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
	535021	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH 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 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 II (000) construction with a basement built in 1981. The building was equipped with a supervised, automatic wet sprinkler system with an anti-freeze loop and an addressable fire alarm system. The facility had a capacity of 90 certified Medicare and Medicaid beds with a census of 74.	K 000		
K 018 SS=E	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	Facility Policy It is the policy of the Wyoming Retirement Center to make sure there are no impediments which prevent corridor doors from closing and that such doors are provided with a means suitable for keeping the doors closed. It is also our policy to protect areas which are open to corridor areas through the use of a detection component which is integrated into our supervised fire alarm detection system.	

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

Administrator 1/3/2014

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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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 and failed to ensure doors did not required two actions to close in 2 of 8 smoke compartments. The findings were: 1. Observation of resident room #303 on 12/03/13 at 11:22 AM showed a 6 inch stone was placed in front of the corridor door frame which impeded the door from closing with a single action. At the time of the observation, the environmental service manager reported she had advised this resident not to place the stone in this location before. She also reported that the resident continued to block the door open with different objects. 2. Observation of the south pod tub room on 12/03/13 at 12:25 PM showed the top 18 inches of the corridor door was removed. Further observation showed the room was not provided with a smoke detection device as required for rooms open to the corridor. At the time of the observation, the environmental services manager reported the top portion of the door was removed so staff members could call for assistance if necessary. She could not explain why the smoke detector was not added once the door was modified and the room was opened to the corridor. Reference NFPA 101, 2000 Edition; 19.3.6.1 Corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5. (See also 19.2.5.9.) Exception No. 1: Smoke compartments	K 018	Continued from page 1 Corrective Action #1. The 6 inch rock that was placed in front of the corridor door to room #303 which impeded the door from closing with a single action was removed during survey. The resident who placed the stone was reminded of our facility policy for not blocking doors and why the doors need to close properly. #2. WRC has contacted our vendor who maintains our supervised fire alarm detection system to add a detector in the south pod tub room and to integrate the detector into our system. The additional sensor will be installed as soon as plans have been approved by OHLS and will become part of our system. Prevention Staff will be re-inserviced on our policy of not blocking doors that lead into corridor areas. They will be trained to look for any doors that may be blocked and will remove the item blocking the door immediately. The Housekeepers will also check doors as they clean. API will include this additional detector as part of their Preventive Maintenance checks along with the other detectors in our facility.	

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K 018	Continued From page 2 protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 shall be permitted to have spaces that are unlimited in size open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses ' station or similar space. (d) The space does not obstruct access to required exits.	K 018	Continued from page 2 Compliance Monitoring The Environmental Services Manager, or designee, will conduct spot checks for compliance with items that may be used to block doors and will also review and monitor the PM checks on the new detector. Compliance will be reported monthly for the next 3 months to the Quality Assurance Committee and then at a frequency determined by the committee as success is demonstrated. Completion Date: 1/26/2014	01/26/2014
K 020 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure 1 of 3 openings between floors was sealed. The findings were:	K 020	Facility Policy The Wyoming Retirement Center will ensure the 3 access doors are kept shut to preserve the one hour fire resistance rating. Corrective Action and Prevention The WRC Environmental Services staff will check the three doors daily as part of their rounds to make sure the doors are closed. The ES staff will document their checks on spread sheets to document compliance with this policy. Outside contractors who use the doors for access will also be inserviced on this policy.	

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K 020	Continued From page 3 Observation of the south mezzanine on 12/03/13 at 12:29 PM showed the trap door was propped open. At the time of the observation, the environmental services manager could not explain why the door was propped open. She could not confirm how long the door had been held in the open position. Reference NFPA 101, 2000 Edition; 19.3.1.1 Any vertical opening shall be enclosed or protected in accordance with 8.2.5. Where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. 19.3.1.2 A door in a stair enclosure shall be self-closing and shall normally be kept in the closed position.	K 020	Continued from page 3 Compliance Monitoring The Environmental Manager will review documentation of the three door hatches and will conduct spot checks to verify compliance. She will report her findings to the Quality Assurance Committee for the next three months and as determined by the committee thereafter as compliance is demonstrated. Completion Date: 1/24/2014	1/24/2014
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 or field-applied 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 facility staff interview, the facility failed to ensure hazardous areas were separated from use areas in 1 of 8 smoke compartments. The findings were:	K 029	Facility Policy It is the policy of the Wyoming Retirement Center to make sure there are no penetrations in smoke resisting partitions and doors. Corrective Action The two penetrations mentioned in the boiler room were filled on 12/5/2013. Prevention Maintenance staff will be re-inserviced concerning this facility policy and will check our smoke resisting partitions for penetrations monthly as they complete their Preventive Maintenance checks in each area. Compliance will be documented in the PM check off lists monthly.	

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K 029	Continued From page 4 Observation of the boiler room on 12/03/13 at 9:05 AM showed two wall penetrations. The largest gap measured 1 ½ inches across. At the time of the observation, the environmental services manager could not explain why the penetrations had not been noticed and filed during the monthly safety inspections.	K 029	Continued from page 4 Compliance Monitoring The Environmental Services Manager, or designee, will monitor compliance with this policy by reviewing PM documentation and by conducting spot checks of the partition areas. She will report her findings to the Quality Assurance Committee monthly for three months and quarterly thereafter as compliance is demonstrated. Completion Date: 1/24/2014	1/24/2014
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 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure exit doors were unobstructed in 3 of 8 smoke compartments. The findings were: 1. Observation of exit doors on 12/03/13 between 9 AM and 11 AM showed the loading dock exit door and north commons exit door were locked. At the time of the observation, the environmental services manager confirmed not all residents that access these doors had a clinical need to be protected with locked doors. She reported that she was unaware exit door could not be locked unless all residents had a clinical need for such safety measures. 2. Observation of the south C-pod exit door on 12/03/13 at 12:02 PM showed the door was equipped with a delayed egress device. Further	K 038	Facility Policy It is the policy of the Wyoming Retirement Center to make sure our exit access/doors are readily accessible at all times and unobstructed. Corrective Action The two exit doors mentioned were unlocked on 12/3/2013. The facility will place signs on exit doors that have delayed egress devices indicating continual pressure will release the door lock and time frames depending on what the door does, but not to exceed 15 seconds.	

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K 038	Continued From page 5 observation showed the door was not provided with signage indicating continual pressure would release the door lock. At the time of the observation, the environmental services manager reported she was unaware of the signage requirement. Reference NFPA 101, 2000 Edition; 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. 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. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved,	K 038	Continued from page 5 Prevention Staff will be trained on: #1. Egress doors that cannot be locked on the egress side with a latch or lock that requires the use of a tool or key. #2. Door locking arrangements with delayed egress which can be opened by continual pressure within appropriate time frames as indicated by signs on the doors. The two doors indicated that were locked will remain unlocked. Compliance Monitoring The Environment Services Manager, or designee will monitor training of staff members on doors which remain unlocked and doors which have delayed egress locks to make sure staff have a working knowledge of both systems. She will conduct spot checks to make sure signs have been placed on delayed egress locked doors detailing instructions for unlocking the doors, and for egress doors that remain unlocked. She will check the PM schedules to make sure the doors are in good working condition and are being maintained.	

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K 038	Continued From page 6 supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (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. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038	Continued from page 6 She will report her findings to the QA Committee monthly for the next three months and a frequency thereafter which will be determined by the QA Committee as compliance is demonstrated. Completion Date: 1/24/2014	1/24/2014
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	Facility Policy It is the policy of the Wyoming Retirement Center to conduct fire drills at unexpected times under varying conditions. It is also the policy of the WRC that drills conducted between the hours of 9:00 PM and 6:00 AM have a coded announcement rather than audible alarms as used at other times.	

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K 050	Continued From page 7 This STANDARD is not met as evidenced by: Based on record review and facility staff interview, the facility failed to ensure fire drills held between 9 PM and 6 AM had fire alarm system activation on 1 of 2 shifts. The findings were: Review of the fire drill records showed the second shift occurred between 6 PM and 6 AM. Further review showed the fire drill held on 2/12/13 at 6:35 PM was a silent drill. On 12/03/13 at 2:45 PM, the environmental services manager reported she was unaware fire drill could only be silent drills when conducted between 9 PM and 6 AM.	K 050	Continued from page 7 Corrective Action WRC policies will be amended to reflect the 9:00 PM to 6:00 AM coded announcement. Staff who conduct the drills will be trained concerning when to use coded versus audible alarms. Drills will be held at unexpected times under varying conditions and will be documented. Drills conducted between the 9:00 PM hours and 6:00 AM hours will use silent alarms. All other drills will use audible alarms. Prevention It will be the responsibility of the maintenance staff to make sure coded and audible alarms are held at the appropriate times. Documentation will determine compliance. Compliance Monitoring The Environmental Services Manager will monitor compliance/documentation of completed coded versus audible alarms and will report her findings to the Quality Assurance Committee monthly for the next three months and thereafter at a frequency determined by the committee as compliance is demonstrated. Completion Date: 1/26/2014	01/26/2014
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 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 facility staff interview, the facility failed to ensure there was complete			

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K 056	Continued From page 8 sprinkler coverage and failed to ensure sprinkler heads were properly installed in 2 of 8 smoke compartments. The findings were: 1. Observation of the physical therapy gym on 12/03/13 at 11:10 AM showed two sprinkler heads were installed 11 feet away from the far wall. At the time of the observation, the environmental service manager confirmed the sprinkler heads were standard spray heads and only had a coverage area of 7 ½ feet. She could not explain why these heads had not been noticed and modified during the annual sprinkler inspection. 2. Observation of south C-pod on 12/03/13 between 12 PM and 12:30 PM showed two sprinkler heads in room #339 and one head in room #338 were installed less than 4 inches from the wall. On 12/03/13 at 12:06 PM, the environmental services manager reported this area was previous leased out to an outside company. She also reported that all of the sprinkler heads in the building were replaced three years ago, except for in this area. She could not explain why these heads had not been noticed and modified during the annual sprinkler inspection. Reference NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 5-5.3.2 Maximum Distance From Walls. The distance from sprinklers to walls shall not exceed one-half of the allowable maximum distance between sprinklers. The distance from the wall to the sprinkler shall be measured perpendicular to the wall. Table 5-6.2.2 (b) Protection Areas and Maximum Spacing (Standard Spray Upright/Standard Spray Pendent) for Ordinary Hazard	K 056	Facility Policy It is the policy of the Wyoming Retirement Center to make sure there is complete sprinkler coverage in our facility. Corrective Action The facility will have our contracted sprinkler company look at our sprinkler coverage, including distance of sprinkler heads from walls and type of head design utilized and will develop a plan to make sure our areas are covered. This plan will be submitted to OHLS for review and approval. Upon approval by OHLS, the vendor will make the necessary changes to our system. Prevention Once changes are made to our sprinkler system, our vendor will add the additions/ corrections to their preventive maintenance checks to make sure the system is functional in the future. Compliance Monitoring The Environmental Services Manager, or designee, will report her findings concerning initial changes to the sprinkler system, OHLS approval, work completed and ongoing future maintenance to monitor monthly for compliance and report results quarterly	

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K 056	Continued From page 9 Construction Type, ... All System Type, ... All Protection Area, ... 130 ft2 Spacing, ... 15 ft 5-6.3.3 Sprinklers shall be located a minimum of 4 in. from the wall.	K 056	Continued from page 9 through the Quality Assurance process for review/recommendations. Completion Date: 1/26/2014	01/26/2014
K 062 SS=E	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, record review and facility staff interview, the facility failed to ensure sprinkler heads had the same activation point, failed to ensure exposed CPVC sprinkler pipes were shielded in 5 of 8 smoke compartments, and failed to ensure the backflow preventer was tested on an annual basis. The findings were: 1. Observation of the main mezzanine on 12/03/13 at 9:39 AM showed the room was installed with 10 sprinkler heads. Further observation showed one head was a standard response head while the rest of the heads were newly installed quick response heads. At the time of the observation, the environmental services manager could not explain why this heads was not noticed during the annual sprinkler inspection and replaced so all heads in the room had the same activation point. 2. Observation of the sprinkler system on	K 062	Facility Policy It is the policy of the Wyoming Retirement Center to make sure our automatic sprinkler systems are continuously maintained—including making sure sprinkler heads have the same activation point, CPVC sprinkler pipes are shielded in each smoke compartment, and our back flow preventer test are conducted within a 12 month time frame each year. Corrective Action #1. The standard response sprinkler head was changed to a quick response head on 12/4/2013. #2. The facility will install wooden pipe shields on the sprinkler supply pipes to closets in resident rooms which do not have the shields. #3. A back flow preventer test will be conducted by our vendor.	

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K 062	Continued From page 10 12/03/13 between 10 AM and 12 PM showed the sprinkler supply pipes to the closets in resident room #212, #221, #306 and #324 were exposed CPVC pipes. Further observation showed the pipes were installed three inches away from the building surface. On 12/03/13 at 10:07 AM, the environmental services manager reported she was unaware exposed CPVC pipes were required to be mounted directly to the building surface. She could not explain why the installation contractor had not installed a shield to protect the exposed CPVC piping. 3. Review of the sprinkler system testing records showed the annual back flow preventer test was last performed on 10/31/12, more than 12 months ago. On 12/03/13 at 2:45 PM, the environmental services manager could not explain why the test had not been performed within the past 12 months. Reference NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 5-3.1.5.2 When existing light hazard systems are converted to use quick-response or residential sprinklers, all sprinklers in a compartmented space shall be changed. Reference NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 3-3.5 Other types of pipe or tube investigated for suitability in automatic sprinkler installations and listed for this service, including but not limited to polybutylene, CPVC, and steel differing from that provided in Table 3-3.5 shall be permitted where installed in accordance with their listing limitations, including installation instructions ... Harvel Blazemaster manufactures installation guide for exposed installation stated " Pendent Sprinklers Light Hazard or Residential Pendent	K 062	Continued from page 10 Prevention Our maintenance staff will add the sprinkler head checks, CPVC pipe shields and back flow preventer test to our Preventive Maintenance schedules. Maintenance staff members will be trained on each procedure and will document as each check is completed. Compliance Monitoring The Environmental Services Manager, or designee, will monitor compliance with monthly sprinkler head checks, CPVC pipe shields, and back flow preventer test completion. She will present the results of her findings to the QA Committee monthly for the next 3 months and then at a frequency determined by the committee as compliance is demonstrated. Completion Date: 1/26/2014	01/26/2014

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
	535021	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	880 US HWY 20 SOUTH BASIN, WY 82410

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K 062	Continued From page 11 Sprinklers ...The piping shall be mounted directly to the building surface " . Reference NFPA 101, 2000 Edition, 19.3.5.1, 9.7.5, NFPA 25, 1998 Edition; 9-6.2.1 All backflow preventers installed in fire protection system piping shall be tested annually ...	K 062		
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure combustible decorations were not used in 1 of 8 smoke compartments. The findings were: Observation of resident room #203 on 12/03/13 at 9:52 AM showed a live pine bough wreath was hung on the corridor door. At the time of the observation, the environmental services manager could not explain why the wreath was hung in the corridor. She also reported that she was aware live pine decorations are not allowed in healthcare facilities.	K 073	Facility Policy It is the policy of the Wyoming Retirement Center to make sure no furnishing or decorations of highly flammable character are used. Corrective Action The wreath was removed. Prevention The facility will review our current policy for flammable items in our facility and will place a copy of the policy in the Resident Admission Packet and Resident Handbook. Facility staff will be re-trained on this policy and will be responsible for compliance with this policy. Our Housekeeping staff will monitor rooms as they clean each day for compliance and will report to the Environmental Services Manager. Compliance Monitoring The Environmental Services Manager, or designee will conduct spot checks in the	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.			

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	535021	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/03/2013

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K 144	Continued From page 12 This STANDARD is not met as evidenced by: Based on record review and facility staff interview, the facility failed to ensure 1 of 5 emergency generator tests was performed. The findings were: Review of the emergency generator testing log showed the facility was not inspecting the battery electrolyte levels on a weekly basis. On 12/03/13 at 2:45 PM, the environmental services manager reported she was unaware of the aforementioned inspection. Reference NFPA 101, 2000 Edition, 19.5.1, 9.1.3, NFPA 110. 1999 Edition; 6.3.6 Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer ' s specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects.	K 073	Continued from page 12 facility and will review documentation submitted by our housekeeping staff concerning violations on a daily basis. Findings will be submitted to the QA Committee monthly who will monitor for compliance and will suggest future frequency of audits as success is demonstrated. Completion Date: 01/24/2014	01/24/2014
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:	K 144	Facility Policy It is the policy of the Wyoming Retirement Center to monitor the condition of generator storage batteries, including electrolyte levels on a weekly basis. Corrective Action A generator battery log was started on 12/5/2013 which will document battery condition checks and electrolyte levels. A new battery was purchased on 12/10/2013. Prevention Maintenance staff have added the battery check log to the Preventive Maintenance schedules to make sure the battery is being checked on a weekly basis.	

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	535021	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/03/2013

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K 147	Continued From page 13 Observation of the electrical system on 12/03/13 between 10 AM and 12 PM showed resident room #208 and #317 each had a television set plugged into 6-way power taps. On 12/03/13 at 10:01 AM, the environmental service manager reported she was unaware there was a difference between multi-plug adapters and surge protectors. She also reported the safety inspections did not ensure multi-plug adapters were surge protectors. 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		Continued from page 13 Our Maintenance staff have been inserviced on checking the battery weekly and documenting under our PM schedules. Compliance Monitoring The Environmental Services Manager will monitor weekly documentation of the battery checks completed by our maintenance staff. She will report findings of her audits to the QA Committee bi-weekly for 3 months and thereafter as determined by the committee as compliance is demonstrated. Completion Date: 01/24/2014	01/24/2014
		K 147	Facility Policy It is the policy of the Wyoming Retirement Center to use multi-plug adapters that are surge protectors to make sure electrical wiring and equipment is in accordance with NFPA 70. Corrective Action On 12/5/2013, a search of the facility was conducted to remove any multi-plug adapters that were not rated as surge protectors. The facility is purchasing the surge protectors that are multi-plug adapters to place out in the building.	See below for cont. of Tag K147

Tag K147 Continued:

Prevention

The facility will purchase multi-plug adapters that are surge protectors for residents as needed. Resident Admission packets will include this policy as well as our Resident Handbook. Staff members will be trained on checking multi-plug adapters to make sure they are surge protectors. Housekeeping and Maintenance staff w check rooms as they work in them to make sure the adapters are surge protectors. Housekeepers will document their room checks weekly and will give them to the Environmental Services Manager for review. Any multi-plug adapters that are not surge protectors will be taken out of use.

Compliance Monitoring

The Environmental Services Manager will review the check off sheets provided by each Housekeeper on a weekly basis. She will submit her findings to the QA committee monthly for the first three months and as determined by the committee as compliance is demonstrated. Completion Date: 01/24/2014