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

PRINTED: 12/01/2009
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
	53A002	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

(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 fully sprinklered single story building of Type V (III) construction built in 1964, 1986 and 1996. The building was equipped with a supervised automatic wet sprinkler system and addressable fire alarm system.	K 000		
K 044 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 This STANDARD is not met as evidenced by: Based upon observation and staff interview the facility failed to ensure 3 of 7 facility exit doors were fully operational. The findings were: Observation on 11/16/09 at 4:48 PM revealed the special care unit entrance/exit door to the outside did not completely close with three separate attempts. The door had a self closure device attached. Additional observation at the time revealed a sign attached to the door stating "Please make sure the door clicks." Interview with the DON on 11/17/09 at 8:15 AM revealed the door closure mechanism was not working properly, and the door did not close completely when someone entered or exited through the door. Observation on 11/18/09 at 12:48 PM revealed	K 044	The facility will ensure that horizontal exits meet applicable codes and standards for closure and are fully operational. The Maintenance Manager will ensure that all exit doors are operational and close appropriately. The doors in question were adjusted and now close appropriately. The Chairperson of the Safety Committee will monitor compliance. He will inspect the doors during the monthly Safety Inspection. Results of this monitoring will be reported to the Safety Committee via a performance improvement monitor.	12/31/09

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

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.

Wyoming Dept of Health

DEC 07 2009

Office of Healthcare Licensing and Surveys

Revised/approved & changes on page 2 after T.C. & DON 1/4/10 @ 4PM — JG

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K 044	Continued From page 1 the facility's front door (main entrance) did not close fully with three separate attempts. Additional observation at 12:58 PM revealed the outside exit door in the west wing did not close completely in its frame upon three separate attempts. The door did not have a self closure device attached. Interview with the facility's maintenance manager at the time confirmed the above two observation and stated the doors needed to be adjusted.	K 044	"Angel" hanging was sprayed by fire tech.	
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 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 a cloth wall hanging was flame retardant in 1 of 4 smoke compartments.	K 074	The facility will ensure that draperies, curtains and other loosely hanging fabrics and furnishings are in accordance with provisions of 10.3.1 and NFPA 13. The Maintenance Manager will ensure that all wall hangings met applicable requirements and have flame retardant documentation attached. The Safety Chairperson will monitor compliance during monthly safety inspections. Results of these inspections will be reported to the Safety Committee via a performance improvement monitor.	12/07/09

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K 074	Continued From page 2 The findings were: Observation on 11/18/09 at 1:45 PM revealed a 5 by 6 ft. cloth wall hanging titled "the angel" hanging in the main hallway next to the oxygen storage closet. Examination of the hanging shows there was no flame retardant documentation attached to it. Interview with the facility maintenance manager at the time confirmed the hanging was not flame retardant.	K 074		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure electrical wiring was in compliance with the National Electric Code in 2 of 4 smoke compartments. The findings were: Observation on 11/18/09 at between 12:30 PM revealed electrical outlets over resident sinks in the west wing were not protected against water exposure. The outlets were not GFI (ground fault interrupt) protected. In addition, two outlets over the sink in resident room #209 and one outlet in resident room #211 were also not protected. Interview with the maintenance manager at the time confirmed the above observations.	K 130	The facility will ensure that electrical wiring is in compliance with the National Electric Code. The noted electrical outlets will be replaced with GFI protection. The Maintenance Manager will be responsible for ensuring that electrical outlets are in compliance with the NEC. The Safety Chairperson will monitor compliance during the monthly safety inspections. The results of these inspections will be reported to the Safety Committee via a performance improvement monitor.	12/31/09
K 147 SS=D	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:	K 147		

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K 147	Continued From page 3 Based on observation and staff interview, the facility failed to ensure compliance with the National Electric Code by maintaining the required 3 feet of work space in front of an electrical panel in 1 of 6 smoke compartments. The findings were: Observation on 11/16/09 at 5:22 PM, on 11/17/09 at 1:30 PM, and on 11/18/09 at 1:48 PM revealed a kitchen cart in front of and blocking access to, an electrical panel next to the kitchen entrance doorway. Interview with the maintenance manager at the time of the observation confirmed the 11/18/09 observation.	K 147	The facility will ensure compliance with the NEC by maintaining the required work space in front of an electrical panel. The kitchen cart will no longer be parked in front of the electrical panel. The Maintenance Manager will be responsible for ensuring compliance. The Safety Chairperson will monitor compliance during the monthly Safety Inspection. Results of the monitoring will be reported to the Safety Committee via a performance improvement monitor.	12/01/09