STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING 01 B. WING _____	08/26/2009

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 (NFPA). The facility was a fully sprinkled single story building with a partial basement of Type II (000) construction built in 1981. The building was equipped with a supervised automatic wet fire sprinkler system with an anti-freeze branch and addressable fire alarm system.	K 000	K012 Facility will ensure that the smoke partition is maintained as a continuous membrane in the smoke compartments. This will be accomplished by: 1) Holes in the ceilings have been sealed in the following rooms: a. Resident room #201 in the closet. b. Resident room #217 in the closet. c. North nurses' station medication room (2 holes sealed). d. Resident shower/bath room in the north unit (2 holes sealed). e. North housekeeping closet (one under the light and one in the corner) f. Resident room #317 in the closet. g. Resident room #332 in the closet h. Chapel storage closet 2) Holes in the walls have been sealed in the following rooms: a. Resident room #208 bathroom wall (5 holes sealed).	9/28/09 9/28/09
K 012 SS=E	NFPA 101 LIFE SAFE[redacted]DE STANDARD Building construction ty[redacted] height meets one of the following. 19.1.6[redacted]9.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the smoke partition was maintained as a continuous membrane in 4 of 10 smoke compartments. The findings were: Observation on 8/25/09 between 10 AM and 3 PM revealed the follow concerns: 1. There were ceiling holes approximately 1-inch in diameter in the following locations: a. One hole was noted in the closet of resident room #201. b. One hole was noted in the closet of resident room #217. c. Two holes were noted in the north nurses' station medication room.	K 012		

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

x Anita Cox Mills | x Administrator | x 9/22/09

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.

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Wyoming Dept of Health
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Office of Healthcare Licensing and Surveys

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K 012	Continued From page 1 d. Two holes were observed in resident shower/ bath room in the north unit. e. Two holes were noted in the north housekeeping closet: one under the light and one in the corner. f. There was oone hole in the closet of resident room #317. g. There was one hole in the closet of resident room #332. h. There was one hole in the closet in the chapel storage closet. 2. There were holes approximately 1-inch in diameter in the wall in the following locations: a. The bathroom wall of resident room #208 had five holes noted. b. The bathroom wall in resident room #210 had five holes noted. c. The entry enclave in the "c" hall of the north unit had one hole noted. Interview with the facility maintenance manager at that time confirmed the holes needed to be caulked.	K 012	K012 cont'd b. Resident room #210 bathroom wall (5 holes sealed). c. Entry enclave in the "C" hall of the north unit. 3) Environmental Services Dept. will be in-serviced on ensuring that walls are continuous membranes in the smoke compartments. 4) Environmental Services Manager will audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	9/28/09 9/28/09
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	~~K 018~~		

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K 018	Continued From page 2 in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility used a box of papers to hold open one interior corridor door in 1of 10 smoke compartments. Findings include: Observation on 8/25/09 between 10 AM and 3 PM revealed a box of papers sitting on the floor being used to hold the office door open. The door was equipped with a self closure device. Interview with the facility maintenance manager at that time confirmed the above observation.	K 018	K018 Facility will ensure that there is no impediment to the closing of corridor doors. This will be accomplished by: 1) The box of paper that was holding the interior corridor door open was removed. 2) Environmental Services Manager will audit for compliance and will report results to the Quality Improvement Committee for review and recommendations. 3) Environmental Services Dept. will be in-serviced on ensuring	9/28/09 9/28/09 9/28/09
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	~~K 029~~	that walls are continuous membranes in the smoke compartments. 4) Environmental Services Manager will audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	9/28/09

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K 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a hazardous area was separated from the patient area in 1 of 10 smoke compartments. The findings were: Observation on 8/25/09 between 10 AM and 3 PM revealed a self-closing device on the door to the medical record room did not function so as to close the door in its frame with three tries. Interview with the facility's maintenance manager at the time of the observation confirmed the SCD door did not seal in its frame.	~~K 029~~	K062 Facility will ensure that sprinkler heads are properly maintained in smoke compartments. This will be accomplished by: 1) Gaps between the sprinkler head escutcheons and the ceiling were filled in resident rooms #231, #242, #302, #315 bathroom, the north stairwell, and the wall in the minimal data set office closet.	9/28/09
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 and staff interview the facility failed to ensure sprinkler heads were properly maintained in 4 of 10 smoke compartments. The findings were: Observation on 8/25/09 between 10 AM and 3 PM revealed the following concerns: 1. Gaps greater than 1 inch were observed between the sprinkler head escutcheons and the ceiling in resident rooms #231, #242, #302, #315 bathroom, the north stairwell, and the wall in the minimal data set office closet.	K 062	2) Sprinkler head covers were replaced in the following locations: resident room #205 closet, resident room #208 both closets and the bathroom of the north nurses' station. 3) Environmental Services Dept. will be in-serviced on the proper maintenance of sprinkler heads in smoke compartments. 4) Environmental Services Manager will audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	9/28/09 9/28/09 9/28/09

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K 062	Continued From page 4 2. Sprinkler head covers were missing in the following locations: the closet in resident room #205, both closets in resident room #208 and the bathroom of the north nurses' station. Interview with the facility's maintenance manager at that time confirmed the above observations.	~~K 062~~		
K 069 SS=F	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 record review and staff interview the facility failed to ensure annual maintenance of the kitchen hood fire supression system was performed. The findings were: Review of facility records on 8/26/09 at 9:48 AM revealed the biannual inspection of the facility's fire suspression system in the kitech was conducted on 1/21/09 and then again on 7/14/09 by an outside contractor. Review of both inspection reports revealed the last hydro test of the equipment was conducted in 1995. The hydro test is required every twelve years. The 1/21/09 inspection report specifically stated, "the fire system is 2 years past update. Need to meet UL300." In addition, the 7/01/09 report stated "Hydro test is 2 years out of compliance." Interview with the facility's maintenance manager and the kitchen manager at the time revealed they were both aware the fire suppression system inspections were late.	K 069	K069 Facility will ensure that annual maintenance of the kitchen hood fire suppression system is performed. This will be accomplished by: 1) The fire suppression system in the kitchen will be brought into compliance with UL300. 2) Environmental Services Manager will audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	9/28/09 9/28/09
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance	~~K 147~~		

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K 147	Continued From page 5 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 facility's electric wiring was in compliance with the National Electric Code in 3 of 10 smoke compartments. The findings were: Observation on 8/25/09 between 10 AM and 3 PM revealed a surge protector (SP) plugged into another SP in the social services office. An extension cord was observed to be plugged into a SP in the training room. Observation in the boiler room revealed three feet of coaxial cable coming from an open electrical box. The ends of the coax cable wires were exposed. Finally, several observations on 8/25/09 and again on 8/26/09 between 8:30 AM and 2:48 PM revealed a table and several chairs were placed less than three feet in front of the electrical panels in the employee's dining room. Interview with the maintenance manager confirmed the above observations.	K 147	K147 Facility will ensure that its electrical wiring is in compliance with the NEC in all smoke compartments. This will be accomplished by: 1) One of the surge protectors was removed from the social services office. 2) The extension cord was removed from the surge protector in the training room. 3) The coaxial cable coming from an open electrical box was removed. 4a) The table and chairs were moved more than 3 feet away from the front of the electrical panels in the employee's dining room. b)A sign was put up near the electrical panels stating "All objects must be kept three feet from the electrical panels."	9/28/09 9/28/09 9/28/09 9/28/09 9/28/09

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K 147	Continued From page 5 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 facility's electric wiring was in compliance with the National Electric Code in 3 of 10 smoke compartments. The findings were: Observation on 8/25/09 between 10 AM and 3 PM revealed a surge protector (SP) plugged into another SP in the social services office. An extension cord was observed to be plugged into a SP in the training room. Observation in the boiler room revealed three foot of coaxial cable coming from an open electrical box. The ends of the coax cable wires were exposed. Finally, several observations on 8/25/09 and again on 8/26/09 between 8:30 AM and 2:48 PM revealed a table and several chairs were placed less than three feet in front of the electrical panels in the employee's dining room. Interview with the maintenance manager confirmed the above observations.	K 147	K147 cont'd 5) In-services were held for all staff regarding the above safety issues. 6) Environmental Services Manager will audit for compliance and will report results to the Quality Improvement Committee for review and recommendations.	9/28/09 9/28/09