STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING 01 B. WING _____	01/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

(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 built in 1985. The building was equipped with a supervised automatic dry sprinkler system with an addressable fire alarm system. The facility had a capacity of 60 certified Medicare and Medicaid beds with a census of 41.	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	K-018 1. The doorknob to the diet pantry was replaced on 1-13-2015 with a functioning knob that allows the door to latch and remain latched to the door frame. 2. Resident room #300 had the strike plate replaced on 1-15-15, with one that would allow the door to latch. The door was inspected and will latch and stay latched to the door frame. All doors have been added to a monthly inspection to ensure proper latching. This inspection will be logged in our "tels" preventative maintenance program. Any issues will be reported to the QA committee for solution. Compliance date: 1-30-15	

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

Alison Melle — ADMINISTRATOR — 1/26/15

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 Administrator Alison Melle on 2/10/15 at 1246pm
34254

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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 a means suitable for keeping doors closed to the corridor in 2 of 5 smoke compartments. The findings were: 1. Observation of the Dietary Pantry, adjacent to the nurses station, on 01/12/15 at 9:34 AM revealed the latching hardware had been removed from the door, causing the door to not remain closed into the door frame. At the time of the observation, the Maintenance Manager acknowledge the missing hardware on the door. 2. Observation of resident room #300 on 01/12/15 at 9:37 AM revealed the door would not close completely into the door frame. At the time of the observation, the Facility Maintenance Manager acknowledged the inability of the door to remain closed in the frame. Ref: 2000 NFPA 101, Section 19.3.6.3.2	K 018		
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	K-029 The gap around the fire sprinkler in the kitchen storage room was filled on 1-23-2015. All other sprinklers were also checked and noted to be fine at this time. Maintenance staff was in serviced on 1-26-2015 about the proper way to inspect sprinkler heads for gaps while performing the monthly in house sprinkler system check. All sprinklers will be inspected monthly, and any issues will be reported to the QA committee. Compliance date: 1-30-2015	

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K 029	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to separate hazardous areas from other spaces by smoke resisting partitions in 1 of 5 smoke compartments. The findings were: Observation of the Kitchen Storage Room on 1/12/15 at 8:49 AM revealed a 1/2 inch round penetration in the wall surrounding the sprinkler head. At the time of the observation the Facility Maintenance Manager acknowledged the penetration. Ref: 2000 NFPA 101, Section 19.3.2.1	K 029		
K 050 SS=D	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 document review and staff interview, the facility failed to conduct fire drills at least quarterly on each shift. The findings were: Document review on 01/12/15 from 10:00 AM to	K 050	K-050 Fire drill schedule was updated on 1-19-2015 to allow for unexpected times and varying conditions, while still holding a drill on each shift during a quarter. Drills will be gone over with department heads in morning meeting to monitor dates of drills. Any concerns will be addressed by the QA committee Compliance date: 1-28-2015	

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K 050	Continued From page 3 10:40 AM revealed that no record of fire drills were available for the first shift during the third quarter of 2014, and third shift during the fourth quarter of 2014. Interview with the Facility Maintenance Manager verified that documentation was not available. Ref: 2000 NFPA 101, Section 19.7.1.2	K 050		
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 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that automatic sprinkler systems are continuously maintained per the requirements of NFPA 25. The findings were: Observation of the bathroom sprinkler head located in Room #205 on 01/12/15 at 9:24 AM revealed wall texture had been sprayed on the sprinkler head during the bathroom remodel. At the time of the observation, the Facility Maintenance Manager acknowledged the texture sprayed on the sprinkler head. Ref: 2000 NFPA 101, Sections 19.7.6 and 4.6.12.1 Ref: 1998 NFPA 25, Section 2-2.1.1	K 062	K-062 Bathroom sprinkler in room 205 was cleaned with water to remove texture overspray on 1-23-2015. All sprinklers in the building were inspected at this time and no others were found to have this issue. Maintenance staff was in serviced on 1-26-2015 about the proper way to protect sprinkler heads from texture during maintenance of rooms. This was done to ensure this problem does not happen in the future. Any future concerns will be reported to QA committee Compliance date: 1-30-2015	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no	K 066		

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K 066	Continued From page 4 less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure ashtrays of noncombustible material and metal containers with self-closing covers were being utilized. The finding were: Observation of the smoking area off the dining room on 01/12/15 at 9:46 AM revealed the area was provided with noncombustible ashtrays and metal containers with self-closing lids into which ashtrays could be readily emptied. However upon further observation it was revealed that	K 066	K-066 The trash can was removed from the smoking area adjacent to the dining room on 1-22-2015 to prevent smokers from using it as an ash tray. Both metal ash treys were then moved to a position to be more accessible for the smokers to use. The trash can will not be replaced. Maintenance director will meet with resident council on 2-3-2015 to go over smoking policy, including proper disposal of smoking materials, and the reason the trash can was removed. All staff will also be reminded of smoking policy including disposal of smoking materials at the staff in services on 1-30-2015. Any further problems will be reported to the QA committee. Compliance Date 2-3-2015	

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K 066	Continued From page 5 individuals had been using the garbage can to extinguish cigarettes. Inspection of the lid revealed multiple back marks were cigarettes had been extinguished. Opening the lid of the garbage can revealed multiple cigarette butts located on top of combustible material. At the time of the observation, the Facility Maintenance Manager acknowledge the burn marks on the lid of the garbage can and the cigarette butts located inside the can itself. Ref: 2000 NFPA 101, Section 19.7.4	K 066		