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

PRINTED: 03/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTIONS	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

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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 sprinklered, two-story building of Type II (111) construction built in 1982 and 1992.The building was equipped with a supervised, automatic wet sprinkler system with a dry and an anti-freeze branch and an addressable fire alarm system. The facility had a capacity of 94 certified Medicare and Medicaid beds with a census of 72.	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 2 fire barrier doors was smoke resistant. The findings were: Observation of the east long term care double fire barrier doors on 2/26/13 at 11:10 AM showed one of the two doors was unable to be fully latched into the door frame with the force from the	K 011	1. The facility will continue to ensure that all fire barrier doors are smoke resistant. 2. The latch on the east long term care double fire barrier doors was adjusted on 3/1/2013 to properly close. Work Order 63768 3. The facility will continue to monitor and conduct quarterly checks on fire doors. The Director of Plant Operations will ensure compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Kaiser, NHA — TITLE: Administrator — (X6) DATE: 3/22/2013

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/ TIM WALTNER, DIRECTOR OF PLANT OPERATIONS ON 4/1/13.

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K 011	Continued From page 1 self-closing device, with three attempts. At the time of the observation the director of plant operations could not explain why the door had not been noticed and adjusted during the quarterly safety inspections.	K 011	4. Regular monitoring of smoke barrier doors will be reported on a quarterly basis to the Environment of Care Committee, (EOC) with oversight by the Quality Improvement (QI) committee, and monitored by the Director of Plant Operations.	3/1/2013
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 8 smoke barrier double doors were smoke resistant. The findings were: Observation of the second floor west smoke barrier double doors on 2/26/13 at 3:14 PM showed one of the two doors was unable to be fully latched into the door frame with the force from the self-closing device, with three attempts. At the time of the observation the director of plant operations could not explain why the door had not been noticed and adjusted during the quarterly safety inspections.	K 027	1. The facility will continue to ensure that all fire doors are smoke resistant. 2. The latch on the second floor west smoke barrier double doors was adjusted on 3/15/2013 to properly close. Work order 64245 3. The facility will continue to monitor and conduct quarterly checks on fire doors. The Director of Plant Operations will ensure compliance. 4. Regular monitoring of smoke barrier doors will be reported through the EOC Committee on a quarterly basis with oversight by the QI committee, and monitored by the Director of Plant Operations.	3/15/2013
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 029	1. The facility will continue to ensure that hazardous areas are separated from use areas by smoke resistant partitions and self-closing doors.	

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K 029	Continued From page 2 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 2 of 10 smoke compartments. The findings were: 1. Observation of the storeroom near the long term care conference room on 2/26/13 at 11:14 AM showed the corridor door was not equipped with a self-closing device. At the time of the observation the director of plant operations could not explain why a self-closing device had not been added to the corridor door once the room was converted into a storeroom. 2. Observation of the second floor east storage room on 2/26/13 at 1:25 PM showed the west wall was not completed from floor to ceiling. The wall was missing an 8 inch high and 10 feet long section. At the time of the observation the director of plant operations could not explain why the wall was not noticed and completed during the annual hazardous area inspection.	K 029	2. A self closing device was added to the door on the store room near the long term care conference room on 3/14/2013. Work order 63787 3. The barrier wall in the second floor east storage room was completed on 3/5/2013. Work Order 63788. 4. The facility will continue to monitor and conduct quarterly checks on fire doors, and semi-annual checks every six months on all smoke partitions through hazardous area inspections. A recurring Preventive Maintenance Work Order has been entered into the system to automatically generate a work order for these inspections to be conducted. The Director of Plant Operations will ensure compliance. 5. Regular monitoring of hazardous areas will be reported through the EOC Committee on a quarterly basis, with oversight by the Quality Improvement (QI) committee, and monitored by the Director of Plant Operations.	3/14/2013

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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 sprinkler escutcheon rings were maintained in 1 of 10 smoke compartments. The findings were: Observation of the activities area on 2/26/13 at 11:46 AM showed two sprinkler heads were missing escutcheon rings. At the time of the observation the director of plant operations reported the escutcheon rings were in place during the last annual sprinkler inspection. He could not verify if facility staff members were aware they needed to notify the maintenance department if escutcheon rings were found, after falling from sprinkler assemblies. Reference NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 3-2.7.2 Escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly.	K 062	1. The facility will continue to ensure that escutcheon rings are maintained on all sprinkler heads. 2. The two escutcheon rings on sprinkler heads in the activities area were replaced on 3/1/2013 per work order 63808. 3. Facility staff will be educated at a staff meeting on 3/20/2013 regarding the need to notify the Plant Operations (Maintenance) department if an escutcheon ring is found to have fallen from a sprinkler assembly. 4. The Director of Plant Operations will monitor and ensure compliance through quarterly environmental rounds. A recurring Preventive Maintenance Work Order has been entered into the system to automatically generate a work order for these inspections to be conducted. 5. The results of the monitoring of regular environmental rounds will be reported quarterly through the EOC Committee, with oversight by the QI committee.	3/20/2013
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	K 064		

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K 064	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure portable fire extinguishers were inspected in 1 of 10 smoke compartments. The findings were: Observation of the second floor kitchen on 2/26/13 at 3:24 PM showed the last annual inspection for the portable fire extinguisher was completed during July 2012. Further observation showed a monthly inspection had not been completed for the months of October, November, and December 2012 and January 2013. At the time of the observation the director of plant operations reported the maintenance technician that previously inspected the extinguishers had retired. He could not explain why this extinguisher was not inspected on a monthly basis by the new technician. Reference NFPA 101, 2000 Edition, 19.3.5.5, 9.7.4.1, NFPA 10, 1998 Edition; 4-3 Inspection. 4-3.1 Frequency. Extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals	K 064	1. The facility will continue to ensure that fire extinguishers are inspected monthly by facility staff, and annually by an outside contractor. 2. The fire extinguisher in the second floor kitchen was inspected on 3/1/2013, and added to the list for monthly inspection by facility staff. 3. The Director of Plant Operations will monitor and ensure compliance with monthly and annual inspections of all fire extinguishers through quarterly environmental rounds. 4. The results of the monitoring of regular environmental rounds will be reported quarterly through the EOC Committee, with oversight by the QI committee.	3/1/2013