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	09/11/2013

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 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 V (111) construction built in 1953, 1972 and 1986. The building was equipped with a supervised, automatic wet sprinkler system with an anti-freeze loop and a zoned fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 77.	K 000	Tag: K 018 – # 1 - Facility Policy states that all doors shall close and latch with minimum of force applied. The Maintenance Department will make adjustments to the Puzzle Room doors so that it will latch .The door in question was found to need the hinges tightened, and this was completed. The Door latch was loose in the door and putting oversized screws of a longer length took care of another part of the problem. The door closed after adjustment and perfect operation was obtained. The Maintenance Supervisor will ensure that a quarterly inspection of all doors in the facility is completed and the results will be taken to the monthly QA meetings for a period of 6 months. The quarterly inspection will be ongoing from now forward.	10/09/2013
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	Tag: K 018 - # 2 – Facility Policy states that all doors shall close and latch with a minimum of force applied. The Maintenance Department will make corrections to the door for proper operation. Maintenance found during inspection of the door that the hinges were worn badly. Three new hinges were installed on room # 52 the door in question and this corrected the problem of the door not latching and binding. The Maintenance Supervisor will ensure that a quarterly inspection of all doors in the facility is completed and the results will be taken to the monthly QA meetings for a period of 6 months. The quarterly inspection will be ongoing from now forward.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea Stannard NHA
TITLE: NHA
(X6) DATE: 10/2013

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 APPROVED W/ ANDREA STANNARD, NHA, ON 10/28/13

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure corridor doors were smoke resistant in 1 of 13 smoke compartments. The findings were: 1. Observation of the activities puzzle room on 9/11/13 at 9:47 AM showed the corridor door latch bolt would not insert into the strike plate. At the time of observation, the maintenance supervisor could not explain why the door was not noticed and repaired during the quarterly safety inspections. 2. Observation of resident room #52 on 9/11/13 at 9:47 AM showed the corridor door would bind in the door frame and not fully latch into the door frame. At the time of observation, the maintenance supervisor could not explain why the door was not noticed and repaired during the quarterly safety inspections.	K 018	Tag: K 025 - # 1 – Facility Policy states that there will be no penetrations that are not completely sealed in either smoke or fire barriers within the facility. The Maintenance Supervisor will correct the unsealed pipe penetration. The hole around the pipe was filled with fire foam. Drywall was then cut in half and fitted snuggly around the pipe and secured with screws. The same process was again performed on the other side of the Smoke barrier after climbing in an adjacent access panel. The Maintenance Supervisor will continue to monitor any and all activity from workmen in the attic crawl spaces and inspect for unseal penetrations as soon as any work has been completed. The results of an inspection after work completed will then be taken to that months QA meeting for a period of 6 months.	10/09/2013
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025		10/09/2013

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K 025	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure 2 of 8 smoke barrier walls were smoke resistant. The findings were: 1. Observation of the smoke barrier wall near resident room #61 on 9/11/13 at 12:46 PM showed there was a one inch unsealed pipe penetration. At the time of the observation, the maintenance supervisor could not explain why the hole had not been noticed and repaired during the semi-annual safety inspection. 2. Observation of the smoke barrier wall near resident room #51 on 9/11/13 at 12:52 PM showed there were three unsealed pipe penetrations. The largest gap measured 8 inches square. At the time of the observation, the maintenance supervisor could not explain why the holes had not been noticed and repaired during the semi-annual safety inspection.	K 025	Tag: K 025 - # 2 – Continued: in place and covered with fire foam. The next layer was squared up and inserted and secured with screws and again covered with fire foam. The last layer was also squared and inserted in but not quite flush with old top layer. Fire foam was placed around the penetration and the last top layer was screw in place. Drywall compound was put around the perimeter of the top layer. The other 2 unsealed penetrations consisted of shrunken crack sealer with some areas falling out. Dried and loose pieces were removed and the penetrations were sealed completely .The Maintenance Supervisor will continue to monitor any and all activity from workmen in the attic crawl spaces and inspect for unsealed penetrations as soon as any work has been completed. The results of an inspection after work completed will then be taken to that months QA meeting for a period of 6 months.	10/09/2013
K 029 SS=E	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 or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		

Andrea Stannard NHA 100413

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K 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure hazardous areas were separated from use areas in 3 of 8 smoke compartments. The findings were: 1. Observation of the basement central supply room on 9/11/13 at 9:20 AM showed the corridor door was equipped with a self-closing device. Further observation showed the door was not able to fully latch into the door frame with the power of the self-closing device. At the time of the observation, the maintenance supervisor could not explain why the door had not been noticed and repaired during the quarterly safety inspections. 2. Observation of resident room #23 on 9/11/13 at 10:42 AM showed eight upholstered chairs were being stored in the room. Further observation showed the corridor door was not equipped with a self-closing device. At the time of the observation, the maintenance supervisor could not explain the amount of storage in a room not separated as a hazardous room. 3. Observation of resident room #69 on 9/11/13 at 11:50 AM showed four upholstered chairs and four mattresses were being stored in the room. Further observation showed the corridor door was not equipped with a self-closing device.	K 029	Tag: K 029 - # 1 – Facility Policy states that all doors to a storage area shall close and latch with a minimum of force applied and the lock to a storage area will be on a master key. The Maintenance Department will ensure that the door will close properly in the basement, entering into the central storage room. The door closure was adjusted to a stiffer setting to ensure proper closing. The hinge screws were tightened and the latch oiled and all three contributed to proper working conditions of the door. The Maintenance Supervisor will ensure that a quarterly inspection of all doors in the facility is completed and the results will be taken to the monthly QA meetings for a period of 6 months. K 029 - # 2 - Facility Policy states that all doors to a storage area shall close and latch with a minimum of force applied and the lock to a storage area will be on a master key. The Maintenance Supervisor will correct the deficiency by installing a self-closing device on the door of room # 23. Two adjustable spring hinges were installed on the door in question. The door when opened to its widest closes on its own and latches. The Maintenance Supervisor will ensure that a quarterly inspection of all doors in the facility is completed and the results will be taken to the monthly QA meetings for a period of 6 months.Tag: K 029 - # 3 – Facility Policy states that all doors to a storage area shall close and latch with a minimum of force applied and the lock to a storage area will be on a master key. The Maintenance Supervisor will correct the deficiency by installing a self-closing device on the door of room # 69. Two Adjustable spring hinges were installed on the door in question. The door when opened to its widest closes on its own and latches. The Maintenance Supervisor will ensure that a quarterly inspection of all doors in the facility is completed and the results will be taken to the monthly QA meetings for a period of 6 months.	10/09/2013
K 038 SS=E	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	K 038		

A Stannard NHA 10413

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K 038	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure doors in the means of egress were maintained, failed to ensure egress pathways were maintained and failed to ensure delayed egress locks were maintained in 3 of 8 smoke compartments. The findings were: 1. Observation of the 300 hall on 9/11/13 at 10:24 AM showed the south exit door required excessive force to open and close. At the time of the observation, the maintenance supervisor reported the door was swollen because of the recent rain storms. He also confirmed no modifications had been made to this door to ensure it opened with acceptable force levels. 2. Observation of the south dining room on 9/11/13 at 11:14 AM showed the exterior exit door lead onto a 4 foot wide concrete pathway. Further observation showed a bush completely obstructed the pathway with branches. At the time of the observation, the maintenance supervisor could not explain why the branches had not been noticed and removed during the quarterly safety inspections. 3. Observation of 100 hall on 9/11/13 at 11:25 AM showed the south exit door was equipped with a delayed egress lock. Further observation showed the delayed egress lock would not release with 30 seconds of constant press applied to the crash bar. The lock would release with loss of power and activation of the fire alarm system. At the	K 038	Tag: K 038 - # 1 -- Facility Policy states that the delayed egress doors shall start the lock release process after a force is applied to activate the 15 second count down to irreversible opening and once the door is open there shall be a clear path of egress. The Maintenance Supervisor will investigate and correct the issues with the door at the end of the # 300 hall. The Hinges were lubed on this door as well as tightened and the threshold was cleaned of any dirt and debris. The door was tested at different times on 7 separate days. The door lock and alarm functioned and reset every time it was tested. The Maintenance Supervisor will ensure that a quarterly inspection of all doors in the facility is completed and the results will be taken to the monthly QA meetings for a period of 6 months. Tag: K 038 - # 2- Facility Policy states that the delayed egress doors shall start the lock release process after a force is applied to activate the 15 second count down to irreversible opening and once the door is open there shall be a clear path of egress. The Maintenance Supervisor will investigate and correct the issues with the door in the south dining room. The tree was removed down to the base which leaves more than adequate room for a path of unobstructed egress. The Maintenance Supervisor will ensure the tree is pruned back each spring by putting a reoccurring work order on the Maintenance computer for the month of May.	10/09/2013

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K 038	Continued From page 5 time of the observation, the maintenance supervisor could not explain why the delayed egress lock had not been noticed and adjusted during the quarterly safety inspections. Reference NFPA 101, 2000 Edition, 19.2.1; 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.2.1.4.5 The forces required to fully open any door manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf (133 N) to set the door in motion, and 15 lbf (67 N) to open the door to the minimum required width. Opening forces for interior side-hinged or pivoted-swinging doors without closers shall not exceed 5 lbf (22 N). These forces shall be applied at the latch stile. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.	K 038	Tag: K038 - # 3 - Facility Policy states that the delayed egress doors shall start the lock release process after a force is applied to activate the 15 second count down to irreversible opening and once the door is open there shall be a clear path of egress. The Maintenance Supervisor will investigate and correct the issues with the door at the end of the # 100 hall. The door was cleared of any dirt and debris and the hinges were lubed and tightened. The door was tested on 7 separate dates and times and the door functioned and locked and reset each time without fail. The Maintenance Supervisor will ensure that a quarterly inspection of all doors in the facility is completed and the results will be taken to the monthly QA meetings for a period of 6 months.	10/09/2013

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K 038	Continued From page 6 Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.	K 038	Tag: K 052 - # 1 – Facility policy states that all areas of the fire alarm system testing will meet the requirements of the life safety code whether it is monthly, quarterly, semi-annual or annual testing. The Maintenance Supervisor will ensure that the fire alarm panel emergency batteries shall have a semi-annual load voltage test every 6 months. The Maintenance Supervisor contacted Fremont Electric of Laramie, Wyoming to conduct the tests and we have our first scheduled Inspection set for January 2014. The Maintenance Supervisor has asked Fremont Electric to set Laramie Care Center up with a reoccurring 6 month inspection schedule and a reoccurring work order was generated on the Maintenance computer as well to ensure both parties will be aware of the time frame of the upcoming inspections every 6 months.	10/09/2013
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 facility staff interview, the facility failed to ensure 1 of 7 fire alarm system components was tested. The findings were: Review of the fire alarm system testing records showed the fire alarm system was last tested on 7/10/13. Further review showed the fire alarm panel emergency batteries semi-annual load voltage test had not been performed in the six months prior to the 7/10/13 test. On 9/11/13 at 1:45 PM the maintenance supervisor reported he was unaware of the aforementioned testing requirement. Reference NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition;	K 052		

ASannard NHA 10413

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

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K 052	Continued From page 7 Table 7-3.2 Testing Frequencies. 6. Batteries-Fire alarm systems d. Sealed Lead-Acid Type 1. Charge Test,.....annually (Replace batteries every 4 years.), 2. Discharge Test (30 minutes) ... ...annually 3. Load Voltage Test, ...semi-annually	K 052	Tag: K 076 - # 1 – Facility Policy states that oxygen cylinders of the E type will be secured either in a rack or placed in a portable cart while in use by a resident or awaiting refilling or return to the oxygen company. The Maintenance Supervisor will ensure that the number of tanks in the oxygen room does not exceed the number of spaces in the oxygen storage racks or portable carts. The Maintenance Supervisor placed the 2 tanks in question into portable carts and secured them in by use of the supplied thumb screws made for that purpose. The Maintenance Supervisor will monitor the oxygen room for compliance over the course of a month and bring the results to the QA monthly meetings for a period of 6 months.	10/09/2013
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. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure oxygen cylinders were restrained in the oxygen storeroom. The findings were: Observation of the liquid oxygen storeroom on 9/11/13 at 9:54 AM showed two "E" sized oxygen cylinders were not restrained. Further observation showed there were no open spaces in the oxygen storage racks. At the time of the observation, the maintenance supervisor could not explain why	K 076		

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K 076	Continued From page 8 additional storage racks were not provided. Reference, NFPA 101, 2000 Edition, 19.3.2.3, NFPA 99, 1999 Edition; 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) Nonflammable Gases (any Quantity; In-storage, Connected, or Both) 3. Provisions shall be made for racks or fastening to protect cylinders from accidental damage or dislocation.	K 076	Tag: K 147 - # 1 – Facility Policy states that no multi tap electrical adapters shall be in use in the facility. The Maintenance Supervisor will ensure that the multi tap adapter in question in room # 30 will be removed and a multi outlet surge protector will be put in its place. The Maintenance Supervisor removed the multi tap adapter and replaced it with a new surge protector multi outlet. The facility will inform the current residents and families and any new admissions and their families that Laramie Care Center has a policy against multi taps and they will need to bring in only surge protectors for their loved ones to use. The Maintenance Department will start inspections weekly going from room to room to find any multi taps. When Maintenance discovers one the Residents family will be reminded that they need to be replaced with surge protectors. The Maintenance Supervisor will take the results of the 4 week inspection to the QA meetings for a period of 6 months. The Administrator will assist maintenance in contacting the families and ensuring fast compliance on this issue. The Maintenance Department will do ongoing monthly sweeps of the facility after the 6 month period has elapsed and only after the entire facility has been inspected in all rooms.	10/09/2013
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: Based on observation and facility staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 2 of 8 smoke compartments. The findings were: 1. Observation of resident room #30 on 9/11/13 at 10:30 AM showed the television set was plugged into a 6-way power tap. At the time of the observation, the maintenance supervisor reported he was unaware the power tap was not a surge protector as they have similar appearance. 2. Observation of resident room #14 on 9/11/13 at 11:17 AM showed the clock was plugged into a 3-way power adapter. At the time of the observation, the maintenance supervisor could not explain why the adapter had not been noticed and replaced during the quarterly safety inspections.	K 147		

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10/28/13

(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 9 Reference NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls ... (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147	Tag: K 147 - # 2 – Facility Policy states that no multi tap electrical adapters shall be in use in the facility. The Maintenance Supervisor will ensure that the multi tap adapter in question in room # 14 will be removed and a multi outlet surge protector will be put in its place. The Maintenance Supervisor removed the multi tap adapter and replaced it with a new surge protector multi outlet. The facility will inform the current residents and families and any new admissions and their families that Laramie Care Center has a policy against multi taps and they will need to bring in only surge protectors for their loved ones to use. The maintenance department will start inspections weekly going from room to room to find any multi taps. When Maintenance discovers one the Residents family will be reminded that they need to be replaced with surge protectors. The Maintenance Supervisor will take the results of the 4 week inspection to the monthly QA meetings for a period of 6 months. The Administrator will assist maintenance in contacting the families and ensuring fast compliance on this issue. The Maintenance Department will do ongoing monthly sweeps of the facility after the 6 month period has elapsed and only after the entire facility has been inspected in all rooms.	

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