7002 3150 0001 5295 9586

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS, FOLD AT DOTTED LINE

CERTIFIED MAIL™

RECEIVED
Wyoming Dept of Health

MAR 13 2009

Office of Healthcare Licensing and Surveys

7002 3150 0001 5295 9586 BASIN, WY 82410

(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 the 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 single story building of Type V(000) construction built in 1973. The building was equipped with a supervised automatic wet sprinkler system and fire alarm system. The South Bighorn Hospital is adjacent to the nursing home with a 2 hour fire rated barrier and two 1 ½ hour fire rated doors. The hospital is a Type II (111) building without a sprinkler system. The four hospital rooms closest to the 2 hour fire barrier are nursing home resident rooms.	K 000		
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.	K 018	K018: This facility will ensure all corridor doors are able to resist the passage of smoke. 1. Resident room #201 in zone 3 will have door adjusted to close gap by maintenance. 2. Safety Officer will do physical check of all facility doors for gaps which may allow passage of smoke. 3. Any door identified as having gaps that allow passage of smoke will be adjusted by maintenance. 4. Door gaps will be monitored through quarterly Quality Improvement reporting by Safety Officer.	5/6/09

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

Jackie Cowan | Admin. Strator | 3-12-09

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	535018	02/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

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K 000	INITIAL COMMENTS Requirements for the 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 single story building of Type V(000) construction built in 1973. The building was equipped with a supervised automatic wet sprinkler system and fire alarm system. The South Bighorn Hospital is adjacent to the nursing home with a 2 hour fire rated barrier and two 1 ½ hour fire rated doors. The hospital is a Type II (111) building without a sprinkler system. The four hospital rooms closest to the 2 hour fire barrier are nursing home resident rooms.	K 000		
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.	K 018	K018: This facility will ensure all corridor doors are able to resist the passage of smoke. 1. Resident room #201 in zone 3 will have door adjusted to close gap by maintenance. 2. Safety Officer will do physical check of all facility doors for gaps which may allow passage of smoke. 3. Any door identified as having gaps that allow passage of smoke will be adjusted by maintenance. 4. Door gaps will be monitored through quarterly Quality Improvement reporting by Safety Officer.	5/6/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Admin. Strategist	3-12-09

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	02/19/2009

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 31 corridor doors in zone 3 were able to resist the passage of smoke in 1 of 8 smoke compartments. The findings were: Observation on 02/19/09 between 11:30 AM and 2 PM revealed resident room #201 had gaps between the door frame and the top and both sides of the corridor door that were greater than 1/8 inch. Interview with the facility's maintenance manager on 02/19/09 at 2 PM confirmed the gap and verified that the door needed to be adjusted.	K 018		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance 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 record review and staff interview, the facility failed to ensure 15 of 15 heat detectors were individually tested during the previous year.	K 052	K052: This facility will ensure fire alarm system is installed, tested and maintained. 1. Maintenance staff will perform heat detector testing throughout the facility. 2. Safety Officer will review all fire alarm system test reports and any tests revealed to have not been performed will be immediately performed by maintenance staff. 3. Safety Officer will develop a monitoring tool to ensure annual testing of heat detectors. 4. Heat detector and all fire alarm system testing will be monitored through quarterly Quality Improvement reporting by Safety Officer.	5/6/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X3) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	02/19/2009

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K 052	Continued From page 2 The findings were: Review of the facility's fire alarm records revealed none of the 15 heat detectors had been tested in 2008. The facility's maintenance manager stated the detectors may have been tested, but not documented in the facility's maintenance log.	K 052		
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 fire sprinkler system was properly maintained. The findings were: Observation on 02/19/098 between 11:30 AM and 2 PM revealed the sprinkler head escutcheon in the bathroom of resident room #206 had separated away from the ceiling. Interview with the facility's maintenance manager on 2/19/09 at 2 PM confirmed the escutcheon was not fitted as required..	K 062	K062: This facility will ensure the fire sprinkler system is properly maintained. 1. Maintenance staff will secure the ABC type fire extinguisher in the small kitchen next to the main dining room. 2. Safety Officer will check all fire extinguishers in the facility for secure attachment. Any extinguisher noted to be not secured well to the wall, will be immediately secured by maintenance staff. 3. Safety Officer will develop a quarterly monitoring tool to include physical check of fire extinguishers. 4. Fire extinguishers securely mounted to wall will be monitored through quarterly Quality Improvement reporting by Safety Officer.	5/6/09
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	K064: This facility will ensure automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested. 1. Maintenance Staff will secure sprinkler head escutcheon to ceiling in bathroom of resident room #206.	5/6/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X3) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/19/2009

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K 064	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain 1 of 15 portable fire extinguishers as required. The findings were: Observation on 02/19/098 at 12:30 PM revealed the ABC type fire extinguisher in the small kitchen next to the main dining room was loosely hanging on the wall. Two of the three wall screws had come away from the wall, leaving only one screw holding the extinguisher in place. Interview with the facility's maintenance manager on 2/19/09 at 2 PM confirmed the fire extinguisher was about ready to fall off of the wall.	K 064	2. Safety Officer will check all facility sprinkler head escutcheons to ensure properly secured to the ceiling. Any sprinkler head escutcheons observed to be loose will be immediately secured by maintenance. 3. Safety Officer will develop a quarterly monitoring tool to include observation of securely fastened sprinkler head escutcheons. 4. Secure sprinkler head escutcheons will be monitored through quarterly Quality Improvement reporting by Safety Officer.	
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 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	K066: This facility will ensure metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 1. Maintenance staff will immediately remove plastic garbage can from resident smoking area. 2. Safety Officer will check all facility smoking areas for the presence of plastic trash containers and metal containers. Any plastic trash containers will be immediately removed. Any areas identified as not having metal containers will have a self-closing, covered, metal container placed. 3. Safety Officer will develop a quarterly monitoring tool to include physical check of facility smoking areas to ensure no plastic containers and appropriate ash containers.	5/6/09

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K 066	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure all ashtrays were being emptied into metal containers with self closing covers. The findings were: Observation on 2/17/09 at 5:10 PM, on 2/18/09 at 11:48 AM and on 2/19/09 at 1:48 PM revealed the designated outdoor resident smoking area (patio outside of the west entrance directly next to the dining room) had a lidless plastic garbage can lined with a plastic liner that was being used to dump cigarette butts. Interview with the facility's maintenance manager on 2/19/09 at 2:20 PM confirmed the presence of cigarette butts in the garbage can.	K 066	4. Appropriate smoking area containers will be monitored through quarterly Quality Improvement reporting by Safety Officer.	