STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 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 V (000) construction with plan approval in 1973. The building was equipped with a supervised, automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 37 certified Medicare and Medicaid beds with a census of 29.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	This facility will ensure there is no impediment to closing of doors. 1) Room 204 door will be repaired by Maintenance Staff to ensure appropriate closure of <5 foot pound of pressure. 2) All corridor doors will be checked by Maintenance Staff to ensure <5 foot pounds of pressure are necessary to ensure door closure. Any door identified to require >5 foot pounds of pressure for closure will be immediately adjusted by Maintenance Staff. 3) Maintenance Staff will be inserviced by Safety Officer regarding need to ensure all doors have a <5 foot pounds of pressure for closure.	

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

Administrator | 5/13/14

RECEIVED
WY Dept of Health
JUN 09 2014
Healthcare Licensing and Surveys

PLAN OF CORRECTIONS (POC) ACCEPTABLE WITH JACKIE CLAUDSON (ADMINISTRATOR) ON 06.09.14 JWyatt

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide doors that resisted the passage of smoke in 1 of 2 smoke compartments. The findings were: Observation on 4/23/14 at 9:46 AM revealed that the door to room 204 was warped within the frame and required a force in excess of 5 ft-lbs to fully close and latch the door. Interview with the Director of Facilities at the time of the observation verified the excessive closing force.	K 018	4) Monitored through quarterly Quality Assurance reporting by Safety Officer of door closure observation and testing. 6/6/14	
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 021	This facility will ensure hazardous area enclosures are held open only by devices arranged to automatically close. **1)** Maintenance Staff will adjust automatic closure on Clean Utility room door to ensure door fully closes. **2)** Maintenance staff will check all hazardous area doors with automatic closure devices for appropriate closure. Any door identified to not close properly will have immediate adjustment by maintenance staff. **3)** Safety Officer will inservice Maintenance Staff regarding need to check all automatic closure doors for appropriate closure quarterly. All doors identified to not close properly shall be adjusted immediately.	

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K 021	Continued From page 2 facility failed to provide doors to hazardous areas were self-closing in 1 of 2 smoke compartments. The findings were: Observation on 4/23/14 at 9:20 AM revealed that the automatic closer for the door to the Clean Utility room did not fully close and latch the door. Interview with the Director of Facilities at the time of the observation verified the failure of the closer to close and latch the door.	K 021	4) Monitored by Quality Assurance Committee through quarterly reporting of hazardous area door closures by Safety Officer.	6/6/2014
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide emergency lighting in 1 of 2 smoke compartments. The findings were: Observation on 4/23/14 at 10:45 AM of the corridor serving the soiled linen area revealed that the illumination of the means of egress was not continuous during the time of occupancy - 24 hours. The wall switch opened the lighting circuit where no continuous 24 hour illumination was provided as powered by the emergency generator system. Interview with the Director of Facilities at the time of the observation verified that 24-hour illumination was not available in this area. REFERENCE	K 045	This facility will ensure illumination of means of egress. 1) Maintenance Staff will remove both switches located at both ends of utility egress hall to ensure continuous egress lighting. 2) All means of egress will be checked by Maintenance Staff to ensure continues lighting at all means of egress points. Any egress noted to not have continuous lighting will be immediately fixed to ensure continuous egress lighting. 3) Safety Officer will inservice all maintenance staff regarding need to observe and document all means of egress lighting for continuous lighting. At any time lighting is determined to not meet the need for continuous egress lighting, maintenance staff will immediately identify and fix the issue.	

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K 045	Continued From page 3 NFPA 101, 2000 Edition 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified.	K 045	4) Monitored by Quality Assurance Committee through quarterly reporting of means of egress continuous lighting by Safety Officer.	6/6/2014
K 048 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on document review & staff interview, the facility failed to provide documentation of a written plan for the protection of patients in the event of an emergency. The findings were: Document review on 4/23/14 from 8:50 AM until 10:01 AM revealed that emergency policies were available but that the policies were developed in 1999. Further review of the policies revealed that frequent corrections, additions, and/or modifications had been hand-written onto the master copy. Interview with the Director of Facilities at the time of the observation could not establish that these corrections, additions, and/or modifications had been made on a permanent basis and redistributed to the facility staff.	K 048	This facility will ensure there is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 1) Administrator will have all policies retyped to include changes and corrections to policies. 2) Administrator and Safety Officer will review all emergency policies for appropriateness and changes made. Changes will be included in emergency policy. 3) Administrator and Safety Officer will distribute updated emergency policies to each department and inservice all staff regarding policy changes at individual department meetings. Policies will be reviewed annually by Administrator and Safety Officer and staff inserviced annually.	6/6/2014
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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K 045	Continued From page 3 NFPA 101, 2000 Edition 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified.	K 045		
K 048 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on document review & staff interview, the facility failed to provide documentation of a written plan for the protection of patients in the event of an emergency. The findings were: Document review on 4/23/14 from 8:50 AM until 10:01 AM revealed that emergency policies were available but that the policies were developed in 1999. Further review of the policies revealed that frequent corrections, additions, and/or modifications had been hand-written onto the master copy. Interview with the Director of Facilities at the time of the observation could not establish that these corrections, additions, and/or modifications had been made on a permanent basis and redistributed to the facility staff.	K 048	K048 Continued: 4) Monitored through Quality Assurance Committee through quarterly reporting of policy changes and staff inservices by Safety Officer. 6/6/14	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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K 050	Continued From page 4 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 document review & staff interview, the facility failed to provide fire drills held at unexpected times and at least quarterly on each shift. The findings were: Document review on 4/23/14 from 8:50 AM until 10:01 AM revealed that no record of a fire drill was available for the second shift during the first quarter of 2014. Interview with the Director of Facilities verified that no documentation was available.	K 050	This facility will ensure fire drills are held at unexpected times under varying conditions at least quarterly on each shift. **1)** Safety Officer will conduct fire drill on all shifts before June 6. Fire drills will be documented. **2)** Safety Officer will conduct fire drills on all shifts quarterly. Fire drills will be documented. **3)** Administrator will inservice Safety Officer regarding the need to have quarterly fire drills on each shift. **4)** Monitored by Quality Assurance Committee through quarterly reporting of fire drill completion by Safety Officer. 6/6/14	
K 052 SS=E	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	K 052	This facility will ensure documentation to indicate that the fire alarm systems have been tested are in place. **1) a.** Safety Officer will obtain fire alarm monthly activation documentation indicating fire alarm systems have been tested and are functional.	

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K 052	Continued From page 5 This STANDARD is not met as evidenced by: Based on document review & staff interview, the facility failed to provide documentation identifying a maintenance policy of the fire alarm system or documentation to indicate that the fire alarm systems have been tested in accordance with NFPA 72. The findings were: Document review & interview with the Director of Facilities regarding the testing & maintenance documentation on 4/23/14 from 8:50 AM to 10:00 AM confirmed the lack of testing or maintenance policies for the following aspects of the fire alarm system: 1. Fire alarm - monthly activation (NFPA 72 Table 7-3.2, 23): Documentation was not available at the time of the survey to demonstrate that the fire alarm has been activated monthly. Activation could not be established for the month of February of 2014. 2. Smoke damper operation - annual test (NFPA 90A, 4-4.1): Documentation was not available at the time of the survey to demonstrate that smoke dampers have been tested and operated within the past 12 months. 3. Smoke detectors - in place, smoke entry - annual test (NFPA 72, Table 7-3.2, 15): Documentation was not available at the time of the survey to demonstrate that in-place smoke entry tests have been performed within the past 12 months. 4 Smoke detector sensitivity - bi-annual tests	K 052	**b.** Safety Officer will obtain annual smoke damper operation test from fire alarm testing vendor. **c.** Safety Officer will obtain smoke entry annual test results from fire alarm testing vendor. **d.** Safety Officer will obtain smoke detector sensitivity bi-annual test results from fire alarm vendor. **e.** Safety Officer will obtain heat detector annual test results from fire alarm vendor. **f.** Safety Officer will obtain manual fire alarm box annual test results from fire alarm vendor. **2)** Safety Officer will review all fire alarm documentation for up-to-date fire alarm testing. Any documentation or testing identified to have not been completed in a timely fashion, will immediately be tested or fire alarm testing vendor will be notified to do testing and provide documentation. **3)** Administrator will send letter to fire alarm vendor explaining the need to ensure appropriate and timely fire alarm testing. Safety Officer will develop check list to include appropriate fire alarm tests and timelines to ensure all fire alarm testing is done, reviewed, and documented. **4)** Monitored by Quality Assurance Committee through quarterly reporting of fire alarm testing by Safety Officer.	6/6/2014

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K 052	Continued From page 6 (NFPA 72, Table 7-3.2, 15): Documentation was not available at the time of the survey to demonstrate that sensitivity tests have been performed within the past 24 months. 5. Heat Detectors - annual test (NFPA 72, Table 7-3.2, 15): Documentation was not available at the time of the survey to demonstrate that heat detectors have been tested within the past 12 months. 6. Manual Fire Alarm Boxes - annual test (NFPA 72, Table 7-3.2, 15): Documentation was not available at the time of the survey to demonstrate that manual fire alarm boxes have been tested within the past 12 months.	K 052		
K 056 SS=D	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 staff interview, the facility failed to ensure that the facility has complete sprinkler coverage in 1 of 2 smoke compartments. The findings were:	K 056	This facility will ensure that the facility has complete sprinkler coverage. **1)** Safety Officer will contact fire protection vendor to have sprinkler in kitchen moved to ensure no more than 7 foot distance from furthest wall. **2)** Safety Officer will check all sprinkler heads throughout the facility to ensure all sprinkler heads are no further than 7 foot from furthest wall.	

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K 056 Continued From page 7

Observation of the storage room located within the Kitchen on 4/23/14 at 11:09 AM revealed that one sprinkler head was installed for full coverage of the space. Measurement of the layout revealed that the single head was located at a distance of 8 ' -4 " from the furthest wall in lieu of the 7 ' -6 " maximum allowable distance for standard sprinkler heads. Interview with the Director of Facilities verified that the layout exceeded the maximum allowable sprinkler separation distance for standard sprinkler heads and the Director of Facilities could not verify if the sprinkler head in question was an extended coverage sprinkler head.

K 062 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 document review and staff interview, the facility failed to ensure that automatic sprinkler systems are continuously maintained per the requirements of NFPA 25. The findings were:

Document review and interview with the Director of Facilities of the testing & maintenance documentation on 4/23/14 from 8:50 AM to 10:01 AM confirmed the lack of a testing & maintenance policy of the following aspects of the fire sprinkler system.

K 056

3) Safety Officer will inservice Maintenance Staff regarding the need to have all sprinkler heads no greater than 7 foot from the furthest wall. Maintenance Staff will check sprinkler heads annually and any sprinkler head identified to not meet appropriate standards will result in notification to fire protection vendor for appropriate intervention.

4) Monitored by Quality Assurance Committee through quarterly reporting of sprinkler head review by Safety Officer. 6/6/2014

K 062

This facility will ensure that the automatic sprinkler systems are continuously maintained.

1) a. Safety Officer will contact plumber to do backflow preventer test and testing will be documented.

b. Safety Officer will contact fire alarm vendor and all sprinkler system gauges will be tested which will result in calibration or replacement as appropriate. Testing and intervention will be documented by vendor.

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K 062	Continued From page 8 a. Backflow Preventer - annual test (NFPA 25 9.6.2.1): Documentation was not available at the time of the survey to demonstrate that the backflow preventer has been tested within the past 12 months. b. Gauge recalibration or replacement - 5 years (NFPA 25, 9-2.8.2): Documentation was not available at the time of the survey to demonstrate that the sprinkler system gauges have been calibrated or replaced within the past 5 years.	K 062	K062 Continued: 3) Safety Officer will develop fire system checklist which includes annual backflow preventer testing and 5 year sprinkler system gauge testing to ensure these tests are performed and documented. 4) Monitored by Quality Assurance Committee through quarterly reporting of backflow prevention testing and sprinkler system gauge testing by Safety Officer.	6/6/2014
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 staff interview, the facility failed to maintain electrical wiring and equipment in accordance with the National Electrical Code. The findings were: Observation on 4/23/14 from 9:01 AM to 10:12 AM revealed relocatable power taps (RPT's) were in use in the following patient care areas: Resident Room 105, Resident Room 106, Resident Room 110, Resident Room 111, Resident Room 112, and Resident Room 203. Interview with the Director of Facilities at the time of the multiple observations confirmed the RPT ' s use in patient care areas.	K 147	K147 Continued: 3) Safety Officer will inservice all maintenance staff and nursing staff regarding appropriate reloctable power taps to include surge protection. 4) Monitored by Quality Assurance Committee through quarterly reporting of room checks by maintenance staff for appropriate relocatable power taps by Safety Officer.	6/6/2014
K 154 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period. the authority having jurisdiction is notified,	K 154		

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K 062	Continued From page 8 a. Backflow Preventer - annual test (NFPA 25 9.6.2.1): Documentation was not available at the time of the survey to demonstrate that the backflow preventer has been tested within the past 12 months. b. Gauge recalibration or replacement - 5 years (NFPA 25, 9-2.8.2): Documentation was not available at the time of the survey to demonstrate that the sprinkler system gauges have been calibrated or replaced within the past 5 years.	K 062	**2)** Safety Officer will contract with plumbing contractor to do annual backflow preventer testing. Safety Officer will notify fire alarm vendor that sprinkler system gauge testing must be done at a minimum of every 5 years and documentation provided.	
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 staff interview, the facility failed to maintain electrical wiring and equipment in accordance with the National Electrical Code. The findings were: Observation on 4/23/14 from 9:01 AM to 10:12 AM revealed relocatable power taps (RPT's) were in use in the following patient care areas: Resident Room 105, Resident Room 106, Resident Room 110, Resident Room 111, Resident Room 112, and Resident Room 203. Interview with the Director of Facilities at the time of the multiple observations confirmed the RPT ' s use in patient care areas.	K 147	This facility will ensure electrical wiring and equipment is maintained in accordance with National Electrical Code. **1)** Maintenance staff will replace relocatable power taps in resident room 105, 106, 110, 111, 112, and 203 with relocatable power taps with surge protection. **2)** Maintenance staff will check all facility room for appropriate relocatable power taps. Any relocatable power tap identified without surge protection will be replaced by Maintenance staff.	
K 154 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified,	K 154	This facility will ensure a fire watch system is available in case automatic sprinkler system is out of service3 for more than 4 hours in a 24-hour period.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 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 154	Continued From page 9 and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain a policy to address an event where the automatic sprinkler system is out of service for more than 4 hours in a 24-hour period. The findings were: Document review on 4/23/14 from 8:50 AM to 10:01 AM revealed that no fire watch policy was available for review. Interview and follow up document review with the Director of Facilities from 11:25 AM until 11:50 AM was not able to establish the existence of a fire watch policy.	K 154	**1)** Administrator will review fire watch policy and will incorporate policy into facility emergency plan. **2)** Life Safety Officer will place fire watch policy into every department emergency policy. **3)** Life Safety Officer will inservice all staff regarding addition of fire watch policy into the emergency policies. **4)** Monitored by Quality Assurance Committee through quarterly reporting of, fire watch policy appropriateness and inclusion in department emergency policies.	6/6/2014
K 155 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain a policy to address	K 155	This facility will ensure a fire watch system is available in case automatic sprinkler system is out of service3 for more than 4 hours in a 24-hour period. **1)** Administrator will review fire watch policy and will incorporate policy into facility emergency plan. **2)** Life Safety Officer will place fire watch policy into every department emergency policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/23/2014

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K 155	Continued From page 10 an event where the fire alarm is out of service for more than 4 hours in a 24-hour period. The findings were: Document review on 4/23/14 from 8:50 AM to 10:01 AM revealed that no fire watch policy was available for review. Interview and follow up document review with the Director of Facilities from 11:25 AM until 11:50 AM was not able to establish the existence of a fire watch policy.	K 155	**3)** Life Safety Officer will inservice all staff regarding addition of fire watch policy into the emergency policies. **4)** Monitored by Quality Assurance Committee through quarterly reporting of fire watch policy appropriateness and inclusion in department emergency policies.	6/6/2014