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
	535049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET CASPER, WY 82601

(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 V (111) construction with plan approval in 1992. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch and an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 109 residents.	K 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual.	
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	K-18 1. The kick down attached to the scheduling office door was removed by the facility's Director of Maintenance on 01/08/14 during the survey and the door now closes without impediment. 2. The facility's Director of Maintenance conducted a whole-house audit on 1/9/14. No other corridor doors were impeded from closing and none were identified during the survey. 3. The facility's Director of Maintenance will commence a weekly audit to ensure that no corridor doors are held open or impeded from closing. The results of the audit will be	2/6/14

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

Executive Director 2/6/14

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.

FEB 10 2014 POC ACCEPTED W/ JEN CROSS, E.D., ON 2/19/14.

Healthcare Licensing and Surveys

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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 would resist the passage of smoke in 1 of 7 smoke compartments. The findings were: Observation of the scheduling office on 1/8/14 at 9:52 AM showed the corridor door was impeded from closing by a kick down attached to the bottom of the door. At the time of the observation, the maintenance director reported he was unaware hold open devices that did not release with the activation of the fire alarm system were prohibited.	K 018	recorded on the Director's existing preventative maintenance program (TELS). 4. The results of the aforementioned monthly audits will be reviewed (each month for the next 3 months) at the facility's monthly Performance Improvement committee. The Performance Improvement committee meets monthly and is comprised of no fewer participants than the facility's Medical Director, Director of Nursing, Executive Director, Director of Social Services, Director of Maintenance and other department heads. The committee reviews the results of regularly scheduled audits, requisite inspections and other indicators to ascertain quality areas and/or the need for action driven plans to improve quality/performance. Where necessary, action plan(s) are written, implemented and their results monitored (next month) to ensure improved quality and/or sustained correction of quality.	
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 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure 1 of 5 smoke barrier walls would resist the passage of smoke. The	K 025	K – 25 1. The identified penetrations in the 100 hall and 200 hall smoke barrier walls were repaired on 1/31/14 by the facility's Director of Maintenance. 2. The facility's Director of Maintenance conducted a whole-attic inspection on 1/30/14. There were no other penetrations in smoke barrier walls identified.	2/6/14

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K 025	Continued From page 2 findings were: Observation of the attic on 1/8/14 between 2 PM and 3 PM showed unsealed penetrations in the 100 hall and 200 hall smoke barrier walls. The largest gap measured 2 inches by 4 inches. On 1/8/14 at 2:17 PM, the maintenance director could not explain why the penetrations had not been noticed and repaired during the quarterly safety inspections.	K 025	3. The facility's Director of Maintenance will commence a monthly attic inspection (and post vendor visit inspection) to rule out any penetrations in smoke barrier walls. The results of the inspection will be recorded on the Director's existing preventative maintenance program (TELS). 4. The results of the aforementioned monthly audits will be reviewed (each month for the next 3 months) at the facility's monthly Performance Improvement committee.	2/6/14
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 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 2 of 7 smoke compartments. The findings were: 1. Observation of the activity office on 1/8/14 at 11:36 AM showed there were two 6 foot tall storage racks with activity games and decorations. Further observation showed the corridor door was held open by a magnetic hold	K 029	K – 29 1. The magnetic hold open devise was removed from the Activity Office door on 1/29/14 by the facility's Director of Maintenance and the door now remains closed. In addition, the 10 cardboard file boxes were removed from the nurse manager's office on 1/23/14 by the facility's Director of Maintenance and the office is no longer deemed a hazard. 2. The facility's Director of Maintenance conducted a whole house visual inspection on 1/24/14 to rule out either; 1). Corridor doors held open with magnetic devises that did not release with the activation of the fire alarm system or 2). Storage in offices is hazardous. Furthermore, no other findings were observed during the survey.	

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K 029	Continued From page 3 open device that did not release with the activation of the fire alarm system. At the time of the observation, the maintenance director reported he was unaware the magnetic hold open device was prohibited. 2. Observation of the unit #1 nurse manager's office on 1/8/14 at 11:42 AM showed 10 cardboard file boxes 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 director was unaware this amount of combustibles is deemed a hazard and the self-closing device is required.	K 029	3. The facility's Director of Maintenance will commence a monthly visual inspection to ensure that office doors to corridors are not propped open; nor offices to corridors house too many combustible(s). The results of these inspections will be added to the Director's existing Preventative Maintenance program (TELS). 4. The results of the aforementioned monthly audits will be reviewed (each month for the next 3 months) at the facility's monthly Performance Improvement committee.	
K 050 SS=E	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 This STANDARD is not met as evidenced by: Based on record review and facility staff interview, the facility failed to ensure fire drills were held on 2 of 3 shifts on a quarterly basis. The findings were: Review of the fire drill records showed the first shift occurred between 6 AM and 2 PM and the	K 050	K – 50 1. A fire drill(s) was conducted by the facility's Director of Maintenance on each of the 3 shifts. The drills took place on or before January 31, 2014. 2. The entire facility is included in the fire drills. No one area of the facility is unaffected by a drill. 3. The facility's Director of Maintenance has implemented a schedule whereas one drill is completed each month so that at the end of a quarter, each of the three shifts is covered. Now that all three shifts are current, the new schedule will commence with the evening shift in February 2014. 4. The aforementioned schedule, along with evidence of compliance of same will be	2/6/14

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K 050	Continued From page 4 second shift occurred between 2 PM and 10 PM. Further review showed a fire drill was not conducted on the first shift during the third quarter of 2013. A fire drill was not conducted on the second shift during the third and fourth quarters of 2013. On 1/8/14 at 3:40 PM, the maintenance director could not explain why the previous maintenance director had not conducted the aforementioned fire drills.	K 050	reviewed each month at the facility's Performance Improvement committee. K -52 1. Each of the sited heat detectors was reinstalled on 01/09/14 by the facility's Director of Maintenance. What's more, the fire alarm control panel batteries were replaced by the facility's fire monitoring vendor on 01/14/2014.	
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 3 fire alarm control battery tests was conducted and failed to ensure heat detectors were maintained in 1 of 7 smoke compartments. The findings were: 1. Observation on 1/8/14 at 1:49 PM showed the heat detector in the boiler room and hot water heater room were hanging from the electrical wires. At the time of the observation, the	K 052	2. No other heat detectors were found to be hanging from the electrical wires during the survey. And there is but one fire alarm panel. 3. The facility's Director of Maintenance will increase the frequency of the safety inspection designed to identify violations such as dangling heat detectors to monthly. Furthermore, the Director will inspect the fire alarm control panel batteries semi-annually. The prompt for, as well as the results of, these inspections will be depicted on the Director's existing Preventative Maintenance Program (TELS). 4. The results of the aforementioned monthly audits will be reviewed (each month for the next 3 months) at the facility's monthly Performance Improvement committee.	2/4/14

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K 052	Continued From page 5 maintenance director could not explain why these heat detectors had not been noticed and re-attached to the mounting bases during the quarterly safety inspections. 2. Review of the fire alarm system testing records showed the fire alarm control panel battery semi-annual load voltage test had not been performed since the 1/30/13 annual inspection. On 1/8/14 at 3:40 PM, the maintenance director confirmed there was not a semi-annual battery testing log to review. He could not explain why the previous maintenance director had not performed the load voltage test. NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; 2-1.3.2 In all cases, initiating devices shall be supported independently of their attachment to the circuit conductors. 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, ... annually (30 minutes) 3. Load Voltage Test, ... semi-annually	K 052	K-62 1. The facility's fire sprinkler monitoring contractor is scheduled to replace the sprinkler heads in the picture alcove to match those in the west corridor on 02/06/14 so that the cited heads have the same activation point. 2. No other sprinkler heads were found during the survey to be mismatched. 3. The facility's fire sprinkler monitoring company has been instructed to inspect all heads for appropriate activation during their regularly scheduled visits and notate same on the inspection report. The facility's Director of Maintenance will add the new expectation onto his existing Preventative Maintenance Program (TELS). 4. Copies of the aforementioned reports will be reviewed at the facility's monthly Performance Improvement committee	2/6/14
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	K 062		

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K 062	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure sprinkler heads in the same compartmented space had the same activation point in 1 of 7 smoke compartments. The findings were: Observation of the picture alcove on 1/8/14 at 10:02 AM showed the alcove was part of the west corridor system. Further review showed the two sprinkler heads in the picture alcove were quick response heads while the rest of the sprinkler heads in the corridor were standard response heads. At the time of the observation, the maintenance director reported he was unaware the sprinkler heads were required to have the same activation point. He further reported the sprinkler contractor had not indicated the aforementioned sprinkler heads were required to be replaced. 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.	K 062	K-144 1. The generator's sealed lead acid batteries were tested for conductance by the facility's outside generator vendor on or before 02/7/14. The batteries were fine. In addition, the facility's generator received a full load bank test on 02/07/14. 2. The facility has but one emergency generator. 3. The facility's Director of Maintenance has purchased a conductance tester and will commence performing internal conductance tests on the sealed lead acid batteries. A prompt for the requisite battery test as well as the full load bank test has been added to the Director of Maintenance's existing Preventative Maintenance program (TELS). 4. The results of these two inspections will be reviewed in the applicable month of the facility's Performance Improvement committee.	2/19/14
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.	K 144		

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K 144	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 1 of 5 emergency generator tests was performed and failed to ensure a load bank test was performed annually. The findings were: 1. Review of the emergency generator testing records showed the generator was equipped with sealed lead acid batteries. Further review showed the facility was not performing conductance tests on sealed lead acid batteries. On 1/7/14 at 4:45 PM, the maintenance supervisor reported he was unaware of the conductance test requirement. 2. Review of the emergency generator testing records showed the generator ran at less than 30% of the name plate during the monthly full load test. Records showed the generator ran at 16% of the name plate. Further review showed the last annual load bank test was performed on 12/13/11, more than one year ago. On 1/8/14 at 3:40 PM, the maintenance director could not explain why the previous maintenance director had not ensured the load bank test was performed annually. Reference NFPA 101, 2000 Edition, 19.5.1, 9.1.3, NFPA 110, 1999 Edition; 6.4.2* Generator sets In Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate	K 144		

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K 144	Continued From page 8 kW rating (2) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer 6.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 6.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. 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. NFPA 110, 2005 Edition; 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specifics gravity when applicable and warranted.	K 144	K-147 1. The surveyor identified 6-way power taps were removed from the facility on 1/10/14 by the facility's Director of Maintenance as was the extension cord. 2. The facility's Director of Maintenance conducted a whole house inspection on 1/17/14 to identify the use of other 6-way power taps and/or extension cords. Any and all power taps and/or extension cords discovered during the inspection were removed from the facility in real time and no more exist. 3. The facility's Director of Maintenance in serviced all staff on 2/3/14 with respect to the prohibition of power taps and extension cords. In addition, the facility's Director of Maintenance will commence monthly whole-house visual room to room inspections to rule out the use of 6-way power taps and/or extension cords. The results of the inspections will be depicted on the Directors existing Preventative Maintenance Program (TELS). 4. The monthly inspection results from above will be reviewed each month (for the next 3 months) at the Performance Improvement committee	2/6/14
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 147		

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K 147	Continued From page 9 1. Observation of the electrical system on 1/8/14 between 9:30 AM and 11:30 AM showed the computer in the scheduling office was plugged into a 6-way power tap. Further observation showed television sets in resident rooms #207 and #219 were plugged into 6-way power taps. On 1/8/14 at 9:54 AM, the maintenance director reported he was unaware there was a difference between multi-plug adapters and surge protectors. He also reported the quarterly safety inspections did not ensure multi-plug adapter were surge protectors. 2. Observation of resident room #119 on 1/8/14 at 11:46 AM showed the lights for a Christmas tree were plugged into an extension cord. At the time of the observation, the maintenance director could not explain why this extension cord had not been noticed and removed during the quarterly safety inspections. 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		