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

PRINTED: 08/06/2015
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 _____ MAIN BUILDING 01 B. WING _____	07/21/2015

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 48 residents. A two 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 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	The facility will provide doors in sprinklered buildings that resist the passage of smoke. There is no impediment to the closing of doors. This will be accomplished by: 1. The corridor door to the Beauty Salon will be adjusted by maintenance that when activated, will fully close and latch the door into the frame. 2. Maintenance employees will evaluate corridor doors in the Living Center to ensure that all doors when activated, will fully close and latch the door into the frame.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia Weber RN MSN — TITLE: Administrator — (X6) DATE: 8/14/15

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 Patricia Weber on 8/24/15 @ 2:37pm. 34/54

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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 that resisted the passage of smoke in 1 of 5 smoke compartments. The findings were: Observation on 07/21/15 at 10:05 AM revealed the corridor door to the Beauty Salon was provided with a self-closing device, but when activated would not fully close and latch the door into the frame. At the time of the observation the Facility Maintenance Manager acknowledged the door would not fully close and latch into the frame. Ref: 2000 NFPA 101, Sections 19.3.6.3.1 and 19.3.6.3.2	K 018	3. Director of Facilities will establish a PM that all doors be evaluated to ensure appropriate closure into the frame at least twice a year. Doors will be adjusted when appropriate. 4. A report of this correction will be reported to the Living Center Performance Improvement Committee at the next quarterly meeting in October 2015 by the NHA.	9-4-15
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 continuously maintain a means of	K 038	The facility will continuously maintain a means of egress free of obstructions or impediments to full instant use in case of fire or emergency within smoke compartments. This will be accomplished by: 1. The north solarium exit door will be adjusted by the maintenance department to allow no more than 15# to unlatch the door.	

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K 038	Continued From page 2 egress free of obstructions or impediments to full instant use in case of fire or emergency in 1 of 5 smoke compartments. The findings were: Observation on 07/21/15 at 9:50 AM revealed the North Solarium exit door required more than 15lbf to unlatch the door due to mis-alignment. At the time of the observation the facility maintenance manager acknowledged the excess force needed to unlatch the door. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.4.5	K 038	2. The maintenance department will evaluate all fire door egresses to ensure that the doors can be opened using no more than 15# to unlatch the door. 3. The Director of Facilities will implement a PM that all main egress doors be evaluated quarterly to ensure that no more than 15# as needed to unlatch the door. 4. A report of this correction will be reported to the Living Center Performance Improvement Committee at the next quarterly meeting in October 2015 by the NHA.	9-4-15
K 047 SS=D	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, the facility failed to maintain exit signage to ensure continuous illumination. The findings were: Observation on 07/21/15 at 10:15 AM revealed both the East and North Kitchen exit signs were not continuously illuminated. The bulbs were burned out in both exit signs. At the time of the observations the Facility Maintenance Director acknowledged the signs were not illuminated. Ref: 2000 NFPA 101, Sections 19.2.10.1 and 7.10.5.2	K 047	The facility will maintain exit signage to ensure continuous illumination. This will be accomplished by: 1. Maintenance will replace the two exit light bulbs in the east and north kitchen. 2. Maintenance will round to ensure that all exit light bulbs are functioning. 3. A PM has been established by the Director of Facilities to have Maintenance round at least twice a year to ensure that all exit lights are functioning continuously. Maintenance and Living Center employees will submit a work order when they observe that an exit light is not lit. 4. A report of this correction will be reported to the Living Center Performance Improvement Committee at the next quarterly meeting in October by the NHA.	9-4-15

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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 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to provide documentation identifying certification of the central station fire alarm system in accordance with NFPA 72. The findings were: Document review of the central station fire alarm system on 07/21/15 at 10:30 AM revealed that UL certificate was not posted on or near the fire alarm system. At the time of the review the Facility Maintenance Manager acknowledge the certificate was not posted. Ref: 2000 NFPA 101, Section 19.3.4.1 and 9.6.1.4 1999 NFPA 72, Section 1-6.2.3.1.1	K 052	The facility will provide documentation identifying certification of the central station fire alarm system in accordance with NFPA 72. This will be accomplished by: 1. A UL certificate identifying certification of the central station fire alarm system will be obtained and posted on or near the fire alarm system. 2. The Director of Facilities will ensure that the document certifying the central fire alarm system always be posted on or near the fire alarm system. 3. A report of this correction will be reported to the Living Center Performance Improvement Committee at the next quarterly meeting in October by the NHA.	9-4-15