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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	503 S 18TH ST LARAMIE, WY 82070

(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 two story building with a basement of Type V (111) construction built in 1953, 1972 and 1986. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze branch and a zoned fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds.	K 000		
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 the walls were smoke resistant in 2 of 13 smoke compartments. The findings were: 1. Observation on 6/02/10 at 12:15 PM showed the activities storeroom had one unsealed pipe penetration. The gap between the pipe and wall was 1/2 inch wide. At the time of observation the maintenance supervisor reported storerooms were not routinely inspected. 2. Observation on 6/02/10 at 3:46 PM showed	K 012	K012—The facility will ensure the walls are smoke resistant The unsealed pipe penetration in the activities storeroom was sealed on June 18, 2010. The unsealed circular wall penetrations in room 22 were sealed on June 18, 2010. The 2 inch by 4 inch hole in the wall at #4 nurses station was sealed June 18, 2010. Maintenance will do a do a visual check of the entire building and repair penetrations that are found. The Maintenance Director will be responsible for monitoring storerooms and other areas for wall penetrations and will include this in the Facility Preventive Maintenance Program (F.P.M.P.) and will report to Safety Committee Quarterly	6/18/10

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

Rona Nelson — Administrator — 7/21/10 — 6-24-10

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

FOR Acceptance w/ Fon Notes, NHA, DPH 7/28/10

JUL 07 2010

Office of Healthcare Licensing and Surveys

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K 012	Continued From page 1 resident room #22 had three unsealed circular wall penetrations. The largest gap was 3/4 inch wide. 3. Observation on 6/02/10 at 3:53 PM showed the #4 nurses' station had an unsealed 2 inch by 4 inch hole in the wall.	K 012	K017—The facility will ensure corridor walls are continuous from floor to ceiling. The 3 inch hole in the Lobby's north wall near the baseboard heater pipe will be sealed. Maintenance will do a visual check of the corridors and will repair holes that are found. Maintenance personnel will do routine checks through the F.P.M.P. Maintenance Director will monitor for compliance and will report to Safety Committee quarterly. 7/21/10	
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure corridor walls were continuous from floor to ceiling in 1 of 13 smoke compartments. The findings were: Observation on 6/02/10 at 11:02 AM showed the front lobby's north wall had a 3-inch hole near to the baseboard heater pipe. At the time of	K 017		

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K 017	Continued From page 2 observation the maintenance supervisor reported corridor walls were not routinely inspected.	K 017		
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 observation and staff interview the facility failed to ensure corridor doors were solid core, rated doors and failed to ensure doors were smoke resistant in 2 of 13 smoke compartments. The findings were: 1. Observation on 6/02/10 at 12:15 PM showed the activities storeroom corridor door was not a 1 3/4 inch solid core door. The door was hollow core and was not a 20-minute fire-rated door. At the time of observation the maintenance	K 018	K018—The facility will ensure that corridor doors are 1 ¾ inch solid core, 20 minute fire-rated and smoke resistant. A new 1 ¾ inch, 20 minute fire-rated, solid core door was ordered to replace the one on the activities storeroom. The copy room corridor door has been adjusted to latch properly and is now smoke resistant. Maintenance personnel will monitor corridor doors through the F.P.M.P. Maintenance Director will monitor for compliance and will report to the Safety Committee quarterly. 7/21/10	

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K 018	Continued From page 3 supervisor reported he was aware all corridor doors were to be 20-minute fire-rated. He could not explain why the door had not been noticed and replaced. 2. Observation on 6/02/10 at 4:40 PM showed the copyroom corridor door was not smoke resistant. The door would bind with the top right corner of the door frame. At the time of observation the maintenance supervisor reported corridor doors were routinely inspected.	K 018	K027—The facility will ensure that the smoke barrier doors are smoke resistant The smoke barrier doors near the MDS office have been adjusted and new metal flashing has been installed. The doors are now smoke resistant. The 4 unsealed penetrations in the 2 smoke barrier doors next to room #26 were sealed with fire caulking on 6/4/2010. Maintenance personnel will check all smoke barrier doors for compliance. The Maintenance Director will set up for routine checks of the smoke barrier doors through the F.P.M.P. and will report any problems to the Safety Committee quarterly. 7/21/10	
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 4 of 16 smoke barrier doors were smoke resistant. The findings were: 1. Observation on 6/02/10 at 2:15 PM showed the double smoke barrier doors near the Minimum Data Set office were not smoke resistant. The gap between the doors was 1/4- inch. At the time of the observation the maintenance supervisor reported he was aware that smoke barrier doors could not have a gap greater than 1/8 inch. He	K 027		

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K 027	Continued From page 4 further reported barrier doors were not routinely inspected. 2. Observation on 6/02/10 at 3:29 PM showed one of two smoke barrier doors near resident room #26 was not 1-3/4 inch thick. The door had four unsealed penetrations that were 1-inch deep. At the time of observation the maintenance supervisor reported he did not know the holes needed to be filled as they didn't pass all the way through the door.	K 027	K038—The facility will ensure that exit access's will be unobstructed at all times. The material obstructing the staircase was removed on 6/2/10. The Maintenance Director will monitor through the F.P.M.P and will report to the Safety Committee quarterly.	7/21/10
K 038 SS=D	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 exit access was unobstructed at all times in 1 of 13 smoke compartments. The findings were: Observation on 6/02/10 at 4:51 PM showed the second floor staircase landing was obstructed by a computer and snow skis. At the time of observation the maintenance supervisor reported staff was moving out of the second floor apartment, and the items were theirs. He further reported he was aware all exit access pathways are required to be unobstructed.	K 038		
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	K 052		

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K 052	Continued From page 5 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 observation and record review the facility failed to ensure the central station certificate was posted and fire alarm pull stations were unobstructed in 1 of 13 smoke compartments. The findings were: 1. Observation of the main fire alarm panel on 6/02/10 at 10:02 AM showed the central station certificate was not posted. At the time of observation the maintenance supervisor reported he was not aware the certificate was required to be posted within 36 inches of the main panel. 2. Observation of 6/02/10 at 2:24 PM showed the fire alarm pull station near the time clock was obstructed by a mop and trash can. At the time of observation the maintenance supervisor reported he was aware that all pull stations were required to be unobstructed. He could not explain why storage was occurring in this location.	K 052	K052—The facility will ensure that a current central station certificate will be posted and fire pull stations will be unobstructed. The current central station certificate was posted on 6/3/10. The mop and trash can were removed on 6/3/10 and the fire pull station by the time clock is now unobstructed. All pull stations were checked and are unobstructed Maintenance Director will monitor for compliance and will report to Safety Committee Quarterly. 7/21/10	
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	K 056	K056—The facility will ensure that all required areas of the building will have fire sprinklers.	

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K 056	Continued From page 6 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 observation and staff interview the facility failed to ensure exterior canopies had sprinkler coverage in 1 of 13 smoke compartments. The findings were: Observation on 6/02/10 at 12:07 PM showed the central courtyard exterior canopy did not have sprinkler coverage. Further review showed the canopy was constructed of wood trusses and plywood sheathing. The canopy measured 6 feet by 18 feet. At the time of observation the administrator reported he was aware of the sprinkler requirement for canopies wider than 4 ft.	K 056	The facility will have fire sprinklers installed in all required areas of the building including under the canopy in the central courtyard. The facility has contracted with Western States Fire Sprinkler Co. to install the needed fire sprinklers. The plan for work needed to be done, will be submitted to the Wyoming Department of Health Engineers by September 1, 2010. Estimated time for the State to approve the plans, October 1, 2010. The work will be scheduled to be done between November 1 and November 20, 2010. We will call for a final inspection by November 30, 2010. Administrator will be responsible to see that the work is completed. A waiver until December 2, 2010 has been applied for. (See waiver request of June 24, 2010)	
K 062 SS=F	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:	K 062	annual inspection of the building will be conducted to ensure all areas of the building have fire sprinkler coverage. The Maintenance Director will be responsible and will report to the QA Committee yearly.	

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K 062	Continued From page 7 Based on observation, record review and staff interview the facility failed to ensure escutcheon rings were properly maintained, failed to ensure sprinklers were not obstructed or corroded and failed to ensure items were not stored on sprinkler pipes in 6 of 13 smoke compartments. The findings were: 1. Observation of the sprinkler sytem on 6/02/10 at 10:27 AM showed 1 of 2 sprinkler escutcheon ring in resident room #6 was not smoke resistant. The gap between the ring and ceiling was 1/2 inch wide. At the time of observation the maintenance supervisor reported he was aware of the installation requirement. He could not explain why the ring had not been noted and repaired. 2. Observation of the sprinkler system on 6/02/10 between 12 PM and 4 PM showed the sprinklers in the corridor near resident room #51 and the telephone room and a sprinkler in the station 4 conference room were obstructed. The sprinklers were installed within 12-inches of ceiling mounted lights and the bottom of the lights were below the bottom of the sprinkler deflectors. At 12:22 PM the maintenance supervisor reported he was aware of the spacing requirement. He further reported that the system was inspected annually by an outside contractor, and obstructed sprinklers were not identified on the November 2009 report. 3. Observation of the sprinkler system on 6/02/10 between 2:30 PM and 4:30 PM showed the sprinklers in boiler room #3 and the kitchen housekeeping closet were corroded. At 2:47 PM the maintenance supervisor reported he was aware of the requirement. He further reported that	K 062	K062—The facility will maintain the automatic sprinkler system in reliable operating condition and will inspect and test it periodically. The sprinkler escutcheon in room #6 has been sealed. All corroded sprinkler heads will be replaced and all obstructed sprinkler heads will be moved and will not be obstructed. This will be done by Western Fire Sprinkler Company when they install the sprinklers cited in K-Tag #56. Administrator will be responsible to see that the work is completed. A waiver until December 15, 2010 has been applied for. (See waiver request of June 24, 2010) 7/21/10	

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K 062	Continued From page 8 the system was inspected annually by an outside contractor and no obstructed sprinklers were noted on the November 2009 report. 4. Observation of the sprinkler system on 6/02/10 at 4:55 PM showed wood was being stored on top of the sprinkler pipes in the maintenance shop. The wooden planks spanned the two sprinkler lines. At the time of observation the maintenance supervisor was not aware items could not be stored on or hung from sprinkler piping.	K 062	K066—The facility will ensure staff follow smoking policies. The area near the north east exit has been cleaned up. In the 3 staff training meetings held on June 7, 2010, the staff were again reminded and trained on the facility smoking policy. They were also reminded of the consequences of not following this policy. Maintenance staff will make periodic visual inspections and enforce policy with staff who smoke. Maintenance Director will report to Safety Committee quaterly. 7/21/10	
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066		

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K 066	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure staff followed smoking policies at 2 of 11 exits. The findings were: Observation of the north east exit on 6/02/10 at 2:56 PM showed cigarette butts were mingled among dried leaves and other debris near the exit door. Further review showed 124 cigarette butts were found near the exit. At the time of observation the maintenance supervisor reported the facility was a non-smoking facility. He stated staff members could not smoke on the facility property, but they did smoke in the alley north of the property line. He further reported staff members would smoke in the alley and then re-enter the facility through one of two north exit doors. He could not explain why the cigarette butts had not been properly disposed of in the provided ashtrays.	K 066		
K 074 SS=D	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 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	K 074	K074—The facility will ensure that fabric wall coverings are flame retardant. The cotton blanket hung on the wall in room #70 was removed on 6/11/10. The Admissions Director was instructed to notify residents and their families that all fabric coverings must be flame retardant. Maintenance Director will monitor for compliance and will report to the Safety Committee quarterly 7/21/10	

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K 074	Continued From page 10 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 fabric wall covering were flame retardant in 1 of 13 smoke compartments. The findings were: Observation of resident room #70 on 6/02/10 at 11:39 AM showed a homemade cotton blanket was hung on the wall from floor to ceiling. At the time of observation the maintenance supervisor reported the blanket did not have flame retardant documentation. He further reported that the blanket had not been treated with a flame retardant spray.	K 074	K147—The facility will ensure that electrical wiring and equipment is in accordance with NFPA 70. The electrical panels including the ones in the south birch soiled utility room, central linen supply room, therapy office and kitchen have been unobstructed. Oxygen concentrators in rooms #12, #8, #72 and #66 have been removed from the bathrooms. The electrical cord run through the wall in the front lobby have been capped.	
K 147 SS=F	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 observation and staff interview the facility failed to ensure electrical equipment had adequate work space, failed to ensure electrical cords were not run through door frames, failed to ensure damaged electrical equipment was replaced, failed to ensure electrical outlets near water sources had ground fault circuit interrupter (GFCI) protection, failed to ensure temporary wiring did not replace fixed permanent wiring and failed to ensure junction boxes had covers in 11	K 147	The electrical outlets in resident room #110, the central linen supply and in the corridor near the spruce hall exit door have been replaced. The electrical outlets at the unit one nurses' station, in the laundry washroom, in the unit three tub room have all been replaced with GFCI receptacles.	

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7/08/10

(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 147	Continued From page 11 of 13 smoke compartments. The findings were: 1. Observation of the electrical system on 6/02/10 between 10 AM and 4:30 PM showed the electrical panels in the South Birch soiled utility room, central linen supply room, therapy office and kitchen were obstructed and could not be opened. The panel doors had items stored directly in front of them. At 10:07 AM the maintenance supervisor reported he was aware electrical equipment require 36-inches of work space in front of the access door. He further reported the electrical system was not routinely inspected. 2. Observation of the electrical system on 6/02/10 between 10 AM and 12 PM showed the oxygen concentrators in resident room #12, #8, #72 and #66 were kept in the restroom and the electrical cord was plugged into an outlet in the restroom. In each location the door was closed. At 10:13 AM the maintenance supervisor reported the concentrator were stored in the restrooms because of the noise they made. He further reported he was not aware that electrical cords were not permitted to run through door frames or other like openings. He further reported the electrical system was not routinely inspected. 3. Observation of the electrical system on 6/02/10 at 11:03 AM showed an electrical cord was run through the wall near the hot water baseboard heater in the front lobby. 4. Observation of the electrical system on 6/02/10 between 10 AM and 1 PM showed the electrical outlets in resident room #110, the central linen supply and in the corridor near the Spruce Hall exit door were damaged. The outlets were either	K 147	The 3-way adaptor was removed from room #4 One of the surge protectors was removed from the calculator in the business office. The lamp in room #51 was unplugged from the 3-way adaptor One of the surge protectors was removed from the television set in room #14 A cover plate was installed on the electrical junction box in the attic. The Director of Maintenance has developed a quarterly electrical inspection form and will inspect the facility quarterly to monitor for compliance. The Director of Maintenance will report his finding quarterly to the safety committee. 7/21/10	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 147	Continued From page 12 cracked or had char marks. At 10:17 AM the maintenance supervisor reported the electrical system was not routinely inspected. He further reported the only time outlets were changed was when the housekeeping staff informed the maintenance staff they were damaged. 5. Observation of the electrical system on 6/02/10 between 11 AM and 4 PM showed the electrical outlets at the unit one nurses' station, in the laundry washroom, in the unit three medication room and in the unit three tub room were located near water sources. Further review showed each location was within 6 feet of a water source, and the outlets did not have GFCI protection. At 11:06 AM the maintenance supervisor reported he was aware of the GFCI requirement. He could not explain why the above mentioned locations did not have GFCI receptacles. 6. Observation of the electrical system on 6/02/10 between 10:30 AM and 5 PM showed electrical appliances were plugged into prohibited electrical adapter in the following locations: a. The concentrator in resident room #4 was plugged into a 3-way adapter. b. The office managers calculator was plugged into two surge protector in-line. c. The lamp in resident room #51 was plugged into a 3-way adapter. d. The television set in resident room #14 was plugged into a surge protector which was, itself, plugged into a 6-way adapter. 7. Observation of the electrical system on 6/02/10 at 6:20 PM showed an electrical junction box in the attic above the staff break room did not have a cover plate. At the time of observation the maintenance supervisor reported he was aware	K 147		

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	535043	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/02/2010

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K 147	Continued From page 13 of the requirement. He further reported the electrical system was not routinely inspected.	K 147		