STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING 0[illegible] - MAIN BUILDING 01 B. WING	02/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET CASPER, WY 82601

(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 with plan approval in 1992. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch and an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 106 residents.	K 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or 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 the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in an accordance with the Sate Operations Manual.	
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 doors of resident rooms #107 and #105 were adjusted on 3/5/15 to ensure that the doors closed and latched properly. 2. A random audit of resident doors were inspected on 3/5/15 to ensure proper closure and latching. Any doors found to not close and/or latch properly were fixed upon discovery. 3. Maintenance person and or designee will inspect a random sampling of resident doors to ensure proper closure and latching weekly for	3/6/15

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

E.D. 3/6/15

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 Admin. Stetor Mathew Guerthman on 3/11/15 at 11:25 Am 34354

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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 protecting corridor openings that are capable of resisting the passage of smoke in 1 of 7 smoke compartments. The findings were: Observation of resident room #105 at 2:16 PM, and resident room #107 at 2:17 PM on 02/11/2014 revealed the doors would not latch and close completely into the door frame. At the time of the observations, the Facility Maintenance Manager acknowledged the inability of the doors to latch into the door frame and remain in a closed position. Ref: 2000 NFPA 101, Sections 19.3.6.3.1 and 19.3.6.3.2	K 018	one month and monthly thereafter for the following two month. 4. All audits and repairs will be summarized, reported and reviewed by the P.I. Committee on a monthly basis for the next three months. The P. I. Committee is the quality assurance group within the facility that is composed of the Executive Director, Director of Nursing, Medical Director and other department managers. The group meets monthly to review clinical audits, customer service issues and other regulatory compliance issues. If a problematic trend(s) is identified the committee develops, or causes the development, of an action plan designed to mitigate the chance of recurrence. The results of the action plan are reviewed in subsequent months for effectiveness and modified as necessary.	
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	K029 1. A. The doors to the copy room and activity room were inspected and closures were adjusted to close properly on 3/4/15. B. Closures were added to the therapy storage room door and the medical records door on 3/6/15. 2. A random audit of office doors were inspected to ensure proper closure on 3/6/15. Any doors found to not close properly will be fixed upon discovery.	3/6/15

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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 ensure hazardous areas were protected from the corridor with self-closing doors in 1 of 7 smoke compartments. The findings were: 1. Observation of the Copy Room on 02/11/2015 at 1:40 PM revealed the door was provided with a self-closing device, but the device would not fully close the door into the frame. At the time of the observation, the Facility Administrator acknowledged the door would not fully close into the frame. 2. Observation of the Physical Therapy Storage Room on 02/11/2015 at 1:58 PM revealed the room was being utilized for the storage of wheel chair pads and other physical therapy equipment. Further observation revealed the lack of a self-closing or automatic closing device on the door. At the time of the observation the Facility Maintenance Manager and the Physical Therapy Manager acknowledged the door was not provided with a self-closing device. 3. Observation of the Activities Office on 02/11/2015 at 2:25 PM revealed the door was provided with a self-closing device, but the device would not fully close the door into the frame. At the time of the observation the, Facility Maintenance Manager acknowledged the door would not fully close into the frame 4. Observation of the Medical Records Office on 02/11/2015 at 2:55 PM revealed the room was utilized for the storage of patient records and files. Further observation revealed the lack of a	K 029	3. Maintenance person will perform weekly inspections of a random sample of office doors to ensure proper closure for one month and monthly for the two months thereafter. Any doors found to not close properly will be fixed upon discovery. 4. All audits and repairs will be summarized, reported and reviewed by the P.I. Committee on a monthly basis for the next three months. K038 1. The discharge door on unit one was serviced and adjusted on 3/6/15 to take less than 15 lbs. of pressure to open. 2. All discharge doors were inspected to ensure they take less than 15 lbs. to open on 3/6/15. Any doors found to not meet that standard were fixed upon discovery. 3. Maintenance person will perform inspections of all exit doors on a weekly basis for the next month and on a monthly basis for the following two months thereafter. Any doors found to not meet the standard will be fixed upon discovery. 4. All audits and repairs will be summarized, reported and reviewed by the P.I. Committee on a monthly basis for the next three months.	3/6/15

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K 029	Continued From page 3 self-closing or automatic closing device on the door. At the time of the observation the Facility Maintenance Manager acknowledged the door was not provided with a self-closing device. Ref; 2000 NFPA 101, Section 19.3.2.1	K 029	K050 1. The facility performed a fire drill for the evening shift on 3/6/15. 2. Surveyor completed a 100% audit for the previous year and evening shift in the second quarter was the only omission for 2014. 3. TELS system tracks and audits required drills. Documentation of these drills will be printed and tracked in a separate binder as well. 4. All audits and drills will be summarized, reported and reviewed by the P.I. Committee on a monthly basis for the next three months.	3/6/15
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure delayed-egress doors for an exit discharge are functional in 1 of 7 smoke compartments. The findings were: Observation of the Unit 1 exit discharge door on 02/11/2015 at 2:20 PM revealed that the door required more than 15 lbf to activate the release process of the delayed-egress. At the time of the observation, the Facility Maintenance Manager acknowledged the excessive force required to activate the release process. Ref: 2000 NFPA 101, Sections 19.2.1 and 7.2.1.6.1(c)	K 038	K052 1. A. Performed Battery test for the first half of 2014 on 3/5/15. B. Activated System for this month on 3/2/15. 2. Surveyor completed audit of the past year battery tests and system activation. The first half of 2014 was the only battery test missing and activations in April and September were missing. 3. TELS system tracks and monitor compliance with semi-annual battery testing as well as monthly activation of system. Documentation will be printed and tracked in a separate binder as well. 4. All audits and documentation will be summarized, reported and reviewed by the P.I. Committee on a monthly basis for the next three months.	3/6/15
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	K 050		

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K 050	Continued From page 4 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 provide fire drills at least quarterly on each shift. The findings were: Document review on 02/12/2015 from 8:10 AM to 9:00 AM revealed that no record of a fire drill was available for the second shift during the second 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	K072 1. The facility's E.D. cleared all exits (including physical therapy exit, all 5 resident corridors and the employee entrance) of all wheelchairs, patient lifts and housekeeping carts on 3/5/15. The exits now have free egress. 2. The facility's E.D. or designee inspected all exits on 3/5/15. 3. Systemically, all staff will be trained on or before 3/6/15 as to the prohibition of equipment in corridors/exits blocking free egress. In addition, the facility's E.D. or designee will inspect each exit daily (5 days per week) for two weeks, weekly for one month and monthly thereafter until compliance is maintained to ensure free egress. 4. All results of these inspections will be summarized, reported and reviewed by the P.I. Committee on a monthly basis for the next three months.	3/6/15
K 052 SS=D	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	K147 1. Covers were placed on all three cited junction boxes on 3/4/15 by the facility's maintenance person. 2. The surveyor inspected 100% of the attic junction boxes and no others had exposed wires. 3. The attic will be inspected by the facility's maintenance person and/or his designee monthly for the next three	

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K 052	Continued From page 5 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to provide documentation indicating that the fire alarm systems had been tested in accordance with NFPA 72. The findings were: Document review of the testing and maintenance documentation on 02/12/2015 from 8:10 AM to 9:00 AM revealed that semi-annual battery load voltage test had not been completed the first half of 2014. Further review revealed documentation could not be provided for monthly systems activation in the months of April and September of 2014. At the time of the review, the Facility Maintenance Manager acknowledged the lack of documentation. Ref: 2000 NFPA 101, Sections 19.3.5.1 and 9.7.5 1999 NFPA 72, Table 7-3.2 sections 6 and 23	K 052	months to ensure there are no exposed wires. 4. All results of these inspections will be summarized, reported and reviewed by the P.I. Committee on a monthly basis for the next three months.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 072		

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K 072	Continued From page 6 facility failed to maintain means of egress free of all obstructions or impediments to full instant use. The findings were: 1. Observation of the Physical Therapy exit on 02/11/2015 at 2:00 PM revealed the exit was blocked by three wheelchairs. At the time of the observation the Facility Administrator, Facility Maintenance Manager, and the Physical Therapy Manager all acknowledged the blocked exit. The wheelchairs where moved immediately upon observation. 2. Observation of all 5 Resident Corridors on 02/11/2015 from 1:45 PM to 3:00 PM revealed patient lifts being stored in the corridors, partially obstructing the means of egress. At the time of the observations, the Facility Administrator and Facility Maintenance Manager acknowledged the patient lifts in the corridors. 3. Observation of the Employee Entrance Corridor on 02/11/2015 at 3:10 PM revealed 3 janitorial carts stored in the corridor, partially obstructing the means of egress. At the time of the observation the Facility Administrator and Facility Maintenance Manager acknowledged the carts in the corridor. Ref: 2000 NFPA 101, Sections 19.2.1 and 7.1.10.1	K 072		
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	K 147		

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K 147	Continued From page 7 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 of the Facility Attic on 02/11/2015 from 3:40 PM to 4:00 PM revealed 3 exhaust fans had been removed. The junction boxes were left open with wires exposed. At the time of the observation, the Facility Maintenance Manager acknowledged the exposed wiring in all three locations. Ref: 2000 NFPA 101, Sections 19.5.1 and 9.1.2 1999 NFPA 70, Article 200	K 147		