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

PRINTED: 09/13/2010
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
	536017	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

(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 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). The facility was a fully sprinkled single story building of Type V (111) construction built in 1978, 1983 and 2008. The building was equipped with a supervised automatic wet sprinkler system with a zoned fire alarm system. The facility had a capacity of 50 certified Medicare and Medicaid beds.	K 000		
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 observation and staff interview the facility failed to ensure 1 of 4 smoke barriers was smoke resistant. The findings were: Observation of the north attic smoke barrier wall on 8/31/10 at 11:56 AM showed there were four	K 025	The facility will ensure smoke barriers are smoke resistant as evidenced by: 1. The Maintenance Director (MD) will repair holes in the smoke barrier by patching the holes and applying joint compound to seal the patches. The MD will monitor the smoke barriers on a quarterly basis to ensure that any opening that may occur will be sealed. The MD will report findings at the quarterly QAA meeting with appropriate follow up.	09/08/2010

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

Administrator 9/24/10

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.

RECEIVED
Wyoming Dept of Health

K.C. reception w/ Heather McKee, NHA; 09/29/10.

Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

9/29/10

(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 025	Continued From page 1 unsealed penetrations. The largest hole was 6 inches in diameter. At the time of observation the maintenance director reported all barriers were inspected quarterly to ensure they were smoke resistant. He further reported an outside contractor had worked in the area and completed his project a month prior to the survey.	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 ares were separated from use areas in 1 of 5 smoke compartments. The findings were: Observation of the medical records storeroom on 8/31/10 at 9:35 AM showed the door was equipped with an automatic-closing device. Further review showed the door was impeded by a binder wedged under the door and would not close automatically. At the time of observation the medical records manager reported she was aware the door was required to be closed.	K 029	The facility will ensure hazardous areas are separated from use areas by smoke resisting doors as evidenced by: 1. The MD will provide an in-service to educate all employees as to the hazards of blocking a fire door open. The MD will monitor for open fire doors on a weekly basis and report at the quarterly QAA meeting with appropriate follow up.	08/31/2010
K 051	NFPA 101 LIFE SAFETY CODE STANDARD	K 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

9/29/ID

(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 051 SS=D	Continued From page 2 A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure smoke detectors were correctly installed in 1 of 5 smoke compartments. The findings were: Observation of the fire alarm system on 8/31/10 between 8 AM and 9 AM showed the smoke detectors in the conference room and nursing supply storeroom were installed closer than 36 inches from the ventilation defuser. The closest	K 051	The facility will ensure smoke detectors are installed no closer than 36 inches to a ventilation defuser in accordance with NFPA 72 as evidenced by: 1. The MD will reinstall smoke detectors in the conference room and nursing supply storeroom such that they are installed no closer than 36 inches from ventilation defusers in accordance with NFPA 72. The MD will monitor smoke detector placement on a quarterly basis and report at the quarterly QAA meeting with appropriate follow up.	10/17/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

9/29/10

(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 051	Continued From page 3 detector was only 6 inches from the defuser. At 8:37 AM the maintenance director reported he was unaware of the spacing requirement. He further reported the system was inspected by an outside contractor on an annual basis, and the last inspection conducted on 2/18/10 did not identify spacing problems.	K 051		
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 extinguisher were properly tested in 1 of 5 smoke compartments. The findings were: Observation of the kitchen K-type fire extinguisher on 8/31/10 at 10:17 AM showed it was manufactured in 2004. Further review showed it was serviced during April 2010. The required five year hydrostatic test was not performed on the extinguisher based on the service tag. At the time of observation the maintenance director reported he was not aware of the five year testing requirement. He further reported that the extinguisher contractor had not mentioned the need for the test during the last inspection.	K 064	The facility will ensure that required five year hydrostatic tests on portable fire extinguishers are conducted in accordance with 9.7.4.1 19.3.5.6 NFPA 10 as evidenced by: 1. The MD will have the kitchen K-type fire extinguisher hydrostatically tested. 2. The MD will monitor all portable fire extinguishers on a quarterly basis to ensure they have been tested in accordance with 9.7.4.1 19.3.5.6 NFPA 10 and report at the quarterly QAA meeting with appropriate follow up.	09/24/2010