF/NF=170 K9: The facility meets the Life Safety Code standards based on acceptance of a plan of corrections "NFPA" National Fire Protection Association	K 000	**Disclaimer** **"This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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."** **K014** 1. **There was no individual resident cited under this deficiency therefore no individual plan of correction can be addressed.** 2. **All residents have the potential to be affected by this practice. The wood paneling on the bottom four feet of the dining room walls will be changed to a Class A or B paneling.** 3. **Maintenance Director will ensure that any paneling placed in the future is the correct fire rating.** 4. **Plans for changing the dining room and any future paneling plans will be brought to the monthly performance improvement committee for review, comments, and suggestions.** 5. **Compliance Date: ~~09/30/06~~** (Waiver Request) ACCEPTED W/ EXPLANATION.	
K 014 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to provide flame retardant interior wall finishes in accordance with NFPA 101 Section 19.3.3.2 and 10.2.3. The findings were: 1. Review of flame retardant documentation on 06/28/06 at 11:41 AM revealed the wood paneling on the bottom four feet of the dining room walls were not class A or B. The documentation	K 014		8/10/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lyreca Patterson, ED, NHA — TITLE: Executive Director — (X6) DATE: 7/28/06

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.

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

FORM APPROVED
OMB NO. 0938-0391

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8/14/06

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K014 SS=D	(Continued)	K014	6. Submit plans and/or blueprints by August 21, 2006 for state approval. Estimated project begin date will be October 10, 2006 and no later than October 23, 2006 Estimated date of project completion will be January 31, 2007	

AUG 10 2006

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lyreca Patterson, ED, NHA	Executive Director	7/28/06

A 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.

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K 014	Continued From page 1 revealed the paneling was class " C " paneling.	K 014	K018 1. **No individual resident was identified in this deficiency therefore no individual plan of correction can be addressed.** 2. **All residents have the potential to be affected by this practice. The gaps on the Business Office Door, Admissions Office Door, and Director of Nurses Office will be repaired. The self closing device on room 101 will be repaired or replaced.** 3. **The Maintenance Director or designee will audit all doors monthly for gaps and that self closing devices are functioning properly.** 4. **Results of the audits will be brought to the monthly performance improvement committee for review, comments, and suggestions.** 5. Compliance Date: 08/11/06	
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. 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 06/28/06 between 11 AM and 12 PM revealed the following corridor doors had gaps greater than the allowed 1/8th of an inch between the top edge of the door and frame: a. The business office. b. The admissions office.	K 018		

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K 018	Continued From page 2 c. The Director of Nurses office. 2. Observation on 06/28/06 at 11:25 AM revealed the self-closing device attached to the corridor door for room #101 was not able to fully latch the door into the frame.	K 018	K025 1. There was no individual resident cited in this deficiency therefore no individual plan of correction can be addressed. 2. All residents have the potential to be affected by this practice. The unsealed cable penetrations above the ceiling tiles near rooms #116 and #225 will be sealed. WITH FIRE RATED CAULKING. 3. Maintenance Director or designee will audit all work done by contractors when they are finished to ensure fire penetrations are sealed. Fire barriers will be checked and repaired quarterly. 4. Results of the audits will be brought to the monthly performance improvement committee for review, comments, and suggestions. 5. Compliance Date: 08/11/06	
K 025 SS=D	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: Based on observations the facility failed to seal penetrations in two of eleven smoke barriers in accordance with NFPA 101 Section 19.3.7.3. The findings were: 1. Observation on 06/28/06 between 3 PM and 4 PM revealed the following vertical smoke barrier walls had unsealed cable penetrations above the ceiling tiles: a. The smoke barrier wall near resident room #116 above the double doors. b. The smoke barrier wall near resident room #225 above the double doors.	K 025		

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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 and observations, the facility failed to test the emergency battery light system in accordance with NFPA 101 Section 7.9.3 and 7.9.1.2. respectively. The findings were: 1. Review of emergency battery light testing records on 06/28/06 at 9:41 AM revealed the monthly 30 second test had not been tested for the months of February and March of 2006 and September, October, and December of 2005. The light had been tested on a quarterly basis. 2. Observation on 06/28/06 at 2:59 PM revealed the emergency battery light located at the generator set would not stay illuminated for 30 seconds. The maintenance director used the test switch and the circuit breaker to test the light. The light did not stay illuminated for more than 5 seconds either time.	K 046	**K046** 1. **There was no individual resident cited under this deficiency therefore no individual plan of correction can be addressed.** 2. **All residents have the potential to be affected by this practice. The emergency battery light 30 second test will be completed monthly as part of preventive maintenance program. The emergency light has been replaced.** 3. **An audit of the emergency battery light will be added to the preventive maintenance program. Maintenance Director will ensure compliance.** 4. **Results of the audits will be brought to the monthly performance improvement committee for review, comments, and suggestions.** 5. **Compliance Date: 08/11/06**	

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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 This STANDARD is not met as evidenced by: Based on record review the facility failed to test the installed fire alarm system in accordance with NFPA 72 Table 7-3.2. The findings were: 1. Review of the fire alarms system testing records on 06/28/06 at 9:25 AM revealed the facility failed to test any component of the fire alarm system in the last 12 months. The last test was conducted on June 23, 2004. 2. Review of the fire alarm system testing records on 06/28/06 at 9:30 AM revealed the smoke detector sensitivity test had not been conducted in the past 2 years as required by the Code. The last test was conducted on June 23, 2004.	K 052	**K052** 1. **There was no individual resident cited in this deficiency therefore no individual plan of correction can be addressed.** 2. **All residents have the potential to be affected by this practice. The fire alarm system will be inspected annually. The smoke detector sensitivity testing will be conducted every two years as required.** 3. **Maintenance Director will audit and add testing to preventive maintenance program to ensure compliance.** 4. **Results of the audit will be brought to the monthly performance improvement committee meeting for review, comments, and suggestions.** 5. Compliance Date: 08/11/06	

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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 observations, the facility was not fully sprinkled as required by NFPA 101 Section 19.3.5.1, NFPA 13 Section 5-13.6.1, 5-1.1, 5-6.4.1.1 and 5-7.4.1.1 respectively. The findings were: 1. Observation on 06/28/06 at 11:05 AM revealed neither of the hydraulic elevators had sidewall sprinklers installed at the base of the hoistway as required by the Code. 2. Observation on 06/28/06 between 1 PM and 2 PM revealed the following locations did not have sprinkler coverage: a. The second floor small dining room closet. b. The third floor small dining room closet. 3. Observation on 06/28/06 between 12:30 PM and 1:30 PM revealed the following closets had sprinkler heads located more than the allowed 12 inches below a smooth ceiling: a. Resident room #206 was 17 inches below the ceiling.	K 056	**K056** 1. **There was no individual resident cited in this deficiency therefore no individual plan of correction can be addressed.** 2. **All residents have the potential to be affected by this practice. The hydraulic elevators will have installed sidewall sprinklers at the base of the hoistway. Sprinkler coverage will be added to the second and third floor small dining room closets. Sprinkler heads in resident closets in rooms #206, 222, and 225 will be placed at the allowable 12 inch height. Documentation will be acquired to allow sidewall sprinkler heads to be located 6-12 inches below the ceiling or 12-18 inches as allowed by the exception. If documentation cannot be acquired sprinkler heads will be moved to the allowed 6 inches below the ceiling.** 3. **An audit of all sprinkler heads will be completed for height compliance and any others out of compliance will be corrected.** 4. **Results of the audit will be brought to the monthly performance improvement committee for review, comments, and suggestions.** 5. Compliance Date: ~~11/30/06~~ (Waiver Request) ACCEPTED W/ FMS ADDITION KS	B/10/06

FORM APPROVED
OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 056 SS=E	(continued)	K 056	b. Submit plans and/or blueprints by August 21, 2006 for state approval. Estimated project begin date will be October 10, 2006 and no later than October 23, 2006 Estimated date of project completion will be January 31, 2007	

#2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 056	Continued From page 6 b. Resident room #222 was 17 inches below the ceiling. c. Resident room #225 was 17 inches below the ceiling. 4. Observation on 06/28/06 between 12:30 PM and 1 PM revealed facility lacked the documentation to allow sidewall sprinler heads to be located between 6 inches and 12 incehes below the ceiling or 12 inches to 18 inches as allowed by the exception for 5-7.4.1.1. The following locations had sidewall sprinkler heads located more than the normally allowed 6 inches below the ceiling: a. Resident room #208 was 11 ½ inches below. b. Resident room #206 was 11 ¾ inches below. c. Resident room #205 was 12 ½ inches below.	K 056	**K147** 1. **No individual resident was cited in this deficiency therefore no individual plan of correction can be addressed.** 2. **All residents have the potential to be affected by this practice. B bed in room 325 will be repaired. Temporary electrical wiring will be removed.** 3. **An inservice will be conducted to all appropriate staff about temporary wiring and exposed insulation on wiring. An audit of all wiring on beds will be completed monthly by maintenance director or designee.** 4. **Results of the audits and inservices will be brought to the monthly performance improvement committee for review, comments, and suggestions.** 5. **Compliance Date: 08/11/06**	
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 110-27 and 400-8 respectively. The findings were: 1. The electrical cord for bed "B" in resident room #325 had exposed insulation near the plug. 2. Observation on 06/28/06 between 10:30 AM and 2:30 PM revealed the following locations had temporary electrical wiring replacing permanent wiring due to insufficient electrical receptacles: a. The activities office had a surge protector plugged into a surge protector.	K 147		

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K 147	Continued From page 7 b. Resident room #202 had the radio plugged into a 3-way adapter.	K 147		