PRINTED: 05/16/2005
FORM APPROVED
OMB NO. 0938-0391

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
	535017	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/03/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 333 N BRIDGER AVE PINEDALE, WY 82941

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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 V (111) with a wet sprinkler system. The building is one story with direct ground level access. The fire alarm system had smoke detectors in the corridors and commons areas. K6: Date of Plan Approval: 1978, 1983 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=64;SNF/NF=6; NF 54 K9: The facility meets the Life Safety Code standards based on acceptance of a plan of corrections "NFPA" National Fire Protection Association	K 000	MAY 27 2005	
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, 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 19.3.6.3.3 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations	K 018	The facility will ensure that passage of smoke is prohibitive from resident rooms into corridors. This will be accomplished by: 1] The doors to rooms #10, 108, and 204 will be adjusted or sealed with UL approved door edge seal. 2] The Maintenance staff will conduct quarterly inspections of all doors and	6/17/05 7/1/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah J. Wood — TITLE: Administrator — (X6) DATE: 5/27/05

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.

ADDITIONS & MODIFICATIONS OF THIS POC WERE DISCUSSED WITH DEBORAH WOOD, RN ON 5/27/05 @ 1230 PM VIA TELECONFERENCE

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K 018	Continued From page 1 in all health care facilities as of March 13, 2006. This STANDARD is not met as evidenced by: Based on observation and staff interview on 5/3/05 between 9 AM and 11 AM, the facility failed to protect 3 of 58 corridor door openings in accordance with NFPA 101 Section 19.3.6.3. The findings were: 1. Room #10, #108, and #204 had gaps between the top edge of the corridor doors and the door frames that were greater than the allowed 1/8 th of an inch. Maintenance staff verified the above findings.	K 018	report findings immediately to the Administrator. 3] Findings of door inspections will also be reported at quarterly QI meetings.	
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 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 on 5/03/05 between 9:30 AM and 10 AM, the facility failed to provide 1 of 5 hazardous areas with	K 029	The facility will ensure that doors are free from obstruction. This will be accomplished by: 1] The box in the medical records office has been moved and the staff member inserviced not to block the door movement. 2] The Maintenance Director will inservice staff at the upcoming general staff meeting that no door is to be blocked at any time. 3] The Maintenance Director will monitor doorways for obstruction on	6/1/05

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K 029	Continued From page 2 proper separation in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. The medical records storeroom door was impeded by a box placed in the swing path. Maintenance staff verified the above finding.	K 029	morning walk-thrus and report any findings to the Administrator.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times as defined in section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview on 5/3/05 between 11 AM and 11:30 AM, the facility failed to provide egress corridors unobstructed and accessible at all times in accordance with NFPA 101 Section 19.2.1 and 7.1.10.1. The findings were: 1. The kitchen service corridor was obstructed by a 36-inch square bread cart. Maintenance staff verified the cart was always stored in the corridor.	K 038	The facility will ensure that exits are readily accessible. This will be accomplished by: 1] The bread cart and service carts have been removed and alternate storage has been found. 2] All staff will be inserviced on the standard for obstruction of corridors and exits. 3] Maintenance will monitor all exit corridors and report any obstructions to the proper department supervisor and the Administrator.	6/1/05
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050	The facility will ensure that fire drills are performed in accordance with current regulation. This will be accomplished by: 1] There was a bookkeeping error. In order to prevent this same error recurring test records will be reviewed for the quarterly QI meetings.	6/1/05

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K 050	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and staff interview on 5/2/06 between 2 PM and 4 PM, the facility failed to conduct quarterly fire drills on each shift in accordance with NFPA 101 Section 19.7.1.2. The findings were: 1. Review of the fire drill records revealed the second shift had not conducted a fire drill during the first quarter of 2005. Maintenance staff verified the finding and reported the first shift had conducted two drills during the quarter with the second drill mistakenly being recorded as being completed by the the second shift.	K 050	2] Department supervisors and the Administrator will be notified of fire drill compliance.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system 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 and staff interview on 5/3/06 between 8:45 AM and 11 AM, the facility	K 056	The facility will ensure that sprinklers are appropriate for fire suppression. This will be accomplished by: 1] The walk in cooler and walk in freezer are to be removed and replaced with new units, in conjunction with a dietary department expansion and remodel. 2] During the construction the automatic sprinkler system will be upgraded to current standards. Blue prints and specifications are currently being put together for state review and approval. Sprinkler heads will be added to the exterior roof overhang area, at the	11/2/06

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K 056	Continued From page 4 was constructed of combustible material and not fully sprinkled as required by NFPA 13 Section 5-1.1 and 5-13.8.1. The findings were: 1. The two walk-in refrigerator units in the kitchen did not have sprinkler coverage as required by the Code. 2. The exterior roof above the front entrance was wider than 4 feet and did not have sprinkler coverage as required by the Code 3. Maintenance staff verified the above findings.	K 056	same time as the upgrade in the dietary department. This will reduce downtime and expense for this project.	
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 observations and staff interview on 5/3/06 between 1030 AM and 11 AM, the facility failed to maintain the installed sprinkler system in accordance with NFPA 25 Section 2-2.1.1. The findings were: 1. The sprinkler head above the kitchen's dish room corridor door had visible signs of corrosion. 2. Several sprinkler heads in the east wing attic had insulation falling down from the rafters onto the sprinkler heads, potentially obstructing their spray patterns. 3. Maintenance staff verified the above findings.	K 062	The facility will ensure that sprinkler heads are in good working order and free from obstruction. This will be accomplished by: 1] The sprinkler head in the dish room corridor will be replaced. The insulation in the East medical wing attic will be properly reinstalled to clear the area around the sprinkler heads. 2] Maintenance will monitor for sprinklers in poor condition on daily walk-thrus and will conduct annual inspections of the sprinkler heads and report any deficiencies to the Administrator. Maintenance will monitor by conducting quarterly inspections of all attic areas containing sprinklers and verify the sprinklers are not obstructed. 3] Results will be reported to the Administrator.	6/17/05 7/30/05

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K 064 K 064 SS=D	Continued From page 5 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, 9.7.4.1, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and staff interview on 5/3/05 between 11 AM and 11:30 AM, the facility failed to maintain and test 1 of 12 portable fire extinguisher in accordance with NFPA 10 Table 5-2. The findings were. 1. The K-type portable fire extinguisher in the kitchen was manufactured in 1998, and had not receive a five year hydrostatic test as required by the Code. Maintenance staff verified the above finding.	K 064 K 064	The facility will ensure that required testing is performed on extinguishers. This will be accomplished by: 1] The K type extinguisher will be replaced. The existing extinguisher had been dropped and was dented. 2] Maintenance has contacted the contractor that services the extinguishers for this facility and verified that he is aware of the code for K type extinguishers. 3] Maintenance will monitor the K-tank to ensure that it is tested properly and will report any discrepancies to the Administrator.	5/16/05
K 066 SS=D	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	K 066	The facility will ensure that proper receptacles are available in smoking areas. This will be accomplished by: 1] The enclosed metal ash container had been removed by staff to be emptied and cleaned. The container was returned to the proper are during the survey. 2] Staff has been inserviced to place another appropriate ash container in the	5/3/05

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K 066	Continued From page 6 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 This STANDARD is not met as evidenced by: Based on observation and staff interview on 5/3/05 between 10 AM and 11 AM, the facility failed to adopt and enforce written smoking regulations that include the minimal provisions outlined in NFPA 101 Section 19.7.4. The finding was: 1. The designated resident smoking area outside of the east exit was not equipped with an ashtray or a metal container with a self-closing cover. The maintenance staff equipped the area with the proper equipment before the survey was completed.	K 066	smoking area when removing one for any purpose. 3] Maintenance will monitor the smoking area weekly to ensure that a proper container is in place and will report any issues to the Administrator.	
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Solid linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .6 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5	K 075	The facility will ensure that soiled linen and trash receptacles do not exceed regulation for square footage. This will be accomplished by: 1] The excess containers have been removed and the laundry staff has been inserviced by the environmental	5/6/05

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K 075	Continued From page 7 This STANDARD Is not met as evidenced by: Based on observations and staff interview on 5/3/05 between 9 AM and 10 AM, The facility failed to limit the amount of soiled linen or trash collection receptacles in 1 of 3 bathrooms in accordance with NFPA 101 Section 19.7.5.5. The findings were: 1. The west hall bathroom stored six soiled linen containers. The Code only allows four containers, based on the square footage of the room. Maintenance staff verified the above finding.	K 075	services supervisor as to correct numbers per room. 2] The environmental services supervisor will monitor weekly the number of containers in all rooms and report to the Administrator.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4.3.1.1.2, 19.3.2.4 This STANDARD Is not met as evidenced by: Based on observation and staff interview on 5/3/05 between 10:30 AM and 11 AM, The facility failed to provide proper oxygen storage for 9 of 32 oxygen cylinders in accordance with NFPA 99	K 076	The facility will ensure that oxygen tanks are properly stored. This will be accomplished by: 1] The company that supplies the oxygen has been contacted and they have provided more secure storage capability for the "E"tanks. 2] Maintenance has inserviced the nurse aids that handle oxygen, giving them instruction in the proper storage of full and empty tanks. 3] Maintenance will conduct weekly checks of the oxygen storage area and	5/16/05

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K 076	Continued From page 8 Section 4-3.1.1.1. The finding was: 1. The oxygen storage room had 9 "E" size oxygen cylinders that were not restrained in order to prevent falling as required by the Code. Maintenance staff verified the above finding.	K 076	report those checks to the Administrator.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130	The facility will ensure that electrical code will be followed. This will be accomplished by:	6/17/05 7/1/05
	This STANDARD is not met as evidenced by: Based on observation and staff interview on 5/3/05 between 10 AM and 11 AM, the facility failed to provide an electrical system installed in accordance with NFPA 70 Section 430-131. The finding was: 1. The walk-in cooler had three fans that did not have covers over their electrical connections as required by the Code. Maintenance staff verified the above finding.		1] The electrical contractor has been contacted and will rewire the fans in the walk in cooler as required by the appropriate code. 2] Completion of this work will be reported to the Administrator.	