STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING 01 - MAIN BUILDING 01	11/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET CASPER, WY 82601

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 with plan approval in 1992. The building was equipped with a supervised automatic wet sprinkler system with a dry branch and an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 105 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 the state and federal 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 the State Operations Manual.

K 012 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

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 1 of 7 smoke compartments. The findings were:

Observation of the SCU shower on 11/28/12 at 3:23 PM showed a 12 inch square hole was cut into the wall. At the time of the observation the maintenance director could not explain when or why the hole was cut. He could not explain why the hole was not noticed and repaired during the quarterly safety inspections.

K 012

01/13/13

K012 The facility will ensure that walls are maintained and smoke resistant. This will be accomplished by:

1 The facility's Director of Maintenance repaired the hole in the SCU shower on 12/20/12.

2. The facility's Director of Maintenance conducted a whole house audit on 12/20/12 to rule out any other penetrations within smoke barrier walls. Any holes were repaired upon discovery.

3. The facilities Director of Maintenance (or his designee) will commence a monthly audit

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

Executive Director 12/21/12

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 Accept TJD w/ JLN Approval E.D. on 1/2/13

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(X4) ID PREFIX TAG	(X5) 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 012 Continued From page 1

Reference, NFPA 101, 2000 Edition:
19.1.6.4 Each exterior wall of frame construction and all interior stud partitions shall be firestopped to cut off all concealed draft openings, both horizontal and vertical, between any cellar or basement and the first floor. Such firestopping shall consist of wood not less than 2 in. (5 cm) (nominal) thick or shall be of noncombustible material.

K 025 NFPA 101 LIFE SAFETY CODE STANDARD SS=E

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 observation and staff interview, the facility failed to ensure 2 of 5 smoke barrier walls were smoke resistant. The findings were:

1. Observation on 11/28/12 at 1:25 PM showed the attic smoke barrier wall above the dining room had two unsealed pipe penetrations. The largest gap measured ¼ inch across. At the time of the observation the maintenance director could not explain why the gap was not noticed and filled

K 012 of smoke barrier walls during their Monthly Safety Rounds inspection. Penetration(s) will be repaired upon discovery.

4. Any findings discovered during the aforementioned audit will be reported by the facility's Director of Maintenance at the facility's monthly Performance Improvement meeting for three months or until ongoing compliance is established. The facility maintains a monthly Performance

K 025 Improvement Committee (PI). Committee members consist of no less than Medical Director, Director of Nursing, Executive Director and the Director of Maintenance. The committee reviews reports, data, indexes and other pertinent data in attempt to identify areas that need improvement. If areas are identified, an action plan (designed to target improvement) is developed and implemented out of the committee. The results of the action plan are reviewed at the next scheduled meeting(s).

01/13/13

K025 The facility will ensure that smoke barrier walls are free from unsealed penetrations. This will be accomplished by:

1. The two smoke barrier wall penetrations above the dining room and in room #225 were sealed with fire caulk by the facility's Director of Maintenance on 12/20/12.

2. The facility's Director of Maintenance conducted a whole house audit on 12/20/12 to rule out any other penetrations within smoke

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K 025 Continued From page 2
during the quarterly safety inspections.

2. Observation on 11/28/12 at 1:33 PM showed the smoke barrier wall above the double doors near resident room #225 had an unsealed pipe penetration. The gap measured ⅛ inch across. At the time of the observation the maintenance director could not explain why the gap was not noticed and filled during the quarterly safety inspections.

K 029 NFPA 101 LIFE SAFETY CODE STANDARD
S/S=E

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 from use areas in 1 of 7 smoke compartments. The findings were:

Observation of mechanical room #3 on 11/28/12 at 11:30 AM showed there was an unsealed pipe penetration. The gap measured ¾ inch across. At the time of the observation the maintenance director could not explain why the gap was not

K 025 barrier walls. Any holes were repaired upon discovery.

3.The facility's Director of Maintenance (or his designee) will commence a monthly audit of smoke barrier walls during their Monthly Safety Rounds inspection. Penetration(s) will be repaired upon discovery.

4. Any findings discovered during the aforementioned audit will be reported by the Director of Maintenance at the facility's monthly Performance Improvement meeting for three months or until ongoing compliance is established.

01/13/13

K029 The facility will ensure that hazardous areas are separated from smoke compartments. Cross reference POC to K-12 and K-25. This will be accomplished by:

1. The penetration in mechanical room #3 was sealed and filled with fire caulk by the facility's Director of Maintenance on 12/20/12.

2. The facility's Director of Maintenance conducted a whole house audit on 12/20/12 to rule out any other penetrations within smoke barrier walls. Any holes were repaired upon discovery.

3.The facility's Director of Maintenance (or his designee) will commence a monthly audit of smoke barrier walls during their Monthly

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K 038 Continued From page 3
noticed and filled during the quarterly safety inspections

K 038 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

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 2 of 3 courtyard access doors were properly marked. The findings were:

Observation on 11/28/12 between 10 AM and 11:30 AM showed the cowboy dining room and theater room courtyard access doors were not marked with No Exit signs. On 11/28/12 at 11:07 AM the maintenance director reported the aforementioned areas were recently painted. He could not explain why the No Exit signs were not reinstalled.

Reference NFPA 101, 2000 Edition, 19.2.10.1, " 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 029 Safety Rounds inspection. Penetration(s) will be repaired upon discovery.

K 038 4. Any findings discovered during the aforementioned audit will be reported by the Director of Maintenance at the facility's monthly Performance Improvement meeting for three months or until ongoing compliance is established.

01/13/13

K038 The facility will ensure courtyard access doors are properly marked. This will be accomplished by:

1. The cowboy dining room and the theater room courtyard access doors have been marked with No Exit signs by the facility's Director of Maintenance 11/30/12.

2. The facility's Director of Maintenance conducted a whole house audit on 11/30/12 to rule out any other No Exit signage that may be needed.

3.The facility's Director of Maintenance (or his designee) will commence a monthly audit of No Exit signage during their Monthly Safety Rounds inspection. Signage will be posted upon discovery.

4. Any findings discovered during the aforementioned audit will be reported by the Director of Maintenance at the facility's monthly Performance Improvement meeting for three months or until ongoing compliance is established.

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K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by. Based on observation and staff interview, the facility failed to ensure the spare sprinkler cabinet had the adequate amount of heads. The findings were Observation of the spare sprinkler cabinet on 11/28/12 at 11:29 AM showed there was only one 286 degree upright heads to replace the sprinkler heads installed in mechanical room #3. At the time of the observation the maintenance director reported he relied upon the sprinkler contractor to provide the adequate sprinkler heads. Reference, NFPA 101, 2000 Edition, 19.3.5.1, 9.7.6, NFPA 25, 1998 Edition; 2.4.1.4 A supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. The cabinet shall be so located that it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100 degrees Fahrenheit. 2.4.1.5 The stock of Spare Sprinklers shall be as follows.	K 062	K062 The facility will ensure the spare sprinkler cabinet has the adequate amount of heads required. This will be accomplished by: 1. The replacement cabinet was stocked with the required number of spare sprinklers which consisted of two of each type and temperature rating sprinklers by the facility's Director of Maintenance on 11/30/12. 2. The facility's Director of Maintenance conducted a whole house audit on 11/30/12 to rule out any other spare sprinklers that may be needed. 3.The facility's Director of Maintenance (or his designee) will commence a monthly audit of the sprinkler cabinet during his Mon thly Safety Rounds inspection. The sprinklers will be replaced upon discovery. 4. Any findings discovered during the aforementioned audit will be reported by the Director of Maintenance at the facility's monthly Performance Improvement meeting for three months or until ongoing compliance is established.	01/13/13

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K 062	Continued From page 5 (a) ...Under 300 sprinklers no fewer than 6 sprinklers (b) 300 - 1000 sprinklers no fewer than 12 sprinklers.	K 062		
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 portable fire extinguishers were tested on a monthly basis in 2 of 7 smoke compartments. The findings were: Observation of portable fire extinguishers on 11/28/12 between 11 AM and 12 PM showed the last annual inspection occurred during September 2012. Further observation showed the November 2012 inspection had already been performed. Observation of the two portable fire extinguishers in the special care unit and the extinguisher in mechanical room #3 had not received monthly inspections for October 2012 and November 2012. At the time of the observation the maintenance director could not explain why the extinguishers had not been inspected on a monthly basis. Reference NFPA 101, 2000 Edition, 19.3.5.6, 9.7.4.1, NFPA 10, 1998 Edition: 4-3.1 Frequency. Extinguishers shall be inspected when initially placed in service and	K 064	J64 The facility will ensure portable fire extinguishers are tested on a monthly basis. This will be accomplished by: 1) The two portable fire extinguishers in the special care unit and the fire extinguisher in mechanical room #3 were tested by the facility's Director of Maintenance on 11/30/12. 2. The facility's Director of Maintenance conducted a whole house audit on 11/30/12 to rule out any other testing needed on the fire extinguishers. 3.The facility's Director of Maintenance (or his designee) will commence a monthly audit of all fire extinguisher during their Monthly Safety Rounds inspection. 4. Any findings discovered during the aforementioned audit will be reported by the Director of Maintenance at the facility's monthly Performance Improvement meeting for three months or until ongoing compliance is established.	01/13/13

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K 064	Continued From page 6 thereafter at approximately 30-day intervals . . .	K 064	K069 The facility will ensure the kitchen hood fire suppression system will be tested on a semi-annual basis. This will be accomplished by: 1) The kitchen hood fire suppression system was tested by Phoenix Fire Company on 11/30/12. 2. The facility's Director of Maintenance conducted an audit on 11/30/12 to rule out any other fire safety concerns in the kitchen. 3. The facility's Director of Maintenance (or his designee) will commence a monthly audit of the kitchen hood fire suppression system during their Monthly Safety Rounds inspection and will notify Phoenix Fire Company of any concerns. The Director of Maintenance will ensure semi-annual inspections are completed by Phoenix Fire Company. 4. Any findings discovered during the aforementioned audit will be reported by the Director of Maintenance at the facility's monthly Performance Improvement meeting for three months or until ongoing compliance is established.	01/13/13
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by Based on record review and staff interview, the facility failed to ensure the kitchen hood fire suppression system was tested on a semi-annual basis. The findings were Review of the kitchen hood fire suppression system testing records showed the last semi-annual inspection occurred during January 2011. On 11/26/12 at 2:25 PM the maintenance director confirmed there were no other records to review. He also reported the previous service contractor was unwilling to send them testing records as the facility ended the service contract with that company Reference, NFPA 101, 2000 Edition, 19.3.2.6, 9.2.3, NFPA 96, 1998 Edition, 8-2* An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons			
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	K 074	K074 The facility will ensure that all window curtains are flame retardant. This will be accomplished by:	01/13/13

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K 074	Continued From page 7 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: Based on observation and staff interview, the facility failed to ensure window curtains were flame retardant in 2 of 7 smoke compartments. The findings were: Observation on 11/28/12 between 9:30 AM and 12 PM showed the window curtains in the following areas did not have flame retardant documentation attached to them: 1. the executive director ' s office 2 the beauty shop 3 the main dining room, and 4 the seaside ding room On 11/28/12 at 11:45 AM the housekeeping supervisor reported she did not have a log showing when curtains were treated with a flame retardant solution. Observation of the fabric wall covering (blanket) in the cowboy dining showed documentation showing a flame retardant solution	K 074	1. Flame retardant was applied to the executive director's office, the beauty shop, the main dining room and the seaside dining room by the facility's housekeeping manager on 12/19/12. 2. The facility's housekeeping manager conducted a whole house audit on 12/19/12 to rule out any other window curtains that may need flame retardant. 3.The facility's housekeeping manager (or her designee) will commence a monthly audit of all window curtains. Flame retardant will be applied upon discovery. 4. Any findings discovered during the aforementioned audit will be reported by the Director of Maintenance or designee at the facility's monthly Performance Improvement meeting for three months or until ongoing compliance is established.	

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K 074	Continued From page 8 was applied and was attached to the blanket. She could not explain why the aforementioned curtains did not have documentation attached to them.	K 074		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD SS=D 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 observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 2 of 7 smoke compartments. The findings were: 1. Observation of resident #216 on 11/28/12 at 9:50 AM showed the wheel chair charger was plugged into an extension cord. At the time of the observation the maintenance director could not explain why the extension cord had not been notice and removed during the monthly safety inspections. 2. Observation of the telephone room on 11/28/12 at 11:34 AM showed a switch gear component was plugged into two in-line surge protectors. At the time of the observation the maintenance director reported this room was not routinely inspected. Reference NFPA 101, 2000 Edition, 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: (1) As a substitute for the fixed wiring of a	K 147	K147 The facility will ensure temporary electrical wiring does not replace permanent fixed wiring. This will be accomplished by: A) The extension cord in resident room #216 was removed and the wheel chair charger was plugged directly into an outlet. The in-line surge protectors were removed. These duties were completed by the facility's Director of Maintenance on 11/28/12. IN THE TELEPHONE ROOM. 2. The facility's Director of Maintenance conducted a whole house audit on 11/30/12 to rule out any other surge protectors or in-line surge protectors that were n ot appropriately being utilized. 3.The facility's Director of Maintenance (or his designee) will commence a monthly audit monitoring the use of extension cords and surge protectors during their Monthly Safety Rounds inspection. Any of these items that are not being appropriately utilized will be removed upon discovery. 4. Any findings discovered during the aforementioned audit will be reported by the Director of Maintenance at the facility's monthly Performance Improvement meeting for three months or until ongoing compliance is established.	01/13/13

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K 147	Continued From page 9 structure (2) Where run through holes in walls ... (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147		