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

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WY Dept of Health
SEP 18 2014
Healthcare Licensing and Surveys

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535046	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN'S NURSING HOME	625 EAST BROADWAY JACKSON, WY 83001

(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, 1-story building of Type V (111) construction built in 1990. The building was equipped with a supervised, automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 60 certified Medicare and Medicaid beds with a census of 51 residents. A 2-hour fire-rated barrier was provided at the corridor of the material management area at the east end of the facility to separate the adjacent hospital from the nursing care facility.	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of 1 common fire barrier wall between the nursing care facility and adjacent hospital. The findings were: Observation on 6/18/14 at 10:18 AM revealed the	K 011	The common fire barrier wall between the nursing care facility and the adjacent hospital will maintain a two hour fire resistance rating. Communicating openings occur only in corridors and are protected by approved self-closing doors. This will be accomplished by: 1. The Maintenance staff will install a self-closing device on the door as noted. 2. Maintenance employees will not remove self-closing devices from doors that maintain a two hour fire rating. 3. Director of Facilities, will monitor the facility to ensure that a two hour fire resistance rating is maintained between the nursing facility and the hospital. 4. A report of this correction will be reported at the Living Center quarterly Performance Improvement Committee.	8.2.2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia Wilson NHA
TITLE: Administrator
(X6) DATE: 9-16-14

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.

POC Accepted via Phone Call with Cheryl Sawyer (Acting Administrator) on 9/18/14 @ 11:31 AM. [initials]
[signature] 9/18/14

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K 011	Continued From page 1 door closing device for the 1-1/2 hour labeled fire door in the 2-hour fire barrier was removed. Interview with the administrator during the observation confirmed the location of the common fire barrier wall. Additional interview revealed the facility would install a closing device in lieu of continuing the survey throughout the hospital.	K 011		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a complete smoke detection system in the spaces open to the corridors in 1 of 4 smoke compartments. Observation on 6/18/14 at 9:40 AM of the vaulted	K 017	The facility will provide a complete smoke detection system in the spaces open to the corridor. This will be accomplished by: 1. The Maintenance Supervisor will contact API to install, program and test a smoke detector in the "vaulted" ceiling at the central nurses' station. 2. The Director of Facilities inspect spaces that open into the corridor for presence of smoke detection devices. Smoke detection devices will be installed as needed. 3. This report will be submitted and reported at the Living Center quarterly Performance Improvement Committee meeting and at the SJMC Safety Committee Meeting.	8.2.2014

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K 017	Continued From page 2 ceiling area of the Center Core -Nurse Control Area open to the exit access corridor was absent from smoke detection as required in Section 19.3.4.5.2 of the Life Safety Code (LSC). Interview with the administrator during the observation confirmed no smoke detection was provided.	K 017	The facility will provide minimum safety requirements for cooking equipment per NFPA 96 for deep fat fryers. This will be accomplished by the following: 1. Maintenance staff will re-install a splash guard divider between the deep fat fryer and the adjacent griddle per NFPA 96, Section12.1.2.4. 2. The kitchen staff will ensure that the required positioning of equipment will be appropriately maintained under the hood. 3. The Food Service Manager will in-service the dietary staff about appropriately positioning equipment under the hood. 4. The Food Service Manager and/or designee will monitor that equipment is appropriately positioned under the hood. 5. A report of these inspections will be given to the Registered Dietitian and reported at the quarterly Living Center Performance Improvement Committee meetings.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide the minimum safety requirements for cooking equipment per NFPA 96 for 1 of 1 deep fat fryers. The findings were: Observation of the deep fat fryer in the Kitchen on 6/18/14 at 10:17 AM revealed that a minimum 16-inch space had not been provided for the adjacent griddle per NFPA 96, Section 12.1.2.4. Interview with the facility maintenance staff at the time of the observation acknowledged that the separation distance was not provided. Additional observation and interview revealed that the existing hood did not allow the equipment to be adjusted while maintaining the required positioning under the hood. The facility maintenance and kitchen staff advised that a splash guard had previously been installed, but that a previous inspector (agency unknown) had stated that it could be removed. The kitchen staff indicated that the existing splash guard would be reinstalled.	K 069		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		8.2.2014

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K 076	Continued From page 3 Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to store the medical oxygen cylinders separated away from combustible or incompatible materials in 1 of 4 smoke compartments in accordance with NFPA 99. Observation of the storage room adjacent to the bathing area of the north wing on 6/18/14 at revealed 3 - "E" cylinders of compressed medical oxygen were nestled in and amongst cardboard boxes of unknown contents with floor mats on shelving above and other storage of unknown combustible items. Interview with administrator revealed an unfamiliarity of the storage in that room and confirmed the gas cylinders were not separated 5 feet from the combustible items or enclosed in a cabinet with a 1/2-hour fire protection rating as required in Section 8-3.1.11.2 of NFPA 99.	K 076	The facility will appropriately store medical oxygen cylinders from combustible or incompatible materials in accordance with NFPA 99. This will be accomplished by the following: 1. The facility will ensure that oxygen cylinders are separated 5 feet from combustible items. 2. All cardboard containers will be removed from the storage closet and the contents will be stored away from oxygen cylinders. 3. If oxygen cylinders are stored in this storage room, a five foot space will be allowed between the cylinder and other combustible materials. 4. The LC Unit Secretary will regularly monitor that the Living Center is complying with this standard. Immediate feedback will be given to staff if there is not the allowable 5 feet separation needed between oxygen cylinders and combustibles. 5. A report of these inspections will be given to the NHA for any additional follow-up. 6. This will be reported by the NHA at the quarterly Living Center Performance Improvement Committee meetings.	8.2.2014
K 130 SS=D	NFPA 101 MISCELLANEOUS	K 130		

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K 130	Continued From page 4 OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the required handrails were installed at the ramps in the exit discharges of 2 of 4 exits. The findings were: Observation on 6/18/14 at 9:04 AM of exit discharge of the west wing and at 9:18 AM of the north wing exit discharge revealed ramps with more than a 6-inch rise had a guard rail mounted on a 12 high concrete curb/retaining wall on one side, but the required graspable handrails on either sides of the ramps were not installed within reach as required by Section 7.2.2.4 and 7.2.5.4 of the Life Safety Code. Interview during the observations with administrative staff confirmed that no graspable handrails were installed. Based on observation and staff interview, the facility failed to ensure the exterior fenced assembly area had two widely separated means of egress, marking of the way to exits, occupant capacity sign posting, and fire alarm system notification in 1 of 3 assembly use areas. Based on observation, document review, and staff interview on 6/18/14 at 9:58 AM of the fenced assembly area revealed it contained several tables with chairs, benches, and a barbecuing area with three portable grills. Interview with the administrator revealed the area was being used for resident, visitor, and staff gatherings. Document review of the construction plans revealed the net area (excluding the	K 130	The facility will ensure that required handrails are installed at the ramps in the exit discharges. This will be accomplished by the following; 1. The Maintenance staff will install graspable handrails as required at the west and north wing exit discharge. 2. The hand rails will be installed within reach as required by Section 7.2.2.4 and 7.2.5.4 of the Life Safety Code. 3. Director of Facilities will ensure that this installation is completed 4. Director of Facilities will report this at the SJMC Safety Committee Meeting. 12-15-14 See time limited waiver request. (PG) The facility will ensure the exterior fenced assembly area has two widely separated means of egress, marking of the way to exits, occupant capacity sign posting, and the fire alarm system notification. This will be accomplished by the following:	

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K 130	Continued From page 5 landscaped areas) measured from the scaled drawings was approximately 3,750 square feet. The design occupant load for the net area was derived from 15 square feet per person as 250 persons. The 1 of 2 widely separated means of egress were not provided with doors equipped with panic hardware that swing in the direction of egress in accordance with Section 13.2.4.2, 13.2.2.2.3, and 7.2.1.7 of the Life Safety Code (LSC). The unlatched fence gates swung in the direction of egress travel while the other available means of egress had latched doors into the building that did not swing in the direction of travel nor had the required panic hardware. The doors into the building were noted to be equipped with keyed locks prohibited in Section 7.2.1.5 of the LSC. An occupant load sign was not posted for the area as required in Section 13.7.9.3 of the LSC. Exit signage was absent from the area as required in Section 13.2.10 of the LSC. Fire alarm occupant notification devices were absent from the area as required in Section 19.3.4.3 of the LSC.	K 130	1. Director of Facilities will submit a drawing of fire safety modifications to the Living Center courtyard to the Wyoming Department of Health for approval. 2. These modifications will include another exit access from the courtyard, lighted exit signs, occupant capacity sign, and fire alarm system notification. 3. Upon approval of WDH, these plans will be implement and completed. 4. Director of Facilities will ensure completions of these modifications by appropriate construction staff. 5. A report of compliance will be given to the Living Center Performance Improvement Committee and to the SJMC Safety Committee. 3-15-15 See time limited waiver request (Sw)	