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
	535013	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/30/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(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 (NFPA). The facility was a fully sprinkled three story building of Type II (222) construction built in 1972. The building was equipped with a supervised automatic wet sprinkler system with a fire alarm system.	K 000	POC APPROVED W/ DOC STACKS - NBA. DJ 4/24/09. *This plan of correction is the center's credible allegation of compliance.* *Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the [redacted] 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 federal and state law.*	
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 staff interview the facility failed to ensure hazardous areas were separated from use areas on one of three floors. The findings were: Observation on 3/25/09 at 11:10 AM revealed the south set of double doors to the laundry could not be latched. Three attempts were made with the	K 029	K-029: On 03/25/09 the Maintenance Director replaced the latches on both sets of double doors to the laundry room. The Maintenance Director or designee will conduct a facility-wide audit to confirm that facility doors latch properly. The Maintenance Director will incorporate into the preventive maintenance schedule a facility-wide inspection to determine if any doors are not latching properly and if not repair accordingly. Random audits will be conducted monthly, for 3 months by the Maintenance Director or designee to confirm that all doors are latching properly. Results of the random audits will be presented to the QA&A Committee monthly for 3 months. Date of compliance is May 11th, 2009	

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

Executive Director 4/20/09

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.

Hand Delivered
APR 20 2009
Office of Healthcare Licensing and Surveys

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K 029	Continued From page 1 same results. Review of the latch on the left door showed significant wear to the latch bolt where it struck the front of the other door. Interview with the maintenance director at the time of observation revealed the laundry doors were not routinely inspected to determine if they latched properly.	K 029		
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure exit signs were properly illuminated on one of three floors. The findings were: 1. Observation on 3/25/09 between 1:30 PM and 2:30 PM revealed exit signs in the southwest stairwell, near resident room #118 and the east sign in the first floor dining room each had one of two light bulbs that was not illuminated. 2. Interview with the maintenance director on 3/25/09 at 1:58 PM revealed each exit sign were inspected monthly. Review of the inspection records showed the last inspection occurred on 2/23/09. The director further reported that the fluorescent bulbs installed in the signs were continually being replaced facility-wide.	K 047	K-047: On 03/26/09 the Maintenance Director replaced the light bulbs that were not illuminated for both the southwest stairwell, near resident room #118 and the east sign in the first floor dining room. The Maintenance Director or designee will conduct a facility-wide audit to confirm that exit and directional signs are continuously illuminated properly and if bulbs are not illuminated will replace bulbs. The Maintenance Director will continue to conduct exit and direction sign illumination audits per the preventive maintenance schedule. Random audits will be performed monthly for 3 months by the Maintenance Director or designee to confirm that all exit and directional signs are displayed with continuous illumination. Results of the random audits will be presented to the QA&A committee monthly for 3 months Date of compliance is May 11th, 2009	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all	K 064		

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K 064	Continued From page 2 health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure portable fire extinguishers were inspected monthly on two of three floors. The findings were: 1. Observation on 3/25/09 between 11 AM and 12 PM revealed the portable fire extinguishers in the generator room and social services office had not received monthly inspections since the annual inspection that had occurred in September 2008. 2. Interview with the maintenance director on 3/25/09 at 11:22 AM revealed the facility usually signed the service tag after each monthly inspection. He further reported that he did not have an inspection log to ensure all extinguishers had been inspected. He had no other evidence to review.	K 064	K- 064: On 03/25/09 Phoenix Fire conducted a facility wide portable fire extinguisher monthly inspection, this inspection included the fire extinguishers in the generator room and social services office. The Maintenance Director or designee will incorporate into the preventive maintenance schedule an inspection log to ensure all extinguishers are inspected. Random audits will be performed monthly for 3 months by the Maintenance Director or designee to confirm that portable fire extinguishers are inspected monthly. Results of the random audit will be presented to the QA&A Committee monthly for 3 months. Date of compliance is May 11th, 2009.	
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 ensure temporary electrical wiring was prohibited on one of three floors. The findings were:	K 147		

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K 147	Continued From page 3 Observation on 3/25/09 at 11:31 AM revealed the computer in the beauty shop was plugged into a surge protector, which was itself plugged into an extension cord. The extension cord originated in the bathroom then ran up the wall into and through the ceiling cavity and back down to the floor in the south end of the shop. Interview with the maintenance director at the time of observation revealed the electrical equipment in the beauty shop was not routinely inspected.	K 147	K-147: The Maintenance Director or designee will remove the extension cord in beauty shop. The Maintenance Director or designee will conduct a facility-wide audit to confirm extension cords are not being utilized. The Maintenance Director will incorporate the beauty shop into the already existing preventive maintenance schedule of routine checking to confirm extension cords are not being used. Random audits will be performed monthly for 3 months by the Maintenance Director or designee to confirm that extension cords are not being used. Results of the random audits will be presented to the QA&A committee monthly for 3 months. Date of compliance is May 11th, 2009	